

**Must be
Postmarked
On or Before
May 28, 2007**

In re Pharmaceutical Industry Average Wholesale Price Litigation
Docket No. 01-CV-12257-PBS, MDL No. 1456 – GSK Settlement

For Official Use Only

CONSUMER CLAIM FORM



I'd Like a Payment from the GSK Settlement Fund.

If you would like to submit a claim for part of the Settlement Fund, complete this form and mail it to the address below, along with one proof of payment for each drug (see Section D below). You may be asked for more information at a later time.

Your claim must be postmarked on or before May 28, 2007.

It should be mailed to:

GSK AWP Litigation Administrator
c/o Complete Claim Solutions, LLC
P.O. Box 24743
West Palm Beach, FL 33416

Section A – Claimant Identification

Please indicate whether you are claiming on your own behalf as a Class Member or on behalf of someone else who is a Class Member:

- I am a Class Member
- I am an heir of a Class Member and am filing on behalf of the Class Member

If you are an heir filing on behalf of a Class Member, please indicate the Class Member's name and your relationship to the Class Member in the space provided below:

Section B – Contact Information for the Person Completing this Form

Name

Street Address

Apartment

City

State

Zip Code

Section C – Purchase Information

In the chart below, please provide the *total amount* paid (not monthly) by the Class Member, or the amount the Class Member is obligated to pay, for each of the GSK Covered Drugs listed below, during the Class Period listed at the top of the column. Please place the *total amount* (not monthly) of the payment under the column that corresponds to the Class to which the Class Member belongs. A Class Member may have payments in just one of the Classes or both. For the difference between the two Classes, please consult the Notice.

Do not include flat co-payments.

	<u>Drug Name</u>	<u>Medicare Part B Class</u> January 1, 1991 – January 1, 2005	<u>Private Payor Class</u> January 1, 1991 – August 10, 2006
GSK Category A Drugs	Kytril Injection (granisetron HCL)	\$	\$
	Zofran Injection (ondansetron HCL)	\$	\$
GSK Category B Drugs	Alkeran (melphalan)	\$	\$
	Imitrex (sumatriptan)	\$	\$
	Kytril Tablets (granisetron HCL)	\$	\$
	Lanoxin (digoxin)	\$	\$
	Myleran (busulfan)	\$	\$
	Navelbine (vinorelbine tartrate)	\$	\$
	Retrovir (zidovudine)	\$	\$
	Ventolin (albuterol)	\$	\$
	Zofran Orals (ondansetron HCL)	\$	\$
	Zovirax (acyclovir)	\$	\$
	Zantac (ranitidine HCL)	\$	\$

Section D – Proof of Payment

For each of the drugs for which you have provided a purchase amount in the table in Section C above, you must provide one (1) proof of payment.

Proof of payment may be in the form of any of the following:

- (1) a written prescription for the drug;
- (2) a receipt, cancelled check, or credit card statement that shows that you or the Class Member have paid for the drug;
- (3) an EOB (explanation of benefits) that shows you or the Class Member made or are obligated to make a percentage co-payment for the drug;
- (4) a letter from your or the Class Member's physician stating that he or she prescribed and that the Class Member paid or is obligated to pay a percentage co-payment for the drug at least once and setting forth the amount of the co-payment; or
- (5) a notarized statement signed by you or the Class Member indicating you or the Class Member paid or are obligated to pay a percentage co-payment for the drug between January 1, 1991 through August 10, 2006, including the total of all percentage co-payments for the drug during that time period.

Section E – Claimant Signature

I declare that the information provided here is correct. If not submitting this for myself, I declare that I am authorized to submit this form on behalf of the Class Member identified above.

Signature

Date

Print Name