IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

PART F

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.

For Judge Balkman's Consideration

Case No. CJ-2017-816
Honorable Thad Balkman

William C. Hetherington
Special Discovery Master

DEFENDANTS TEVA PHARMACEUTICALS USA, INC., CEPHALON, INC., WATSON LABORATORIES, INC., ACTAVIS LLC, AND ACTAVIS PHARMA, INC., f/k/a WATSON PHARMA, INC.'S MOTION FOR SUMMARY JUDGMENT AND BRIEF IN SUPPORT

REDACTED VERSION

THIS DOCUMENT WAS FILED IN ITS ENTIRETY UNDER SEAL ON APRIL 23, 2019

EXHIBIT 27

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

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MIKE HUNTER,
ATTORNEY GENERAL OF OKLAHOMA,
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Case Number
CJ-2017-816

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(1) PURDUE PHARMA L.P.;
(2) PURDUE PHARMA, INC.;
(3) THE PURDUE FREDERICK COMPANY;
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(8) ORTHO-McNEIL-JANSSEN PHARMACEUTICALS, INC., f/k/a JANSSEN PHARMACEUTICALS, INC.;
(9) JANSSEN PHARMACEUTICA, INC., f/k/a JANSSEN PHARMACEUTICALS, INC.;
(10) ALLERGAN, PLC, 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.

VIDEO DEPOSITION OF STEVEN ALAN CRAWFORD, M.D.
TAKEN ON BEHALF OF THE DEFENDANTS
ON FEBRUARY 13, 2019, BEGINNING AT 9:06 A.M.
IN OKLAHOMA CITY, OKLAHOMA

Reported by: Cheryl D. Rylant, CSR, RPR
Video Technician: Kaleb Pianalto
PAGES 1 - 360

you're -- you're testing my memory from more than 20 years ago. 09:27 09:27

Q. Understood. 09:27

To the best of your recollection -- 09:27

A. To the best of my recollection. 09:27

Q. And did you have patients with chronic noncancer pain who were on an opioid therapy for an extended period of time? 09:27 09:27 09:27

A. Please define extended length of time. 09:27

Q. At least six months. 09:27

A. Yes, sir. 09:27

Q. And -- 09:27

A. Again, as best as I can remember. 09:27

Q. And as best as you recall, did you have patients who were on opioid therapy for at least six months who received benefit, in your medical judgment, from their chronic opioid therapy? 09:27 09:27 09:27

A. That's even harder to remember. I would have to say that -- and what you mean by "benefit." They seemed to get pain relief, but I don't recall any specifics at this point regarding any of those patients, to be honest. 09:27 09:28 09:28 09:28 09:28

Q. Sure. And I -- let me see if I can ask the question slightly differently to -- to help clarify some issues. 09:28 09:28 09:28

When you prescribe a medication, at any point in your career, do you make a risk benefit -- or strike that. 09:28

When you prescribe any medication for any patient, do you perform, in your best medical judgment, an analysis that the benefits of the medication outweigh the risk for that particular patient? 09:28

MS. BALDWIN: Object to -- object to form. 09:28

THE WITNESS: That's a -- say it one more time. 09:28

Q. (By Mr. Ehsan) Sure. Let me -- let me try to keep it simpler. 09:28

When you prescribe a medication for a patient -- 09:28

A. Uh-huh. 09:28

Q. -- you've made the medical decision that the benefits of the medication outweigh the risk for the patient you're prescribing the medication for, correct? 09:28

MS. BALDWIN: Object to form. 09:29

THE WITNESS: And the answer is yes. 09:29

Q. (By Mr. Ehsan) That's true for any prescription medication, correct? 09:29

MS. BALDWIN: Object to form. 09:29

THE WITNESS: Yes, sir. 09:29

Q. (By Mr. Ehsan) So for -- when it comes to 09:29

opioid therapy for a chronic noncancer pain patient, you would only prescribe the opioid if you believed that the benefits outweighed the risk for that particular individual, correct? 09:29

MS. BALDWIN: Object to form. 09:29

THE WITNESS: Again, repeat that question. 09:29

Q. (By Mr. Ehsan) Sure. 09:29

When you prescribe an opioid for a chronic noncancer patient, you are making the medical judgment that the benefits of the medication outweigh the risk for the patient you're prescribing it to, correct? 09:29

MS. BALDWIN: Object to form. 09:29

THE WITNESS: Yes. 09:29

Q. (By Mr. Ehsan) And if the patient were to continue on that therapy, that would necessarily mean you've made the continued medical judgment that the medication is continuing to provide more benefit than risk for that patient, correct? 09:29

MS. BALDWIN: Object to form. 09:30

THE WITNESS: Can I ask you a question? 09:30

Q. (By Mr. Ehsan) Please. 09:30

A. Can you further define what you mean by "continuing"? 09:30

Q. Sure. 09:30

comments. 09:38

Q. And that is true for almost every 09:38

prescription medication, correct? 09:38

MS. BALDWIN: Object to form. 09:38

Q. (By Mr. Ehsan) Well, let me ask the question 09:38

slightly better. 09:38

All prescription medications carry risks, correct? 09:38

A. Yes, sir, all medications, whether they're 09:38

prescription or not. 09:38

Q. That's true. You can potentially do a lot of 09:38

harm with over-the-counter medications as well, 09:38

correct? 09:38

A. Yes, sir. 09:38

Q. So when you prescribe any medication, you 09:38

engage in a risk and benefit an -- assessment for the 09:39

patient receiving the medication, correct? 09:39

A. Yes, sir. 09:39

Q. So for -- specifically focusing on opioids. 09:39

Opioids have risk of respiratory depression, correct? 09:39

A. Yes, sir. 09:39

Q. They carry the risk of constipation, correct? 09:39

A. Yes, sir. 09:39

Q. They carry the risk of mental confusion or 09:39

fogginess, correct? 09:39

A. Yes, sir. 09:39

Q. They carry the risk of potentially increasing intracranial pressure, correct? 09:39

A. Yes, sir. 09:39

Q. And they also carry the risk of potential addiction, misuse, or abuse, correct? 09:39

A. Yes, sir. 09:39

Q. Now, when -- when did you first start prescribing opioids in any clinical setting? 09:39

A. Again, it was a number of years ago, but I think it must have been during my residency. 09:39

Q. So some -- somewhere back in the '80s. Would that be fair? 09:40

A. '70s. '79 was when I started my residency. 09:40

Q. And at the time -- going back to '79 to present. Were you aware that opioids carried the risk of respiratory depression? 09:40

A. Yes, sir. 09:40

Q. When did you first become aware of that risk? 09:40

A. Probably during medical school, but, again, that's been a number of years ago. 09:40

Q. And that is an understanding you've held consistently to present? 09:40

A. Yes, sir. 09:40

Q. Focusing on the risk of constipation with opioids. When did you first understand that opioids 09:40

carry the risk of constipation? 09:40

A. Again, probably during medical school. 09:40

Q. And you've consistently held that view to present? 09:40

A. Yes, sir. 09:40

Q. How about the risk of opioids for addiction, abuse, or misuse, when did you first become aware of that risk? 09:40

A. During medical school. 09:40

Q. And that -- 09:40

A. Or --

Q. Go ahead. 09:40

A. Sorry.

Q. I'm sorry. 09:40

A. During medical school. 09:40

Q. And have you had -- and have you held that understanding to present? 09:40

A. No. 09:40

Q. Okay. How -- how has your understanding of the risk of -- of the fact that opioids have a risk of abuse and misuse -- let me strike that and ask the question differently. 09:41

Has there ever been a point in time where you believed that opioids didn't cause or didn't carry the risk of abuse or misuse? 09:41

medi -- of a medication to a patient, what sources of information do you rely on for both the risk and the benefits? 11:23

A. A wide variety of information. 11:23

Q. Do you rely on the labeling information? 11:23

A. Labeling meaning the? 11:23

Q. Package insert. 11:23

A. Yes, sir. That's one aspect. 11:23

Q. Do you rely on the published literature? 11:23

A. Yes, sir. 11:23

Q. Do you rely on -- 11:23

A. Medical literature, not the popular literature. 11:23

Q. Yes, thank you. Published medical literature. 11:23

A. Yes, sir. 11:23

Q. Do you rely on materials you may have been provided in continuing medical education programs? 11:23

A. Yes, sir. 11:23

Q. Do you rely on -- do you rely on representations made to you by drug detailers? 11:23

A. I have listened to them, and they usually supply references when they do discuss. 11:23

Q. So I -- and I want -- just to be clear. So let me back up and ask a preliminary question. 11:24

Do you get visits from pharmaceutical detailers in your current position as chair of the department at OU? 11:24

A. Very limited now. 11:24

Q. Did you have drug detailers visit you while you were at the -- your prior post at the Oklahoma clinic? 11:24

A. The Oklahoma City Clinic. Yes, sir. 11:24

Q. In those instances, did the -- as best you remember, did those -- those drug pharmaceutical representatives provide you labels related to -- 11:24

A. Provided? I'm sorry? 11:24

Q. Package inserts related to the medications. 11:24

A. Yes, sir. 11:24

Q. Did they provide you any literature, medical literature associated with either the drug or the disease state? 11:24

A. Yes, sir. 11:24

Q. Have you ever found -- strike that. Let me ask you this way. 11:24

Did they also have conversations with you? 11:25

A. Yes, sir. 11:25

Q. Did you ever rely on the conversation of a pharmaceutical representative to the exclusion of the information that was included, either the label or 11:25

the available medical literature? 11:25
A. No, sir. 11:25
Q. And to just use plain English. Did you 11:25
believe that you would take the word of a 11:25
pharmaceutical rep as scientifically -- as scientific 11:25
gospel when there's the label and/or published 11:25
medical literature? 11:25
MS. BALDWIN: Object to form. 11:25
THE WITNESS: Rephrase. 11:25
Q. (By Mr. Ehsan) Sure. 11:25
In relying on information to make your prescribing 11:25
decision, you would rely on the label and the 11:25
published medical literature, but you wouldn't 11:25
necessarily rely on something a drug representative 11:26
told you about the medication, correct? 11:26
MS. BALDWIN: Object to form. 11:26
THE WITNESS: If that's the only 11:26
information I had, I would do my own research. 11:26
Q. (By Mr. Ehsan) So if all you have is the 11:26
word of a pharmaceutical representative, you feel 11:26
that it's incumbent upon you to go do your homework, 11:26
correct? 11:26
A. Some. The -- again, they would supply 11:26
literature, too. 11:26
Q. And to the extent that they've made the 11:26

process more convenient by providing you the label or particular literature, then you would use those materials as part and parcel of the medical information you gather in assessing the risk and benefits of a medication, correct? 11:26

A. That is correct. 11:26

Q. I'm going to hand you -- 11:26

A. Are we through with this one? 11:26

Q. Yes, sir. 11:26

A. Okay. Just trying to clean up my desk space here. 11:26

(Whereupon, Crawford Exhibit No. 4 was marked for identification and made part of the record.) 11:27

Q. (By Mr. Ehsan) It's incumbent upon me not to talk while she's trying to put that sticker on, because she's got to type and put the sticker on. 11:27

A. Skilled.

Q. I've handed you what's been marked as Exhibit 4 to your deposition. I believe this is a copy of the SB 1446 that we've been talking about. And it's rather thick, but if you need to take a look at it, by all means, do so. 11:27

A. I -- I recognize it as that, yes, sir. I've not seen it. I've only seen it electronically. I've 11:27

not had a paper copy. 11:27

Q. And if you -- thankfully, this one is 11:27

paginated. 11:27

A. Thank goodness. 11:27

Q. If you go to Page 4 of the document, what -- 11:28

A. Page 4.

Q. -- is labeled as Page 4. 11:28

Do you see that -- in the middle of the page, 11:28

there's item C. There's -- there's a paragraph 11:28

that's underlined? 11:28

A. Yes, sir. 11:28

Q. And it states, "The Board shall require the 11:28

licensee receive no less than 1" -- in parenthesis 11:28

1 -- "hour of education in pain management, or 1," 11:28

and numerically and then both -- and also written 11:28

out -- "hour of application for -- of education 11:28

opioid use or addiction each year preceding an 11:28

application for renewal of a license, comma, unless 11:28

licensee has demonstrated to the satisfaction of the 11:28

board that the licensee does not currently hold a 11:28

valid federal Drug Enforcement Administration 11:28

registration number," period. 11:28

Did I read that correctly? 11:29

A. Yes, sir. 11:29

Q. And this is what we were talking about, that 11:29

oxycodone, and oxymorphone have the highest potential for abuse and associated risk of fatal overdose due to respiratory depression. Fentanyl can be abused and is subject to criminal diversion. The high content of fentanyl in the patches called Duragesic may be a particular target for abuse and diversion." 02:09 02:09 02:09 02:09 02:09 02:09

