IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

PART C

STATE OF OKLAHOMA, ex rel., MIKE HUNTER, ATTORNEY GENERAL OF OKLAHOMA,	
Plaintiff,	
vs.	**Case No. CJ-2017-816** **Judge Thad Balkman**
(1) PURDUE PHARMA L.P.; **(2) PURDUE PHARMA, INC.;** **(3) THE PURDUE FREDERICK COMPANY;** **(4) TEVA PHARMACEUTICALS USA, INC.;** **(5) CEPHALON, INC.;** **(6) JOHNSON & JOHNSON;** **(7) JANSSEN PHARMACEUTICALS, INC;** **(8) ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC., n/k/a JANSSEN PHARMACEUTICALS;** **(9) JANSSEN PHARMACEUTICA, INC., n/k/a JANSSEN PHARMACEUTICALS, INC.;** **(10) ALLERGAN, PLC, f/k/a ACTAVIS PLC, f/k/a ACTAVIS, INC., f/k/a WATSON PHARMACEUTICALS, INC.;** **(11) WATSON LABORATORIES, INC.;** **(12) ACTAVIS LLC; and** **(13) ACTAVIS PHARMA, INC., f/k/a WATSON PHARMA, INC.,**	**Special Master:** **William Hetherington**
Defendants.	

STATE OF OKLAHOMA } S.S.
CLEVELAND COUNTY }
FILED
MAY 10 2018
In the office of the
Court Clerk MARILYN WILLIAMS

Continuation of:

THE STATE'S OPPOSITION TO DEFENDANTS TEVA PHARMACEUTICALS USA, INC., CEPHALON, INC., WATSON LABORATORIES, INC., ACTAVIS LLC, AND ACTAVIS PHARMA, INC. f/k/a WATSON PHARMA, INC.'S MOTION TO COMPEL DISCOVERY

The Underestimated Cost of the Opioid Crisis

The Council of Economic Advisers

November 2017

4

Executive Summary

November 2017

The opioid drug problem has reached crisis levels in the United States—in 2015, over 33,000 Americans died of a drug overdose involving opioids. CEA finds that previous estimates of the economic cost of the opioid crisis greatly understate it by undervaluing the most important component of the loss—fatalities resulting from overdoses. This paper estimates the economic cost of these deaths using conventional economic estimates for valuing life routinely used by U.S. Federal agencies. It also adjusts for underreporting of opioids in overdose deaths, includes heroin-related fatalities, and incorporates nonfatal costs of opioid misuse. CEA estimates that in 2015, the economic cost of the opioid crisis was $504.0 billion, or 2.8 percent of GDP that year. This is over six times larger than the most recently estimated economic cost of the epidemic.

1. The Opioid Crisis and Previous Cost Estimates

Opioids are largely effective for their main prescribed uses of reducing acute pain and as anesthesia during surgery. A side effect of these beneficial treatment effects is that they also have high potential for abuse, which can lead users to substitute to more lethal opioids without accepted medical uses such as heroin or illicitly produced fentanyl. Survey data indicate that 2.4 million Americans have an opioid-use disorder (Substance Abuse and Mental Health Services Administration 2016). This includes individuals who abuse prescription painkillers such as OxyContin and Vicodin and individuals who abuse heroin or other illicit opioids.

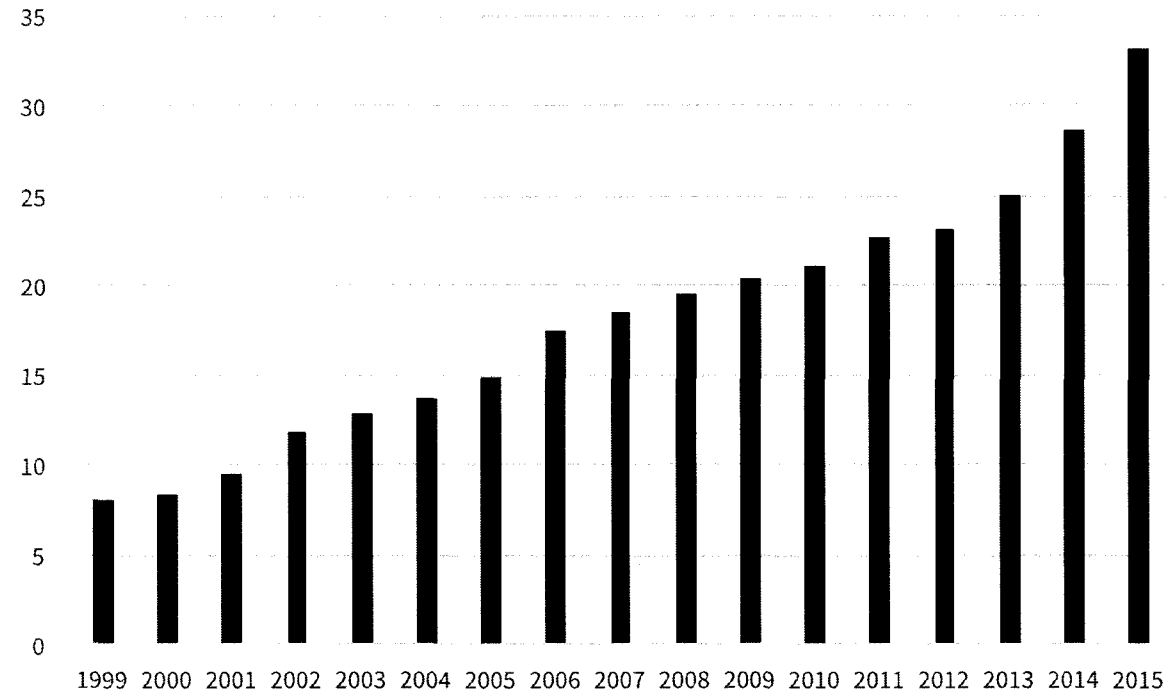
The opioid drug problem has reached crisis levels in the United States. Over 50,000 Americans died of a drug overdose in 2015, of which 63 percent (33,091) reportedly involved opioids.[1] The problem is worsening at an alarming pace, with opioid-involved overdose deaths doubling in the past ten years and quadrupling in the past sixteen (see Figure 1). In response, the Trump Administration has undertaken a series of actions, including creating the President's Commission on Combatting Drug Addiction and the Opioid Crisis and declaring a public health emergency under the Public Health Services Act.

In assessing the benefits of fiscal and regulatory policies that limit opioid abuse in the United States, it is important to understand the costs associated with the epidemic that policies might

[1] Provisional fatality data for 2016 are available, including the number of overdose deaths involving specific types of opioids (e.g., heroin). However, the number of overdose deaths involving at least one opioid is not identified, nor is the age distribution of deaths available at this time, both of which are required for CEA's analysis.

mitigate. While there are a number of studies that attempt to measure losses induced by the opioid crisis, CEA argues that these methods vastly underestimate losses by undervaluing the most important one—the fatalities resulting from overdoses that involve opioids.

Figure 1. Opioid-involved Overdose Deaths, 1999-2015
(Thousands of Deaths)



Source: CDC Wonder database, multiple cause of death files

Studies of the economic cost of the epidemic focus mainly on healthcare costs and find that prescription opioid abusers utilize significantly more healthcare resources than non-addicted peers (e.g., White et al. 2005; White et al. 2009; McAdam-Marx et al. 2010; McCarty et al. 2010; Leider at al. 2011; Johnston et al. 2016; Kirson et al. 2017). Others account for additional costs, including foregone earnings from employment and higher costs to the criminal justice system (e.g., Birnbaum et al. 2006; Birnbaum et al. 2011; Hansen et al. 2011; Florence et al. 2016). Among the most recent (and largest) estimates was that produced by Florence et al. (2016), who estimated that prescription opioid overdose, abuse, and dependence in the United States in 2013 cost $78.5 billion. The authors found that 73 percent of this cost was attributed to nonfatal consequences, including healthcare spending, criminal justice costs and lost productivity due to addiction and incarceration. The remaining 27 percent was attributed to fatality costs consisting almost entirely of lost potential earnings.

While these estimates are informative about certain types of costs, they are only a partial account of the damage imposed by the opioid epidemic. The crisis has worsened in recent years, with an increasing role played by heroin abuse, and evidence suggests that fatality statistics understate the number of opioid-related deaths. We address each of those issues in our analysis below, but most importantly, we fully account for perhaps the epidemic's greatest cost, the value of lives lost due to opioid-related overdose. We do so by applying conventional methods used routinely by Federal agencies in cost-benefit analysis for health related interventions. Previous studies and estimates fail to fully account for the lives lost to overdose. Studies that only include healthcare expenditures typically capture none of the value of lives lost, and studies that account for earnings losses among those who die account for only a fraction of the loss from such mortality. Extensive research indicates that people value fatality risk reduction far beyond the value of lost earnings due to premature death, as earnings do not take into account other valuable activities in life besides work. Using conventional estimates of the losses induced by fatality routinely used by Federal agencies, in addition to making other adjustments related to illicit opioids, more recent data, and underreporting of opioids in drug overdose death certificates, CEA finds that the overall loss imposed by the crisis is several times larger than previous estimates.

2. Economic Cost of the Opioid Crisis

A. Valuation of the costs of premature fatality

We diverge from the previous literature by quantifying the costs of opioid-related overdose deaths based on economic valuations of fatality risk reduction, the "value of a statistical life" (VSL). Federal agencies routinely rely on VSL measures in health and safety settings when estimating the expected fatality risk-reduction benefits of a proposed regulation, policy, or program, as these estimates inform benefit-cost analyses and regulatory impact analyses (Office of Management and Budget n.d.). Such valuations are typically based on how individuals trade off wealth for reduced mortality risks. As an example, wage differentials between occupations with different fatality risks can be used to infer how much greater occupational risk on the job would be accepted for greater compensation (Viscusi 2013).

