United States District Court
Eastern District of Pennsylvania

In Re: Suboxone (Buprenorphine Hydrochloride and Nalaxone) Antitrust Litigation	Civil Action No. 2:13-md-02445

INSTRUCTIONS FOR SUBMITTING YOUR CLAIM FORM

A Third-Party Payor ("TPP") End Payor Class member, or an authorized agent for a TPP, can complete this Claim Form. If both an End Payor Class member and its authorized agent submit a Claim Form, the Settlement Administrator will only consider the End Payor Class member's Claim Form. The Settlement Administrator may request supporting documentation in addition to the documentation and information requested below. The Settlement Administrator may reject a claim if the End Payor Class member or their authorized agent does not provide all requested documentation in a timely manner.

If you are an End Payor Class member submitting a Claim Form on your own behalf, you must provide the information requested in "**Section A – COMPANY OR HEALTH PLAN END PAYOR CLASS MEMBER ONLY**," in addition to the other information requested by this Claim Form.

If you are an **authorized agent** of one or more End Payor Class members, you must provide the information requested in "**Section B – AUTHORIZED AGENT ONLY**," in addition to the other information requested by this Claim Form. **Do not submit a Claim Form on behalf of any End Payor Class member unless that End Payor Class member provided you with prior written authorization to submit this Claim Form. Such written authorization must accompany this Claim Form.**

If you are submitting a Claim Form only as an authorized agent of one or more End Payor Class members, you may submit a separate Claim Form for each End Payor Class member, OR you may submit one Claim Form for all such End Payor Class members as long as you provide the information required for each End Payor Class member on whose behalf you are submitting this Claim Form.

If you are submitting Claim Forms both on your own behalf as an End Payor Class member AND as an authorized agent on behalf of one or more End Payor Class members, you should submit one Claim Form for yourself, completing Section A and another Claim Form or Claim Forms as an authorized agent for the other End Payor Class member(s), completing Section B.

To qualify to receive a payment from the Settlement, you must complete and submit this Claim Form either on paper or electronically on the website, www.SuboxAntitrust.com, and you may need to provide certain requested documentation to substantiate your Claim.

Your failure to complete and submit the Claim Form postmarked (if mailed) or received (if submitted online) on or before **February 17, 2024,** will prevent you from receiving any payment from the Settlement. Submission of this Claim Form does not ensure that you will share in the payments related to the Settlement. If the Settlement Administrator rejects or reduces your Claim, you may invoke the dispute resolution process described on page 6.

CLAIM INFORMATION AND DOCUMENTATION REQUIREMENTS

Please provide the following information to support your Claim of membership in a class defined as follows ("End Payor Class"):

All persons or entities who purchased and/or paid for some or all of the purchase price for Co-Formulated Buprenorphine/Naloxone (Suboxone and/or its AB-rated generic equivalent) in any form, for consumption by themselves, their families or their members, employees, plan participants, beneficiaries or insureds in Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming, and District of Columbia between December 22, 2011 and August 21, 2023, the date on which the Court entered the Plaintiffs' proposed Preliminary Approval Order (the "Class Period").

a) Unique patient identification number or code

b) NDC Number (a list of NDC Numbers can be downloaded from the Settlement website, www.SuboxAntitrust.com) – *e.g.*, 00000-0000-00

c) Fill Date or Date of Service – *e.g.*, 1/1/2012

d) Location (State) of Service – *e.g.*, CA

e) Amount Billed (not including dispensing fee) – *e.g.*, $123.50

f) Amount Paid by the TPP net of co-pays, deductibles, and co-insurance – *e.g.*, $118.50

If you are submitting a Claim Form on behalf of multiple End Payor Class members, also provide the following information for each purchase or reimbursement:

g) Plan or Group Name

h) Plan or Group FEIN

For your convenience, an exemplar spreadsheet containing these categories is attached at the end of this Claim Form. In addition, an Excel spreadsheet can be downloaded from the website, www.SuboxAntitrust.com. Please use this format if possible. Following the exemplar spreadsheet, the website provides a list of the NDCs that the Settlement Administrator will consider. If possible, please provide the electronic data in Microsoft Excel, ASCII flat file pipe "|", tab-delimited, or fixed-width format.

