United States District Court
Eastern District of Pennsylvania

In Re: Suboxone (Buprenorphine Hydrochloride and Nalaxone) Antitrust Litigation	Civil Action No. 2:13-md-02445

Instructions for Submitting Your Consumer Claim Form

If you are a member of the End Payor Class as a consumer, you may file a claim for a share of the Settlement Fund. You must complete this Claim Form and mail it to the Settlement Administrator at the address provided below postmarked, or submit your claim online at www.SuboxAntitrust.com, no later than February 17, 2024.

- Complete all required portions of the attached Claim Form:

1. Complete *Section A*.
2. Answer the question in *Section B* to determine your eligibility.
3. Provide information about your total purchases of Co-Formulated Buprenorphine/Naloxone ("Suboxone") in *Section C*.
4. If possible, provide documentation of at least one purchase of Co-Formulated Buprenorphine/Naloxone ("Suboxone") as described in *Section D*.
5. Review and sign the Claim Form in *Section E*, which includes the Certification that the information you provide is true and correct to the best of your knowledge.

- By signing and submitting the Claim Form, you are swearing under penalty of perjury that you qualify to submit a claim according to the criteria given in *Section B*.
- You have two options for submitting a Claim Form:
    - You can mail the completed and signed Claim Form and Certification by First-Class U.S. Mail, postage prepaid, postmarked no later than **February 17, 2024**, to:

Settlement Administrator 54388
c/o A.B. Data, Ltd.
P.O. Box 173080
Milwaukee, WI 53217

OR

- You can complete and submit the Claim Form and Certification using the Settlement Administrator's website, www.SuboxAntitrust.com. When you complete the online Claim Form, you will receive an acknowledgement that your claim has been submitted. If you choose this option and file a claim electronically, your electronic signature and submission of the form will conform to the requirements of the Electronic Signatures Act, 15 U.S.C. § 7001, *et seq.*, and will have the same force and effect as if you signed the Claim Form in hard copy.

- If your completed Claim Form is not postmarked or filed online by **February 17, 2024**, you will not receive any payment from the Settlement. Submission of this Claim Form does not ensure that you will share in the payments related to the Settlement.

MUST BE POSTMARKED ON OR BEFORE, OR SUBMITTED ONLINE BY, FEBRUARY 17, 2024.

Consumer Claim Form

Use Blue or Black Ink Only

Attention: This Form Is Only to Be Filled Out for a Consumer and Not a Third-Party Payor.

Section A: Claimant Identification

Claimant's Name

Tarrant County, Texas

Agent/Legal Representative (if any)

County Judge Tim O'Hare / Attorney David K. Hudson

Street Address

100 E. Weatherford Street

City: Fort Worth | State: TX | Zip Code: 76196

Daytime Telephone Number: 817-884-1233 (Atty Hudson)

Email Address*: dkhudson@tarrantcountytx.gov

*By providing your email address, you authorize the Settlement Administrator to use it to send you information relevant to this claim.

Section B: Should I File a Claim Form?

You may be eligible to file a Claim Form and receive a cash distribution from the proposed Settlement if you purchased and/or paid for some or all of the purchase price for Co-Formulated Buprenorphine/Naloxone (Suboxone and/or its AB-rated generic equivalent) in any form during the period December 22, 2011 through August 21, 2023 (the "Class Period"), for consumption by yourself or your family and not resale, in Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming, and District of Columbia.

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

a) Pharmacy benefit managers;
b) Defendant and its officers, directors, management, employees, subsidiaries, or affiliates;
c) All governmental entities, except for government funded employee benefit plans;
d) All persons or entities who purchased Suboxone and/or its AB-rated generic equivalent in any form for purposes of resale or directly from Defendant or its affiliates;
e) The judges in this case and any members of their immediate families; or
f) Any entity that previously submitted a valid exclusion request from the Class.

If you excluded yourself from the Class, you may not file a claim.

