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MEMORANDUM

TO: Health and Welfare Plan Clients

FROM: Slevin & Hart, P.C.

DATE: September 19, 2023

RE: Suboxone Class Action

This memorandum is to notify you of a proposed settlement of a class action lawsuit pending in the Eastern District of Pennsylvania against Indivior, Inc., and others ("Indivior") in connection with the manufacture and marketing of the opioid addiction treatment drug Co-Formulated Buprenorphine/Naloxone (Suboxone and/or its AB-rated generic equivalent). Plaintiffs claim that Indivior violated certain state laws causing class members to overpay for Suboxone. **If the Fund is a member of the settlement class (the "End Payor Class") and wishes to participate in the settlement, it has until February 17, 2024 to submit a claim under the instructions below. If the Fund is an eligible End Payor Class member but wishes to opt-out of the settlement, it must do so by October 12, 2023. If the Fund is an eligible End Payor Class member but takes no action, it forfeits its right to receive proceeds from the settlement (if approved) or to otherwise recover from the Defendant.**

Action: **As with other class actions of this type, we assume that the Fund does not wish to opt out and that it will file a claim.** If correct, the Fund should request documentation from its PBM to determine if it is a class member. A sample spreadsheet to submit claims data is available at In Re Suboxone Antitrust Litigation (suboxantitrust.com).

Eligible End Payor Class: All persons or entities who purchased and/or paid for some or all of the purchase price for Co-Formulated Buprenorphine/Naloxone (Suboxone and/or its AB-rated generic equivalent) in any form, for consumption by themselves, their families or their members, employees, plan participants, beneficiaries or insureds between December 22, 2011 and August 21, 2023, in all states, the District of Columbia, and Puerto Rico, with the exception of Indiana and Ohio.

The Court has preliminarily approved a proposed settlement between the End Payor Class and Indivior providing for the payment of $30 million into a Settlement Fund for distribution to End Payor Class members submitting valid claims forms. The proposed settlement is subject to final approval by the Court, with a hearing on October 19, 2023.

Submitting a Claim Form: Claim Forms must be submitted by February 17, 2024. They can be submitted either online or by mailing the Claim Form. The Claim Form is attached to this memorandum (*see* Tab 1). If submitted online, it can be accessed, completed and submitted at https://www.suboxantitrust.com/Tpp. If the Fund chooses to submit by mail, the completed form must be mailed to the address listed below and postmarked on or before February 17, 2024:

In re Suboxone Antitrust Litigation
c/o A.B. Data, Ltd.
P.O. Box 173080
Milwaukee, WI 53217
Toll-Free Telephone: 1-877-311-3735
Website: www.SuboxAntitrust.com

Note that when submitting a claim, the Fund will need to file a Third-Party Payor claim rather than a Consumer claim. Supporting documentation must be included with the Claim Form if the Fund's claim exceeds $300,000. If the Fund's claim is $300,000 or more, the claim will need to include the following information: (a) unique patient identification numbers or codes; (b) NDC Numbers (a list of NDC Numbers is attached to this memorandum as Tab 2); (c) Fill Dates or Dates of Service; (d) location (state) of services; (e) amounts billed (not including dispensing fee); and (f) amounts paid by Third-Party Payor net of co-pays, deductibles, and co-insurance.

If the Fund's claim is for less than $300,000, supporting documentation is not mandatory, but the Settlement Administrator may request supporting documentation later. A sample spreadsheet that the Fund may use to submit claims data is available at: SuboxoneTPP Filing Template 8-24-2023.xlsx.

Opting-Out of the Settlement: The Fund may exclude itself from the End Payor Class and retain the right to file a separate lawsuit against Indivior by sending a request by mail to the address below or email to info@SuboxAntitrust.com that the Fund wishes to be excluded from the End Payor Class. The request should include the Fund Representative's name, address, telephone number, and signature. TPPs must also provide data sufficient to prove End Payor Class membership. If by email, the opt-out notice should be sent to info@SuboxAntitrust.com. If by mail, the notice should be mailed to:

Settlement Administrator 54388
ATTN: EXCLUSIONS
P.O. Box 173001
Milwaukee, WI 53217

Any opt-out notices must be postmarked or submitted by email no later than October 12, 2023.