Q. In representing to you that this was a 2005 label, would the language in the bolded box warning adequate -- well, strike that. 02:09 02:09 02:09

Would you agree with me, Dr. Crawford, that the language you just read from this box warning convey a message that this drug carries a risk of abuse, misuse, or addiction? 02:09 02:09 02:09 02:09

A. Yes. 02:09

Q. And it states it quite plainly, correct? 02:10

A. Yes, sir. 02:10

Q. So if this is the 2005 label for Duragesic, a doctor who would have read this label in 2005 would have been able to understand that this meant that all Schedule II opioids carry a significant risk of addiction and criminal diversion, correct? 02:10 02:10 02:10 02:10 02:10

A. That's what it says. 02:10

Q. And when you prescribe Duragesic to your patients today, are you aware that there's a risk of addiction and abuse associated with the fentanyl, 02:10 02:10 02:10

which is the active ingredient in Duragesic? 02:10

A. Yes, sir. 02:10

Q. Now, I think you mentioned that one of the 02:10

sources of information you rely in assessing the risk 02:11

and benefit of a medication was the drug label. Do 02:11

you recall that testimony? 02:11

A. Yes, sir. 02:11

Q. And I just wanted to make sure I heard you 02:11

when -- when we had this discussion correctly. But 02:11

is it your practice to make sure you are familiar 02:11

with the prescribing information or label for a drug 02:11

if you're going to prescribe it to a patient? 02:11

A. Yes, sir. 02:11

Q. And would you agree with me, Doctor, that you 02:11

would never disregard the information -- or strike 02:11

that.

Would you agree with me, Doctor, that you never 02:11

disregarded information in a product label based on 02:11

something a pharmaceutical representative told you; 02:11

is that correct? 02:11

MS. BALDWIN: Object to the form. 02:11

THE WITNESS: I don't recall ever doing 02:11

that, no. 02:11

Q. (By Mr. Ehsan) Could yourself -- see 02:11

yourself doing that? 02:12

MS. BALDWIN: Object to the form. 02:12
THE WITNESS: To re -- to -- 02:12
Q. (By Mr. Ehsan) Let me -- 02:12
A. -- believing a -- what a pharmaceutical rep says and they're saying, "No, this drug is safe," is what you're -- 02:12
Q. Yes, sir. 02:12
A. If a -- if a drug rep came and told me this is a safe medicine, to give as high a dose as I wanted, I think it's poppycock, but. 02:12
Q. So if a -- a pharmaceutical representative or detailer came to you and told you Duragesic is not addicting, despite the bold information that's in this label, you would defer to the bolded information in the label, correct? 02:12
MS. BALDWIN: Object to the form. 02:12
THE WITNESS: In the issue of current, yes. In the mid '90s, which this wasn't part of, I had that belief challenged. 02:12
Q. (By Mr. Ehsan) Understood. And that's the article we talked about, correct? 02:12
A. Yes, sir. 02:12
Q. Understood. 02:12
And the -- the science has continued to -- to -- strike that. 02:12

information regarding any of the medications Janssen manufactures? 03:37

A. What do you mean by "misleading"? 03:37

Q. Something that was -- you found to be poppycock, I think was the -- the word we discussed earlier. 03:37

A. It's a medical term. 03:37

At the time that they were giving it to me, no. 03:37

Q. Do you recall a Janssen pharmaceutical representative providing you any information at any time that was inconsistent with what the medical literature at the time showed? 03:37

A. As far as I knew, no. 03:37

Q. Putting Janssen aside, focusing on Johnson & Johnson. Have you ever been -- had a pharmaceutical representative from Johnson & Johnson visit you in your clinical practice? 03:37

A. I believe I did. 03:38

Q. To the extent you recall, do you recall any statement that was misleading by a Johnson & Johnson pharmaceutical representative made to you? 03:38

A. I -- I don't recall. 03:38

Q. And sitting here today, do you recall a Johnson & Johnson pharmaceutical representative ever telling you something that was inconsistent with the 03:38

weight of the scientific evidence at the time that 03:38
that statement was made? 03:38
A. No. 03:38
Q. Do you believe any prescriptions you've 03:38
written for an -- an opioid was inconsistent with the 03:38
science that was available regarding those 03:38
medications at the time you wrote the prescription? 03:38
MS. BALDWIN: Object to form. 03:38
THE WITNESS: The science that was -- I 03:38
would say the opinion of -- of experts and others at 03:38
the time influenced the way I prescribed. 03:39
Q. (By Mr. Ehsan) At any time you prescribed an 03:39
opioid medication, do you ever believe your 03:39
prescription -- prescribing decision was inconsistent 03:39
with the labeling information for the medication you 03:39
prescribed? 03:39
MS. BALDWIN: Object to form. 03:39
THE WITNESS: At this moment, I can't 03:39
recall that far back, whether I ever did anything 03:39
that wasn't part of the label. I doubt it, but I 03:39
can't -- it's too long ago. 03:39
Q. (By Mr. Ehsan) And you're certainly 03:39
entitled, as a prescriber, to prescribe a medication 03:39
off-label; is that correct? 03:39
A. That is correct. 03:39

Q. But when you prescribe a medication off-label, you maybe have less available information regarding the potential risks and benefits of the medication, correct? 03:39

A. That is -- 03:39

MS. BALDWIN: Object to the form. 03:39

THE WITNESS: That is correct. 03:39

MR. EHSAN: If we can take a one-minute break, I think I'm done. 03:40

THE WITNESS: Okay. 03:40

VIDEO TECHNICIAN: We're going off the record at 3:40 p.m. 03:40

(Break was taken.) 03:40

VIDEO TECHNICIAN: We're back on the record at 4:06 p.m. 04:06

Q. (By Mr. Ehsan) Dr. Crawford, before we went on break, you identified the article that we've been talking about that was published in the mid '90s, and you identified the author as Brown and the journal as the journal of the American -- the journal that's the Journal of American Board of Family Practice; is that correct? 04:06

A. Or family medicine, yes, sir. 04:07

Q. Would this be an article by Richard L. Brown, Chronic Opioid Analgesic Therapy For Chronic Low Back 04:07

specific instance where you didn't make a prescribing decision in the best interest of your patient?

MS. BALDWIN: Object to form.

THE WITNESS: If I know what I do today, I probably would not have accelerated many of my patients with their opioid prescribing and tried my best to limit those, particularly to less than 90 MME, or even less, 50 MME.

Q. (By Mr. Ercole) Are you aware of any instance -- well, can you -- can you -- are you aware of any instance where you did not make a prescribing decision that was in the best interest of the patient based upon the science available at that time?

MS. BALDWIN: Objection to form.

THE WITNESS: Based on what I knew at the time, I thought I made the right decision at the time.

Q. (By Mr. Ercole) Have you ever heard of the company Cephalon?

A. I've heard of it.

Q. Do you know whether that company manufactures opioid medicines?

A. I think I am now. I wouldn't -- if you had asked me, you know, a year ago, I probably wouldn't. It's a relatively smaller company from what I know,

but don't know much more about it than that. 04:49

Q. Sure. 04:49

So is it -- is it -- is it fair to say, then, that 04:49

you were -- you never -- since you didn't know of 04:49

Cephalon until about a year ago, you never interacted 04:49

with any Cephalon sales representative? 04:50

A. Not -- not that I'm aware of. I can't 04:50

remember any Cephalon sales reps. 04:50

Q. And it's fair to say that you're not aware of 04:50

any false or misleading statements that -- that any 04:50

representatives of Cephalon ever made to you? 04:50

A. At the time, no. I don't know if -- if I -- 04:50

anyway, no, not at the time. 04:50

Q. Well, I guess, sitting here today, can you -- 04:50

can you identify -- 04:50

A. Even -- even today, I don't know of any 04:50

specific Cephalon-related materials that would be 04:50

considered something that would be out of the pail as 04:50

it were. 04:50

Q. Sitting here today, are you aware of any 04:50

Cephalon-related materials that you would have 04:50

received? 04:50

MS. BALDWIN: Object to form. 04:50

THE WITNESS: No. 04:50

Q. (By Mr. Ercole) Sitting here today, are you 04:51

aware of any statements made by Cephalon to any prescribers in Oklahoma? 04:51

MS. BALDWIN: Object to form. 04:51

THE WITNESS: I'm -- I'm not aware of any, but I -- that's -- yes. Don't know. Have no idea. 04:51

Q. (By Mr. Ercole) You mentioned before that within the last 10 years, you've had limited, if any, interactions with pharmaceutical representatives; is that fair to say? 04:51

A. That is correct. 04:51

Q. And do you recall any interactions with pharmaceutical sales representatives within the last 10 years? 04:51

A. Vaguely, yes. 04:51

Q. And do you recall the companies for which any of those sales representatives worked? 04:52

A. The most recent were vaccine manufacturers reps, science representatives, not marketing representatives, Sanofi Pasteur and Pfizer. I'm trying to think of the other. GSK. I give talks on vaccines and like to know what they're coming up with, with new products. So I do meet with the science reps, but not with the marketing reps. 04:52

Q. Fair enough. 04:52

How about since 2011, are you aware of any 04:52

interactions you've had with any representatives of pharmaceutical companies concerning its opioid medicine? 04:52 04:52 04:52

A. No, sir. 04:53

Q. And have you ever heard of the company Teva Pharmaceuticals? 04:53 04:53

A. Yes. 04:53

Q. And I assume, since 2011, you're not aware of any interactions you've had with any representative of Teva Pharmaceuticals, correct? 04:53 04:53 04:53

MS. BALDWIN: Object to form. 04:53

THE WITNESS: No, sir. 04:53

Q. (By Mr. Ercole) Do you -- sitting here today, do you recall any interactions that you've ever had with a representative of Teva Pharmaceuticals? 04:53 04:53 04:53 04:53

A. I think when we had reps coming, I believe Teva had a PPI drug -- I think that's right. You know what I mean by a PPI? 04:53 04:53 04:53

Q. And, now, please feel free to enlighten us. 04:53

A. Proton pump inhibitor. 04:53

Q. Okay. 04:53

A. And which one it is, I don't know. It's like a Prilosec. It wasn't a Prilosec, but something like that. I think that they were one of the 04:53 04:53 04:53

manufacturers of one of those drugs. That's the -- 04:53
the only thing I vaguely recall of Teva. 04:53
Q. And just so my notes are clear, that's -- 04:54
sitting here, that's the only product you ever recall 04:54
being discussed with you by any representative of 04:54
Teva; is that correct? 04:54
A. That's all that I can vaguely recall, and 04:54
it's a distant memory. 04:54
Q. And that -- that particular PPI product may 04:54
have been actually manufactured by a -- a different 04:54
company? 04:54
A. Could. Could. But I -- I don't know. I 04:54
wouldn't put a lot of money on my memory on that one. 04:54
Q. And it's -- it's been some time, correct? 04:54
A. Yes. 04:54
Q. Can you -- 04:54
MR. ERCOLE: Can we go off the record for 04:54
one minute? 04:54
VIDEO TECHNICIAN: We're going off the 04:54
record at 4:55 p.m. 04:54
(Break was taken.) 04:54
VIDEO TECHNICIAN: We're back on the record 05:02
at 5:02 p.m. 05:02
Q. (By Mr. Ercole) Doctor, we were talking 05:02
about the PPI inhibitor. Do you recall that? 05:02

A. Yeah. 05:02

Q. And I guess you recall sort of one 05:02

interaction with, perhaps, a Teva representative 05:02

regarding a PPI inhibitor, correct? 05:02

A. Right. 05:03

Q. Any statements from Teva Pharmaceuticals 05:03

regarding opioids that you ever recall receiving? 05:03

A. No, sir. 05:03

Q. Any statements regarding opioids that you -- 05:03

from Teva Pharmaceuticals that you recall being 05:03

disseminated in Oklahoma at all? 05:03

MS. BALDWIN: Object to form. 05:03

THE WITNESS: I don't recall any. 05:03

Q. (By Mr. Ercole) So sitting here today, you 05:03

can't identify any, correct? 05:03

A. No, sir. 05:03

MS. BALDWIN: Object to form. 05:03

Q. (By Mr. Ercole) Doctor, sitting here today, 05:03

are you aware of any false or misleading statement 05:03

any sales representative for any drug manufacturer 05:03

ever made to you or -- strike that. Let me rephrase. 05:03

Sitting here today, are you aware of any false or 05:03

mislead -- misleading statement any sales 05:03

representative for any drug manufacturer ever made to 05:03

you? 05:04

MS. BALDWIN: Object to form, asked and answered. 05:04

THE WITNESS: As I said, I think, from what I know now, there were manufacturers' reps that encouraged the use of opioids in chronic severe nonmalignant pain. 05:04

