IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

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

Plaintiff,

vs.

(1) PURDUE PHARMA L.P.;
(2) PURDUE PHARMA, INC.;
(3) THE PURDUE FREDERICK COMPANY,
(4) TEVA PHARMACEUTICALS USA, INC.;
(5) CEPHALON, INC.;
(6) JOHNSON & JOHNSON;
(7) JANSSEN PHARMACEUTICALS, INC,
(8) ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC., n/k/a JANSSEN PHARMACEUTICALS;
(9) JANSSEN PHARMACEUTICA, INC., n/k/a JANSSEN PHARMACEUTICALS, INC.;
(10) ALLERGAN, PLC, f/k/a ACTAVIS PLC, f/k/a ACTAVIS, INC., f/k/a WATSON PHARMACEUTICALS, INC.;
(11) WATSON LABORATORIES, INC.;
(12) ACTAVIS LLC; and
(13) ACTAVIS PHARMA, INC., f/k/a WATSON PHARMA, INC.,

Defendants.

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

DOCUMENTS SEALED PER COURT ORDER DATED APRIL 16, 2018 THAD BALKMAN DISTRICT JUDGE

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Part B

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EXHIBIT 5

IN THE DISTRICT COURT OF CLEVELAND COUNTY

STATE OF OKLAHOMA

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MIKE HUNTER,
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Case Number
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(11) WATSON LABORATORIES, INC.;
(12) ACTAVIS, LLC; and
(13) ACTAVIS PHARMA, INC., f/k/a WATSON PHARMA, INC.,

Defendants.

VIDEO DEPOSITION OF JOHN HASSLER
STATE OF OKLAHOMA 3230(C)(5) WITNESS
TAKEN ON BEHALF OF THE PLAINTIFF
ON FEBRUARY 20, 2019, BEGINNING AT 9:05 A.M.
IN OKLAHOMA CITY, OKLAHOMA

Reported by: Cheryl D. Rylant, CSR, RPR

Video Technician: Gabe Pack

topics related to marketing strategies; is that correct?

A. Yes.

Q. You're here to testify about something called branded marketing strategies in Oklahoma and the country; is that right?

A. Yes.

Q. You're here to talk about unbranded marketing strategies and what Teva did with unbranded marketing in the country and in Oklahoma, correct?

A. Yes.

Q. And you're here to talk about continuing medical education that Teva did in Oklahoma and -- and nationally for opioids, correct?

A. Yes.

Q. So we'll get into each one of those areas, but we'll just take those one at a time. Branded marketing, what is that?

A. It's marketing activities that are specific to a branded product, in this case a branded pharmaceutical product.

Q. So it has to mention a specific drug; is that right?

A. Yes.

Q. Branded marketing is marketing that relates

to a specific drug such as Actiq; is that right?

A. Yes.

Q. Or Actiq is an opioid, correct?

A. Yes.

Q. It's an opioid that Teva makes, right?

A. Yes.

Q. It's fentanyl?

A. Yes, it's a transdermal immediate-release fentanyl product.

Q. Right. And it's a lozenge, is that right, that's on a stick?

A. I'm sorry, I said transdermal. It's a transmucosal.

Yes. It's a lozenge -- it's a lozenge that's on a stick that the patient places against their cheek and gum for the drug to be absorbed into their system.

Q. So branded marketing for Actiq would be some sort of marketing that actually refers to Actiq or uses the Actiq label; is that right?

A. Yes. If it -- if it mentions the drug name and the indication, it is a branded marketing piece.

Q. Branded marketing pieces are different than unbranded, right?

A. Yes.

Q. Branded marketing pieces have to be approved

and are regulated by the FDA. That's one difference, right?

A. Yes. In the case of Actiq, the branded marketing pieces actually had to be pre-approved by the FDA before they were used. Other branded marketing materials for other products have to be submitted to the FDA upon use.

Q. And then unbranded marketing materials, though, those aren't submitted to the FDA; is that right?

A. That's correct.

Q. Okay. So let's talk about what unbranded marketing materials are.

What is -- when we use the term "unbranded marketing" in the pharmaceutical industry, what does that mean?

A. Unbranded marketing materials are generally disease state materials that don't mention a specific product but more generally talk about characteristics of a specific disease state, and oftentimes they're meant to help improve the treatment of a condition that is not specific to a particular drug.

Q. Unbranded marketing doesn't mention, and can't mention, a particular drug; is that right?

A. That's correct.

Q. That's what makes it unbranded, is there is no brand name product in the marketing, right?

A. Yes.

Q. Now, unbranded marketing still has to be accurate, correct?

A. Yes.

Q. And just so we're clear, Teva has used both branded and unbranded marketing for its opioids, correct?

MR. FIORE: Object to the form.

THE WITNESS: Yes. And in both cases, the materials still go through an internal review process that has a legal, regulatory, and medical reviewer evaluate the piece. If there are changes that they require, those changes have to be made to the piece before the piece is actually used.

MR. BURNS: Drew, do we have our normal arrangement that an objection by one Defendant is an objection for all?

MR. PATE: That's fine today, yeah.

MR. BURNS: Great. Thank you.

Q. (By Mr. Pate) Okay. So what you're say -- an internal review process. You said both branded and unbranded go through an internal review process; is that right?

Q. So you have a brand name drug like OxyContin. That's a brand name, right?

A. Yes.

Q. That's a branded product of Purdue Pharmaceuticals, right?

A. Yes.

Q. And then if you have a generic version, it's a substitutable version of OxyContin, right?

A. Yes.

MR. FIORE: Object to form.

Q. (By Mr. Pate) And in -- in that specific case actually, your company sells a generic version of OxyContin, correct?

A. Yes.

Q. It sells what's called and authorized generic of OxyContin, right?

A. I think that's correct.

Q. And an authorized generic is literally the exact same drug, just in a different package and with your -- a generic label on it, right?

MR. FIORE: Object to form.

THE WITNESS: The FDA would say that any substitutable generic is the exact same drug. In this case, it is an authorized version of that drug from the innovator.

Q. (By Mr. Pate) And so you say, to market that generic form of OxyContin that your company sells, you made a product announcement; is that right?

MR. FIORE: Object to form.

THE WITNESS: Yes.

Q. (By Mr. Pate) So when you're about to release a generic product on the market, you tell the pharmacists and the distributors, the large chain pharmacies, that you have a generic version of that product that's about to be available; is that right?

MR. FIORE: Object to the form.

THE WITNESS: Generally, yes. I'm not sure exactly how much can be communicated in advance of the approval, but they -- they make announcements that they have product approval and are able to ship that generic version of that product to those wholesalers and pharmacies.

Q. (By Mr. Pate) And you make those announcements more to the -- the pharmacist side of the -- of the business rather than the doctor side; is that right?

MR. FIORE: Object to form.

THE WITNESS: Yes.

Q. (By Mr. Pate) Because the doctor doesn't typically pick between the brand name and the

generic, right?

A. Correct.

Q. The -- that decision is usually made by the pharmacist when they're filling the prescription, right?

A. Yes.

Q. So that's why you want to let -- when you're marketing a generic, the most important thing is to let the pharmacists know that that generic version of the drug is available, as you said, at typically a lower price point, right?

MR. FIORE: Object to form.

THE WITNESS: Yes, it -- when you use the term "marketing," I relate that more to what we do with the brands where we market and promote a product. On the generic side, it's -- it's typically we announce the availability and -- and then the market has whatever uptake they're going to have based on the -- on the pricing and the prescriptions that the physicians are generating, typically of the innovative product.

Q. (By Mr. Pate) Right. Because, as you said, the market -- I think you said the market exists already for that drug at the time that you release the generic version, right?

A. Yes.

Q. There's already been a branded product out there in the marketplace for some period of time, right?

A. Yes.

Q. And it has created whatever market for that product through its own marketing efforts, right?

A. Yes.

Q. And then, when your company releases a generic version, you step into that same marketplace with what's typically a cheaper version of the same product, right?

A. Lower price.

Q. Lower price.

And so the marketplace has already been defined somewhat by whatever the innovator, as you called them, has done for marketing that product; is that right?

A. I think the market has been defined by the choice that the physicians have made and where they choose to use this product. And the utility that they found in it, that really defines the -- the universe of the prescriptions for any given innovative product, and then the generics simply enter that market and create alternatives that bring

generic OxyContin, right?

MR. FIORE: Object to form.

THE WITNESS: Yes. It's still a very small portion of the market, but I believe that the two together had more than either had separately.

Q. (By Mr. Pate) Now, let's talk about when Teva first released generic OxyContin. When did that happen?

A. I believe that the first release was in the mid 2000s that led to a lawsuit that was resolved, but I don't -- I don't know the particulars of the lawsuit and the agreement. The one that I'm most familiar with is the agreement that was reached at the end of 2014, which is the terms that we were just discussing.

Q. The lawsuit you referred to, that was a patent lawsuit, right?

A. That's my understanding, yes.

Q. Which basically Purdue was saying, "We have a patent on this drug, you're not allowed to sell it yet," right?

A. Yes.

MR. BURNS: Object to form.

Q. (By Mr. Pate) And you guys said, "Yes, we can," and then there was a settlement, right?

MR. FIORE: Object to form and scope.

THE WITNESS: I can't speak to the particulars of the lawsuit, but it did result in a settlement.

Q. (By Mr. Pate) All right. Now, prior to the mid 2000s, prior to you releasing your generic version of OxyContin, what marketing related to OxyContin did Teva do?

A. None.

Q. None?

A. Not -- not that I know of, no.

Q. What did you do to ensure that your generic version of OxyContin would be sold?

MR. FIORE: Object to form, assumes facts not in evidence.

THE WITNESS: Ask me that -- I'm trying to understand the question.

Q. (By Mr. Pate) Sure.

We talked earlier about how, when you're releasing a brand name product, you're going to have a marketing strategy in place, right?

A. Yes.

Q. To help drive sales, right?

A. Yes.

Q. You released a generic version of OxyContin

in the mid 2000s, right?

A. Yes.

Q. What was your marketing strategy?

A. The generic company, or Teva, Teva's generic business simply announces product availability within -- for an innovative product and makes that product available through pharmacies. Typically those products are AB rated that allows the pharmacy to substitute that generic product for the branded product at the point of sale. And that's the -- the core of what generics do to launch a new generic product.

Q. So to summarize -- I can try. To market your generic OxyContin, you announced that you had a generic OxyContin product available at a lower price point; is that right?

MR. FIORE: Object to the form.

THE WITNESS: Yes.

Q. (By Mr. Pate) Other than that, you didn't, for example, start sending sales reps into doctors' offices to talk about your generic OxyContin, right?

A. No.

Q. You didn't --

A. Teva did not do so. I believe that Actavis used the Canadian -- I'm sorry -- the Kadian sales

force to announce product availability. But in any of those cases, they don't promote the therapeutic benefit of any given therapy. And in this case, they were trained, "You're only to make a product announcement to create awareness of that product being available."

Q. So Actavis released a generic form of OxyContin around the same time Teva did?

A. I'm sorry, I -- let me back up. I'm -- I'm not sure that I just stated something that was correct.

I don't -- I don't know that Actavis did that for OxyContin. I -- I confused that with oxymorphone.

Q. What's oxymorphone?

A. It's a generic version of Opana, where the innovator had removed specific strengths of the drug from the marketplace so that when the generic version of that product became available, there were no scripts being written by physicians because there were -- the product had actually been removed. And there was no safety concern for the product removal, and so, in that case, physicians who had found value for specific patients for those specific strengths of that compound, the company made those doctors aware that that was available now, but it -- but, again,

they didn't promote the -- the efficacy or safety of it. They simply announced that that product that they had used in the past was now available should they choose to use it again in the future. And that was the extent of the product announcement for that -- that compound. And I -- I apologize, I -- I confused the two drugs.

Q. All right. So just so we're clear. Actavis, at one point, released a generic version of Opana?

A. Yes.

Q. That's what you referred to as oxymorphone, correct?

A. Yes.

Q. When it did that, it used the sales force for their drug, Kadian, to make a product announcement that that generic Opana was now available?