Objecting to the Settlement: The Fund may also object to the settlement or speak at the Fairness Hearing. If the Fund objects to all or any part of the Settlement, or desires to speak at the Fairness Hearing, **it must file a written letter of objection and/or a notice of intention to speak**

along with a summary statement with the Court and with Co-Lead Counsel and counsel for the Defendant by October 5, 2023.

Please contact us with any questions.

TAB 1

United States District Court
Eastern District of Pennsylvania

In Re: Suboxone (Buprenorphine Hydrochloride and Nalaxone) Antitrust Litigation	Civil Action No. 2:13-md-02445

INSTRUCTIONS FOR SUBMITTING YOUR CLAIM FORM

A Third-Party Payor ("TPP") End Payor Class member, or an authorized agent for a TPP, can complete this Claim Form. If both an End Payor Class member and its authorized agent submit a Claim Form, the Settlement Administrator will only consider the End Payor Class member's Claim Form. The Settlement Administrator may request supporting documentation in addition to the documentation and information requested below. The Settlement Administrator may reject a claim if the End Payor Class member or their authorized agent does not provide all requested documentation in a timely manner.

If you are an End Payor Class member submitting a Claim Form on your own behalf, you must provide the information requested in "**Section A – COMPANY OR HEALTH PLAN END PAYOR CLASS MEMBER ONLY**," in addition to the other information requested by this Claim Form.

If you are an **authorized agent** of one or more End Payor Class members, you must provide the information requested in "**Section B – AUTHORIZED AGENT ONLY**," in addition to the other information requested by this Claim Form. **Do not submit a Claim Form on behalf of any End Payor Class member unless that End Payor Class member provided you with prior written authorization to submit this Claim Form. Such written authorization must accompany this Claim Form.**

If you are submitting a Claim Form only as an authorized agent of one or more End Payor Class members, you may submit a separate Claim Form for each End Payor Class member, OR you may submit one Claim Form for all such End Payor Class members as long as you provide the information required for each End Payor Class member on whose behalf you are submitting this Claim Form.

If you are submitting Claim Forms both on your own behalf as an End Payor Class member AND as an authorized agent on behalf of one or more End Payor Class members, you should submit one Claim Form for yourself, completing Section A and another Claim Form or Claim Forms as an authorized agent for the other End Payor Class member(s), completing Section B.

To qualify to receive a payment from the Settlement, you must complete and submit this Claim Form either on paper or electronically on the website, www.SuboxAntitrust.com, and you may need to provide certain requested documentation to substantiate your Claim.

Your failure to complete and submit the Claim Form postmarked (if mailed) or received (if submitted online) on or before **February 17, 2024,** will prevent you from receiving any payment from the Settlement. Submission of this Claim Form does not ensure that you will share in the payments related to the Settlement. If the Settlement Administrator rejects or reduces your Claim, you may invoke the dispute resolution process described on page 6.

CLAIM INFORMATION AND DOCUMENTATION REQUIREMENTS

Please provide the following information to support your Claim of membership in a class defined as follows ("End Payor Class"):

All persons or entities who purchased and/or paid for some or all of the purchase price for Co-Formulated Buprenorphine/Naloxone (Suboxone and/or its AB-rated generic equivalent) in any form, for consumption by themselves, their families or their members, employees, plan participants, beneficiaries or insureds in Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming, and District of Columbia between December 22, 2011 and August 21, 2023, the date on which the Court entered the Plaintiffs' proposed Preliminary Approval Order (the "Class Period").