Transaction data supporting claims is mandatory for claims of $300,000 or more, although the Settlement Administrator may also require transaction data for claims of less than $300,000, so keep related transaction data and any other documentation supporting your Claim in case the Settlement Administrator requests it later. If your Claim is for less than $300,000, you should still provide the transaction data with your Claim submission if you can. If, after an audit of your Claim, the Settlement Administrator still has questions about your Claim and you have not provided sufficient substantiation of your Claim, the Settlement Administrator may reject your Claim.

Please contact the Settlement Administrator at 1-877-311-3735 with any questions about the required claims information or documentation. Please do not contact the Court concerning this matter.

MUST BE POSTMARKED ON OR BEFORE, OR SUBMITTED ONLINE BY FEBRUARY 17, 2024.

THIRD-PARTY PAYOR CLAIM FORM

Use Blue or Black Ink Only

ATTENTION: THIS FORM IS ONLY TO BE FILLED OUT ON BEHALF OF A THIRD-PARTY PAYOR (OR AN AUTHORIZED AGENT) AND NOT INDIVIDUAL CONSUMERS.

- Complete Section A only if you are filing as an individual TPP End Payor Class member.
- Complete Section B only if you are an authorized agent filing on behalf of one or more TPP End Payor Class members.

Section A: Company or Health Plan End Payor Class Member Only

Company or Health Plan Name

Contact Name

Care of (if applicable)

Street Address

Floor/Suite

City

State

Zip Code

Area Code - Telephone Number

Tax Identification Number

Email Address

List other names by which your company or health plan has been known or other Federal Employer Identification Numbers ("FEINs") it has used since December 22, 2011.

☐ Health Insurance Company/HMO

☐ Self-Insured Employee Health or Pharmacy Benefit Plan

☐ Self-Insured Health & Welfare Fund

☐ Other (Explain)

Section B: Authorized Agent Only

As an authorized agent, please check how your relationship with the End Payor Class member(s) is best described (you may be required to provide documentation demonstrating this relationship):

☐ Third-Party Administrator or Administrative Services Only Provider

☐ Pharmacy Benefit Manager

☐ Other (Explain):

Authorized Agent's Company Name

Contact Name

Street Address

Floor/Suite

City

State

Zip Code

Area Code - Telephone Number

Authorized Agent's Tax Identification Number

Email Address

Please list the name and FEIN of every End Payor Class member (*i.e.,* Company or Health Plan) for whom you have been duly authorized to submit this Claim Form (attach additional sheets to this Claim Form as necessary). Alternatively, you may submit the requested list of End Payor Class member names and FEINs in an electronic format, such as Excel or a tab-delimited text file. Please contact the Settlement Administrator to determine what formats are acceptable.

END PAYOR CLASS MEMBER 'S NAME	END PAYOR CLASS MEMBER 'S FEIN

Section C: Purchase Information

The Court-approved plan of allocation provides for different recoveries depending on the state or states in which the Suboxone purchases for which you paid or provided reimbursement were made. The states are divides into two groups, called Repealer States and Non-Repealer States. Please type of print in the boxes below, for the groups or states and territories listed in those boxes, the total amount paid or reimbursed for purchases of Co-Formulated Buprenorphine/Naloxone (Suboxone and/or its AB-rated generic equivalent) in any form during the period December 22, 2011 through August 21, 2023 (the "Class Period"), made by your members, employees, insureds, participants, or beneficiaries in the Repealer States, Non-Repealer States, or both, net of co-pays, deductibles, and or co-insurance.

Do not submit a Claim Form for or on behalf of any of the following excluded groups:

a) Pharmacy benefit managers;
b) Defendant and its officers, directors, management, employees, subsidiaries, or affiliates;
c) All governmental entities, except for government funded employee benefit plans;
d) All persons or entities who purchased Suboxone and its AB-rated generic equivalents for purposes of resale or directly from Defendant or its affiliates; or
e) The judges in this case and any members of their immediate families.

Note that the Court-approved plan of allocation provides for different recoveries depending on the state or states in which your Suboxone purchases were made.

REPEALER STATE SUBOXONE PRESCRIPTIONS	**TOTAL AMOUNT PAID**
Provide the total amount paid or reimbursed for prescriptions of Suboxone and its AB-rated generic equivalents from December 22, 2011 through August 21, 2023, in Alabama, Alaska, Arizona, California, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, West Virginia, and Wisconsin, net of co-pays, deductibles, and co-insurance.	