A. Yes.

Q. What kind of a drug is Kadian?

A. It's a morphine opioid product.

Q. It's an opioid?

A. Yes.

Q. When you bought Actavis, did you buy the rights to Kadian?

A. Not to the brand.

Q. Only the generic?

A. Teva has a generic form of that product.

Q. All right. Opana has since been pulled from the marketplace by the FDA, correct?

A. I wasn't aware of that.

Q. Do you still sell generic Opana?

MR. FIORE: Object to form and scope.

THE WITNESS: We had provided the list of products that we sell, and I don't recall whether that was on the list or not. That was provided I think at a deposition two weeks ago.

Q. (By Mr. Pate) Did Teva -- separate from Actavis or before you acquired Actavis, did Teva have its own generic oxymorphone product at some point?

MR. FIORE: Objection to form and scope.

THE WITNESS: I don't recall.

Q. (By Mr. Pate) All right. So let's go back to OxyContin.

A. Okay.

Q. You testified that in the mid 2000s, Teva released its version of generic OxyContin, correct?

A. Yes.

Q. And when it did that, it made a product announcement, right?

A. I believe so.

Q. It said, "We have a generic version of

the product and continue to use the product at an out-of-pocket exposure that they could afford.

Q. What unbranded marketing related to opioids -- well, let me start over.

I believe you testified earlier that Teva started some type of branded marketing in the mid '90s?

MR. FIORE: Object to form.

THE WITNESS: When we were talking about the copy approval or promotion material review process?

Q. (By Mr. Pate) Yes.

A. Yes.

Q. Were those for opioid products?

A. No.

Q. When did Teva start selling generic opioids?

A. My best recollection is I believe that Barr Laboratories had a couple of opioid products, and that would have been around 2006. I don't recall whether they continued to sell them after Teva's acquisition or not. But in the mid 2000s I believe is when -- that's my best recollection as to when Teva started to sell generic opioids.

Q. At the same time it started selling generic OxyContin?

A. I --

MR. FIORE: Object to form.

THE WITNESS: I think that was one of the earlier products.

Q. (By Mr. Pate) All right. At that time, what unbranded marketing was Teva specifically doing related to chronic pain or opioids?

A. I -- I don't recall seeing specific initiatives, in that it really isn't part of what the generic companies do. There may be specific small grants in different areas, but the generics usually ride in the wake of what a branded company has done to build a market for an innovative product, and then the generics simply announce availability of generic versions of that product and there isn't -- there isn't much, if any, disease education that generics typically engage in that come to mind.

Q. As distinct from the company Cephalon, just asking specifically about Teva now. Does it engage currently in the unbranded marketing related to -- well, let me back up. That's a bad question.

Prior to the acquisition of Cephalon by Teva, did Teva, as far as you know -- or what unbranded marketing did Teva use related to chronic pain or opioids?

MR. FIORE: Object to form.

THE WITNESS: Prior to Cephalon?

Q. (By Mr. Pate) Prior to Cephalon.

A. I'm struggling to think of any marketing materials that Teva would have controlled from a generics standpoint. It's just not a routine practice for the generics business. I can't think of an example. This would have been prior to 2011. I'm -- I'm sorry, I'm not coming up with -- with anything.

Q. All right. Prior to 2011, Cephalon used unbranded marketing as part of its marketing strategy for Actiq and Fentora, correct?

A. Yes.

Q. After 2011, Cephalon and Teva, now as part of one company, continued to use unbranded marketing and branded marketing for those products, correct?

A. Yes.

Q. At that time, Teva was also selling a number of generic opioid products by then, correct?

A. Yes.

Q. Including generic OxyContin, correct?

A. Yes.

Q. Prior to Teva acquiring the Actavis and Watson entities, what unbranded marketing did those specific companies use related to chronic pain or

opioids?

MR. FIORE: Objection to form.

THE WITNESS: I don't recall seeing examples of unbranded communication that those companies -- the generic side of those companies sponsored. I recall product announcements when they launched generic products, but I can't think of specific examples of non-branded disease state communication that would -- that they had issued.

Q. (By Mr. Pate) Those product announcements are made where?

A. Typically they're sent out to pharmacies or they may be advertised in trade journals to announce the product availability of the generic product and whether they're an AB-rated or a substitutable product for a specific brand. They can use different channels to communicate that type of information. Via trade journals, via direct mail, or via e-mail blast are the most frequent channels that I've seen examples of from those organizations.

(Whereupon, Deposition Exhibit No. 9 was marked for identification and made part of the record.)

Q. (By Mr. Pate) I'm going to hand you a document. I know you've seen this one, because I've

asked you about it. This one is marked as Exhibit 9 this time. Do you recognize that one?

A. Yes.

Q. All right. I'm going to ask you fewer questions about it this time.

Is that unbranded marketing, Exhibit 9? Well, let me start over.

Just so it's clear to the jury, Exhibit 9 is a brochure entitled Making Pain Talk Painless, correct?

A. Yes.

Q. The subheading says A Guide to Help You Talk With Your Doctor About Pain Management, right?

A. Yes.

Q. It's got the Cephalon label right underneath that, right?

A. Yes.

Q. The Bates number on this one is TEVA_OK_00116233. All right?

A. Yes.

Q. Is Exhibit 9 an example of unbranded marketing?

A. Yes.

Q. Okay. This one is dated July 2006, if you look at the very back, bottom of the page.

A. Yes.

EXHIBIT 6

IN THE DISTRICT COURT OF CLEVELAND COUNTY

STATE OF OKLAHOMA

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

TRANSCRIPT OF PROCEEDINGS
HAD ON DECEMBER 5, 2017
AT THE CLEVELAND COUNTY COURTHOUSE
BEFORE THE HONORABLE THAD BALKMAN
DISTRICT JUDGE

REPORTED BY: ANGELA THAGARD, CSR, RPR

But the reason I bring it up is it shows that they're just not paying attention to what we pled, or more likely, they paid attention but they won't talk about it because it's not good for them.

So let's just be clear. What does the State not do. We don't assert failure to warn claims. That's not in our petition. We don't assert federal claims. We're not in federal court. We don't seek relief under federal law. We're not challenging FDA approval. We're not challenging the FDA labels. We're not asking them to rewrite labels. We're not asking FDA to do anything. We hope they will, but that's not our case. And we're not asking them to do anything that's not currently possible under FDA rules.

But let's assume for a minute that we were. Contrary to what they're telling you, your Honor, and what they said in the briefs, there's nothing that prevents the defendants from strengthening their warnings. They could do that. It's not part of our case. But it's not true that they can't do it. And I'm going to get to this PROP petition and what it is and what really happened there in a moment.

But the Supreme Court says very, very clearly that FDA, when it comes to strengthening labels, it's not both a floor and a ceiling. What they're trying to say is if the FDA says one thing, that's all we ever have to do. That's not true. Drug companies can come in, if the evidence warrants and if

they find information that says their drugs are harmful or not labeled appropriately, they can come in and strengthen those warnings.

Now, they have to deal with the FDA, and ultimately the FDA can approve or reject that. But there's no prohibition against it. As the Supreme Court said, the very idea that FDA would bring an enforcement action against a manufacturer for strengthening a warning pursuant to the Changes Being Effected regulation is difficult to accept.

Now, how that all might play out if one or more of these defendants wanted to change their labels in front of the FDA, I don't know. It's really not an issue in this case. We hope they'll take the steps to help fix this problem at the federal level, but that's not what we're dealing with.

Going to your questions about marketing, this is what we're dealing with. We're dealing with a pervasive, systemic conspiracy and campaign individually and together by these defendants to market these drugs in a way that is contrary to what they're approved by the FDA to do. Pure and simple.

Going to show you this picture. I think you'll see it again with Mr. Whitten. This is a photograph of a poppy field in Tasmania. Now, on the left, you can barely see it, but there's a sign that says Tasmanian Alkaloids, and you'll see that logo that's a poppy in a white box.

You know, you'll hear with Mr. Whitten's presentations

things about group pleading and all this and these defendants saying that they're all lumped together. Tasmanian Alkaloids was until recently owned by Johnson & Johnson. Now, we don't know yet, hopefully we'll learn during discovery, which defendants got their root drugs and compounds from different sources. But we believe that Johnson & Johnson was at the very root of all this.

They were an approved grower. They supplied the source, content, organic compounds that other companies used to make their opioid-based products. Which of these defendants did, we're not entirely sure yet, but I think it'll be all of them or quite a few of them.

And this is a poppy field that we believe was owned or at least operating in some part in conjunction with J & J. But look at this sign. This is just -- it's a base, so it's coming out of the ground. "Illegal use of crop may cause death."

This is an organic flower. But its base level, its first use, just getting into that field, consuming it -- and Mr. Whitten will talk more about this -- could kill you. This is serious stuff from the very genesis of it coming into existence.

This opioid epidemic, in 1996 there wasn't a problem. We've had issues with morphine and opium throughout history. But in 1996 -- and again, Reggie, Mr. Whitten, will talk about this -- opioid use and abuse and the way we see it now with

pain pills wasn't a problem. Okay. That problem began with these defendants.

And this is a great quote from Andrew Kolodny. The defendants don't like Dr. Kolodny. He's the one that filed the PROP petition, which we'll talk about in a moment. But he's a very strong voice and courageous voice in dealing with this issue and bringing it to the national attention.

This is what Dr. Kolodny says about defendants in their marketing, not their labels. This is an out of control epidemic, not caused by a virus or a bacteria. This epidemic has been caused by a brilliant marketing campaign that dramatically changed the way physicians should treat pain.

I want to think about that for just a second on marketing and how it relates to preemption. I don't know if the Court has heard of the Sackler family, but the Sackler family is who founded Purdue. Just a brief history on that. It'll be a major part of our case, I'm sure.

But Arthur Sackler was credited as the person who really created what we now know as pharmaceutical marketing and advertising. All of us -- I'm sure your Honor knows, all of us have friends or family who may have been a pharmaceutical sales rep. It's something that we're very familiar with, with young men and women coming out of college and calling upon doctors and hospitals to advertise and sell a drug.

Well, before Mr. Sackler, that really wasn't a thing. I

products, the Teva and Cephalon products that are sold, and if you look at the appendix to the State's petition which shows the amount of prescriptions that they've reimbursed for those products, what you will see, your Honor, is there's two products that Cephalon sold. One, Actiq, hasn't been reimbursed for the State of Oklahoma in the last nine years. Nine years, zero.

In 2018, there was one prescription. Fentora was prescribed a little bit more, but if you look there, their chart goes through the middle of 2017. Not a single prescription of Fentora in 2017, and only one in 2016.

So that's why when I get into issues like they don't differentiate between defendants, they're not particular about who said what and caused what, it really matters. It matters to each of us. I'm using my client as an example, and frankly we're an extreme because we're such a small player here and our drugs have still such a narrow niche. But the fact is the pleading standard that they have to meet applies to all of us, and they haven't done it.

And I'll just briefly go through the background. I think you've already gotten a flavor for this, but there are a number of defendant families here, and there is separate legal entities within each of these families.

I joked at the outset that I had a long list of clients. That's in part because Teva USA and Cephalon are separate

companies, sister subsidiaries that I represent. Their parent recently acquired some Actavis entities, so I also represent now the listed Actavis entities. Before that acquisition in 2016, they were part of Allergan. Allergan is actually a named defendant in this petition, but they have not been served.

I'll just -- we can brush over this. You have the list. But the point here is simply that each of these companies manufactures and sells different opioid products for different time periods, different marketing practices, different approved indications for those drugs.

Again, when you engage in this kind of broad and improper group pleading, as the State has done, you tend to blur over these distinctions. And the distinctions are important for all the reasons you heard a little bit today in terms of, Well, our label says this, and we're proof of this.

You can't say that we've committed fraud by promoting for chronic pain when we were specifically approved for chronic pain. You can't claim that we committed fraud by talking about pseudoaddiction when the FDA specifically approved language in there that recognized that if a patient is seeking drugs, there's probably two reasons, one of two reasons: Either he or she's an addict, or he or she's in pain, and it's not being adequately treated.

This is a list of Janssen's product. The Actavis defendants that I mentioned I represent, they only manufacture

generic opioids. We've heard time and again this case is about promotion, promotion of opioids, marketing activity. Generic companies, your Honor -- I don't know how familiar you are with the industry, but generic companies do not market their products.

