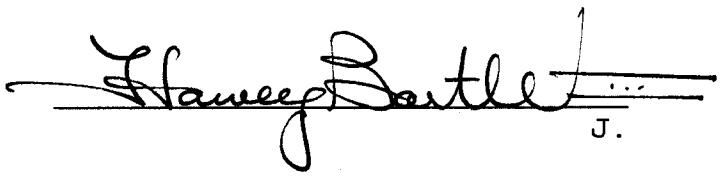
IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

IN RE: DIET DRUGS (PHENTERMINE/ FENFLURAMINE/DEXFENFLURAMINE) PRODUCTS LIABILITY LITIGATION	MDL NO. 1203
THIS DOCUMENT RELATES TO: SHEILA BROWN, et al. v. AMERICAN HOME PRODUCTS CORPORATION	CIVIL ACTION NO. 99-20593

PRETRIAL ORDER NO. 9103

AND NOW, this 1st day of July, 2013, upon consideration of the Joint Motion for an Order Approving a New Procedure Regarding Medicare-Covered Claims (Dkt. No. 99-20593, Doc. No. 4365) filed by Class Counsel and Wyeth, and there having been no responses thereto, it is hereby ORDERED that Court Approved Procedure No. 17 attached to this Order is APPROVED.

BY THE COURT:



J.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

IN RE: DIET DRUGS (PHENTERMINE/FENFLURAMINE/ DEXFENFLURAMINE) PRODUCTS LIABILITY LITIGATION	**MDL No. 1203**
THIS DOCUMENT RELATES TO: SHEILA BROWN, ET. AL. V. AMERICAN HOME PRODUCTS CORPORATION	**CIVIL ACTION No. 99-20593**

COURT APPROVED PROCEDURE NO. 17

(Processing of Medicare Claims)

AND NOW, in accordance with the Nationwide Class Action Settlement Agreement and the agreement of Class Counsel, Wyeth LLC and the AHP Settlement Trust ("Trust") it is hereby ORDERED as follows:

1. ***Incorporation of Settlement Agreement Definitions.*** Unless otherwise specified in this Procedure, references to a Paragraph refer to Paragraphs of this Procedure. The capitalized terms used in this Procedure shall have the same meaning as those terms have in the Settlement Agreement and/or the Seventh Amendment to the Settlement Agreement.

2. ***Scope of this Procedure.*** This Procedure applies to all claims for Matrix Compensation Benefits under the Settlement Agreement sent to Audit by the Trust after the Effective Date of this Procedure.

3. ***Additional Definitions for Purposes of this Procedure.***

(a) "Claimant" means the Diet Drug Recipient or Representative Claimant of a deceased or incompetent Diet Drug Recipient who has submitted a Covered Claim.

(b) "Covered Claim" or "Covered Claims" means the claims for Matrix Compensation Benefits referred to in Paragraph 2 of this Procedure.

(c) "Diet Drug Recipient" means the Diet Drug Recipient whose medical condition forms the basis of a Covered Claim.

(d) "Medicare" refers to the federal Medicare program and all representatives of that program, including the Centers for Medicare & Medicaid Services and any Coordination of Benefits Contractor or other representative engaged by the Medicare program.

(e) "Medicare Claim" or "Medicare Claims" means any actual or potential claims by Medicare for reimbursement under the Medicare Secondary Payer Act, 42 U.S.C.A. §§ 1395y(b) *et seq.*, and the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA").

(f) "Medicare Consultant" has the meaning defined in Paragraph 8 of this Procedure.

(g) "Medicare Counsel" has the meaning defined in Paragraph 9 of this Procedure.

(h) "Medicare Eligible Diet Drug Recipient" or "Medicare Eligible Diet Drug Recipients" has the meaning defined in Paragraph 6(a) of this Procedure.

(i) "MMSEA Query" has the meaning defined in Paragraph 6(a) of this Procedure.

(j) "Post Audit Determination" means the notice issued by the Trust to a Claimant announcing the Trust's determination of the Matrix Compensation Benefits payable, if any, on a Covered Claim.

