UNITED STATES BANKRUPTCY COURT
FOR THE DISTRICT OF DELAWARE

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

06509442001761

NORTH CAROLINA XIX DRUG REBATE Program
PO BOX 751979
CHARLOTTE NC 28275 1979

Creditor Telephone Number (919) 851- 8888

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR
64 248

Check here if this claim ☐ replaces 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) Rebate due from Manufacturer based on federal rebate agreement
☐ 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 _____ (date) to _____ (date)

2 DATE DEBT WAS INCURRED

3 IF COURT JUDGMENT, DATE OBTAINED

4 TOTAL AMOUNT OF CLAIM AT TIME CASE FILED

$ 2,445 40	$ _____	$ _____	$ 2,445 40
(unsecured)	(secured)	(unsecured priority)	(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

☐ 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 $ _____

6 UNSECURED NONPRIORITY CLAIM $ 2,445 40

☑ 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

7 UNSECURED PRIORITY CLAIM

☐ 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

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~~ Oct 26, 2004 for Governmental Units

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
SEP 07 2004
BMC
Women First Healthcare Inc
00171

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)

Deborah B Atkinson - Deborah B Atkinson - Mgmt A/D Budget

Penalty for presenting fraudulent claim is a fine of up to $500 000 or imprisonment for up to 5 years or both 18 U S C §§ 152 AND 3571

Source State Agencies
Target Manufacturers

Manufacturer *WOMEN FIRST HEALTHCARE, INC*
5355 MIRA SORRENTO PLACE

64248

SAN DIEGO, CA 92121

Invoice	Original Bill Amt.	Paid Amt.	Price Adjustments	Unit Adjustments	Admin Adjustments	Mfg Rate Adjustments	Balance Due	Interest Assessed / Adjusted	Interest Paid	Total Amount Due
1200464248	$2 382 27	$0 00	$0 00	$0 00	$0 00	$0 00	$2 382 27	$0 00	$0 00	$2 382 27
4200364248	$300 89	$1 861 60	$0 00	$0 00	$-0 01	$1 560 72	$0 00	$0 00	$0 00	$0 00
3200364248	$688 36	$1 534 96	$0 00	$63 15	$0 00	$846 58	$63 13	$0 00	$0 00	$63 13
2200364248	$897 47	$2 052 03	$0 00	$0 00	$0 00	$1 154 56	$0 00	$0 00	$0 00	$0 00
1200364248	$428 50	$2 628 27	$0 00	$0 00	$0 00	$2 199 77	$0 00	$0 00	$0 00	$0 00
4200264248	$998 14	$1 120 64	$0 00	$0 00	$-0 01	$122 51	$0 00	$0 00	$0 00	$0 00
3200264248	$357 38	$459 62	$0 00	$0 00	$0 02	$102 22	$0 00	$0 00	$0 00	$0 00
2200264248	$310 05	$310 05	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00
1200264248	$413 62	$413 62	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00
4200164248	$440 39	$440 39	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00
3200164248	$344 09	$344 09	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00
2200164248	$282 66	$282 66	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00
1200164248	$239 33	$239 33	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00	$0 00
4200064248	$97 37	$194 99	$0 00	$0 00	$0 00	$97 62	$0 00	$0 00	$0 00	$0 00
3200064248	$49 67	$121 42	$0 00	$0 00	$-0 02	$71 77	$0 00	$0 00	$0 00	$0 00
2200064248	$0 00	$20 37	$0 00	$0 00	$0 00	$20 37	$0 00	$0 00	$0 00	$0 00
Totals	**$8,230 19**	**$12,024 04**	**$0 00**	**$63 15**	**$-0 02**	**$6,176 12**	**$2,445 40**	**$0 00**	**$0 00**	**$2,445 40**

The State of North Carolina is assessing interest on all drug rebate balances older than 38 days (all prior aged balances) and all balances that age beyond 38 days going forward

The current interest assessed is shown on your summary sheet and broken down by quarter If payment for prior invoices was received past the 38 day time period, interest will be assessed for the number of days the payment was late

The HCFA interest policy and calculation is being used

The ROSI forms MUST be included with the payment with any pricing corrections for this or any previous quarters noted

The check should be accompanied by an explanation of the amount which applies to each quarter summarized, NDC level documentation of payments per quarter, and documentation of interest paid by quarter