It's a very low volume industry. What they do is they benefit from the mandatory state substitution law that exists in every state, including Oklahoma. So for example, if I'm a branded pharmaceutical company and I'm selling my product, I might market that product. If you, your Honor, go to the FDA and get approval for what's called an AB-rated generic, so it's basically bioequivalent to my product and it's approved, and Mr. Cheffo goes into the neighborhood CVS and presents a prescription for my product, the CVS will automatically substitute your generic. That's how the generic business works.

In fact, generics are required to adhere to follow the label of the brand. The whole idea is to get the lower cost generics on the market quicker, and state law and federal law does certain things to encourage that. But as a result, generic companies don't need to promote. It's not cost effective for them to do so.

So we're going to focus on causation first, your Honor. And our position is that they failed to plead causation. They both failed to plead proximate causation and but-for causation.

And again, this is one where hopefully, there's no disagreement.

The State doesn't dispute that causation is an element of each of its claims. It's expressed differently. I have a list of the citations to support that point, but there doesn't seem to be a dispute that causation -- that they're required to plead causation and ultimately prove it. Our point is that they haven't either pled -- have not and cannot plead causation here.

This is important. So this is proximate causation. Woodward is very clear. Oklahoma law precludes liability when the connection between an alleged harm and the challenged conduct is too remote, too attenuated, or is broken by superseding intervening events -- causes, excuse me.

And we'll get through it, because if you look at the State's petition, they're seeking damages, they're seeking recovery for monies that they paid through their Medicaid program or prescriptions. So they're kind of looking for their out-of-pocket expense for supposedly improper prescriptions. But then they have a much broader and much more ambitious list of damages, including social harm -- I won't go through the whole list. But for each of those, you need to look to see whether they have actually pled proximate cause.

Here -- I don't need to read this to you, but here, if you look at the way that pharmaceuticals -- and again, these are

EXHIBIT 7

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
(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.	)	

PORTIONS OF THIS TRANSCRIPT ARE CONFIDENTIAL UNDER PROTECTIVE ORDER AND UNDER SEAL

TRANSCRIPT OF PROCEEDINGS
HAD ON SEPTEMBER 27, 2018
AT THE CLEVELAND COUNTY COURTHOUSE
BEFORE THE HONORABLE WILLIAM C. HETHERINGTON, JR.,
RETIRED ACTIVE JUDGE AND SPECIAL DISCOVERY MASTER

REPORTED BY: ANGELA THAGARD, CSR, RPR

Honor, but again, we stand by that these things have been addressed in the production of documents.

MR. BECKWORTH: Your Honor, just real briefly. All this is before you. It's been before you since you ruled in April. I shouldn't have to come in here and keep filing motions saying I didn't get this stuff. I shouldn't.

And whatever he's talking about that may or may not have been produced, it shouldn't take a motion to show cause to get it two days later. That tells me it was, in fact, a push of a button.

MR. LAFATA: That's all incorrect.

MR. BARTLE: Your Honor, may I just say a few words? Thank you, Judge. I wasn't planning on speaking today. This wasn't a motion against Teva, but obviously, things came up.

First, your Honor, I don't ever remember pounding on any table in any courtroom. And if I did, I certainly apologize for that. With regard to, you know, Mr. Beckworth's repeated comments, which are odd to me, that perhaps he may be hurting people's feelings, I want to assure him -- and I spent five years in the Marines, Judge. I've been yelled at by professionals. He and his team don't come even close. So I can assure them that they shouldn't necessarily worry about that.

You know, there are two sides to every story, Judge. I think there was a -- I'm old enough to remember Paul Harvey.

He used to start every radio show with, Now for the rest of the story. I saw Mr. Beckworth characterize a settlement of the patent litigation as conspiracy. To me, it's a settlement of a patent litigation.

Everything about the 245 prescriptions that I said at every previous hearing and this one are true. They're in their complaint and the basis of their fraud claims. It's amazing to me that they cite in Exhibit 3 to their -- they list them specifically in Exhibit 3 to their complaint -- I'm sorry, their petition -- and say it in their petition, yet every time I say it, it causes a huge rise on this side of the table.

If they want to change their complaint to include generics, Judge, they can do it. But from our perspective, as we sit in correspondence to the Court, generics aren't part of this case. Generics weren't promoted.

This is a fraud case, Judge. It's a fraud case. That's what this case is. It's fraud. It's not the fact that Teva entered into a patent litigation -- or a settlement patent litigation with Purdue. It's about promotion.

I still don't know, because the State still won't tell me, what fraudulent misrepresentations any doctor in Oklahoma relied upon to issue any Teva prescription to any Oklahoma patient. I still don't know that. Either they can't tell me, or they won't. But they can't.

So when I talk about those 245 prescriptions, Judge, which

is the basis of their fraud claims here, that's from their petition. I didn't make that up. I didn't pull that out of thin air. And they're going to get up here and say something about how this is all about generics and I'm misreading their petition, but I'm not. And the petition says it.

Also, Judge, you know, every time we come here, talk about my clients killing people, my clients murdering people, these are FDA approved critical drugs that make people able to live their lives without pain. My client makes oncology drugs. Cancer patients.

In my view, that's a great thing. The cancer patients who are going through some of the most painful things that anybody could imagine -- I've never had cancer, hope I never do. I've seen people go through it. It's horrible. I'm sure everybody has.

My client makes a drug that lets them live their lives. My client's not a murderer. Didn't kill anyone. Didn't prescribe a single drug in the state of Oklahoma. And they talk about, Oh, we talk about doctors.

The doctors of Oklahoma prescribe these drugs. These are doctors who went to medical school, often had residencies and fellowships. Every one of these drugs on the label, it says Schedule II. It's a Schedule II drug. It wasn't a secret.

And they talk about sales reps misrepresenting. Sales reps -- the sales reps that I've been to and read, testified

they promoted the drug on label in accordance with the label -- the FDA approved label. Nothing wrong with that. Nothing illegal about it.

So if they're going to assert my client's a murderer, then I should know -- and this might be the subject of a motion to compel -- the basis for those claims. And I think it's frankly unhelpful. It's unhelpful for this case.

I could file a motion to compel tomorrow on the State. They're doing a rolling production. I get it; it's hard. We're doing a rolling production. We produce millions of documents. But it's unhelpful to have these continual motions to compel when they're working as hard as they can, we're working as hard as we can.

But from my view, your Honor, again, I was not planning on speaking today. Apparently, they were aware that this motion had nothing to do with my client. We're working very hard to produce documents, and we produced documents. They cited some of them today. And we're going to continue to produce them.

But these uniseriate motions to compel are unhelpful because it forces everyone to come here for something that they're working hard to produce documents, we're working hard to produce documents.

And in my view, I think that some phone calls and perhaps letters, we would be better served by that, than by wasting the Court's time with motions to compel. Thank you.

EXHIBIT 8

IN THE DISTRICT COURT OF CLEVELAND COUNTY

STATE OF OKLAHOMA

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

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TRANSCRIPT OF PROCEEDINGS
HAD ON OCTOBER 3, 2018
AT THE CLEVELAND COUNTY COURTHOUSE
BEFORE THE HONORABLE THAD BALKMAN
DISTRICT JUDGE
AND WILLIAM C. HETHERINGTON, JR.,
RETIRED ACTIVE JUDGE AND SPECIAL DISCOVERY MASTER

REPORTED BY: ANGELA THAGARD, CSR, RPR

Think of the importance for my defense of getting access to know who the doctors were, who the patients were, and getting access to be able to do the discovery about this.

The State's case, the State's theory is that the physicians were somehow misled about what the risks and consequences of the drugs were. Under the TIRF REMS program, I can specifically show they were not misled.

Both the physician and the patient had the FDA approved materials about these specific drugs. It directly refutes the plaintiff's case. I'm entitled to discovery to get access to that information.

Here's what else is going on. Paragraph 67 of the petition, the plaintiff alleges that the defendants somehow convinced the doctors that opioids were effective for noncancer pain, and that's part of the State's case.

Well, under the TIRF REMS program, I think I'm going to be able to show of these 245 prescriptions, not one of them was for anything except cancer. I think I'm going to be able to show that, but I've got to get discovery on that claims data and be able to show that.

And there's no reason to play cat and mouse about it. They had the 245 claims in front of them when they made Exhibit 3. We don't need to argue, we don't need to hypothesize, we don't need to guess about which 245 claims it is. They know. They just need to give us the data.

Now, I anticipate -- I anticipate the State will want to advance a couple of arguments. I think they're going to want to talk about generic drugs. Now, keep in mind I represent more than one defendant here. Actavis Pharma, Inc., for example makes generic opioid.

The generics, they're a different deal. They're not branded. They don't do advertising. That's a different argument for a different day. The argument I'm making today is about Cephalon. Those drugs are branded. It's different from the generics.

I also anticipate the State will argue that, Well, Robert's clients are all in the same corporate family, so you just -- just wrap it all up into one, and just call it one big ball of wax. But the law -- the law of the state of Oklahoma has always recognized the existence of corporations.

The law of Oklahoma has always been that you cannot just assume that we're going to automatically pierce the corporate veil and ignore the existence of different corporations. And the State agrees with me on that.

That's the reason they named Cephalon separately as a defendant, because it's a separate corporation. That's the reason why they made separate allegations in paragraphs 37 about Cephalon. And I'm entitled to the information allowing me to defend Cephalon.

In conclusion, your Honor, I hope the Court will not lose

sight of the overall posture of this case. The State is the plaintiff. The State is seeking to penalize our clients, not only to impose liability, but to impose penalties. They're asking for penalties under the Fraud Control Act. They're asking for penalties under the Medicaid Program Integrity Act.

The plaintiff wants to penalize our clients based on the State's allegations that, Well, the physicians received some representations, those representations were material to the prescribing decision. The physician relied on those representations when they made the decision to prescribe that drug for that patient.

They want to impose penalties on that theory. But when we ask for discovery to find out, are those facts actually true, the State says, No, no, that's secret, that's secret, you don't get to know that.

That posture, that flies in the face of our entire system of justice. We are entitled to the information. We're entitled to defend our client. And we're entitled to the information under the Oklahoma Discovery Code. It's clearly required and clearly required under the due process clauses of the Oklahoma Constitution and the Federal Constitution. Thank you.

THE COURT: Thank you, Mr. McCampbell.

MR. COATS: On behalf of Purdue, we won't make a separate argument. We'll just adopt the arguments made by

EXHIBIT 9

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

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

Plaintiffs

vs. Case 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 LYNN WEBSTER, M.D.

TAKEN ON BEHALF OF THE PLAINTIFF

ON FEBRUARY 18, 2019, BEGINNING AT 9:11 A.M.

IN SALT LAKE CITY, UTAH

REPORTED BY: VICKIE LARSEN, CSR/RMR

A. That's correct.

Q. And prior to OxyContin hitting the market, there had never been an extended release oxycodone product; isn't that right?

A. I wasn't aware of it.

Q. Right. And so physicians' experience with oxycodone at that point in time before OxyContin was launched was with combination products; correct?

A. That's correct.

MR. DUCK: Would you guys like to take a break?

THE WITNESS: Yeah, I could go to the bathroom.

MR. ROBINSON: You need one?

THE WITNESS: Yeah.

THE VIDEOGRAPHER: Off the record. The time is 10:27.

(There was a break taken.)

THE VIDEOGRAPHER: Returning on the record, the time is 10:35.

Q. BY MR. DUCK: You mentioned earlier that you personally have been visited by sales representatives; right?

A. Yes.

Q. And you've been visited by Purdue sales representatives?

A. Oh, yes.

Q. Are you aware that Purdue and the other defendants in this lawsuit refer to physicians upon whom they call as "targets"?

MR. EHSAN: Object to form.

MR. ERCOLE: Objection to form.

THE WITNESS: You know, I don't know about targets.

Q. BY MR. DUCK: You never heard that before?

A. No.

Q. Do you know that you had been specifically identified by these defendants as a target?

MR. HOFFMAN: Objection to form.

THE WITNESS: No.

Q. BY MR. DUCK: Did you know that you had been specifically identified by Purdue as a key opinion leader target?

MR. HOFFMAN: Objection. Foundation.

THE WITNESS: No.