Although the VSL is widely used to value the risk of fatalities, there is not a consensus on what value the VSL should take in various settings. Viscusi and Aldy (2003) discuss the range of empirical estimates of the VSL and summarize how the concept has been applied in Federal government regulatory and health policy. The authors report that U.S. regulatory agencies used a wide range of VSL estimates between 1985 and 2000, with a minimum of $1.4 million

and a maximum of $8.9 million (both in 2015 dollars).[2] More recently, Robinson and Hammitt (2016) review selected previous research, drawing from both revealed-preference and stated-preference studies, and recommend using a central estimate of $9.4 million, with sensitivity analysis at $4.4 million and $14.3 million (in 2015 dollars).[3] In a meta-analysis that corrects for publication bias, Viscusi (2015) estimates a VSL that ranges from $7.9 million to $11.5 million (in 2015 dollars), and in subsequent work, Viscusi and Masterman (2017) use those estimates to estimate the income elasticity of VSL and country-specific VSLs for a sample of 189 countries with available World Bank income data.

Three Federal agencies have issued formal guidance on the VSL to inform their rule-making and regulatory decision-making. The U.S. Department of Transportation's (DOT) guidance (U.S. DOT 2016) suggests using a value of $9.6 million (in 2015 dollars) for each expected fatality reduction, with sensitivity analysis conducted at alternative values of $5.4 million and $13.4 million. According to a recent white paper prepared by the U.S. Environmental Protection Agency's (EPA) Office of Policy for review by the EPA's Science Advisory Board (U.S. EPA 2016), the EPA's current guidance calls for using a VSL estimate of $10.1 million (in 2015 dollars), updated from earlier estimates based on inflation, income growth, and assumed income elasticities. Guidance from the U.S. Department of Health and Human Services (HHS) suggests using the range of estimates from Robinson and Hammitt (2016) referenced earlier, ranging from a low of $4.4 million to a high of $14.3 million with a central value of $9.4 million (in 2015 dollars). The central estimates used by these three agencies, DOT, EPA, and HHS, range from a low of $9.4 million (HHS) to a high of $10.1 million (EPA) (in 2015 dollars).

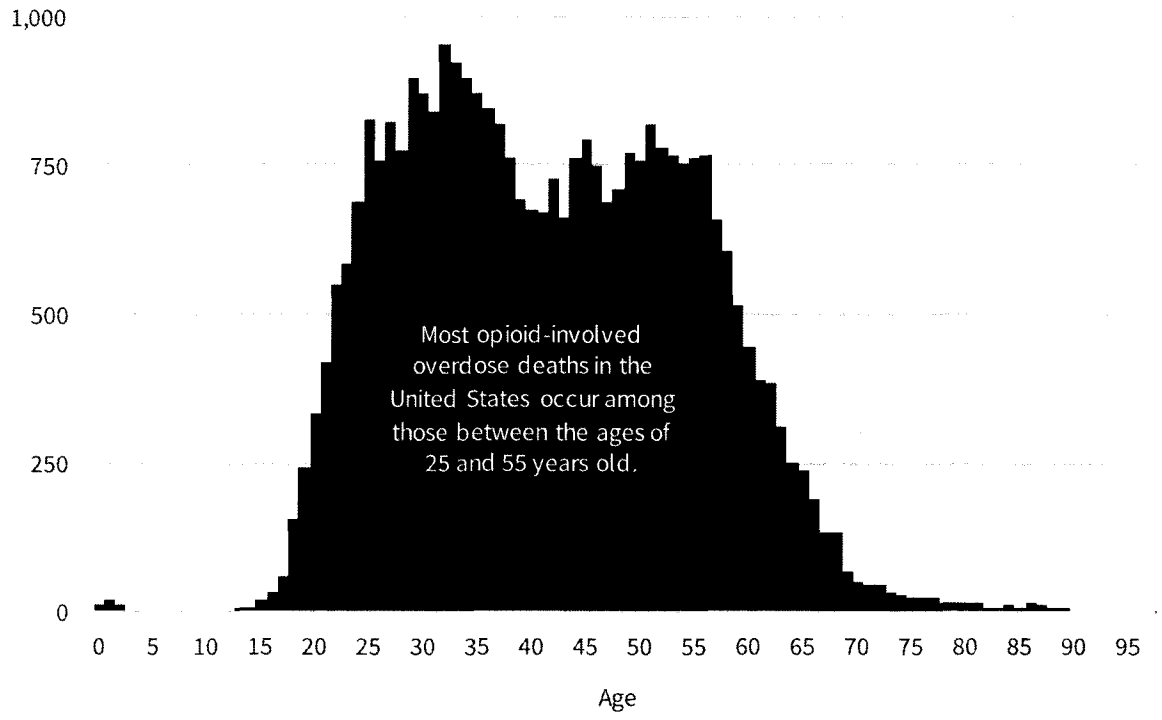
Some argue, however, that VSL estimates are prone to being overstated. Individuals may not fully understand the nature or extent of fatality risks presented, or they may overreact to particularly salient, recent, or very low-risk but truly terrible events, so that estimates of their willingness to pay to avoid these risks may be biased upward. Another concern, evident in the literature on wage differentials and occupational risk, is that failing to control for confounding factors will bias VSL estimates upwards. In the labor market context, for example, higher risk occupations may need to offer higher wages to attract workers, but fatality risks and wages also reflect other factors such as individual skills, care, and working conditions, making it difficult to assess the causal relationship between risks and wages. Thus, it is important to consider a range of VSL estimates when assessing the cost of fatalities.

[2] To facilitate comparisons between VSL estimates, we adjust all estimates below to account for inflation and real income growth, following the procedure described in U.S. Department of Transportation (2016), p. 8.
[3] Revealed preference approaches are based on decisions that implicitly trade off wealth for fatality risk reductions (e.g., the decision to work in risky occupations), while stated preference approaches are based on surveys about this tradeoff.

Finally, it can be important in some contexts to incorporate variation in how different groups of people value reductions in fatality risks. To this end, some VSL studies provide estimates that vary by age group. Aldy and Viscusi (2008) investigate the relationship between VSL and age, finding that the value initially rises, then falls, with age, implying an inverted U-shaped relationship between age and the VSL. Their estimates suggest that individuals in the 25 to 34 year-old and 35 to 44 year-old age groups place the greatest value on fatality risk reduction, among those age groups analyzed in their study (ages 18 to 62). In the analysis that follows, we adopt Aldy and Viscusi's (2008) approach for our preferred estimates, allowing VSL to vary with age to control for the age distribution of overdose deaths. We also present results based on a wide range of age-invariant VSL estimates.

B. Cost of opioid-related fatalities

Figure 2. Opioid-involved Overdose Deaths by Age in 2015
(Number of deaths)



Source: CDC Wonder database, multiple cause of death files

There were 33,091 officially reported opioid-involved overdose deaths in the United States in 2015. Figure 2 below shows the distribution of opioid-involved deaths by age, indicating that most deaths occur among those between the ages of approximately 25 and 55 years old. The overall fatality rate was 10.3 deaths per 100,000 population, and in the 25 to 55 year old age

group, fatality rates were much higher, ranging from 16.1 to 22.0 deaths per 100,000 population.

However, recent research has found that opioids are underreported on death certificates. Ruhm (2017) estimates that in 2014, opioid-involved overdose deaths were 24 percent higher than officially reported.[4] We apply this adjustment to the 2015 data, resulting in an estimated 41,033 overdose deaths involving opioids. We apply this adjustment uniformly over the age distribution of fatalities.

Table 1: Estimated Cost of Opioid-involved Overdose Deaths in 2015 (2015 $)

VSL Assumption	Estimated Cost of Fatalities
Age-dependent	$431.7 billion
Low	$221.6 billion
Middle	$393.9 billion
High	$549.8 billion

Note: We assign the VSL of 18 to 24 year-olds for fatalities in the 0 to 17 year-old group, and we assign the VSL of 55 to 62 year-olds for fatalities in the over-62 year-old group. Two fatalities had no reported age; they were assigned the average VSL over all other fatalities. We also adjust Aldy and Viscusi's figures for the effects of inflation and real income growth, following the procedure described in the U.S. DOT (2016), p. 8.
Source: Aldy and Viscusi (2008); U.S. Department of Transportation (2016); CDC WONDER database, multiple cause of death files; Ruhm (2017); CEA calculations.

Combining these adjusted data with alternative VSL estimates, we calculate the implied cost of lives lost to opioid-involved overdoses in 2015.[5] Table 1 shows our fatality cost estimates under several alternative assumptions for VSL; naturally, higher values of the loss induced by premature fatality produce higher estimates of the total fatality cost of opioid-involved overdoses. Our preferred estimate is based on Aldy and Viscusi's age-adjusted approach and yields total fatality costs of $431.7 billion. Using age-dependent value estimates and age-specific fatalities data yields a high estimate because in the present epidemic, fatalities are concentrated in the age groups with the highest valuations. This is CEA's preferred estimate

[4] Ruhm analyzes death certificate data and, for overdose deaths in which at least one category of drug is specified, identifies factors that are associated with whether an opioid or heroin is present at death. For overdose deaths for which no specific drug or drugs are indicated on the death certificate, Ruhm then imputes the probability that an opioid or heroin was present at death.

[5] We treat the costs from overdose deaths as being experienced fully in the year of death. An alternative approach would essentially amortize the fatality costs over the counterfactual remaining life expectancy of overdose victims, so that the mortality costs in any given year would be the sum of amortized costs from fatalities in that year as well as in preceding years.

given its reflection of the age distribution of fatalities. We also present cost estimates under three alternative VSL assumptions without age-adjustment: low ($5.4 million), middle ($9.6 million), and high ($13.4 million), values suggested by the U.S. DOT and similar to those used by HHS. For example, our low fatality cost estimate of $221.6 billion is the product of the adjusted number of fatalities, 41,033, and the VSL assumption of $5.4 million. Our fatality cost estimates thus range from a low of $221.6 billion to a high of $549.8 billion.

C. Cost of nonfatal opioid misuse

In addition to the cost of fatalities each year, opioid misuse among the living imposes important costs as well. We proceed to estimate those non-fatality costs in two steps. First, we use Florence et al. (2016)'s estimates to obtain a per-person measure of costs of opioid misuse among those who do not die within the year. Second, we multiply that per-person cost by the number of individuals with an opioid use disorder in 2015 to obtain non-fatality costs in 2015.

Florence et al. (2016) estimate that prescription opioid misuse increases healthcare and substance abuse treatment costs by $29.4 billion, increases criminal justice costs by $7.8 billion, and reduces productivity among those who do not die of overdose by $20.8 billion (in 2015 $). The total nonfatal cost of $58.0 billion divided by the 1.9 million individuals with a prescription opioid disorder in 2013 results in an average cost of approximately $30,000.

