IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

PART E

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

Plaintiff,

vs.

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

Defendants.

For Judge Balkman's Consideration

Case No. CJ-2017-816
Honorable Thad Balkman

William C. Hetherington
Special Discovery Master

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

REDACTED VERSION

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

EXHIBIT 21

IN THE DISTRICT COURT OF CLEVELAND COUNTY

STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., MIKE HUNTER, ATTORNEY GENERAL OF OKLAHOMA, Plaintiff,	)	
-vs-	)	No. CJ-2017-816
PURDUE PHARMA, L.P.; et al., Defendants.	)	

* * * * *

VIDEOTAPED DEPOSITION OF JASON BEAMAN, D.O.

TAKEN ON BEHALF OF THE DEFENDANTS

IN OKLAHOMA CITY, OKLAHOMA

ON MARCH 26, 2019

COMMENCING AT 9:14 A.M.

* * * * *

instaScript, L.L.C.
101 Park Avenue, Suite 910
Oklahoma City, Oklahoma 73102
405.605.6880
schedule@instascript.net

REPORTED BY: BETH A. McGINLEY, CSR, RPR

A They were involved in facilitating the communications, but not in the actual criteria. They did not have any input into the criteria.

Q Can you tell me the particular input that Dr. Clauw had into the criteria?

A Well, Dr. Clauw would have been involved in all three steps, and I -- I can't tell you exactly what he wanted in or what -- wanted out, but he would have been involved in all three steps.

Q What is Dr. Clauw's medical specialty, if you know?

A I believe him to be a pain management physician.

Q Okay. What is Dr. Mazloomdoost's medical specialty, if you know?

A I believe him to be a pain management physician.

Q Do you know anything about Dr. Mazloomdoost's training or experience, other than you believe him to be a pain management specialist?

A No.

Q You never reviewed his CV or anything like that?

A I did not review his CV.

Q Do you know anything about Dr. Clauw's training or experience, other than having a general understanding that he is a pain management specialist?

A No.

Q What about Dr. Kolodny, do you know what kind of -- what is Dr. Kolodny's specialty, if you know?

A Dr. Kolodny is a specialist in addiction psychiatry.

Q Uh-huh. Can you tell me what input Dr. Mazloomdoost had into the criteria?

A It would be the same for Dr. Clauw, that he was involved in establishment of all three criteria. I can't point to any one condition or criteria that he recommended or didn't recommend.

Q Would the same answer -- would you have the same answer for Dr. Kolodny's input?

A Yes.

Q Nothing specific that you can point to that he -- that he offered or -- or requested be included in the criteria?

A Correct.

Q Okay. When did you and this group of other physicians develop this set of three criteria?

A It would have been -- I -- probably June or July.

Q Of 2018?

A Yes, ma'am.

Q And so you finalized the set of criteria, obviously, before you began your review of the actual

prescription data, correct?

A Yes. There was a condition that was added, and that was --

Q What was that?

A -- I believe, sickle cell anemia, which required me to go back and rereview records, applying that.

Q And you -- it was added. When was that condition added?

A In the fall sometime, but I can't be certain as to when.

Q And who added that condition?

A I -- I can't remember. I believe it may have been Dr. Manzloom- --

Q Mazloomdoost?

A Yes.

Q It wasn't your idea to add that?

A It was not.

Q Okay. Okay. Do you have any recollection of any particular communications you had with Dr. Mazloomdoost as to why he wanted to add sickle cell anemia?

A No.

Q Okay. Did you discuss that with the other physicians, as to whether or not they agreed with that addition?

A Yes.
Q And they did?
A They did.
Q Okay. All right. And, again, you would agree with me that this set of three criteria reflected on Page 2 of your disclosure was developed solely for use in this litigation, correct?
A Yes. It -- it was developed so that we could provide the objective review of the medical records.
Q What -- what you deemed to be an objective review --
A Yes.
Q -- of the medical records, correct?
A Correct.
Q Okay. Did you review or rely on any source material, written documents, or other publications, for your input into the criteria?
A I would say that my expertise as a physician comes from the frequent review of documentation and education and materials, and, certainly, I relied on that. Can I point to a specific document? Not necessarily. Certainly, we know that the 2016 CDC guidelines --
Q Uh-huh.
A -- list 90 MME, along with several specialty organizations.

knowledge of physicians prior to being involved in this case.

