



Jan 19, 2012

Dear McLane Retail Store;

In order to facilitate expeditiously the return of all affected Novartis Consumer Health recall product, we will need each retail store to execute the following action plan

- McLane retail outlet must either email the completed Product Response form to BRFResponse@Inmar.com or fax the attached completed Product Response form to Inmar at 888-908-8603 prior to shipping product back to Inmar.
- A copy of the completed Product Response form MUST be put inside the return box.

McLane retail outlet must put recall affected product in box and return to Inmar via one of the following Drop off location types:

- FedEx Kinkos Store
- FedEx Customer Counter (at a FedEx facility)
- Hand to a FedEx Driver
- We have attached a facsimile of the FedEx label you need to get from FedEx with all the applicable information
 - The Return authorization #: 535MultiB 0112 which must be in the reference field.
 - The return location: INMAR-Ft. Worth
4200 Empire Rd
Ft. Worth, TX 76155
 - Your store address.
- Insure you advise FedEx of the Novartis Account # **317 531877**.

[Credit for returns will be provided to McLane who will in turn credit retail.](#)

These returns must be effected/completed within the next 60 days. Failure to follow all the above steps completely may result in your retail location not getting credit for the returned product.

Thank you



Product Recall Response Form

Recall of Multiple Excedrin[®], Gas X[®] -Prevention[®], Bufferin[®] and No Doz[®] SKUs

Date: _____

From: *Customer Name:* _____

Mailing Address: _____ *Contact Name:* - _____

_____ *Tel Number:* _____

McLane Division: _____

McLane Account Number: _____

Please check all that apply:

We have read and understand the recall instructions provided in the January____, 2012 Recall Notice for Excedrin[®], GasX[®] Prevention[®], Bufferin and No Doz[®] SKUs

We have none of the recalled product in-stock.

We have the recalled product in- stock, and have placed it on hold: **Please see the attachment for all affected SKUs. Please indicate on the attachment the quantity of returned products.**

For those customers that have further shipped any of the recalled products:

We have notified our consignees to advise them about this recall and included a copy of the Recall Notice.

Product Return: We would like a Returns Kit containing pre-paid shipping labels to return product directly to Inmar. We will need _____ shipping labels.

PLEASE EMAIL OR FAX COMPLETED PRODUCT RECALL RESPONSE FORM TO: INMAR
Fax - # 1-888-908-8603; Email – BRFResponse@inmar.com Questions: 1-800-821-5293

NOTE: Credit will not be issued if form is not filled out completely.

Please indicate amount of returned product below.

Item Number	Description	Pack	Repack	Size	GTIN	Number of Returned Units
446914	EXCEDRIN BACK&BODY	1	24	24 CT	10300676238248	
160887	EXCEDRIN EXTRA STRNGHT	1	72	24 TABS	10300672030242	
472936	EXCEDRIN MIGRAINE CAPS	1	24	24 CT	10300672039245	
146175	EXCEDRIN MIGRAINE TABS	1	24	24 TBLTS	10300672037241	
83600	EXCEDRIN PM	1	24	24 TABS	10300672053241	
432690	NO DOZ CAPLETS	1	36	16CT	40300672070164	