We apply this average cost to the 2.4 million people with opioid disorders in 2015, resulting in a total cost of $72.3 billion for non-fatal consequences (Substance Abuse and Mental Health Services Administration 2016).[6] It is important to note that while Florence et al. (2016) estimate the average cost for prescription opioid disorders only, we apply it to heroin disorders as well. This may understate the cost of nonfatal consequences of heroin as criminal justice system costs may be higher for illicit drugs such as heroin than for prescription drugs. However, we note that only 14 percent of the 2.4 million individuals with an opioid use disorder in 2015 presented with a heroin use disorder in isolation; others either had a prescription opioid disorder or both disorders present. Thus, applying the Florence et al. (2016) estimate to all opioid disorders is unlikely to significantly bias our total cost estimates, of which non-fatal costs are only a small portion, as discussed further below.

D. Total cost of the opioid crisis

Table 2 presents total cost estimates under alternative VSL assumptions. Our preferred estimate is in the first row, indicating that fatality costs are $431.7 billion (as reported in Table

[6] We use the number of people meeting the criteria for opioid disorders, not those who report current use (within the last 30 days) or recent use (within the last year). The figure includes individuals with prescription opioid use disorder, heroin use disorder, or both disorders simultaneously.

1) and non-fatality costs are $72.7 billion, bringing total costs to $504.0 billion in 2015. Fatality costs comprise over 85 percent of total costs, highlighting the crucial role played by mortality risk valuations when assessing the costs of this epidemic. Overall, our total cost estimates range from a low of $293.9 billion to a high of $622.1 billion.

Table 2: Estimated Cost of the Opioid Crisis in 2015 (2015 $)

VSL Assumption	Fatality Costs	Non-fatality Costs	Total Costs
Age-dependent	$431.7 billion	$72.3 billion	$504.0 billion
Low	$221.6 billion	$72.3 billion	$293.9 billion
Middle	$393.9 billion	$72.3 billion	$466.2 billion
High	$549.8 billion	$72.3 billion	$622.1 billion

Note: We assign the VSL of 18 to 24 year-olds for fatalities in the 0 to 17 year-old group, and we assign the VSL of 55 to 62 year-olds for fatalities in the over-62 year-old group. Two fatalities had no reported age; they were assigned the average VSL over all other fatalities. We also adjust Aldy and Viscusi's figures for the effects of inflation and real income growth, following the procedure described in the U.S. DOT (2016), p. 8.
Source: Aldy and Viscusi (2008); U.S. Department of Transportation (2016); CDC WONDER database, multiple cause of death files; Substance Abuse and Mental Health Services Administration (2016); Ruhm (2017); CEA calculations.

CEA's preferred cost estimate of $504.0 billion far exceeds estimates published elsewhere. Table 3 shows the cost estimates from several past studies of the cost of the opioid crisis, along with the ratio of the CEA estimate to each study's estimate in 2015 dollars. Compared to the recent Florence et al. (2016) study—which estimated the cost of prescription opioid abuse in 2013—CEA's preferred estimate is more than six times higher, reported in the table's last column as the ratio of $504.0 billion to $79.9 billion, which is Florence et al.'s estimate adjusted to 2015 dollars. Even CEA's low total cost estimate of $293.9 billion is 3.7 times higher than Florence et al.'s estimate.

Table 3: Comparison of CEA Estimated Cost to Estimates from Other Studies

Study	Study year	Opioids included	Nonfatal costs	Fatal costs	Adjustment for under-counting	Cost (2015 $)	Ratio of CEA estimate to study estimate
Birnbaum et al. (2006)	2001	Prescription	Yes	Earnings	No	$11.5 billion	43.8
Birnbaum et al. (2011)	2007	Prescription	Yes	Earnings	No	$61.5 billion	8.2
Florence et al. (2016)	2013	Prescription	Yes	Earnings	No	$79.9 billion	6.3
CEA (2017)	2015	Prescription & illicit	Yes	Value of statistical life	Yes	$504.0 billion	1.0

Note: Each of the studies listed includes healthcare, criminal justice and employment costs in nonfatal costs. CEA nonfatal costs are calculated by applying Florence et al. (2016) estimates of the per-person average nonfatal costs of prescription opioid disorders to individuals with prescription opioid and heroin disorders in 2015. CEA fatal costs are calculated by applying the age-dependent VSL to drug overdose deaths involving any opioid in 2015.

There are several reasons why the CEA estimate is much larger than those found in the prior literature. First, and most importantly, we fully account for the value of lives lost based on conventional methods used routinely by Federal agencies in cost-benefit analysis for health related interventions.[7] Second, the crisis has worsened, especially in terms of overdose deaths which have doubled in the past ten years. Third, while previous studies have focused exclusively on prescription opioids, we consider illicit opioids including heroin as well. Fourth, we adjust overdose deaths upward based on recent research finding significant underreporting of opioid-involved overdose deaths.

3. Future CEA Analysis of the Opioid Crisis

This is the first but not the last publication CEA plans to issue on the opioid crisis to provide policymakers with the economic analysis needed to review and assess potential policy options. A better understanding of the economic causes contributing to the crisis is crucial for evaluating the success of various interventions to combat it. For example, supply-side interventions that raise the economic costs of supplying legal prescriptions of opioids may have unintended consequences depending on the extent of demand side substitution induced towards illicit opioids. CEA will conduct further economic analysis of actual and proposed demand- and supply-side interventions; consider the impact of public programs such as Medicare and Medicaid; and explore the important role of medical innovation in combatting the crisis.

[7] Note that the Florence et al. (2016) estimate of $1.3 million in lost productivity per fatality understates losses by at least a factor of three, assuming we use the wage rate to value the other (nonworking) two-thirds of time lost due to premature death. Another perspective is to consider the present value of earnings lost due to early death: for example, the loss of earnings of $50,000 per year for 20 years, discounted at 3 percent, yields a present value of $744,000; trebling that figure gets to $2.2 million, still less than half of DOT's lower bound VSL estimate of $5.4 million.

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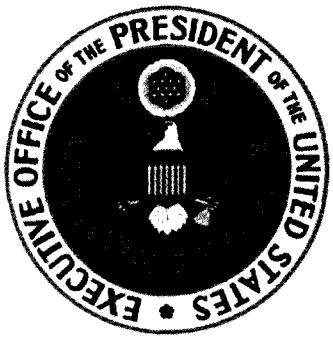

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November 2017

THE OKLAHOMA COMMISSION ON OPIOID ABUSE

FINAL REPORT

OKLAHOMA ATTORNEY GENERAL MIKE HUNTER, CHAIRMAN

JANUARY 23, 2018

5

[Cover letter from AG Hunter]

THE OKLAHOMA COMMISSION ON OPIOID ABUSE

The Oklahoma Commission on Opioid Abuse was formed when the Legislature passed Senate Joint Resolution 12 and it was signed into law on May 18, 2017. Attorney General Mike Hunter chaired the Commission. Members of the Commission were appointed by Governor Mary Fallin, the Speaker of the House of Representatives Charles McCall, and the President Pro Tempore of the Senate Mike Schulz. The Commissioners included: Kevin Buchanan (President, District Attorneys Council), Shanetha Collier, D.D.S. (Dental Director, Family Health Center of Southern Oklahoma), Chelsea Church, Pharm.D., D.Ph. (Executive Director, Oklahoma State Board of Pharmacy), Representative Tim Downing (House District 42), Senator A.J. Griffin (Senate District 20), Bob Howard (Board Member, Oklahoma Board of Medical Licensure and Supervision), John Scully (Director, Oklahoma Bureau of Narcotics and Dangerous Drugs), Layne Subera, D.O. (Family Medicine Practitioner, Skiatook Osteopathic Clinic), Kevin Taubman, M.D. (President, Oklahoma State Medical Association), and Terri White (Commissioner, Department of Mental Health and Substance Abuse Services).

The Commission held five open meetings between August and December of 2017 to focus on the specific problems Oklahoma is facing due to the opioid epidemic. Five principal areas were targeted: law enforcement, the medical community, prevention, treatment, and drug endangered children. Numerous state agencies delivered presentations and provided information to the Commission regarding the epidemic and the State's response. The following is a brief summary of the information that was presented to the Commission and used in formulating the list of final recommendations.

The Epidemic

Dr. Andrew Kolodny, a nationally recognized expert on the opioid epidemic, spoke to the Commission and explained that in 1996 the culture of prescribing opioids began to change dramatically. Opioid manufacturers became focused on enticing doctors to prescribe opioids for common chronic pain conditions. Doctors were told that opioid addiction is rare, that opioids are safe and effective, and that they are easily discontinued. Unfortunately, we now know that opioids are extremely addictive and are not an effective way to manage chronic pain. Sometimes, opioids can even make pain worse – a phenomenon called hyperalgesia.

This message from the pharmaceutical industry was especially persuasive due to the carefully chosen purveyors. As part of the early strategy, doctors often did not hear the information directly from the drug companies; rather, they were inundated with scripted propaganda utilizing their peers in pain management, medical societies, hospitals, and medical boards. This was a brilliant, multi-faceted marketing campaign directed at multiple levels of the medical community and its messages were found in textbooks, journal articles, and in the news media;

however, the initial evidence that authors were citing was not peer-reviewed and was, instead, based on a one-paragraph letter to the editor of the New England Journal of Medicine in 1980.

As "pain" was being concurrently touted as the "fifth vital sign" by these same manufacturers, doctors were made to believe that prescribing opioids for common conditions was not only acceptable, but mandatory. With this backdrop, many doctors were rightfully fearful of being sanctioned for *under*-prescribing powerful opioids and for not fully treating a patient's pain.

In the early 2000s, deaths from prescription opioids began rising rapidly. In 2008, the International Narcotics Control Board released data showing that global consumption of opioid analgesics for the treatment of moderate to severe pain had increased more than two and one half times in the previous decade. More particularly, the United States was consuming 85% of the oxycodone and 99% of the hydrocodone in the world, even though the United States only comprises 4.6% of the world's total population. As more and more people consumed these drugs, more became addicted.

