Sun Pharmaceuticals Industries, Inc.

URGENT: DRUG RECALL – RESPONSE FORM

Decitabine for Injection, 50 mg/vial, 1 vial

Retail Level

07/01/2024

Please fill out this form completely. By doing so, this will acknowledge that you have read and understand the recall instructions and have taken the appropriate action.

Customer Name: | DEA#:

DEA # is required, if it is not provided, the processing of your form will be delayed.

Address:

City: | State: | Zip:

Contact Name (Please Print):

Telephone#: | Email:

Contact Signature: | Date:

DEBIT MEMO# (If unsure, leave blank):

Wholesaler Information if not directly purchased from Sun Pharma:

Wholesaler Name: | DEA#:

City: | State: | Zip:

I have checked my stock and communicated to my customers at the appropriate level:

- ☐ I confirm that all locations that received the impacted products have been notified to the retail level _____(Initial and date)
- ☐ I do not have any stock of the recalled items. **OR**

  ☐ I have quarantined and listed in the box below the quantity of recalled units and I will be returning to Inmar, as soon as possible. Upon receipt of this Response Form, Inmar, will issue return authorization label(s). Please indicate the # of needed box labels_____.

Product Name	Package Description	NDC#	Lot#	Expiration Date	Total Number of Units (number of full cartons) or prescription packs (partial cartons)
Decitabine for Injection 50 mg/vial	1 vial, single-dose in 1 carton	47335-361-41	HAD2964A	07/2024	

If you have any questions regarding this form or product return please contact Inmar at (1-877-887-8784)

Office hours 9:00 am to 5:00pm EST Monday through Friday.

Please fax this form to: 1-817-868-5362 or E-mail rxrecalls@inmar.com

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