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endo pharmaceuticals
an endo international company

RECALL RESPONSE FORM

Implantation Kit for VANTAS®
(histrelin acetate) subcutaneous implant

PRODUCT DESCRIPTION	LOT #	EXP DATE	Units Returning
VANTAS Implantation Kit	0000000723	5/31/2015	
VANTAS Implantation Kit	0000000725	5/31/2015	
VANTAS Implantation Kit	0000001197	6/30/2015	
VANTAS Implantation Kit	0000001207	6/30/2015	
VANTAS Implantation Kit	0000001208	6/30/2015	
VANTAS Implantation Kit	0000002141	10/31/2015	
VANTAS Implantation Kit	0000002142	10/31/2015	
VANTAS Implantation Kit	0000002172	10/31/2015	
VANTAS Implantation Kit	0000002173	10/31/2015	
VANTAS Implantation Kit	0000002240	10/31/2015	
VANTAS Implantation Kit	0000002241	10/31/2015	
VANTAS Implantation Kit	0000002242	11/30/2015	
VANTAS Implantation Kit	0000002429	12/31/2015	
VANTAS Implantation Kit	0000002430	12/31/2015	
VANTAS Implantation Kit	0000002431	12/31/2015	

This recall impacts the **IMPLANTATION KIT ONLY** and **NOT** the VANTAS® subcutaneous implant.

Please check ALL appropriate boxes:

☐ I have read and understand the recall instructions provided in the January 16, 2015 letter.

☐ I have checked my stock, and I do not have any of the VANTAS® Implantation Kits listed above.

☐ I have checked my stock, and I do have inventory of the VANTAS® Implantation Kits.
- I have quarantined inventory, and I have listed in the box above the quantity of units in the appropriate product lots currently held for return.
- Upon receipt of this Recall Response Form by Inmar, Inmar will issue Return Authorization Labels. Please indicate the number of box labels needed: _____

☐ I would like replacement VANTAS® Implantation Kits sent to me.

☐ I have identified and notified my customers that were shipped or may have been shipped this product by _____ (specify date and method of notification).

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 ☐ Retailer ☐ Hospital pharmacy

☐ Manufacturer ☐ Pharmacy - Retail ☐ Hospital/medical facility

☐ Physician's Office ☐ Other: _____

Please fill out this form completely.

Contact Name_____DEA #_____

Telephone #_____

Firm Name_____

Address_____

City_____State_____Zip_____

Contact Signature_____Date_____

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

Purchased From: Name_____DEA #_____

Address_____

City_____State_____Zip_____

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

If you have any questions regarding this form or product return please contact Inmar at 1-800-967-5952.
Hours: Mon – Fri 7am – 5pm CST