INSTRUCTIONS FOR SUBMITTING YOUR THIRD-PARTY PAYOR CLAIM FORM

A Third-Party Payor ("TPP") Class Member or an authorized agent can complete this Claim Form. If both a Class Member and its authorized agent submit a Claim Form, the Notice and Claims Administrator will only consider the Class Member's Claim Form. The Notice and Claims Administrator may request supporting documentation in addition to the documentation requested below. The claim may be rejected if any requested documentation is not provided in a timely manner.

If you are a Class Member submitting a Claim Form on your own behalf, you must provide the information requested in "**Part 1, Section A – COMPANY OR HEALTH PLAN CLASS MEMBER ONLY**," in addition to the other information requested by this Claim Form.

If you are an **authorized agent** of one or more Class Members, you must provide the information requested in "**Part 1, Section B – AUTHORIZED AGENT ONLY**," in addition to the other information requested by this Claim Form.

You may submit a separate Claim Form for each Class Member, OR you may submit one Claim Form for all such Class Members as long as you provide the information required for each Class Member on whose behalf you are submitting the form.

If you are submitting Claim Forms both on your own behalf as a Class Member AND as an authorized agent on behalf of one or more Class Members, you should submit one Claim Form for yourself, completing Section A and another Claim Form or Forms as an authorized agent for the other Class Member(s), completing Section B. **Do not submit a Claim Form on behalf of any Class Member unless that Class Member provided prior authorization to submit the Claim Form.**

In order to qualify to receive a payment from the Settlements, you must complete and submit this Claim Form either on paper or electronically on the Settlement Website, and you may need to provide certain requested documentation to substantiate your Claim.

Your failure to complete and submit the Claim Form postmarked or filed online by **July 3, 2020**, will prevent you from receiving any payment from the Settlements. Submission of this Claim Form does not ensure that you will share in the payments related to the Settlements. If the Notice and Claims Administrator disputes a material fact concerning your Claim, you will have the right to present information in a dispute resolution process. For more information on this process, visit www.dvtmedslawsuit.com.

CLAIM DOCUMENTATION REQUIREMENTS

Please provide the below information to support your claim for Lovenox® or generic enoxaparin dispensed at pharmacies that the Class Member purchased, paid for or reimbursed for in **Arizona, Arkansas, California, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kansas, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, South Dakota, Tennessee, Utah, Vermont, West Virginia, and Wisconsin**, from September 21, 2011 through September 30, 2015.

a) Unique patient identification number or code.

b) NDC Number (a list of NDC Numbers is included with this Claim Form) – e.g., 00000-0000-00

c) Fill Date or Date of Service – e.g., 01/01/2007

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

e) Amount Billed (not including dispensing fee) – e.g., $40.00

f) Amount Paid by TPP net of co-pays, deductibles, and co-insurance – e.g., $20.00

Information submitted will be covered by the Protective Order entered by the Court. 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 Settlement Website, www.dvtmedslawsuit.com. Please use this format if possible. A list of the NDCs that will be considered by the Notice and Claims Settlement Administrator is provided following the exemplar spreadsheet.

If possible, please provide the electronic data in Microsoft Excel, ASCII flat file pipe "|", tab-delimited, or fixed-width format.

Please provide as much of the requested information as possible. The requested information is by default mandatory for claims of $300,000 or more, although the Notice and Claims Administrator may also require documentation for claims of less than $300,000. For claims of less than $300,000, you should still provide the information if you can, even if not specifically requested by the Notice and Claims Administrator. Claims that do not have any documentary substantiation at all may be rejected.

Do not include in your claim any payments or reimbursements to hospitals or similar healthcare providers. For TPPs, the settlement only includes purchases at pharmacies.

Please contact the Notice and Claims Administrator at **1-888-208-9630** with any questions about the required claims data.