If there are any questions or concerns regarding the invoice or the interest assessed, contact the EDS Drug Rebate Unit at (919) 851-8888

Source State Agencies
Target Manufacturers

Manufacturer *WOMEN FIRST HEALTHCARE, INC*
5355 MIRA SORRENTO PLACE

64248

PLEASE PROVIDE MISSING URA.
IF NO LONGER VALID
SUBMIT TERMINATION DATE

State Code NC
Period Covered

Invoice # 1200464248
01/01/2004 - 03/31/2004

SAN DIEGO, CA 92121

NDC Number	Drug Name	Rebate Amt. Per Unit	Total Units Reimb	Total Rebate Amt. Claimed	No of Scripts	Total Reimb Amount
64248000410	BACTRIM 400-80MG TABLET	0 000000	96 000	$0 00	12	$105 41
64248009110	EQUAGESIC TABLET	0 577700	1 500 000	$866 55	18	$1 763 98
64248010101	ORTHO-EST 0 625 TABLET	0 024700	716 000	$17 69	24	$391 13
64248010201	ORTHO-EST 1 25 TABLET	0 065500	516 000	$33 80	15	$263 28
64248011710	BACTRIM DS TABLET	0 933800	238 000	$222 24	8	$389 79
64248031001	ESCLIM 0 025MG PATCH	1 459600	112 000	$163 48	14	$465 90
64248032001	ESCLIM 0 0375MG PATCH	1 437900	52 000	$74 77	7	$208 13
64248033001	ESCLIM 0 05MG PATCH	1 331700	259 000	$344 91	32	$1 038 78
64248034001	ESCLIM 0 075MG PATCH	0 351900	16 000	$5 63	2	$65 98
64248035001	ESCLIM 0 1MG PATCH	1 177300	176 000	$207 20	24	$727 13
64248041910	SYNALGOS-DC CAPSULE	0 795000	405 000	$321 98	8	$532 52
64248041912	SYNALGOS-DC CAPSULE	0 795000	156 000	$124 02	4	$188 00
	Totals		**4,242 000**	**$2,382 27**	**168**	**$6,140 03**

North Carolina Drug Rebate Recapitulation Cover Page

Confidential Information

STATE OF NORTH CAROLINA
DIVISION OF MEDICAL ASSISTANCE
NORTH CAROLINA DRUG REBATE SYSTEM
SHARMAN LEINWAND, PHARMACY PROGRAM MANAGER (DMA)
SHARON H GREESON, PHARMACY PROGRAM MANAGER (EDS)

QUARTER	2003 3
LABELER	**64248 WOMEN FIRST HEALTHCARE, INC**

DATE OF REPORT 08/10/2004

ENTERED INTO NORTH CAROLINA DRUG REBATE SYSTEM

BY _____

DATE _____

ADJUSTMENT CODES	DISPUTE CODES	
0) Original Invoice	A) Rebate per unit amount has been revised by labeler	Q) Utilization/quantity is inconsistent with the number of prescriptions
1) Converted Invoice	B) Labeler has calculated rebate where none was reported by State	R) Utilization/quantity is inconsistent with pharmacy reimbursement levels
4) Price Adjust From Manufacturer or Prior Period Adjustment	C) Units invoice adjusted through mutual agreement between labeler/State	S) Utilization/quantity is inconsistent with State historical trends
5) Unit Correction	D) Labeler/State unit discrepancy (e g GM vs ML)	T) Utilization/quantity is inconsistent with lowest dispensable package size
6) Mfg Rate Adjustment	E) Labeler/State decimal discrepancy	U) Product not rebate eligible (Give details)
9) Administrative Adjustment	F) Converted NDC (e g correction to package size)	V) No record of sales in State (Attach data source)
	G) Transferred NDC to another labeler code (documentation required)	W) Closed out All disputes settled
	H) Utilization change from the State	Y) Other Math errors > $10
	I) Rebate per unit amount adjusted through labeler/State correspondence	Z) Other Math errors < $10
	N) Discontinued/Terminated NDC with expired shelf life	
	O) Invalid/Miscoded NDC	
	P) State units invoiced exceeded expected unit sales	

