MUST BE POSTMARKED ON OR BEFORE JUNE 1, 2022

BCBSM, Inc. v. Vyera Pharmaceuticals, et al.,
No. 21-cv-1884-DLC (S.D.N.Y.)

FOR OFFICIAL USE ONLY

CLAIM FORM

YOUR CLAIM MUST BE POSTMARKED OR SUBMITTED ONLINE ON OR BEFORE **June 1, 2022**.

Submit the Claim Form using the Claims Administrator's website, www.DaraprimTPPsettlement.com

OR

Mail your claim to: *Daraprim TPP Settlement*, c/o A.B. Data, Ltd., P.O. Box 173115, Milwaukee, WI 53217

ATTENTION: THIS FORM IS ONLY TO BE FILLED OUT ON BEHALF OF A THIRD-PARTY PAYOR, NOT INDIVIDUAL CONSUMERS

PART I – CLAIMANT IDENTIFICATION

SECTION A	OR	SECTION B
ONLY IF YOU ARE FILING AS A SETTLEMENT CLASS MEMBER SUCH AS AN INSURANCE COMPANY OR HEALTH PLAN		ONLY IF YOU ARE AN AUTHORIZED AGENT FILING ON BEHALF OF ONE OR MORE SETTLEMENT CLASS MEMBERS

Section A: Settlement Class Member

Company or Health Plan Name

Contact Name

Address 1

Address 2

City

State

Zip

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 August 7, 2015.

Health Insurance Company/HMO

Self-Insured Employee Health Plan

Self-Insured Health & Welfare Fund

Other (Explain)

Section B: Authorized Agent Only

** As an Authorized Agent, please check how your relationship with the Settlement Class Member(s) is best described:

Third-Party Administrator

Pharmacy Benefit Manager

Other (Explain)

Authorized Agent's Company Name

Contact Name

Address 1

Address 2

City

State

Zip

Area Code – Telephone Number

Authorized Agent's Tax Identification Number

Email Address

Please list the name and FEIN of every Settlement 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 Settlement Class Member names and FEINs in an electronic format, such as Excel or a tab-delimited text file saved on a disk or flash drive. Please contact the Claims Administrator to determine what formats are acceptable.

SETTLEMENT CLASS MEMBER'S NAME	SETTLEMENT CLASS MEMBER'S FEIN

PART II – AMOUNT CLAIMED

Please type or print in the box below, the total amounts paid or reimbursed for Daraprim in any of the eligible states and territories listed below during the period from August 7, 2015, through January 28, 2022. The eligible states and territories are: Arizona, Arkansas, California, District of Columbia, Florida, Hawaii, Idaho, Illinois, Iowa, Kansas, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, 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.

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

(a) Natural person consumers;
(b) Defendants and their employees, affiliates, parents, and subsidiaries, whether or not named in the Complaint;
(c) All federal and state governmental entities except for cities, towns, municipalities, or counties with self-funded prescription drug plans;
(d) Fully insured health plans (*i.e.*, health plans that purchased insurance covering 100% of their reimbursement obligation to members); and
(e) Judges assigned to this case and any members of their immediate families.

DARAPRIM PRESCRIPTIONS	**TOTAL AMOUNT PAID**
Purchases or Reimbursements from August 7, 2015, through January 28, 2022.	$

You must submit claims data and information in support of the purchase amounts stated above if your total net claim amount is more than $100,000. Instructions on how to do so are found in the Claims Documentation Instructions on the Claims Administrator's website or included with this Claim Form. If your total net claim is

$100,000 or less, you need not provide complete claims data with this Claim Form, but the Claims Administrator may require supporting documentation after reviewing your Claim.

PART III – CERTIFICATION

By signing and submitting this Claim Form, the claimant(s) or the person(s) who represent(s) the claimant(s) agree(s) to the release above and certifies (certify) as follows:

1. that I (we) have read and understand the contents of the Notice, the Plan of Allocation, and this Claim Form, including the releases provided for in the Settlement and the terms of the Plan of Allocation;

2. that the claimant(s) is (are) members of the Settlement Class, as defined in the Notice, and is (are) not excluded by definition from the Settlement Class as set forth in the Notice;

3. that the claimant(s) has (have) **not** submitted a Request for Exclusion from the Settlement Class;

4. that I (we), or the Settlement Class Member(s) I (we) represent, paid the total amount set forth above for Daraprim during the period from August 7, 2015, through January 28, 2022;