Q. (By Mr. Ercole) Okay. 05:04

A. And I -- to say -- to state the exact person that did that, no, I can't tell you that. But I do believe I remember that there was encouragement of that. 05:04

Q. Sure. 05:04

So you mentioned -- you used the words manufacturer reps that encouraged the use of opioids, correct? 05:04 05:05

A. Yes. 05:05

Q. Okay. My question is a little bit different than that. 05:05

Sitting -- 05:05

A. Okay. 05:05

Q. -- here today, can you recall any false or misleading statement that any sales representative for any drug manufacturer ever said or made to you? 05:05

MS. BALDWIN: Objection, asked and answered multiple times. 05:05

comfortable with now. 05:10

Q. (By Mr. Ercole) And you say "higher dose," 05:10
right? 05:10

A. Higher and longer, yes, sir. 05:10

Q. When you say -- so higher, is that -- just so 05:10
that my notes are clear, higher and longer. What do 05:11
you mean by "higher and longer"? 05:11

A. Higher, greater than 90 MME -- 05:11

Q. Uh-huh. 05:11

A. -- for a definite, but even greater than 50, 05:11
which I have some patients on, and continuing to 05:11
help -- to have to follow those patients. And 05:11
longer, that the longer you have somebody on it, the 05:11
harder it is to have them reduce those doses. 05:11

Q. Sitting here today, though, can you actually 05:11
say that you would not have written a particular 05:11
opioid prescription for a particular patient based 05:11
upon your medical assessment? 05:11

MS. BALDWIN: Object to form, asked and 05:11
answered multiple times. 05:11

THE WITNESS: I would probably use much 05:11
less of a strength and escalating that dose, as I've 05:11
said before. 05:11

Q. (By Mr. Ercole) Sure. 05:11

And -- and fair enough with respect to strength. 05:11

But at least with respect to the opioid -- initial opioid prescription itself? 05:12

A. I -- I -- 05:12

Q. Is it -- I mean, you've been talking about -- about strength -- 05:12

A. Right. 05:12

Q. -- and -- and the -- the dose of the opioid prescription, correct? 05:12

My question is a little bit different, which is, sitting here today, can you identify any particular patient for -- for which you would not have written an opioid prescription that you actually did write a prescription for? 05:12

MS. BALDWIN: Object to form, asked and answered. 05:12

THE WITNESS: At this point, no, I can't -- I -- I don't recall any particular patient. There's patients that came to me who were already on opioids that I would attempt more aggressively to reduce their dose, but -- and that I've continued on that -- the higher dose that I'm now trying to reduce because of the change in belief of the use of chronic long-term high-dose opioids. 05:13

Q. (By Mr. Ercole) And, again, your -- the answer that you just gave deals with sort of moving 05:13

from a higher dose of opioids to a lower dose of opioids, correct? 05:13

A. And shorter -- 05:13

MS. BALDWIN: Object to form. 05:13

THE WITNESS: -- duration. 05:13

Q. (By Mr. Ercole) Sure. 05:13

The -- you mentioned the labels of -- we talked about the labels of -- of opioids and what they disclose, correct? 05:13 05:14 05:14

A. Yes, sir. 05:14

Q. And the -- is it fair to say that the -- do you have any reason to doubt that the labels of opioid medicines over the last three decades disclosed the risk of -- of abuse and addiction with respect to those medicines? 05:14 05:14 05:14 05:14 05:14

MS. BALDWIN: Object to form. 05:14

THE WITNESS: So 30 years ago would have been 1998; is that right? Or 1988? '88. 05:14 05:14

Q. (By Mr. Ercole) '88. Your -- your math is better than mine, but -- 05:14 05:14

A. It's late in the day. I'm trying to think. It's '88. I have no idea, in 1988, what the drug insert said. Show me one. 05:14 05:14 05:14

Q. Give me one second. 05:15

A. Sure. 05:15

EXHIBIT 28

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel.,
MIKE HUNTER,
ATTORNEY GENERAL OF OKLAHOMA,
Plaintiff,

Case Number
CJ-2017-816

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., f/k/a JANSSEN PHARMACEUTICALS, INC.;
(9) JANSSEN PHARMACEUTICA, INC., f/k/a JANSSEN PHARMACEUTICALS, INC.;
(10) ALLERGAN, PLC, 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.

VIDEO DEPOSITION OF DANIEL J. CLAUW, M.D.

STATE OF OKLAHOMA 3230(C)(5) WITNESS
TAKEN ON BEHALF OF THE DEFENDANTS
ON MARCH 26, 2019, BEGINNING AT 7:57 A.M.
IN OKLAHOMA CITY, OKLAHOMA

Reported by: Cheryl D. Rylant, CSR, RPR
Video Technician: Gabe Pack

PAGES 1 - 327

correct? 09:59
A. No. 09:59
MR. LEONOUDAKIS: Objection, form, outside 09:59
the scope. 09:59
THE WITNESS: No. Because, again, there 09:59
are some practices that are just simply wrong, 09:59
you know, regardless of what the FDA did or what 09:59
the -- you know, what -- what other people have -- 09:59
that -- you know, the -- for example, the high doses 09:59
of opioids, so over 90 oral morphine equivalents a 09:59
day of opioids. Yeah, the -- the label change 09:59
permits that, but do I think that ever should be done 09:59
for people with chronic pain? No. I don't think 10:00
there was ever any data or evidence. And we don't 10:00
even start assessing benefit-risk unless there's 10:00
benefit. You can't -- if a treatment doesn't have 10:00
benefit, then it doesn't really matter how small the 10:00
risk might be. But in this case, we have the 10:00
opposite. We have amazing amounts of risk, 10:00
incredibly high risk and harm and -- and really no 10:00
discernible benefit with respect to the long-term 10:00
studies. 10:00
Q. (By Ms. Laurendeau) So if I understand you 10:00
correctly, if there's no benefit, then the 10:00
risk-benefit analysis should always be no 10:00

prescription of opioids, correct? 10:00

A. No. I already said that I -- that -- that I 10:00
disagreed with the initial decision, but now, 20-some 10:00
years later after -- after we've had the experience 10:00
using opioids in chronic pain that we have, there are 10:00
individual people that have benefitted, especially 10:00
from intermittent use of low dosages of opioids. And 10:01
so I will acknowledge that, even though I wouldn't 10:01
have made the decision to approve opioids for chronic 10:01
pain, the 20-some years of clinical experience since 10:01
has indicated that, in some rare individuals, the 10:01
benefit exceeds the harm. 10:01

Q. And it's for a doctor, with a patient, to 10:01
determine whether the expected benefits exceed the 10:01
potential harm and to decide whether to prescribe 10:01
opioids for long-term chronic pain for his or her 10:01
patient, correct? 10:01

A. I mean, ultimately, that's who the prescriber 10:01
is, so that's ultimately who makes the decision. 10:01
I -- you know, again, I don't agree with that 10:01
decision, but that's -- that is where the -- where 10:01
the decision is made. 10:01

Q. And you, as a thought leader in pain, haven't 10:01
actually treated any patients for chronic long-term 10:01
pain in the state of Oklahoma, have you? 10:02

A. No. 10:02

Q. And do you think you're qualified to second guess the prescribing decisions of primary care physicians and pain care specialists in the state of Oklahoma? 10:02

MR. LEONOUDAKIS: Objection to form -- 10:02

THE WITNESS: Absolutely. 10:02

MR. LEONOUDAKIS: -- outside the scope. 10:02

Q. (By Ms. Laurendeau) Okay. And that's what you're intending to do in your expert opinions? 10:02

MR. LEONOUDAKIS: Objection, form, outside the scope. 10:02

THE WITNESS: I'm not going to -- I don't believe that I'll be asked to opine on individual physicians' prescribing patterns. But I will opine on what I think, you know, was inappropriate use of opioids under any circumstance. Because I believe that it's pretty easy to -- to make that kind of assessment. 10:02

Q. (By Ms. Laurendeau) It's easy for you to make that assessment? 10:02

A. These are the same assessments that have been made by the whole pain field. Even -- even people that are more -- that are more so proponents of using opioids for chronic pain than me would say that you 10:02

yet, that prescriber wrote a prescription for an opioid, can -- can that statement be said to have influenced that prescriber's behavior? 03:01

MR. LEONOUDAKIS: Objection, form. 03:01

THE WITNESS: I'm -- could you be more clear? When you say a "statement," I don't know what you mean. 03:01

Q. (By Ms. Coates) Well, so you haven't identified any specific statement to me, but you have said that -- that manufacturers' aggressive marketing improperly influenced prescribing behavior. But if a particular prescriber did not receive that marketing material, for whatever reason, can it -- can it be said that they were improperly influenced by that statement? 03:01

MR. LEONOUDAKIS: Objection, form. 03:02

THE WITNESS: Well, they could still be improperly influenced by all the other things that I alluded to, which is, most, if not all, of the opioid manufacturers were supporting these non-branded efforts that were trying to maximize the benefit of opioids and minimize the side effect of opioids. And so to the extent that -- that -- that any of these entities that you just mentioned were involved in that, then they were -- yes, they -- they -- they 03:02

would be very capable of influencing prescribing without actually having a drug rep visit that particular office. 03:02 03:02 03:02

Q. (By Ms. Coates) Okay. And sitting here today, do you know, one way or another, whether the entities I mentioned contributed to unbranded promotion that you're mentioning? 03:03 03:03 03:03 03:03

MR. LEONOUDAKIS: Objection, form. 03:03

THE WITNESS: I don't remember if they did or not. 03:03 03:03

Q. (By Ms. Coates) And I believe you spoke earlier about prescribers needing to have accurate information, but so long as that they have accurate information available to them and make an informed decision together with their patient, that's the proper way to decide to prescribe an opioid based on that patient's medical history, condition, diagnosis; is that correct? 03:03 03:03 03:03 03:03 03:03 03:03 03:03 03:03 03:03 03:03

A. Yes. 03:03

MR. LEONOUDAKIS: Objection, form. 03:03

Q. (By Ms. Coates) Are you aware of the TIRF REMS program? 03:03 03:04

MR. LEONOUDAKIS: Objection, form. 03:04

THE WITNESS: I don't know what the TIRF REMS program is. I know about a lot of 03:04 03:04

different REMS programs that were associated with opioids -- with specific opioids, but, no, I'm not familiar with what the TIRF REMS program is. 03:04 03:04 03:04

MS. COATES: Can we mark this as Exhibit 9? 03:05

(Whereupon, Clauw Exhibit No. 9 was marked for identification and made part of the record.) 03:05 03:05

Q. (By Ms. Coates) Can you read the title of this document? 03:05 03:05

A. Proposed Transmucosal Immediate Release Fentanyl, Risk Evaluation and Mitigation Strategy. So now I see what TIRF REMS is. 03:05 03:05 03:05

Q. Okay. And if you look at the top, it actually says initial REMS approval 12/2011; is that correct? 03:05 03:05 03:05

A. Yes. 03:05

Q. And if you look at the very back page, you can see that it was electronically signed by Bob A. Rappatore on 12/28/2011; is that correct? 03:05 03:05 03:05

A. Yes. 03:05

Q. So I'm not going to have you read this entire document, but I would like to point to you a couple of its requirements, because I think they relate to what you've testified to. 03:06 03:06 03:06 03:06

So can you read the first requirement under B, Elements to Assure Safe Use, on Page 2 of the 03:06 03:06

EXHIBIT 29

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel.,
MIKE HUNTER, ATTORNEY GENERAL
OF OKLAHOMA,
Plaintiff,
vs. No. CJ-2017-816

(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, INC.;
(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.

