NOVEN PHARMACEUTICALS, INC
URGENT: DRUG RECALL – RESPONSE FORM
XELSTRYM, 13.5 MG/9HR, 30 patches
CII
Retail Level
10/31/2024

N131227 RCL259-24

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 :

Wholesaler Name:	DEA#:	
City:	State:	Zip:

I have checked my stock and:

- ☐ I confirm that all locations that received the impacted products have been notified to the retail level. (Circle One) **YES** **YES-Corporate Notified** **NO (Why?)**_____

  _____

- ☐ 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 Full Cartons/30 Patches	Total Partial Carton Exact Patch Count
XELSTRYM, 13.5 MG/9HR, 30 patches	68968-0215-3	95598	2/28/2025		

If you have any questions regarding this form or product return please contact Inmar at 877-902-5680 (office hours 9am to 5pm EST Monday through Friday).

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

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