Q Okay. When you say "the knowledge of physicians," are you talking about the knowledge of physicians as to the risks and benefits of opioids?

A Yes.

Q So, prior to your involvement in this case, you did not have an opinion as to whether or not physicians in Oklahoma possessed the requisite knowledge of the risks and benefits in order to be able to responsibly prescribe opioid medications?

A Yes, to the best of my recollection.

Q Okay. So it's only since your involvement in this case that you have come to the conclusion or formed the opinion that the majority of physicians in the state of Oklahoma lack the requisite knowledge of the risks and benefits of opioids in order to be able to make responsible prescribing decisions?

A I think that's a fair statement.

Q Okay. And what information have you reviewed or what research have you done, since becoming involved in this case, that has led you to that conclusion?

A As -- as being an expert in this case, I have reviewed marketing material that says such things as opioids are not addicting, that certain opioid medications

are not addicting. I've seen referenced a concept of pseudoaddiction, as I understand it, is, if a patient is showing or exhibiting signs of opioid addiction, that the proposed solution was to give them even more of the addicting substance because the premise was that their pain was not being adequately treated and that their sym-- signs and symptoms of addiction were actually signs and symptoms of untreated pain and that they require more of the addictive substance.

I have seen information regarding money that was paid by pharmaceutical companies to different medical information dissemination venues, like CME, publications, and medical journals. Some of this, I've reviewed as part of this case; some of this, I have become aware through my reading outside of the case. But, definitely, just being involved in this case has opened my eyes to what physicians were told and to -- and -- and how that was told to them.

Q Okay. In the context of your work as an expert in this case, have you interviewed any physicians in the state of Oklahoma about information they have received, at any time, from opioid manufacturers? Marketing information.

A Not -- not as part of the involvement in this case.

Q Have you done research on that at all, outside this --

A I've had conversations. I haven't done formal research.

Q Okay. So you've just had sort of casual conversations, form here -- here and there, with physicians, about how or what type of pharmacy marketing material -- pharmaceutical marketing materials they may have received regarding opioids?

A And -- and their overall belief about opioids --

Q Okay.

A -- yes.

Q But, again, you've not done any formal research, either in the context of your work in this case or otherwise, regarding the extent to which physicians in the state of Oklahoma have been influenced by marketing information that they may have received from pharmaceutical manufacturers, have you?

A I -- I haven't done that research, no.

Q And you've not personally received information from any of the pharmaceutical manufacturers named in this case, about their opioid products, other than what you told me about earlier, which was seeing, perhaps, a pamphlet on Actiq at one point in time, correct?

A Not other than what we discussed earlier.

Q Okay. Do you need -- do you need --
A I'm good.
Q Okay.
A I'm good.
Q All right. You said that -- a moment ago, that you saw something in some of the materials that you've reviewed since you got involved in this case, where there was a -- something that proposed a solution to give more of a substance to a patient who was exhibiting signs of addiction, and you referred to the term "pseudoaddiction." What entity or entities proposed that solution that you referred to?
A I believe I've seen it several times, but the -- the information that comes to mind, I believe, was in marketing material by Cephalon.
Q By Cephalon?
A Yes.
Q Okay. And what was the drug that was being marketed in that material, Doctor?
A I can't recall.
Q Okay. Do you know what opioid medications Cephalon manufactures or has manufactured in the past?
A No, I would just be guessing.
Q You'd be guessing, okay.
A Yeah.

A It's a difficult question to answer --
Q Uh-huh.
A -- because I don't think medicine has decided on what the full benefit of opioids are. I certainly believe that we are doing our best to teach them the most recent, up-to-date consensus, but that may evolve, as with most things in medicine.
Q And that's a great point, Doctor. As with most things in medicine, the understanding of -- of disease processes, the understanding of medications and their appropriate uses, evolves over time; that's fair, correct?
A Including the influence of pharmaceutical companies and our knowledge of how much that influence actually changes prescribing habits.
Q But, again, that's not something you've done any research on, is it?
A No.
Q All right. And you don't intend to offer an opinion, as an expert in this case, on the impact of pharmaceutical marketing on -- on physicians in Oklahoma, as it relates to their prescribing habits for opioids?
A Not other than to say I believe physicians should not be interacting with pharmaceutical representatives on a regular basis.
Q Okay. Other than that --

A No.