VIDEOTAPED DEPOSITION OF ERIN KREBS, M.D.
TAKEN ON BEHALF OF THE DEFENDANTS
ON MARCH 19, 2019, BEGINNING AT 9:12 A.M.
IN OKLAHOMA CITY, OKLAHOMA

VIDEOTAPED BY: Gabe Pack
REPORTED BY: Jane McConnell, CSR RPR CMR CRR
Pages 1-277

A Correct. 09:51:32

Q Thank you. I apologize. I don't mean to 09:51:33

be difficult, but the verbal answers are necessary 09:51:35

for the transcript. 09:51:37

Doctor, if I could turn your attention to 09:51:39

Page 33 of this document. 09:51:42

A Do you want me to finish with the 09:51:51

sentence? 09:51:53

Q I apologize. Sure, by all means. 09:51:53

A Okay. The next clause, careful assessment 09:51:57

and diagnosis of the etiology of pain, I agree with 09:51:59

that statement. 09:52:03

Alternative therapies to manage pain, I 09:52:05

would not have worded that that way because I don't 09:52:09

know what "alternative therapies" refers to in this 09:52:12

circumstance. But I think if it refers to 09:52:15

consideration of the various options to manage pain, 09:52:20

then I agree with that. 09:52:23

Patient education on the risks and 09:52:27

benefits of opioids, I agree that patients should 09:52:29

be provided information about risks and potential 09:52:34

benefits, if any, of opioids, as well as opioids 09:52:38

compared with other analgesic options. 09:52:44

And shared decision-making about treatment 09:52:50

options, shared decision-making is a concept that 09:52:52

involves mutual sharing of information. So I provide information to the patient, the patient provides information to me, we deliberate over the potential choices, and then we agree on something. 09:52:58 09:53:03 09:53:06 09:53:10

Sometimes people refer to shared decision-making in a more formalized structured manner. That kind of approach would be really time consuming but might be appropriate for a very big decision, something like whether to go with chemotherapy and radiation or to go with surgery first, for example. 09:53:15 09:53:18 09:53:21 09:53:23 09:53:27 09:53:28 09:53:32

In this statement, if we're talking about shared decision-making as the more informal process of simply exchanging information, deliberating about options and deciding on a treatment strategy, then I agree with that part of the sentence. 09:53:34 09:53:36 09:53:39 09:53:42 09:53:45

Q In your own clinical practice, do you individualize your opioid prescribing decisions with the patients that you treat? 09:53:47 09:53:50 09:53:53

A I do in the sense that individualizing treatment means incorporating best evidence in terms of both benefits and harms, understanding of the patient's conditions and their options, co-morbidities, contraindications, the potential risks of the treatment, the potential benefit of the 09:53:56 09:53:59 09:54:05 09:54:07 09:54:09 09:54:14

treatment compared with other options and the patient's values, long-term goals, what they hope to get out of this, their understanding of their condition and the treatment options, all those things and more, yes. 09:54:17 09:54:22 09:54:25 09:54:28 09:54:29

Q So you may have two patients with the exact same pain diagnosis, let's say severe osteoarthritis, who may receive very different therapies because of other factors that are specific to each of those two patients; would that be fair? 09:54:31 09:54:33 09:54:38 09:54:41 09:54:43

MR. LEONOUDAKIS: Objection; form. 09:54:47

A I would say it's hard to say that two patients with osteoarthritis have the exact same diagnosis since that is a condition that has a lot of diversity in terms of how it manifests and how people experience that, sure. 09:54:48 09:54:50 09:54:53 09:54:56 09:55:00

Q (BY MR. EHSAN) And even if they happened to be twins who had the exact same life experiences to get a disease state that was very similar, they may have different goals, they may have different pain tolerances, they may have a different value system for their own shared decision-making; would that be fair? 09:55:04 09:55:07 09:55:11 09:55:14 09:55:17 09:55:19 09:55:22

MR. LEONOUDAKIS: Objection; form. 09:55:23

A I'm not sure the question makes sense. 09:55:25

Twins are identical at birth perhaps, but not after that. 09:55:29 09:55:33

Q (BY MR. EHSAN) My point was simply that even if the disease states in two patients were similar, they may still want different things out of their therapy which would necessitate different therapeutic courses for each of them? 09:55:36 09:55:37 09:55:39 09:55:43 09:55:46

MR. LEONOUDAKIS: Objection; form. 09:55:49

A Different individuals with the same diagnosis have different priorities, values, preferences, and their treatment course should reflect that. 09:55:51 09:55:53 09:55:57 09:55:59

Q (BY MR. EHSAN) Doctor, if I could turn your attention to Page 33. I just want to make sure we're done with that sentence, right? 09:56:03 09:56:05 09:56:11

A Yes. 09:56:13

Q Page 33, please. This is "Appendix A, Sample Opioid Prescribing Patient Agreement." Is that correct? 09:56:13 09:56:19 09:56:22

A It's "Appendix A, Sample Opioid Prescription Patient Agreement," correct. 09:56:24 09:56:26

Q Do you use these kinds of agreements in your clinical practice? 09:56:28 09:56:31

A No. 09:56:32

Q Have you ever used these kinds of 09:56:35

can help improve the quality of care a patient receives versus a system in which you just see the first available physician? 01:42:48 01:42:52 01:42:56

A I would say as a primary care doctor, I believe in the power of longitudinal relationships with patients and that that can improve care. I'm not sure that that's exactly what you're saying but -- 01:42:58 01:43:01 01:43:04 01:43:06 01:43:08

Q Your answer is -- you answered my question. 01:43:09 01:43:11

Doctor, likewise, you agree that patient selection is an important factor in mitigating the risks of opioids while trying to maximize their potential benefit, correct? 01:43:12 01:43:15 01:43:18 01:43:20

MR. LEONOUDAKIS: Objection to form. 01:43:23

A I think not quite correct. So patient selection, I don't like that phrasing because I don't select my patients. My patients come to me. I select their treatments. So it's not like I have a drug and I'm looking to select the patients for it which may be the industry approach. 01:43:24 01:43:37 01:43:44 01:43:46 01:43:52 01:43:55

But from my perspective, I take a patient, I have a patient, and I look for the best treatment approach for that individual patient. 01:43:57 01:44:00 01:44:04

And I've already talked about how I think 01:44:07

individual factors are important in determining the appropriate treatment approach. 01:44:12 01:44:15

I also -- I think what you were getting at a little bit is I am guessing you were suggesting some patients might be too high risk for opioids. Is that what you were -- 01:44:19 01:44:22 01:44:25 01:44:30

Q (BY MR. EHSAN) Let me try to ask my question differently since you don't like the term "patient selection." That's fine. 01:44:31 01:44:33 01:44:35

As a physician, you recommend different treatment options for different patients, correct? 01:44:39 01:44:44

A True. 01:44:47

Q And part of the thinking that goes into making those recommendations is trying to maximize potential benefit of therapy and minimizing the risk of that therapy for that particular patient, correct? 01:44:48 01:44:50 01:44:53 01:44:55 01:44:58

A Perfect, yes. 01:44:58

Q So, therefore, in deciding whether or not to recommend opioids -- 01:44:59 01:45:02

A Uh-huh. 01:45:04

Q -- irrespective of the reason -- 01:45:04

A Uh-huh. 01:45:06

Q -- you having a longitudinal relationship with the patient may allow you to better understand 01:45:06 01:45:11

all the details of the patient's history to make a better, more informed decision about how to best maximize therapies, benefits and minimize the risk no matter what the therapy may be, correct? 01:45:14 01:45:17 01:45:19 01:45:23

MR. LEONOUDAKIS: Objection; form. 01:45:25

A I'd say that is true, absolutely. The better you know a patient, the more you can -- you have a better understanding of those factors. That matters more in certain circumstances than it does in others. So it would matter particularly for a big treatment decision, a long-term treatment decision. It might matter less for a decision with -- that is short-term or minor. 01:45:26 01:45:30 01:45:34 01:45:36 01:45:38 01:45:42 01:45:44 01:45:49

Q (BY MR. EHSAN) Chronic use of opioids would be a long-term decision, correct? 01:45:56 01:45:57

A Uh-huh, yes. 01:45:59

Q And you are in part relying on the patient providing you a adequate and complete history of their past problems including substance use problems, correct? 01:45:59 01:46:02 01:46:05 01:46:08

MR. LEONOUDAKIS: Objection; form. 01:46:10

A History is a source of valuable information, but not always accurate information. 01:46:17 01:46:19

Q (BY MR. EHSAN) You, likewise, are relying on the patient to provide you a accurate and 01:46:22 01:46:24

EXHIBIT 30

BEFORE 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

(1) PURDUE PHARMA, LP;
(2) PURDUE PHARMA, INC.;
(3) THE PURDUE FREDERICK
COMPANY;
(4) TEVA PHARMACEUTICALS
USA, INC.;
(5) CEPHALON,INC.,
(6) JOHNSON & JOHNSON;
(7) JANSSEN
PHARMACEUTICALS, INC.;
et al.

Defendants.

VIDEOTAPED DEPOSITION OF MELANIE ROSENBLATT, MD

ON BEHALF OF THE PLAINTIFF

ON MARCH 28TH, 2019

IN OKLAHOMA CITY, OKLAHOMA

REPORTED BY: MARTINE MCLAUGHLIN BUCK, CSR, CLR

line test is?

A I do not.

Q You've never heard that phrase?

A No.

Q Have you ever heard the phrase litmus test?

A Yes.

Q And that's commonly used to mean we're drawing the line somewhere?

A Okay.

Q Those three criteria, you understand, he was essentially using as a litmus test. Right?

MR. ERCOLE: Objection to form.

THE WITNESS: I did not understand that. I understood it to mean that he thinks that those are the three criteria that make this a -- that made him decide whether these were medically necessary or unnecessary prescriptions.

BY MR. WHITTEN:

Q Well, that's a line of sorts, isn't it?

A It looks to me from the disclosure that that's an all-or-none phenomenon for him.

It either is or isn't medically necessary based on three criteria.

Q I think we're saying the same thing, aren't we? You draw a line somewhere?

A I don't know. I know what I'm saying. I don't know what you're saying. But he seems to have three criteria, period. And that's what he uses to determine medical necessity.

Q Look, I'm not speaking as a doctor, because I'm not a doctor. I'm just speaking as an ordinary human being, like our judge or our jury.

You've got to draw the line somewhere to say something is medically necessary or medically unnecessary. Correct?

MR. ERCOLE: Objection to form.

THE WITNESS: I don't know. I've never heard -- heard that -- that description in deciding whether something is medically necessary or unnecessary. I make those decisions all day long in my practice, and I've never thought I draw a line somewhere. I just decide if something is or isn't medically appropriate based on all of the information I have.

BY MR. WHITTEN:

Q Look, I'm shocked --

A -- in every medical decision that I make.

Q I've got to tell you, I'm a little surprised in what you're saying. May I explore that for a moment? In medicine, you have a litmus test for a number of things. Right?

A Sure.

MR. ERCOLE: Objection to form.

THE WITNESS: I don't use a litmus test. I use my medical judgment.

BY MR. WHITTEN:

Q Well, look, your medical judgment has certain bright line tests that you learned in medical school. Right?

A I did not learn bright line tests in medical school. That's your term. I think it's a legal term. It's not how I was trained.

Q Actually, it's not a legal term at all. It's a term that people use all of the time. Let me try it a different way.

Do you know what objective versus subjective means?

A Yes.

Q So if -- you can't see in this room probably, but we have various paintings on the wall. And if I say that's a pretty painting, and you say, no, I think it's an ugly painting, we're both talking about our subjective opinions. Right?

A Right.

Q But if -- if we're talking about a thermometer, for example, in medicine, you have a number in medicine that you generally consider to be generally accepted as a normal temperature and an abnormal temperature, do you not?

A Generally speaking, yes.

Q Right. Well, every parent in America has taken the temperature of their children. Right?

MR. ERCOLE: Objection to form; calls for speculation.

THE WITNESS: I would imagine so.

BY MR. WHITTEN:

Q Do you have children?

A I'm sure there are some that do. I do.

Q I've raised a bunch of them. And generally what temperature do we consider to be

lot of people run with low blood pressure, and that's normal for them.

Temperature also. People run different temperatures. There's a range of normal, 98.6 is generally considered to be the absolute normal, but that's not to say that 97 -- if you run 97, you're -- you're low or if you run 96, you're low.

The same is true of any test, and what I said before we cut out, is I use the example of an X-ray. As if there's a -- if there's a finding on an X-ray that is of some concern --

MR. ERCOLE: Mr. Whitten --

THE WITNESS: Are you laughing? Did you cut out?

MR. WHITTEN: Go right ahead. Yes, I am laughing.

MR. ERCOLE: Are you done laughing? Are you done laughing?

