

**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

GSK AWP THIRD-PARTY PAYOR CLAIM FORM

To get a share of the Settlement Fund, you need to complete and sign this Claim Form and mail it postmarked on or before **May 28, 2007** to: GSK AWP Litigation Administrator, c/o Complete Claim Solutions, LLC, P.O. Box 24743, West Palm Beach, FL 33416.

The information you provide will be kept confidential and will be used only for administering this Proposed Settlement. If you have any questions, please call the Claims Administrator at **1-888-568-7645**.

A TPP Class Member or an authorized agent can complete this Claim Form. If both a Class Member and its authorized agent submit a Claim Form, the Claims Administrator will only consider the Class Member's Claim Form. The Claims Administrator may request supporting documentation. The claim may be rejected if any requested documentation is not provided.

If one or more Class Members has authorized you to submit a Claim Form on its behalf, you must provide the information requested in Section B in addition to the other information requested by this Claim Form. You may submit a separate Claim Form for each Class Member that has duly authorized you to do so, OR you may submit one Claim Form for all such Class Members that have authorized you to do so, as long as you provide the information required (as indicated below) for each Class Member on whose behalf you are submitting the form.

If you are submitting Claim Forms both on your own behalf as a Class Member AND on behalf of one or more Class Members that have authorized you to do so, you should submit one Claim Form for yourself and another Claim Form or Forms for the other Class Member(s). **Do not submit a Claim Form on behalf of any Class Member without specific prior authorization from that Class Member.**

SECTION A – CLAIMANT IDENTIFICATION

Please indicate whether you are claiming on your own behalf as a Class Member or as the authorized agent of one or more Class Members by placing an "X" in the appropriate space below. If you wish to make a claim as a Class Member *and also* as the authorized agent of other Class Members, please complete one Claim Form for your claim as a Class Member and a separate Claim Form for those Class Members for whom you are authorized to submit a claim:

I am the Class Member I am filing as the authorized agent of a Class Member**

** As Authorized Agent, please check how your relationship with the Class Member is best described:

Third Party Administrator (other than a Pharmacy Benefits Manager)

Pharmacy Benefits Manager

Other (Explain): _____



SECTION B – CLASS MEMBER OR AGENT INFORMATION

Class Member's/Authorized Agent's Name

Street Address

Floor/Suite

City

State

Zip Code

(_____) _____

(_____) _____

Area Code – Telephone Number

Area Code – Fax Number

Class Member's/Authorized Agent's Tax Identification Number

If you file as a Class Member, list other names by which you have been known or other Federal Employer Identification Numbers ("FEINs") you have used from January 1, 1991 through August 10, 2006.

If you are filing as the Class Member, check the term below that best describes your company/entity:

- | | |
|---|--|
| <input type="checkbox"/> Health Insurance Company/HMO | <input type="checkbox"/> Self-Insured Employee Health Plan |
| <input type="checkbox"/> Self-Insured Union Health & Welfare Fund | <input type="checkbox"/> Other (Explain): _____ |

SECTION C – CLAIM BY AUTHORIZED AGENT

Please list the Federal Employer Identification Number and the name of every Class Member for whom you have been duly authorized to submit this Claim Form (attach additional sheets to this Proof of Claim as necessary). Alternatively, you may submit the requested list of Class Member names and FEINs in an acceptable electronic format. Please contact the Claims Administrator to determine what formats are acceptable.

SECTION D – TOTAL AMOUNT OF GSK COVERED DRUG PURCHASES

For each Class Member on whose behalf you are submitting a claim, state the total and final amount paid or reimbursed for each GSK Covered Drug with a date of service or date of fill from January 1, 1999 to December 31, 2003, net of co-pays, deductibles and co-insurance. If you are claiming more than \$300,000, you will need to provide additional information (*See* Section F). If necessary, please duplicate this section so that you use it once for each Class Member on whose behalf you are submitting a claim.

Current Name of Class Member: _____

	<u>Drug Name</u>	<u>MediGap TPP Class</u> January 1, 1999 - December 31, 2003	<u>Private Payor TPP Class</u> January 1, 1999 - December 31, 2003
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)	\$	\$

Claimant certifies that the figures are true and accurate and are based upon actual records maintained by or otherwise available to the claimant.