Q -- you're not planning to come in and say that physicians have been influenced in a -- to a certain degree, that has caused them to prescribe some percentage more than they would otherwise have prescribed or things of that nature?

A No.

Q Okay. Let me ask you this -- and, again, I want to -- I'll -- you sort of answered this question. I want to make sure it's clear on the record because of how it was qualified.

Do you intend to offer an opinion, as an expert for the State, as to the number or percentage of physicians in the state of Oklahoma who lack the full, complete and accurate knowledge as to the risks and benefits of opioids, so as to be able to reasonably prescribe opioids?

A I -- I don't plan on offering that opinion.

Q All right, thank you. And you've never done any work to interview or otherwise collect data, formally collect data from Oklahoma physicians, as to what types of information they have received from pharmaceutical manufacturers about opioids, have you?

A I have not.

Q And you've never done any formal interviews or

collected any formal data regarding whether or to what extent Oklahoma physicians have been influenced in their prescribing habits based on information they've obtained by -- or from manufacturers, have you?

A I -- I have not personally collected. I think that there are articles that I've read that have had that information, but I didn't personally collect it and I don't plan on offering an opinion on that.

Q Okay. And you've certainly not interviewed or formally collected data from any patients regarding their experiences in being prescribed opioids by their physicians, are you?

A Well, I -- I -- I would think I would disagree with that. I have had numerous conversations with patients in my career, about their experience in being prescribed opioid medications, about -- from their physicians.

In an addiction medicine practice, and even in a psychiatric practice, it is commonplace to talk to patients about their opioid use, including what they were getting from their physicians, and how -- in my role as a consult psychiatrist at O- -- OSU Medical Center, I often, I would say almost daily, evaluated patients that had overdosed on opioid medications that had been prescribed by their physicians.

Q And when did you -- I'm sorry, I didn't mean -- were -- I didn't mean to interrupt you.

A I'm done.

Q Okay. And when did you do that? During what period of time were you evaluating, almost daily, patients that had been -- that had overdosed on opioid medication?

A Since starting at OSU Medical Center in July of 2015, until approximately one year ago. In the last year, it would be intermittently.

Q Okay. Let me make sure I've got the date. So starting in July of 2015, when you took on the position as the chair of the Department of Psychiatry and, what, Behavioral --

A Sciences.

Q -- Sciences -- until what date or what approximate date were you --

A Approximately 12 months from today.

Q Okay. So until sometime in March of 2018. So for two and a half years, approximately, you were seeing patients on a daily basis --

A Almost daily basis.

Q -- on an almost daily basis, that had overdosed on opioid medication?

A Yes.

Q Okay. So during that two-and-a-half-year

filled outpatient. So I think some prescriptions were prescribed by a physician in the hospital, but on discharge --

Q Uh-huh.

A -- so that the patient would have been handed the prescription. It did not include medications that were prescribed during the course of the hospitalization, itself.

Q Well, and did -- did the materials that you reviewed always include discharge prescriptions or prescriptions that were given upon discharge by a physician in the hospital? In other words, that's something different than an outpatient prescription; wouldn't you agree?

A Possibly, but I don't think I would know.

Q Okay. All right. So you don't know -- I guess what I'm getting at is: If there were prescriptions that were made to a patient in an inpatient setting, that are included among the 38,400-and-some-odd, you have no way of distinguishing whether they were made in an inpatient setting or an outpatient setting?

A Well, they were filled outpatient.

Q Okay. All right. So if they were filled outpatient, but they were made during an inpatient setting, do you know if medical records were requested

from the inpatient facility so that it -- so that a review could be done as to the basis for those prescriptions?

A No.

Q You don't know?

A No, I... no, I don't know.

Q Okay. All right. And -- and it indicates -- I think I know the answer to this, but in no -- in no instance did you or anyone in the group of individuals you mentioned, who have been involved in this review process, make contact with or communicate with any particular physician to determine whether or not the physician had performed a functional assessment evaluation, if -- if it seemed to be missing from the medical records?

A We did not communicate with any physicians located within the sample.

Q Okay. Let's go to your third criteria, which is the -- it says here, "The prescription was not provided for any of the following diagnoses." Are you with me on that?

A Yes, ma'am.

Q So I just want to make sure, again, I understand. If a prescription was, in fact, made for one of the listed diagnoses, you would nece- -- trying not to use the words "necessary" too much, so let me start over.