MR. WHITTEN: I am laughing. I am absolutely laughing. I cannot believe that this is so difficult. I absolutely can't believe it. I didn't know you --

MR. ERCOLE: I was just making sure you are done laughing.

MR. WHITTEN: No. I'm still laughing at you, Brian, but, no.

MR. ERCOLE: Okay.

MR. WHITTEN: I cannot -- I didn't know you could hear me, either. But I can't believe that this is this difficult.

BY MR. WHITTEN:

Q Doctor, I'm just trying to say --

A I'm not trying to be difficult, sir. I'm not trying to be difficult, sir. What I'm saying is in my medical practice, my medical experience, I use all of my numbers and lab value and test and data in the context of a clinical picture.

Q I didn't ask for anything that remotely called for that as an answer. Nothing.

A Okay.

Q Nothing like that at all. I'm talking a very general concept. And I'm not trying to practice medicine here.

I'm just saying in science we make assumptions and sometimes we draw a line to get an approximate estimate of something else. Isn't that generally true?

MR. ERCOLE: Objection to form;

vague.

THE WITNESS: Yes. I can say that that's generally true in science. Okay.

BY MR. WHITTEN:

Q Great. We're making progress.

Do you know how Dr. Beaman came up with the three criteria that's in his disclosure?

A I do not. I -- I -- I do not.

Q Did you make any effort whatsoever to find out how Dr. Beaman got that criteria?

MR. ERCOLE: Objection to form.

THE WITNESS: I did not. I wondered. I did not.

BY MR. WHITTEN:

Q Well, did you ask?

A It seems to me it's arbitrary.

MR. ERCOLE: Objection.

THE WITNESS: I'm sorry?

BY MR. WHITTEN:

Q You said it seems to you that it's arbitrary?

A Yeah.

Q Is that what you said?

A Yes.

EXHIBIT 31

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

PURDUE PHARMA, L.P.; et al.,

Defendants.

VIDEOTAPED DEPOSITION OF:	DAVID T. COURTWRIGHT, PH.D.
DATE TAKEN:	March 22, 2019
TIME:	9:05 a.m. to 2:47 p.m.
PLACE:	Lexington Hotel 1515 Prudential Drive Jacksonville, FL 32207
BEHALF OF:	The Defendant(s)
REPORTER:	Michelle R. Hordinski, RMR, CRR

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familiar to doctors. But there's a kind of revolution that occurs in the 19th century that turns out to have very fateful implications.

In the mid-19th century physicians in France, in Scotland, in England, in the United States, began developing methods of hypodermic administration, especially for morphine.

Now, morphine is a drug that doctors very much want to use because it's purified. One of the things I learned in my research is that, in the early 19th century, opium used to drive doctors crazy because the licit drug, the licit drug, was often heavily adulterated. People cheated. In order to stretch the product, they would add lead and mud and straw. And that's a terrible problem because, as you probably know opium was taken by pill in the 19th century. And it would drive you crazy trying to figure out, what is the actual dose of the active ingredient if this product is adulterated?

Morphine solves that problem. You know what you've got if you have the purified alkaloid. But there are often unpleasant gastric effects of taking opium orally. And by injecting it subcutaneously, you can bypass that problem. Rapid onset of action is another advantage for somebody who's experiencing trauma.

That's why morphine injections are used in battlefield situations, for example.

But, of course, the catch was that this was also very euphorigenic, and it strongly reinforced the patient and the potential for abuse and addiction was greater.

Now, in Dark Paradise, this is essentially the story that I tell. Around 1870, doctors began publishing articles in medical journals saying, hey, we've got a problem here. There is a significant risk -- in fact, a heightened risk -- of addiction through the injection of morphine. We need to be really careful about how we use this drug. Don't ever leave the needle and syringe with the patient. Disguise the medication if you possibly can.

By the 1880s, doctors like James F.A. Adams, who was publishing in the Boston and medical surgical -- sorry, Boston Medical and Surgical Journal are giving advice like, try other analgesics first like the coal/tar derivatives. Don't use this as your first line of defense.

So in -- in the professional medical literature, one can discern the emergence of advice that I would describe as narcotic conservatism. You've got to be careful. There's high potential for addiction

with these drugs.

Often these articles were accompanied by detailed case histories of iatrogenic morphine addicts. And so one of the questions that I ask in Dark Paradise is, well, okay, if this medical literature starts to surface in 1870, why is it taking until 1895 for the per capita consumption of medicinal opiates in the United States to begin to decline?

And I think that part of the reason for that is that the American medical profession had not really matured. It hadn't matured into the medical science that we know today. And there wasn't a lot that doctors could do for patients.

Later on, yes, they did develop alternative therapies for treating and curing diseases, but at the time being able to provide symptomatic relief of pain with just a quick injection of morphine was almost like having a magic wand. Well, they overused that wand, and as a result there was a big increase in iatrogenic addiction.

However, over time the teaching, the new cautionary teaching, made its way into medical school curricula and medical textbooks. Several examples of which are cited in the book, and the rising generation of physicians learned to be more cautious about these

Q. You're not being impolite, Doctor. I just want to make sure we're following the protocols here.

Would those regulators include state officials?

A. Yes. I just gave you the Oregon example, 1953.

Q. And what type of warnings are you talking about besides the ones you've already testified about?

A. Oh, no. Let me -- let me go back. Okay. So I'm rereading the sentence. Regulators warned pharmaceutical manufacturers and distributors of the addictive potential of new semisynthetic and synthetic products that they proposed to market.

What I had in mind actually was two episodes that involved the Bureau of Narcotics. In my research, those were in 1947 and 1949. And they were -- those did not involve states. Those involved the federal government.

Q. And when, Doctor, did the FDA start requiring -- I'm sorry. Let me start back.

When did the scheduling of pharmaceuticals begin in the United States?

A. Well, so the Controlled Substances Act was enacted in 1970, and it took effect in 1971. So I guess the right answer to the question is 1971.

Q. And are you aware if opioids have been scheduled since 1971?

MR. DUCK: Objection to form.

THE WITNESS: Yes, under the provisions of the Controlled Substances Act, opiates were and continue to be scheduled after 1971.

BY MR. BARTLE:

Q. And for opiates that are identified as Schedule II, those are identified as being -- as having a high potential for abuse, correct?

A. That is correct, yes.

Q. And when a pharmaceutical is identified or determined by the DEA to be -- and the FDA to be Schedule II, that information is required to be put on the label for that pharmaceutical, correct?

MR. DUCK: Objection to form.

THE WITNESS: I would -- I would want to go back and do some research to discover whether that labeling requirement was part of the original law or was subsequently added. So I -- I don't know when that was required. But I'll take your word for it, that it's --

BY MR. BARTLE:

Q. Well, don't take my word for it, but you'll agree with me that it is required now?

MR. DUCK: Objection to form.

BY MR. BARTLE:

Q. Correct?

A. Yes. But the date -- again, I would want to do research as to whether that was part of the original package enacted by Congress in 1970 or whether that was subsequently added.

Q. And what was the purpose for requiring a label on a pharmaceutical that would include the schedule of the --

A. Well, among other things --

MR. DUCK: Doctor, just a second.

BY MR. BARTLE:

Q. Doctor, you gotta wait. No worries.

What was the purpose, in your view, of requiring that the label for a particular pharmaceutical include its schedule?

MR. DUCK: Objection to form. Beyond the scope.

THE WITNESS: Well, there -- there are a number of purposes, actually. It is suggestive of the potency of the drug, but beyond that there are different refill requirements for these drugs.

If you are dealing with, say, a Schedule III controlled substance, you have to go back, and you

have to see your doctor every six months. That's not necessarily the case with a Schedule IV or Schedule V.

Physicians need to know what the -- what the procedures are for refilling prescriptions and so on.

BY MR. BARTLE:

Q. And those refill requirements, for example, would also apply to the Schedule II pharmaceuticals, correct?

MR. DUCK: Same objections.

THE WITNESS: Correct.

BY MR. BARTLE:

Q. It's all -- the purpose of the label also is to inform the doctor about the nature and potential side effects of a particular pharmaceutical, right?

MR. DUCK: Same objections.

THE WITNESS: I don't -- I don't know that that's necessarily the case. The purpose of -- in my research and legislative history of the Controlled Substances Act, what I found is that the purpose of the scheduling is to subject these different drugs to different degrees of control. Some needed to be more tightly controlled than others; hence, we're not going to allow telephone

prescription refills for this drug, but we might allow them for that drug.

I think the doctors would have been, by the 1970s, would have been well aware of the addictive potential of a Schedule II controlled substance. I don't think it came to them as a blast of news. Oh, this is now Schedule II; I need to worry about it.

These -- these drugs were well known to be potent narcotics.

BY MR. BARTLE:

Q. And you would agree with me that a physician should be aware of the schedule of a pharmaceutical before he prescribes it?

MR. DUCK: Objection. Form.

THE WITNESS: As a general proposition, I would say, yes, that would be part of normal medical education and performances, as well.

BY MR. BARTLE:

Q. Are you aware of any changes in the mid to late 1970s -- mid to late 20th century about the -- in the medical education of -- with regard to the potency and scheduled nature of opiates?

A. With respect to the time period which I am expected to cover, no.

Medical professionals were still advised to be cautious with respect to the use of these drugs and the treatment of chronic, non-malignant pain into the 1970s. Beyond that, I'm not prepared to go.

Q. And then you write in that top paragraph, the second sentence, This cautionary knowledge and these institutions prevented further large-scale epidemics of iatrogenic narcotic addiction until the end of the 20th century.

Do you see that?

A. Yeah.

Q. Are you aware of any efforts taken by the State of Oklahoma to prevent further large-scale epidemics of iatrogenic narcotic addiction prior to 1980?

A. The statutes I -- the prescription control laws I referred to earlier.

Q. Beyond that, you're not aware of any efforts?

A. There is a reference to Oklahoma in Dark Paradise that involves a report prepared by the Bureau of Narcotics sometime in the 1930s -- I think it was -- I think it was around 1938 -- in which they drew upon data from several states, including Oklahoma, in an attempt to make a national estimate of addiction prevalence.

And this -- let me explain the context. I think that the Bureau of Narcotics was low-balling the estimate, and I think that they were deliberately picking largely rural states to -- to essentially demonstrate to Congress that they were doing a good job and that addiction was down. And they -- they picked states like Oklahoma, which is interesting because it's consistent with everything else that I know about heroin addiction and narcotic addiction generally in the -- in the mid-20s century, which is it became a big city problem. It was centered in cities like New York and Chicago and Detroit, especially heroin addiction.

And so the rural areas generally had low rates of narcotic addiction, which is, I suspect, why they picked the state of Oklahoma. The problem was -- was insignificant in the state of Oklahoma in the 1930s.

Interestingly, that had not been the case in the late 19th century. I did, among many statistical analyses in the book, I looked at the available statistical evidence and how it shook out with respect to urban or rural areas. And in the late 19th century, addicts were pretty evenly spread throughout the country. They were in rural places. They were in urban places.

And that had changed by the mid-20th century.

EXHIBIT 32

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex reo.,
MIKE HUNTER, ATTORNEY GENERAL
OF OKLAHOMA,

Plaintiff,

vs. No. CJ-2017-816

(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., a/k/a JANSSEN PHARMACEUTICALS, INC.;
(9) JANSSEN PHARMACEUTICALS, INC., a/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.

VIDEOTAPE DEPOSITION OF GARY SCHICK, M.D.
TAKEN ON BEHALF OF THE DEFENDANTS
ON MARCH 1, 2019 AT 9:01 AM
IN OKLAHOMA CITY, OKLAHOMA

VIDEOTAPED BY: C.J. Shelton

REPORTED BY: Jody Graham, CSR, RPR, RMR, CRR

Q Sure. I don't know that I could ask it the same way. Do opioids possess any addiction potential?

A Yes. Obviously.

Q Okay. Tell me about that in your practice and to your knowledge and experience?

A Well, in my practice it's never been really that big of a problem because I don't usually give them enough to let them get to a dependent state. At least anymore. I mean, it was -- in the past I used to do a little bit more of that, but I don't do that now.

But patients do get dependent on the regular dosing of the medication so that they still feel okay. If they don't get their medications, they're going to start feeling poorly and have withdrawal symptoms. From a dependent standpoint that's -- I mean, that's what they do.

I don't know where else to take that.

Q Sure. That's fine.

A That's just what they do.

Q Sure. So opioids can be addictive?

A Absolutely.

Q Is that a risk that is known to you currently?

A Yes.