a) Unique patient identification number or code

b) NDC Number (a list of NDC Numbers can be downloaded from the Settlement website, www.SuboxAntitrust.com) – *e.g.*, 00000-0000-00

c) Fill Date or Date of Service – *e.g.*, 1/1/2012

d) Location (State) of Service – *e.g.*, CA

e) Amount Billed (not including dispensing fee) – *e.g.*, $123.50

f) Amount Paid by the 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 purchase or reimbursement:

g) Plan or Group Name

h) Plan or Group FEIN

For your convenience, an exemplar spreadsheet containing these categories is attached at the end of this Claim Form. In addition, an Excel spreadsheet can be downloaded from the website, www.SuboxAntitrust.com. Please use this format if possible. Following the exemplar spreadsheet, the website provides a list of the NDCs that the Settlement Administrator will consider. If possible, please provide the electronic data in Microsoft Excel, ASCII flat file pipe "|", tab-delimited, or fixed-width format.

Transaction data supporting claims is mandatory for claims of $300,000 or more, although the Settlement Administrator may also require transaction data for claims of less than $300,000, so keep related transaction data and any other documentation supporting your Claim in case the Settlement Administrator requests it later. If your Claim is for less than $300,000, you should still provide the transaction data with your Claim submission if you can. If, after an audit of your Claim, the Settlement Administrator still has questions about your Claim and you have not provided sufficient substantiation of your Claim, the Settlement Administrator may reject your Claim.

Please contact the Settlement Administrator at 1-877-311-3735 with any questions about the required claims information or documentation. Please do not contact the Court concerning this matter.

In Re: Suboxone (Buprenorphine Hydrochloride and Naloxone) Antitrust Litigation
Civil Action No. 2:13-md-02445 (E.D. Pa.)

MUST BE POSTMARKED ON OR BEFORE, OR SUBMITTED ONLINE BY FEBRUARY 17, 2024.

THIRD-PARTY PAYOR CLAIM FORM

Use Blue or Black Ink Only

ATTENTION: THIS FORM IS ONLY TO BE FILLED OUT ON BEHALF OF A THIRD-PARTY PAYOR (OR AN AUTHORIZED AGENT) AND NOT INDIVIDUAL CONSUMERS.

- Complete Section A only if you are filing as an individual TPP End Payor Class member.
- Complete Section B only if you are an authorized agent filing on behalf of one or more TPP End Payor Class members.

Section A: Company or Health Plan End Payor Class Member Only

Company or Health Plan Name

Contact Name

Care of (if applicable)

Street Address Floor/Suite

City State Zip Code

Area Code - Telephone Number Tax Identification Number

Email Address

List other names by which your company or health plan has been known or other Federal Employer Identification Numbers ("FEINs") it has used since December 22, 2011.

___ Health Insurance Company/HMO

___ Self-Insured Employee Health or Pharmacy Benefit Plan

___ Self-Insured Health & Welfare Fund

___ Other (Explain)

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Section B: Authorized Agent Only

As an authorized agent, please check how your relationship with the End Payor Class member(s) is best described (you may be required to provide documentation demonstrating this relationship):

___ Third-Party Administrator or Administrative Services Only Provider

___ Pharmacy Benefit Manager

___ Other (Explain): _____

Authorized Agent's Company Name

Contact Name

Street Address | Floor/Suite

City | State | Zip Code

Area Code - Telephone Number | Authorized Agent's Tax Identification Number

Email Address

Please list the name and FEIN of every End Payor Class member (*i.e.,* Company or Health Plan) 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 End Payor Class member names and FEINs in an electronic format, such as Excel or a tab-delimited text file. Please contact the Settlement Administrator to determine what formats are acceptable.

END PAYOR CLASS MEMBER 'S NAME	END PAYOR CLASS MEMBER 'S FEIN

Section C: Purchase Information

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 divides into two groups, called Repealer States and Non-Repealer States. Please type of 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.

Do not submit a Claim Form for or on behalf of any of the following excluded groups:

a) Pharmacy benefit managers;
b) Defendant and its officers, directors, management, employees, subsidiaries, or affiliates;
c) All governmental entities, except for government funded employee benefit plans;
d) All persons or entities who purchased Suboxone and its AB-rated generic equivalents for purposes of resale or directly from Defendant or its affiliates; or
e) The judges in this case and any members of their immediate families.