If the prescription was made for one of the

listed diagnoses on Page 2 of your disclosure, that prescription would be deemed to be not medically unnecessary?

A Correct.

Q Okay. Regardless of whether it met the other two criteria, correct?

A That is correct.

Q Okay.

A You had to meet all three criteria.

Q Okay. Let's talk about those particular diagnoses real quick. The first is post-cervical and lumbar laminectomy with epidural scarring and arachnoiditis. You see that?

A Yes.

Q Are you an expert in treating those conditions?

A No.

Q The next one is spinal cord injuries. Are you an expert in treating those conditions?

A No. Although I will tell you that it is very common for family medicine to treat the pain related to a spinal cord injury.

Q Okay. The next one is spastic neuropathic pain other than multiple sclerosis. Do you see that?

A Yes.

Q Are you an expert in treating that condition?

A Yes.
Q All right. Are you able to tell me how many times?
A No. It would have been related to my work as a hospitalist --
Q Uh-huh.
A -- upon discharging someone from the hospital, and would have been infrequent. I would say probably less than 10.
Q Less than 10 times, and that's in your work since be- -- since completing your residency?
A Correct.
Q Okay. On the occasions that you have prescribed medication -- opioid medications, post your residency, have -- have they always been prescriptions that would have met -- that -- well, have they always been prescriptions that would be not medically unnecessary under your criteria here?
A I don't believe any of my prescriptions would have met this criteria.
Q As being medically unnecessary?
A Yes.
Q Okay. So you believe all the prescriptions that you've ever made for opioids, during your career, have been not medically unnecessary?

A That is correct.

Q Okay. What are some of the conditions that you recall, either during your residency or after your residency, where you have found it to be appropriate or medically necessary to prescribe opioids?

A So when I prescribed opioids, I would say, in residency, the overwhelming majority would have probably been chronic pain. I had a attending physician who had a large panel of chronic pain patients and, when he was gone, out of the clinic, or if a patient needed an emergent visit, they would be put in the resident's schedule, including my own, and I would be asked to refill that patient's medication.

After residency -- also during residency, it would have been post-C-section or vaginal birth.

Q Uh-huh. Okay.

A Then after residency, it would be probably mostly related to a post-surgical patient.

Q Uh-huh.

A I can't think of any specific examples of when it was not a post-surgical patient, but certainly that could have existed.

Q Okay. So back when you were working with the attending physician that had the chronic pain patient population, what kinds of opioids were you prescribing?

Do you recall which ones?

A My best recollection is that it would have been hydrocodone, oxycodone and possibly MS Contin.

Q Okay. In terms of the patients that you have prescribed opioids for during the time you worked as a hospitalist, either post-surgical patients or post-C-section/vaginal birth patients, what opioids -- what type of opioids were you prescribing? Same thing?

A I believe it -- it would have been almost exclusively hydrocodone.

Q Hydrocodone, okay.

A Notwithstanding tramadol.

Q Okay. Is it your expert opinion, Doctor, that opioids should not, under any circumstances, be prescribed for post-surgical pain?

A No.

Q So you would concede that, in some cases, it is appropriate for opioids to be prescribed for post-surgical acute -- acute pain?

A Yes.

Q Okay. And -- and would you also agree that it is, sometimes, medically necessary to prescribe opioids for post-C-section or vaginal birth acute pain?

A I -- I think depending on the -- on the extent of, like, labial tear --

Q Uh-huh.

A -- or other trauma to the vagina, but, as a general rule, opioids should not be routinely used for post-vaginal birth pain.

Q Uh-huh.

A I would agree that they are sometimes appropriate for post-C-section pain.

Q Okay. Why did you not include post-surgical acute pain or -- or post-vaginal birth on your list in Item No. 3?

A Well, if they were acute pain, then they should not have been over 90 MME.

Q Okay. So, in your opinion, there is no circumstance in which a prescription of over 90 MME should be prescribed for any type of post-surgical acute pain? Is that your expert testimony, or expert opinion?

A That you should not give 90 MME to an opioid-naive individual.

Q Okay. So that's a little bit different than what I asked. So what -- what's an opioid-naive individual, Doctor? Explain --

A Somebody that has not taken an opioid before.

Q Okay. So let's take the -- the example of an opioid -- of an individual who is not opioid naive, okay? Is it your expert opinion that, with such an individual, a

prescription for over 90 MME should never be prescribed for post-surgical acute pain?