4. ***Time for Medicare Claim Determinations.*** The time periods prescribed by this Procedure shall apply to the determination and resolution of Medicare Claims relating to any Covered Claim, rather than Section VII.D.2 and VI.C.4 of the Settlement Agreement.

5. ***Medicare and Subrogation Information Form.*** Every Claimant who has submitted a Covered Claim shall submit to the Trust a completed form, substantially in the form attached as Exhibit A, in which the Claimant: (a) provides, under oath and subject to penalty of perjury, information about whether any insurer, HMO, government agency (including Medicare or Medicaid), or other third-party payor, has asserted a Subrogation Lien or Claim with respect to any potential recovery by the Claimant; (b) authorizes Medicare to release information relating to the Diet Drug Recipient to the Trust and its representatives; and (c) notifies the Trust whether the Claimant will use the services of the Trust's Medicare Consultant to help the Claimant resolve any Medicare Claims as to the Covered Claim.

6. ***MMSEA Query.***

(a) Wyeth shall submit identifying information on all Diet Drug Recipients subject to Covered Claims to Medicare for a query ("MMSEA Query") under MMSEA to determine which Diet Drug Recipients are or were eligible for Medicare benefits ("Medicare Eligible Diet Drug Recipients"). Wyeth shall report the results of each MMSEA Query to the Trust within five business days after receiving such results. The MMSEA Query shall occur as soon as is reasonably practicable after the filing of a Covered Claim with the Trust on the schedule permitted under the MMSEA and any applicable regulations or guidances.

(b) The Trust shall provide Wyeth with such information as may be required to permit Wyeth to report to Medicare any payments by the Trust on Covered Claims pursuant to the MMSEA.

7. ***Medicare Claim Resolution and Payment.***

(a) On any Covered Claim, the Trust shall issue payment of the Settlement Agreement benefit due to the Claimant pursuant to the Settlement Agreement and any applicable Orders of the Court without further procedures relating to Medicare unless before payment on the claim, the Trust has received notice that Medicare has reported that the Diet Drug Recipient subject to the Covered Claim is or was a Medicare Eligible Diet Drug Recipient in response to an MMSEA Query by Wyeth pursuant to Paragraph 6(a) of this Procedure or the Trust has received actual notice of a Medicare Claim with respect to such Covered Claim, in which event the remaining provisions of this Paragraph 7 shall apply.

(b) Within five business days after (1) receiving notice that Medicare has reported that a Diet Drug Recipient subject to a Covered Claim is or was a Medicare Eligible Diet Drug Recipient in response to an MMSEA Query by Wyeth pursuant to Paragraph 6(a) of this Procedure or (2) receiving actual notice of a Medicare Claim with respect to a Covered Claim, the Trust shall report to Medicare the existence of the claim as to the Diet Drug Recipient and shall request that all information in Medicare's possession regarding the Diet Drug Recipient be provided to the Trust pursuant to the authorization provided pursuant to Paragraph 5 of this Procedure. This report to Medicare shall be in lieu of any notice to Medicare that might otherwise be required by Section VI.C.4.f and VII.D.2 of the Settlement Agreement.

(c) The Trust shall issue a Post Audit Determination in which it makes a final determination of the amount that is to be reimbursed to Medicare from any recovery on a Covered Claim no later than the date that is the later of: (1) 240 days from the date on which the Trust receives notice of the outcome of the audit on the Covered Claim or (2) 90 days from the date on which the Trust issues its final Post Audit Determination on a Covered Claim after the conclusion of all proceedings occurring after the Trust has issued its initial Post Audit Determination after the audit or notice of denial of a Covered Claim, including a contest of the Trust's initial Matrix determination, an appeal to the Arbitration process under Section VI.C.4 of the Settlement Agreement, an order by the Court on a claim that is subject to the show cause process specified in Sections VI.E.7 and VI.E.8 of the Settlement Agreement, or an appeal from any order by the Court on the claim. Absent an agreement between a Claimant and Medicare as to the amount that the Trust is to reimburse Medicare from the Matrix benefit recovery of the Claimant, the Trust shall determine the amount, if any, payable to Medicare out of the Matrix Compensation Benefit payable to the Claimant, based solely on the information available to the Trust as of the time it is required to issue a Post Audit Determination making a final determination of that amount under this subsection 7(c) and shall distribute the Matrix Compensation Benefits to the Claimant and to Medicare pursuant to the provisions of Sections VII.D.2 and VI.C.4 of the Settlement Agreement. If requested by the Claimant, the Trust may extend the cut-off date for adjudicating any Medicare claim as provided in this Paragraph 7(c), provided that any such extension or extensions in the aggregate may not exceed 90 days.

