**United States District Court**
**District of Massachusetts**

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| IN RE: RANBAXY GENERIC DRUG APPLICATION ANTITRUST LITIGATION | MDL No. 2878<br>Master File No. 19-md-02878-NMG |

## INSTRUCTIONS FOR SUBMITTING YOUR THIRD-PARTY PAYOR PROOF OF CLAIM

An End-Payor Class Member, also known as a Third-Party Payor ("TPP") Class Member, or an authorized agent can complete this Proof of Claim. If both a Class Member and its authorized agent submit a Proof of Claim, the Settlement Administrator will only consider the Class Member's Proof of Claim. 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 Class Member or their authorized agent does not provide all requested documentation in a timely manner.

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

If you are an **authorized agent** of one or more Class Members, you must provide the information requested in "**Section B – AUTHORIZED AGENT ONLY**," in addition to the other information requested by this Proof of Claim. **Do not submit a Proof of Claim on behalf of any Class Member unless that Class Member provided prior authorization to submit the Proof of Claim.**

If you are submitting a Proof of Claim only as an authorized agent of one or more Class Members, you may submit a separate Proof of Claim for each Class Member, OR you may submit one Proof of Claim 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 Proofs of Claim 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 Proof of Claim for yourself, completing Section A and another Proof of Claim or Proofs of Claim as an authorized agent for the other Class Member(s), completing Section B.

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

Your failure to complete and submit the Proof of Claim postmarked (if mailed) or received (if submitted online) on or before **October 11, 2022** will prevent you from receiving any payment from the Settlement. Submission of this Proof of Claim 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 pages 5-6.

### CLAIM INFORMATION AND DOCUMENTATION REQUIREMENTS

Please provide the following information to support your Claim for purchases and/or reimbursement AB-Rated generic Nexium, brand and/or AB-rated generic Diovan, and brand and/or AB-rated generic Valcyte for use by your

members, employees, insureds, participants, or beneficiaries, where such persons purchased the drug in a pharmacy or received the drug by mail-order prescription, in the United States or its territories.

a) Unique patient identification number or code

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

c) Fill Date or Date of Service – *e.g.*, 01/01/2018

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 Proof of Claim on behalf of multiple Class Members, also provide the following information for each purchase or reimbursement:

g) Plan or Group Name

h) Plan or Group FEIN

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 Proof of Claim. In addition, an Excel spreadsheet can be downloaded from the Settlement website, www.RanbaxyTPPLitigation.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 per drug, although the Settlement Administrator may also require transaction data for claims of less than $300,000 per drug, 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 1-877-888-9232 with any questions about the required claims information or documentation.

**MUST BE POSTMARKED ON OR BEFORE, OR SUBMITTED ONLINE BY OCTOBER 11, 2022**

# THIRD-PARTY PAYOR PROOF OF CLAIM AND RELEASE

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 Class Member.
- Complete Section B only if you are an authorized agent filing 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

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 September 28, 2012.

☐ 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 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 Class Member (*i.e.,* Company or Health Plan) for whom you have been duly authorized to submit this Proof of Claim (attach additional sheets to this Proof of Claim 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. Please contact the Settlement Administrator to determine what formats are acceptable.

| CLASS MEMBER'S NAME | CLASS MEMBER'S FEIN |
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## Section C: Purchase Information

Please type or print in the box below, the total amount paid or reimbursed for AB-Rated generic Nexium, brand and/or AB-rated generic Diovan, and brand and/or AB-rated generic Valcyte net of co-pays, deductibles, and co-insurance for use by your members, employees, insureds, participants, or beneficiaries, where such persons purchased the drug in a pharmacy or received the drug by mail-order prescription in the United States and its territories during the applicable time periods.