A I -- I -- I don't like speaking in absolutes, so I'm not going to say never.

Q Uh-huh.

A But I think that that would be rare.

Q Okay. But that's -- again, as we talked last time, that was -- that would be something that you, as an expert and a -- and a professional -- a physician, would leave to the individualized decision-making of the -- of the physician treating the patient?

A Making a -- a full risk/benefit analysis, yes.

Q Right, okay. Okay. Doctor, if -- get these Exhibits 9 and 10 in front of you again, these two spreadsheets we looked at a minute ago.

And, again, as I explained to you, these are the spreadsheets that we pulled from the MMIS data -- that's Exhibit 9 -- and then from the OK Expert 16 data, which is Exhibit 10, which we believe relate to the 245 prescriptions of Actiq or Fentora that were referred to in the petition.

Based on these spreadsheets that we pulled, it appears that the re- -- the statistical review that you and the review team that you've described reviewed -- or -- or I should say made determinations as to only three

of the 245; is that accurate?

A Yes.

Q Okay. And with regard to the three prescriptions of Actiq or Fentora out of the 245 referenced in the petition, of those three that were reviewed, you found that they were not medically unnecessary; is that correct?

A I don't know, because I'm not sure of the designation of the -- of the "Y" in the column.

Q So would we be able to compare that with the data you brought with you?

A Yes, we should be able to.

Q So let's do that, so we don't have any confusion.

A What page is that?

Q It's on the -- it's the last three lines of --

A Of --

Q -- the OK Expert 16 document.

A Okay.

Q Which is Exhibit No. 10. And there's an ICN number that corresponds which each -- with each of those.

A We're going to test the system here.

Q Uh-huh.

MR. DUCK: By the way, I sent electronic versions to --

A Not outside of the fact that they were part of a -- of a statistical analysis.

Q (By Ms. Patterson) Okay. But they weren't -- but -- but they weren't actually reviewed?

A They were not reviewed by me.

Q Okay. Or anyone, to your knowledge, for the --

A Not to my knowledge.

Q Okay. So, as an expert, sitting here in this case, do you plan to offer an opinion to the jury in this case, as to whether or not any of the claims in -- at Lines 1 through 242 of Exhibit 10, were medically unnecessary?

MR. DUCK: Objection to form.

A I would say I don't plan on offering an opinion, one way or the other, except to -- my testimony that a certain percentage of the prescriptions that I reviewed were medically unnecessary, certainly as that -- and that would be extrapolated to the 245.

Q (By Ms. Patterson) So the only way you would be able to offer an opinion, as to the -- as to prescriptions 1 through 242 on this particular spreadsheet, would be to extrapolate based on the fact that three out of 245 were found to be not medically unnecessary?

A Well, the --

MR. DUCK: Objection to form.

A The three out of the 245 were part of the larger sample.

Q (By Ms. Patterson) Uh-huh.

A And this is -- the -- the State is claiming, and I agree with it, that this is an indivisible injury, so I would not separate out the -- the three from 245 or the 245 out from the 8,000 or the 8,000 out from nine million.

Multiple patients were prescribed multiple different opioids for multiple different reasons. It's not clean-cut and indivisible, so, I mean, I think that you can draw broad conclusions based on the three out of 245, but I would not -- I would not limit it.

MS. PATTERSON: Objection, nonresponsive.

Q (By Ms. Patterson) You understand that Actiq and Fentora are -- are rather unique in the particular indication that -- that -- that they have, right?

A In that they are approved for cancer --

Q Right.

A -- related breakthrough pain.

Q Correct.

A Yes.

Q Okay. And so based on what I've seen in this data, okay, you reviewed -- you and your team reviewed only three of 245 distinct Actiq and Fentora prescriptions and you found that the three that you reviewed were not

medically unnecessary, correct?

A Correct.

Q Okay. Is it your plan to test- -- to -- to provide the jury with an expert opinion that any of the other 242 Actiq and Fentora prescriptions listed on Exhibit No. 10 were medically unnecessary?

MR. DUCK: Objection to form.

A Other than that they would have been included in the sample for which Dr. Gibson analyzed.

Q (By Ms. Patterson) Well -- well, they weren't included in the sample. We already estab- --

A They were included in the statistical analysis, not in the sample, but they were included in the universe in which Dr. Gibson analyzed.

