



RECALL RESPONSE FORM

VOLUNTARY RECALL – WHOLESALE LEVEL

PRODUCT DESCRIPTION	NDC NUMBER	LOT #	EXP DATE	Units Returning
Levetiracetam Oral Solution, USP 100 mg/mL, 16 FL OZ	0603-1384-58	0000000106	6/16	

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.

Store Name _____ DEA # _____
**DEA # is required, if not provided the processing of your form will be delayed.*

Address _____

City _____ State _____ Zip _____

Contact Name (please print) _____ Telephone # _____

Contact Signature _____ Date _____

I have checked my stock and:

_____ Do not have any stock of the recalled products listed above.

OR

Have quarantined and listed in the box above the quantity of units the above product lots. I will be returning to CLS MedTurn, an Inmar company, as soon as possible. Upon receipt of this Response Form, CLS MedTurn, an Inmar company, will issue return authorization labels _____ (please indicate the # of box labels needed.)

If you did not purchase the product directly from the Manufacturer please complete the below section.

Purchased From: Name _____ DEA # _____

Address _____

City _____ State _____ Zip _____

If you have any questions regarding this form or product return please contact
CLS MedTurn, an Inmar company at 1-800-967-5952

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