PERIOD 20033 LABCODE 64248

NDC	NAME	ADJUSTMENT CODE	AMOUNTS	REP PER		UNITS	RATE
64248-0004 10	BACTRIM	0	3 11	20033		80 000	0 038900
	BACTRIM	6	-0 47	20034		0 000	-0 005900
Voucher CV64248 20033 1			2 64			80 000	0 033000
	NET INVOICED		2 64				
	NET PAID		2 64				
	BALANCE DUE		0 00		PAYMENT	UNITS	RATE
64248-0091 10	EQUAGESIC	0	329 24	20033		1 170 000	0 281400
	EQUAGESIC	6	208 61	20034		0 000	0 178300
Voucher CV64248 20033 1			537 85			1 170 000	0 459700
	NET INVOICED		537 85				
	NET PAID		537 85				
	BALANCE DUE		0 00		PAYMENT	UNITS	RATE
64248-0101-01	ORTHO EST	0	17 24	20033		455 000	0 037900
	ORTHO EST	6	1 68	20034		0 000	0 003700
Voucher CV64248 20033 1			18 93			455 000	0 041600
	NET INVOICED		18 92				
	NET PAID		18 93				
	BALANCE DUE		-0 01		PAYMENT	UNITS	RATE
64248-0102-01	ORTHO EST	0	40 15	20033		759 000	0 052900
	ORTHO EST	6	7 13	20034		0 000	0 009400
Voucher CV64248 20033 1			47 29			759 000	0 062300
	NET INVOICED		47 28				
	NET PAID		47 29				
	BALANCE DUE		-0 01		PAYMENT	UNITS	RATE
64248-0117 10	BACTRIM DS	0	187 50	20033		321 000	0 584100
	BACTRIM DS	5	63 15	20041		80 000	0 000000
	BACTRIM DS	6	65 88	20034		0 000	0 205246
Voucher CV64248 20033 1			253 38			321 000	0 789346
	NET INVOICED		316 53				
	NET PAID		253 38				
	BALANCE DUE		63 15		PAYMENT	UNITS	RATE
64248-0310-01	ESCLIM	0	83 01	20033		136 000	0 610400
	ESCLIM	6	61 37	20034		0 000	0 451254
Voucher CV64248 20033 1			144 38			136 000	1 061654
	NET INVOICED		144 38				
	NET PAID		144 38				
	BALANCE DUE		0 00		PAYMENT	UNITS	RATE
64248-0320-01	ESCLIM	0	19 66	20033		24 000	0 819100
	ESCLIM	6	11 55	20034		0 000	0 481174
Voucher CV64248 20033 1			31 21			24 000	1 300274
	NET INVOICED		31 21				
	NET PAID		31.21				
	BALANCE DUE		0 00		PAYMENT	UNITS	RATE

PERIOD 20033 LABCODE 64248

NDC	NAME	ADJUSTMENT CODE	AMOUNTS	REP PER	UNITS	RATE
64248-0330-01	ESCLIM	0	0 00	20033	261 000	0 000000
	ESCLIM	6	292 58	20034	0 000	1 121000
Voucher CV64248 20033 1			292 58		261 000	1 121000
	NET INVOICED		292 58			
	NET PAID		292 58			
	BALANCE DUE		0 00	PAYMENT	UNITS	RATE
64248-0350-01	ESCLIM 0 1MG	0	0 00	20033	124 000	0 000000
	ESCLIM 0 1MG	6	118 60	20034	0 000	0 956448
Voucher CV64248 20033 1			118 60		124 000	0 956448
	NET INVOICED		118 60			
	NET PAID		118 60			
	BALANCE DUE		0 00	PAYMENT	UNITS	RATE
64248-0419 10	SYNALGOS DC	0	0 00	20033	530 000	0 000000
	SYNALGOS DC	6	72 66	20034	0 000	0 137100
Voucher CV64248 20033 1			72 66		530 000	0 137100
	NET INVOICED		72 66			
	NET PAID		72 66			
	BALANCE DUE		0 00	PAYMENT	UNITS	RATE
64248-0419 12	SYNALGOS DC	0	0 00	20033	51 000	0 000000
	SYNALGOS DC	6	6 99	20034	0 000	0 137100
Voucher CV64248 20033 1			6 99		51 000	0 137100
	NET INVOICED		6 99			
	NET PAID		6 99			
	BALANCE DUE		0 00	PAYMENT	UNITS	RATE
REPORT TOTALS	NET INVOICED		1 589 64			
	NET PAID		1 526 51			
	BALANCE DUE		63 13			