

**PROOF OF CLAIM**

In re  
**Women First HealthCare, Inc ,  
Debtor**

Case Number  
**04-11278 (MFW)**

NOTE This form should not be used to make a claim for an administrative expense arising after the commencement of the case. A request for payment of an administrative expense may be filed pursuant to 11 U.S.C. § 503.

- Check box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars.
- Check box if you have never received any notices from the bankruptcy court in this case.
- Check box if this address differs from the address on the envelope sent to you by the court.

If you have already filed a proof of claim with the Bankruptcy Court or BMC, you do not need to file again.  
**THIS SPACE IS FOR COURT USE ONLY**

**Name of Creditor and Address**  
06509442000921  
STATE OF MISSISSIPPI DIV MEDICAID  
ACS STATE HEALTHCARE  
PO BOX 6014  
RIDGELAND MS 39158 6014

Creditor Telephone Number **(601) 359-5552**

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR

Check here  replaces  
if this claim  or  
 amends a previously filed claim dated \_\_\_\_\_

**1 BASIS FOR CLAIM**

- Goods sold
  - Services performed
  - Money loaned
  - Personal injury/wrongful death
  - Taxes
  - Other (describe briefly)  
*Medicaid Drug Rebates*
  - Retiree benefits as defined in 11 U.S.C. § 1114(a)
  - Wages, salaries, and compensation (Fill out below)
- Last four digits of SS # \_\_\_\_\_  
Unpaid compensation for services performed from \_\_\_\_\_ to \_\_\_\_\_  
(date) (date)

**2 DATE DEBT WAS INCURRED** *3/31/04*

**3 IF COURT JUDGMENT, DATE OBTAINED**

**4 TOTAL AMOUNT OF CLAIM AT TIME CASE FILED**  
\$ 2,503.06 (unsecured)      \$ \_\_\_\_\_ (secured)      \$ \_\_\_\_\_ (unsecured priority)      \$ 2,503.06 (Total)

If all or part of your claim is secured or entitled to priority, also complete Item 5 or 7 below.  
 Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.

**5 SECURED CLAIM**

**7 UNSECURED PRIORITY CLAIM**

Check this box if your claim is secured by collateral (including a right of setoff).  
Brief description of collateral:  
 Real Estate       Motor Vehicle  
 Other \_\_\_\_\_  
Value of Collateral \$ \_\_\_\_\_  
Amount of arrearage and other charges at time case filed included in secured claim if any \$ \_\_\_\_\_

Check this box if you have an unsecured priority claim.  
Amount entitled to priority \$ \_\_\_\_\_  
Specify the priority of the claim:  
 Wages, salaries, or commissions (up to \$4,925)\* earned within 90 days before filing of the bankruptcy petition or cessation of the Debtor's business, whichever is earlier. 11 U.S.C. § 507(a)(3)  
 Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(4)  
 Up to \$2,225 of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(6)  
 Alimony, maintenance, or support owed to a spouse, former spouse, or child. 11 U.S.C. § 507(a)(7)  
 Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8)  
 Other. Specify applicable paragraph of 11 U.S.C. § 507(a) (\_\_\_\_).  
*Amounts are subject to adjustment on 4/1/07 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.*

**6 UNSECURED NONPRIORITY CLAIM** \$ 2,503.06

Check this box if a) there is no collateral or lien securing your claim, or b) your claim exceeds the value of the property securing it, or if c) none or only part of your claim is entitled to priority.

**8 CREDITS** The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim.

**9 SUPPORTING DOCUMENTS** Attach copies of supporting documents, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, mortgages, security agreements, and evidence of perfection of lien. DO NOT SEND ORIGINAL DOCUMENTS if the documents are not available; explain. If the documents are voluminous, attach a summary.

**10 DATE-STAMPED COPY** To receive an acknowledgment of your claim, please enclose a self-addressed, stamped envelope and an additional copy of this proof of claim.