By 2009, almost every state in the country, including Oklahoma, experienced a sharp increase in the number of Americans suffering from opioid addiction. To answer the question of why deaths involving opioids were rising so rapidly, researchers began examining the number of deaths compared to the number of opioid prescriptions. They found that as opioid prescriptions rose meteorically, so did the number of overdose deaths.

In 2016, the Centers for Disease Control reported that more than 64,000 Americans died from drug overdoses and 11.5 million people misused prescription opioids. Thus, more Americans died from drug overdoses in 2016 than died in the Vietnam War. This national epidemic has struck the state of Oklahoma equally hard. Oklahoma has consistently ranked near the top of states for opioid abuse. In 2014, Oklahoma was ranked number one in the abuse of painkiller drugs. In 2016, there were 899 drug overdose deaths in Oklahoma which represents a 68% increase from 2007.

Law Enforcement

Several representatives from the law enforcement community were invited to present to the Commission. Commissioners heard from members of the Oklahoma Bureau of Narcotics and Dangerous Drugs ("OBNDD"), the Drug Enforcement Agency ("DEA"), the Medicaid Fraud Unit of the Attorney General's office, the Department of Health, the Tulsa Police Department Special Investigation Division, and the New Jersey State Police.

Drug diversion is a major problem for law enforcement. Diversion occurs when legal drugs are diverted to the illicit market. This can occur through doctor shopping, forged prescriptions, and employee theft, which is a growing problem. Specifically, diversion occurs in nursing homes as there is ample access to just about any type of medication, including opioids. Accurate documentation and the secure storage and disposal of medications are major concerns.

Diversion also occurs when pharmaceuticals are shipped from the manufacturer to the wholesaler and to the distributors. While the physical diversion of drugs along the distribution path is occurring and problematic, according to several law enforcement officials, the most prolific cause of diversion is "doctor shopping" whereby patients visit multiple doctors seeking prescriptions for opioids. Many presenters agreed that the mandatory use of electronic prescribing would help alleviate the problem of forged prescriptions and doctor shopping.

Law enforcement also faces the challenge of new, very powerful synthetic opioids, specifically fentanyl and its analogues. Carfentanil, which is one-hundred times as potent as fentanyl, is extremely deadly. An amount the size of a few grains of sand can kill a human. Because the drug is so potent, small amounts of the drug can be easily shipped through the regular postal system. The minute quantity and profitability of the drug is driving the rapid increase in its availability and use. Data collection and inter-agency collaboration is necessary to adequately address this growing problem.

Another issue unique to law enforcement officers is the use and availability of opioid overdose reversal drugs such as Naloxone. Commissioners learned about programs sponsored by the Department of Mental Health and Substance Abuse Services which are distributing Naloxone to law enforcement and members of the community. This drug saves lives and should be widely available.

Finally, drug addiction imposes many costs on society and the criminal justice system. Drug Enforcement Administration officials stated that in 2016, 60% of overdose deaths were attributable to pharmaceuticals and 40% were attributable to street drugs. Four out of five heroin users started out using prescription drugs. This switch from licit to illicit drug use has caused law enforcement to begin placing a larger emphasis on the abuse of prescription drugs, understanding that this is where addiction often begins.

One effective tool in fighting the epidemic of drug addiction is the state's system of drug courts. Drug courts, and other specialty courts such as family drug courts, exist in seventy-three (73) counties in Oklahoma. District Attorney Kevin Buchanan expressed the view that these courts, along with mental health courts, are the answer to the opioid crisis and that Oklahoma's outcomes are among the best in the nation. Commissioner Terri White added that $50 million is needed to adequately fund drug courts. Diverting those who are addicted to pain medication from prison to treatment is a necessary step in helping our state recover from the opioid epidemic.

The Medical Community

The medical community holds a unique position in the opioid epidemic because of its prescribing authority. Prescribers include medical doctors, osteopathic physicians, dentists, and veterinarians. Members of each of these groups addressed the Commission and one thing became clear: additional education regarding proper prescribing and risks of addiction is key to

stemming the over-prescribing of opioids. Furthermore, the expansion of prescriptive authority to mid-level providers is not recommended.

In addition, pharmacists can be a second line of defense against addiction and diversion. While pharmacists are not prescribers, they do have the opportunity to assist and educate patients. Additional training and education is needed to give pharmacists the ability to better recognize the signs of addiction and diversion.

Prevention

The Commission was presented with various types of prevention efforts. The Prescription Monitoring Program ("PMP"), which is administered by the Oklahoma Bureau of Narcotics and Dangerous Drugs, is a powerful tool which prescribers and pharmacists can use to detect doctor-shoppers and others at risk for addiction.

The Commissioners also learned about the use of screening tools and methods such as "SBIRT" which stands for Screening, Brief Intervention, and Referral to Treatment. This process is used to help identify those most at risk for addiction and to refer them to appropriate services before they experience a fatal event. This type of intervention could be especially helpful for children, coaches, and young athletes.

Treatment

Treatment options for those already addicted were also discussed. Many of the presenters explained to the Commission that addiction is a brain disease and should be treated as such. Medication assisted treatment ("MAT") is one option for treatment. Drugs like buprenorphine are used to stop the cravings and reduce withdrawal symptoms. More medical professionals need to be trained in addiction treatment. One of the barriers to treatment is the federal limit on the number of patients that can be treated with drugs like buprenorphine.

In addition to its need for more treatment providers, Oklahoma also needs more avenues of treatment. There are currently more people than ever before seeking treatment for opioid addiction but, sadly, only approximately 10% of people who need treatment are receiving it. Every day there are 600 to 800 people on waiting lists for inpatient treatment services. Increasing the number of inpatient treatment beds as well as the number of outpatient treatment options is necessary to gaining control of the epidemic.

Drug Endangered Children

One of the most disturbing topics covered by the Commission was the effect of the opioid epidemic on the youngest Oklahomans. The number of drug-exposed newborns is consistently rising, and is expected to double in 2017 to over 1,000. Neonatal Abstinence Syndrome ("NAS")

is a group of symptoms which newborns exhibit after exposure to opioids while in the womb. After birth, these babies have high-pitched cries, are inconsolable, and shake violently as a result of the withdrawal they experience. In addition, their hospital stays are weeks longer than that of healthy newborns and the medical costs are, on average, more than ten times higher. While we are aware that the problem exists, experts advised us that there is a lack of uniform data available to comprehensively study NAS.

For children in middle school and high school, there is a lack of substance abuse education in schools. While some private schools are doing a good job in the area of drug testing and education, more can be done. The Commission was introduced to programs like "Project Here" in Massachusetts, which provides internet-based screening and educational tools for all of the middle schools in that state. There are also evidence-based programs in the State that could be more widely utilized.

In addition to a lack of education, there is also a lack of treatment resources for children and young adults. Oklahoma has only one accredited recovery high school (the Mission Academy in Oklahoma City) and it is the only such school in the nation that is privately funded. Sober living dorms on college campuses are also lacking. Though at least one program exists at Oklahoma State University, more can be done to support college students who face addiction and need recovery support.

THE RECOMMENDATIONS

After evaluating the information provided by the presenters, the Commission drafted a number of legislative and policy recommendations that we believe are essential to fighting the opioid epidemic. Specifically, we recommend the following legislative actions:

- Enact legislation to criminalize the trafficking of fentanyl and its analogues
- Enact legislation to mandate the use of electronic prescriptions ("e-prescribing")
- Enact a Good Samaritan Law to grant limited immunity to individuals who call to report a drug overdose
- Enact legislation, such as a tax on the manufacturers, wholesalers, and distributors of opioids, as a funding mechanism for opioid addiction treatment
- Enact legislation that would require medical clinic owners to register with the Oklahoma Bureau of Narcotics and Dangerous Drugs "(OBN")
- Enact legislation that imposes maximum quantity limits on first, second, and subsequent opioid prescriptions and includes formal patient notice and informed consent requirements
- Enact legislation that requires opioid manufacturers, wholesalers, and distributors to register with the OBN

- ❖ Enact legislation to create a Drug Overdose Fatality Review Board or Task Force to study causes of opioid overdoses and identify ways to prevent death and refer appropriate cases for criminal prosecution

In addition to these specific legislative recommendations, we also believe there are numerous steps that can be taken which do not require legislation. Specifically, we recommend the following:

- Encourage use of the ODMap application by law enforcement, first responders, and health officials to track overdose events in real time so that resources can be directed to "hot-spot" areas and criminal investigations can be conducted, if necessary
- Support expanded and improved utilization of the PMP by providers and proactive programming by OBN administrators which would provide alerts to prescribers and pharmacists regarding dangerous prescription combinations, high daily dosages of opioids, and doctor-shopping
- Work together with Oklahoma's federal congressional delegation to remove the federal limits on the number of patients to whom physicians can prescribe treatment drugs like buprenorphine
- Create a statewide emergency department ("ER") discharge database to study overdose events and aftercare results
- Encourage the mandatory offering of Naloxone by prescribers and pharmacists to individuals receiving their first opioid prescription or those receiving an opioid prescription in addition to a benzodiazepine
- Provide all first responders with Naloxone and training on how to recognize signs of an overdose and how to use the drug
- Encourage nursing homes and long-term care facilities to develop best practices with regard to medication safety, storage, and disposal and to promote best practices with regard to accurately documenting patient medications
- Pursue rule changes with the appropriate medical boards to require at least one hour of continuing education for all prescribers every reporting period on proper prescribing and the risks of opioids and recognizing addiction and diversion
- Pursue rule changes with the appropriate board to require at least one hour of continuing education every reporting period for pharmacists on how to recognize signs of addiction and diversion
- Mid-level prescribers who are not trained physicians (M.D., or D.O.) should not be allowed prescriptive authority for Schedule II opioids
- Propose and provide complete specific training for law enforcement personnel and investigators through the Oklahoma Council on Law Enforcement Education and Training ("CLEET") on handling opioid diversion investigations
- Support the expansion of insurance coverage for evidence-based pain management treatment options that do not involve opioid prescriptions

- Support federal parity laws that require insurance companies to cover addiction treatment expenses just like any other biological malady
- Continue and expand the first responder overdose program through the Department of Mental Health and Substance Abuse Services, which is providing Naloxone to first responders
- Expand the 19 community-based Naloxone programs in the State to include homeless shelters
- Make more inpatient treatment beds and outpatient treatment options immediately available
- Support the expansion of OSU's Project ECHO in order to increase the number of doctors trained in addiction medicine and increase their availability to patients in rural areas of Oklahoma
- Promote and encourage the use of SBIRT tools by primary care and other providers to increase the identification of addiction and make appropriate referrals for treatment
- Promote training for middle school and high school student athletes and coaches on the risk of addiction to opioid pain medications after sports injuries and encourage the use of early intervention screening tools
- Explore educational pilot programs for middle school and high school students on the risks of opioid addiction and early intervention tools
- Explore pilot programs for sober living on college campuses and support existing programs at OSU through DMHSAS
- Promote the establishment of drug courts in the remaining four counties that do not currently have them and encourage legislators to adequately fund drug courts and other specialty courts throughout the state
- Review current drug law to determine drug court eligibility and expand eligibility in light of recent changes in the law which made some drug possession crimes misdemeanor offenses

CONCLUSION

While the formal work of the Commission has ended with the issuance of this report, we recognize that the more difficult work of legislative and policy changes must now begin. The Attorney General and all of the Commissioners express our resolve to work diligently with the executive, legislative, and judicial branches of government as well as state agency heads and community leaders to quickly implement the necessary legislative changes and the policy recommendations discussed herein. Through our work, we wish to honor the memory of all those whose lives were tragically lost to an opioid overdose by helping to make treatment and recovery support more widely available to all who are suffering.