Note that the Court-approved plan of allocation provides for different recoveries depending on the state or states in which your Suboxone purchases were made.

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.	

Section D: Proof of Payment and Disputes Regarding Claim Amounts

Please provide as much of the information requested above as possible. Transaction data supporting claims is mandatory for claims of $300,000 or more, although the Settlement Administrator may also require transaction data for claims of less than $300,000, so keep related transaction data and any other Claim Documentation supporting your Claim (*e.g.*, invoices) in case the Settlement Administrator requests it later. If your Claim is for less than $300,000, you should still provide the transaction data with your Claim submission if you can. If, after an audit of your Claim, the Settlement Administrator still has questions about your Claim and you have not provided sufficient substantiation of your Claim, the Settlement Administrator may reject your Claim.

If the Settlement Administrator rejects or reduces your claim and you believe the rejection or reduction is in error, you may contact the Settlement Administrator to request further review. If the dispute concerning your claim cannot be resolved by the Settlement Administrator and Class Counsel, you may request that the Court review your claim.

To request Court review, you must send the Settlement Administrator a signed written statement that (a) states your reasons for contesting the rejection or payment determination regarding your claim; and (b) specifically states that you "request that the Court review the determination regarding this claim." You must include all Claim Documentation supporting your argument(s). The Settlement Administrator and Class Counsel will present the dispute to the Court for review, which may include public filing with the Court of your claim and the supporting documentation. Please note: Court review should only be sought if you disagree with the Settlement Administrator's determination regarding your claim.

Section E: Certification

By signing below, I hereby swear and affirm that I am familiar with the contents of the Instructions accompanying this Claim Form. I certify that the information I have set forth in the above Claim Form and in any documents attached by me are true, correct, and complete to the best of my knowledge.

I further certify I have provided all of the information requested above to the extent I have it.

To the extent I have been given authority to submit this Claim Form by one or more End Payor Class members on their behalf, and accordingly am submitting this Claim Form in the capacity of an authorized agent with authority to submit it, and to the extent I have been authorized to receive on behalf of the End Payor Class member(s) any and all amounts that may be allocated to them from the Net Settlement Fund, I certify that such authority has been properly vested in me and that I will fulfill all duties I may owe the End Payor Class member(s). If amounts from the Net Settlement Fund are distributed to me and an End Payor Class member later claims that I did not have the authority to claim and/or receive such amounts on its behalf, I or my employer will hold the End Payor Class, Class Counsel, and the Settlement Administrator harmless with respect to any claims made by the End Payor Class member.

I/We hereby submit to the jurisdiction of the United States District Court for the Eastern District of Pennsylvania for all purposes connected with this Claim Form, including resolution of disputes relating to this Claim Form. I/We acknowledge that any false information or representations contained herein may subject me to sanctions, including the possibility of criminal prosecution. I agree to supplement this Claim Form by furnishing documentary backup for the information provided herein upon request of the Settlement Administrator.

I certify that the above information supplied by the undersigned is true and correct to the best of my

knowledge and that this Claim Form was executed this _____ day of _____ 20____.

Signature	Position/Title
Print Name	Date

Mail the completed Claim Form to the address below, along with any supporting documentation as described in the CLAIM INFORMATION AND DOCUMENTATION REQUIREMENTS on page 2 above, postmarked on or before **February 17, 2024**, or submit the information online at the website below by that date:

In re Suboxone Antitrust Litigation
c/o A.B. Data, Ltd.
P.O. Box 173080
Milwaukee, WI 53217
Toll-Free Telephone: 1-877-311-3735
Website: www.SuboxAntitrust.com

REMINDER CHECKLIST:

1. Please complete and sign the above Claim Form. Attach or upload any documentation supporting your claim.
2. Keep a copy of your Claim Form and supporting documentation for your records.
3. If you would also like acknowledgement of receipt of your Claim Form, please complete the form online or mail this form via Certified Mail, Return Receipt Requested.
4. If you move and/or your name changes, please send your new address and/or your new name or contact information to the Settlement Administrator at info@SuboxAntitrust.com or via U.S. Mail at the address listed above.