Please note that certain groups have been excluded from the Classes in this case. Do not submit a Proof of Claim for or on behalf of any of the following excluded groups:

(a) natural person consumers;
(b) Defendants Sun Pharmaceutical Industries Limited and Ranbaxy Inc., their officers, directors, management, employees, subsidiaries, and affiliates;
(c) federal and state governmental entities, except for cities, towns, municipalities, or counties with self-funded prescription drug plans;
(d) entities who purchased Diovan, Nexium, Valcyte, or their AB-rated generic versions for purposes of resale;
(e) fully insured health plans (i.e., health plans that purchased insurance covering 100% of their reimbursement obligation to members);
(f) pharmacy benefit managers; or
(g) any entity that previously submitted a valid exclusion request from one or more of the Classes.

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| **DIOVAN** | TOTAL AMOUNT YOU PAID OR REIMBURSED FOR **BRAND AND/OR AB-RATED GENERIC DIOVAN** NET OF CO-PAYS, DEDUCTIBLES, AND CO-INSURANCE FROM **SEPTEMBER 28, 2012 THROUGH APRIL 1, 2020**: | $ |
| **VALCYTE** | TOTAL AMOUNT YOU PAID OR REIMBURSED FOR **BRAND AND/OR AB-RATED GENERIC VALCYTE** NET OF CO-PAYS, DEDUCTIBLES, AND CO-INSURANCE FROM **AUGUST 1, 2014 THROUGH APRIL 1, 2020**: | $ |
| **NEXIUM** | TOTAL AMOUNT YOU PAID OR REIMBURSED FOR **ONLY AB-RATED GENERIC NEXIUM** NET OF CO-PAYS, DEDUCTIBLES, AND CO-INSURANCE FROM **MAY 27, 2014 THROUGH FEBRUARY 1, 2019**: | $ |

## 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 per drug, although the Settlement Administrator may also require transaction data for claims of less than $300,000 per drug, 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 Lead 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 Lead 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**

I/We have read and am/are familiar with the contents of the Instructions accompanying this Proof of Claim. I/We certify that the information I/we have set forth in the above Proof of Claim and in any documents attached by me/us are true, correct, and complete to the best of my/our knowledge. I/We certify that I/we, or the Class Member(s) I/we represent:

a) paid or reimbursed for brand and/or generic Diovan and Valcyte, and generic Nexium in the total amount set forth above for use by members, employees, insureds, participants, or beneficiaries, where such persons purchased the drug in a pharmacy or received the drug by mail-order prescription, in the United States and its territories in the applicable time periods;

b) did not seek to be excluded ("opt out") from one or more of the Classes in this Action;

c) did not pay for or provide reimbursement of brand and/or generic Diovan and Valcyte, and generic Nexium for purposes of resale;

d) has/have not served as officer, director, management, employee of the Defendants, or their subsidiaries or affiliates; and

e) is/are not a federal and state governmental entities (except that cities, towns, municipalities or counties with self-funded prescription drug plans may submit Proofs of Claims).

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

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

I/We hereby submit to the jurisdiction of the United States District Court for the District of Massachusetts for all purposes connected with this Proof of Claim, including resolution of disputes relating to this Proof of Claim. I/We acknowledge that any false information or representations contained herein may subject me to sanctions,

including the possibility of criminal prosecution. I/We agree to supplement this Proof of Claim 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 Proof of Claim was executed this _____ day of _____, 20____.**

| Signature | Position/Title |
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| **Print Name** | **Date** |
| | |

Mail the completed Proof of Claim to the address below, along with any supporting documentation as described in the CLAIM INFORMATION AND DOCUMENTATION INSTRUCTIONS on pages 1-2 above, postmarked on or before **October 11, 2022**, or submit the information online at the website below by that date:

Ranbaxy TPP Litigation
c/o A.B. Data, Ltd.
P.O. Box 173137
Milwaukee, WI 53217
Toll-Free Telephone: 1-877-888-9232
Website: www.RanbaxyTPPLitigation.com

**REMINDER CHECKLIST:**

1. Please complete and sign the above Proof of Claim. Attach or upload any documentation supporting your claim.
2. Keep a copy of your Proof of Claim and supporting documentation for your records.
3. If you would also like acknowledgement of receipt of your Proof of Claim, 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@RanbaxyTPPLitigation.com or via U.S. Mail at the address listed above.