The Oklahoma Commission on Opioid Abuse Commissioners

Kevin Buchanan was elected as the district attorney for Washington and Nowata counties in 2011. He currently serves as president of the District Attorneys Council. Prior to his current role, he worked in private practice as a criminal defense attorney. Mr. Buchanan received a bachelor's degree from Oklahoma State University and a law degree from the University of Tulsa.

Shanetha L. Collier, D.D.S., is the Dental Director for the Family Health Center of Southern Oklahoma in Tishomingo, Oklahoma. Dr. Collier is a native of Durant, Oklahoma. She obtained her undergraduate degree from Oklahoma State University, and then her doctor of dental surgery degree from the University of Oklahoma College of Dentistry. She currently practices general dentistry in Tishomingo, Oklahoma.

Chelsea Church, Pharm.D., D.Ph., is the Executive Director of the Oklahoma State Board of Pharmacy. Ms. Church graduated from the University of Oklahoma College of Pharmacy, and completed a Primary Care Pharmacy Practice residency in Tuscaloosa, AL. She was an Associate Professor with Southwestern Oklahoma State University for thirteen years, specializing in Internal Medicine. In 2012, she joined the Oklahoma State Board of Pharmacy as a CLEET-certified Pharmacist Compliance Officer. In July 2017, she was named Executive Director of the Board of Pharmacy.

Representative Tim Downing represents District 42 in the Oklahoma House of Representatives, where he currently serves as the assistant majority whip and as vice chair of the civil and environmental judiciary committee. He is an officer in the United States Army Reserves and he previously worked at the attorney general's office. Rep. Downing received a bachelor's degree from the University of Oklahoma, a master's from Oral Roberts University, and a law degree from Regent University in Virginia.

Senator AJ Griffin represents district 20 in the Oklahoma Senate, where she currently serves as the Chair for the Senate Appropriations Subcommittee on Health and Human Services and the Chair of the Rural Caucus. She is a manager for a non-profit dedicated to improving the lives of Oklahoma children and families. During her time in the Senate, she has worked to write and pass legislation to address Oklahoma's fastest growing substance abuse issue—prescription drug addiction. Sen. Griffin also authored legislation to better protect victims of child abuse. She received a bachelor's degree from Oklahoma State University and a master's degree from the University of Central Oklahoma.

Bob Howard is an Oklahoma City businessman involved in several ventures through his investment company, REHCO, LLC. He is also the president of Mercedes-Benz Volvo of Oklahoma City and managing partner of Midtown Renaissance, a real estate company engaged

in the redevelopment of Oklahoma City's Midtown District. Mr. Howard also serves on the Oklahoma Board of Medical Licensure and Supervision.

John Scully, Director of the Oklahoma Bureau of Narcotics and Dangerous Drugs, is serving as an ex officio member on the commission, per Senate Concurrent Resolution 12. He has been the director of the OBNDD since March 2016. Prior to his appointment, Director Scully was a member of the Oklahoma City Police Department for 32 years, where he served in many capacities, including deputy chief for the final eight years of his tenure. He received both a bachelor's and master's degree from Southern Nazarene University. Director Scully is a graduate of the FBI National Academy in Quantico, Virginia, the Police Executive Research Forum in Boston, Mass., and the DEA Drug Unit Commander Academy in Quantico, Virginia.

Layne Subera, DO is a doctor of osteopathic medicine. Dr. Subera currently practices family medicine at the Skiatook Osteopathic Clinic. Dr. Subera is board certified in Family Practice and Osteopathic Manipulative Treatment by the America Osteopathic Board of Family Physicians. He is a member of the American Osteopathic Association, the American College of Osteopathic Family Physicians, the Oklahoma Osteopathic Association, and the American Academy of Professional Coders. Subera received a bachelor's degree from Oklahoma State University and a doctor of osteopathic medicine degree from Oklahoma State University.

Kevin Taubman, M.D. is the president of the Oklahoma State Medical Association and is an assistant professor in the University of Oklahoma School of Community Medicine, Department of Surgery and Vascular Fellowship Program director in Tulsa. He completed his general surgery residency at Kern Medical Center at the University of California, San Diego. Dr. Taubman completed his fellowship in vascular/endovascular surgery and interventional radiology at the Heart and Vascular Institute of the Penn State University Milton S. Hershey Medical Center. His specialties include carotid artery disease, arterial aneurysm, peripheral arterial disease and venous disease.

Terri White, Commissioner of the Department of Mental Health and Substance Abuse Services, is serving as an ex officio member on the commission, per Senate Concurrent Resolution 12. She was the first female to be appointed by then-Governor Brad Henry as Oklahoma Secretary of Health from 2009 to 2011. She has been recognized by The Journal Record newspaper as one of Oklahoma's top "Achievers Under 40" and is a three-time honoree of The Journal Record's "50 Women Making a Difference." In 2014, White received the "Kate Barnard Award" from the Oklahoma Commission on the Status of Women, an award created to honor women who have made a difference in Oklahoma through public service. In 2011, she was inducted into the University of Oklahoma's Anne and Henry Zarrow School of Social Work Hall of Fame. She is also volunteer faculty with the University's School of Medicine and is a Henry Toll Fellow with the Council of State Governments. White received both her bachelor's and master's degrees from the University of Oklahoma.

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., MIKE HUNTER, ATTORNEY GENERAL OF OKLAHOMA,	
Plaintiff,	
vs.	**Case No. CJ-2017-816**
	Judge Thad Balkman
(1) PURDUE PHARMA L.P.; **(2) PURDUE PHARMA, INC.;** **(3) THE PURDUE FREDERICK COMPANY,** **(4) TEVA PHARMACEUTICALS USA, INC.;** **(5) CEPHALON, INC.;** **(6) JOHNSON & JOHNSON;** **(7) JANSSEN PHARMACEUTICALS, INC,** **(8) ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC., n/k/a JANSSEN PHARMACEUTICALS;** **(9) JANSSEN PHARMACEUTICA, INC., n/k/a JANSSEN PHARMACEUTICALS, INC.;** **(10) ALLERGAN, PLC, f/k/a ACTAVIS PLC, f/k/a ACTAVIS, INC., f/k/a WATSON PHARMACEUTICALS, INC.;** **(11) WATSON LABORATORIES, INC.;** **(12) ACTAVIS LLC; and** **(13) ACTAVIS PHARMA, INC., f/k/a WATSON PHARMA, INC.,**	
Defendants.	

ORDERS OF SPECIAL DISCOVERY MASTER ON APRIL 19th 2018 MOTION REQUESTS

On April 19, 2018, the above and entitled matter was heard before the undersigned on the parties' various motions, objections and requests for relief. The undersigned Special Discovery Master having reviewed the pleadings, heard oral arguments and being fully advised in the premises finds as follows:

Purdue's Motion To Compel Production Of Documents

6

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., MIKE HUNTER, ATTORNEY GENERAL OF OKLAHOMA,	)	
Plaintiff,	)	**Case No. CJ-2017-816**
vs.	)	**Judge Thad Balkman**
(1) PURDUE PHARMA L.P.; (2) PURDUE PHARMA, INC.; (3) THE PURDUE FREDERICK COMPANY, (4) TEVA PHARMACEUTICALS USA, INC.; (5) CEPHALON, INC.; (6) JOHNSON & JOHNSON; (7) JANSSEN PHARMACEUTICALS, INC, (8) ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC., n/k/a JANSSEN PHARMACEUTICALS; (9) JANSSEN PHARMACEUTICA, INC., n/k/a JANSSEN PHARMACEUTICALS, INC.; (10) ALLERGAN, PLC, f/k/a ACTAVIS PLC, f/k/a ACTAVIS, INC., f/k/a WATSON PHARMACEUTICALS, INC.; (11) WATSON LABORATORIES, INC.; (12) ACTAVIS LLC; and (13) ACTAVIS PHARMA, INC., f/k/a WATSON PHARMA, INC.,	)	
Defendants.	)	

ORDERS OF SPECIAL DISCOVERY MASTER ON APRIL 19th 2018 MOTION REQUESTS

On April 19, 2018, the above and entitled matter was heard before the undersigned on the parties' various motions, objections and requests for relief. The undersigned Special Discovery Master having reviewed the pleadings, heard oral arguments and being fully advised in the premises finds as follows:

Purdue's Motion To Compel Production Of Documents

Purdue seeks to compel production of documents responsive to RFPs requested in its first set of requests for production. Purdue Pharma L.P. seeks production of documents numbered two, four, six, seven, eight, and nine. Purdue Fredrick Co. seeks production of documents responsive to requests number one, five, six and seven. Plaintiff, State of Oklahoma, ex. rel. Attorney General of Oklahoma (State) has filed its objection thereto and request to strike as moot.

