# Exhibit I

IN RE SUBOXONE ANTITRUST LITIGATION
C/O AB DATA, LTD.
PO BOX 173080
MILWAUKEE, WI 53217

{NameAndAddress}

**NOTICE OF DEFICIENCY AND**
**REQUEST FOR ADDITIONAL INFORMATION**

| | |
|---|---|
| **DATE:** | **{PostmarkDate}** |
| **RE:** | **Suboxone TPP Settlement** |
| **CLAIM NUMBER:** | **{ClaimNumber}** |
| **RESPONSE DEADLINE:** | **{ResponseDeadline}** |

Dear Claimant:

We have processed the Third-Party Payor Claim Form ("Claim") and any supporting documentation that you submitted in *In Re: Suboxone (Buprenorphine Hydrochloride and Naloxone) Antitrust Litigation*. However, we noted one or more deficiencies in the Claim you submitted. To resolve the deficient condition(s) within your Claim, you must submit a written response with any required information as specified below, postmarked no later than the Response Deadline printed above. Please include a copy of this notice with your response. **Failure to respond to this request with the required information to cure the deficient condition(s) identified below by the Response Deadline will result in the disallowance of your Claim.**

{INELIGIBLE WORDING GOES HERE}

If you disagree with the deficient condition(s) identified in this notice, you may contact us for assistance and/or request Court review of our administrative determination regarding your Claim.

To request Court review of your Claim, you must send a letter to the Settlement Administrator at the address printed at the top of this notice, postmarked no later than the Response Deadline set forth above. Your letter must: (1) include a copy of this notice; (2) specifically state that you request Court review of the full or partial rejection of the Claim; (3) state your argument(s) for why you are contesting the full or partial rejection of the Claim; and (4) include any and all documentation supporting your argument(s). If the dispute concerning your Claim cannot be resolved, your Claim will be presented to the Court for review, which may include public filing of your Claim and supporting documentation with the Court. **PLEASE NOTE: COURT REVIEW SHOULD ONLY BE SOUGHT IF YOU DISAGREE WITH THE SETTLEMENT ADMINISTRATOR'S DETERMINATION REGARDING YOUR CLAIM.**

Responses may be submitted to info@SuboxAntitrust.com or the return address on the top of this letter. If you have any questions about this notice or if you want to confirm the status of your Claim after you submit a response to this notice, please contact us at 877-311-3735 or email us at info@SuboxAntitrust.com. Please reference the Claim Number listed above in any communication.

Sincerely yours,

A.B. DATA, LTD.
Settlement Administrator

**ADDENDUM – SUBOXONE TPP SETTLEMENT** Claim Number: {ClaimNumber}

## MISSING TAX ID

In the box below, please type or print the Tax Identification Number for the End Payor Class member.

| Tax Identification Number | |
|---|---|

## MISSING AMOUNT

The Court-approved plan of allocation provides for different recoveries depending on the state or states in which the Suboxone purchases for which you paid or provided reimbursement were made. The states are divided into two groups, called Repealer States and Non-Repealer States. Please type or print in the boxes below, for the groups or states and territories listed in those boxes, the total amount paid or reimbursed for purchases of 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"), made by your members, employees, insureds, participants, or beneficiaries in the Repealer States, Non-Repealer States, or both, net of co-pays, deductibles, and or co-insurance.

| REPEALER STATE SUBOXONE PRESCRIPTIONS | TOTAL AMOUNT PAID |
|---|---|
| Provide the total amount paid or reimbursed for prescriptions of Suboxone and its AB-rated generic equivalents from December 22, 2011 through August 21, 2023, 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, net of co-pays, deductibles, and co-insurance. | $ |

| NON-REPEALER STATE SUBOXONE PRESCRIPTIONS | TOTAL AMOUNT PAID |
|---|---|
| Provide the number of prescriptions and total amount paid for prescriptions of Suboxone and its AB-rated generic equivalents from December 22, 2011 through August 21, 2023, in Arkansas, Colorado, Connecticut, Delaware, Georgia, Idaho, Kentucky, Louisiana, Montana, New Jersey, Oklahoma, Texas, Washington, and Wyoming net of co-pays, deductibles, and co-insurance. | $ |

*You **must** submit claims data and information in support of the purchase amounts stated above if your Total Amount Paid is more than $300,000 (see Claim Documentation Requirements below). If your Total Amount Paid is $300,000 or less, you need not provide complete claims data with the Claim, but the Settlement Administrator may later require supporting documentation.*

## MISSING SIGNATURE

**By signing below, you confirm under the penalties of perjury that all the information provided in your previously submitted Claim, along with any additional information provided, is true, correct, and complete.** ***Please note that signing a Claim that contains false information could constitute perjury.***

Signature

Position/Title

Print Name

Date

## CLAIM DOCUMENTATION REQUIREMENTS

You must provide all the information requested in "Part II: Amount Claimed" of the Claim Form, available on the Settlement website, www.SuboxAntitrust.com. You must submit claims data and information in support of the purchase amounts if your total net claim amount is more than $300,000. The total amount paid or reimbursed for purchases of 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"), made by your members, employees, insureds, participants, or beneficiaries in the Repealer States, Non-Repealer States, or both, net of co-pays, deductibles, and or co-insurance.

If you must submit claims data and information, it is mandatory that you provide the data for all categories listed below. Affidavits that do not include the information listed below will not be accepted:

a) Unique patient identification number or code
b) NDC Number (a list of NDC Numbers is available on the Settlement website) – e.g., 00000-0000-00
c) Fill Date or Date of Service – e.g., 01/01/2012
d) Location of Service – e.g., CA
e) Amount Billed (not including dispensing fee) – e.g., $123.50
f) Amount Paid by TPP net of co-pays, deductibles, and co-insurance – e.g., $118.50

If you are submitting a Claim Form on behalf of multiple End Payor Class members, also provide the following information for each prescription:

g) Plan or Group Name
h) Plan or Group FEIN – provide group number for each transaction

An exemplar spreadsheet containing these categories is available for download on the Settlement website suboxantitrust.com. Please use this format if possible. A list of the NDCs that will be considered by the Settlement Administrator is also provided at the Settlement website.