



## **RECALL RESPONSE FORM**

**Oxycodone HCl / Acetaminophen Tablets, USP 10mg/325mg,  
100 Count Bottle**

### **VOLUNTARY RECALL – RETAIL LEVEL**

<b>PRODUCT DESCRIPTION</b>	<b>NDC NUMBER</b>	<b>LOT #</b>	<b>EXP DATE</b>	<b>Units Returning</b>
Oxycodone HCl/APAP Tablets, USP 10mg/325mg	0603-4982-21	T062A14A	12/15	

**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.

The affected product was distributed by Qualitest between April 11, 2014 and July 16, 2014.

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 notified my customers that were sold/shipped affected recalled product**

Circle one: YES or NO-I did not sell/ship affected product.

#### **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 to be returned. I will be returning the product 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**