

Lupin Pharmaceuticals, Inc.**RECALL****Cefixime for Oral Suspension USP 100 mg/5 mL****Retail Level****8/26/2024**

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 Lupin:

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	NDC#	Lot#	Expiration Date	Total Quantity of Units (full and partial bottles)
Cefixime for Oral Suspension USP 100 mg/5 mL (50 mL pack size)	68180-405-01	F201517	11/30/2024	

If you have any questions regarding this form or product return please contact Inmar at 877-899-0982
Office hours 9am to 5pm EST Mon thru Fri.

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