Q. BY MR. DUCK: Has any sales representative ever referred to you to your face as a target?

A. No.

Q. I'll give you an example here of a document we'll mark as Exhibit 6. This was used in a prior deposition, so that's why there's another sticker on it.

(Exhibit 6 was marked for identification.)

Q. BY MR. DUCK: You see this -- this document Exhibit 6 is titled "Proposed Target KOLs For PPR Communications"?

A. I see it.

Q. You see who the last person on the list is?

A. Yes.

Q. It's your name; right?

A. That's my name.

Q. Do you recognize some of the other names on this list?

A. I do.

Q. Do you know who Charles Argoff is?

A. I do.

Q. Do you know who Gerry Aronoff

is?

A. Yes.

Q. How about Myra Christopher?

A. Yes.

Q. Ted Cicero?

A. Yes.

Q. Barry Cole?

A. Yes.

Q. June Dahl?

A. Yes.

Q. Perry Fine, you know him; right?

A. Yes.

Q. He's from Salt Lake City; correct?

A. Correct.

Q. You've done a lot of work with Perry Fine?

MR. ROBINSON: Form.

THE WITNESS: I don't know that I've done a lot of work with Perry Fine, no.

Q. BY MR. DUCK: Okay. He's someone you've worked with in the past?

MR. ROBINSON: Form.

You can answer.

THE WITNESS: We've been on maybe a -- on stage together or to talk on CMEs, but we've never done research or any formal work together. Maybe an ADCOM, but not very often.

Q. BY MR. DUCK: Okay. You'll see Scott Fishman, you know who that is?

A. Yes.

Q. And you see Aaron Gilson there?

A. Yes.

Q. And I mentioned to you earlier, he gave a deposition in this case?

A. You did.

Q. And then we also see Russ Portenoy on the right side?

A. Yes.

Q. Alan Spanos, do you know who that is?

A. I do -- Alan Spanos. No, I don't know that. I know the name, but I don't know him.

Q. Do you know anything about him?

A. No.

Q. And, again, you're the last

person on this list; right?

A. Yes.

Q. So how long have you been practicing, Dr. Webster?

A. I started practice in 1980.

Q. 1980. So --

A. I practiced for 30 years before I then moved to doing just clinical research.

Q. Okay. 30 years of practice?

A. Of seeing patients.

Q. Of seeing patients.

During that time you were visited by sales representatives; right?

A. Yes.

Q. And until today, you had never seen the phrase "target" with respect to these companies identifying who they would use, who they would call on; right?

MR. ERCOLE: Objection to form.

THE WITNESS: I've never seen or heard that term, except I know that I was a -- a KOL and that -- because of the amount I published and the respect I have in the field that -- that people sought out my opinion.

Q. BY MR. DUCK: Do you know what IMS data is?

A. Yes.

Q. You're aware that companies use IMS data?

A. Yes.

Q. And you -- you know that IMS data shows prescribing volume for a particular physicians; correct?

A. Yes.

Q. So Purdue, for instance, can determine what kinds of opioids you've prescribed and how often you've prescribed them?

A. That's what I understand.

Q. And you're aware that these companies take IMS data and rank physicians in what they call deciles?

MR. ERCOLE: Objection to form.

MR. HOFFMAN: Objection. Form.

THE WITNESS: I have heard that, yes.

Q. BY MR. DUCK: And the top deciles are typically the primary targets of these defendants. Did you know that?

well -- sorry. On the first page, you see this is the 2003 GAO Report to Congressional Requesters. The title is "Prescription Drugs OxyContin Abuse and Diversion and Efforts to Address the Problem"; correct?

A. Yes.

Q. Were you aware there was an OxyContin specific GAO report?

A. You know, I can't remember at this time if I was aware of it.

Q. Okay. On the second page there is a highlights column on the left-hand side, and there is a section entitled "Why GAO Did This Study."

Do you see that?

A. Yes.

Q. And you're aware that "GAO" stands for the United States General Accounting Office?

A. Correct.

Q. And that section states, "Amid heightened awareness that many patients with cancer and other chronic diseases suffer from undertreated pain, the Food and Drug Administration (FDA) approved Purdue Pharma's

controlled-release pain reliever OxyContin in 1995. Sales grew rapidly, and by 2001 OxyContin had become the most prescribed brand-name narcotic medication for treating moderate-to-severe pain. In early 2000, reports began to" suffer about -- "surface about abuse and diversion for illicit use of OxyContin, which contains the opioid oxycodone. GAO was asked to examine concerns about these issues. Specifically, GAO reviewed (1) how OxyContin was marketed and promoted (2) what factors contributed to the abuse and diversion of OxyContin, and (3) what actions have been taken to address OxyContin abuse and diversion."

Did I read that right?

A. Correct.

Q. All right. And on the right side we see the section of this report entitled "What GAO Found"; right?

A. Correct.

Q. All right. That states, "Purdue conducted an extensive campaign to market and promote OxyContin using an expanded sales force to encourage physicians,

including primary care specialists, to prescribe OxyContin not only for cancer pain, but also as an initial opioid treatment for moderate-to-severe noncancer pain. OxyContin prescriptions, particularly those for noncancer pain, grew rapidly, and by 2003 half of all OxyContin prescribers were primary care physicians. The Drug Enforcement Administration (DEA) has expressed concerns that Purdue's aggressive marketing of OxyContin focused on promoting the drug to treat a wide range of conditions to physicians who may not have been adequately trained in pain management. FDA has taken two actions against Purdue for OxyContin advertising violations. Further, Purdue did not submit an OxyContin promotional video for FDA review upon its initial use in 1998 as required by FDA regulations."

Did I read that paragraph right?

A. Yes.

MR. HOFFMAN: Object to form. Foundation.

abuse. Moreover, the significant increase in OxyContin's availability in the marketplace may have increased opportunities to obtain the drug illicitly in some states. Finally, the history of abuse and diversion of prescription drugs, including opioids in some states, may have predisposed certain areas to problems with oxycodone. However, GAO cannot assess the relationship between the increased availability of OxyContin and locations of abuse and diversion because the data on abuse and diversion are not reliable, comprehensive or timely."

Did I read that right?

A. Yes.

Q. You're aware that around this time what have been referred to as "hot spots" of OxyContin abuse were cropping up?

MR. HOFFMAN: Objection to form.

THE WITNESS: I -- you know, I -- that sounds vaguely familiar, but I'm -- I'm not keenly tuned in to that.

Q. BY MR. DUCK: And were you

aware that Purdue aggressively promoted OxyContin following its launch?

MR. HOFFMAN: Object to form. Foundation.

THE WITNESS: I'm not aware of Purdue's marketing plan.

Q. BY MR. DUCK: And the documents we've looked at today, in particular the Richard Sackler speech, suggested that OxyContin would be aggressively promoted such that a blizzard of prescriptions would follow; correct?

MR. HOFFMAN: Object to form. Foundation.

THE WITNESS: I think that's what it implies for sure.

Q. BY MR. DUCK: If you'll turn to Page 6. The very last paragraph of this Page 6 says, "We received comments on a draft of this report from FDA, DEA, and Purdue."

You see that?

A. Yes.

Q. The last sentence of this -- well, let me just keep reading. It goes on, "Purdue agreed with our recommendation that

risk management plans for Schedule II controlled substances contain a strategy for monitoring" -- "monitoring and identifying potential abuse and diversion problems. DEA reiterated its statement that Purdue's aggressive marketing of OxyContin exacerbated the abuse and diversion problems and noted that its -- it is essential that risk management plans be put in place prior to the introduction of controlled substances into the marketplace. Purdue said that the report appeared to be fair and balanced, but that we should add that the media is one of the factors contributing to abuse and diversion problems with OxyContin. We incorporated their technical comments where appropriate."

Were you aware that Purdue had stated that this GAO report was fair and balanced?

A. I don't remember being aware of that.

MR. HOFFMAN: Sorry. Object to the form. Foundation.

Q. BY MR. DUCK: And you have no reason to disagree with the DEA's statement

physicians?

MR. ERCOLE: Objection to form.

MR. ROBINSON: Objection.

THE WITNESS: I think back in the '90s that sales reps were supposed to educate.

Q. BY MR. DUCK: Okay. And you've seen from the documents so far that the primary targets for Purdue, at least, were primary care physicians; right?

MR. HOFFMAN: Object to form. Foundation.

THE WITNESS: Well, you've shown me documents here. I'm not sure these -- this is proposed targets. I don't think these are primarily --

Q. BY MR. DUCK: Well, you saw the GAO report; right?

A. Yeah, I saw that.

Q. And you saw that more than half of prescribers of OxyContin at the time of that report in 2003 were primary care physicians?

MR. HOFFMAN: I'm sorry, misstates the document. It says

"nearly half," it doesn't say "more than half."

Q. BY MR. DUCK: All right. The GAO report says that nearly half of the prescribers of OxyContin were primary care physicians; right?

A. Most physicians who prescribe medications are primary care. There are far more physicians -- primary care physicians than there are specialists, so it would be -- it would be obvious that -- that primary care would probably prescribe more of all drugs, not just opioids.

Q. Yeah, and maybe that's the reason why Purdue targeted primary care -- primary care physicians?

A. I don't know why --

MR. HOFFMAN: Objection to form.

MR. ROBINSON: Objection.

THE WITNESS: I don't know why they targeted.

Q. BY MR. DUCK: Okay. So did you know that sales representatives don't even have to have a science degree? They could be

an English major. Did you know that?

A. Yes.

MR. HOFFMAN: Objection to form.

Q. BY MR. DUCK: Does that surprise you?

A. You know, it doesn't matter who they are, to me, because I evaluate the science based upon my knowledge and expertise, not really what a sales rep is going to provide me.

Q. How do you feel about an art history major educating primary care physicians about OxyContin in the 1990s?

MR. HOFFMAN: Object to form. Lacks foundation.

THE WITNESS: No art history major tried to educate me.

Q. BY MR. DUCK: How do you feel about a graphic design major trying to educate a family doctor about OxyContin in 1998?

MR. HOFFMAN: Object to form.

MR. ROBINSON: Objection. Form. Foundation.

Q. BY MR. DUCK: It's preposterous, isn't it, sir?

A. Well, I don't know what they're trying to educate. I know what it is -- if they're just bringing them literature as a courier or as a librarian. I mean, librarians can teach too. I mean, I'm not here to say that's good or bad, because I don't know what it is that they did.

Q. BY MR. DUCK: And did you know that Purdue had over a thousand sales representatives at a point in time?

A. I have no idea what Purdue did.

MR. HOFFMAN: Object to form. Lacks foundation.

Q. BY MR. DUCK: No idea?

A. No idea.

Q. Are you defensive at all of Purdue's marketing?

MR. ROBINSON: Objection.

THE WITNESS: Defensive?

MR. DUCK: Yeah.

THE WITNESS: You mean do I think they did everything right?

MR. DUCK: Right.

side.

A. Yeah, okay.

Q. Okay. You see we've got this media coverage section. And you're mentioned there in the second bullet point, it says, "Recent coverage has increased slightly as a result of the investigation of AAPM President Dr. Webster. His practice is under investigation for several deaths that occurred throughout the years, but he is still highly respected and defended among peers."

Do you see that?

A. Yes.

Q. And then below that there's a partnership section. You see that?

A. I do.

Q. "Corporate members include Endo, Medtronic, Neurogesx, Pfizer, PriCara, Purdue, Horizon, and Teva. Corporate members receive a logo/description on the website, participate in the annual corporate ad board, acknowledgment in the quarterly publication and annual meeting program book, and logo inclusion/advertising at the annual meeting.

Cost is 9,500" bucks.

See that?

A. Yes.

Q. There's also mention here to a survey sponsored by APS and AAPMed along with Janssen Pharmaceutica; right?

MR. ERCOLE: Objection to form.

THE WITNESS: It says that.

Q. BY MR. DUCK: Do you remember working with Janssen on that?

MR. ROBINSON: Objection.

Form. Read the entire bullet.

THE WITNESS: I don't remember that.

Q. BY MR. DUCK: Okay. Last bullet says, "Teva is also currently working with the organization on a partnership to create awareness of the individual burden of pain."

Do you recall that?

A. I don't recall it specifically. I know that AAPMed continually worked to try to bring awareness to the burden of pain, and Teva could have been one of the partners.