The original of this completed proof of claim form must be sent by mail or hand delivered (FAXES NOT ACCEPTED) so that it is received on or before 4:00 pm, Eastern Time on August 31, 2004.

BY MAIL TO  
Women First HealthCare Inc  
c/o BMC Group f/k/a Bankruptcy Management Corp  
PO Box 983  
El Segundo CA 90245 0983

BY HAND OR OVERNIGHT DELIVERY TO  
Women First HealthCare Inc  
c/o BMC Group f/k/a Bankruptcy Management Corp  
1330 East Franklin Ave  
El Segundo CA 90245

**THIS SPACE FOR COURT USE ONLY**  
**FILED**  
**AUG 30 2004**  
**BMC**

DATE SIGNED  
*8/27/04*

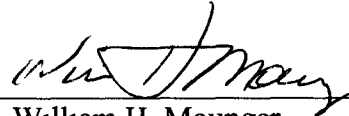
SIGN and print the name and title, if any, of the creditor or other person authorized to file this claim (attach copy of power of attorney if any).  
*W. J. [Signature]*

Women First Healthcare Inc  
  
00151

CLAIM OF THE MISSISSIPPI DIVISION OF MEDICAID

The Medicaid Drug Rebate Program created by the Omnibus Reconciliation Act of 1990 (OBRA '90), which added Section 1927 to the Social Security Act, became effective on January 1, 1991. This law requires that manufacturers enter into an agreement with the Centers of Medicare and Medicaid Services to provide rebates for their drug products paid for by Medicaid.

Attached to this claim is a copy of the unpaid invoice for the rebates due the Mississippi Division of Medicaid for the first quarter of 2004.



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William H. Mounger  
Special Assistant Attorney General  
Counsel for the Division of Medicaid

As of 07/06/2004

**State of Mississippi  
Division of Medicaid**

1/1/2004 - 3/31/2004

Quarter Bill 1Q2004

Invoice Number 3711

PATTI CONSILVIO  
(64248) WOMEN FIRST HEALTHCARE, INC  
5355 MIRA SORRENTO PLACE  
SAN DIEGO, CA 92121-

CURRENT QUARTER AMOUNT	\$2,505 88
UNIT CHANGES	(\$2 82)
<b>TOTAL</b>	<b>\$2,503 06</b>

**REFER TO INVOICE # 3711 ON YOUR CHECK**

Note if there is an asterisk (\*) in front of an NDC, unit conversions have been calculated before the invoices were produced

Please be sure to remit all payments to the Ridgeland, Mississippi address listed below

Principal Due (on Section 2) will reflect payments received by ACS but may not reflect payments sent to Mississippi directly. The processing time for payments is greatly increased when payments are sent to Mississippi, as the payment information must then be forwarded to the Ridgeland address

If you have any questions or concerns, please contact one of the following at (601)-206-2900

Kwanza Price - Drug Rebate Analyst  
Robert Reedy III, CPhT - PBM Account Manager

**PLEASE RETURN THIS STUB WITH YOUR PAYMENT AND ATTACHMENTS**

Manufacturer WOMEN FIRST HEALTHCARE, INC  
Manufacturer ID 64248  
Invoice Number 3711  
Quarter Billed 1Q2004

Make checks payable to State of Mississippi - Division of Medicaid and mail to  
ACS State Healthcare  
Attention Robert Reedy - Drug Rebate  
P.O. Box 6014  
Ridgeland, MS 39158-6014

