INSTRUCTIONS FOR SUBMITTING YOUR HOSPITAL CLAIM FORM

A hospital Class Member or an authorized agent can complete this Claim Form. The Notice and 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 hospital submitting a Claim Form on your own behalf, you must provide the information requested in "**Part 1, Section A**," in addition to the other information requested by this Claim Form.

If you are an **authorized agent** of one or more Class Member hospitals, you must provide the information requested in "**Part 1, 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 hospital, OR you may submit one Claim Form for all such hospitals as long as you provide the information required for each hospital on whose behalf you are submitting the form.

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

In order to qualify to receive a payment from the Settlements, 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.

Your failure to complete and submit the Claim Form postmarked or filed online by **September 1, 2020**, 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 Settlements. If the Notice and Claims Administrator disputes a material fact concerning your Claim, you will have the right to present information in a dispute resolution process. For more information on this process, visit www.dvtmedslawsuit.com.

CLAIM DOCUMENTATION REQUIREMENTS

Please provide the below information to support your claim for Lovenox® or generic enoxaparin purchased in **Arizona, Arkansas, California, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kansas, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, South Dakota, Tennessee, Utah, Vermont, West Virginia, and Wisconsin**, other than for resale, from September 21, 2011 through September 30, 2015.

a) Medicare Provider Number (a/k/a CMS Certification Number)

b) National Provider Identifier (NPI)

c) Hospital Name

d) Address

e) City

f) State

g) Zip Code

h) Phone Number

i) Date of purchase (invoice date)

j) Item Description

k) NDC Number (a list of NDC Numbers is included with this Claim Form) – e.g., 00000-0000-00

l) Labeled Concentration (Dosage/strength; e.g., 40mg/0.4ML)

m) Type (branded Lovenox or generic enoxaparin)

n) Number of Syringes Purchased

o) Number of boxes/units

p) Cost per Unit

q) Extended Cost

r) Total Net Amount Paid – e.g., $20.00

s) Credits (e.g., for returned products)

t) Rebates received

Information submitted will be kept strictly confidential pursuant to the Protective Order entered by the Court. For your convenience, an exemplar spreadsheet containing these categories is attached at the end of this Claim Form. In addition, an Excel spreadsheet can be downloaded from the Settlement Website, www.dvtmedslawsuit.com. Please use this format if possible. A list of the NDCs that will be considered by the Notice and Claims Administrator is provided following the exemplar spreadsheet.

If possible, please provide the electronic data in Microsoft Excel, ASCII flat file pipe "|", tab-delimited, or fixed-width format. Please contact the Notice and Claims Administrator at **1-888-208-9630** with any questions about the required claims data.

Please provide as much of the requested information as possible. The requested information is by default mandatory for claims of $300,000 or more, although the Notice and Claims Administrator may also require documentation for claims of less than $300,000. For claims of less than $300,000, you should still provide the information if you can, even if not specifically requested by the Notice and Claims Administrator. Claims that do not have any documentary substantiation at all may be rejected.

Please note that hospitals can only make claims for Lovenox® and generic enoxaparin purchased by the hospital pharmacy for use at the hospital. Hospitals may not make claims for Lovenox® and generic enoxaparin purchased for resale. For example, a hospital with an affiliated retail pharmacy could make claims for the Lovenox® and generic enoxaparin it bought to use or dispense at the hospital, but not for Lovenox® and generic enoxaparin it bought to re-sell at the pharmacy.

MUST BE POSTMARKED ON OR BEFORE SEPTEMBER 1, 2020

Enoxaparin Antitrust Settlement
Case No. 15-cv-01100

HOSPITAL CLAIM FORM

Use Blue or Black Ink Only

ATTENTION: THIS FORM IS ONLY TO BE FILLED OUT ON BEHALF OF A HOSPITAL AND NOT INDIVIDUAL CONSUMERS OR THIRD PARTY-PAYORS

- Complete Section A only if you are filing as a Hospital Class Member.
- Complete Section B only if you are an authorized agent on behalf of one or more Hospitals

Section A: Hospital Class Member Only

Hospital Name

Contact Name

Address 1

Address 2

Floor/Suite

City

State

Zip Code

Area Code - Telephone Number

Tax Identification Number

Email Address

List other names by which your hospital has been known or other Federal Employer Identification Numbers ("FEINs") it has used since September 21, 2011.

Section B: Authorized Agent Only

As an Authorized Agent, please explain relationship with the Class Member(s):

Authorized Agent's Company Name

Contact Name

Address

Floor/Suite

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., Hospital) 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 Notice and Claims Administrator to determine what formats are acceptable.

CLASS MEMBER'S NAME	CLASS MEMBER'S FEIN

Please type or print in the box below, the total amount paid for Lovenox® or generic enoxaparin in

- **Arizona, Arkansas, California, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kansas, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, South Dakota, Tennessee, Utah, Vermont, West Virginia, and Wisconsin**, other than for resale,

- from September 21, 2011 through September 30, 2015.

TOTAL AMOUNT YOU PAID FOR <u>LOVENOX®</u>	$
TOTAL AMOUNT YOU PAID FOR <u>GENERIC ENOXAPARIN</u>	$

Please provide as much as possible of the information described in the "CLAIM DOCUMENTATION REQUIREMENTS" section of the instructions above. The requested information is by default mandatory for claims of $300,000 or more, although the Notice and Claims Administrator may also require documentation for claims of less than $300,000. For claims of less than $300,000, you should still provide the information if you can, even if not specifically requested by the Notice and Claims Administrator. Claims that do not have sufficient documentary support may be rejected.

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 the above Claim Form and in any documents attached by me are true, correct and complete to the best of my knowledge. I certify that I or the Class Member I represent paid the total amount set forth above in out-of-pocket expenditures for purchases of Lovenox® or generic enoxaparin in **Arizona, Arkansas, California, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kansas, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, South Dakota, Tennessee, Utah, Vermont, West Virginia, and Wisconsin** during the period from September 21, 2011 through September 30, 2015. I further certify that I or the Class Member I represent did not opt out of the Class in this Action. Nor did I or the represented Class Member purchase such Lovenox® or generic enoxaparin for purposes of resale. In addition, I have not (or the represented Class Member has not) served as counsel, officer, director, agent, or employee of any of the Defendants, or a corporate parent, subsidiary, affiliate, or other related entity thereof; or served as a judge or justice assigned to hear any aspect of this lawsuit.

To the extent I have been given authority to submit this Claim Form by a Class Member 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 identified on a separate sheet of paper submitted with this form, and to the extent I have been authorized to receive on behalf of this Class Member(s) any and all amounts that may be allocated to it from the Settlement Fund, I certify that such authority has been properly

vested in me and that I will fulfill all duties I may owe the Class Member. In the event amounts from the Settlement Fund are distributed to me and a Class Member later claims that I did not have the authority to claim and/or receive such amounts on its behalf, I and/or my employer will hold the Class, counsel for the Class, and the Notice and Claims Administrator harmless with respect to any claims made by the Class Member.

I hereby submit to the jurisdiction of the United States District Court for the Middle District of Tennessee for all purposes connected with this 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 Notice and Claims 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

Mail the completed Claim Form, along with any supporting documentation as described in Claim Documentation Instructions on page 2 above, postmarked on or before **September 1, 2020** to:

Enoxaparin Antitrust Settlement
c/o A.B. Data, Ltd.
P.O. Box 173090
Milwaukee, WI 53217
Toll-Free Telephone: 1-888-208-9630
Website: www.dvtmedslawsuit.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 Notice and Claims Administrator via the Settlement Website or U.S. Mail (the addresses are listed above).