MUST BE POSTMARKED NO LATER THAN NOVEMBER 19, 2010

BMS AWP SETTLEMENT
THIRD-PARTY PAYOR CLAIM FORM

OFFICIAL USE ONLY

In re: Pharmaceutical Industry Average Wholesale Price Litigation
Docket No. 01-CV-12257 PBS, MDL No. 1456

To get a share of the Settlement Fund, you need to complete and sign this Claim Form and submit it to:

BMS AWP TPP Settlement Administrator
P.O. Box 24648
West Palm Beach, FL 33416

This Claim Form must be received or postmarked no later than November 19, 2010.

The information you provide will be kept confidential and will be used only for administering this settlement. If you have any questions, please call the Claims Administrator at **1-877-690-7097.**

A TPP Settlement Class Member ("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 Claims Administrator will only consider the Class Member's Claim Form. The Claims Administrator may request supporting documentation. The claim may be rejected if any requested documentation is not provided.

If one or more Class Members has authorized you to submit a Claim Form on its behalf, you must provide the information requested in Section B in addition to the other information requested by this Claim Form. You may submit a separate Claim Form for each Class Member that has duly authorized you to do so, OR you may submit one Claim Form for all such Class Members that have authorized you to do so. If you are submitting Claim Forms both on your own behalf as a Class Member AND on behalf of one or more Class Members that have authorized you to do so, you should submit one Claim Form for yourself and another Claim Form for the other Class Member(s). **Do not submit a Claim Form on behalf of any Class Member without specific prior authorization from that Class Member.**

SECTION A – CLAIMANT IDENTIFICATION

Please indicate whether you are claiming on your own behalf as a Class Member or as the authorized agent of one or more Class Members by placing an "X" in the appropriate space below. If you wish to make a claim as a Class Member *and also* as the authorized agent of other Class Members, please complete one Claim Form for your claim as a Class Member and a separate Claim Form for those Class Members for whom you are authorized to submit a claim:

☐ I am the Class Member

☐ I am filing as the Authorized Agent of a Class Member**

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

☐ Third Party Administrator (other than a Pharmacy Benefits Manager)

☐ Pharmacy Benefits Manager

☐ Other (Explain): _____

SECTION B – CLASS MEMBER OR AGENT INFORMATION

Class Member's/Authorized Agent's Name

Street Address

Floor/Suite

City

State

Zip Code

Area Code – Telephone Number

Area Code – Fax Number

Class Member's/Authorized Agent's Tax Identification Number

If you file as a Class Member, list other names by which you have been known or other Federal Employer Identification Numbers ("FEINs") you have used from January 1, 1991 through December 31, 2004.

If you are filing as the Class Member, check the term below that best describes your company/entity:

- ☐ Health Insurance Company/HMO
- ☐ Self-Insured Union Health & Welfare Fund
- ☐ Self-Insured Employee Health Plan
- ☐ Other (Explain):

SECTION C – CLAIM BY AUTHORIZED AGENT

Please list the name and FEIN of every Class Member 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 acceptable electronic format. Please contact the Claims Administrator to determine what formats are acceptable.

SECTION D – TOTAL AMOUNT OF BMS DRUG PURCHASES

For the Class Member on whose behalf you are submitting a claim, state the total and final amount paid or reimbursed, net of rebates, chargebacks, co-pays, and/or co-insurance for each BMS Drug set out in the chart below with a date of service or date of fill from January 1, 2003 to December 31, 2003. If you are claiming more than $300,000, you will need to provide additional information (*See* Section F):

Drug Name	MediGap TPP Class	Private Payor TPP Class
Blenoxane	$	$
Cytoxan	$	$
Etopophos	$	$
Paraplatin	$	$
Rubex	$	$
Taxol	$	$
Vepesid	$	$
TOTAL $	$	$

Claimant certifies that the figures are true and accurate and are based upon actual records maintained by or otherwise available to the claimant.

SECTION E – JURISDICTION OF THE COURT AND CERTIFICATION

By signing below, I hereby swear and affirm that: (1) I have authority to submit this Claim Form either directly or on behalf of the Class Member or as its Authorized Agent, and, in turn, have been given the authority to submit this Claim Form by each Class Member identified in this Claim Form and in any attachments to it, and to receive on behalf of each such Class Member any and all amounts that may be allocated from the TPP Settlement Pool to such Class Member; (2) the information contained in this Claim Form and any attachments hereto is true and accurate, based on records maintained by or otherwise available to me; (3) I, the Authorized Agent (if any), and the Class Member on whose behalf this Claim Form is submitted, hereby submit to the jurisdiction of the United States District Court for the District of Massachusetts (the "Court") for all purposes associated with this Claim Form and the Settlement, including resolution of disputes relating to this Claim Form; (4) in the event that amounts from the TPP Settlement Pool are distributed to the Authorized Agent of a Class Member, and the Class Member later claims that the Authorized Agent did not have the authority to claim and receive such amounts on its behalf, the Authorized Agent, I, and/or my employer will hold the Class, Counsel for the Class, Defendants, Counsel for Defendants, and the Claims Administrator harmless with respect to any claims made by said Class Member.