(d) If the Trust has issued payment on the Medicare Claim relating to any Covered Claim pursuant to this Procedure and thereafter any additional amount is determined to be due to Medicare in connection with such Covered Claim, the Trust shall pay any such additional amount out of the account established under Paragraph 3 of Pretrial Order No. 1823 or, if such

account has been exhausted by such time, out of the Settlement Fund, unless the Trust determines that the Claimant made any material misrepresentation to the Trust regarding any Medicare Claim relating to the Covered Claim. The total amount paid to Medicare on a Covered Claim under Paragraph 7(c) and this Paragraph 7(d) of this Procedure shall not exceed the Matrix Compensation Benefits payable on the Covered Claim, less an appropriate allowance for costs and expenses of procurement of the Claimant's recovery.

(e) If the Trust has issued any payment to Medicare on the Covered Claim and thereafter receives a refund from Medicare of any of such payment, the Trust shall distribute the refunded amount to the Claimant pursuant to the Settlement Agreement and any applicable Orders of the Court.

(f) If Class Counsel, the Trust, and/or Wyeth is found liable to Medicare for any failure to satisfy any Medicare claim relating to a Covered Claim, the Trust shall pay such liability out of the account established pursuant to Pretrial Order No. 1823 or, if such account has been exhausted by such time, out of the Settlement Fund.

8. ***Medicare Consultant.*** As set forth in Paragraph 6 of CAP 10 and Pretrial Order No. 8054, the Trust shall make available to Claimants the services of a vendor with expertise in Medicare Claim resolution ("Medicare Consultant") to advise and assist Claimants who elect to use the services of such Medicare Consultant in expediting the resolution of Medicare issues relating to Covered Claims. The Trust shall pay the fees and costs of the Medicare Consultant out of the account established under Paragraph 3 of Pretrial Order No. 1823 or, if such account has been exhausted by such time, out of the Settlement Fund.

9. ***Medicare Counsel.*** The Trust shall engage counsel with expertise in Medicare Claims and Medicare payment and reimbursement policies and procedures ("Medicare Counsel") to advise and assist the Trust in the resolution of Medicare issues relating to Covered Claims. The Trust shall pay the fees and costs of its Medicare Counsel out of the account established under Paragraph 3 of Pretrial Order No. 1823 or, if such account has been exhausted by such time, out of the Settlement Fund.

10. ***Eighth Amendment Resolutions.*** This Procedure shall apply to Covered Claims resolved by Wyeth under the Eighth Amendment to the Settlement Agreement, unless the Claimant and Wyeth agree in the Notice of Agreement submitted on the resolution that this Procedure shall not apply to the claim.

11. ***Effective Date and Duration.*** This Procedure shall become effective upon the date of entry of an Order approving this Procedure and shall remain in effect until terminated by Order of the Court.

12. ***CAP 10 Inapplicable to Covered Claims.*** Upon the Effective Date of this Procedure, CAP 10 shall not apply to any Covered Claim and shall be of no further force and effect with respect to each such Covered Claim.

13. ***Retained Jurisdiction.*** The Court retains continuing and exclusive jurisdiction over the interpretation and enforcement of this Procedure.

