MUST BE RECEIVED BY JANUARY 15, 2020	*Vista Healthplan, Inc., et al., v. Cephalon, Inc. et al.* Civil No. 06-CV-01833 U.S. District Court for the Eastern District of Pennsylvania	FOR OFFICIAL USE ONLY

THIRD-PARTY PAYOR CLAIM FORM

Use Blue or Black Ink Only

ATTENTION: THIS CLAIM FORM IS ONLY TO BE FILLED OUT BY THIRD-PARTY PAYORS, NOT INDIVIDUAL CONSUMERS

Part I – CLAIMANT IDENTIFICATION

SECTION A	OR	SECTION B
ONLY IF YOU ARE FILING AS A CLASS MEMBER		ONLY IF YOU ARE AN AUTHORIZED AGENT FILING ON BEHALF OF ONE OR MORE CLASS MEMBERS

Section A: Company or Health Plan Class Member Only

Company or Health Plan Name

Contact Name

Mailing 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 from June 24, 2006 through August 8, 2019.

☐ 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 Class Member(s) is best described:

☐ Third-Party Administrator

☐ Pharmacy Benefits Manager

☐ Other (Explain):

Authorized Agent's Firm Name

Contact Name

Street Address

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 Settlement Administrator to determine what formats are acceptable.

CLASS MEMBER'S NAME	CLASS MEMBER'S FEIN

PART II – CLAIM FOR PROVIGIL® OR GENERIC PROVIGIL® (MODAFINIL)

Please type or print in the box below the total amount paid or reimbursed for Provigil® or generic Provigil® (modafinil) net of co-pays, deductibles, and co-insurance in the following States: Alabama, Arizona, California, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Mexico, New York, North Carolina, North Dakota, South Dakota, Tennessee, Utah, Vermont, West Virginia and Wisconsin, other than for resale, from June 24, 2006 through August 8, 2019. You may not include amounts for which you have been reimbursed by another entity. For mail order purchases, the state of residence of the patient is deemed to be the state in which the purchase occurred.

PROVIGIL® OR GENERIC PROVIGIL® PAYMENTS	TOTAL AMOUNT PAID
Total Purchases or Reimbursements for Provigil® or Generic Provigil® (modafinil) with service or fill dates from June 24, 2006 through August 8, 2019:	$

*You **must** submit claims data and information in support of the purchase amounts stated above if your Total Amount Paid is more than $300,000 (see Part III). If your Total Amount Paid is $300,000 or less, you need not provide complete claims data with this Claim Form, but the Settlement Administrator may later require supporting documentation.*

PART III – CLAIM DOCUMENTATION INSTRUCTIONS

If your Total Amount Paid amount in Part II above is more than $300,000, you **must** provide documentation with your Claim Form sufficient to show the amount of purchases of Provigil® or generic Provigil® (modafinil) during the relevant period. Please provide the required data fields as presented in the table below.

Provigil® or Generic Provigil® Payments or Reimbursements from 06/24/06 through 08/08/19					
Unique Patient Identifier or Code	NDC Number	Fill/Service Date	State of Service	Amount Billed	Amount Paid by TPP

A HIPAA QUALIFIED PROTECTIVE ORDER HAS BEEN ENTERED TO PROTECT THE CONFIDENTIALITY OF ALL INFORMATION THAT YOU SEND TO THE SETTLEMENT ADMINISTRATOR AND TO LIMIT ITS USE TO ONLY THIS CLAIM PROCESS.

PART IV – PURCHASE INFORMATION REGARDING PERIOD FROM 6/1/06 TO 9/30/13

In addition to the information you provide above, please also type or print in the box below the total amount paid or reimbursed for Provigil® or generic Provigil® (modafinil) net of co-pays, deductibles, and co-insurance in the following States: Alabama, Arizona, California, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Mexico, New York, North Carolina, North Dakota, South Dakota, Tennessee, Utah, Vermont, West Virginia and Wisconsin, other than for resale, from **June 1, 2006 through September 30, 2013**. You may not include amounts for which you have been reimbursed by another entity. For mail order purchases, the state of residence of the patient is deemed to be the state in which the purchase occurred.

PROVIGIL® OR GENERIC PROVIGIL® PAYMENTS	TOTAL AMOUNT PAID
Total Purchases or Reimbursements for Provigil® or Generic Provigil® (modafinil) with service or fill dates from **June 1, 2006 through September 30, 2013:**	$

PART V – CERTIFICATION AND JURISDICTION OF THE COURT

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 this Claim Form and in any documents attached by me are true, correct and complete to the best of my knowledge. I certify that the Class Member(s) I represent paid the total amount set forth above in out-of-pocket expenditures for purchases or reimbursements of brand or generic Provigil® prescriptions and that the Class Member(s) were at risk for this amount. In addition, I certify that the Class Members I represent are neither: (i) governmental entities (other than a government funded employee benefit plan); nor (ii) fully insured health plans (*i.e.*, plans that purchase insurance from another third-party payor covering 100% of the plan's reimbursement obligations to its members).

To the extent I have been given authority to submit this Claim Form by a Class Member(s) 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(s) identified, I have been authorized to receive payment on behalf of the Class Member(s). In the event amounts from the Settlement Fund are distributed to me, and a Class Member(s) later contends that I did not have authority to claim and/or receive such amounts on its behalf, I agree to hold the Class, Class Counsel, and the Settlement Administrator harmless with respect to any claims made by the Class Member(s).

I hereby submit to the jurisdiction of the United States District Court for the Eastern District of Pennsylvania for all purposes connected with the 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 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 Claim Form was executed this _____ day of _____, 20__.

Signature

Position/Title

Print Name

Date

PART V –RELEASES

The Cephalon, Mylan and Ranbaxy Settlement Agreements describe in detail what claims you are releasing in this case (whether or not you file a Claim Form, unless you have excluded yourself). If you would like to review the Releases, they are available at www.ProvigilSettlement.com.

Your completed Claim Form must be received by the Settlement Administrator on or before January 15, 2020. If you are mailing the Claim Form, send it, along with any supporting documentation, to the Settlement Administrator at the following address:

Vista Healthplan v. Cephalon
Settlement Administrator
c/o A.B. Data, Ltd.
P.O. Box 170300
Milwaukee, WI 53217

Toll-Free Telephone: 1-877-241-7503 Email: info@ProvigilSettlement.com

Website: www.ProvigilSettlement.com.

If you are submitting your Claim Form through the Settlement Administrator's website, it must be submitted by January 15, 2020.

REMINDER CHECKLIST:

1. Please complete and sign the above Claim Form. Attach or upload any documentation supporting your Claim Form.
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 a Claim Form online or mail this Claim 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 via the Settlement Website or U.S. Mail (the addresses are listed above).