Q. Okay. If you'll flip the page

to Page 13, and remember the page. It's weird how you got to flip.

A. Yeah.

I think they're setting up our lunch. Okay.

Q. Now we've got the influence section here, and it says, AAPM is very active on the Hill, both on a state and national level and frequently issue position papers."

Do you see that?

A. I see it.

Q. AAPM had a lobbying aspect to it?

A. No. It had a partnership within the Pain Care Coalition who had a -- I believe it had lobbying. But we never had anything that was directly lobbying.

Q. What was the Pain Care Coalition?

A. It's a group of organizations like the American Society of Anesthesiologists and the American Academy of Pain Medicine, one or two other organizations.

Q. Who started the Pain Care Coalition?

A. I have no idea.

Q. It states, "It also worked as part of a coalition with AAPM's committee for legislative affairs, the Pain Care Coalition, the American Pain Foundation, and other organizations to secure the inclusion of pain care in the ACA and the passage of two bills, the 2009 National Defense Authorization Act, and the Veteran's Pain Care Act of 2008, provides a continuous stream of updates on national and state legislation. Finally, AAPM points more than 40 state representatives to monitor local issues and assist in the quest for pain medicine specialty recognition"; right?

A. Yes.

Q. Third bullet point states, "AAPM is committed to helping meet the deliverables identified in the IOM report. Many of the AAPM's current educational efforts can be viewed here," and there's a link; correct? Right?

A. That's correct.

so-called KOLs have given depositions, testimony in this case; right?

MR. ROBINSON: Objection. To the extent you know anything personally outside of any communications you've had with counsel.

THE WITNESS: I do not.

MR. EHSAN: Objection to the form.

MR. ERCOLE: Same objection.

THE WITNESS: I do not know.

Q. BY MR. DUCK: Would it surprise you to learn that other KOLs that have testified in this case feel that they were used by the pharmaceutical companies --

MR. EHSAN: Objection.

Q. BY MR. DUCK: -- that are defendants in this case?

MR. ERCOLE: Objection.

MR. ROBINSON: Objection.

THE WITNESS: I'd be surprised if that's what they thought.

Q. BY MR. DUCK: You would be?

A. Uh-huh.

Q. Because you don't feel that way?

A. No.

Q. You don't feel like they used your influence to increase prescriptions of their drugs?

A. No, I do not.

Q. You don't feel that they asked you to be a key opinion leader or presenter for them to increase peer to peer influence opportunities?

A. No, I think that that might be true.

MR. EHSAN: Objection. Form.

THE WITNESS: I mean, I think that I'm well respected in my field, and so to ask me to be involved in anything that they're doing would probably be something useful to them. But that doesn't mean that I -- I did anything to help them.

Q. BY MR. DUCK: Well, that may not have been your intent, and that's not my question.

My question is, you would agree

that -- I think this is what you just said -- that these defendants asked you to do things because they perceived a business positive?

MR. EHSAN: Objection to form.

MR. ERCOLE: Same objection. Mischaracterizes testimony.

MR. EHSAN: Object to form.

THE WITNESS: I've never perceived it that way. I've always perceived it that they respect what I stand for and they appreciate my views, and so they've asked me to give -- probably be engaged because of that.

Q. BY MR. DUCK: Now, if your views were that opioids were terrible drugs that should never be prescribed, these defendants probably wouldn't have had you speak for them, would they?

MR. HOFFMAN: Object to form.

MR. ERCOLE: Same objection.

THE WITNESS: I always lectured about how harmful they were. That's -- that's what I lectured about. I rarely said anything other

A. Correct.
Q. Some of the medicines can be short-acting opioids?
MR. DUCK: Objection to form.
THE WITNESS: Some can be short-acting.
Q. BY MR. ERCOLE: There can be long-acting opioids?
MR. DUCK: Objection to form.
THE WITNESS: Yes.
Q. BY MR. ERCOLE: Are there other differences between --
A. Rapid onset, intra- -- intrathecal.
Q. Any others?
A. No.
Q. Yeah, do you want to explain what you mean by "rapid onset opioids"?
A. I think of transmucosal as -- as a rapid onset. So something that's quickly absorbed so that immediate onset, and it's usually transmucosal. So Actiq would be that example, or Fentora.
Q. When you say "transmucosal" -- sorry, just for breaking it down even

farther -- what do you mean by that?

A. Well, you -- it's something you place in your mouth, and you place it on the mucosa, which is the inner lining of your mouth. And that then goes across into the blood stream and is picked up. So that's transmucosal. So the mucous, mucosa, mucosa, so it's transmucosa.

Q. And you mentioned "intrathecal," what do you mean by that?

A. That's giving it into the spinal canal.

Q. Is it fair to say that with respect to opioid manufacturers, different opioid manufacturers may engage in different types of promotional activities based upon the -- the medicine that they manufacture?

MR. DUCK: Objection. Form.

THE WITNESS: Yes.

Q. BY MR. ERCOLE: And some manufacturers -- like some generic manufacturers may not even promote their medicines to doctors at all; is that fair to say?

MR. DUCK: Objection to form.

THE WITNESS: There are -- yes, a lot of generics don't spend any money on marketing or reaching out to doctors.

Q. BY MR. ERCOLE: And is it fair to say that you can't just lump all opioid manufacturers together just like you can't lump all physicians together?

MR. DUCK: Objection to form.

THE WITNESS: Well, I think -- it depends upon what level you're talking about. I mean, I think there is -- each company is different, and so they've got different products so they would be different.

Q. BY MR. ERCOLE: Have you ever heard of the company Actavis Pharma, Inc.?

A. Yes.

Q. Do you recall any communications that you've had with Actavis Pharma, Inc.?

A. No, I don't recall it. It's possible, but I don't recall.

Q. Do you recall, sitting here today, any funding that you would have

received from Actavis Pharma, Inc.?

A. I -- I can't recall ever receiving funding.

Q. Are you aware of any promotional or marketing statements about opioids that were ever made by Actavis Pharma, Inc.?

A. I cannot recall.

Q. Assuming -- sitting here today, you're unaware of any false or misleading statements that would have been made by Actavis Pharma, Inc.?

A. I don't --

MR. DUCK: Objection to form.

THE WITNESS: I don't recall.

Q. BY MR. ERCOLE: Have you ever had any communications with Watson Laboratories, Inc.?

A. I know one of my former employees moved to Watson, and so what do you mean "communication"? I'm not sure I talked to him about anything they were doing, so it kind of depends on what your question is.

Q. Fair enough.

Do you recall receiving any

funding from Watson Laboratories, Inc.?

A. No.

Q. Do you recall any promotional or marketing statements about opioids from Watson Laboratories, Inc.?

A. I don't recall any.

Q. Are you aware of any false or misleading statements by or attributable to Watson Laboratory, Inc.?

MR. DUCK: Objection to form.

THE WITNESS: I haven't seen anything from them, I don't believe.

Q. BY MR. ERCOLE: And counsel today for the -- for the State never mentioned Actavis Pharma, Inc.; correct?

MR. DUCK: Objection to form.

THE WITNESS: I don't remember that being mentioned.

Q. BY MR. ERCOLE: Sure. He never showed you any documents involving Actavis Pharma, Inc., did -- did they?

A. No, I don't think so.

MR. DUCK: Objection to form.

Q. BY MR. ERCOLE: With respect to Watson Laboratories, Inc., did counsel for

the State today ever show you any documents concerning Watson Laboratories, Inc.?

A. Not that I'm familiar. No, I don't recall.

Q. Did counsel for the State ever reference Watson Laboratories, Inc.?

A. I don't believe so.

Q. How about Actavis, LLC, have you ever heard of that entity?

A. Well, I know Actavis. I don't know what the other part of it is, and if there's a difference.

Q. Sure. About -- ever received, to the best of your recollection, any funding from Actavis, LLC?

A. Not that I recall.

Q. Are you aware of any -- aware of any promotional or marketing statements about opioids that were ever made by Actavis, LLC?

A. No.

Q. Aware of any false or misleading statements attributable to Actavis, LLC --

A. No.

Q. -- sitting here today?

A. No.

Q. You've -- counsel for the State mentioned -- has used the word -- the name "Teva."

Do you recall that?

A. Yes.

Q. And counsel for the State never differentiated as to what Teva entity it was referring to or not referring to, but have you ever heard of the -- of the company Teva Pharmaceuticals USA?

MR. DUCK: Objection to form.

THE WITNESS: You know, I think of Teva as Teva, and I'm not sure I know the difference with -- if there are different Tevas.

Q. BY MR. ERCOLE: Fair enough.

Are you aware of any false or misleading statements, sitting here today, that Teva USA has made?

MR. DUCK: Objection to form.

THE WITNESS: No.

Q. BY MR. ERCOLE: Are you aware of any marketing at all that Teva USA has

done regarding opioids in Oklahoma?

MR. DUCK: Objection to form.

THE WITNESS: No.

Q. BY MR. ERCOLE: There was some discussion earlier about Cephalon. Do you recall that?

A. Yes.

Q. Cephalon is different than Teva; correct?

A. Well, I don't know what you mean by that. Cephalon is what developed Fentora and Actiq, and it was acquired by Teva, is what my understanding is. So it was a different company, but then it folded into Teva, is what my understanding is.

Q. Would you be surprised to learn that Teva USA and Cephalon are two distinct companies even today?

MR. ROBINSON: Objection.

Form.

THE WITNESS: I guess I would be surprised. I didn't know that.

Q. BY MR. ERCOLE: With respect to Cephalon, at any stage in time are you aware of any false or misleading statements that

Cephalon has ever made?

MR. DUCK: Objection to form.

THE WITNESS: Only what was presented to me today that the Cephalon admitted to doing something wrong.

Q. BY MR. ERCOLE: You have no independent knowledge of that; correct?

MR. DUCK: Objection. Form.

THE WITNESS: That's correct, I don't.

Q. BY MR. ERCOLE: And you have no independent knowledge, is it fair to say, of any -- of any false or misleading statements that Cephalon has ever made in the state of Oklahoma; is that fair to say?

MR. DUCK: Objection to form.

THE WITNESS: That's correct.

Q. BY MR. ERCOLE: And sitting here today, there were no documents presented to you showing any false or misleading statements made my Cephalon in the state of Oklahoma; correct?

A. Again, it's one document that -- that the executives -- or there was

some kind of fine, and I don't know if that applied to Oklahoma or not.

Q. Are you aware that that was -- are you aware that that was -- that addressed the issue of off-label promotion?

A. That's what he -- that's what I learned today.

Q. Sure. And we'll get into sort of off-label prescribing issues, but is it fair to say that off-label prescribing can, in some instances, form the appropriate standard of care for patients?

MR. DUCK: Objection to form.

THE WITNESS: Off-label prescribing is common. 30 to 40 percent, probably, of all -- of all prescribing across the board, all medicines, is off-label. And it's -- it's not uncommon to off-label -- prescribe off-label and that's why -- well, it's just not uncommon.

Q. BY MR. ERCOLE: And what is sort of off-label prescribing, just to give some additional context there?

A. It just means --

MR. ROBINSON: Objection.
Form. In context, you talking today?
Q. BY MR. ERCOLE: I'm talk- -- at any -- at any point in time, you know, have you as a trained medical professional always attempted to make prescribing decisions in the best interest of your patient?
A. I think the key there is "attempted," key word.
Q. There was some discussion earlier today about visits by sales representatives.
Do you recall that?
A. Yes.
Q. As a trained medical professional, did you ever prescribe a medicine because of some statement a sales representative would have said to you?
MR. DUCK: Objection. Form.
THE WITNESS: I think that sales -- sales reps, or MSLs, whatever they may be called, had -- did have influence by providing me data, information. I think it was very useful sometimes.

So, yes, I think they do. They -- they could -- they influenced me and I think they do influence physicians.

Q. BY MR. ERCOLE: And at the end of the day, is it -- is it fair to say that with respect to your prescribing as the trained medical professional, you are the one that exercises your own independent medical judgment as to what is in the best interest of the patient?

MR. ROBINSON: Objection. Asked and answered.

Go ahead.

THE WITNESS: Ultimately, it's always my decision, regardless of what somebody else has said, even another physician. It's still -- if I write the script, I'm responsible.