Q Right. Well --

A The nine million.

Q Oh, well, sure, they were included in the nine million. That's a given. But they weren't included in the statistical sample that he had you review, were they?

A They were not.

Q Okay. Okay. One last thing I wanted to ask you about Exhibit 10. If you'd go to the last page -- and this is, again, on the OK Expert 16, and if you look in the "C Stratum 3" column and the "Sample Stratum" columns.

In the "C Stratum 3", column those three prescriptions that we looked at, at Lines 243, 44 and 45, are all listed as medium, do you see that, on the last page?

A Yes, I do.

Q Okay. And I think we both are under the same assumption that that relates to the stratums that you assisted Dr. Gib- -- Gibson in coming up with, correct?

A I -- I believe that to be likely, yes.

Q And then over in the next column, though, there's the word "High" next to those three lines, but that column, for every other prescription on this data -- on this spreadsheet, is empty. So do you know what the -- the designation "High" there means?

A I do not.

Q Okay. Doctor, do you recall, in your deposition last time, you talked about a different group of prescriptions for Actiq or Fentora that you thought might exist, and I think you used the term -- or you referenced a group of 2700 prescriptions for Actiq or Fentora?

A Yes.

Q Okay. Have you thought any more about that since your last deposition, to determine where you got that information?

A No.

Q Okay.

A It's -- it's my recollection that the 2700 was a larger time frame than what was listed at the 245.

Q Okay.

A But that's as much understanding as I have about it.

Q Okay. And the 245, as we talked about last time, or at least according to the State's petition, was -- and this is Exhibit 3 to the State's petition -- was from the time period -- they were dispensed between 1/1 of 2007 and 6/21 of 2017. That's what Exhibit 3 says --

A Okay.

Q -- if you'll at look it. Okay. Again, that's Exhibit 3 to the petition.

But you think the 2700 prescriptions that you were thinking about in your last deposition covered just a -- a broader period of time?

A Yes.

Q Okay. Do you know if any of those 2700 prescriptions that you referred to in your last deposition are contained in the very large spreadsheet that you brought me today as Exhibit No. 2?

A I do not.

Q You don't know, one way or the other?

A I do not. We did not do the -- the sample based on individualized medications or manufacturers or whatnot.

Q Right. So, in order for me to determine whether or not any of -- there are any other prescriptions for Actiq or Fentora in what you've brought me as Exhibit No. 2, I'd have to go back -- well, what would I have to do? Would -- do you know?

A I would not know.

Q Okay. All right. But, as you point out, there's no way, in looking at what you brought, to determine what particular opioid medication is associated with any of these prescriptions in the databa- -- or in the spreadsheet you brought, correct?

A Not in what I brought today, no.

Q Okay. I asked you, in your last deposition, whether the State has undertaken any kind of analysis, that you're aware of, to determine which of the 2700 prescriptions of Actiq or Fentora were excessive or unnecessary, and you answered "Yes." And I said, "Who did that for the State?" And you said, "I did." Is that still accurate testimony?

A Yeah, in that it would have been included in the nine million of which we did a sample, of which I did a review of a subset of that and then provided Dr. Gibson that information.

Q Okay. But, again, you cannot provide me with a number of -- of how many, if any, of the 2700 prescriptions you may have determined to be medically unnecessary, can you?

A I can't provide you any --

MR. DUCK: Objection to form.

A I can't provide you any specific information on specific medications or manufacturers.

Q (By Ms. Patterson) Because you didn't look at that?

A I did not look at that for the purpose of my review.

Q Okay. Okay. Let's look at 912853... okay. Got it.

Okay, Doctor, let's --

A Are you done with Exhibit 2 for now?

Q We -- well, no, we're probably going to actually use it to look up some of this stuff that I'm going to show you on some specific --

A Okay.

Q -- patients.

So what I'm going to show you right now, I'm going to mark as Exhibit 11 for this deposition, is...

MR. DUCK: Thanks.

Q (By Ms. Patterson) ...a document that was

previously marked as Exhibit 18 at your prior deposition. And then I'm going to mark Exhibit No. 12, a document that was previously marked as Exhibit 19 --

MR. DUCK: Thank you.

Q (By Ms. Patterson) -- at your prior deposition. And --

A If I could just have a second to --

Q You sure can.

A -- review this.

