1-10

Must Be
Postmarked By
February 1, 2010

# AWP TRACK 2 SETTLEMENT CLASS 3 CLAIM FORM

OFFICIAL USE ONLY

## FOR PAYMENTS MADE OUTSIDE OF MEDICARE PART B

**How to Apply for a Payment from the Proposed Settlement**

If you would like to submit a claim in the Settlement, complete this form and mail it to the address below.

**YOUR CLAIM MUST BE RECEIVED OR POSTMARKED BY FEBRUARY 1, 2010.**

Your claim should be mailed to:

AWP Track 2 Settlement Administrator
P.O. Box 951
Minneapolis, MN 55440-0951

## Section A: Claimant Identification

Please provide us with the following information related to the individual who was prescribed one or more of the Class Drugs. This person is referred to as the "Claimant."

Claimant's First Name:

Claimant's Last Name:

Address:

City:

State:

Zip Code:

Daytime Telephone Number:

## Section B: Claimant Representative Information

If you are the Claimant, do not complete this section. Complete this section only if you are a representative (such as a spouse, guardian, executor or personal representative) filing this claim on behalf of the Claimant listed above. Please provide YOUR name, relationship to the Claimant, and YOUR contact information in the spaces provided below.

Contact Name:

Relationship to Claimant:

Address:

City:

State:

Zip Code:

Daytime Telephone Number:

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## Section C: Should I file a Claim Form?

Please answer the following questions in order to determine if the Claimant is eligible for cash from the Proposed Settlement:

| | | |
|---|---|---|
| 1. Were you, or the Claimant that you are filing on behalf of, prescribed any of the drugs listed in Attachment A of the Notice during the period from January 1, 1991 to March 1, 2008? | ☐ Yes | ☐ No |
| 2. Did you, or the Claimant that you are filing on behalf of, pay cash or a percentage of the cost of the drug(s)? | ☐ Yes | ☐ No |

Note: If you paid a flat co-payment (i.e., your out-of-pocket expense was always the same for every drug, like a $10 or $25 co-pay) you did not pay a percentage of the cost.

If you answered ***No*** to either of the questions above, you are not eligible to receive any benefits from this Proposed Settlement. You may disregard this Notice and Claim Form. If you answered ***Yes*** to both of the questions above, you should fill out Section D, Section E and Section G below.

## Section D: Choose a Refund Option – You Have Two Options

Please check ***only one*** of the boxes below in order to choose your refund option:

☐ **Option 1:** I choose the **EASY REFUND** option. I understand that I will receive a payment of up to $35.00 from the Settlement and that I will not be required to provide additional documentation unless requested by the Claims Administrator **AND** you must sign and date the Claim Form in Section G on page 10 and mail it to the Claims Administrator at the address indicated on page 10.

☐ **Option 2:** I choose the **FULL REFUND** option. I understand that in order to receive a full refund I must provide one form of proof of a cash payment or a percentage co-payment for each separate Class Drug listed on the charts in Section E for which I am seeking a refund. The list of acceptable forms of proof are listed below in Section F under "Option 2: FULL REFUND." Please include all proof(s) of payment when submitting this Claim Form.

## Section E: Drug Purchase Information - Fill out ONLY if you chose Option 2 – FULL REFUND

**Instructions for Completing the Out-of-Pocket Expenditures on Class A & B Drugs Chart**

In the Out-of-Pocket Expenditures on Class A & B Drug Charts below, please provide the total amount paid (not monthly) by the Claimant, or the amount the Claimant is obligated to pay, for each of the drugs listed during the time periods in the chart.

- Print clearly
- Do not include flat co-payments in the total amounts paid
- Enter the full amount paid, not a monthly amount

| Out-of-Pocket Expenditures on Class A Drugs | | | |
|---|---|---|---|
| **Drug Name** | Total Amount Paid From *January 1, 1991* to *November 30, 1997* | Total Amount Paid From *December 1, 1997* to *December 31, 2003* | Total Amount Paid From *January 1, 2004* to *March 1, 2008* |
| Anzemet (injection & tablets) | $ | $ | $ |
| Aranesp | $ | $ | $ |
| Epogen | $ | $ | $ |
| Ferrlecit | $ | $ | $ |
| InFed | $ | $ | $ |
| Neulasta | $ | $ | $ |
| Neupogen | $ | $ | $ |