Q. BY MR. ERCOLE: Sitting here today, are you aware of any false or misleading statement that any sales representative has ever made to you about opioids?

MR. DUCK: Objection to form.

THE WITNESS: Well, I can't -- I can't remember -- I can't remember anything that was false, but I do remember one time when a rep came in to me and wanted -- and was recommending that I use the medicine for postop pain, OxyContin, you know, for example.

And I had told the rep that I didn't think that was appropriate. It was an extended release for a short period of time, and I did not believe that was appropriate.

Now, I've learned that it's very widely used for postop pain, for postop acute pain, but I was uncomfortable that the rep said that to me, and she never repeated it.

Q. BY MR. ERCOLE: And in that instance, you chose not to use the medicine for postop pain --

A. That's correct.

Q. -- in that case?

A. And I told her she shouldn't be detailing it that way.

credentialing bodies, and they're the ones who have to review with their independent sources the content to make sure that it's fair and balanced.

Q. And with respect to CMEs that you were involved in, did you develop the content of those CMEs?

A. Often, not always. I may not have had 100 percent input in all of them, but most of the time I would contribute most of the content.

Q. And are you aware -- strike that.

With respect to any of the CMEs that you were involved in, are you aware of any false or misleading statements that were made?

MR. ROBINSON: Objection.

MR. DUCK: Objection to form.

MR. ROBINSON: Form.

THE WITNESS: I'm not aware of anything false that I've ever said, except maybe to my wife -- no.

Q. BY MR. ERCOLE: There was some -- you mentioned before that you've

given CMEs about the risks and abuses -- well, the risk potential and abuse potential of opioids; correct?

A. Correct.

Q. And was that the -- strike that.

When you say "risk potential and abuse potential of opioids," what are you referring to there?

MR. DUCK: Objection to form.

THE WITNESS: Well, and all opioids have a risk of contributing to abuse, addiction, overdose, and death.

And so most of my lectures were to try to help physicians learn how to assess for that risk, and so that's -- that's really a large part of it.

And different molecules would have different risk profiles, and whether they were short-acting, rapid onset, or extended release. So it was all about trying to educate risk mitigation to the prescribers.

Q. BY MR. ERCOLE: And the -- those CMEs that you're talking about here,

they would have been developed independent of pharmaceutical companies; correct?

MR. DUCK: Objection to form.

THE WITNESS: By CM- -- by the definition of CME, they are independent. They're funded by pharma, but they're not developed by pharma.

Q. BY MR. ERCOLE: Sure. With respect to that funding, are you aware of any CME where -- that you were involved in where the funding somehow influenced the particular opinion or discussion you were giving?

MR. DUCK: Objection to form.

THE WITNESS: I would not have contact with the company, so I wouldn't know that.

Q. BY MR. ERCOLE: And sort of the -- strike that.

With respect to there was some discussion, I believe, of speaker programs --

A. Yes.

Q. -- earlier.

What's a speaker program?

A. Those are promotional programs.

Those are educational but promotional. I mean, those are where pharmaceutical companies or device companies contract with physicians to talk about their product in a promotional way.

Q. And did you serve as a speaker for Cephalon at some point?

A. I think Cephalon is the only company that I did that with for a short time, and I can't remember how long, but I did speak on the speaker bureau. The content was not promoting their product, though. I only spoke about the risk and abuse, and that's the reason I would do it.

Q. And with respect to the -- the speaker programs that you did for Cephalon, the opinions you gave regarding risks and abuse, those were your own opinions; correct?

MR. DUCK: Objection to form.

THE WITNESS: Yes, that's correct.

Q. BY MR. ERCOLE: And you wouldn't have done those speaker programs if they weren't your opinions; is that fair to say?

MR. DUCK: Objection to form.

THE WITNESS: That is absolutely correct. Much of it was based on my research and science. And so, I mean, most of the -- of what's been developed in this field is -- is really come from my research and helped physicians understand what the risks are and how to mitigate those risks.

Q. BY MR. ERCOLE: And with respect to speaker programs that you did, do you feel like they were helpful to physicians?

MR. DUCK: Objection to form.

THE WITNESS: I was hopeful that they were helpful.

Q. BY MR. ERCOLE: How about with respect to the CMEs?

MR. DUCK: Objection to form.

THE WITNESS: So, yes, I mean, I think when you can put out good science that is new, I'm hoping that -- and -- because it was the topic area, I was hoping that it was useful

to the doctors.

Q. BY MR. ERCOLE: Anything -- anything false or misleading that you can recall ever saying in any speaker program that you were involved in?

MR. ROBINSON: Objection to form.

MR. DUCK: Objection to form.

THE WITNESS: No.

Q. BY MR. ERCOLE: Dr. Webster, you've written books about opioids; is that fair to say, or at least one book?

MR. ROBINSON: Objection.

MR. DUCK: Objection to form.

MR. ERCOLE: All right. Let me ask it again.

MR. ROBINSON: Lacks foundation.

Q. BY MR. ERCOLE: Have you written any -- any books about opioids?

MR. ROBINSON: Objection. Lacks foundation. Form.

THE WITNESS: I wrote a book about how to prescribe opioids and mitigate the risk for practitioners.

it -- at the beginning, they did not believe there was much risk at all.

And I think that that -- that was just about not knowing and probably not understanding how to assess for risk at the time, because there are a lot of people who have chronic pain who have comorbid medical -- mental health problems that clearly increase the risk.

And so I would tell patients, If you take the medicine as directed, you should not have a problem with addiction.

And I think that's true, but I think it -- it didn't -- I didn't appreciate that there were people that probably were at greater risk at the beginning. But that's why I developed the opioid risk tool, because I knew that there was something more there. And we were beginning to see people with problems.

But who -- who and why, and how do you -- how do you identify those

people, that's why I did the literature search. I don't think I was unique. I think that's the way we collectively in the field as experts understood where we were and where the science was at the time.

Q. BY MR. ERCOLE: And -- and those views were -- were views that you independently developed based upon the science and the field at that time?

A. Yeah. Wasn't from pharma. I mean, this is -- this is something that I developed on my own because I wanted -- I didn't want to cause any harm, and I wanted to be a leader in the field to make sure that others knew what I knew and what I'd learned, what I'd published.

Q. You were shown some documents today pertaining to Cephalon and Teva. Do you recall that?

A. Yes.

MR. LEONOUDAKIS: Objection. Form.

Q. BY MR. ERCOLE: If you turn to, I believe it's Exhibit 9. I think it's the

document with "Actiq" on the front of it.

A. I see it.

Q. Before today, did you have any independent knowledge of this document?

A. No.

Q. Did you ever see this document before?

A. No.

Q. Do you have any understanding of the -- given that you -- strike that.

Given that you have no independent knowledge of this document, did you have any understanding of the intent of this document?

MR. LEONOUDAKIS: Objection. Form.

THE WITNESS: Not what we reviewed today. There are more pages here than we reviewed earlier, so I don't -- I can't comment on anything I haven't reviewed.

Q. BY MR. ERCOLE: Sure. At least with respect to the -- to the pages that you reviewed; correct?

I'll ask the question this way:

THE WITNESS: You bet.

MR. HOFFMAN: -- if we can wrap up.

THE WITNESS: I'll go to the bathroom, if that's all right.

THE VIDEOGRAPHER: Off the record. The time is 6:00.

(There was a break taken.)

THE VIDEOGRAPHER: Returning on the record. The time is 6:14.

Q. BY MR. HOFFMAN: Just going back for a moment, Dr. Webster. We had a discussion about a Purdue sales rep and something that she said about using OxyContin and postoperative pain. We've already discussed that. But I want to ask you a question I guess more generally.

Other than that one instance that we talked about where you didn't prescribe for those types of patients or on that basis, can you recall any other statements by any pharmaceutical sales representatives at any point in time that you disagree with?

A. No.

Q. Do you believe that you ever did anything medically inappropriate for any of your patients based upon any marketing by pharmaceutical companies?

MR. LEONOUDAKIS: Objection, form.

THE WITNESS: No, I don't believe so.

Q. BY MR. HOFFMAN: Do you believe you ever did anything medically inappropriate for your patients based upon any discussions with pharmaceutical sales representatives?

MR. LEONOUDAKIS: Objection. Form.

THE WITNESS: No.

Q. BY MR. HOFFMAN: And I take it you're not aware of any doctors in the state of Oklahoma who have ever done anything medically inappropriate for their patients based upon any marketing of pharmaceutical companies or any discussions with sales representatives?

MR. LEONOUDAKIS: Objection. Form.

THE WITNESS: No.

Q. BY MR. HOFFMAN: Now, plaintiffs' counsel did not share this with you earlier, but I'm going to read a quote from the State of Oklahoma's complaint in this case. It's called a petition. And I will read from Paragraph 62 of the State's petition.

It reads, in part, "Like Dr. Portenoy, multiple defendants utilized Dr. Webster as a KOL, providing him with funding and consultant fees in exchange for spreading their misrepresentations regarding opioids and opioid use in general through CMEs and speeches."

Were you aware that the State had made that allegation against you?

A. No.

Q. Do you believe that in exchange for consulting fees you have spread the misrepresentations of any defendants in this case?

A. That's flatly wrong.

Q. Just to wrap up, Doctor, you did mention earlier that -- we had the discussion about prescribing OxyContin for

EXHIBIT 10

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.; 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.;
ALLERGAN, 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 SCOTT FISHMAN, M.D.

February 26, 2019

9:43 a.m.

4860 Y Street, Suite 3020

Sacramento, California

REPORTED BY:

MARYANN H. VALENOTI

CSR #11266, RPR, CRR

Q. And you worked with them for many years?

A. Yes.

Q. Do you believe that had they known this, they would have wanted to engage with Janssen as a key opinion leader?

MR. EHSAN: Objection, calls for speculation.

THE WITNESS: I -- yeah, I don't know what they would do or what they were thinking.

BY MS. BALDWIN:

Q. If you turn to Page 8, it looks like they sampled consistent of the -- the sample of 1,000 physicians were from five different regions; correct?

MR. EHSAN: Objection to form.

THE WITNESS: Yes.

BY MS. BALDWIN:

Q. And they broke down the Respondents by specialty, and the majority were primary care physicians; is that correct?

A. Yes.

MR. EHSAN: Same objection.

THE WITNESS: Yes.

BY MS. BALDWIN:

Q. And then there's -- on the following page,

there is a table that shows the number and percentage of doctors by Duragesic decile in each region. Do you see that?

MR. EHSAN: Objection to form.

THE WITNESS: Yes. Can you tell me what a "Duragesic decile" means?

MR. ROBINSON: You can't ask questions.

THE WITNESS: Sorry.

BY MS. BALDWIN:

Q. Well, again, did you know -- you didn't know until I told you today that -- correct, that Janssen ranked physicians based on how often they prescribed their products; correct?

A. Correct.

MR. EHSAN: Objection to form.

BY MS. BALDWIN:

Q. And it's typically on a scale of 1 to 10?

A. Yes.

MR. EHSAN: Objection to form.

BY MS. BALDWIN:

Q. You didn't know that prior to today?

MR. EHSAN: Objection to form.

THE WITNESS: I think it was a scale of 1 to 7. On Page 6 it says 1 to 7, but I did not know that until today.

BY MS. BALDWIN:

Q. Yeah, 1 to 7 is the influence of a key opinion leader on prescribing.

A. Oh, I see. Got it.

MR. EHSAN: Objection to form.

BY MS. BALDWIN:

Q. This is a pretty --

A. Yeah, involved.

Q. This PowerPoint is a pretty involved analysis of the influence of key opinion leaders on physicians prescribing. Would you -- wouldn't you say?

MR. EHSAN: Objection to form.

MR. ROBINSON: Objection to form.

THE WITNESS: Yes.

BY MS. BALDWIN:

Q. If you turn to Page 12, do you see that they -- Janssen did a point allocation summary. "Each Respondent was asked to assign points based on the level of influence of these parameters on his prescribing. The most influential factor was assigned 100 points, and no two factors were to be assigned the same value by a Respondent. A summary of the response is as follows in the next two slides: First one with overall results, and the

second one by specialty group of Respondent"; correct?

MR. EHSAN: Objection to form.