Signature

Position

Print Name

Month/Day/Year

The following additional information is to be provided by the Individual that signs and certifies this Claim Form: I am filing this Claim Form as the authorized employee of the following Class Member or Authorized Agent for a Class Member:

Name of Individual's Employer

Business Address

Floor/Suite

City

State

Zip Code

Area Code – Telephone Number

Area Code – Fax Number

Email Address

Mail the completed Claim Form to the address listed on page 1, postmarked no later than **NOVEMBER 19, 2010**.

SECTION F – CLAIM DOCUMENTATION INSTRUCTIONS

If you are claiming less than $300,000 of total purchases of all BMS Drugs for the 2003 period, you do not need to attach any additional information. However, even if your purchase amount is less than $300,000, you should retain the information required for claims over $300,000 because any claim may be audited.

If you are claiming $300,000 or more of total purchases of all BMS Drugs you must provide documentation with your Claim Form to have your claim considered by the Claims Administrator. Please provide the required data fields necessary for your participation as a TPP Class Member as presented in the Data Field Layout sample on page 5, for all paid claims with a date of service or date of fill between January 1, 2003 to December 31, 2003 net of co-pay deductibles or co-insurance. Please provide this data along with the Claim Form to the Claims Administrator received or postmarked no later than November 19, 2010**:**

1. J-Code or NDC Number – provide the applicable J-Code or NDC Number for each transaction. A list of the J-Codes and NDC Numbers are annexed as Attachment A.
2. Patient Identifier – provide a random encrypted patient identification number. This number must consistently reflect the same patient.
3. Service and/or Fill Date – we expect service date will be available for J-Code entries and fill date will be available for NDC entries. Please include both if they are available.
4. Group Number – provide the group number assigned to each transaction. As part of the auditing process, you may be asked to provide the corresponding group name for each group number. Only the Claims Administrator will have access to this information.
5. Amount Billed – billed charges or the initial amount billed by the provider or providers before any adjustments.
6. Net Amount Paid – final amount paid for each discrete transaction, net of co-pays, deductibles, co-insurance, and any other credits and adjustments after initial payment.

OTHER INFORMATION

- If you are able, please provide units for each transaction.
- Please provide the electronic data in either Mircosoft Excel format or ASCII flat file pipe delimited "I" or fixed-width format. ***Refer to the sample layout below.***
- Finally, please provide a list of all self-funded healthcare plans ("SFPs") for which you are authorized to make a claim.
- All information you provide is subject to the protective order governing this action.

Data Field Layout for Claims of $300,000 or More

NDC or J-Code	Patient Identifier	Service/Fill Date	Group Number	Amount Billed	Net Amount Paid
				$	$
				$	$
				$	$
				$	$
				$	$
			COLUMN TOTALS	$	$
			TOTAL CLAIM	$	

ATTACHMENT A - LIST OF J-CODES AND NDC NUMBERS

NDC	DRUG	DESCRIPTION
00015301020	Blenoxane	BLENOXANE INJ 15 UNIT VL
00015301026	Blenoxane	BLENOXANE INJ 15 UNIT VHA
00015301097	Blenoxane	BLENOXANE 15 UNITS VIAL
00015306301	Blenoxane	BLENOXANE INJ 30 UNIT VL
00015306326	Blenoxane	BLENOXANE INJ 30 UNIT VHA
00015050001	Cytoxan	CYTOXAN FOR INJ 100 MG
00015050041	Cytoxan	CYTOXAN INJ 100MG
00015050141	Cytoxan	CYTOXAN INJ 200MG
00015050241	Cytoxan	CYTOXAN INJ 1X500MG VIAL
00015050301	Cytoxan	CYTOXAN TABS 50MG
00015050302	Cytoxan	CYTOXAN TABLETS 50MG
00015050303	Cytoxan	CYTOXAN TABLETS 50 MG
00015050348	Cytoxan	CYTOXAN TABS 50MG
00015050401	Cytoxan	CYTOXAN TABS 25MG
00015050541	Cytoxan	CYTOXAN PINJ 1X1G VIAL
00015050641	Cytoxan	CYTOXAN INJ 1X2GM VIAL
00015053910	Cytoxan	CYTOXAN 100MG LYOPH W/CYT
00015053941	Cytoxan	CYTOXAN LYOPHILIZED 100MG
00015054610	Cytoxan	CYTOXAN 200MG LYOPH W/CYT
00015054641	Cytoxan	CYTOXAN LYOPHILIZED 200MG
00015054710	Cytoxan	CYTOXAN 500MG LYOPH W/CYT
00015054712	Cytoxan	CYTOXAN LYO 500MG VL VHA
00015054741	Cytoxan	CYTOXAN LYOPH 500MG
00015054810	Cytoxan	CYTOXAN 1 GM LYOPH W/CTYOG
00015054812	Cytoxan	CYTOXAN 1G 6X50ML VHA+
00015054841	Cytoxan	CYTOXAN LYOPHILIZED 1GM
00015054910	Cytoxan	CYTOXAN 2GM LYOPH W/CYTOG
00015054912	Cytoxan	CYTOXAN 2G 6X100ML VHA+
00015054941	Cytoxan	CYTOXAN LYOPHILIZED 2GM
00087050001	Cytoxan	CYTOXAN 100MG VIAL
00087050041	Cytoxan	CYTOXAN 100MG VIAL
00087050101	Cytoxan	CYTOXAN 200MG VIAL
00087050141	Cytoxan	CYTOXAN 200 MG VIAL
00087050201	Cytoxan	CYTOXAN 500MG VIAL
00087050241	Cytoxan	CYTOXAN 500MG VIAL
00087050301	Cytoxan	CYTOXAN 50MG TABLET
00087050302	Cytoxan	CYTOXAN 50MG TABLET
00087050303	Cytoxan	CYTOXAN 50MG TABLET
00087050401	Cytoxan	CYTOXAN 25MG TABLET
00087050541	Cytoxan	CYTOXAN 1GM VIAL
00087050641	Cytoxan	CYTOXAN 2GM VIAL
00087054741	Cytoxan	CYTOXAN LYOPHILIZED 500MG