Q When did you first learn about the risks of opioids?

A I guess medical school or even before.

Q Okay.

A I mean, just always known that they were addictive.

Q Was that something that was taught in medical school?

A Sure, yeah.

Q And when did you go to medical school again? I think we talked about it briefly.

A '90 -- I graduated in '95. So '91 to '95. Four years.

Q Is that something that's common knowledge in the medical community?

A Yes.

Q And you've been in the Oklahoma medical community for how many years?

A Well, let's see. I started off as a P.A. I graduated P.A. school in 1986, I think. So I practiced as a medical person since 1986 through the VA before going to medical school. Before that I worked in nursing homes. So, I mean, I have a couple years there as well.

Q Okay. Then let me take a little sidetrack

here. Tell me about your work as a P.A. and in nursing homes.

A Well, when I was in college, to get into P.A. school at the time you had to have some kind of medical experience. And there was no way for me to get any other kind of medical experience so I went to work in a nursing home.

I did lots of wound care and vital signs and took care of people in the nursing homes or other banged up people that they took in there for convalescence. That gave me medical experience that so when I interviewed for P.A. school they let me in.

After a couple years of V.A. school I went to the VA Hospital working in the inpatient rehab unit. Mostly strokes, lot of amputations, brain injury, spinal cord injury, stuff like that.

Q Okay. With your P.A. work, did that in any way involve medication prescriptions?

A Not very much.

Q Okay. That wasn't --

A I was doing mostly inpatient rehab.

Q Okay.

A We did have a lot of outpatients that we followed from a spinal cord standpoint mostly, so there were various medications that we used for

A Every time they come in, the same form.
Q Oh. Okay. After one time --
A Yeah. It's not just the first time.
THE REPORTER: Hang on, you guys. Please, one at a time.
MR. CURRAN: Sorry.
THE WITNESS: Every time they come in it's the same form. They have to fill it out again.
Q (BY MR. CURRAN) All right. Do you consider health insurance coverage when making your prescription decision?
A No. I don't. My nurse tells me when it won't work, and then we go back and rediscuss that yeah.
Q Okay. So it is considered --
A Considered somehow or another, but I don't know that much about the insurance. I don't -- I just see the patients and take care of them the best I can whatever their insurance is.
Q How about scientific literature? Do you consider that when making your prescription decision, either specifically or generally?
A Scientific literature. Sure. I mean, we've been through it at various times with medical school. And if there's a new drug out that I want to consider,

I read through the stuff. So I've read through the literature there. But then after that first time probably not.

I go back to what are the effects of the medication, what are its side effects and what are the patient's risk profiles.

Q After all that do you ultimately rely on your own judgment and knowledge in making prescription decisions?

A Yes.

Q Is what pain medication you choose to prescribe a patient based on an individualized assessment of the patient's needs?

A Absolutely.

Q And a risk/benefit profile for that patient?

A Yes.

Q And we touched on this a second ago. What kind of risk assessment, if any, do you perform?

A Well, on my initial evaluations, some of the social history has to do with how much alcohol you drink or do you currently or have you ever taken any other kind of nonprescription medications or illicit medications, I think is the word I have there.

And then I have examples such as marijuana, heroin, cocaine. And I think there's one other one,

meth on there. Have you ever used any of these specifically? And then a blank for anything else and when did they last use them.

There's, you know, other social factors. Are you working? I don't have any physical abuse questions on there, but there's a lot of those kind of things. If you see somebody that you think is physically abused, that would certainly be a risk factor as well. So I pay attention to those kind of things.

Q Why is that important?

A Well, because there are certain things that are going to be more highly -- or more prone to becoming addicted to medications than others.

Q Do you assess a patient's demeanor before making a prescription decision?

A Absolutely.

Q Is it possible in your mind to make a prescription decision without looking at the patient and assessing their demeanor?

A No.

Q Is there a one-size-fits-all approach to medication?

A Absolutely not.

Q Would you agree that each patient's needs

are -- and medical issues are unique?

A Yes.

Q And you touched on this a second ago. With regard to functional improvement, how do you assess that when deciding which, if any, medicines to prescribe?

A Oh, one of the things that I discuss with the patients are what is it you're trying to get out of being here. Is it just less pain in your knee or is it so you can get up and go to church or is it, you know, that you've got to take care of your grandkids? We talk about functional things.

And I bring in -- if they don't talk about functional things, if all they'll ever tell me is they want less pain, then I bring up the functional things because I pay more attention to those things than sometimes the patients do.

And I tell them that monitoring the effects of their treatment is going to have a lot to do with are they functioning and are we able to decrease their pain levels. And so I monitor those things closely.

Q With regard to dosages, do you have a limit on the dosages of a medication that you will prescribe?

A Yeah. Pretty much. I mean, it's like 4 to

opioid is. I mean, it's pain.

Q Right.

A So I don't know -- I've never prescribed them for anything other than pain.

Q Do you see SoonerCare patients, Doctor?

A Rarely.

Q Okay. Do you know, do you have a general understanding of what SoonerCare is?

A Yeah. It's kind of the Medicaid program.

Q Once you've decided that an opioid is appropriate, do you consider brand versus generic types of drugs or do you care?

A I don't really care.

Q Okay.

A Not usually. Unless the patient cares. I think that most of the generics are reasonably as good as the originals, most of the time.

Q When you prescribe, do you usually make a distinction between brand and generic?

A No.

Q Okay. Why not?

A It's just not relevant to me. I don't really care. If the patient comes back and tells me the medication's not working or that they've had that brand before, whatever, you know, generic or label, I

mean, I don't -- I'll kind of abide by their wishes, but I don't tell them that I want them to get a particular brand.

Q And I think we touched on this a second ago. Do you as the physician consider what kind of or type of insurance they have when deciding between possible prescriptions?

A No. Not unless I'm told that that prescription isn't covered. If it comes back they're not covered, then I'll go back and try to come up with something else that is when we get that list. But seems like the insurance companies don't want to tell you what's covered. They only want to tell you what's not covered.

Q Are there any other factors, Doctor, that influence your prescribing --

MR. ANGELOVICH: Objection. Form.

Q (BY MR. CURRAN) -- that we haven't talked about?

A Other factors. You've gone over a lot of stuff. Age of the patient, I guess we didn't really talk about because NSAIDs are more risky in the more age of the person. And in young people, obviously, you want to stay away from them because of issues with longer term needs. So I guess age is the only thing

we haven't talked about.

Q Do you have any knowledge of how -- and I forgot to ask this, and I apologize. Do you have any knowledge of where or how patients on SoonerCare get their prescriptions filled?

A I do not.

Q Let's change topics just for -- have you ever dealt -- you personally dealt with any pharmaceutical sales representatives?

A They've come in intermittently. Not very much anymore, but they used to come in more.

Q Throughout your career have you personally dealt with pharmaceutical sales representatives?

A Yes.

Q Describe your personal involvement with pharmaceutical sales representatives?

A Well, I'm usually pretty busy in the clinic so if they're -- well, it's changed a little bit so...

In the past they kind of had -- they kind of come in the clinic and walk around a little bit. And they'd come up and talk to the nurse. And she would tell me when there's somebody there.

And when I would come out of the room, I would stop by and talk to them for a couple minutes and head on back into the rooms.

Q Generally speaking, what do they want? What's the purpose of those visits, if you recall?

A Well, they want to tell you what drugs they're covering and give you any new data about them and see if you have any questions.

Q Okay. Specifically do you recall any dealings with sales reps from Cephalon?

A I'm not going to remember what company they were from or --

Q Are you -- is that true no matter what the company's name?

A Yeah. There are drugs and there are sales reps and there are companies, but I don't keep them in my head.

Q Do you keep track of how many times sales reps may come by your office?

A No. I know that it was a problem more in that they were just kind of walking around in the clinic so they were taking up the nurse's time. So we eventually made up a little rule that they could only come into a certain room.

And the way we do it now is that if the sales reps come in and want to talk to somebody, the nurses put them in a certain room and they let us know they're there. And we go by and say hi to them.

rheumatologists so they use a lot of drugs that I don't use. And so if there's common medications, they might be there longer because they're going to go to each one of us probably. If it's a medication that only I use, then they probably just come and talk to me and then go. I don't know how long they're out there because I go back in the rooms.

Q Do you or have you ever relied on any representation a pharmaceutical sales representative has made about a particular drug?

A Relied on what they tell me as the reason to prescribe it?

Q Sure. Relied on anything they've told you.

A Well, sure. I mean, I listen to what they tell me. And if they have a new article or something that implies a positive effect of one of the medications or a negative effect of one of the medications then, yeah, I listen to those.

Q Well, you listen to them, but do you do any follow-up after that representation has been made?

A With the drug reps?

Q No. Not with them, but on your own.

A If I've had a problem with that, yeah. I mean, there's, you know, certain medications that -- I had a lady that had a lot of sweating with Cymbalta,

so, you know, I learned that to be a big problem with Cymbalta. So, you know, I pay attention to that probably with patients that -- that's why all my questions are there, is to find those sorts of things.

Q Sure. Let me ask it a different way. I've been a little bit unclear. I apologize.

Have you ever made a prescription decision based solely on what a drug rep has represented to you?

A No.

Q Regardless of a representation that may have been made to you, do you rely on your own medical judgment in making a prescription decision?

A Yes.

Q Why?

A Well, because I'm the one that knows the patient more than -- you know, it's not like any one medication is the right one for every patient that comes through. So I have to take in all those factors that we've talked about earlier and this particular individual and who's around them and what's going to go on in their lives to make a decision about what I think is going to be the best, you know -- and probably polymedication regimen for them, along with everything else that I treat them.

Q What do you mean by that, polymedication?

A Well, they're probably going to be on multiple meds. You know, they're on Tylenol or ibuprofen and they're also on an antidepressant. Or they're on this other antidepressant that I don't even use. So I know I can't use this.

They're already on three or four other -- maybe they're on several heart medications. They're on all kinds of stuff. People come in with lists of medications that take two pages. And, of course, you have to look at what you're getting ready to give them and the potential side effects with that other soup that they're already on.

Q To make an individualized decision?

A Yes.

Q Do you have any personal knowledge of any pharmaceutical company's sales or marketing practices or efforts in Oklahoma?

A I know the drug reps come by once in a while.

Q Do you know anything about why they come to you or -- why they come to you with any degree of frequency?

A Well, like I said, I don't remember the last time I talked to a drug rep. So, you know, if --

Q Okay. Is it fair to say your knowledge and exposure to sales representatives is limited to whoever may have visited your office?

A Right.

Q And, again, you don't recall any Teva, Cephalon, Actavis or Watson representative that has ever made a visit to you or your office; correct?

A No. I know at the moment when they're there, but -- but I don't even know which drugs are made by which companies, to tell you the truth.

Q Do you have any personal knowledge as to which Oklahoma providers or doctors any of the companies may have targeted or visited or how often?

A No. I'm not in any of their offices so...

Q Does it surprise you to know that companies who make pain medications make sales calls on doctors who prescribe medications?

A Would it surprise me?

Q Does that surprise you?

A No.

Q Would it offend you to know that some of these companies might refer to you or any other doctor as sales targets?

A No.

Q Would it surprise or offend you to know that

they classify you and other doctors based on prescribing habits?

A No.

Q Have you ever heard the term "super prescriber" or "super core prescriber"?

A I don't think so.

Q To your knowledge, has anything a sales rep has said to you or anything they may have done ever improperly influenced your prescribing decisions?

A No.

Q Whether that be prescribing a drug at all or prescribing a certain dosage of a drug. Is that still true?

A I don't think so.

Q Do you have any personal knowledge of how sales representatives from any pharmaceutical companies are paid?

A No. But -- no. I don't think so.

Q Is that anything you concern yourself with?

A No.

Q Why not?

A Well, I'm trying to figure out how to take care of the patient. I've got -- that's my biggest time frame is taking care of the patient. Not anything else.

three patients on OxyContin. I have at least one lady on fentanyl. I don't have -- I may have one guy -- one guy that's still on MS Contin.

And then I have, you know, a lot of patients that are taking a few Norco per day or -- which is hydrocodone and -- or a few Percocet per day, oxycodone.

Q And -- oh, I'm sorry.

A I was just -- that's oxycodone.

Q And I think you mentioned earlier that you probably had right now 3- to 400 patients that are on opioids?

A No. That was just a throw-out guess. I really don't know the numbers. I don't know the numbers. There's -- I have no idea how many patients I follow, but fair percent are on some opioid.

