In Re Restasis (Cyclosporine Ophthalmic Emulsion) Antitrust Litigation	Case No. 18-md-2819

INSTRUCTIONS FOR SUBMITTING YOUR THIRD-PARTY PAYOR CLAIM FORM

A Third-Party Payor ("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 Notice and Claims Administrator will only consider the Class Member's Claim Form. The Notice and Claims Administrator may request supporting documentation in addition to the documentation and information requested below. The Notice and Claims Administrator may reject a claim if the TPP Class Member or their authorized agent does not provide all requested documentation in a timely manner.

If you are a Class Member submitting a Claim Form on your own behalf, you must provide the information requested in "**Section A – COMPANY OR HEALTH PLAN CLASS MEMBER ONLY**," in addition to the other information requested by this Claim Form.

If you are an **authorized agent** of one or more Class Members, you must provide the information requested in "**Section B – AUTHORIZED AGENT ONLY**," in addition to the other information requested by this Claim Form. **Do not submit a Claim Form on behalf of any Class Member unless that Class Member provided prior authorization to submit the Claim Form.**

If you are submitting a Claim Form only as an authorized agent of one or more Class Members, you may submit a separate Claim Form for each Class Member, OR you may submit one Claim Form for all such Class Members as long as you provide the information required 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 as an authorized agent on behalf of one or more Class Members, you should submit one Claim Form for yourself, completing Section A and another Claim Form or Forms as an authorized agent for the other Class Member(s), completing Section B.

To qualify to receive a payment from the Settlement, you must complete and submit this Claim Form either on paper or electronically on the Settlement website, and you may need to provide certain requested documentation to substantiate your Claim.

Your failure to complete and submit the Claim Form postmarked or filed online by **August 11, 2022**, will prevent you from receiving any payment from the Settlement. Submission of this Claim Form does not ensure that you will share in the payments related to the Settlement. If the Notice and Claims Administrator rejects or reduces your Claim, you may invoke the dispute resolution process described on pages 5-6.

CLAIM INFORMATION AND DOCUMENTATION REQUIREMENTS

Please provide the following information to support your Claim for purchases and/or reimbursement of Restasis® for use by your members, employees, insureds, participants, or beneficiaries, where such persons purchased the drug in a pharmacy or received Restasis® by mail-order prescription, in the following states: Arizona, Arkansas*, California,

Colorado, the District of Columbia, Florida, Hawaii, Illinois, Iowa, Kansas, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, Rhode Island, South Dakota, Tennessee, Utah, West Virginia, and Wisconsin from May 1, 2015 through July 31, 2021.

**With respect to Arkansas only, Class Members must have paid for and/or provided reimbursement for Restasis® between May 1, 2015 and July 31, 2017.*

a) Unique patient identification number or code

b) NDC Number (a list of NDC Numbers is included with this Claim Form) – *e.g.*, 00000-0000-00

c) Fill Date or Date of Service – *e.g.*, 01/01/2016

d) Location (State) of Service – *e.g.*, CA

e) Amount Billed (not including dispensing fee) – *e.g.*, $40.00

f) Amount Paid by TPP net of co-pays, deductibles, and co-insurance – *e.g.*, $20.00

g) A notation identifying claims for which, as of the date in item c) above, you were not providing prescription drug coverage, and, instead, acted in an Administrative Services Only (ASO) or Third-Party Administrator (TPA) capacity.

Information submitted will be covered by the Protective Order entered by the Court. For your convenience, an exemplar spreadsheet containing these categories is attached at the end of this Claim Form. In addition, an Excel spreadsheet can be downloaded from the website, www.RestasisLitigation.com. Please use this format if possible. Following the exemplar spreadsheet, the website provides a list of the NDCs that the Notice and Claims Administrator will consider. If possible, please provide the electronic data in Microsoft Excel, ASCII flat file pipe "|", tab-delimited, or fixed-width format.

Please provide as much of the information requested above as possible. Transaction data supporting claims is mandatory for claims of $100,000 or more, although the Notice and Claims Administrator may also require transaction data for claims of less than $100,000, so keep related transaction data and any other documentation supporting your Claim (*e.g.*, invoices) in case the Notice and Claims Administrator requests it later. If your Claim is for less than $100,000, you should still provide the transaction data with your Claim submission if you can. If, after an audit of your Claim, the Notice and Claims Administrator still has questions about your Claim and you have not provided sufficient substantiation of your Claim, the Notice and Claims Administrator may reject your Claim.