SECTION E – JURISDICTION OF THE COURT AND CERTIFICATION

Please duplicate this section and submit it for each TPP Class Member on whose behalf you are submitting a claim.

By signing below, I hereby swear and affirm that: (1) I have authority to submit this Claim Form either directly or on behalf of the Class Member or as its Authorized Agent, and, in turn, have been given the authority to submit this Claim Form by each Class Member identified in this Claim Form and in any attachments to it, and to receive on behalf of each such Class Member any and all amounts that may be allocated from the TPP Settlement Pool to such Class Member; (2) Each entity on whose behalf I have submitted a claim is a TPP Class Member, and I have not included claims on behalf of any TPP Class Member that are readily identifiable as having been based on a reimbursement standard other than AWP; (3) the information contained in this Claim Form and any attachments hereto is true and accurate, based on records maintained by or otherwise available to me; (4) I, the Authorized Agent (if any), and the Class Member on whose behalf this Claim Form is submitted, hereby submit to the jurisdiction of the United States District Court for the District of Massachusetts (the “Court”) for all purposes associated with this Claim Form and the Proposed Settlement, including resolution of disputes relating to this Claim Form; and (5) in the event that amounts from the TPP Settlement Pool are distributed to the Authorized Agent of a Class Member, and the Class Member later claims that the Authorized Agent did not have the authority to claim and receive such amounts on its behalf, the Authorized Agent, I and/or my employer will hold the Class, Counsel for the Class, Defendants, Counsel for Defendants, and the Claims Administrator harmless with respect to any claims made by said Class Member.

Signature

Position

Print Name

Month/Day/Year

The following additional information is to be provided by the Individual that signs and certifies this Claim Form: I am filing this Claim Form as the authorized employee of the following Class Member or Authorized Agent for Class Member:

Name of Individual's Employer

Business Address

City

State

Zip Code

(_____)_____
Area Code – Telephone Number

(_____)_____
Area Code – Fax Number

E-mail Address

Mail the completed Claim Form to the address listed on the reverse side, postmarked on or before **May 28, 2007**.

SECTION F – CLAIM DOCUMENTATION INSTRUCTIONS

If you are claiming less than \$300,000 of total purchases of all GSK Covered Drugs for the 1999-2003 period, you do not need to attach any additional information. However, even if your purchase amount is less than \$300,000, you should retain the information required for claims over \$300,000 because any claim may be audited.

If you are claiming \$300,000 or more of total purchases of all GSK Covered Drugs, you must provide documentation with your Claim Form sufficient to show the amount of purchases of each GSK Covered Drug during the period of January 1, 1999 to December 31, 2003, net of co-pays, deductibles, and/or co-insurance. In addition, inclusion of the following data fields will facilitate the claims review process, and TPP Class Members with claims in excess of \$300,000 are therefore requested to provide it if practicable:

a. J-Code or NDC Number - The applicable J-Code or NDC Number for each transaction. The applicable J-Codes for each GSK Covered Drug as well as a list of NDC numbers is attached on page 10 of the Notice as Attachment 1.

b. Patient Identifier - A random encrypted patient identification number for each transaction, which can be used to track claims.

c. Age - Age information (*i.e.*, the difference between date of birth and date of service or date of fill, rounded down to the nearest year) for each transaction.

d. Service and/or Fill Date - Service date will often be available for J-Code entries and fill date will be available for NDC entries. If both are available, please include.

e. Group Number - The group number assigned to each transaction. As part of the auditing process, you may be asked to provide corresponding group name for each group number. Only the Claims Administrator will have access to this information.

f. Amount Billed - The billed charges or the initial amount billed by the provider or providers before any adjustments.

g. Units - If available, the units for each transaction should be provided.

OTHER INFORMATION

- Finally, each TPP Class Member shall provide a list of all self-funded healthcare plans (“SFP’s”) or other entities for which it is authorized to make a claim, including the identity of each entity on whose behalf the TPP Class Member is authorized to act by name and by the Federal Employer Identification Number assigned to such entity by the United States Internal Revenue Service, if the TPP Class Member has this information.

- All information you provide is subject to the protective order governing this action.

Please contact the Claims Administrator at 1-888-568-7645 with any questions about the required claims data.

Mail the completed Claim Form, postmarked on or before May 28, 2007, to:

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