hikma.

Hikma Pharmaceuticals USA Inc.

Recall Return Response Form
Retail Level- Initiated 11/03/2020
SODIUM CHLORIDE INJECTION USP, 0.9%, 2mL vial

Please complete and return this form immediately by FAX 1-817-868-5362 or email to rxrecalls@inmar.com.

Please check ALL appropriate boxes:

☐ I have read and understand the instructions provided in the enclosed **Sodium Chloride Injection USP., 0.9%mg/mL, 2 mL vial** recall packet.

☐ I **have** checked my stock of the recalled product listed below and have quarantined inventory and will be returning the number of units shown below. Upon receipt of this Return Response Form, Inmar Rx Solutions, Inc., will issue return authorization shipping label(s) and a return kit.
Please indicate the number of needed box labels _____.

☐ I **do not have** any stock of the below recalled product and will not be making a return.

☐ I **have** informed all my customers of the Retail Level Recall

Recalled Product: Sodium Chloride Injection USP., 0.9%, 2 mL vial, 25 vials/carton and bulk-pack

Lot No.	Exp. Date	Product Packaging	NDC No.	Ship Dates	Total Full unit cartons (sealed)	Total Units (vials)
068322	06/2021	2mL vial/25 pack	0641-0497-25	10/26/2018-09/22/2020		
078338	07/2021	2mL vial/bulk pack	0641-0497-17	08/23/2018-08/23/2018		
088391	08/2021	2mL vial/bulk pack	0641-0497-17	10/16/2018-10/16/2018		
098340	09/2021	2mL vial/bulk pack	0641-0497-17	11/05/2018-11/05/2018		
108325	10/2021	2mL vial/bulk pack	0641-0497-17	11/15/2018-11/15/2018		
010018	01/2023	2mL vial/bulk pack	0641-0497-17	03/19/2020-03/19/2020		

Company Name: _____ DEA# _____

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

Address: _____ City_____

State_____ Zip_____Phone Number: _____

Fax Number: _____ Email Address: _____

Contact Name: ***(please print)*** _____

Contact Name Signature: _____ Date: _____

If you did not purchase the product directly from Hikma (formerly known as West-Ward) please complete the below section:

Purchased From: Wholesaler Name _____DEA #_____

City_____State_____ Zip_____

- If you have any questions regarding this form or product return please contact **Inmar Rx Solutions, Inc.** at 855-627-7295 during office hours from 9:00am to 5:00pm EST, Monday through Friday.
- Please send this form to **Inmar Rx Solutions, Inc.** by FAX: 1-817-868-5362 or E-mail: rxrecalls@inmar.com.
- Please include a copy in the box with your returns to ensure proper credit.