BY THE COURT

Harvey Bartle, Senior Judge

July 1, 2013

AGREED:

CLASS COUNSEL:

Date: 6·10·2013

Michael D. Fishbein, Esquire
Levin, Fishbein, Sedran & Berman
510 Walnut Street, Suite 500
Philadelphia, PA 19106

WYETH LLC

Date: 6/10/2013

Orran L. Brown
BrownGreer PLC
115 S. 15th Street, Suite 400
Richmond, Virginia 23219

MEDICARE AND SUBROGATION INFORMATION FORM

I. INFORMATION ON POSSIBLE MEDICAL CLAIMS

NAME OF DIET DRUG RECIPIENT:	Last Name	First Name	Middle Initial
DDR NUMBER:			

The Trust cannot process this claim until you properly complete and return this Form.

A. ASSERTED CLAIMS

Has any insurer, HMO, government agency (including Medicare or Medicaid), or other third party payor who paid or provided healthcare benefits asserted a Subrogation Lien or Claim **with respect to any potential recovery related to the conditions which are the basis for the Matrix Compensation Claim you submitted for benefits** under the Nationwide Class Action Settlement Agreement with American Home Products Corporation? (Check the appropriate box below.)

☐ **YES (If YES, answer Questions 1 - 3)** ☐ **NO (If NO, proceed to Question 4)**

1. Provide the following information about the third party payor (if more than one, see Question 3):

NAME:	Last Name	First Name	Middle Initial
ADDRESS:	Street		
	City	State	Zip Code
AMOUNT OF CLAIM:	**$**		

2. Does the Claimant contest the lien or claim? ☐ **YES** ☐ **NO**

If you answered YES to Question 2, describe why:

3. Are there additional third party payors who have asserted a lien or claim?

☐ **YES** ☐ **NO** (If there is more than one third party payor, provide the name(s), full address(es) and amount(s) of claim(s) on a separate sheet and return it with this Form.)

4. Has Medicare paid for any of your medical care for conditions related to the basis for your Matrix Compensation Claim? ☐ **YES** ☐ **NO**

B. SIGNATURE AND CERTIFICATION

CERTIFICATION BY DIET DRUG RECIPIENT

The undersigned hereby consents to the disclosure of the Diet Drug Recipient's personal identifying information along with information from this Form to third parties identified on this Form or who otherwise assert a subrogation lien, claim, or other interest in this claim and to the Centers for Medicare & Medicaid Services and the Department of Health & Human Services so the Trust can adjudicate all relevant claims.

The person(s) signing below acknowledges and understands that this Form and any attachments to it are official documents sanctioned by the United States District Court for the Eastern District of Pennsylvania which presides over the Nationwide Class Action Settlement Agreement with American Home Products Corporation, and submitting it to the AHP Settlement Trust is equivalent to filing it with the Court.

Each person declares under penalty of perjury that all of the information provided in this Form and any attachments is true and correct to the best of his/her knowledge, information and belief.

	Last Name	First Name	Middle Initial
NAME OF DIET DRUG RECIPIENT:			
SIGNATURE BY DIET DRUG RECIPIENT:			
DATE:	____/____/____ (month) (day) (year)		

If this claim is brought by a Representative Claimant of a deceased or incapacitated Diet Drug Recipient, that Representative Claimant must complete the following.

	Last Name	First Name	Middle Initial
NAME OF REPRESENTATIVE CLAIMANT:			
SIGNATURE BY REPRESENTATIVE CLAIMANT:			
ACTING AS REPRESENTATIVE OF:			
CAPACITY IN WHICH ACTING AS REPRESENTATIVE:			
SOURCE OF AUTHORITY TO ACT AS REPRESENTATIVE:			
DATE:	____/____/____ (month) (day) (year)		

B. SIGNATURE AND CERTIFICATION			
CERTIFICATION BY CLAIMANT'S COUNSEL (If Applicable)			
This Form is an official document sanctioned by the United States District Court for the Eastern District of Pennsylvania, which presides over the Nationwide Class Action Settlement Agreement with American Home Products Corporation, and submitting it to the AHP Settlement Trust is equivalent to filing it with the Court. I declare under penalty of perjury that all of the information provided in this Form is true and correct to the best of my knowledge, information and belief.			
NAME OF ATTORNEY:	Last Name	First Name	Middle Initial
SIGNATURE BY ATTORNEY:			
DATE:	_____/_____/_____ (month) (day) (year)		

