[Settlement Class Member Name]
[Street Address]
[City] [State] [Zip]
Notice ID: [Notice ID]
Confirmation Code: [Confirmation Code]

MAKENA CLASS ACTION CLAIM FORM

Maher v. AMAG Pharmaceuticals Inc., 2:20-cv-00152-JXN-JBC (D.N.J.)

If mailed, this Claim Form must be postmarked no later than November 10, 2025.
If submitted online, it must be submitted by 11:59 p.m. ET on November 10, 2025.

By timely submitting this Claim Form, you will be included in the Settlement Class and the Class Action Settlement Agreement and Release. **If you fail to submit your Claim Form by the deadline, your claim will be rejected, and you will be deemed to have waived all rights to receive a class benefit under the Settlement.**

CLAIM FORM INSTRUCTIONS

IMPORTANT: Please read the instructions below before completing this Claim Form.
In completing this Claim Form, you may receive a payment of some or all of the amount you paid out-of-pocket for doses of Makena that you were prescribed between March 8, 2019 and July 11, 2025.

Covered Products include Makena (hydroxyprogesterone caproate injection), regardless of dose or formulation, and regardless of whether supplied in single- or multi-dose vials or auto-injector, including but not limited to those sold under National Drug Codes: 64011-243-01; 64011-247-02; or 64011-301-03. Covered Products do *not* include any generic or compounded version of hydroxyprogesterone caproate.

The amount you are eligible to receive will depend on the information you provide with this Claim Form:

- Each Settlement Class Member who timely submits a valid Claim Form with Proof of Treatment and Proof of Out-of-Pocket Payment of a Covered Product shall receive the full amount of out-of-pocket costs incurred for each treatment with a Covered Product during the Class Period, as reflected on the Proof of Treatment and Proof of Out-of-Pocket Payment (subject to potential *pro rata* adjustments described below). Each dose taken of Makena constitutes a "treatment."

- Each Settlement Class Member who timely submits a valid Claim Form without Proof of Treatment or Proof of Out-of-Pocket Payment, but for whom the amount of out-of-pocket costs incurred can be reliably substantiated through records in Class Counsel's possession, shall receive the full amount of out-of-pocket costs incurred for each Makena treatment with a Covered Product during the Class Period, as reflected in such records (subject to potential *pro rata* adjustments, as described below). Each dose taken of Makena constitutes a "treatment."

- Each Settlement Class Member who timely submits a valid Claim Form with Proof of Treatment but without Proof of Out-of-Pocket Costs, and for whom the amount of out-of-pocket costs incurred cannot be reliably substantiated through records in the Class Counsel's possession, shall receive $22 for each Makena treatment during the Class Period, as reflected on the Proof of Treatment, unless the Class Member was a participant in any Government Healthcare Program at the time of treatment, in which case said Class Member shall receive $4 for each treatment (subject to potential *pro rata* adjustments, as described below). Each dose taken of Makena constitutes a "treatment."

Each Settlement Class Member who timely submits a valid Claim Form without Proof of Treatment and without Proof of Out-of-Pocket Costs, and for whom the number of treatments and amount of out-of-pocket costs incurred cannot be reliably substantiated through records in Class Counsel's possession, shall receive $1 for each treatment with a Covered Product during the Class Period (subject to potential *pro rata* adjustments, as described below), and provided that the total amount shall not exceed $40. Each administration of a dose of Makena constitutes a "treatment."

- Each Settlement Class Members' payment shall be increased or decreased on a *pro rata* basis such that the total amount paid to all Settlement Class Members equals the Available Settlement Funds.

If you fail to return your Claim Form by the deadline, your claim will be rejected, and you will be deemed to have waived all rights to receive a class benefit under the Settlement.

To be valid, your Claim Form must be completely and accurately filled out, signed and dated, and include all requested information. If your Claim Form is incomplete, untimely, illegible, not signed, or contains false information, it may be rejected by the Claim Administrator.

A. NAME & CONTACT INFORMATION

If your name and address (printed at the top of this Claim Form) are incorrect, please provide corrected information below. Please provide your phone number and e-mail address in case the Claim Administrator needs to contact you about your claim.

Full Name _____

Home Street Address _____

City, State, ZIP Code _____

Telephone Number: _____

E-mail Address: _____

B. TREATMENT AND PURCHASE INFORMATION

For each dose of Makena you purchased or received between March 8, 2019 and July 11, 2025, please provide, under penalty of perjury, to the best of your recollection and knowledge: (a) the number of doses purchased or taken (b) the location (i.e., pharmacy) and approximate date range over which Makena was purchased or taken; (c) the amount, if any, you paid out-of-pocket, i.e., net of any insurance coverage/reimbursement, copay assistance or any other financial assistance; and (d) whether you participated in any Government Healthcare Program on the date of purchase or administration. "Government Healthcare Program" means any plan or program that provides health benefits to individuals, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by any federal or state government entity or agency, including but not limited to the federal Medicaid Program and any state Medicaid program.

