

**Must be Postmarked
On or Before
May 31, 2013**

For Official Use Only

In re Wellbutrin XL Antitrust Litigation,
Case No. 2:08-cv-2433
U.S. District Court for the Eastern District of Pennsylvania

THIRD-PARTY PAYER CLAIM FORM

The information you provide will be kept confidential and will be used only for administering this Proposed Settlement. If you have any questions please call the Settlement Administrator at **1-800-358-6980**.

A TPP Class Member or an authorized agent can complete this Claim Form. The Settlement Administrator may request supporting documentation. The claim may be rejected if any requested documentation is not provided.

If one or more Class Members has authorized you to submit a Claim Form on its behalf, you must provide the information requested in Section B in addition to the other information requested by this Claim Form. You may submit a separate Claim Form for each Class Member that has duly authorized you to do so, OR you may submit one Claim Form for all such Class Members that have authorized you to do so, as long as you provide the information required (as indicated below) for each Class Member on whose behalf you are submitting the form.

***Your claim form must be postmarked by May 31, 2013 and mailed to
Wellbutrin XL Indirect Purchaser Claims Administrator, PO Box 973, London, KY
40743-0973***

SECTION B – CLASS MEMBER OR AGENT INFORMATION

Class Member's/Authorized Agent's Name

Street Address

Floor/Suite

City

State

Zip Code

()
Area Code – Telephone Number

()
Area Code – Fax Number

Class Member's/Authorized Agent's Tax Identification Number

If you are filing as a Class Member, list other names by which you have been known or other Federal Employer Identification Numbers (“FEINs”) you have used from November 14, 2005 through April 29, 2011.

If you are filing as the Class Member, check the term below that best describes your company/entity:

Health Insurance Company/HMO Self-Insured Employee Health Plan

Self-Insured Union Health & Welfare Fund Other

(Explain): _____

SECTION C – CLAIM BY AUTHORIZED AGENT

Please list the FEIN and the name of every Class Member for whom you have been duly authorized to submit this Claim Form (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 acceptable electronic format. Please contact the Settlement Administrator to determine what formats are acceptable.

SECTION D – TOTAL AMOUNT OF WELLBUTRIN XL REIMBURSEMENTS

The following information is provided to assist in completing these calculations:
As a <u>Third-Party Payer</u> (“TPP”), you are a Class Member if you: <ul style="list-style-type: none">• Purchased an AB-rated generic equivalent of Wellbutrin XL® (“Generic XL”) in California, Florida, Nevada, New York, Tennessee and/or Wisconsin; and/or• Purchased 150 mg or 300 mg Wellbutrin XL in California, Florida, Nevada, New York, Tennessee and/or Wisconsin <i>before</i> Generic XL was available for such dosages <i>and</i> purchased Generic XL in the same state after it became available. Only TPPs that made these purchases during the Class Period November 14, 2005 to April 29, 2011 are included in the Class.
<ul style="list-style-type: none">• The 150 mg dosage of Generic XL first became available on May 29, 2008
<ul style="list-style-type: none">• The 300 mg dosage of Generic XL first became available on December 14, 2006
<ul style="list-style-type: none">• The brand or generic Wellbutrin XL must have been <i>purchased</i> at a pharmacy located in one of the Class states, regardless of where the TPP or insured member resides.

CALCULATED CLAIM TOTAL SPREADSHEET

Class Member Name: _____

Class Member FEIN: _____

STEP 1:

Calculate the Class Members' Generic Purchases

State the total and final amount paid or reimbursed for either the 150 mg and/or 300mg dosage of Generic XL purchased by the Class Members in the following states:

	150 mg Purchases between May 29, 2008 and April 29, 2011	300 mg Purchases between December 14, 2006 and April 29, 2011
California		
Florida		
Nevada		
New York		
Tennessee		
Wisconsin		
TOTAL GENERIC		

STEP 2:

Calculate the Class Members' Brand Purchases

State the total and final amount paid or reimbursed for either the 150mg and/or 300mg dosage of Wellbutrin XL purchased by the Class Members in the following states *before* that dosage of Generic XL became available. Only Wellbutrin XL purchases made in the same states where the Class Member also purchased Generic XL will be included in your total claim amount.

	150 mg Purchases between November 14, 2005 and May 29, 2008	300 mg Purchases between November 14, 2005 and December 14, 2006
California		
Florida		
Nevada		
New York		
Tennessee		
Wisconsin		
TOTAL BRAND		

STEP 3:

Calculate the Claim Grand Total

GRAND TOTAL

If you are claiming an aggregate amount of Generic and Brand Purchases that exceed more than \$100,000, you will need to provide additional claims data and information as provided in Section F below. For any claim not exceeding \$100,000, please ensure that all data used to calculate the Claim Grand Total is preserved until further notice.

Claimant certifies that the figures are true and accurate and are based upon actual records maintained by or otherwise available to the claimant.

