MUST BE POSTMARKED ON OR BEFORE JULY 25, 2022

FOR OFFICIAL USE ONLY

In re EpiPen (Epinephrine Injection, USP) Marketing, Sales Practices, and Antitrust Litigation
Case No. 2:17-md-02785-DDC-TJJ, MDL No. 2785 (D. Kan.)

THIRD PARTY PAYOR PROOF OF CLAIM

If you submitted a Proof of Claim form in 2021 as part of the settlement in this case with the Pfizer Defendants and you wish to participate in the settlement with the Mylan Defendants as well, you DO NOT need to do anything further and DO NOT need to submit a new Proof of Claim form. You should only submit a Proof of Claim form now if you wish to participate in the settlement with the Mylan Defendants and did not previously submit a Proof of Claim form. If you submit a Proof of Claim form now, YOUR CLAIM MUST BE POSTMARKED OR SUBMITTED ONLINE ON OR BEFORE **JULY 25, 2022.**

Submit the Proof of Claim form using the Settlement Administrator's website, www.EpiPenClassAction.com

OR

Mail your claim to: *EpiPen Settlement*, c/o A.B. Data, Ltd., P.O. Box 173113, Milwaukee, WI 53217

ATTENTION: THIS FORM IS ONLY TO BE FILLED OUT ON BEHALF OF A THIRD-PARTY PAYOR, NOT INDIVIDUAL CONSUMERS. IF YOU ARE AN INDIVIDUAL CONSUMER AND WANT TO MAKE A CLAIM, PLEASE FILL OUT THE CONSUMER FORM.

PART I – CLAIMANT IDENTIFICATION

SECTION A	OR	SECTION B
ONLY IF YOU ARE FILING AS A CLASS MEMBER FOR YOUR COMPANY'S HEALTH PLAN		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

City | State | Zip

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 August 24, 2011.

☐ 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 Benefit Manager

☐ Other (Explain)

Authorized Agent's Company Name

Contact Name

Address 1

Address 2

City State Zip

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 or flash drive. 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 for branded and authorized generic EpiPen® or EpiPen Jr® (collectively, "EpiPen") devices, net of co- pays, deductibles, and co- insurance, between August 24, 2011, and November 1, 2020, inclusive.

Please note that certain groups have been excluded from the Class in this case. Do not submit a claim for or on behalf of any of the following excluded groups:

a. Pfizer, Inc., Meridian Medical Technologies, Inc., King Pharmaceuticals, Inc. (n/k/a King Pharmaceuticals LLC), Mylan N.V., Mylan Specialty L.P., Mylan Pharmaceuticals Inc., and their officers, directors, managers, employees, subsidiaries, and affiliates (collectively, the "Defendants");

b. Government entities, other than government-funded employee benefit plans;

c. Fully insured health plans (*i.e.*, plans that purchased insurance that covered 100% of the plan's reimbursement obligations to its members);

d. Entities that purchased branded or authorized generic EpiPen devices directly from one or more of the Defendants;

e. All third-party payors who own or otherwise function as a Pharmacy Benefit Manager or control an entity who functions as a Pharmacy Benefit Manager; and

f. Any entity that previously opted out of the Class in this Action.

EPIPEN PRESCRIPTIONS	**TOTAL AMOUNT PAID**
Purchases or Reimbursements between August 24, 2011, and November 1, 2020, for branded or authorized generic EpiPen devices	$

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 the Settlement Administrator's website or included with this Claim Form. 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 after reviewing your Claim.

PART III – CERTIFICATION

I (We) have read and am (are) familiar with the contents of this Claim Form. I (We) certify that the information I (we) have set forth above 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) or the Class Member(s) I (we) represent paid the total amount set forth above in expenditures for purchases or reimbursements of branded or authorized generic EpiPen devices in the United States and its territories and possessions including Puerto Rico between August 24, 2011, and November 1, 2020, inclusive. I (We) further certify that I (we) or the Class Member(s) I (we) represent did not opt out of the certified Class in this Action. Nor did I (we) or the represented Class Member(s) purchase such EpiPen devices for purposes of resale. In addition, I (we): (1) have not (or the represented Class Member has not) served as counsel, officer, director, agent, or employee of one of the Defendants, or a corporate parent, subsidiary, affiliate, or other related entity thereof; and (2) did not purchase branded or authorized generic EpiPen devices directly from Defendants; and (3) do not own or otherwise function as a Pharmacy Benefit Manager or control an entity who functions as a Pharmacy Benefit Manager.

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 payment 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 Kansas 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 _____, 2022.

Signature	Position/Title
Print Name	**Date**

If you have not completed this Claim Form online and submitted it electronically through the Settlement Administrator's website, you must mail the completed Claim Form, along with any supporting documentation as described above, postmarked on or before **July 25, 2022**, to the following address:

EpiPen Settlement
c/o A.B. Data, Ltd.
P.O. Box 173113
Milwaukee, WI 53217

Toll-Free Telephone: 1-877-221-7632 Website: www.EpiPenClassAction.com

REMINDER CHECKLIST:

1. If you did not already submit a Proof of Claim form in 2021 as part of the settlement with the Pfizer Defendants in this case, please complete and sign the above Proof of Claim form. Attach or upload any documentation supporting your claim if you choose to submit documentation with your claim. If you did already submit a Proof of Claim form in 2021 as part of the settlement with the Pfizer Defendants, you do not need to submit a second Proof of Claim form.

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).