NDC	DRUG	DESCRIPTION
00015340420	Etopophos	ETOPOPHOS 100MG VIAL
00015321030	Paraplatin	PARAPLATIN 50 MG/5 ML VIAL
00015321076	Paraplatin	PARAPLATIN 50 MG/5 ML VIAL
00015321130	Paraplatin	PARAPLATIN 150 MG/15 ML VIAL
00015321176	Paraplatin	PARAPLATIN 150 MG/15 ML VIAL
00015321230	Paraplatin	PARAPLATIN 450 MG/45 ML VIAL
00015321276	Paraplatin	PARAPLATIN 450 MG/45 ML VIAL
00015321310	Paraplatin	PARAPLATIN 50MG W/CYTO
00015321329	Paraplatin	PARAPLATIN 1 0X5ML VHA+
00015321330	Paraplatin	PARAPLATIN 50MG LYOPHILIZ
00015321410	Paraplatin	PARAPLATIN 150MG LYOPH CY
00015321429	Paraplatin	PARAPLATIN 1 0X1 5ML VHA+
00015321430	Paraplatin	PARAPLATIN 1X150MG LYO VL
00015321510	Paraplatin	PARAPLATIN 450MG VL W/CYT
00015321529	Paraplatin	PARAPLATIN 10X45ML VHA+
00015321530	Paraplatin	PARAPLATIN 1X450MG LYO VL
00015321630	Paraplatin	PARAPLATIN 600 MG/60 ML VIAL
00015335122	Rubex	RUBEX 10MG LYOPHILIZED
00015335124	Rubex	RUBEX 10MG IMMUNEX LABEL
00015335222	Rubex	RUBEX 50MG LYOPHILIZED
00015335224	Rubex	RUBEX 50MG IMMUNEX LABEL
00015335322	Rubex	RUBEX 100 MG LYOPHILIZED
00015335324	Rubex	RUBEX 100MG IMMUNEX LABEL
00015345620	Taxol	TAXOL 30MG CONC FOR INJ
00015345699	Taxol	TAXOL 30MG/5ML VIAL
00015347520	Taxol	TAXOL 30MG/5ML VHA+ LABEL
00015347527	Taxol	TAXOL 30MG SEM-SYN VIAL
00015347530	Taxol	TAXOL 30MG INJ MULTIDOSE
00015347620	Taxol	TAXOL 100MG/16.7ML VHA+ L
00015347627	Taxol	TAXOL 100MG SEM-SYN VIAL
00015347630	Taxol	TAXOL 100MG INJ MULTIDOSE
00015347911	Taxol	TAXOL 300MG/50ML VIAL
00015306120	Vepesid	VEPESID 500MG
00015306124	Vepesid	VEPESID 500MG 25ML VL VHA
00015306220	Vepesid	VEPESID 1GM/50ML
00015306224	Vepesid	VEPESID 1G 50ML VIAL VHA+
00015308420	Vepesid	VEPESID INJ 150MG/7.5ML
00015309145	Vepesid	VEPESID 50MG CAPSULES
00015309510	Vepesid	VEPESID 100MG VIAL W/CYTO
00015309519	Vepesid	VEPESID 20MG/ML AMPUL
00015309520	Vepesid	VEPESID INJ 100MG/5ML
00015309530	Vepesid	VEPESID 100MG VL W/O CYTO

NDC	DRUG	DESCRIPTION
00015309595	Vepesid	VEPESID 20 MG/ML VIAL
00015309597	Vepesid	VEPESID 20MG/ML AMPUL
00015309615	Vepesid	VEPESID 10MG/ML VIAL
00015309695	Vepesid	VEPESID 10MG/ML VIAL

J-CODE	
Drug	**J-Code**
Blenoxane	J9040
Cytoxan	J8530
	J9070
	J9080
	J9090
	J0991
	J9092
	J9093
	J9094
	J9095
	J9096
	J9097
Etopophos	J9181
	J9182
	J8560
Paraplatin	J9045
Rubex	J9000
	J9001
Taxol	J9265
Vepesid	J9181
	J9182
	J8560