

POSTMARKED NO LATER THAN
OCTOBER 23, 2009.

**BEXTRA AND CELEBEX SETTLEMENT
THIRD-PARTY PAYOR CLAIM FORM**

FOR OFFICE USE ONLY

In re Bextra and Celebex Marketing, Sales Practices and Products Liability Litigation
No. M:05-cv-01699-CRB

To get a share of the Settlement Fund, you need to complete and sign this Claim Form and mail it postmarked by **October 23, 2009** to Bextra and Celebex Claims Administrator, c/o Rust Consulting, Inc., P.O. Box 24675, West Palm Beach, FL 33416.

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 **1-800-547-9360**.

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 December 31, 1998 through July 29, 2005.

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

Health Insurance Company/HMO

Self-Insured Employee Health Plan

Self-Insured Union Health & Welfare Fund

Other (Explain):

SECTION C - CLAIM BY AUTHORIZED AGENT

Please list the FEIN and the name 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 BEXTRA OR CELEBREX PURCHASES

For the Class Member on whose behalf you are submitting a claim, state the total and final amount paid or reimbursed, net of co-pays, and/or co-insurance for Bextra below with a date of service or date of fill from November 16, 2001 through April 7, 2005. If you are claiming more than \$300,000 you will need to provide additional information (See Section F):

Total Bextra Amount:

\$

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

* If, and only if, the Class Member on whose behalf you are submitting a claim did not pay or reimburse for Bextra (i.e., if the Total Amount of Bextra Purchases, as defined above, is \$0.00), but did pay or reimburse for Celebrex on or before July 29, 2005, state the total and final amount paid or reimbursed, net of co-pays, and/or co-insurance for Celebrex below with a date of service or date of fill on or before July 29, 2005. Any Class Member submitting claims for both Bextra Purchases and Celebrex Purchases will have their claims for Celebrex Purchases disregarded.

If you are claiming more than \$300,000 you will need to provide additional information (See Section F):

* Total Amount of Celebrex Purchases:

\$

Claimant certifies that the figure is true and accurate and is 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 a) to submit this Claim Form either directly or on behalf of the Class Member or as its Authorized Agent, and, in turn, b) 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 Northern District of California (the "Court") for all purposes associated with this Claim Form and the Settlement, including resolution of disputes relating to this Claim Form; and
- (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 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 Class Member:

Name of Individual's Employer:

Business Address:

Floor/Suite:

City:

State:

Zip Code:

Area Code – Telephone Number:

Area Code – Fax Number:

E-mail Address:

By completing this Claim Form you are releasing any and all claims brought or that could have been brought against Pfizer arising out of the payment, purchase, or reimbursement of or for Bextra and/or Celebrex related to this case.

Mail the completed Claim Form, postmarked by **October 23, 2009**, to:

Bextra and Celebrex Claims Administrator
c/o Rust Consulting, Inc.
P.O. Box 24675
West Palm Beach, FL 33416



SECTION F - CLAIM DOCUMENTATION INSTRUCTIONS

If you are claiming less than \$300,000 of total purchases for eligible drugs with dates of service or dates of fill on or before July 29, 2005, 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 eligible drugs you must provide electronic documentation with your Claim Form to have your claim considered by the Claims Administrator. Attached is a mock spreadsheet reflecting the required data fields necessary for your participation as a TPP Class Member. Please provide the required data fields as presented in the attached mock spreadsheet, for all paid claims with a date of service or date of fill on or before July 29, 2005, net of co-pay deductibles or co-insurance. Please provide this electronic data along with the Claim Form to the Claims Administrator no later than **October 23, 2009**.

1. NDC Number – provide the applicable NDC Number for each transaction. A list of NDC Numbers is attached.
2. Service and/or Fill Date – Please include both if they are available. Only the Claims Administrator will have access to this information.
3. Patient Identifier – provide a random encrypted patient identification number. This number must consistently reflect the same patient.
4. Amount Billed – billed charges or the initial amount billed by the provider or providers before any adjustments.
5. 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

- Each Class Member shall provide a list of all self-funded healthcare plans (“SFP’s”) or other entities for which it is authorized to make a claim, including the identity of each entity on whose behalf the Class Member is authorized to act by name and by the Federal Employer Identification Number assigned to such entity by the United States Internal Revenue Service.
- If you are able, please provide units for each transaction.
- Please provide the electronic data in either Microsoft Excel format or ASCII flat file pipe delimited “I” or fixed-width format.
- All information you provide is subject to the protective order governing this action.

All information you provide will remain confidential and used for no purpose other than for the administration of claims in this case as ordered by the Court.

Please contact the Claims Administrator at 1-800-547-9360 with any questions about the required claims data.

Bextra® NDC Codes							
NDC CODE			Product	Sales Code	Potency	Package Size	Packages per Case
0025	1975	31	Bextra® (valdecoxib) Tablets Rx	2301	10 mg	100's	96
0025	1975	51	Bextra® (valdecoxib) Tablets Rx	2303	10 mg	500's	48
0025	1980	31	Bextra® (valdecoxib) Tablets Rx	2304	20 mg	100's	96
0025	1980	51	Bextra® (valdecoxib) Tablets Rx	2306	20 mg	500's	24
0025	1975	34	Bextra® (valdecoxib) Tablets Unit Dose Pak Rx	2302	10 mg	(10x10)	10
0025	1980	34	Bextra® (valdecoxib) Tablets Unit Dose Pak Rx	2305	20 mg	(10x10)	10

Celebrex® NDC Codes							
NDC CODE			Product	Sales Code	Potency	Package Size	Packages per Case
0025	1515	01	Celebrex® (celecoxib) Capsules Rx	2180	50 mg	60's	12
0025	1520	31	Celebrex® (celecoxib) Capsules Rx	2157	100 mg	100's	48
0025	1520	51	Celebrex® (celecoxib) Capsules Rx	2159	100 mg	500's	24
0025	1525	31	Celebrex® (celecoxib) Capsules Rx	2160	200 mg	100's	48
0025	1525	51	Celebrex® (celecoxib) Capsules Rx	2162	200 mg	500's	24
0025	1530	02	Celebrex® (celecoxib) Capsules Rx	2164	400 mg	60's	48
0025	1520	34	Celebrex® (celecoxib) Capsules Unit-Dose Pak Rx	2158	100 mg	(10x10)	10
0025	1525	34	Celebrex® (celecoxib) Capsules Unit-Dose Pak Rx	2161	200 mg	(10x10)	10
0025	1530	01	Celebrex® (celecoxib) Capsules Unit-Dose Pak Rx	2163	400 mg	(10x10)	10

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