PRODUCT RECALL RESPONSE FORM

URGENT DRUG RECALL - RETAIL

Please complete the required information and fax it to **1-817-868-5362**
or email to **rxrecalls@inmar.com**

To the Attention of Drug Safety/ Recall Services-Viona Pharmaceuticals Inc.

S. No	Product Detail	NDC Number	Lot No.	Exp Date	No. of Bottle Purchased	No of the Bottles consumed	No. of bottles in Possession	No of Bottles to be returned
1.	Dapsone Gel 7.5%	72578-094-03	T400514	02/2026				
2.	Dapsone Gel 7.5%	72578-094-03	T400808	03/2026				
3.	Dapsone Gel 7.5%	72578-094-02	T400513	02/2026				
4.	Dapsone Gel 7.5%	72578-094-02	T400807	03/2026				
5.	Dapsone Gel 7.5%	72578-094-02	T401152	06/2026				
6.	Dapsone Gel 7.5%	72578-094-02	T401303	07/2026				
7.	Dapsone Gel 7.5%	72578-094-02	T401304	07/2026				
8.	Dapsone Gel 7.5%	72578-094-02	T401399	07/2026				
9.	Dapsone Gel 7.5%	72578-094-02	T401696	08/2026				

No. of Returns kit required: _____

Please mark as applicable

__ We currently do not have any inventory of the above-listed Lot/bottles

__ We are notifying our customers

__ We have identified and notified my customers that were shipped or may have been shipped this product by_____;

__ Attached is the list of customers who received/ may have received this product. Please notify my customers.

Any adverse event associated with recalled product? ___ Yes ___ No
If yes, please explain:

Please check appropriate box to describe your business

___ Wholesaler/Distributor

___ Retailers

___ Repackager

___ Manufacturer

___ Pharmacy- Retail

___ Hospital/ Medical Facility

___ Hospital Pharmacies

___ Medical Laboratory

___ Other: _____

Name: _____

Title: _____

Tel Number: _____

Firm Name: _____ DEA#_____

Address: _____

City/ State: _____

If you have not purchased, the concerned lot directly from Viona Pharmaceuticals Inc., then please provide details of your wholesaler: _____(Name, City)

DEA#_____

Signature: _____ Date: _____

20 Commerce Drive, Ste 340, Cranford, NJ 07016
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