A. State's objection and motion to strike as moot is **overruled**. Specific finding is made that under the claims made in this petition, details of medical necessity and reimbursable claims under the Oklahoma Medicaid system, State's claims review and reimbursement process and the identity of State personnel with knowledge about efforts to prevent opioid abuse and diversion are all relevant or potentially relevant areas of inquiry in this case. State argues the only documents that will be withheld or objected to are privileged and confidential information. Therefore, both Purdue Pharma L.P. and Purdue Frederick Company's motion to compel are **sustained** to be produced as soon as practically possible under the agreed "rolling production" process. The undersigned acknowledges State's argument that its objections have been withdrawn. Nevertheless, production is **ordered** consistent with findings made herein:

Purdue Pharma L.P.

1. RFP No. 2 – State's objection withdrawn during meet and confer, motion to compel **sustained**;

2. RFP No. 4 – State's objection withdrawn during meet and confer, motion to compel **sustained**;

3. RFP No. 6 – State's objection withdrawn during meet and confer, motion to compel **sustained**;

4. RFP No. 7 – State's objection withdrawn during meet and confer, motion to compel **sustained**;

5. RFP No. 8 – State's objection withdrawn during meet and confer, motion to compel **sustained**;

6. RFP No. 9 - State's objection withdrawn during meet and confer, motion to compel **sustained**.

Purdue Frederick Co.

1. RFP No. 1 – State's objection withdrawn during meet and confer, motion to compel **sustained**;

2. RFP No. 5 – State's objection withdrawn during meet and confer, motion to compel **sustained**;

3. RFP No. 6 – State's objection withdrawn during meet and confer, motion to compel **sustained**;

4. RFP No. 7 – State's objection withdrawn during meet and confer, motion to compel **sustained.**

State's Second Motion To Compel

State has served notice for corporate designee depositions as described in exhibits one through six of State's motion:

1. The open letter published by or on behalf of the Purdue Defendants in the New York Times on Thursday, December 14, 2017, entitled, "We manufacture prescription opioids. How could we not help fight the prescription and illicit opioid abuse crisis?" ("Open letter"), including but not limited to all actions taken by Purdue Defendants in support of the recommendations and initiatives identified in the Open Letter, and the reasons the Open Letter was written and published.

2. The Purdue Defendants' decision to discontinue marketing or promoting opioids to prescribers.

3. The J&J Defendants' past and present relationship with Tasmanian Alkaloids, the corporate structure and management of Tasmanian Alkaloids during its affiliation with any J&J Defendants, and the terms of any asset purchase agreement, acquisition agreement, and/or purchase and sale agreement by and between any J&J Defendants and Tasmanian Alkaloids, including terms related to the assumption of liability.

4.-6. All actions available or necessary to address, fight, update and/or reverse the opioid epidemic. (One Notice For Each Defendant Group)

To these notices, the three Defendant groups have filed requests for protective orders and to quash the deposition notices, to which State has responded. The following Orders are entered with regard thereto:

1. Open Letter (Purdue)

State has described with reasonable particularity two areas of inquiry with regard to this "Open Letter": 1. All actions taken by the Purdue Defendants in support of the recommendations and initiatives identified in the Open Letter; 2. The reasons the Open Letter was written and published. State shall be limited to these two areas of inquiry to include any follow-up inquiry that may become reasonably necessary to identify the exact actions taken, who took them, when and where. To this extent, State's motion to compel is **sustained** and Defendants' opposition thereto and request to quash the notice is **overruled**.

2. Purdue Defendants'decision to discontinue marketing or promoting opioids to prescribers.

State's motion to compel is **sustained** and Defendants' request to quash the notice on this topic is **overruled** as a fact witness could produce likely relevant evidence as it relates to decisions to discontinue marketing and promoting opioids.

3. J&J Defendants/Tasmanian Alkaloids

Finding is entered that State has pled with reasonable particularity the relationship between J&J Defendants and Tasmanian Alkaloids (Not a party to this litigation) during a portion of the relevant time period in this litigation. As a former subsidiary of Johnson & Johnson, Tasmanian Alkaloids manufactured the poppy-based opiate ingredient used in many of the United States marketed and distributed opioids. The J&J Defendants had a direct financial interest in the sale of the opioid products generally, not just limited to their own branded opioids. That places J&J Defendants in a position of having a financial interest in opioids generally and possible motive relevant to issues raised in this case.

State's motion to compel is **sustained** and Defendants' request to quash the notice on this topic is **overruled**.

4-6. Abatement Actions

State gives notice to each Defendant group to depose a corporate designee regarding fact testimony similar to the line of inquiry requested of Purdue Defendants in item notice No. 1. The added fact with regard to Purdue Defendants' being the "Open Letter". These notices are necessarily limited to fact testimony and as argument indicated, cannot include opinion testimony that seeks to elicit a legal opinion on a primary issue a finder of fact may have to determine and that is an action plan, factually and legally, fashioned to abate the opioid crisis. Certain Defendants through negotiations in other cases have agreed to disclose factual efforts that are currently under way and actions planned and expected to take place in the future to seek to abate the opioid crisis. Settlement negotiations are privileged, and there is a strong public policy disfavoring intrusion into confidential and privileged settlement discussions. 12 O.S. § 2408; Fed. R. Evid. 408; *Goodyear Tire & Rubber Co. v. Chiles Power Supply, Inc.*, 332 F.3d 976, 980 (6th Cir. 2003). Further, expert witnesses do not have to be determined and disclosed until the deadline of September 14, 2018, with expert depositions to be completed by January 25, 2019.

Therefore, each Defendant groups' request for a Protective Order and to Quash the notice as drafted is **sustained** and should State so desire, new deposition notices to issue to fact witnesses to be designated by each Defendant group for inquiry by State into factual efforts that are currently under way and actions planned and expected to take place in the future which seek to address, fight or abate the opioid crisis.

April 4, 2018 Order of Special Discovery Master On State's First Motion to Compel.

Defendant groups have filed objections to and requests to strike or modify the above referred-to discovery order. Argument was heard and considered at the April 19, 2008 hearing and the following orders are entered:

1. Review of the record indicates State did not move to compel RFP No. 17 and objections to and requests to strike any findings made by the undersigned with regard to RFP No. 17 are **sustained**. Further, the undersigned recognizes that certain Defendants have already produced and there are agreements for future production relevant to the RFPs in question. Any rulings, orders or modifications to previous orders with regard RFPs take into consideration this reality and the ongoing "rolling production" process. Nothing in the undersigned's orders here-in are meant to require duplication of production.

A. With regard to findings made numbered "1" through "7" of the April 4th Order, the following findings are entered:

1. Regarding finding numbered "3", the finding the likely relevant time period for Purdue defendants is from the original OxyContin release date of May 1, 1996 to present is amended in part to specific findings that will be made below as to each State requested RFP and Purdue Defendants' request to modify is **sustained** to that extent.
2. The balance of the findings made numbered "1" through "7" of the April 4th Order remain unchanged and any Defendant requests to modify or strike are **overruled.**

B. Requests For Production, State's First Motion To Compel

RFP No. 1 – Defendants' various motions to strike or modify are **overruled** subject to the previous ruling that Defendants must specifically identify any category of documents from other cases they intend to withhold as non-public or confidential governmental investigations or regulatory actions;

RFP No. 2 – Defendants' various motions to strike or modify are **overruled** subject to the previous ruling that Defendants must specifically identify any category of documents from other cases they intend to withhold as non-public or confidential governmental investigations or regulatory actions;

RFP No. 3 – This RFP in conjunction with RFP 4 and in part 5 seek discovery of sales, training and marketing materials that did help define the pharmaceutical industry's approach to sales, relevant to the claims made in this case. Regarding document discovery concerning sales, training and education materials for opioid sales representatives, the relevant time period is found to be from May 1, 1996, the commencement of the marketing of the original OxyContin as it relates to Purdue, and the known marketing start dates for the balance of the Defendant groups. Such production as to Purdue may be restricted to materials in Purdues' possession, possession of its current employees, and its third-party sales representatives under promotional contracts on and after 1996 and relevant to branded or un-branded advertisements and/or marketing materials. Therefore, Defendants' various motions to strike or modify are **sustained** in part and **overruled** in part;

RFP No. 4 – Purdue is **ordered** to produce training and education materials provided to medical liaisons, retained or funded by You concerning medical liaisons with health care professionals, KOLs, and front groups regarding opioids and/or pain treatment for branded and unbranded materials beginning in 2004 and thereafter. Other Defendants are so **ordered** beginning with their relevant marketing time period. Therefore, Defendant groups' various motions to strike or modify are **sustained** in part and **overruled** in part;

RFP No. 5 – Defendants are **ordered** to produce related communications relevant to RFP 4, 5, 7 and 9 currently in their possession, Purdue beginning in 2004 and thereafter and other Defendants' beginning with the relevant marketing time period. Therefore, Defendant groups' various motions to strike or modify are **sustained** in part and **overruled** in part;

RFP No. 6 – Defendant groups' motions to strike or modify are **sustained** in part and **overruled** in part, in that production shall be **ordered** of all branded or un-branded advertisements and/or marketing materials published by You concerning opioids, including, without limitation all videos, pamphlets, brochures, presentations and treatment guidelines. Purdue beginning in 2004 and thereafter and other Defendants' beginning with the relevant marketing time period. Drafts of such materials are **not ordered** located or produced;

RFP No. 7 – Defendant groups' motions to strike is **sustained** as this RFP is now included in Orders entered in RFPs 3, 4, 5 and 6;

RFP No. 8 – Defendant groups' motions to strike is **sustained** as this RFP is now included in Orders entered in RFPs 3, 4, 5 and 6;

RFP No. 9 – Defendant groups' motions to strike is **sustained** as this RFP is now included in Orders entered in RFPs 3, 4, 5 and 6;

RFP No. 10,11 – Defendant groups' motion to strike or modify is **sustained** in part and **overruled** in part as to RFP 10 and 11. Defendant groups are **ordered** to produce documentation reflecting amount spent by You on advertising and marketing related to branded or unbranded opioid advertising, and to KOLs and other Front Groups, Purdue beginning in 2004 and thereafter and other Defendant groups beginning with the relevant marketing date;

