

**MUST BE RECEIVED BY
JANUARY 15, 2020**

Vista Healthplan, Inc. et al. v. Cephalon, Inc. et al.
Civil No. 06-CV-1833 (E.D. Pa.)
State of California v. Teva Pharm. Indus. Ltd.
Civil No. 19-CV-03281 (E.D. Pa.)

FOR OFFICIAL USE ONLY



COVER PAGE -- CONSUMER CLAIM FORMS

The Consumer Claim Forms that follow in Sections I and II are to be used for making claims in the following two cases:

Vista HealthPlan, Inc. v. Cephalon, Inc. ("Class Action Settlement")

and

State of California v. Teva ("California Attorney General Settlement")

To submit a claim for the Class Action Settlement, complete Section I.

To submit a claim for the California Attorney General Settlement, complete Section II.

Note: Persons residing in California between June 24, 2006 and December 31, 2012 may be eligible to submit claims to one or both settlements. To submit a claim for both the Class Action Settlement and the California Attorney General Settlement, you must complete both Sections I and II.

Whether you submit a Claim Form for the Class Action Settlement, or the California Attorney General Settlement, or both Settlements, you MUST:

Mail Your
Claim Form to:

Provigil Settlement
c/o A.B. Data, Ltd
P.O. Box 170300
Milwaukee, WI 53217

OR

Submit your Claim Form online using the Settlement Administrator's Website: www.ProvigilSettlement.com.

Do **not** send your Claim Form to the Court, the Parties or their counsel.

YOUR CLAIM MUST BE RECEIVED BY THE SETTLEMENT ADMINISTRATOR

ON OR BEFORE JANUARY 15, 2020

SECTION I – Class Action Settlement Claim Form

Section A: Claimant Identification

Please provide us with the following information related to the individual who **PAID** for Provigil[®] or generic versions of Provigil[®] (modafinil). This person is referred to as the “Claimant.” If the person who **PAID** for the Provigil[®] or generic versions of Provigil[®] is different than the person who was prescribed the drugs, then the Claimant is still the person who **PAID** for the drugs. So, for example, if a parent purchased Provigil[®] for their child, then the parent is the Claimant.

Claimant’s Name

Agent/Legal Representative

Street Address

City

State

Zip Code

Daytime Telephone Number

E-Mail Address*

*By providing your e-mail address, you authorize the Settlement Administrator to use it in providing you with information relevant to this claim.

Section B: Class Definition

You should file this Claim Form if you are in 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 and purchased Provigil[®] or generic versions of Provigil[®] (modafinil) intended for consumption by you or your family during the period from June 24, 2006 through August 8, 2019. “Purchased” in this case means you paid for some or all of the purchase price of the cost of the drug. (For example, “purchased” includes making a co-payment).

BY CHECKING THIS BOX, YOU ARE CONFIRMING THAT YOU PURCHASED PROVIGIL[®] OR MODAFINIL IN ONE OF THE STATES LISTED ABOVE DURING THE PERIOD FROM JUNE 24, 2006 THROUGH AUGUST 8, 2019.

Section C: Exclusions

The following individuals are excluded from the Class, and therefore may not participate in the Settlements:

Employees of Defendants;

Insured individuals covered by plans imposing a flat dollar co-pay that was the same dollar amount for generic as for brand drug purchases; and

Insured individuals who purchased only generic modafinil pursuant to a fixed co-pay applicable to generic drugs.

BY CHECKING THIS BOX, YOU ARE CONFIRMING THAT YOU DO NOT FALL WITHIN ANY OF THESE EXCLUSIONS, AND MAY THEREFORE PARTICIPATE IN THE SETTLEMENTS.

Section D: Purchase Information

Below, please write down the Total Amount Paid for Provigil[®] or generic versions of Provigil[®] (modafinil) from June 24, 2006 through August 8, 2019 for purchases made 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.** (For mail order purchases, the state of residence of the patient is deemed to be the state in which the purchase occurred.)

A Claimant “paid” for Provigil[®] or generic versions of Provigil[®] (modafinil) if, for example, the Claimant had insurance and paid a co-payment or a co-insurance payment (that is, the Claimant’s unreimbursed out-of-pocket cost) and insurance covered the rest. Also, an insured Claimant may have “paid” for the drug if she paid for the entire cost of the drug because the Claimant had not met a deductible. A Claimant not covered by insurance who purchased the drug would also be considered to have “paid” for the drug.

TOTAL AMOUNT YOU PAID FOR PROVIGIL[®] OR MODAFINIL FROM JUNE 24, 2006 THROUGH AUGUST 8, 2019
\$

Section E: Required Proof of Payment

Please provide proof of at least one purchase of Provigil[®] or modafinil.

Examples of acceptable proofs of payment include, but are not limited to:

- Records from your pharmacy showing that you paid for Provigil[®] or modafinil;
- An EOB (explanation of benefit) from your insurer that shows you paid for Provigil[®] or modafinil; or
- A letter from your Doctor stating that you were prescribed Provigil[®] or modafinil during the relevant time period.

If you are having difficulty obtaining appropriate proof of payment, please contact the Settlement Administrator for assistance.

Even if you cannot locate proof of one purchase, you should still submit this Claim Form if you believe you are a Class Member because the Settlement Administrator may be able to help you find proof of payment.

NOTE: The Settlement Administrator may ask for additional proof of payment after you submit your Claim Form, so please keep all records of your purchases.

Section F: 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.