TAB 2

NDC_NBR	PRODUCT_NAME
00054018813	BUPRENORPHINE HCL/NALOXON
00054018913	BUPRENORPHINE HCL/NALOXON
00093572056	BUPRENORPHINE HCL/NALOXON
00093572156	BUPRENORPHINE HCL/NALOXON
00228315403	BUPRENORPHINE HCL/NALOXON
00228315473	BUPRENORPHINE HCL/NALOXON
00228315503	BUPRENORPHINE HCL/NALOXON
00228315567	BUPRENORPHINE HCL/NALOXON
00228315573	BUPRENORPHINE HCL/NALOXON
00378876516	BUPRENORPHINE HYDROCHLORI
00378876593	BUPRENORPHINE HYDROCHLORI
00378876616	BUPRENORPHINE HYDROCHLORI
00378876693	BUPRENORPHINE HYDROCHLORI
00378876716	BUPRENORPHINE HYDROCHLORI
00378876793	BUPRENORPHINE HYDROCHLORI
00378876816	BUPRENORPHINE HYDROCHLORI
00378876893	BUPRENORPHINE HYDROCHLORI
00406192303	BUPRENORPHINE HCL/NALOXON
00406192403	BUPRENORPHINE HCL/NALOXON
00406800503	BUPRENORPHINE HYDROCHLORI
00406802003	BUPRENORPHINE HCL/NALOXON
00781721606	BUPRENORPHINE HYDROCHLORI
00781721664	BUPRENORPHINE HYDROCHLORI
00781722706	BUPRENORPHINE HYDROCHLORI
00781722764	BUPRENORPHINE HYDROCHLORI
00781723806	BUPRENORPHINE HYDROCHLORI
00781723864	BUPRENORPHINE HYDROCHLORI
00781724906	BUPRENORPHINE HYDROCHLORI
00781724964	BUPRENORPHINE HYDROCHLORI
00904700906	BUPRENORPHINE HYDROCHLORI
00904701006	BUPRENORPHINE HYDROCHLORI
12496120201	SUBOXONE
12496120203	SUBOXONE
12496120401	SUBOXONE
12496120403	SUBOXONE
12496120801	SUBOXONE
12496120803	SUBOXONE
12496121201	SUBOXONE
12496121203	SUBOXONE
12496128302	SUBOXONE
12496130602	SUBOXONE
16590066630	SUBOXONE
16729054910	BUPRENORPHINE HYDROCHLORI
16729055010	BUPRENORPHINE HYDROCHLORI
35356000430	SUBOXONE
42291017430	BUPRENORPHINE HCL/NALOXON

42291017530 BUPRENORPHINE HCL/NALOXON
42858060103 BUPRENORPHINE HYDROCHLORI
42858060203 BUPRENORPHINE HYDROCHLORI
43063018407 SUBOXONE
43063018430 SUBOXONE
43598057901 BUPRENORPHINE HYDROCHLORI
43598057930 BUPRENORPHINE HYDROCHLORI
43598058001 BUPRENORPHINE HYDROCHLORI
43598058030 BUPRENORPHINE HYDROCHLORI
43598058101 BUPRENORPHINE HYDROCHLORI
43598058130 BUPRENORPHINE HYDROCHLORI
43598058201 BUPRENORPHINE HYDROCHLORI
43598058230 BUPRENORPHINE HYDROCHLORI
47781035503 BUPRENORPHINE HYDROCHLORI
47781035511 BUPRENORPHINE HYDROCHLORI
47781035603 BUPRENORPHINE HYDROCHLORI
47781035611 BUPRENORPHINE HYDROCHLORI
47781035703 BUPRENORPHINE HYDROCHLORI
47781035711 BUPRENORPHINE HYDROCHLORI
47781035803 BUPRENORPHINE HYDROCHLORI
47781035811 BUPRENORPHINE HYDROCHLORI
49999039515 SUBOXONE
49999039530 SUBOXONE
50268014411 BUPRENORPHINE HCL/NALOXON
50268014415 BUPRENORPHINE HCL/NALOXON
50268014511 BUPRENORPHINE HCL/NALOXON
50268014515 BUPRENORPHINE HCL/NALOXON
50383028793 BUPRENORPHINE HCL/NALOXON
50383029493 BUPRENORPHINE HCL/NALOXON
51862060830 BUPRENORPHINE HYDROCHLORI
52427069203 BUPRENORPHINE HYDROCHLORI
52427069211 BUPRENORPHINE HYDROCHLORI
52427069403 BUPRENORPHINE HYDROCHLORI
52427069411 BUPRENORPHINE HYDROCHLORI
52427069803 BUPRENORPHINE HYDROCHLORI
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52427071203 BUPRENORPHINE HYDROCHLORI
52427071211 BUPRENORPHINE HYDROCHLORI
52959074930 SUBOXONE
53217013830 BUPRENORPHINE HCL/NALOXON
54123011430 ZUBSOLV
54123090730 ZUBSOLV
54123091430 ZUBSOLV
54123092930 ZUBSOLV
54123095730 ZUBSOLV
54123098630 ZUBSOLV
54569549600 SUBOXONE