Please contact the Notice and Claims Administrator at 1-877-868-6810 with any questions about the required claims information or documentation.

MUST BE POSTMARKED ON OR BEFORE, OR SUBMITTED ONLINE BY AUGUST 11, 2022

Restasis Settlement
Case No. 18-md-2819

THIRD-PARTY PAYOR CLAIM FORM

Use Blue or Black Ink Only

ATTENTION: THIS FORM IS ONLY TO BE FILLED OUT ON BEHALF OF A THIRD-PARTY PAYOR (OR AN AUTHORIZED AGENT) AND NOT INDIVIDUAL CONSUMERS.

- Complete Section A only if you are filing as an individual TPP Class Member.
- Complete Section B only if you are an authorized agent filing on behalf of one or more TPP 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 May 1, 2015.

☐ Health Insurance Company/HMO

☐ Self-Insured Employee Health or Pharmacy Benefit Plan

☐ Other (Explain)

Self-Insured Health & Welfare Fund

Section B: Authorized Agent Only

As an authorized agent, please check how your relationship with the Class Member(s) is best described (you may be required to provide documentation demonstrating this relationship):

☐ Third-Party Administrator or Administrative Services Only Provider

☐ 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 Claim Form 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. Please contact the Notice and Claims Administrator to determine what formats are acceptable.

CLASS MEMBER'S NAME	CLASS MEMBER'S FEIN

Section C: Purchase Information

Please type or print in the box below, the total amount paid or reimbursed for Restasis® net of co-pays, deductibles, and co-insurance for use by your members, employees, insureds, participants, or beneficiaries, where such persons purchased the drug in a pharmacy or received Restasis® by mail-order prescription:

- in Arizona, Arkansas, California, Colorado, the District of Columbia, Florida, Hawaii, Illinois, Iowa, Kansas, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, Rhode Island, South Dakota, Tennessee, Utah, West Virginia, and Wisconsin;

- from May 1, 2015 through July 31, 2021 (for Arkansas only from May 1, 2015 through July 31, 2017).

TOTAL AMOUNT YOU PAID FOR RESTASIS® – NET OF CO-PAYS, DEDUCTIBLES, AND CO-INSURANCE	$

Authorized Agents Only: For each Class Member for whom you are submitting this Claim Form, please provide the above information with respect to purchases made by the Class Member's members, employees, insureds, participants, or beneficiaries. If you are submitting claims for multiple Class Members, please provide, separately for each Class Member, as much of the transaction data and other information and documentation requested in the "CLAIM INFORMATION AND DOCUMENTATION REQUIREMENTS" section of the instructions above as possible. Fill out the box above with the combined amounts paid by all Class Members for whom you are submitting this Claim Form, net of co-pays, deductibles, and co-insurance.

Section D: Proof of Payment and Disputes Regarding Claim Amounts

Please provide as much of the information requested above as possible. Transaction data supporting claims is mandatory for claims of $100,000 or more, although the Notice and Claims Administrator may also require transaction data for claims of less than $100,000, so keep related transaction data and any other documentation supporting your Claim (*e.g.*, invoices) in case the Notice and Claims Administrator requests it later. If your Claim is for less than $100,000, you should still provide the transaction data with your Claim submission if you can. If, after an audit of your Claim, the Notice and Claims Administrator still has questions about your Claim and you have not provided sufficient substantiation of your Claim, the Notice and Claims Administrator may reject your Claim.

If the Notice and Claims Administrator rejects or reduces your claim and you believe the rejection or reduction is in error, you may contact the Notice and Claims Administrator to request further review. If the dispute concerning your claim cannot be resolved by the Notice and Claims Administrator and Class Counsel, you may request that the Court review your claim.

To request Court review, you must send the Notice and Claims Administrator a signed written statement that (a) states your reasons for contesting the rejection or payment determination regarding your claim; and (b)

specifically states that you "request that the Court review the determination regarding this claim." You must include all documentation supporting your argument(s). Your request must be postmarked no later than 30 days after the Notice and Claims Administrator dates its response to your request for it to review your claim. The Notice and Claims Administrator and Class Counsel will present the dispute to the Court for review, which may include public filing with the Court of your claim and the supporting documentation. Please note: Court review should only be sought if you disagree with the Notice and Claims Administrator's determination regarding your claim.