II. CONSENT FOR RELEASE OF INFORMATION

A. MEDICARE BENEFICIARY INFORMATION

NAME OF DIET DRUG RECIPIENT:	Last Name	First Name	Middle Initial
Medicare Health Insurance Claim Number (The number on your Medicare card):			
Date of Injury/Illness/Condition that is the basis for your Matrix Compensation Claim:			

B. CONSENT

I, _____ (print your name exactly as shown on your Medicare card) hereby authorize the CMS, its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement for the specified date of injury/illness to the AHP Settlement Trust and its representatives as follows:

NAME OF ENTITY:	AHP Settlement Trust		
CONTACT FOR ENTITY:			
ADDRESS:	Street		
	City	State	Zip Code
TELEPHONE:			

I agree that CMS may release information to the above entity for two years from when I sign and date this Form.

NAME OF DIET DRUG RECIPIENT:	Last Name	First Name	Middle Initial
SIGNATURE BY DIET DRUG RECIPIENT:			
DATE:	____/____/____ (month) (day) (year)		

II. CONSENT FOR RELEASE OF INFORMATION

If this claim is brought by a Representative Claimant of a deceased or incapacitated Diet Drug Recipient, that Representative Claimant must complete the following. The Representative Claimant must include documentation establishing the authority of the individual signing on the beneficiary's behalf. Go to www.msprc.info for further instructions on what Medicare requires to show authority to act for another.

	Last Name	First Name	Middle Initial
NAME OF REPRESENTATIVE CLAIMANT:			
SIGNATURE BY REPRESENTATIVE CLAIMANT:			
ACTING AS REPRESENTATIVE OF:			
CAPACITY IN WHICH ACTING AS REPRESENTATIVE:			
SOURCE OF AUTHORITY TO ACT AS REPRESENTATIVE:			
DATE:	____/____/____ (month) (day) (year)		

CERTIFICATION BY CLAIMANT'S COUNSEL (If Applicable)

This form is an official document sanctioned by the United States District Court for the Eastern District of Pennsylvania, which presides over the Nationwide Class Action Settlement Agreement with American Home Products Corporation, and submitting it to the AHP Settlement Trust is equivalent to filing it with the Court.

I declare under penalty of perjury that all of the information provided in this form is true and correct to the best of my knowledge, information and belief.

	Last Name	First Name	Middle Initial
NAME OF ATTORNEY:			
SIGNATURE BY ATTORNEY:			
DATE:	____/____/____ (month) (day) (year)		

Note: If the Attorney has an electronic signature, you can place it in this Form. If not, Medicare will accept "/s/" followed by the typewritten name of the attorney.

III. CLASS MEMBER ELECTION REGARDING PROCESSING OF ANY POSSIBLE MEDICARE CLAIM			
NAME OF DIET DRUG RECIPIENT:	Last Name	First Name	Middle Initial
CLAIM NUMBER:			

☐ I elect to use the services of the Trust's Medicare Consultant to assist in resolving any claims by Medicare relating to any Matrix Compensation Benefits found payable on my current Matrix claim. I understand that the Trust's Medicare Consultant may not reach any agreement that resolves any claims by Medicare relating to any Matrix Compensation Benefits found payable on my current Matrix claim without my express written consent and that the Trust shall pay all fees and costs of the Trust's Medicare Consultant that are incurred in its o assist in reaching a resolution of Medicare claims related to my current Matrix claim. **If you elect to use the services of** the Trust's Medicare Consultant**, sign and return to the Trust a copy of the HIPAA authorization form that is attached.**

☐ I elect not to use the services of the Trust's Medicare Consultant to resolve any claims by Medicare relating to any Matrix Compensation Benefits found payable on my current Matrix claim.

