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

THIRD-PARTY PAYOR PROOF OF CLAIM AND RELEASE

Use Blue or Black Ink Only

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

PART I – CLAIMANT IDENTIFICATION

SECTION A		SECTION B
ONLY IF YOU ARE FILING AS A CLASS MEMBER FOR YOUR COMPANY'S HEALTH PLAN	**OR**	ONLY IF YOU ARE AN AUTHORIZED AGENT FILING ON BEHALF OF ONE OR MORE CLASS MEMBERS

Section A: Company or Health Plan Class Member Only

Company or Health Plan 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 company or health plan has been known or other Federal Employer Identification Numbers ("FEINs") it has used since July 23, 2009.

☐ Health Insurance Company/HMO ☐ Self-Insured Employee Health Plan ☐ Self-Insured Health & Welfare Fund

☐ Other (Explain)

Section B: Authorized Agent Only

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

☐ Third-Party Administrator

☐ Pharmacy Benefits Manager

☐ Other (Explain):

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., Company or Health Plan) 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 electronic format, such as Excel or a tab-delimited text file saved on a disk. Please contact the Settlement Administrator to determine what formats are acceptable.

CLASS MEMBER'S NAME	CLASS MEMBER'S FEIN

PART II – AMOUNT CLAIMED

Please type or print in the box below, the total amount paid or reimbursed, net of co-pays, deductibles, and co-insurance, 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, from July 23, 2009 through February 25, 2018, inclusive.

Note that this Settlement excludes all federal and state governmental entities, excluding cities, towns, or municipalities with self-funded prescription drug plans.

SOLODYN® AND/OR GENERIC VERSION PRESCRIPTIONS	**TOTAL AMOUNT PAID**
Purchases or Reimbursements From July 23, 2009 to February 25, 2018, inclusive.	$

You must submit claims data and information in support of the purchase amounts stated above if your total net claim amount is more than $300,000. Instructions on how to do so are found in the Claims Documentation Instructions on Page 1. If your total net claim is $300,000 or less, you need not provide complete claims data with this Claim Form, but the Settlement Administrator may require supporting documentation.

PART III – CERTIFICATION

I (We) have read and am (are) familiar with the contents of the Instructions accompanying this Claim Form. I (We) certify that the information I (we) have set forth in the above Proof of Claim and in any documents attached by me (us) are true, correct and complete to the best of my (our) knowledge. I (We) certify that I (we) of the Class Member(s) I (we) 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® 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 (We) further certify that I (we) or the Class Member(s) did not opt out of the certified Class in these Actions. Nor did I (we) of the represented Class Member(s) purchase such Solodyn® for purposes of resale. In addition, I (we) have not (or the represented Class Member(s) 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 (we) have been given authority to submit this Proof of Claim by a Class Member(s) 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(s) identified on a separate sheet of paper submitted with this form, and to the extent I (we) have been authorized to receive on behalf of this Class Member(s). In the event amounts from the Settlement Fund are distributed to me (us) and a Class Member(s) later claims that I (we) did not have authority to claim and/or receive such amounts on its behalf, I (we) and/or my (our) employer will hold the Class, counsel for the Class, and the Settlement Administrator harmless with respect to any claims made by the Class Member(s).

I (We) hereby submit to the jurisdiction of the United States District Court for the District of Massachusetts for all purposes connected with the Proof of Claim, including resolution of disputes relating to this Proof of Claim. I(we) acknowledge that any false information or representations contained herein may subject me (us) to sanctions, including the possibility of criminal prosecution. I (we) 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	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 **July 31, 2018** to:

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

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 above).