IN RE OPANA ER ANTITRUST LITIGATION	MDL DOCKET NO. 2580 Lead Case No. 14-cv-10150
This document relates to: END-PAYOR ACTIONS	

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 Claims and Notice Administrator will only consider the Class Member's Claim Form. The Claims and Notice Administrator may request supporting documentation in addition to the documentation and information requested below. The Claims and Notice Administrator may reject a Claim if the TPP Class Member or their authorized agent does not provide all requested documentation 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 "**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 "**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 Class Member unless that Class Member provided prior authorization to submit the Claim Form.**

If you are submitting a Claim Form only as an authorized agent of one or more Class Members, 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.

To qualify to receive a payment from the Settlement, 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 **January 5, 2023**, 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 Claims and Notice 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 of brand or generic Opana ER (oxymorphone hydrochloride extended release) in the 5, 10, 20, 30, and 40 mg strengths, sold by Endo or Impax for use by your members, employees, insureds, participants, or beneficiaries, where such persons purchased the drug in a pharmacy or received brand or generic Opana ER (oxymorphone hydrochloride extended release) by mail-order prescription, in the following states:

> Arizona*, California, Florida, Hawaii, Iowa, Maine, Massachusetts*, Michigan, Minnesota, Missouri, Mississippi*, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Pennsylvania, Oregon, South Dakota, Tennessee, Utah, Vermont, West Virginia, Wisconsin, and the District of Columbia (the "Applicable States") from April 2011 through September 2018.

* *With respect to Arizona, Massachusetts, and Mississippi unjust enrichment claims, Class Members must have purchased, paid for, and/or provided reimbursement for some or all of the purchase price of brand or generic Opana ER (oxymorphone hydrochloride extended release) from June 4, 2011, through September 2018.*

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.*, 01/01/2011
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

If you are submitting a Claim Form on behalf of multiple Class Members, also provide the following information for each prescription:

g) Plan or Group Name
h) Plan or Group FEIN – provide group number for each transaction

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 website, www.OpanaERAntitrustLitigation.com. Please use this format if possible. Following the exemplar spreadsheet, the website provides a list of the NDCs that the Claims and Notice Administrator will consider. 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 information requested above as possible. Transaction data supporting Claims is mandatory for Claims of $100,000 or more, although the Claims and Notice Administrator may also require transaction data for Claims of less than $100,000, so keep related transaction data and any other documentation supporting your Claim (*e.g.*, invoices) in case the Claims and Notice Administrator requests it later. If your Claim is for less than $100,000, you should still provide the transaction data with your Claim submission if you can. If, after an audit of your Claim, the Claims and Notice Administrator still has questions about your Claim and you have not provided sufficient substantiation of your Claim, the Claims and Notice Administrator may reject your Claim.

Please contact the Claims and Notice Administrator at 1-877-888-6423 with any questions about the required Claims information or documentation.

MUST BE POSTMARKED ON OR BEFORE, OR SUBMITTED ONLINE BY, JANUARY 5, 2023

Opana ER Settlement

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 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

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 April 1, 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 or Administrative Services Only Provider

☐ 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. Please contact the Claims and Notice Administrator to determine what formats are acceptable.

CLASS MEMBER'S NAME	CLASS MEMBER'S FEIN

Section C: Purchase Information

Please type or print in the box below, the total amount paid or reimbursed for brand or generic Opana ER (oxymorphone hydrochloride extended release), in the 5, 10, 20, 30, and 40 mg strengths, sold by Endo or Impax 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 brand or generic Opana ER (oxymorphone hydrochloride extended release) by mail-order prescription:

Arizona*, California, Florida, Hawaii, Iowa, Maine, Massachusetts*, Michigan, Minnesota, Missouri, Mississippi*, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Pennsylvania, Oregon, South Dakota, Tennessee, Utah, Vermont, West Virginia, Wisconsin, and the District of Columbia from April 2011 through September 2018.