| Out-of-Pocket Expenditures on Class B Drugs | |
|---|---|
| **Drug Name** | Total Amount Paid From *January 1, 1991* to *March 1, 2008* |
| AccuNeb | $ |
| Acetylcysteine | $ |
| Acyclovir sodium | $ |
| Adenosine | $ |
| Adriamycin PFS/RFS | $ |
| Adrucil | $ |
| Aggrastat | $ |
| Albuterol sulfate | $ |
| Alcohol injection | $ |
| A-methapred | $ |
| Amikacin sulfate | $ |

| Out-of-Pocket Expenditures on Class B Drugs (continued) | |
|---|---|
| **Drug Name** | Total Amount Paid From ***January 1, 1991*** to ***March 1, 2008*** |
| Aminocaproic acid | $ |
| Aminosyn / Aminosyn II / Amino acid | $ |
| Amphocin / Amphotericin B | $ |
| Aristocort / Aristospan | $ |
| Aromasin | $ |
| Ativan | $ |
| Azmacort | $ |
| Bebulin | $ |
| Bioclate | $ |
| Bleomycin sulfate | $ |
| Brevibloc | $ |
| Buminate | $ |
| Bupivacaine | $ |
| Calcijex | $ |
| Calcimar | $ |
| Camptosar / Irinotecan hydrochloride | $ |
| Carbocaine / Mepivicaine | $ |
| Cefizox | $ |
| Chromium tr meta / Chromic chloride | $ |
| Cimetidine hydrochloride | $ |
| Cipro / Ciprofloxacin hydrochloride | $ |
| Cisplatin | $ |

## Out-of-Pocket Expenditures on Class B Drugs (continued)

| Drug Name | Total Amount Paid From *January 1, 1991* to *March 1, 2008* |
|---|---|
| Claforan | $ |
| Cleocin T / Clindamycin phosphate | $ |
| Copper trace / Cupric chloride | $ |
| Cromolyn sodium | $ |
| Cytosar-U / Cytarabine | $ |
| Depo provera / Medroxyprogesterone acetate | $ |
| Depo-testosterone / Testosterone cypionate | $ |
| Dexamethasone acetate / Dexamethasone sodium / Dexamethasone sodium phosphate | $ |
| Dextrose / Dextrose sodium chloride / Ringers lactated with dextrose | $ |
| Diazepam | $ |
| Dicarbazine (dtic – dome) | $ |
| Diltiazem hydrochloride | $ |
| Dopamine hydrochloride | $ |
| Doxorubicin / Doxorubicin hydrochloride | $ |
| DTIC Dome | $ |
| Eligard | $ |
| Ellence / Epirubicin HCL | $ |
| Enalaprilat | $ |
| Enbrel | $ |
| Epinephrine | $ |
| Erythromycin / Erythromycin base | $ |

| Out-of-Pocket Expenditures on Class B Drugs (continued) | |
|---|---|
| **Drug Name** | Total Amount Paid From ***January 1, 1991*** to ***March 1, 2008*** |
| Estradiol | $ |
| Etoposide | $ |
| Famotidine | $ |
| Fentanyl citrate | $ |
| Fluorouracil | $ |
| Fluphenazine HCL | $ |
| Furosemide | $ |
| Gamimune N / Gammagard / Gammagard S/D / Gammar / Gammar P.I.V. | $ |
| Gentamicin sulfate | $ |
| Gentran / Gentran NACL | $ |
| Glycopyrrolate | $ |
| Helixate / Helixate FS | $ |
| Heparin / Heparin lock flush / Heparin sodium | $ |
| Humate-P | $ |
| Hydromorphine | $ |
| Idamycin / Idarubicin hydrochloride | $ |
| Imipramine HCL | $ |
| Intal | $ |
| Ipratropium bromide | $ |
| Iveegam | $ |
| Ketorolac / Ketorolac tromethamine | $ |

## Out-of-Pocket Expenditures on Class B Drugs (continued)

| Drug Name | Total Amount Paid From *January 1, 1991* to *March 1, 2008* |
|---|---|
| Kineret | $ |
| Koate- HP | $ |
| Kogenate | $ |
| Labetalol | $ |
| Lasix | $ |
| Leucovorin calcium | $ |
| Leukine | $ |
| Levofloxacin | $ |
| Lidocaine hydrochloride | $ |
| Liposyn II / Fat emulsion | $ |
| Lorazepam | $ |
| Lovenox | $ |
| Lyphocin | $ |
| Magnese chloride | $ |
| Magnesium sulfate | $ |
| Mannitol | $ |
| Marcaine | $ |
| Medrol / Methylprednisolone | $ |
| Metaproterenol sulfate | $ |
| Methotrexate sodium | $ |
| Metoclopramide | $ |