MUST BE POSTMARKED ON OR BEFORE JULY 3, 2020

Enoxaparin Antitrust Settlement
Case No. 15-cv-01100

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 and NOT INDIVIDUAL CONSUMERS OR HOSPITALS

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

Section A: Company or Health Plan Class Member Only

Company or Health Plan Name

Contact Name

Address 1

Address 2

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 September 21, 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 Class Member(s) is best described (you may be required to provide documentation demonstrating this relationship):

☐ Third-Party Administrator

☐ Pharmacy Benefits Manager

☐ Other (Explain):

Authorized Agent's Company Name

Contact Name

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 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 Class Member names and FEINs in an electronic format, such as Excel or a tab-delimited text file saved on a disk. Please contact the Notice and Claims Administrator to determine what formats are acceptable.

CLASS MEMBER'S NAME	CLASS MEMBER'S FEIN

Please type or print in the box below, the total amount paid or reimbursed for Lovenox® or generic enoxaparin dispensed at pharmacies net of co-pays, deductibles, and co-insurance:

- in **Arizona, Arkansas, California, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kansas, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, South Dakota, Tennessee, Utah, Vermont, West Virginia, and Wisconsin**,

- from September 21, 2011 through September 30, 2015.

TOTAL AMOUNT YOU PAID FOR LOVENOX® DISPENSED AT PHARMACIES – NET OF CO-PAYS, DEDUCTIBLES, AND CO-INSURANCE	$
TOTAL AMOUNT YOU PAID FOR GENERIC ENOXAPARIN DISPENSED AT PHARMACIES NET OF CO-PAYS, DEDUCTIBLES, AND CO-INSURANCE	$

For each Class Member for whom you are submitting this Claim Form, please provide as much of the claims data and other information requested in the "CLAIM DOCUMENTATION REQUIREMENTS" section of the instructions above as possible.

The requested information is by default mandatory for claims of $300,000 or more, although the Notice and Claims Administrator may also require documentation for claims of less than $300,000. For claims of less than $300,000, you should still provide the information if you can, even if not specifically requested by the Notice and Claims Administrator. Claims that do not have any documentary support at all may be rejected.

I have read and 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 certify that I or the Class Member I represent paid the total amount set forth above in out-of-pocket expenditures for purchases for purchases of Lovenox® or generic enoxaparin from pharmacies in **Arizona, Arkansas, California, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kansas, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, South Dakota, Tennessee, Utah, Vermont, West Virginia, and Wisconsin**, from a pharmacy, during the period from September 21, 2011 through September 30, 2015. I further certify that I or the Class Member I represent did not opt out of the Class in this Action. Nor did I or the represented Class Member purchase such Lovenox® or generic enoxaparin for purposes of resale. Nor did I or the represented Class Member purchase only Lovenox® without any purchase of generic enoxaparin from September 21, 2011 through September 30, 2015. In addition, I have not (or the represented Class Member has not) served as counsel, officer, director, agent, or employee of any of the Defendants, or a corporate parent, subsidiary, affiliate, or other related entity thereof; or served as a judge or justice assigned to hear any aspect of this lawsuit.

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 a Class Member on its behalf, and accordingly am submitting this Claim Form in the capacity of an Authorized Agent with authority to submit it by the Class Member identified on a separate sheet of paper submitted with this form, and to the extent I have been authorized to receive on behalf of this Class Member(s) any and all amounts that may be allocated to it from the Settlement Fund, I certify that such authority has been properly vested in me and that I will fulfill all duties I may owe the Class Member. In the event amounts from the Settlement Fund are distributed to me and a Class Member later claims that I did not have the authority to claim and/or receive such amounts on its behalf, I and/or my employer will hold the Class, counsel for the Class, and the Notice and Claims Administrator harmless with respect to any claims made by the Class Member.

I hereby submit to the jurisdiction of the United States District Court for the Middle District of Tennessee for all purposes connected with this Claim Form, including resolution of disputes relating to this Claim Form. I 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 Notice and Claims 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, along with any supporting documentation as described in Claim Documentation Instructions on page 2 above, postmarked on or before **July 3, 2020** to:

Enoxaparin Antitrust Settlement
c/o A.B. Data, Ltd.
P.O. Box 173090
Milwaukee, WI 53217
Toll-Free Telephone: 1-888-208-9630
Website: www.dvtmedslawsuit.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 Notice and Claims Administrator via the Settlement Website or U.S. Mail (the addresses are listed above).