Q And it sounds like probably it would be primarily at this point in time the Norco and the Percocet?

A Hydrocodone is probably my number one opioid now since the state took Darvocet away from us.

Q Tell me, when did the state take Darvocet away from you?

A Gosh, probably eight years ago, as a guess.

Q Do you know why?

A Well, they said it was causing heart problems. I never saw that, but that was my understanding of the reason. I don't know if it's the state or the feds, but somebody took propoxyphene away from us.

Q I think you testified to this in your -- or testified to this earlier, but I want to ask again just to make sure. At any point in time during the entirety of your medical practice, do you believe an opioid sales rep ever influenced your decision to prescribe that opioid product?

A No. I think that -- I mean, depending on how you want to answer that, when Butrans first came out I didn't know anything about it so, yes, the rep coming by influenced me to know that it existed and make a decision about whether or not I thought it was appropriate for any of my patients. And I have had a couple of patients that I've used it on.

Q At any point during your medical practice do you believe that any opioid sales rep influenced the amount or the manner in which you prescribed an opioid?

A No.

Q Do you have a belief one way or another whether the fact that these drug companies paid their

sales reps hundreds of thousands of dollars a year, do you think they would do that if they weren't effective?

MR. CURRAN: Object to the form.

THE WITNESS: I have no idea what they pay them.

Q (BY MR. ANGELOVICH) All right. When was the last time that you saw a Purdue sales rep?

A I have no idea. It may have been years. Because the only drugs they have -- what is it you said, OxyContin, MS Contin or Duragesic? Or what was the other one?

MR. BURNS: I probably shouldn't answer that question, but the other one I said was Butrans.

THE WITNESS: Butrans. Okay. You know, the last time I saw one of those reps -- I don't remember. It's been years since I've seen one of those reps.

Q (BY MR. ANGELOVICH) Okay. Are you aware that Purdue has fired its entire sales force?

MR. CURRAN: Object to the form.

THE WITNESS: No.

Q (BY MR. ANGELOVICH) Are you aware that the stated purpose of firing their entire sales force is to help abate the opioid crisis?

MR. CURRAN: Object to the form.

EXHIBIT 33

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel.,
MIKE HUNTER, ATTORNEY GENERAL
OF OKLAHOMA,
Plaintiff,
vs. No. CJ-2017-816
PURDUE PHARMA L.P.;
PURDUE PHARMA, INC.;
THE PURDUE FREDERICK
COMPANY;
TEVA PHARMACEUTICALS
USA, INC.;
CEPHALON, INC.;
JOHNSON & JOHNSON;
JANSSEN PHARMACEUTICALS, INC.;
ORTHO-McNEIL-JANSSEN
PHARMACEUTICALS, INC., n/k/a
JANSSEN PHARMACEUTICALS, INC.;
JANSSEN PHARMACEUTICA,
INC., n/k/a JANSSEN
PHARMACEUTICALS, INC.;
ALLERGAN, PLC, f/k/a
ACTAVIS PLC, f/k/a ACTAVIS, INC.,
f/k/a WATSON PHARMACEUTICALS, INC.;
WATSON LABORATORIES, INC.;
ACTAVIS LLC; and
ACTAVIS PHARMA, INC.,
f/k/a WATSON PHARMA, INC.,

Defendants.
_____/

VIDEOTAPED DEPOSITION OF LESLIE OLLAR-SHOEMAKE, D.O.
TAKEN ON BEHALF OF THE DEFENDANTS
ON MARCH 13, 2019, BEGINNING AT 4:00 P.M.
IN OKLAHOMA CITY, OKLAHOMA

VIDEOTAPED BY: Greg Brown
REPORTED BY: D. Luke Epps, CSR, RPR

Q I'm not going to burden you with that today. Let's talk about C-sections.

A Yes.

Q Is C -- describe what a C-section is.

A C-section is delivery of a baby via an abdominal incision.

Q Okay. And is that -- can that be a fairly invasive procedure?

A Seven layers of tissue I'm cutting through to deliver the baby, yes.

Q Okay. Would it affect your practice here in Norman, Oklahoma, if a -- if you were not able to prescribe opioids to mothers post C-section?

MS. HARNESS: I think you're asking her expert questions again.

MS. FISCHER: I'm trying to, again, be specific to a specific procedure in her practice here in Norman and not ask the general question. I thought I worked around the objection that you had, Ms. Harness, I'm sorry, asking specific procedures and not being specific to the allegations in the case.

MR. LEONOUDAKIS: Objection.

THE WITNESS: I can't imagine having a surgery and not having opioids available after

surgery. No matter what the surgery is, no matter whether it's a second, third or fourth degree laceration vaginally, I can't imagine that happening.

MS. FISCHER: That's all the questions I have. Thank you. Sorry.

DIRECT EXAMINATION

BY MR. MERKLEY:

Q Dr. Ollar-Shoemake, I just have two quick questions. Have you ever been visited by a sales rep for an opioid medication?

MR. LEONOUDAKIS: Objection. Form.

THE WITNESS: No.

Q (BY MR. MERKLEY) In your 26 years of practice, have you ever been misled by a representative of an opioid manufacturer?

MR. LEONOUDAKIS: Objection. Form.

THE WITNESS: No.

MR. MERKLEY: Nothing further. Thank you for your time.

MR. LEONOUDAKIS: Pass the witness?

MR. MERKLEY: Pass the witness.

CROSS-EXAMINATION

BY MR. LEONOUDAKIS:

Q Okay. Doctor, my name is Ross

Leonoudakis. I represent the state of Oklahoma in this case, and I just have a few follow-up questions.

MS. RYAN: Ross, before you start --

MR. LEONOUDAKIS: Yeah.

MS. RYAN: I don't mean to interrupt you. Can we have an agreement that an objection by one of us is good for all of us?

MR. LEONOUDAKIS: Yes, you can.

MS. RYAN: Okay. Thank you.

Q (BY MR. LEONOUDAKIS) Doctor, who -- who did you meet with to prepare for this deposition today?

A My attorney.

Q Okay. Did you talk with anybody from any of the defendants' law firms? Do you know?

A I talked to Nick.

Q Okay. Talk to anybody else?

A No.

Q What did you and Nick talk about?

A He asked me if -- he told me that there was a case that he was involved in involving narcotics, and did I prescribe narcotics, and had I been repped, and I said no, and he said would you testify on our behalf for that reason.

Q Okay. Nobody else from Nick's firm called you?

A No.

Q Okay. And you didn't meet with any of them to prepare for your deposition today?

A No.

Q Okay. These three lawyers in here represent drug -- opioid manufacturers. Are you aware of that?

A Yes.

Q And these three defendants have all acknowledged that there's an opioid crisis in this country. Did they tell you that?

MR. MERKLEY: Object to the form.

MS. RYAN: Objection. Form.

MS. FISCHER: Object to the form.

MS. HARNESS: Object to the form. She's already testified that she never talked to them except for Nick, and she told you what she talked about. So that question is argumentative with what she's already said. It's an improper question, and I object to the form.

Q (BY MR. LEONOUDAKIS) Okay. Did any of these -- has anybody told you that the defendants in this lawsuit are blaming doctors for the opioid

EXHIBIT 34

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., f/k/a JANSSEN PHARMACEUTICALS, INC.;
(9) JANSSEN PHARMACEUTICA, INC., f/k/a JANSSEN PHARMACEUTICALS, INC.;
(10) ALLERGAN, PLC, 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 Number
CJ-2017-816

VIDEO DEPOSITION OF BURL G. BEASLEY, PH.D.
TAKEN ON BEHALF OF THE DEFENDANTS
ON FEBRUARY 11, 2019, BEGINNING AT 9:10 A.M.
IN OKLAHOMA CITY, OKLAHOMA

Reported by:
Cheryl D. Rylant,
CSR, RPR
JOB NO. 3188577
PAGES 1 - 262

mentioned the word proper prescriber training, but I believe that vernacular has kind of fallen away. So I don't -- I don't believe we call it proper prescriber training anymore. 10:42 10:42 10:42 10:42

Q. Okay. Was something like this implemented? 10:42

A. Yeah. He did a pain management tool kit, is what he ended up doing. And that may be from this. 10:43 10:43

Q. Did you -- okay. Now, flip over to the module. 10:43 10:43

A. Uh-huh. 10:43

Q. It's titled -- if you can flip over to the -- no, flip over to the -- yeah, keep going. 10:43 10:43

A. Okay. Hold on. 10:43

Q. Yeah, right there. 10:43

A. Right here? Okay. 10:43

Q. So it says module 3, controlled substances -- 10:43

A. Uh-huh. 10:43

Q. -- Burl Beasley. 10:43

A. Uh-huh. 10:43

Q. Did you author this? 10:43

A. I believe I copied this from another module. I was doing some training at the time. 10:43 10:43

Q. Okay.

A. So I would say no. And I've -- hopefully I have referenced this in the document somewhere. 10:43 10:43

There's a bunch of references at the back. 10:43

Q. Okay.

A. See ASH -- the number 1? And number -- so 10:43
there's references there. 10:44

Q. Yeah. So you -- 10:44

A. So I authored this, but I didn't just pull 10:44
all this out. I'm not that smart, you know -- 10:44

Q. Right.

A. -- to do all this. So I used the references 10:44
that are listed to compile this e-mail. 10:44

Q. Okay. Fair enough. 10:44

A. Okay. 10:44

Q. Do you know why it's called module 3? 10:44

A. Because it was a training module through the 10:44
ASHP, American Society of Hospital Pharmacists. 10:44
Since I had just started in 2014, one of the first 10:44
things I was charged with was to monitor the opioids 10:44
that were being dispensed in Oklahoma. So I wanted 10:44
to edge my -- educate myself as to what that would 10:44
entail. 10:44

Q. And so I guess I'm asking, is there a module 10:44
1 and 2? 10:44

A. Yes. 10:44

Q. What -- what was mod -- what was module 1 and 10:44
mod -- module 2? 10:44

A. I believe module 1 -- 10:44
MR. HILL: Objection. 10:44
THE WITNESS: -- was just an introduction 10:44
to pain. 10:44
Q. (By Ms. Fischer) Okay. And did you 10:44
author -- did you author 1 and 2 as well? 10:45
A. No. 10:45
Q. Okay. Do you know who did those? 10:45
A. Let me see if I see names. Number 1, ASHP 10:45
Foundation, Pain and Palliative Care Traineeship 10:45
Program. On the references. 10:45
Q. Do you recall -- okay. 10:45
Do you re -- are you familiar enough with this 10:45
module -- I'm going to ask you some questions about 10:45
it. Do you need to look at it? 10:45
A. Yeah, let me look at it -- 10:45
Q. Oh, sure. 10:45
A. -- for a minute.
Q. Go ahead. 10:45
A. Yeah. Okay. I'm ready. 10:46
Q. Okay. You pointed at something? 10:46
A. Well, I'm thinking this module 3 right here 10:46
is from him, pharmacology. So he was asking me to do 10:47
the pharmacology portion of his whole program. 10:47
That's where that module 3 comes from. 10:47

EXHIBIT 35

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel.,
MIKE HUNTER, ATTORNEY GENERAL
OF OKLAHOMA,
Plaintiff,
vs. No. CJ-2017-816
PURDUE PHARMA L.P.;
PURDUE PHARMA, INC.;
THE PURDUE FREDERICK
COMPANY;
TEVA PHARMACEUTICALS
USA, INC.;
CEPHALON, INC.;
JOHNSON & JOHNSON;
JANSSEN PHARMACEUTICALS, INC.;
ORTHO-McNEIL-JANSSEN
PHARMACEUTICALS, INC., n/k/a
JANSSEN PHARMACEUTICALS, INC.;
JANSSEN PHARMACEUTICA,
INC., n/k/a JANSSEN
PHARMACEUTICALS, INC.;
ALLERGAN, PLC, f/k/a
ACTAVIS PLC, f/k/a ACTAVIS, INC.,
f/k/a WATSON PHARMACEUTICALS, INC.;
WATSON LABORATORIES, INC.;
ACTAVIS LLC; and
ACTAVIS PHARMA, INC.,
f/k/a WATSON PHARMA, INC.,

Defendants.
_____/

VIDEOTAPED DEPOSITION OF STATE OF OKLAHOMA
3230(c)(5) WITNESS BURL BEASLEY
TAKEN ON BEHALF OF THE DEFENDANTS
ON FEBRUARY 12, 2019, BEGINNING AT 9:14 A.M.
IN OKLAHOMA CITY, OKLAHOMA

VIDEOTAPED BY: Greg Brown
REPORTED BY: D. Luke Epps, CSR, RPR

at that. If you could mark this as 5, please. Do you want to take a break, Doctor? Are you okay?