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 Claim Form 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(s) I represent, paid or reimbursed for Restasis® in the total amount set forth above for use by members, employees, insureds, participants, or beneficiaries, where such persons purchased the drug in a pharmacy or received Restasis® by mail-order prescription, in the following states: Arizona, Arkansas (*only from May 1, 2015 through July 31, 2017)*, California, Colorado, the District of Columbia, Florida, Hawaii, Illinois, Iowa, Kansas, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, Rhode Island, South Dakota, Tennessee, Utah, West Virginia, and Wisconsin from May 1, 2015 through July 31, 2021. I further certify that I, or the Class Member(s) I represent, did not seek to be excluded ("opt out") from the Class in this Action. Nor did I, or the represented Class Member(s), pay for or provide reimbursement of Restasis® for purposes of resale. In addition, I have not (or the represented Class Member(s) has/have not) served as counsel, officer, director, agent, or employee of the Defendant, or a corporate parent, subsidiary, affiliate, or other related entity thereof; or served as a judge or justice assigned to hear any aspect of this lawsuit.

I further certify I have provided all of the information requested above to the extent I have it.

To the extent I have been given authority to submit this Claim Form by one or more Class Members on their behalf, and accordingly am submitting this Claim Form in the capacity of an authorized agent with authority to submit it, and to the extent I have been authorized to receive on behalf of the Class Member(s) any and all amounts that may be allocated to them 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(s). If 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 Notice and Claims 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 Eastern District of New York for all purposes connected with this Claim Form, including resolution of disputes relating to this Claim Form. 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 Claim Form by furnishing documentary backup for the information provided herein, upon request of the Notice and Claims Administrator.

I certify that the above information supplied by the undersigned is true and correct to the best of my knowledge and that this Claim Form was executed this _____ day of _____, 20____.

Signature

Position/Title

Print Name

Date

Mail the completed Claim Form to the address below, along with any supporting documentation as described in the CLAIM INFORMATION AND DOCUMENTATION INSTRUCTIONS on pages 1-2 above, postmarked on or before **August 11, 2022**, or submit the information online at the website below by that date:

Restasis Settlement
c/o A.B. Data, Ltd.
P.O. Box 173107
Milwaukee, WI 53217
Toll-Free Telephone: 1-877-868-6810
Website: www.RestasisLitigation.com

REMINDER CHECKLIST:

1. Please complete and sign the above Claim Form. Attach or upload any documentation supporting your claim.
2. Keep a copy of your Claim Form and supporting documentation for your records.
3. If you would also like acknowledgement of receipt of your 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 Notice and Claims Administrator at info@RestasisLitigation.com or via U.S. Mail at the address listed above.

In Re Restasis (Cyclosporine Ophthalmic Emulsion) Antitrust Litigation

Purchases and/or reimbursement of Restasis® for use by your members, employees, insureds, participants, or beneficiaries, where such persons purchased the drug in a pharmacy or received Restasis® by mail-order prescription, in the following states: Arizona, Arkansas*, California, Colorado, the District of Columbia, Florida, Hawaii, Illinois, Iowa, Kansas, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, Rhode Island, South Dakota, Tennessee, Utah, West Virginia, and Wisconsin from May 1, 2015 through July 31, 2021.

***With respect to Arkansas only, Class Members must have paid for and/or provided reimbursement for Restasis® between May 1, 2015 and July 31, 2017.**

Unique Patient Identifier or Code	NDC Number	Fill/Service Date	State of Service	Amount Billed	Amount Paid by TPP	ASO/TPA Capacity

Restasis NDC List

The list below is available to assist in locating eligible purchases. We do not represent that this list is all inclusive. You may search your records using either the NDC, the name, or the active ingredients. Please contact the Notice and Claims Administrator if you identify additional products that you believe may be eligible for confirmation.

NDC
0023-9163-12
0023-9163-30
0023-9163-60
50090-1242-0
54868-4793-1
0023-5301-01
0023-5301-05