* *With respect to Arizona, Massachusetts, and Mississippi unjust enrichment claims, Class Members must have purchased, paid for, and/or provided reimbursement for some or all of the purchase price of brand or generic Opana ER (oxymorphone hydrochloride extended release) from June 4, 2011, through September 2018.*

TOTAL AMOUNT YOU PAID FOR BRAND OR GENERIC OPANA ER (OXYMORPHONE HYDROCHLORIDE EXTENDED RELEASE) 5, 10, 20, 30, AND 40 MG SOLD BY ENDO OR IMPAX – NET OF CO-PAYS, DEDUCTIBLES, AND CO-INSURANCE:	$

Authorized Agents Only: For each Class Member for whom you are submitting this Claim Form, please provide the above information with respect to purchases made by the Class Member's members, employees, insureds, participants, or beneficiaries. If you are submitting Claims for multiple Class Members, please provide, separately for each Class Member, as much of the transaction data and other information and documentation requested in the "CLAIM INFORMATION AND DOCUMENTATION REQUIREMENTS" section of the instructions above as possible. Fill out the box above with the combined amounts paid by all Class Members for whom you are submitting this Claim Form, 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 $100,000 or more, although the Claims and Notice Administrator may also require transaction data for Claims of less than $100,000, so keep related transaction data and any other documentation supporting your Claim (*e.g.*, invoices) in case the Claims and Notice Administrator requests it later. If your Claim is for less than $100,000, you should still provide the transaction data with your Claim submission if you can. If, after an audit of your Claim, the Claims and Notice Administrator still has questions about your Claim and you have not provided sufficient substantiation of your Claim, the Claims and Notice Administrator may reject your Claim.

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

To request Court review, you must send the Claims and Notice 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 documentation supporting your argument(s). The Claims and Notice 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 Claims and Notice Administrator's determination regarding your Claim.

Section E: Certification

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(s) I represent, paid or reimbursed for brand or generic Opana ER (oxymorphone hydrochloride extended release) in 5, 10, 20, 30, and 40 mg strengths sold by Endo or Impax 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 brand or generic Opana ER (oxymorphone hydrochloride extended release) by mail-order prescription, in the Class States listed in Section C.

I further certify that I, or the Class Member(s) I represent, did not seek to be excluded ("opt out") from the Classes in this Action. Nor did I, or the represented Class Member(s), pay for or provide reimbursement of brand or generic Opana ER (oxymorphone hydrochloride extended release) for purposes of resale. In addition, I (or the represented Class Member(s)) am/are not among the entities excluded from the Classes, including the following: Defendants and their counsel, officers, directors, management, employees, subsidiaries, or affiliates; Persons or entities whose only purchases of or reimbursements or payments for brand or generic Opana ER (oxymorphone hydrochloride extended release) were of or for the generic Opana ER product sold by Actavis South Atlantic LLC or its successors; All governmental entities and Medicare Part D plans and beneficiaries, except for non-Medicare Part D government-funded employee benefit plans; All persons or entities who purchased Opana ER for purposes of resale or directly from Defendants or their affiliates; Fully insured health plans (plans that purchased insurance from another third-party payor covering 100 percent of the plan's reimbursement obligations to its members); Flat co-payers (consumers who paid the same co-payment amount for brand and generic drugs); Any consumer who purchased only Endo's brand version of Opana ER after the AB-rated generic version became available in January 2013 (*i.e.*, "brand loyalists"); Consumers with copay insurance plans who purchased only generic versions of Opana ER (*i.e.*, "generic-only copay consumers"); Pharmacy Benefit Managers; All Counsel of Record; or the Court, Court personnel, and any member of their immediate families.

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 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 Class Member(s) any and all amounts that may be allocated to them 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(s). If 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 Classes, counsel for the Classes, and the Claims and Notice 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 Northern District of Illinois 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 Claims and Notice 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 INSTRUCTIONS on pages 1-2 above, postmarked on or before **January 5, 2023**, or submit the information online at the website below by that date:

Opana ER Class Action
c/o A.B. Data, Ltd.
P.O. Box 173067
Milwaukee, WI 53217
Toll-Free Telephone: 1-877-888-6423
Website: www.OpanaERAntitrustLitigation.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 Claims and Notice Administrator at info@OpanaERAntitrustLitigation.com or via U.S. Mail at the address listed above.