Section C: Purchase Information

a) The Court-approved plan of allocation provides for different recoveries depending on the state or states in which your Suboxone purchases were made. The states are divides into two groups, call Repealer States and Non-Repealer States. If you are an eligible claimant, please type or print in the boxes below the total number of prescriptions and amounts paid for Suboxone and its AB-rated generic equivalents for purchases made in Repealer States, Non-Repealer States, or both. List your purchases over the entire Class Period. If any purchases were made by mail-order, the state to which the prescription was sent (most likely your state of residence) is considered the place of purchase.

REPEALER STATE SUBOXONE PRESCRIPTIONS	NUMBER OF PRESCRIPTIONS	TOTAL AMOUNT PAID
Provide the number of prescriptions and total amount paid for prescriptions of Suboxone and its AB-rated generic equivalents purchased in Alabama, Alaska, Arizona, California, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, West Virginia, and Wisconsin.		

NON-REPEALER STATE SUBOXONE PRESCRIPTIONS	NUMBER OF PRESCRIPTIONS	TOTAL AMOUNT PAID
Provide the number of prescriptions and total amount paid for prescriptions of Suboxone and its AB-rated generic equivalents in Arkansas, Colorado, Connecticut, Delaware, Georgia, Idaho, Kentucky, Louisiana, Montana, New Jersey, Oklahoma, Texas, Washington, and Wyoming.	265	$60, 972.08

Section D: Claim Documentation and Disputes Regarding Claim Amounts

You may file a claim by providing the information requested in Section C and completing the certification below.

If possible, you should also submit any of the following, which are all acceptable as claim documentation:

1) Records from your pharmacy showing that you purchased Suboxone and its AB-rated generic equivalents at least once; or
2) A note from your doctor (or records) describing the amount of Suboxone and its AB-rated generic equivalents you were prescribed.

Note: You may have a claim even if you cannot provide any of the above claim documentation as long as you provide the certification below. However, if you do not provide the above documentation, the Settlement Administrator may ask for additional claim documentation after you submit your Claim Form, so please keep all

records of your purchases. Claims may be selected for audit and rejected because of fraud concerns, or potentially inaccurate amounts based on expected average purchases.

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

To request Court review, you must send the Settlement 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). The Settlement 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 that Court review should only be sought if you disagree with the Settlement 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 is true, correct, and complete to the best of my knowledge. I certify that I or the End Payor Class member(s) I represent:

a) indirectly purchased and/or paid for **Suboxone and its AB-rated generic equivalents** in any form during the period December 22, 2011 through August 21, 2023, for consumption by me, my family members, or the End Payor Class members I represent, where the drug was purchased in a pharmacy or received by mail-order prescription, in Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming, and District of Columbia;

b) am not one of the following excluded parties:

i. Pharmacy benefit managers;
ii. Defendant and its officers, directors, management, employees, subsidiaries, or affiliates;
iii. All governmental entities, except for government funded employee benefit plans;
iv. All persons or entities who purchased Suboxone and its AB-rated generic equivalents for purposes of resale or directly from Defendant or its affiliates;
v. The judges in this case and any members of their immediate families.

I and/or the End Payor Class member I represent have not previously submitted a valid exclusion request from the Class.

I further certify I have provided all 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 End Payor 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 End Payor 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 End Payor Class member(s). If amounts from the Net Settlement Fund are distributed to me and an End Payor Class member later claims that I did not have the authority to claim and/or receive such amounts on its behalf, I will hold the End Payor Class, Class Counsel, and the Settlement Administrator harmless with respect to any claims made by

the End Payor Class member.

I hereby submit to the jurisdiction of the United States District Court for the Eastern District of Pennsylvania 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 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 Claim Form was executed this _____ day of _____ 20____.

Signature	Print or Type Name

Mail the completed Claim Form postmarked on or before **February 17, 2024**, along with claim documentation, if available, to the following address, or submit the information online at the website below:

Settlement Administrator 54388
c/o A.B. Data, Ltd.
P.O. Box 173080
Milwaukee, WI 53217
Toll-Free Telephone: 1-877-311-3735
Website: www.SuboxAntitrust.com

Reminder Checklist:

1. Please complete and sign the above Claim Form, or complete the online 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 Settlement Administrator at info@SuboxAntitrust.com or via U.S. Mail at the address listed above.