Q Yep. And I'll just tell you, just to be clear for the record, and then you can have as much time as you need: These -- both of these documents relate to a patient who had a identifier number of 912853, if you want to --

MR. DUCK: And, I'm sorry, can you say that one more time?

MS. PATTERSON: Sure. Now, this is not the ICN number.

MR. DUCK: ID.

THE WITNESS: Oh. 912?

MS. PATTERSON: It's -- it's 912853. It's the de-identified member number.

MR. DUCK: 196. It's Page 196.

THE WITNESS: And row?

MR. DUCK: Oh. 13467.

EXHIBIT 22

IN THE DISTRICT COURT OF CLEVELAND COUNTY

STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., MIKE HUNTER, ATTORNEY GENERAL OF OKLAHOMA,	)	
Plaintiff,	)	
-vs-	)	No. CJ-2017-816
PURDUE PHARMA, L.P., et al.,	)	
Defendants.	)	

VIDEO DEPOSITION OF ADRIANE FUGH-BERMAN

TAKEN ON BEHALF OF THE DEFENDANTS

IN OKLAHOMA CITY, OKLAHOMA

ON MARCH 6, 2019

COMMENCING AT 9:05 A.M.

INSTASCRIPT, LLC
101 PARK AVENUE, SUITE 910
OKLAHOMA CITY, OKLAHOMA 73102
(405) 605-6880
www.instascript.net

REPORTED BY: KIM GLOVER, CSR, RPR, RMR, CLR

defendants, 11, 12, and 13, the Watson Actavis defendants. I also represent those defendants. All right?

A Okay. Thank you.

Q Prior to --

MR. BECKWORTH: Just objection real quick. There's also a joint defense agreement, so you understand these lawyers are also working together. That wasn't fairly told in this line of questioning.

MS. PATTERSON: I'll object to the representation, but that's fine, Mr. Beckworth.

Q (By Ms. Patterson) Do you understand that these are the defendants that have been sued in this case?

A Yes.

Q Okay. Now, before I showed you this petition and went over with you the specific defendants who are actually named in this case, did you know who the defendants were in this case?

A I knew about most of them. I'm not sure about Actavis.

Q So you knew that there were Purdue defendants?

A Yes.

Q And you knew that they were Johnson & Johnson or Janssen defendants?
A Yes.
Q And you knew that there were Teva or Cephalon defendants?
A Yes.
Q Do you know about the Actavis entities?
A I don't think so.
Q Have you ever heard of Actavis, LLC, or Actavis Pharma?
A Yes.
Q Do you know what products, if any, those companies manufacture that are opioids?
A I would not be able to name them, no.
Q Okay. What about Watson Laboratories and Watson Pharma, do you know what opioid medications those companies have, in the past or currently, manufactured?
A Watson makes a number of generics, but I don't recall exactly what opioids they make.
Q Okay. Are you aware of Watson making anything, other than generic medications?
A I'm not sure.
Q Okay. Do you know if Actavis makes only generic medications?

A I don't know.

Q Let me ask you just a few general questions before we get into more specific areas.

First of all, the petition that I have provided you that was filed by the State of Oklahoma refers to an opioid epidemic. And it refers to that throughout the document, but just so you are with me, if you will turn to the second page of the document, which is a table of contents. And you will see down under the section -- no. You were -- right there. Right there. Yeah, you're right.

Second page of the document, it's a table of contents, and you will see there's a section entitled "Factual Allegations."

Do you see that, down toward the middle?

A Yes.

Q And you will see in Subheading A there, for example, it says, "Defendants' conduct created a devastating opioid epidemic in Oklahoma."

Do you see that?

A Yes.

Q All right. Do you believe that there is an opioid epidemic in this country currently?

MR. BECKWORTH: Hold on. just a

second. Objection. It's beyond the scope of her report. She's not here to testify as an epidemiologist.

I would also state for the record that your client, Nancy, and every other one has admitted that there is an opioid epidemic and a crisis.

Her testimony and her report is very clearly set out in her disclosure. She is not here as a drafter of a petition, she's not here as a lawyer, and she's certainly not here as an epidemiologist.

So, with that, I will instruct you that, if you can answer the question about epidemiology, you're free to do so.

MS. PATTERSON: And I'll just object for the record, Brad. If you're going to do this all day long, we're going to be here a long time and we're going to have a problem getting finished.

You know that's not an appropriate speaking objection. Okay?

MR. BECKWORTH: Disagree.