54569573900	SUBOXONE
54569573901	SUBOXONE
54569573902	SUBOXONE
54569639900	SUBOXONE
54569640800	BUPRENORPHINE HCL/NALOXON
54868570700	SUBOXONE
54868570701	SUBOXONE
54868570702	SUBOXONE
54868570703	SUBOXONE
54868570704	SUBOXONE
54868575000	SUBOXONE
55045378403	SUBOXONE
55700014730	SUBOXONE
55700018430	BUPRENORPHINE-NALOXONE
55700090130	BUPRENORPHINE HYDROCHLORI
59385001201	BUNAVAIL
59385001230	BUNAVAIL
59385001401	BUNAVAIL
59385001430	BUNAVAIL
59385001601	BUNAVAIL
59385001630	BUNAVAIL
60429058630	BUPRENORPHINE HCL/NALOXON
60429058633	BUPRENORPHINE HCL/NALOXON
60429058711	BUPRENORPHINE-NALOXONE
60429058730	BUPRENORPHINE HCL/NALOXON
60429058733	BUPRENORPHINE HCL/NALOXON
60687062611	BUPRENORPHINE HYDROCHLORI
60687062665	BUPRENORPHINE HYDROCHLORI
60687063711	BUPRENORPHINE HYDROCHLORI
60687063765	BUPRENORPHINE HYDROCHLORI
62175045232	BUPRENORPHINE HYDROCHLORI
62175045832	BUPRENORPHINE HYDROCHLORI
62756096983	BUPRENORPHINE HCL/NALOXON
62756097083	BUPRENORPHINE HCL/NALOXON
63629403401	SUBOXONE
63629948201	BUPRENORPHINE HYDROCHLORI
63629948301	BUPRENORPHINE HYDROCHLORI
63874108503	SUBOXONE
65162041503	BUPRENORPHINE HCL/NALOXON
65162041603	BUPRENORPHINE HCL/NALOXON
66336001630	SUBOXONE
68071151003	SUBOXONE
70518100700	BUPRENORPHINE HCL/NALOXON
70518231100	BUPRENORPHINE HYDROCHLORI
70518312900	BUPRENORPHINE HCL/NALOXON
70518338900	BUPRENORPHINE HYDROCHLORI
71335129601	BUPRENORPHINE HYDROCHLORI

71335137801 BUPRENORPHINE HYDROCHLORI
71335172501 BUPRENORPHINE HCL/NALOXON
71335172502 BUPRENORPHINE HCL/NALOXON
71335185801 BUPRENORPHINE HYDROCHLORI
71335185802 BUPRENORPHINE HYDROCHLORI

TC_GPI_NAME
Buprenorphine HCl-Naloxone HCl Dihydrate
Buprenorphine HCl-Naloxone HCl Dihydrate
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Buprenorphine HCl-Naloxone HCl Dihydrate
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