SECTION E – JURISDICTION OF THE COURT AND CERTIFICATION

By signing below, I hereby swear and affirm that: (1) I have authority to submit this Claim Form either directly or on behalf of the Class Member or as its Authorized Agent, and, in turn, have been given the authority to submit this Claim Form by each Class Member identified in this Claim Form and in any attachments to it, and to receive on behalf of each such Class Member any and all amounts that may be allocated from the Settlement to such Class Member; (2) Each entity on whose behalf I have submitted a claim is a TPP Class Member, (3) the information contained in this Claim Form and any attachments hereto is true and accurate, based on records maintained by or otherwise available to me; (4) I, the Authorized Agent (if any), and the Class Member on whose behalf this Claim Form is submitted, hereby submit to the jurisdiction of the United States District Court for the Eastern District of Pennsylvania (the "Court") for all purposes associated with this Claim Form and the Proposed Settlement, including resolution of disputes relating to this Claim Form; (5) that I have read and agree to the Release quoted in Section G below; and (6) in the event that amounts from the Settlement are distributed to the Authorized Agent of a Class Member, and the Class Member later claims that the Authorized Agent did not have the authority to claim and receive such amounts on its behalf, the Authorized Agent, I and/or my employer will hold the Class, Counsel for the Class, Defendants, Counsel for Defendants, and the Settlement Administrator harmless with respect to any claims made by said Class Member.

Signature

Position

Print Name

Month/Day/Year

The following additional information is to be provided by the Individual that signs and certifies this Claim Form: I am filing this Claim Form as the authorized employee of the following Class Member or Authorized Agent for Class Member:

Name of Individual's Employer

Business Address

City

State

Zip Code

()
Area Code – Telephone Number

()
Area Code – Fax Number

*E-mail**Address*

Mail the completed Claim Form to the address listed on the reverse side, postmarked on or before May 31, 2013.

SECTION F – CLAIM DOCUMENTATION INSTRUCTIONS

Each Claimant with an adequate claim of Branded and Generic Purchases exceeding \$100,000 must submit documentation. Please provide data and information with your Claim Form sufficient to show your purchases of Wellbutrin XL 150mg and 300mg and its AB-rated generic equivalents during the period **November 14, 2005** to **April 29, 2011**, net of co-pays, deductibles, and/or co-insurance for purchases made by your members, employees, insureds, participants, or beneficiaries in the following six states: California, Florida, Nevada, New York, Tennessee, and Wisconsin.

To the extent possible, please provide the following data fields:

- 1. Unique patient identification number or code.**
- 2. Units – number of tablets purchased with each prescription**
- 3. Pharmacy or Provider State – The two character abbreviation of the state in which the pharmacy or other provider where the prescription was purchased is located.**
- 4. NDC Code (attached as Exhibit “A” to Claim Form)**
- 5. Fill Date**
- 6. Amount Billed (not including dispensing fee)**
- 7. Amount paid by patient: co-payment.**
- 8. Amount paid by patient: co-insurance.**
- 9. Amount Paid by TPP net of co-pays, deductibles and co-insurance.**

Pursuant to order of the Court, TPPs who provide this information will fall within the safe harbor of the Health Insurance Portability and Accountability Act for court-ordered production of personal health information, 45 C.F.R. § 164.512(e)(1)(i), and TPPs shall have no liability under HIPAA or any state confidentiality statute, regulation, or other requirement, for supplying such member information to the Claims Administrator. Further, TPPs will not be deemed to be guarantors for the completeness or accuracy of the data they provide. TPPs shall not be liable in any way to any party, class member, member, or any other person or entity for any claim related to the completeness or accuracy of any data provided, or for any other liability of any kind.

OTHER INFORMATION

- Finally, each TPP Class Member shall provide a list of all self-funded healthcare plans (“SFP’s”) or other entities for which it is authorized to make a claim, including the identity of each entity on whose behalf the TPP Class Member is authorized to act by name and by the Federal Employer Identification Number assigned to such entity by the United States Internal Revenue Service.
- If possible, please provide the electronic data in either Microsoft Excel format or ASCII flat file pipe delimited “T” or fixed-width format.

Please contact the Settlement Administrator at 1-800-358-6980 with any questions about the required claims data.

SECTION G – THE RELEASE PROVIDED IN THE STIPULATION OF SETTLEMENT

Releases Applicable to Settling Plaintiffs other than Named Plaintiffs:

1. Valeant and its Affiliates, and Valeant's subsidiaries and their respective Affiliates, shall be released by all Settling Plaintiffs other than the Named Plaintiffs (and those class members' officers, directors, agents, representatives, parents, subsidiaries and affiliates) for all claims, regardless of legal theory, relating to the price of Wellbutrin XL and/or its generic versions purchased through the date of this agreement, that were or are related to those asserted in the Litigation, under the laws of California, Florida, Nevada, New York, Tennessee and Wisconsin.
2. Valeant shall release the Settling Plaintiffs other than Named Plaintiffs (and their Affiliates) for all claims, regardless of legal theory, that would have been a compulsory or permissive counterclaim in the Litigation, under the laws of California, Florida, Nevada, New York, Tennessee and Wisconsin.
3. The foregoing releases shall not apply to claims (1) under Article II of the Uniform Commercial Code, (2) for indemnification, subrogation, reimbursement, contribution, and/or liability, under the law of products liability and/or personal injury, or (3) otherwise not contained in [the] Paragraphs 18A and 18B of the Settlement Agreement.