URGENT: DRUG RECALL – RESPONSE FORM

Please Complete This Form and Fax to: 817-868-5362
or Email to: rxrecalls@inmar.com

Product Name	Package Description	Lot Number	NDC Number	Expiration Date
Sumatriptan Succinate Tablets, 50 mg	100 Count Bottle	JKT4175A	62756-521-88	11/2020
Sumatriptan Succinate Tablets, 50 mg	9 (1 x 9) Unit-of-use Tablets	JKU1939A	62756-521-69	04/2022
Sumatriptan Succinate Tablets, 50 mg	9 (1 x 9) Unit-of-use Tablets	JKU1940A	62756-521-69	04/2022
Sumatriptan Succinate Tablets, 50 mg	9 (1 x 9) Unit-of-use Tablets	JKU1940B	62756-521-69	04/2022
Sumatriptan Succinate Tablets, 100 mg	9 (1 x 9) Unit-of-use Tablets	JKT4174A	62756-522-69	11/2021
Sumatriptan Succinate Tablets, 100 mg	9 (1 x 9) Unit-of-use Tablets	JKU0622A	62756-522-69	01/2022
Sumatriptan Succinate Tablets, 100 mg	9 (1 x 9) Unit-of-use Tablets	JKU1308A	62756-522-69	02/2022

Please check ALL appropriate boxes.

□ I have read and understand the recall instructions provided in the January 13, 2020 letter.

□ I have checked our stock and have quarantined inventory consisting of _____ units.

□ Indicate disposition of recalled product:

□ returned (**specify quantity, date and method**)/held for return;

Number of Labels Required for Return to Inmar: _____

□ previously destroyed (**specify quantity, date and method**);

□ I have identified and notified my retail customers that were shipped or may have been shipped this product by (**specify date and method of notification**); or

□ Attached is a list of retail customers who received/may have received this product. Please notify my customers.

For return of affected product, please email rxrecalls@inmar.com or call 1-800-967-5952.

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Product Name	Affected Lots
Sumatriptan Succinate Tablets, 50 mg	JKT4175A, JKU1939A, JKU1940A, and JKU1940B
Sumatriptan Succinate Tablets, 100 mg	JKT4174A, JKU0622A, and JKU1308A

Any adverse events associated with recalled product? □ Yes □ No
If yes, please explain: _____

Please check the appropriate box(es) to describe your business

□ wholesaler/distributor
□ grocery corporate headquarters
□ repacker
□ pharmacy
□ retailer
□ hospital pharmacies
□ hospital/medical facility
□ Other:

Customer Name: _____ Title: _____

Company: _____ DEA Number: _____

Address: _____

City: _____State: _____ Zip Code: _____

Phone Number: _____

Customer Debit Memo Number: _____

Wholesaler: _____City\State: _____

Wholesaler DEA Number: _____

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