RFP No. 12 – Defendant groups' motion to strike or modify is **sustained** in part in that Defendant groups are ordered to produce all organizational charts identifying your employees involved in (1) the sale, promotion marketing and advertising of your opioids, Purdue since May 1, 1996 and other Defendant groups since the relevant marketing date; and (2) communication with Healthcare Professionals, KOLs and Front Groups regarding opioids, including OxyContin and pain treatment, Purdue beginning in 2004 and other Defendant groups beginning with the relevant marketing date;

RFP No. 13 – Defendant groups' motion to modify or strike is **sustained** in part and **overruled** in part in that a search for all communications between you and trade groups, trade associations, nonprofit organizations and/or other third-party organizations concerning opioids and/or pain treatment since 1996 is overly burdensome on Purdue and likely impossible to comply with. Production of communications from Purdue relevant to this RFP and currently in the possession of Purdue is **ordered** produced from and since 2006. As to other Defendant groups, such communications in their possession are **ordered** produced beginning with the relevant marketing date;

RFP No. 14 – Regarding communications between you and other opioid manufacturers, distributors, wholesalers, pharmacies and/or BPMs as described in this RFP and RFP 15, communications may be relevant to State's conspiracy allegations. Defendant groups' motion to modify or strike is **sustained** in part and **overruled** in part in that a search for all communications referred to in RFP 14 and 15 since 1996 is overly burdensome. Production of communications as described in RFP 14 and 15 and currently in the possession of Purdue is **ordered** produced from and after 2004. As to other Defendant groups, such communications in their possession are ordered produced beginning with the relevant marketing date;

RFP No. 16 – Defendant group's motion to modify or strike is **overruled**;

RFP No. 18 – Defendant groups' motions to strike is **sustained** as this RFP is now included in Orders entered in RFPs 4, 5, 10 and 12;

RFP No. 19 – Defendants' motion to strike or modify the undersigned's April 4, 2018 Order is **overruled**;

RFP No. 20 – Purdue has now produced or agreed to produce documents concerning the concept of "pseudoaddiction" or "pseudo-addiction". Purdue has also agreed to identify custodians of responsive communications and search for documents to produce, relevant to "pseudoaddiction" or "pseudo-addiction". Therefore, Defendants' request to strike or modify is **sustained** subject to State producing future evidence sufficient to demonstrate failure to produce or to expand the scope of this RFP;

RFP No. 21 – Defendants' motion to strike or modify the undersigned's April 4, 2018 Order is **overruled**;

RFP No. 22 – Defendants' motion to strike or modify the undersigned's April 4, 2018 Order is **overruled**;

RFP No. 23 – Defendants' motion to strike or modify the undersigned's April 4, 2018 Order is **overruled**;

RFP No. 24 – This RFP does seek production of virtually every document and communication generated by potentially hundreds of individuals in Purdues' and other Defendants' departments responsible for scientific research, studies, journal articles, and/or clinical trials regarding opioids and/or pain treatment, including all drafts. This request is found to be overly broad and burdensome. Therefore, Defendants' motion to strike or modify this RFP is **sustained** and the April 4, 2018 ruling is **ordered** stricken and State's request to compel is **denied** in this RFP's current form;

RFP No. 25 – Defendants' motion to strike or modify the undersigned's April 4, 2018 Order is **overruled**;

RFP No. 26 – Defendants' motion to strike or modify the undersigned's April 4, 2018 Order is **overruled**;

RFP No. 27 – Defendants' motion to strike or modify the undersigned's April 4, 2018 Order is **overruled**;

RFP No. 28 - Defendants' motion to strike or modify the undersigned's April 4, 2018 Order is **overruled**.

Entered this 25th day of April, 2018,

William C. Hetherington, Jr.
Special Discovery Master

IN THE DISTRICT COURT OF CLEVELAND COUNTY

STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., MIKE HUNTER ATTORNEY GENERAL OF OKLAHOMA, Plaintiff, vs. (1) PURDUE PHARMA L.P.; (2) PURDUE PHARMA, INC.; (3) THE PURDUE FREDERICK COMPANY; (4) TEVA PHARMACEUTICALS USA, INC; (5) CEPHALON, INC.; (6) JOHNSON & JOHNSON; (7) JANSSEN PHARMACEUTICALS, INC.; (8) ORTHO-McNEIL-JANSSEN PHARMACEUTICALS, INC., n/k/a JANSSEN PHARMACEUTICALS; (9) JANSSEN PHARMACEUTICA, INC. n/k/a JANSSEN PHARMACEUTICALS, INC.; (10) ALLERGAN, PLC, f/k/a ACTAVIS PLC, f/k/a ACTAVIS, INC., f/k/a WATSON PHARMACEUTICALS, INC.; (11) WATSON LABORATORIES, INC.; (12) ACTAVIS LLC; AND (13) ACTAVIS PHARMA, INC., f/k/a WATSON PHARMA, INC., Defendants.	Case No. CJ-2017-816

4

TRANSCRIPT OF PROCEEDINGS
HAD ON APRIL 19, 2018
AT THE CLEVELAND COUNTY COURTHOUSE
BEFORE THE HONORABLE WILLIAM C. HETHERINGTON, JR.
RETIRED ACTIVE JUDGE AND SPECIAL DISCOVERY MASTER
AND THE HONORABLE THAD BALKMAN
DISTRICT JUDGE

REPORTED BY: ANGELA THAGARD, CSR, RPR

MR. MERKLEY: Thank you, your Honor.

THE COURT (JUDGE HETHERINGTON): All right. Mr. Brody, let's proceed, please.

MR. BRODY: Thank you, your Honor. And I fear I'm going to be responding to a jury argument with a legal argument here. And I think this argument addresses both the opposition to the State's motion to compel and the motion to quash and/or for a protective order that Janssen filed addressing the two topics. And I'll take them in order.

Starting with the first topic that was noticed, all actions available or necessary to address, fight, abate, and/or reverse the opioid epidemic. And I think that in the course of the argument we heard from the State, the State really made our point.

And the point is grounded in the fact that this is a fact deposition of a corporate designee. And there are a lot of courts around the country who have looked at that issue. What is proper, what is not proper, and they've all come down uniformly on the side of saying that a request for opinion testimony, a request for expert testimony, and a request for legal conclusions in the form of a corporate designee deposition is improper.

We have a number of those cases cited throughout our brief. The State's presentation was most notable for the absence of any contrary case law. It was also notable for the

express admission that what it is seeking is precisely testimony that is opinion testimony that goes to legal conclusions and that is the subject of expert testimony.

And we heard that what they want to know is what these defendants in this case think needs to be done to address this problem. There is no question that that is opinion testimony, and the topic on its face asks for opinion testimony. It also asks for the ultimate legal conclusion.

We heard from counsel, Well, this is the question that Judge Balkman is going to have to answer in this case. And there's case after case, and we've cited them in our brief, Davis, Kanbar, Babcock Power, Brudnicki that say seeking opinion testimony, not fact testimony, from a corporate designee is something that is not a proper subject for this type of deposition notice.

And so what we did in the course of our discussions with the State is we said, Well, let's take a look at this, and let's see if we can draw out something and reframe this in a way where it is going to be a proper subject for testimony.

And you've seen in the briefing, we suggested that we would provide a witness by the end of April to address Janssen's efforts to reduce the risks associated with its opioid medications. And as I'm sure the Court is well aware, one of the primary risks associated with opioid medications is the risk of addiction. And you heard Mr. Beckworth say, It's

entire negotiation process collapses upon itself and the judicial efficiency it fosters is lost.

Not only is there a privilege for settlement discussions in the Sixth Circuit, there is an order from the federal MDL judge February of this year prohibiting the parties from disclosing any of the content of those settlement discussions.

So even if we didn't have -- and the Court really doesn't even need to reach this issue because the topic, as it has been stated, is an improper topic for a corporate designee in seeking, as we heard from Mr. Beckworth, you know, What do you think needs to be done to address this problem; as opposed to, What efforts have you taken to address the risks associated with your products. Or you know, there was even a reference to a Teva statement, and the Teva statement -- and counsel for Teva can get up and address this -- was, Here is what we are doing.

Now, a deposition on, Tell us about the things you are doing is very different from -- that's fact testimony. That's very different from, What do you think needs to be done. And that is where Courts have drawn the distinction. And again, we cite Court after Court that has drawn that distinction and recognized that in that circumstance, the appropriate remedy is to deny the discovery.

Now, again, we're not saying there could never be a deposition that gets that factual information about things that

have been done, steps that have been taken. And certainly, I would expect there's going to be a lot of expert testimony in this case about, you know, what is the proper -- what are the proper steps that are going to be significant for abatement.

You know, for example, does it increase transparency into prescription information available to distributors of these medications in order to stop diversion. Is it, you know, a law in Oklahoma like exists in many other states that limits who can be an owner of a pain clinic. Does it have to be a medical professional, or can you let business interests in there that may have different motivations that are not consistent with the oaths that doctors take to protect their patients. I'm sure we're going to see testimony on that, but it doesn't make it a proper subject for testimony under the rule.

Now, it's no answer to say, Well, just put up a witness, and if we stray into areas that you disagree are going to be part of this, then just object, instruct, you know, and carve out the portions that you think are relevant and the portions that you think are proper and the portions that you think are not.

Because if there's a witness in a deposition and there's a question, for example: Do you think it would make a difference if a manufacturer -- and I'll just use an example of a question that Mr. Beckworth used as an example when we had one of our subsequent meet and confer discussions on this. Do you think

State intends to ask Teva's corporate designee, if it has the opportunity under this deposition topic, about what it's done in the past.

This topic has nothing to do with what Teva has done in the past. All actions available or necessary to address, fight, abate, and/or reverse the opioid epidemic. It does not ask me to prepare a witness on that topic, what Teva has done in the past. It only asks what is available or necessary, which as Mr. Brody explained and which I will not repeat, is the subject of expert testimony.

Further, your Honor, and I'll make this point. I should have made this point at the outset. Teva does not concede that it was responsible for the conduct alleged in the complaint, which is a fraud based claim. These are fraud based claims. Even the public nuisance claim is fraud based claim.

Teva does not concede and denies that it engaged in any misrepresentation fraudulent or otherwise that resulted in the prescription of any opioid to an Oklahoman. And I'll note that Mr. Beckworth mentioned that my client manufactures opioids. It doesn't prescribe them. Not a single Oklahoman in Oklahoma, which makes sense, receives an opioid prescription from Teva Pharmaceuticals. Not a one. And that's I think the one fact that nobody can dispute.