Amount Pd \$ \_\_\_\_\_

State of Mississippi  
Division of Medicaid

1/1/2004 - 3/31/2004

Quarter Bill 1Q2004

Invoice Number 3711

Manufacturer PATTI CONSILVIO  
(64248) WOMEN FIRST HEALTHCARE, INC  
5355 MIRA SORRENTO PLACE  
SAN DIEGO, CA 92121

NDC Number	Drug Name	Package Size	Rebate Amt per Unit	Total Units Reimbursed	Total Rebate Amount Claimed	Num of Script	Other Payments	State Amt Reimbursed
64248-0091-10	EQUAGESIC TABLET	100	0 577700	803 000	\$463 89	14	\$0 00	\$918 14
64248-0101-01	ORTHO-EST 0 625 TABLET	100	0 024700	365 000	\$9 02	13	\$0 00	\$121 34
64248-0102-01	ORTHO-EST 1 25 TABLET	100	0 065500	260 000	\$17 03	8	\$0 00	\$118 09
64248-0150-30	VANIQA 13 9% CREAM	30	0 000000	30 000	\$0 00	1	\$0 00	\$43 23
64248-0310-01	ESCLIM 0 025MG PATCH	8	1 459600	64 000	\$93 41	8	\$0 00	\$255 04
64248-0320-01	ESCLIM 0 0375MG PATCH	8	1 437900	48 000	\$69 02	6	\$0 00	\$186 24
64248-0330-01	ESCLIM 0 05MG PATCH	8	1 331700	364 000	\$484 74	46	\$0 00	\$1,426 00
64248-0340-01	ESCLIM 0 075MG PATCH	8	0 351900	208 000	\$73 20	26	\$0 00	\$828 42
64248-0350-01	ESCLIM 0 1MG PATCH	8	1 177300	594 000	\$699 32	74	\$0 00	\$2,379 51
64248-0419-10	SYNALGOS-DC CAPSULE	100	0 795000	726 000	\$577 17	10	\$0 00	\$933 96
64248-0419-12	SYNALGOS-DC CAPSULE	12	0 795000	24 000	\$19 08	2	\$0 00	\$29 60
				<b>Total</b>	<b>3486 000</b>	<b>208</b>	<b>\$0 00</b>	<b>\$7,239 57</b>
				<b>Credit Balance</b>	<b>\$0 00</b>			
				<b>Final Total</b>	<b>\$2,505 88</b>			

07/06/2004

11 07

6012063119

AOS STATE HEALTHCARE

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Manufacturer PATTI CONSILVIO  
(64248) WOMEN FIRST HEALTHCARE, INC  
5355 MIRA SORRENTO PLACE  
SAN DIEGO, CA 92121

1/1/2004 - 3/31/2004  
Quarter Bill 1Q2004  
Invoice Number 3711

07/06/2004 11 07

6012063119

ACS STATE HEALTHCARE

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Quarter 4Q2003							
NDC	Number of Units	Number of Scripts	Reimbursed Amt	Unit Rebate Amount	Tot Change Amt	Principal Due	
64248-0340-01 ESCLIM 0 075MG PATCH	96 0000	12	\$351 70	0 3519	(\$2 82)	(\$2 82)	
Activity Type	Units Changed	Scripts Changed	Reimb Changed		Amt Changed		
MMIS Unit Change	-8 0000	-1	(\$29 34)		(\$2 82)		
<b>4Q2003 Totals:</b>					<b>(\$2 82)</b>		
<b>Final Totals</b>					<b>(\$2 82)</b>		

STATE OF MISSISSIPPI



**JIM HOOD**  
**ATTORNEY GENERAL**

August 27, 2004

VIA FEDERAL EXPRESS

Women First HealthCare, Inc  
c/o BMC Group, f/k/a Bankruptcy Management Corp  
1330 East Franklin Ave  
El Segundo, CA 90245

RE Women First HealthCare, Inc – Case No 04-11278 (MFW)  
United States Bankruptcy Court for the District of Delaware

Dear Sir or Madam

Enclosed are an original and one copy of the Proof of Claim for the Mississippi Division of Medicaid. Please file the original Proof of Claim in the referenced matter and return the copy stamped "filed" to me in the enclosed postage paid envelope.

If you have any questions please call me at 601-359-5552

Sincerely,

A handwritten signature in cursive script that reads "Bill Mounger".

William H. Mounger  
Special Assistant Attorney General  
Counsel for the Division of Medicaid

Enclosures