Section G: Sworn Statement

By signing this Claim Form, I declare under penalty of perjury that: (1) all of the information provided in this Claim Form is true and correct to the best of my knowledge; (2) the Claimant falls within the definition of the Class listed in Section B above; (3) the Claimant paid the amounts as indicated in this Claim Form for Provigil[®] or generic versions of Provigil[®] (modafinil) for the Claimant's own use (or for the Claimant's family or household) at some time during the period from June 24, 2006 through August 8, 2019; (4) the Claimant does not fall within any of the exclusions listed in Section C above; and (5) if not submitting this Claim Form for myself, I am authorized to submit this Claim Form on behalf of the Claimant identified above.

Please note that signing a Claim Form that contains false information could constitute perjury.

Signature

Print or Type Name

Date

If not submitting this Claim Form through the Settlement Administrator's website, then you must mail the completed Claim Form so that it is **received** on or before **January 15, 2020**, along with proof of payment, by the Settlement Administrator at the following address:

Provigil Settlement
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

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 this 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).

If you are eligible and wish to also file a claim in the California Attorney General Settlement, then you must also fill out Section II below.

SECTION II -- California Attorney General Settlement Claim Form

Section A: Claimant Identification

Please provide us with the following information related to the individual who **PAID** for Provigil[®], Nuvigil[®], and/or generic versions of Provigil[®] (modafinil) dispensed pursuant to a prescription for one or more of these drugs. This person is referred to as the "Claimant." If the person who **PAID** for the Provigil[®], Nuvigil[®], and/or generic versions of Provigil[®] is different than the person who was prescribed the drugs, then the Claimant is still the person who **PAID** for the drugs. So, for example, if a parent purchased Provigil[®] for their child, then the parent is the Claimant.

Claimant's Name

Agent/Legal Representative

Street Address

City

State

Zip Code

Daytime Telephone Number

E-Mail Address*

*By providing your e-mail address, you authorize the Settlement Administrator to use it in providing you with information relevant to this claim.

Section B: Eligible Claimants

You should file this Proof of Claim Form if, during the period from June 24, 2006 through December 31, 2012, you resided in California and purchased and/or paid for Provigil[®], Nuvigil[®], and/or generic versions of Provigil[®] (modafinil) dispensed pursuant to a prescription for personal consumption by you or for another under your caregiving in any state in the United States or the District of Columbia. Your purchases of these drugs are eligible regardless of the out-of-pocket costs you paid, even if you were partially or fully reimbursed by insurance. Employees of the defendants in *Vista Healthplan v. Cephalon* and *State of California v. Cephalon* are not eligible to submit a claim. The judge and his immediate family are not eligible to submit a claim.

BY CHECKING THIS BOX, YOU ARE CONFIRMING THAT, DURING THE PERIOD FROM JUNE 24, 2006 THROUGH DECEMBER 31, 2012, YOU PURCHASED AND/OR PAID FOR PROVIGIL[®], NUVIGIL[®], AND/OR MODAFINIL IN ANY STATE IN THE UNITED STATES OR THE DISTRICT OF COLUMBIA AND YOU WERE A CALIFORNIA RESIDENT AT THE TIME OF EACH PURCHASE.

Section C: Purchase Information

Below, please write down the total number of prescriptions pursuant to which you purchased and/or paid for Provigil[®], Nuvigil[®], and/or generic versions of Provigil[®] (modafinil) during the period from June 24, 2006 to December 31, 2012 in any state in the United States or the District of Columbia. You must have been a California resident at the time you purchased and/or paid for Provigil[®], Nuvigil[®], and/or modafinil.

A Claimant “paid” for Provigil[®], Nuvigil[®], or generic versions of Provigil[®] (modafinil) if, for example, the Claimant had insurance and paid a co-payment or a co-insurance payment (that is, the Claimant’s unreimbursed out-of-pocket cost) and insurance covered the rest. Also, an insured Claimant may have “paid” for the drug if she paid for the entire cost of the drug because the Claimant had not met a deductible. A Claimant not covered by insurance who purchased the drug would also be considered to have “paid” for the drug.

TOTAL NUMBER OF PRESCRIPTIONS FOR PROVIGIL[®], NUVIGIL[®], AND/OR MODAFINIL FROM JUNE 24, 2006 THROUGH DECEMBER 31, 2012 PURSUANT TO WHICH YOU PURCHASED ANY OF THESE DRUGS:	
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Section D: Releases

The Settlement Agreement between the Attorney General of the State of California and Teva Pharmaceutical Industries Ltd. describes in detail what claims you are releasing in this case (whether or not you file a Proof of Claim, unless you have excluded yourself). If you would like to review the Releases, they are available at www.ProvigilSettlement.com/CA.

Section E: Sworn Statement

By signing this Claim Form, I declare under penalty of perjury that: (1) all of the information provided in this Claim Form is true and correct to the best of my knowledge; (2) the Claimant is an Eligible Claimant as described in Section B above; (3) the Claimant purchased Provigil[®], Nuvigil[®], and/or modafinil pursuant to the number of prescriptions stated in Section C above at some time during the period from June 24, 2006 through December 31, 2012; and (4) if not submitting this for myself, I am authorized to submit this form on behalf of the Claimant identified above.

Please note that signing a Claim Form that contains false information could constitute perjury.

Signature

Print or Type Name

Date

If not submitting this Claim Form through the Settlement Administrator’s website, then you must mail the completed Claim Form so that it is received on or before **January 15, 2020**, by the Settlement Administrator at the following address (even if you are submitting claims for both Settlements):

Provigil Settlement
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/CA

REMINDER CHECKLIST:

1. Please complete and sign the above Claim Form.
2. Keep a copy of your Claim Form 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 Settlement Administrator via the Settlement Website or U.S. Mail (the addresses are listed above).