Number of Doses Purchased/ Administered	**Location & Approximate Date Range of Purchase/ Treatment**	**Amount Paid Out-of-Pocket**	**Government Healthcare Program Participant (Yes/No)**

C. PROOF OF TREATMENT AND PROOF OF OUT-OF-POCKET PAYMENT

Please include Proof of Treatment and/or Proof of Out-of-Pocket Payment, for each transaction identified in **Section B**. The Proof of Treatment must be a medical record, insurance record, pharmacy receipt or other document that reliably shows, at a minimum, that you purchased or were treated with Makena, including the date and location of each purchase/treatment. The Proof of Out-of-Pocket Payment must be a medical bill, itemized pharmacy sales receipt, itemized insurance documentation or other document that reliably shows, at a minimum, the purchase of Makena, the amount of out-of-pocket costs incurred by the Settlement Class Member in connection with that purchase, and the date and place of the purchase.

If you do not have Proof of Treatment or Proof of Out-of-Pocket Payment, you can still submit a Claim Form for your purchase or use of Makena as long as you verify, under penalty of perjury, that the information provided is accurate to the best of your knowledge and recollection.

You may redact any medical information and financial information that is unrelated to your purchase of or treatment with Makena that you are including with the submission of this Claim Form.

Please list the number of treatments for which you will be providing Proof of Treatment here: __.

Please list the number of treatments for which you will be providing Proof of Out-of-Pocket Costs here: __.

D. ACKNOWLEDGEMENT OF RESPONSIBILITY FOR LIENS

☐ I acknowledge and agree that I am solely and fully responsible and liable for any and all liens asserted by Government Healthcare Programs, Third-Party Payors or any other person or entity against any Settlement Benefit Payment I receive under this Settlement. Defendant AMAG Pharmaceuticals, Inc. ("AMAG") shall have no liability for any such liens or claims and, as a condition for receiving payment of a Settlement Benefit, I agree to fully indemnify and defend AMAG from and against any claims arising out of my failure to satisfy any such liens.

E. MANNER OF PAYMENT OF CLASS BENEFIT

Please select **one** of the following payment options:

☐ **PayPal** - Enter your PayPal email address: _____

☐ **Venmo -** Enter the mobile number associated with your Venmo account: __ __ __-__ __ __-__ __ __ __

☐ **Zelle -** Enter the mobile number or email address associated with your Zelle account:

Mobile Number: __ __ __-__ __ __-__ __ __ __ or Email Address: _____

☐ **Virtual Prepaid Card -** Enter your email address: _____

☐ **Physical Check -** Payment will be mailed to the address provided at the top of this Claim Form or as updated in Section A.

Please be patient. The Claim Administrator will not be able to send you your payment until after your Claim Form has been processed and Court proceedings are completed.

F. SIGNATURE UNDER PENALTY OF PERJURY

By signing below and submitting this Claim Form, I hereby declare under penalty of perjury that I am the person identified above and that all of the information I have provided on this Claim Form, or that was pre-populated in this Claim Form, is to the best of my recollection and knowledge true and accurate. I understand that AMAG and Class Counsel have the right to verify the accuracy of any purchase/treatment information I provide and that the Court may ultimately determine I am not entitled to receive an award.

_____ _____

Signed Dated

THIS CLAIM FORM MUST BE COMPLETED, SIGNED, AND SUBMITTED TO THE CLAIM ADMINISTRATOR BY NOVEMBER 10, 2025 EITHER ONLINE (AT www.MakenaSettlement.com) OR MAILED TO: MAKENA CLAIM ADMINISTRATOR, 1650 ARCH STREET, SUITE 2210, PHILADELPHIA, PA 19103.

All information submitted in support of your claim is subject to investigation and verification by the Claim Administrator.

If you have any questions about this lawsuit, your rights, or completing the Claim Form, you may also contact Class Counsel:

Richard M. Paul Laura C. Fellows **Paul LLP** info@paulllp.com (816) 984-8100	Stuart Talley **Kershaw Talley Barlow, PC** stuart@ktblegal.com (916)-520-6639	Bruce D. Greenberg **Lite DePalma Greenberg & Afanador** bgreenberg@litedepalma.com (973) 623-3000

DO NOT ADDRESS ANY QUESTIONS ABOUT THIS LAWSUIT TO THE CLERK OF THE COURT, THE JUDGE, COUNSEL FOR AMAG, OR TO ANY AMAG AGENT OR EMPLOYEE.