RECALL STOCK RESPONSE FORM

Product RECALL 10/23/2015 (Meclizine Hydrochloride Tablets USP, 12.5 mg & 25 mg)

VOLUNTARY RECALL TO THE RETAIL LEVEL

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.

Returned by _____DEA #_____

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

Address_____

City_____ State_____ Zip_____

Contact Name (please print)_____Telephone #_____

Contact Signature _____Date_____

I have checked my stock and:

_____Do not have any stock of the recalled **items**.

OR

Have quarantined and listed in the box below the qty of recalled units 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 _____.

Item Description	NDC	Lot	Exp.	Qty returning
Meclizine Hydrochloride Tablets USP, 12.5 mg	49884-034-01 Bottles of 100 tablets	24820001	NOV 2015	
		25783601	OCT 2016	
		25783801	OCT 2016	
		26731201	AUG 2017	
		26762002	FEB 2018	
Meclizine Hydrochloride Tablets USP, 12.5 mg	49884-034-10 Bottles of 1000 tablets	26683201	AUG 2017	
		26762001	FEB 2018	
Meclizine Hydrochloride Tablets USP, 25 mg	49884-035-01 Bottles of 100 tablets	25552101	AUG 2016	
		25712701	SEP 2016	
		25787902	NOV 2016	
		26074601	JAN 2017	
		26259801	APR 2017	
		26220001	MAR 2017	
		26579001	JUN 2017	

		26731801	NOV 2017	
Item Description	**NDC**	**Lot**	**Exp.**	**Qty returning**
Meclizine Hydrochloride Tablets USP, 25 mg	**49884-035-10 Bottles of 1000 tablets**	**24502301**	**OCT 2015**	
		24505901	**OCT 2015**	
		25787901	**NOV 2016**	
		26074701	**JAN 2017**	
		26259701	**MAR 2017**	
		26575801	**JUN 2017**	
		26579002	**JUN 2017**	
		26682801	**SEP 2017**	
		26682901	**SEP 2017**	
		26731702	**NOV 2017**	
		25960301	**NOV 2017**	
		26764801	**MAR 2018**	

In addition, please check the appropriate response below:

_____We **HAVE** received complaints of adverse events associated with use of the product.

_____We **HAVE NOT** received complaints of adverse events associated with use of the product.

If you did not purchase the product directly from the Manufacturer please complete the below section.

Purchased From: Wholesaler Name _____

City_____ State_____

If you have any questions regarding this form or product return please contact Inmar at 1-800-967-5952, prompt # 1 for recall. Office hours: 7am to 5pm CDT Mon thru Fri.

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