5. to the extent I (we) have been given authority to submit this Claim Form by a Settlement Class Member(s) on its (their) behalf, and accordingly am submitting this Proof of Claim in the capacity of an Authorized Agent with authority to submit it by the Settlement Class Member(s) identified on a separate sheet of paper submitted with this form, I (we) have been authorized to receive payment on behalf of this (these) Settlement Class Member(s). In the event amounts from the Settlement Fund are distributed to me (us) and a Settlement Class Member(s) later claim(s) that I (we) did not have authority to claim and/or receive such amounts on its (their) behalf, I (we) and/or my (our) employer will hold the Settlement Class, Lead Counsel, and the Claims Administrator harmless with respect to any claims made by the Settlement Class Member(s).;

6. that the claimant(s) submit(s) to the jurisdiction of the Court with respect to claimant's (claimants') claim, including resolution of disputes relating to this Claim Form, and for purposes of enforcing the releases set forth herein;

7. that I (we) agree to furnish such additional information with respect to this Claim Form as Interim Lead Counsel, the Claims Administrator, or the Court may require;

8. that the claimant(s) waive(s) the right to trial by jury, to the extent it exists, agree(s) to the determination by the Court of the validity or amount of this claim, and waives any right of appeal or review with respect to such determination;

9. that I (we) acknowledge that the claimant(s) will be bound by and subject to the terms of any judgment(s) that may be entered in the Action;

10. that I (we) acknowledge that any false information or representations contained herein may subject me (us) to sanctions, including the possibility of criminal prosecution.

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

You must submit this Claim Form online through the Claims Administrator's website by **June 1, 2022,** or mail the completed Claim Form, along with any supporting documentation as described above, postmarked on or before **June 1, 2022**, to the following address:

Daraprim TPP Settlement
c/o A.B. Data, Ltd.
P.O. Box 173115
Milwaukee, WI 53217

Toll-Free Telephone: 1-877-316-0144 Website: www.DaraprimTPPsettlement.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 Administrator via the Settlement website or U.S. Mail (the addresses are listed above).

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

BCBSM, INC., d/b/a BLUE CROSS and BLUE SHIELD OF MINNESOTA, on behalf of itself and those similarly situated, Plaintiff, v. VYERA PHARMACEUTICALS, LLC, PHOENIXUS AG, MARTIN SHKRELI, and KEVIN MULLEADY, Defendants.	Case No. 1:21-cv-1884-DLC

INSTRUCTIONS FOR SUBMITTING YOUR THIRD-PARTY PAYOR CLAIM FORM

The information you provide will be kept confidential and will be used only for administering the Settlement. If you have any questions, please call the Claims Administrator at **1-877-316-0144**.

A Settlement Class Member or an authorized agent can complete this Claim Form. If both a Settlement Class Member and its authorized agent submit a Claim Form, the Claims Administrator will only consider the Settlement Class Member's Claim Form. The Claims Administrator may request supporting documentation. The claim may be rejected if any requested documentation is not provided in a timely manner.

If you are a **Settlement Class Member** submitting a Claim Form on your own behalf, you must provide the information requested in "**Part I, Section A –SETTLEMENT CLASS MEMBER**," in addition to the other information requested by this Claim Form.

If you are an **authorized agent** of one or more Settlement Class Members, you must provide the information requested in "**Part I, 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 Settlement Class Member, OR you may submit one Claim Form for all such Settlement Class Members as long as you provide the information required for each Settlement Class Member on whose behalf you are submitting the form.

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

In order 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 Form.

Your failure to complete and submit the Claim Form postmarked or filed online by **June 1, 2022**, 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 Settlement. If the Claims Administrator disputes a material fact concerning your Claim Form, you will have the right to present information in a dispute resolution process.

CLAIM DOCUMENTATION REQUIREMENTS

You must provide all the information requested in "Part II: Amount Claimed." You must submit claims data and information in support of the purchase amounts if your total net claim amount is more than $100,000. Your claimed purchase amounts for Daraprim, during the period from August 7, 2015, through January 28, 2022, must be net of co-pays, deductibles, and co-insurance.

If you must submit claims data and information, it is mandatory that you provide the data for all categories listed below. Affidavits that do not include the information listed below will not be accepted.

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.*, 08/07/2015

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 Settlement 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

For your convenience, an exemplar spreadsheet containing these categories can be downloaded from the Settlement website, www.DaraprimTPPsettlement.com. Please use this format if possible. A list of the NDCs that will be considered by the Claims Administrator is also available at www.DaraprimTPPsettlement.com.

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

Please contact the Claims Administrator at **1-877-316-0144** with any questions about the required claims data.