| Out-of-Pocket Expenditures on Class B Drugs (continued) | |
|---|---|
| **Drug Name** | Total Amount Paid From *January 1, 1991* to *March 1, 2008* |
| Midazolam hydrochloride | $ |
| Mithracin | $ |
| Monoclate / Monoclate-P | $ |
| Mononine | $ |
| Morphine sulfate | $ |
| Nadolol | $ |
| Nalbuphine | $ |
| Nebupent | $ |
| Neosar / Cyclophospamide | $ |
| Neostigmine methylsulfate | $ |
| Novacaine / Procaine | $ |
| Novantrone | $ |
| Osmitrol | $ |
| Pancuronium bromide | $ |
| Pentam / Pentamidine isethionate | $ |
| Perphenazine | $ |
| Phenylephrine | $ |
| Potassium acetate / Potassium chloride | $ |
| Prograf | $ |
| Promethazine | $ |
| Propranolol HCL | $ |

## Out-of-Pocket Expenditures on Class B Drugs (continued)

| Drug Name | Total Amount Paid From *January 1, 1991* to *March 1, 2008* |
|---|---|
| Propofol | $ |
| Ranitidine HCL | $ |
| Recombinate | $ |
| Sodium acetate | $ |
| Sodium chloride | $ |
| Solu-cortef / Hydrocortisone sodium succinate | $ |
| Solu-medrol | $ |
| Succinylcholine chloride | $ |
| Taxotere | $ |
| Thioplex / Thiotepa | $ |
| Tobramycin sulfate / Tobramycin/ sodium chloride | $ |
| Toposar | $ |
| Travasol / Travasol with dextrose | $ |
| Trelstar / Triptorelin pamoate | $ |
| Vancocin / Vancocin HCL / Vancomycin / Vancomycin HCL | $ |
| Verapamil HCL | $ |
| Vinblastine sulfate | $ |
| Vincasar / Vincristine / Vinscristine sulfate | $ |
| Water for injection bacteriostatic | $ |
| Zemplar | $ |
| Zinc chloride | $ |

## Section F: Proof of Payment – Provide ONLY if you chose Option 2 – FULL REFUND

If you chose Option 2, you must provide proof that you made a cash payment or a percentage co-payment for each of the Class Drugs you are claiming in the charts in Section E above. You only need to provide one form of proof for each of the drugs.

Any one of the following are acceptable as proof of a cash payment or a percentage co-payment for one of the Class Drugs:

(1) A receipt, cancelled check, or credit card statement that shows a payment for one of the drugs (other than a flat co-payment); or

(2) A letter from a doctor saying that he or she prescribed one of the drugs and you paid all or part of the cost of one of the drugs (other than a flat co-payment) at least once; or

(3) An EOB (explanation of benefits) from your insurer that shows you made or are obligated to make percentage co-payments for the Class Drugs; or

(4) A notarized statement signed by you indicating you paid or are obligated to pay cash or a percentage co-payment for the Class Drugs between January 1, 1991 through March 1, 2008, including the total of all percentage co-payments for the drugs during the time period; or

(5) Records from your pharmacy showing that you made a cash payment or percentage co-payments for the Class Drugs purchased between January 1, 1991 though March 1, 2008.

## Section G: Sworn Statement Regarding Payments Made

**I declare under penalty of perjury that the information provided here is, to the best of my knowledge, correct. I also declare under penalty of perjury that I made a cash payment or a percentage co-pay for one or more of the Class Drugs as indicated in this Claim Form at some time during the period from January 1, 1991 through March 1, 2008. If not submitting this for myself, I am authorized to submit this form on behalf of the Claimant identified above.** [1]

*Signature*

*Print Name*

*Date*

**Mail all pages of this Claim Form along with proof(s) of payment, if any, to the following address:**

AWP Track 2 Settlement Administrator
P.O. Box 951
Minneapolis, MN 55440-0951

Toll-Free Telephone: 1-877-465-8136
www.AWPTrack2Settlement.com

[1] Please note that your signature on this Claim Form indicates that you declare, under penalty of perjury, that you (or someone on whose behalf you are acting) made a cash payment or a percentage co-payment for one or more of the Class Drugs at some time during January 1, 1991 through March 1, 2008. As a result, providing false information on this Claim Form could constitute perjury.