Adverse Event Reporting Form

Whether you are a patient, caregiver or healthcare professional, it is important to report adverse events:

- Please provide as many details as possible to help us to understand the case better.

Disclaimer: *Reporting on ADR/ adverse reactions is a voluntary act, and all information will be treated confidentially. While we value your input, reporting does not constitute medical advice or diagnosis. The ADR form should not be misused or submitted for any purpose other than reporting genuine adverse events. Data may be shared with regulatory authorities as required by prescribed law. We recommend seeking professional medical advice for any health concerns related to the product.*

Note If you don't have the information for the required fields, please state not applicable "NA". If reporting from within the EEA or the UK, please provide initials ONLY; providing other identifiers is optional.*

***Required field**

This adverse event, contact details and the personal information provided shall be handled by Amneal in accordance with Amneal's Privacy Policy. Which is available here https://amneal.com/internet-privacy-policy/ *

☐ I acknowledge Amneal's Privacy Policy

Date of this Report (dd-mmm-yyyy) *

Reporter's Initials *

Does Amneal have permission to contact the Patient's Healthcare Professional about the event you are reporting? Selecting Yes will require the below contact information fields to be filled.

☐ Yes ☐ No ☐ Yes, I am the Healthcare Professional

Reporter's Contact No.

Reporter's Email Id

Reporter Is *

☐ Physician ☐ Other Healthcare Professional ☐ Patient
☐ Family ☐ Caregiver ☐ Other

*Required field

Patient's Initial *

Patient's Age or Date of Birth

Patient's Gender *

☐ Male ☐ Female ☐ Unknown

Patient's Weight (kg)

Does Amneal have permission to contact the Patient about this report?
Selecting Yes will require the below contact information fields to be filled.

☐ Yes ☐ No

Patient's Contact No.

Patient's Email ID

Country where event occurred *

☐ United States of America ☐ India ☐ Other

Adverse Event Description *

Event Reaction Start Date (dd-mmm-yyyy)

Event Reaction Stop Date (dd-mmm-yyyy)

Event Outcome

☐ Recovered/Resolved ☐ Recovering/Resolving ☐ Not recovered/Not resolved / Ongoing
☐ Recovered/Resolved with sequelae ☐ Fatal ☐ Unknown

Product's Name (*Brand/ Generic*) *

Dosage Formulation (*for e.g. Tablet, Capsule, Injection and etc.*).

Product's Strength (*for e.g. 10 mg, 10 ml and etc.*)

Batch/Lot Number

Expiry Date (dd-mmm-yyyy)

Dose