THE WITNESS: Yes.

BY MS. BALDWIN:

Q. Give you an example of Question 10: "Please consider the following specific factors that may influence your prescribing of opioids. Of course many other factors will influence your prescribing, but we are interested in the relative influence of these particular factors"; correct?

MR. EHSAN: Objection to form.

THE WITNESS: Yes.

BY MS. BALDWIN:

Q. And these factors include peer interaction; correct?

A. Yes.

MR. EHSAN: Objection to form.

BY MS. BALDWIN:

Q. Availability of coupons and/or vouchers?

MR. EHSAN: Same objection.

THE WITNESS: Yes.

BY MS. BALDWIN:

Q. Patient request for specific drugs?

MR. EHSAN: Same objection.

THE WITNESS: Yes.

BY MS. BALDWIN:

Q. Sales representative messages?

MR. EHSAN: Same objection.

THE WITNESS: Yes.

BY MS. BALDWIN:

Q. Influence of opinion leaders?

MR. EHSAN: Same objection.

THE WITNESS: Yes.

BY MS. BALDWIN:

Q. Peer-reviewed journal articles or studies?

MR. EHSAN: Same objection.

THE WITNESS: Yes.

BY MS. BALDWIN:

Q. Medical education?

MR. EHSAN: Same objection.

THE WITNESS: Yes.

BY MS. BALDWIN:

Q. Formulary status?

MR. EHSAN: Same objection.

THE WITNESS: Yes.

BY MS. BALDWIN:

Q. Regulatory liability concerns?

A. Yes.

MR. EHSAN: Same objection.

used them before.

We didn't use them excessively in my practice, and we rarely use them at very high doses. So that's a long-winded yes.

You know, I think when I present, that would be the basis that I would come from, and no one would shift me, and some people disagreed with my positions and other people agreed.

In the long run, I believe that the work that I did would be embraced by pharmaceutical companies, because in the long run, pharmaceutical companies wouldn't have successful products unless they were used safely.

BY MR. ERCOLE:

Q. In fact, pharmaceutical companies did sponsor, indirectly at least, presentations that you've given on these very topics; correct?

MS. BALDWIN: Objection, leading.

THE WITNESS: I would say they sponsored the book Responsible Opioid Prescribing, which if you really read it, is basically a book that says be careful.

BY MR. ERCOLE:

Q. It's a book to physicians saying be careful, these are the risks associated with

opioids potentially; correct?

A. This is a dangerous group of drugs that we have to use carefully or we'll use the right to use them, which is something I say in the book.

Q. And the book you're referring to is Responsible Opioid Prescribing; is that correct?

A. Correct.

Q. Just we heard a lot of -- we'll get into some of the content of that book a little bit later, but we had a lot of questions about Responsible Opioid Prescribing. Just to clarify, the opinions expressed in that book are your independent opinions and your independent opinions only; correct?

MS. BALDWIN: Objection, leading.

THE WITNESS: They're my independent opinions, but with that said, I wrote the book as a commissioned production for the Federation of State Medical Boards to articulate what I thought was an important -- were important guiding principles from the model policy, which gave medical boards guidance on how to investigate physicians if they were called out for their prescribing. Does that make sense?

So with that, that was really my

framework, and I built it -- I built the Responsible Opioid Prescribing case out from there.

BY MR. ERCOLE:

Q. Understand, and we'll get into some of these topics a little bit later, but at least with respect to the views expressed in Responsible Opioid Prescribing, the book that you authored, is it fair to say that those views were developed by you independent from any pharmaceutical company influence?

MS. BALDWIN: Objection, leading.

THE WITNESS: Independent of any direct influence. Again, it's all an amalgamation of all the experiences and thoughts and ideas that I've had, but they were in my independent views.

BY MR. ERCOLE:

Q. And the book reflects your independent views; correct?

A. Correct.

MS. BALDWIN: Objection, leading.

THE WITNESS: I would say the book is consistent with my views throughout, throughout its evolution of editions.

BY MR. ERCOLE:

Q. There have been -- with respect to that

book and again we'll get into this a little bit, is it fair to say there have been two editions?

A. There have been three editions. The first two were called First and Second Edition. The third was called the Second Edition Expanded.

Q. Dr. Fishman, you understand this case was brought by the -- strike that. Let me go back.

You mentioned before that you have no direct knowledge, and I don't want to misquote you, but this is what I wrote down. You have no direct knowledge of how any company in this case marketed its drugs. Do you recall saying that?

MS. BALDWIN: Objection, leading.

THE WITNESS: Yes.

BY MR. ERCOLE:

Q. And is that accurate?

A. Yes.

Q. You understand that this case is -- strike that.

With respect to your reference to drugs, that would include opioid medicines; correct?

MS. BALDWIN: Objection.

THE WITNESS: Correct.

BY MR. ERCOLE:

Q. You understand this case is brought by the

Q. So about since say 1993 or so?

A. Correct.

Q. I'm not asking you an exact number, but since that time, do you have a sense of sort of how many pain management -- excuse me, how many patients you've treated for pain-management-related issues as a practicing physician on a weekly basis?

A. Well, it's varied on a weekly basis. I don't know if it's acceptable, but just I've treated thousands of patients over the years.

Q. Have you prescribed opioids for those patients?

A. For some.

Q. Yes. Have you prescribed long-acting opioids for some patients?

A. Again, for some.

Q. And have you provided -- prescribed short-acting opioids for some patients?

A. Yes.

Q. And have you prescribed opioids for noncancer pain?

A. Yes.

Q. And have you prescribed opioids for chronic pain?

A. Yes.

Q. Do you still prescribe opioids today?

A. I do.

Q. Is it fair to say that as a -- as the sort of trained medical professional, you are the person responsible for making a prescribing decision with respect to any particular patient?

A. It's true in respect to my patients.

Q. All I'm asking is about your patients; is that true?

A. Yes, if it's my patient, it's my decision.

Q. You have the responsibility for making that decision; correct?

A. Yes.

Q. You have -- as a trained medical professional, you have the obligation to exercise your independent medical judgment in making that prescribing decision; is that fair to say?

MS. BALDWIN: Objection, leading.

THE WITNESS: Yes.

BY MR. ERCOLE:

Q. With respect to prescriptions of opioids that you've written, have you always exercised your own independent medical judgment in deciding to prescribe that opioid for a particular patient?

A. Yes.

Q. Is it important for prescribers to exercise their own independent medical judgment when making a prescribing decision regarding opioids?

MS. BALDWIN: Objection to form.

THE WITNESS: It's not only important, it's -- it would be beneath the standard of care to do otherwise.

BY MR. ERCOLE:

Q. And with respect to your practice, have you ever -- strike that.

With respect to your pain management practice, have you ever interacted with pharmaceutical representatives who have come to your practice?

A. Yes.

Q. Did those -- did some of those pharmaceutical representatives ever detail you about particular medicines?

A. Yes.

Q. And in writing opioid prescription, did you ever rely blindly on anything a pharmaceutical representative might say about a particular product in that type of situation?

MS. BALDWIN: Object to form.

THE WITNESS: No.

BY MR. ERCOLE:

Q. Is it fair to say it would be beneath the standard of care to rely blindly on what a pharmaceutical representative might say to a particular physician at a particular time?

MS. BALDWIN: Object to form.

THE WITNESS: Sorry.

MS. BALDWIN: Objection to form.

THE WITNESS: I think that's a difficult question to answer because there are some circumstances where a industry representative might actually have the most critical information about delivering a drug, or in modern times today, on implanting a medical device, et cetera. So you can't say always, but we have to be very, very careful, you know, walking that road and that line, and I don't know that I've ever been in that line where I've needed an industry representative to help me.

But I know that right now in every hospital in America we're using new technologies that we have no experience with, and unless we have industry partners who are experienced because they developed the tools, we would be unsafe in

delivering those devices or those technologies.

BY MR. ERCOLE:

Q. With respect to opioid prescribing itself, did you ever prescribe a opioid medicine because of some marketing statement a pharmaceutical company made, as opposed to exercising your own independent medical judgment as to what was in the best needs of the patient?

MS. BALDWIN: Object to form.

THE WITNESS: I did not.

BY MR. ERCOLE:

Q. As a trained medical professional, did you ever prescribe opioid medicine because of some funding that you received indirectly from a pharmaceutical company concerning a publication, as opposed to making your own independent medical judgment?

MS. BALDWIN: Object to form.

THE WITNESS: No.

BY MR. ERCOLE:

Q. Did you ever write an opioid prescription because a pharmaceutical representative, for instance, dropped a lunch off in your office?

MS. BALDWIN: Object to form.

MR. ROBINSON: Object to form, foundation.

THE WITNESS: No.

BY MR. ERCOLE:

Q. How about ever write opioid prescription because were you invited for a dinner program by a pharmaceutical company?

MS. BALDWIN: Object to form.

THE WITNESS: No.

BY MR. ERCOLE:

Q. Were you ever -- did you ever write an opioid prescription because of some offer to sit on an advisory board by a pharmaceutical company?

MS. BALDWIN: Object to form.

THE WITNESS: Absolutely not.

BY MR. ERCOLE:

Q. In fact, all of these -- this notion of doctors exercising their own independent medical judgment to prescribe opioids safely is precisely what you've been teaching about since the late '90s; is that fair to say?

MS. BALDWIN: Objection, leading.

THE WITNESS: Yes.

BY MR. ERCOLE:

Q. How about was it even before the late '90s?

MS. BALDWIN: Same objection.

THE WITNESS: Yes. It's not about opioids, but it's the foundation of my training. You can't rely on any one piece of information, and you certainly can't rely on information that comes solely from conflicted sources.

I mean, it's ironic that that's, in fact, what we did in a field in many ways to get into the problems that we're in, but, yes, that's kind of where -- those are the foundations of my training.

BY MR. ERCOLE:

Q. When you say your "training," where would you have -- where did you learn those?

A. Well, I trained in internal medicine through the Yale system in Greenwich Hospital in Southern Connecticut, and then I trained and did my anesthesia subspecialty training at Mass General at Harvard, and my psychiatry training at Mass General at Harvard. I think those are particularly places that were grounded in that solemn role of a clinician to independently see each patient as an individual and treat them based on their presentation, rather than any other group of ideas or beliefs and datasets, et cetera.

Q. And, in fact, that's the standard of care that physicians are obligated to perform; is that

correct?

MS. BALDWIN: Objection, leading.

THE WITNESS: I believe that's true.

BY MR. ERCOLE:

Q. With respect to your teaching, have you always taught that type of standard of care?

A. Yes.

Q. And does that date back to 1993 when you first started teaching?

A. No, you know, I probably -- so the way that my lineage worked is that I graduated medical school in '90. And then from '90 to '92 and a half, I was doing internal medicine, and then it was back in the day when you could actually overlap different trainings. So I actually was a internal medicine resident, and went up to Boston, and I became actually an internal medicine resident and an anesthesia pain fellow at the same time doing electives in one and training in the other. And then actually there was a time where I was a psychiatry resident, internal medicine resident and an anesthesia fellow for six months. So, you know, that was -- so, really, I became faculty -- I technically became faculty at Harvard Medical School in my fellowship, but I became formal

faculty after my psychiatry residency, which was I think at the end in 1995. So that's really when my teaching career began.

Q. So I assume basically if you survived all of that, you could basically survive anything; is that fair to say?

A. I'm surprised I did it.

Q. At least since 1995 you've been teaching about -- about opioids; is that fair to say?

MR. ROBINSON: Objection, form.

MS. BALDWIN: Objection, form.

BY MR. ERCOLE:

Q. I'll reask it. You've been teaching students at least as of since 1995; correct?

MS. BALDWIN: Objection.

MR. ROBINSON: Objection.

THE WITNESS: Opioids have been an issue since then.

BY MR. ERCOLE:

Q. And pharmacovigilance has been an issue sense then; is that fair to say?

A. Yes.

Q. And at least since 1995, have you trained your students on the potential risks associated with opioid?

A. Yes.

Q. And since 1995, have you trained your students on the potential for a risk of addiction associated with opioids?

A. Yeah. You know, I have to say that I was in that last cohort that was trained that if you used opioid for pain, you had very minimal risk of addiction, and that had to be unlearned over many years. So I'm not sure I would want to use my training in 1995, my teaching in 1995 as a reference standard for that.