And with regard to the outer limits, the opioid epidemic, it's not even limited to Oklahoma. It's asking us, requiring a

more.

So is it broad? Yeah. There's a lot to ask about. It's 22 years of this. It's a lot. But we've got to do our job, and I'm begging your Honor to let us get to work. Thank you.

THE COURT: Anything else?

MR. BRODY: Your Honor, again, the one thing that we did not hear from the State was anything about propriety of the topic. The fact that we are here arguing about this topic in front of the Court, you know, if we had gotten a proper deposition topic, if the State had accepted, you know, what we proposed, let's make this about fact testimony, not opinion testimony, we wouldn't be before the Court. They might have already taken the deposition.

So you know, all of this talk about delay is a red herring here. We have a significant legal issue that is in front of your Honor, and it boils down to an effort to elicit opinion testimony, expert testimony, and testimony about privileged and confidential settlement discussions from a corporate designee who would be appearing as a fact witness. And the law says that's improper.

That doesn't mean we're not going to get to discovery about, for example, Purdue is putting a witness up about the ad. That's a red herring as well. That deposition is scheduled for May 10th. So again, nothing -- we heard nothing about the legal issue that is before your Honor and nothing

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., MIKE HUNTER, ATTORNEY GENERAL OF OKLAHOMA,	)	
Plaintiff,	)	
vs.	)	Case No. CJ-2017-816 Judge Thad Balkman
(1) PURDUE PHARMA L.P.; (2) PURDUE PHARMA, INC.; (3) THE PURDUE FREDERICK COMPANY; (4) TEVA PHARMACEUTICALS USA, INC.; (5) CEPHALON, INC.; (6) JOHNSON & JOHNSON; (7) JANSSEN PHARMACEUTICALS, INC; (8) ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC., n/k/a JANSSEN PHARMACEUTICALS; (9) JANSSEN PHARMACEUTICA, INC., n/k/a JANSSEN PHARMACEUTICALS, INC.; (10) ALLERGAN, PLC, f/k/a ACTAVIS PLC, f/k/a ACTAVIS, INC., f/k/a WATSON PHARMACEUTICALS, INC.; (11) WATSON LABORATORIES, INC.; (12) ACTAVIS LLC; and (13) ACTAVIS PHARMA, INC., f/k/a WATSON PHARMA, INC.,	)	
Defendants.	)	

PLAINTIFF'S INITIAL DISCLOSURE OF INDIVIDUALS LIKELY TO HAVE DISCOVERABLE INFORMATION THAT MAY BE USED TO SUPPORT THE CLAIMS OR DEFENSES

8

Plaintiff, the State of Oklahoma, provides these Initial Disclosures of Individuals Likely to Have Discoverable Information That May Be Used to Support the Claims or Defenses pursuant to the Court's January 29, 2018 Scheduling Order (the "Scheduling Order"). Under the Scheduling Order, the parties must "disclose the name and, if known, the address and telephone number of each individual likely to have discoverable information—along with the subjects of that information—that the disclosing party may use to support its claims or defenses."

These Initial Disclosures are based upon information presently known to Plaintiff, and are made without prejudice to Plaintiff's ability to produce information, documentation, or data that is subsequently discovered. Discovery is ongoing and Plaintiff's investigation is continuing. As such, Plaintiff anticipates it will learn of additional persons that may have such information. Plaintiff further incorporates into these Initial Disclosures all individuals identified by all other parties to this action in their respective Initial Disclosures, and reserves the right to depose and rely upon the testimony of all such individuals. Plaintiff reserves the right to amend and/or supplement these Initial Disclosures at any time, and further reserves the right to use any information provided or produced by Defendant who may join this action subsequent to these Initial Disclosures.

By making these Initial Disclosures, Plaintiff does not concede the relevance of any of the information provided or waive any protections available pursuant to any applicable privileges, such as the attorney-client and/or work product privileges.

Individuals	Area of Knowledge	Contact Information
Terri White	Likely possesses knowledge regarding the OMDHSAS, its processes, practices and procedures utilized by OMDHSAS for claims submitted for treatment under OMDHSAS' programs. Also likely possesses knowledge regarding the courses of action, programs, or other efforts the State has considered or implemented regarding preventing unnecessary opioid prescriptions.	To be contacted through Plaintiff's undersigned counsel.
Nancy Nesser	Likely possesses knowledge regarding the processes, practices and procedures utilized by the OHCA regarding claims, including any claims for medication assisted treatment, submitted for reimbursement from SoonerCare. Also likely possesses knowledge regarding the courses of action, programs, or other efforts the State has considered or implemented regarding preventing unnecessary opioid prescriptions.	To be contacted through Plaintiff's undersigned counsel.
Mark Reynolds	Likely possesses knowledge regarding the OMDHSAS, its processes, practices and procedures utilized by OMDHSAS for claims submitted for treatment under OMDHSAS' programs and the OMDHSAS data storage systems.	To be contacted through Plaintiff's undersigned counsel.
Burl Beasley	Likely possesses knowledge regarding the OHCA, its processes, practices and procedures utilized by the OHCA regarding claims, including any claims for medication assisted treatment, submitted for reimbursement from SoonerCare.	To be contacted through Plaintiff's undersigned counsel.
Don Vogt	Likely possesses knowledge of the State's prescription monitoring program.	To be contacted through Plaintiff's undersigned counsel.
Employees of the Department of Mental Health and Substance Abuse	Likely possess knowledge regarding the OMDHSAS, its processes, practices and procedures utilized by OMDHSAS for claims submitted for treatment under OMDHSAS' programs.	To be contacted through Plaintiff's undersigned counsel.

Employees of the Oklahoma Health Care Authority	Likely possess knowledge regarding the OHCA, its processes, practices and procedures utilized by the OHCA regarding claims, including any claims for medication assisted treatment, submitted for reimbursement from SoonerCare.	To be contacted through Plaintiff's undersigned counsel.
Employees of the Oklahoma Bureau of Narcotics	Likely possess knowledge regarding the State's prescription monitoring program.	To be contacted through Plaintiff's undersigned counsel.
Employees of the Oklahoma Pharmacy Board	Likely possess knowledge regarding Drug Utilization Review Board and approved pharmaceuticals under SoonerCare.	To be contacted through Plaintiff's undersigned counsel.
Employees of the Oklahoma Department of Corrections	Likely possess knowledge regarding incarcerations related to opioids and/or opioid prescriptions and addiction treatment for incarcerated individuals.	To be contacted through Plaintiff's undersigned counsel.
Employees of the Oklahoma State Department of Health	Likely possess knowledge regarding the effect of the opioid epidemic on Oklahomans and their health.	To be contacted through Plaintiff's undersigned counsel.
Employees and former employees of the Purdue Defendants	Likely possess knowledge regarding, *inter alia*, the Purdue Defendants' opioids, false marketing campaigns, and financial information.	
Employees and former employees of the Janssen Defendants	Likely possess knowledge regarding, *inter alia*, the Janssen Defendants' opioids, false marketing campaigns, and financial information.	
Employees and former employees of the Teva/Cephalon Defendants	Likely possess knowledge regarding, *inter alia*, the Teva/Cephalon Defendants' opioids, false marketing campaigns, and financial information.	
Representatives of the American Academy of Pain Medicine	Likely possess knowledge regarding, *inter alia*, Defendants' marketing campaigns and funding from Defendants.	
Representatives of the American Chronic Pain Association	Likely possess knowledge regarding, *inter alia*, Defendants' marketing campaigns and funding from Defendants.	

Representatives of the American Pain Society	Likely possess knowledge regarding, *inter alia*, Defendants' marketing campaigns and funding from Defendants.	
Representatives of the Federation of State Medical Boards	Likely possess knowledge regarding, *inter alia*, Defendants' marketing campaigns and funding from Defendants.	
Representatives of the National Pain Foundation/Global Pain Initiative	Likely possess knowledge regarding, *inter alia*, Defendants' marketing campaigns and funding from Defendants.	
Representatives of the Pain & Policy Studies Group	Likely possess knowledge regarding, *inter alia*, Defendants' marketing campaigns and funding from Defendants.	
Richard Sackler	Likely possesses knowledge regarding the Purdue Defendants' misrepresentations and fraudulent marketing campaign regarding opioids.	
Perry Fine	Likely possesses knowledge regarding, *inter alia*, Defendants' marketing campaigns and funding from Defendants.	
Scott Fishman	Likely possesses knowledge regarding, *inter alia*, Defendants' marketing campaigns and funding from Defendants.	
Kathleen Foley	Likely possesses knowledge regarding, *inter alia*, Defendants' marketing campaigns and funding from Defendants.	
David Haddox	Likely possesses knowledge regarding Defendants' marketing campaigns, particularly the Purdue Defendants.	
Russell Portenoy	Likely possesses knowledge regarding Defendants' marketing campaigns, including Defendants' involvement with the American Pain Foundation and American Academy of Pain Medicine, and funding from Defendants.	

Lynn Webster	Likely possesses knowledge regarding Defendants' marketing campaigns, including Defendants' involvement with the American Academy of Pain Medicine, and funding from Defendants.	
Daniel Alford	Likely possesses knowledge regarding, *inter alia*, Defendants' marketing campaigns and funding from Defendants.	
Myra Christopher	Likely possesses knowledge regarding Defendants' marketing campaigns, including Defendants' involvement with the Center for Practical Bioethics and American Pain Foundation, and funding from Defendants.	
Aaron Gilson	Likely possesses knowledge regarding Defendants' marketing campaigns, including Defendants' involvement with the Pain & Policy Studies Group, and funding from Defendants.	
Bob Twillman	Likely possesses knowledge regarding Defendants' marketing campaigns, including Defendants' use of the Academy of Integrative Pain Management (formerly the American Academy of Pain Management), and funding from Defendants.	
Charles Argoff	Likely possesses knowledge regarding, *inter alia*, Defendants' marketing campaigns and funding from Defendants, and funding from Defendants.	

Dated: March 15, 2018

/s/ Michael Burrage

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CERTIFICATE OF SERVICE

I certify that a true and correct copy of the above and foregoing was mailed and emailed on March 15, 2018 to:

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