NAME OF DIET DRUG RECIPIENT	Last Name	First Name	Middle Initial
SIGNATURE BY DIET DRUG RECIPIENT:			
DATE:	____/____/____ (month) (day) (year)		

If this claim is brought by a Representative Claimant of a deceased or incapacitated Diet Drug Recipient, that Representative Claimant must complete the following.			
NAME OF REPRESENTATIVE CLAIMANT:	Last Name	First Name	Middle Initial
SIGNATURE BY REPRESENTATIVE CLAIMANT:			
ACTING AS REPRESENTATIVE OF:			
CAPACITY IN WHICH ACTING AS REPRESENTATIVE:			
SOURCE OF AUTHORITY TO ACT AS REPRESENTATIVE:			
DATE:	____/____/____ (month) (day) (year)		

COUNSEL SIGNATURE (If Applicable)			
NAME OF ATTORNEY:	Last Name	First Name	Middle Initial
SIGNATURE BY ATTORNEY:			
DATE:	____/____/____ (month) (day) (year)		

VI. AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) (45 C.F.R. §164.508(c))

	Last Name	First Name	Middle Initial
NAME OF DIET DRUG RECIPIENT:			
CLAIM NUMBER:			

A. PURPOSE

This document will authorize the following entity to represent me for purposes of resolving liens and/or reimbursement interests, if any, in my third-party claim. The entity named below is authorized to request and receive from you any and all information related to this claim, and discuss, negotiate, and ultimately resolve this claim on my behalf.

B. ENTITY AUTHORIZED TO RECEIVE AND USE INFORMATION

The [Trust's Medicare Consultant]**, its agent, or any assigned agency possessing knowledge needed in procuring judgment or settlement**

Mailing Address:

I hereby give any lien holder and its contract representatives permission to share the information described below with [the Trust's Medicare Consultant], or its representatives. It is understood that [the Trust's Medicare Consultant] and its representatives may re-disclose this information in their efforts to resolve your interest, including to representatives of the AHP Settlement Trust, [address]. Furthermore, it is understood that this health-related information will no longer be protected by the Federal privacy regulations. Therefore, I release the lien holder and its contract representatives from all liability arising from the disclosure of health-related information under this Agreement.

C. INFORMATION TO BE DISCLOSED

Claims/lien information and confirming medical records regarding any conditional payments made, or medical care performed, by the lien holder relating to the injury or negligence charges for the period beginning with the date of incident.

D. RIGHT TO REVOKE

I understand that I am entitled to inspect the terms of this release, and that I may request and receive a copy of the same. I understand that I may inspect or request copies of any health related information disclosed by this authorization if the lien holder or its contract representatives initiated this request for disclosure. I understand that I may revoke this authorization by notifying the lien holder through its contract representatives or plan administrator in writing, knowing that previously disclosed information would not be subject to my revocation request.

I understand refusal to authorize disclosure of my personal medical information will have no effect on his/her enrollment, coverage, or the amount the lien holder pays for the health services he/she receives.

This authorization will expire three years from the date below.

	Last Name	First Name	Middle Initial
NAME OF DIET DRUG RECIPIENT			
SIGNATURE BY DIET DRUG RECIPIENT:			

VI. AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) (45 C.F.R. §164.508(c))			
DATE:	____/____/____ (month) (day) (year)		
If this claim is brought by a Representative Claimant of a deceased or incapacitated Diet Drug Recipient, that Representative Claimant must complete the following.			
NAME OF REPRESENTATIVE CLAIMANT:	Last Name	First Name	Middle Initial
SIGNATURE BY REPRESENTATIVE CLAIMANT:			
ACTING AS REPRESENTATIVE OF:			
CAPACITY IN WHICH ACTING AS REPRESENTATIVE:			
SOURCE OF AUTHORITY TO ACT AS REPRESENTATIVE:			
DATE:	____/____/____ (month) (day) (year)		
COUNSEL SIGNATURE (If Applicable)			
NAME OF ATTORNEY:	Last Name	First Name	Middle Initial
SIGNATURE BY ATTORNEY:			
DATE:	____/____/____ (month) (day) (year)		