(Exhibit 5 marked for identification.)

A No. I'm good.

Q Okay. So this is a section of the Oklahoma Administrative Code. It's Title 17 [sic], Chapter 30, Subchapter 3, Part 1 entitled the "Creation and Implementation of Rules; Applicability." Do you see that?

A Yes.

Q And it's talking about the Health Care Authority; is that correct?

MR. HILL: Objection. Form. Scope.

THE WITNESS: Yes.

Q (BY MS. KELLY) And if you go down to Subsection D, it says that "Payments to practitioners on behalf of Medicaid eligible individuals," and that would be SoonerCare members; right? Those are the Medicaid eligible individuals?

A That's correct.

Q "Is made only for services that are medically necessary and essential to the diagnosis and treatment of the patient's presenting problem." Do you see that?

A Yes.

Q Okay. So that means that any services that the Health Care Authority pays for for SoonerCare members have to be medically necessary; right?

MR. HILL: Objection. Scope. Form.

THE WITNESS: That's correct.

Q (BY MS. KELLY) And when we're talking about medical services, that includes pharmacy benefits; right?

A Yes.

Q So reimbursing a claim for a prescription would fall within this definition of medical services; right?

MR. HILL: Objection. Form. Scope.

THE WITNESS: Yes.

Q (BY MS. KELLY) And that would include opioid prescriptions; right?

A Yes.

Q So if the Health Care Authority pays for an opioid prescription for a SoonerCare member, that opioid prescription has to have been medically necessary; correct?

MR. HILL: Objection. Form and scope.

THE WITNESS: Yes.

Q (BY MS. KELLY) Okay. And the services

that the Health Care Authority pays for for SoonerCare patients also, as we saw before, have to be essential to the diagnosis and treatment of the patient's presenting problem; right?

A Yes.

Q So if the Health Care Authority pays for an opioid prescription for a SoonerCare member, that opioid prescription was essential to the treatment of the patient's presenting problem; right?

MR. HILL: Objection. Form. Scope.

THE WITNESS: By the time it gets to us, we would think that it's medically necessary, yes.

Q (BY MS. KELLY) And not just medically necessary, though; right? The rules require that it has to be -- it's medically necessary and essential to the diagnosis and treatment; right?

MR. HILL: Objection. Form and scope.

THE WITNESS: Uh-huh. That's what it says.

Q (BY MS. KELLY) Okay. Who determines whether a service for a SoonerCare patient is medically necessary?

MR. HILL: Objection. Form. Scope.

THE WITNESS: In my scope for a prescription, it's the physician and the patient.

Q So it's up to the Health Care Authority to decide whether the services that it pays for a SoonerCare member are medically necessary; right?

MR. HILL: Objection. Form and scope.

THE WITNESS: Yes.

Q (BY MS. KELLY) And it's only the Health Care Authority that can make that decision under what we just read; right?

MR. HILL: Objection. Form and scope.

THE WITNESS: In this context, yes.

Q (BY MS. KELLY) Okay. So the Health Care Authority only pays for medically-necessary prescriptions for SoonerCare patients; right?

MR. HILL: Objection. Form and scope.

THE WITNESS: I would like to think so, yes.

Q (BY MS. KELLY) Well, we know so because we just looked at the law that says that's all they can do, right?

A Uh-huh. Uh-huh.

MR. HILL: Objection. Form and scope. That's a different question.

Q (BY MS. KELLY) Right?

A Yes.

Q Okay. And that includes prescription

opioids; right?

A Yes.

Q Okay. So the Health Care Authority only pays for medically-necessary opioid prescriptions for SoonerCare patients; right?

MR. HILL: Objection. Form and scope. Duplicative.

THE WITNESS: Say that again.

Q (BY MS. KELLY) The Health Care Authority only pays for medically-necessary opioid prescriptions for SoonerCare patients; right?

MR. HILL: Objection. Form. Scope.

THE WITNESS: By the time it gets to us, we would think that it is medically necessary.

Q (BY MS. KELLY) Well, it's not just that you would think that. As we looked, it says the services provided shall meet -- shall meet medical necessity criteria; right?

A We said that --

MR. HILL: Objection. Form. Scope. Argumentative at this point. He's answered your question.

THE WITNESS: Yes.

Q (BY MS. KELLY) Okay. So for every prescription for -- for every opioid prescription

for a SoonerCare patient that the Health Care Authority has paid for, the Health Care Authority has made the determination that that prescription was medically necessary; correct?

A Yes.

MR. HILL: Objection. Form and scope.

Q (BY MS. KELLY) And that's been true from 1996 through today?

MR. HILL: Objection. Form and scope.

THE WITNESS: I wasn't at the Health Care Authority before then, but I would assume so if it's --

Q (BY MS. KELLY) Okay. Who at the Health Care Authority makes the decision that services like pharmacy benefits, and we'll talk about that specifically, are medically necessary?

A Can you repeat the question?

Q Sure.

A I'm not sure I understand what -- what you're asking.

Q Who within the -- well, let's go back and take a look at this, and you'll see -- which is Exhibit 5. It says "Medical necessity is established through consideration of the following standards"; right?

A Uh-huh. Yeah.
Q And then if you flip over and it lists six different standards; correct?
A Yes.
Q Who is responsible within the Health Care Authority for making sure that the claims that the Health Care Authority determines are medically necessary and that it therefore reimburses are considered in light of these six standards?
MR. HILL: Objection. Form. Vague.
THE WITNESS: I think everybody at the Health Care Authority.
THE COURT REPORTER: I'm sorry?
THE WITNESS: Everybody at the Health Care Authority --
THE COURT REPORTER: Thank you.
THE WITNESS: -- would be responsible.
Q (BY MS. KELLY) Is there something other than these six standards that the Health Care Authority uses to determine whether a service for a SoonerCare patient is medically necessary?
MR. HILL: Objection. Scope. Form.
THE WITNESS: I don't know.
Q (BY MS. KELLY) If the Health Care Authority determines that a service, including a

A That's correct.

Q -- which oversees Pharmacy Management Consultants who does these prior authorizations; right?

A That's correct. Yes.

Q And testifying here today on behalf of the state, you can't identify any specific example where the Health Care Authority reimbursed a claim for prescription opioid, and then went back and determined that, in fact, that claim was medically unnecessary, can you?

MR. HILL: Objection. Form and scope. You're outside of your topics. He's made a very reasonable effort to come here prepared to testify about the topics that you identified. To the extent you personally can answer that question, you can try to do so.

THE WITNESS: I conducted an audit of topical compounded claims. We were spending $100,000 a month on creams and lotions and potions that are put on your skin, and of those, several of them contained opioids. Now, it might not have been OxyContin, but it was morphine or an opioid. So we put systems in place that disallowed those kinds of claims. So there are things that we have done.

Specifically to you and this lawsuit, no, but there are things that we have done.

Q (BY MS. KELLY) And when the Health Care Authority suspects that there are medically -- a large number of medically unnecessary claims being submitted, it can conduct things like the audit you just described; right?

MR. HILL: Objection. Form.

THE WITNESS: When we know of it, we could.

Q (BY MS. KELLY) Okay. And to date, you haven't done anything like that related to prescription opioids; is that fair to say?

A Not to my knowledge.

MR. HILL: Objection. Form and scope.

Q (BY MS. KELLY) And the Health Care Authority is obviously aware? You're here today testifying for them about the lawsuit that's been brought in this case; right?

A Yes.

MR. HILL: Objection. Form.

Q (BY MS. KELLY) Has the Health Care Authority as a result of what's being alleged in this lawsuit undertaken an audit to go back and review opioid prescription claims that it has

previously approved?

MR. HILL: Objection. Form and scope. You're asking about the Health Care Authority or the state?

MS. KELLY: Health Care Authority.

MR. HILL: Same objection.

THE WITNESS: We haven't gone back retrospectively, but we're putting in morphine milligram equivalent edits starting this month. So going back and looking and recouping our money, no.

Q (BY MS. KELLY) Why not?

A Probably resources --

MR. HILL: Objection. Form and scope.

THE WITNESS: -- time, the effort. We just said a million scripts to look at. We've got to figure out somebody to compile that data and figure out where the fraud is, and then go back and recoup that money. So I would think that would be something that Program Integrity would do or Quality Assurance in assistance with the Pharmacy Department.

Q (BY MS. KELLY) And has that process been started?

MR. HILL: Objection. Form and scope.

THE WITNESS: We have not undertaken that

effort to my knowledge.

Q (BY MS. KELLY) Has there been a discussion about starting that process?

MR. HILL: Objection. Form.

THE WITNESS: No, there has not.

Q (BY MS. KELLY) Why not?

MR. HILL: Objection. Form and scope.

THE WITNESS: I think we are just trying to, like I said earlier, whack-a-mole. We are a payer, so we are not the ones to decide what physicians prescribe. So going back and looking at all those diagnoses and claims data would take time and resources that frankly we don't have right now. Could it be done? Yes. Has anybody done it yet? No.

Q (BY MS. KELLY) And to your knowledge, there's been no discussion about doing that; right?

A No.

MR. HILL: Objection. Form and scope.

Q (BY MS. KELLY) You said when you were talking about the topical compounded creams --

A Yes.

Q -- that there were -- you guys put systems in place --

A Yes.

Q Okay. What was the active pharmaceutical ingredient that you were looking at to determine whether it was in these creams?

A There were several. Gabapentin was one. Clonidine was another. Estradiol was another. I believe testosterone was another. So there were several, and so what pharmacies were doing were just dumping all these into a tub and mixing them and saying put this on. So if you're getting a cream for clonidine and you have high blood pressure, now you've put something for high blood pressure on your skin. So now you may have possibly an interaction with what you're taking orally. So you go to a pharmacy and get your tub of cream, and then you go to Walmart and get your blood pressure medicine, and they don't talk to each other. So that was the patient safety issue.

Q And so was this audit retrospective in that you were looking at prior claims that were paid, and then there were also prospective steps taken in that you were not going to be paying for these creams going forward?

A That's correct.

Q Okay. Did all of these compounded creams contain opioids? I know you mentioned some of them

did.

A Not all of them, no.

Q Okay. Were any -- do you know whether any of the compounded creams in your audit that were found to be medically unnecessary contain an API that was manufactured by any of the defendants in this lawsuit, Teva, Purdue, and Janssen?

A I did not look at drug manufacturers.

Q Okay. And you understand that one of the topics that you're testifying about here today as a representative of the state, it's actually Topic 9, is the administration of any pharmacy benefit program by you or on your behalf; right?

A Yes.

Q And so you're testifying on behalf of SoonerCare about that; right?

A Yes.

Q In your capacity as the state's representative about the administration of any pharmacy benefit program, are you aware of any prescription that was reimbursed by the state of Oklahoma prior to today for an opioid manufactured by either Purdue, Janssen, or Teva that has since been determined to be medically unnecessary?

MR. HILL: Objection. Form.

THE WITNESS: Not that I know of.

Q (BY MS. KELLY) Okay. We were talking about Exhibit 20 before we took a break. Do you still have that in front of you, Doctor?

(Exhibit 20 marked for identification.)

A Yes.

Q And that is a petition for medication prior authorization. Do you see that?

A Yes.

Q That's another one of the prior authorization forms that the Health Care Authority uses; right?

A It is Pharm-4, the generic prior authorization form.

Q Okay. And the Health Care Authority sets what information has to go in this prior authorization form; right? That's up to the Health Care Authority?

A That's correct.

Q So for example, this generic form includes the name of the medication; right?

A Yes.

Q It includes the strength of the medication; right?

A Yes.

Q That's sometimes referred to as the dose? Well, no. You know what? It's not referred to as the dose, so let me strike that. It includes the fill quantity; right?

A Yes.

Q The day's supply; right?

A Yes.

Q The prescriber name; correct?

A Yes.

Q The diagnosis; correct?

A Yes.

Q What happens if the person submitting this form does not complete all of the information that's requested?

A I believe it's marked as incomplete.

Q Okay. This also asks the doctor to list previous Tier 1 or OTC trials; right?

A Correct.

Q This form doesn't require a doctor to enter their DEA number, does it?

A No.

Q Are you familiar with the fact that for Schedule II drugs, doctors have to register with -- or I guess I should say prescribers have to register with the DEA before they can prescribe Schedule II