



RECALL RESPONSE FORM

Implantation Kit for SUPPRELIN[®] LA **(histrelin acetate) subcutaneous implant**

PRODUCT DESCRIPTION	LOT #	EXP DATE	Units Returning
SUPPRELIN LA Implantation Kit	0000000248	4/30/2015	
SUPPRELIN LA Implantation Kit	0000000416	4/30/2015	
SUPPRELIN LA Implantation Kit	0000000423	4/30/2015	
SUPPRELIN LA Implantation Kit	0000001095	5/31/2015	
SUPPRELIN LA Implantation Kit	0000001097	5/31/2015	
SUPPRELIN LA Implantation Kit	0000001284	6/30/2015	
SUPPRELIN LA Implantation Kit	0000001406	6/30/2015	
SUPPRELIN LA Implantation Kit	0000001407	6/30/2015	
SUPPRELIN LA Implantation Kit	0000001761	6/30/2015	
SUPPRELIN LA Implantation Kit	0000001784	6/30/2015	
SUPPRELIN LA Implantation Kit	0000001934	10/31/2015	

This recall impacts the **IMPLANTATION KIT ONLY** and **NOT** the SUPPRELIN[®] LA 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 SUPPRELIN[®] LA Implantation Kits listed above.
- ☐ I have checked my stock, and I do have inventory of the SUPPRELIN[®] LA 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 SUPPRELIN[®] LA 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:

- | | | |
|---|--|--|
| <input type="checkbox"/> Wholesaler/distributor | <input type="checkbox"/> Retailer | <input type="checkbox"/> Hospital pharmacy |
| <input type="checkbox"/> Manufacturer | <input type="checkbox"/> Pharmacy - Retail | <input type="checkbox"/> Hospital/medical facility |
| <input type="checkbox"/> Physician's Office | <input type="checkbox"/> Other: _____ | |

Please fill out this form completely.

Contact Name _____ Title _____

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