NON-REPEALER STATE SUBOXONE PRESCRIPTIONS	**TOTAL AMOUNT PAID**
Provide the number of prescriptions and total amount paid for prescriptions of Suboxone and its AB-rated generic equivalents from December 22, 2011 through August 21, 2023, in Arkansas, Colorado, Connecticut, Delaware, Georgia, Idaho, Kentucky, Louisiana, Montana, New Jersey, Oklahoma, Texas, Washington, and Wyoming net of co-pays, deductibles, and co-insurance.	

Section D: Proof of Payment and Disputes Regarding Claim Amounts

Please provide as much of the information requested above as possible. Transaction data supporting claims is mandatory for claims of $300,000 or more, although the Settlement Administrator may also require transaction data for claims of less than $300,000, so keep related transaction data and any other Claim Documentation supporting your Claim (*e.g.*, invoices) in case the Settlement Administrator requests it later. If your Claim is for less than $300,000, you should still provide the transaction data with your Claim submission if you can. If, after an audit of your Claim, the Settlement Administrator still has questions about your Claim and you have not provided sufficient substantiation of your Claim, the Settlement Administrator may reject your Claim.

If the Settlement Administrator rejects or reduces your claim and you believe the rejection or reduction is in error, you may contact the Settlement Administrator to request further review. If the dispute concerning your claim cannot be resolved by the Settlement Administrator and Class Counsel, you may request that the Court review your claim.

To request Court review, you must send the Settlement Administrator a signed written statement that (a) states your reasons for contesting the rejection or payment determination regarding your claim; and (b) specifically states that you "request that the Court review the determination regarding this claim." You must include all Claim Documentation supporting your argument(s). The Settlement Administrator and Class Counsel will present the dispute to the Court for review, which may include public filing with the Court of your claim and the supporting documentation. Please note: Court review should only be sought if you disagree with the Settlement Administrator's determination regarding your claim.

Section E: Certification

By signing below, I hereby swear and affirm that I am familiar with the contents of the Instructions accompanying this Claim Form. I certify that the information I have set forth in the above Claim Form and in any documents attached by me are true, correct, and complete to the best of my knowledge.

I further certify I have provided all of the information requested above to the extent I have it.

To the extent I have been given authority to submit this Claim Form by one or more End Payor Class members on their behalf, and accordingly am submitting this Claim Form in the capacity of an authorized agent with authority to submit it, and to the extent I have been authorized to receive on behalf of the End Payor Class member(s) any and all amounts that may be allocated to them from the Net Settlement Fund, I certify that such authority has been properly vested in me and that I will fulfill all duties I may owe the End Payor Class member(s). If amounts from the Net Settlement Fund are distributed to me and an End Payor Class member later claims that I did not have the authority to claim and/or receive such amounts on its behalf, I or my employer will hold the End Payor Class, Class Counsel, and the Settlement Administrator harmless with respect to any claims made by the End Payor Class member.

I/We hereby submit to the jurisdiction of the United States District Court for the Eastern District of Pennsylvania for all purposes connected with this Claim Form, including resolution of disputes relating to this Claim Form. I/We acknowledge that any false information or representations contained herein may subject me to sanctions, including the possibility of criminal prosecution. I agree to supplement this Claim Form by furnishing documentary backup for the information provided herein upon request of the Settlement Administrator.

I certify that the above information supplied by the undersigned is true and correct to the best of my knowledge and that this Claim Form was executed this _____ day of _____ 20____.

Signature	Position/Title

Print Name	Date

Mail the completed Claim Form to the address below, along with any supporting documentation as described in the CLAIM INFORMATION AND DOCUMENTATION REQUIREMENTS on page 2 above, postmarked on or before **February 17, 2024**, or submit the information online at the website below by that date:

In re Suboxone Antitrust Litigation
c/o A.B. Data, Ltd.
P.O. Box 173080
Milwaukee, WI 53217
Toll-Free Telephone: 1-877-311-3735
Website: www.SuboxAntitrust.com

REMINDER CHECKLIST:

1. Please complete and sign the above Claim Form. Attach or upload any documentation supporting your claim.
2. Keep a copy of your Claim Form and supporting documentation for your records.
3. If you would also like acknowledgement of receipt of your Claim Form, please complete the form online or mail this form via Certified Mail, Return Receipt Requested.
4. If you move and/or your name changes, please send your new address and/or your new name or contact information to the Settlement Administrator at info@SuboxAntitrust.com or via U.S. Mail at the address listed above.