URGENT: DRUG RECALL – RESPONSE FORM

Please Complete This Form and Fax to: 817-868-5362
or Email to: rxrecalls@inmar.com

Product Name	Lot Number	UPC Number	NDC Number	Expiration Date
Fexofenadine HCl and Pseudoephedrine HCl Extended-Release Tablets, USP, 60 mg/120 mg "Wal-Fex D®" (30 Count)	GKS1014	3 11917 19454 7	0363-2110-30	09/2019
Fexofenadine HCl and Pseudoephedrine HCl Extended-Release Tablets, USP, 60 mg/120 mg "Wal-Fex D®" (20 Count)	GKT0406	3 11917 19453 0	0363-2110-20	03/2020
Fexofenadine HCl and Pseudoephedrine HCl Extended-Release Tablets, USP, 60 mg/120 mg "Wal-Fex D®" (30 Count)	GKT0484A	3 11917 19454 7	0363-2110-30	04/2020
Fexofenadine HCl and Pseudoephedrine HCl Extended-Release Tablets, USP, 60 mg/120 mg "Allergy Relief D" (30 Count)	GKT0484B	0 50428 39131 0	69842-990-30	04/2020
Fexofenadine HCl and Pseudoephedrine HCl Extended-Release Tablets, USP, 60 mg/120 mg "Allergy Relief D" (20 Count)	GKT0791	0 50428 43023 1	69842-990-20	06/2020

Please check ALL appropriate boxes.

□ I have read and understand the recall instructions provided in the June 5, 2019 letter.

□ I have checked our stock and have quarantined inventory consisting of _____ units.

□ Indicate disposition of recalled product:

□ returned (**specify quantity, date and method**)/held for return;

Number of Labels Required for Return to Inmar: _____

□ previously destroyed (**specify quantity, date and method**);

□ I have identified and notified my retail customers that were shipped or may have been shipped this product by (**specify date and method of notification**); or

□ Attached is a list of retail customers who received/may have received this product. Please notify my customers.

For return of affected product, please email rxrecalls@inmar.com or call 1-800-967-5952.

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Product Name	Affected Lots
Fexofenadine HCl and Pseudoephedrine HCl Extended-Release Tablets, USP, 60 mg/120 mg	GKS1014, GKT0406, GKT0484A, GKT0484B, and GKT0791

Any adverse events associated with recalled product? □ Yes □ No
If yes, please explain: _____

Please check the appropriate box(es) to describe your business

□ wholesaler/distributor
□ grocery corporate headquarters
□ repacker
□ pharmacy
□ retailer
□ hospital pharmacies
□ hospital/medical facility
□ Other:

Customer Name: _____ Title: _____

Company: _____ DEA Number: _____

Address: _____

City: _____State: _____ Zip Code: _____

Phone Number: _____

Customer Debit Memo Number: _____

Wholesaler: _____City\State: _____

Wholesaler DEA Number: _____

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