Q. Whatever teaching that you would have done in 1995, would have been teaching that you sort of independently developed; is that fair to say?

MS. BALDWIN: Objection, leading.

THE WITNESS: Yes.

BY MR. ERCOLE:

Q. And since 1995, have you taught your students that before prescribing a particular medicine, they should read the label table of the medicine?

A. I don't know that I could tell you that that's a specific thing I've advised students to do.

Q. Is it self-evident that before --

A. Yes.

Q. Let me just finish before you respond.

A. Sorry.

Q. Thank you. Is it self-evident that before prescribing a medicine, a provider needs to and should understand the contents of the label of that medicine?

MS. BALDWIN: Objection, form, leading.

THE WITNESS: Yes.

BY MR. ERCOLE:

Q. And is it fair to say that before writing a prescription of a medicine, that a provider should understand the risks associated with that medicine?

MS. BALDWIN: Object to form, leading.

THE WITNESS: Yes.

BY MR. ERCOLE:

Q. And whether implicitly or explicitly, are those concepts that have been made clear in teaching that you've done since 1995?

MS. BALDWIN: Object to form.

THE WITNESS: They're consistent.

BY MR. ERCOLE:

Q. Is it fair to say that with respect to the labels of medicines, including opioids, the labels

MS. BALDWIN: Object to form.

THE WITNESS: Yes.

BY MR. ERCOLE:

Q. And would that apply to opioids as well?

MS. BALDWIN: Objection, same objection.

THE WITNESS: Yes.

BY MR. ERCOLE:

Q. And does the -- that training begins in medical school; is that fair to say?

MS. BALDWIN: Same objection.

THE WITNESS: The training should begin in medical school.

MS. BALDWIN: Same objection in case you didn't hear me.

THE WITNESS: Sorry.

BY MR. ERCOLE:

Q. Since 1995, have you trained your students to obtain informed consent from a patient before writing opioid prescription?

MS. BALDWIN: Objection, leading.

THE WITNESS: You know, I don't think that we emphasized that -- I emphasized that or we as a field emphasized that as much as we should and do now.

BY MR. ERCOLE:

Q. When you say "we as a field," what field are you referring to?

A. Pain medicine.

Q. That is -- that's the medical community; is that correct?

A. Yes.

Q. And we'll get into some of these documents, but at least in the 1990s you were publishing articles about opioid contracts; is that fair to say?

A. That's right.

Q. What is an opioid contract?

A. An opioid contract is a bilateral agreement between a patient and a prescriber that outlines the expectations and the procedure for receiving an opioid and can serve as an informed consent process.

Q. Do you know, do you recall when you first started using opioid contracts in your particular practice, if you've done at all?

A. Oh yeah. From the beginning they were used in my training.

Q. And what -- when you say "from the beginning," are you referring to 1995, for

instance?

A. Probably 1993 I think we were using opioid contracts when I started my pain fellowship.

Q. And those opioid contracts would have disclosed the risks associated with using opioids; is that fair to say, to the patient?

MS. BALDWIN: Objection.

THE WITNESS: So you seem to know about the paper that I did. We actually did a survey of opioid contracts and most of them didn't and most of them really didn't meet informed consent criteria. So I don't think in the early days it did. The contracts in the early days was really to benefit the prescriber at the -- and putting the patients in kind of the one-down position.

BY MR. ERCOLE:

Q. With respect to the opioid contracts that you utilized in your practice, did those contracts disclose the risks associated with opioids?

MS. BALDWIN: Objection.

THE WITNESS: They ultimately did -- sorry, they ultimately did as they evolved in my practice, but probably didn't in the early days.

BY MR. ERCOLE:

Q. And you as a physician or your practice

would have controlled what went into an opioid contract and what didn't go into an opioid contract; is that fair to say?

MS. BALDWIN: Objection, leading.

THE WITNESS: Yes, yes.

BY MR. ERCOLE:

Q. The pharmaceutical companies did not -- did not control what you as a physician decided to put or not put into a particular opioid contract; correct?

MS. BALDWIN: Objection, leading.

THE WITNESS: Well, I don't think they had any binding input. I do vaguely recall that some companies actually, to be helpful, came up with agreement language that they would put forward for some period of time, but they didn't influence what I put in my contract or we put in our contract in my clinic.

BY MR. ERCOLE:

Q. Is it fair to say that since 1995 you've trained your students to utilize the opioid contracts in connection with their contract?

A. Yes.

MS. BALDWIN: Objection, leading.

BY MR. ERCOLE:

Q. And is it fair to say there are many different manufacturing --

A. There are many different manufacturers. I think they're all manufacturers. So I'm not sure that there are a variety of them. They're all manufacturers.

Q. That's an excellent clarification. I appreciate that.

But different companies manufacture opioids; correct?

A. Yes.

Q. And those manufacturers manufacture different types of opioids; is that fair to say?

A. Yes.

Q. And opioid medicines are different; is that correct?

MS. BALDWIN: Object to form.

THE WITNESS: Opioid medicines are, yeah, an overarching group of different molecules and different formulations.

BY MR. ERCOLE:

Q. And different opioids may be approved by the FDA at different times?

A. Correct.

Q. And some of those medicines may be generic medicines; is that true?

MS. BALDWIN: Object to the form.

THE WITNESS: Yes.

BY MR. ERCOLE:

Q. And some may be branded medicines?

MS. BALDWIN: Object to the form.

THE WITNESS: Yes.

BY MR. ERCOLE:

Q. And some may be short acting opioids?

A. Yes.

MS. BALDWIN: Objection, object to the form.

BY MR. ERCOLE:

Q. Some may be long acting opioids?

MS. BALDWIN: Object to form.

THE WITNESS: Yes.

BY MR. ERCOLE:

Q. And may be different delivery systems with respect to those opioid medicines?

MS. BALDWIN: Object to form.

THE WITNESS: Yes.

BY MR. ERCOLE:

Q. And with respect to marketing, is it fair to say that opioid manufacturers may engage in

different types of marketing, if any?

MS. BALDWIN: Object to form.

THE WITNESS: I assume so.

BY MR. ERCOLE:

Q. For instance, generic manufacturers may not market their medicines at all?

MS. BALDWIN: Object to form.

BY MR. ERCOLE:

Q. Is that fair to say?

A. Yes.

Q. Dr. Fishman, do you have -- do you recall any communications that you've ever had with anyone from a company known as Actavis Pharma?

A. I don't recall.

Q. Do you recall receiving directly or indirectly any funding from a company called Actavis Pharma?

A. I don't.

Q. Are you aware of any promotional or marketing statements ever made about opioids by such a company?

A. I do not.

Q. How about do you recall any communications that you've ever had with a company by the name of Watson Laboratories?

A. I don't.

Q. Are you aware of any funding that you received directly or indirectly from any company known as Watson Laboratories?

A. I don't. I would not be surprised if the American Pain Foundation received funding from those or the American Academy of Pain Medicine or the American Pain Society, organizations I had a role in. So when you say "indirectly," maybe there is a connection there, but I don't recall working with those companies or receiving anything from them.

Q. Sure. Well, sitting here today, do you recall any of those other entities that you've just -- third-party entities you just described ever receiving any funding from Watson Laboratories?

MS. BALDWIN: Object to form.

THE WITNESS: I don't recall, but I wouldn't be surprised if they did.

BY MR. ERCOLE:

Q. Okay. But sitting here today you don't recall? I just want to make sure.

A. Correct, I do not recall.

MS. BALDWIN: Object to form.

BY MR. ERCOLE:

Q. Are you aware of any promotional or marketing statements made about opioids from Watson Laboratories?

A. No.

Q. Have you ever had any communications with a company known as Actavis, LLC, to the best of your understanding?

A. Not that I recall.

Q. Do you ever -- were you ever aware of any funding that you've received directly or indirectly from a company known as Actavis, LLC?

A. Not that I know of.

Q. Are you aware of any promotional or marketing statements about opioids made by Actavis, LLC?

A. Not that I am aware of.

Q. Are you aware of what medicines, if any, Actavis Pharma, Watson Laboratories or Actavis, LLC manufactures?

A. I am not.

Q. Do you recall any documents that the State showed you today about any of those entities?

MS. BALDWIN: Object to form.

THE WITNESS: I think there was one

document that listed Watson, and, I mean, it could have even been in my book. I think I saw the name "Watson" somewhere.

BY MR. ERCOLE:

Q. Sitting here today, can you recall specifically about --

A. I don't know if that happened today, no.

MS. BALDWIN: Object to form.

BY MR. ERCOLE:

Q. Are you aware of any -- Dr. Fishman, are you aware of any -- you've heard of the company Teva, USA; is that fair to say?

A. Yes.

Q. Are you aware of any false or misleading statements that Teva USA has ever made about opioids?

A. No.

Q. You've heard of the company Cephalon; is that fair?

A. Yes.

Q. Are you aware of any -- strike that.

Do you have any personal knowledge of any false or misleading statements that Cephalon has ever made about opioids?

MS. BALDWIN: Object to form. I should

say I have a history with Cephalon in that they made misleading statements about me.

BY MR. ERCOLE:

Q. Okay. With respect to making misleading statements about you, do you recall what that issue was?

A. The issue was that I agreed to do a public service announcement, and I think it was Cephalon at the time, and then it became Teva, and I signed an agreement that said that I wasn't getting paid, and it would only be for public service, public education. It was actually a commentary that I made at a professional meeting about the risk of addiction and abuse in children. They wound up putting it up on their marketing website, unbeknownst to me, something that they later took off and apologized for.

Q. So is it fair to say when that issue was brought to your attention, that they immediately took off the video from the website?

A. Yes.

MS. BALDWIN: Object to form.

THE WITNESS: Yes.

BY MR. ERCOLE:

Q. You said Cephalon also apologized to you.

risks of opioids.

BY MR. ERCOLE:

Q. And then Cephalon went and put that, actually, on its website; is that correct?

MS. BALDWIN: Objection, leading.

THE WITNESS: That is correct, or Teva did. I'm not sure.

BY MR. ERCOLE:

Q. Fair enough. Once you said, Hey, could you take that down because there was an incorrect attribution of some payment to you in there, they immediately did that; is that fair to say?

MS. BALDWIN: Objection, leading.

THE WITNESS: They took it down because it was never intended to be used in their marketing, and there was also an inaccurate attribution of payment to me.

BY MR. ERCOLE:

Q. In connection with that particular video, was there anything false or misleading other than the attribution of payment to you that was associated with that?

MS. BALDWIN: Object to form.

THE WITNESS: No.

BY MR. ERCOLE:

Q. Other than that medication attribution of you receiving a payment, anything false or misleading that you can recall Cephalon making about opioids?

MS. BALDWIN: Object to form.

THE WITNESS: No.

BY MR. ERCOLE:

Q. With respect to the misattribution of payment that you just described, that was disclosed as part of the video; is that correct?

MR. ROBINSON: Object to form.

MS. BALDWIN: Objection.

THE WITNESS: I actually don't know. It was somehow transmitted to media sources that I was paid, so Cephalon made a statement that I wasn't -- in fact, reproduced this document I had them sign that stated that I would not be paid. These were my own ideas. This would only be used for a public service announcement, and it would not be used for marketing purposes or for corporate purposes.

BY MR. ERCOLE:

Q. So we looked at and I asked you to look at Exhibit 1 in your CV. There are a number of different categories in this particular document,

it's very extensive, very impressive. If you look to, it looks like it's Bates marked as FISH 8; do you see that on the bottom right-hand corner? There is a section that says, "Teaching Lectures and Presentations"; do you see that?

A. Yes.

Q. And it looks like there are -- if you scroll through, it looks like there are 566 of them; do you see that?

A. Yes, as of August 2017.

Q. Sitting here today with respect to those lectures and presentations, could you identify a single one of those lectures or presentations that did not reflect your own independent medical opinion?

A. No.

Q. Because they all did reflect your own --

MS. BALDWIN: Object to form.

BY MR. ERCOLE:

Q. They all did reflect your own independent medical opinion?

MS. BALDWIN: Objection, leading.

THE WITNESS: They did.

BY MR. ERCOLE:

Q. And if you turn to the next category, it