

MUST BE POSTMARKED  
ON OR BEFORE  
JULY 31, 2018

*In re Solodyn (Minocycline  
Hydrochloride) Antitrust Litigation*  
Case No. 1:14-md-2503 (D. Mass.)

FOR OFFICIAL USE ONLY



**CONSUMER PROOF OF CLAIM**

**YOUR CLAIM MUST BE POSTMARKED ON OR BEFORE JULY 31, 2018**

**Mail your claim to:** Solodyn Settlement  
c/o A.B. Data, Ltd  
P.O. Box 173034  
Milwaukee, WI 53217

OR

Submit the Proof of Claim form using the Settlement Administrator's Website, [www.SolodynCase.com](http://www.SolodynCase.com)

**Section A: Claimant Identification**

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: Should I File a Claim Form?**

As a **Consumer**, you may eligible for cash from the Proposed Settlement if:

- At any time from July 23, 2009 to February 25, 2018 you purchased or paid for some or all of the purchase price for 45mg, 55mg, 65mg, 80mg, 90mg, 105mg, 115mg, and/or 135mg Solodyn and/or its generic versions of one or more of these dosages, in Alabama, Alaska, Arizona, Arkansas, California, Florida, Hawaii, Idaho, Illinois, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming, the District of Columbia and Puerto Rico, in tablet form, for consumption by yourself or your family.
- The following are **NOT** eligible members of the Class:

- Defendants and their counsel, officers, directors, management, employees, subsidiaries, or affiliates;
- All persons or entities that purchased Solodyn or its generic equivalents for purposes of resale or directly from the Defendants or their affiliates;
- Flat co-payers (consumers who paid the same co-payment amount for brand and generic drugs); and
- The judges in this case and any members of their immediate families.

By checking this box, I confirm that I have read the definition of the class and I am not excluded from participating in the Proposed Settlement.

**Section C: Purchase Information**

Provide the total amount of the Class Member’s out-of-pocket expenditures for purchases or reimbursement of 45mg, 55mg, 65mg, 80mg, 90mg, 105mg, 115mg, and/or 135mg Solodyn and/or its generic versions of one or more of these dosages, in Alabama, Alaska, Arizona, Arkansas, California, Florida, Hawaii, Idaho, Illinois, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming, the District of Columbia and Puerto Rico, in tablet form, for consumption by yourself or your family from July 23, 2009 through February 25, 2018, inclusive.

Only include purchases in the states listed above from July 23, 2009 through February 25, 2018.

SOLODYN <sup>®</sup> AND/OR ITS GENERIC VERSION PRESCRIPTIONS	TOTAL AMOUNT PAID
Purchases or Reimbursements from July 23, 2009 through February 25, 2018, inclusive.	\$

**Section D: Note Regarding Documentation**

You do not need to provide any documentation at this time. However, the Settlement Administrator may ask for additional proof of payment. Any one of the following is acceptable as claim documentation for Solodyn<sup>®</sup> brand or generic versions of Solodyn<sup>®</sup> prescriptions purchased or reimbursed between July 23, 2009 and February 25, 2018, inclusive:

- 1) Itemized receipts, cancelled checks, or credit card statement that show a payment for Solodyn<sup>®</sup> or generic versions of Solodyn<sup>®</sup>; or
- 2) An EOB (explanation of benefits) from your insurer that shows you paid for Solodyn<sup>®</sup> or generic versions of Solodyn<sup>®</sup>; or
- 3) Records from your pharmacy showing that you paid for Solodyn<sup>®</sup> or generic versions of Solodyn<sup>®</sup>.

**Section E: Certification**

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 Proof of Claim 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 or reimbursements of 45mg, 55mg, 65mg, 80mg, 90mg, 105mg, 115mg, and/or 135mg Solodyn<sup>®</sup> and/or its generic versions of one or more of these dosages, in Alabama, Alaska, Arizona, Arkansas, California, Florida, Hawaii, Idaho, Illinois, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming, the District of Columbia and Puerto Rico, in tablet form, for consumption by yourself or your family from July 23, 2009 through February 25, 2018, inclusive. I further certify that I or the represented Class

Member did not purchase such Solodyn® or generic versions of Solodyn® 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 Medicis Pharmaceutical Corp., Impax Laboratories, Inc., Lupin Limited, Lupin Pharmaceuticals Inc., and Sandoz Inc, (together, the "Defendants"), or a corporate parent, subsidiary, affiliate, or other related entity thereof; or a judge or justice assigned to hear any aspect of this lawsuit.

To the extent I have been given authority to submit this Proof of Claim by a Class Member on its behalf, and accordingly am submitting this Proof of Claim 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 Settlement 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 District of Massachusetts for all purposes connected with this Proof of Claim, including resolution of disputes relating to this Proof of Claim. 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 Proof of Claim by furnishing documentary backup for the information provided herein, upon request of the Settlement Administrator.

**I certify that the above information supplied by the undersigned is true and correct to the best of my knowledge and that this Proof of Claim form was executed this \_\_\_\_\_ day of \_\_\_\_\_, 2018.**

Signature

Print or Type Name

Mail the completed Claim Form postmarked on or before **July 31, 2018**, along with proof of payment, if required, to the following address:

Solodyn Settlement

c/o A.B. Data, Ltd.

P.O. Box 173034

Milwaukee, WI 53217

Toll-Free Telephone: 1-800-332-7414

Website: [www.SolodynCase.com](http://www.SolodynCase.com)

**REMINDER CHECKLIST:**

1. Please complete and sign the above Proof of Claim form. Attach or upload any documentation supporting your claim.
2. Keep a copy of your Proof of Claim form and supporting documentation for your records.
3. If you would also like acknowledgement of receipt of your Proof of 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 in the Notice).