MS. PATTERSON: I get to ask the questions. You can object to scope and then let's just move on. Okay?

you see that?

A Yes.

Q And I see the reference -- or that term, "complementary medicine," used a number of other places in your CV. Very briefly, what is complementary medicine?

A So there have been various terms that have been used to describe therapies or practices that are not routinely taught in medical schools or routinely practiced by medical doctors.

So, over time, those terms have included complementary medicine, alternative medicine, integrative medicine, et cetera.

So complementary medicine is -- is one of those terms, but they are really all the same.

Q Okay. All right. Moving on up the list there on the first page, there is a reference to your work as a consultant for the George Washington University School of Public Health and Health Services.

And I note in there it says, "Analyze prescription drug marketing data in the District of Columbia." Do you see that?

A Yes.

Q And I noticed that some other places in

your CV there are references to work you have done specific to the District of Columbia, which is where you live; correct?

A Yes.

Q All right. Have you analyzed prescription drug marketing data in the State of Oklahoma?

A I have not.

Q Okay. Are you aware of any studies, research, or articles that have analyzed prescription drug marketing data in the State of Oklahoma?

A There are -- there are many research articles that have looked at pharmaceutical marketing practices nationally, and there is no reason to think that those practices would be any different in the State of Oklahoma.

Q But, to answer my question, are you aware of any studies, research, or articles that have specifically analyzed prescription drug marketing data in the State of Oklahoma?

A Well, I'm not aware of any published studies that have -- that have examined general pharmaceutical marketing in the State of Oklahoma. I don't think that those studies are actually necessary for looking at the effect of pharmaceutical marketing

of opioids in the State of Oklahoma.

We have the companies, we have -- we have documents -- I have documents and sales calls and plans for marketing from several companies to specific Oklahoma physicians.

Q Okay. Are you finished with your answer?

A Yes.

MS. PATTERSON: Objection, nonresponsive.

Q (By Ms. Patterson) My question is: Are you aware of any studies, research, or articles that have specifically analyzed prescription drug marketing data in the State of Oklahoma?

MR. BECKWORTH: Objection. She has answered it several times.

THE WITNESS: There -- I have not seen published studies in the medical literature on pharmaceutical marketing practices specifically in the State of Oklahoma.

Q (By Ms. Patterson) Okay. As I understand one of your prior answers, I think what you're telling us is that you believe you can rely, for purposes of your opinions in this case, on studies and research that have been done on a national level

regarding prescription drug marketing practices?

A That would be part of what I would rely on.

Q What else do you rely on?

A On the companies' -- on companies' own documents, including call notes and including plans for pharmaceutical marketing and there are -- and the numbers of call visits, for example, that occurred in the State of Oklahoma.

Q So the only information you have on call notes, with regard to calls made on doctors in the State of Oklahoma, is based on the information that was provided to you by the lawyers for the State; correct?

A They provided me with some call notes. There are many others, and at some point, I actively prevented them from providing me with additional call notes, because there were so many of them.

Q You actively prevented counsel for the State from providing you with additional call notes. Is that what I understood you to say?

A I have examples of -- I have some examples of call notes.

Q Right. I understand. But your understanding is that you have been provided --

A There are many of them, and my understanding is that there are many other call notes that are -- can also be used as examples.

Q Okay. All I'm trying to understand is what you've looked at and what you think is out there.

A I have looked at numerous call notes. I have a sample of them here.

Q Sure. I understand.

A There are many more that exist.

Q I understand. And you have not -- let me do it this way.

Your understanding from your interactions with counsel for the State is that there are -- there's a large group of call notes, but you have only been provided a subset of that; correct?

A I have been provided with a subset of call notes, because there are so many of them, yes.

Q Okay. Do you know what percentage of the universe of call notes that the State has that you have been provided?

A I do not.

Q Okay. Have you asked to review -- as we sit here today, have you asked to review any additional call notes?

A I was provided some call notes and

and their patients than that of other morphine alternatives" --

Q (By Ms. Patterson) You don't need to read it to me. If you can just point me --

A Okay.

Q -- tell me what page it's on.

A Sorry. It's on Page 10.

Q Page 10, okay.

A So this is Oklahoma's --

Q Okay.

A -- sales manager.

Q Okay.

A The --

Q Is there any other --

A -- information in that --

Q I'm sorry. I didn't mean to cut you off.

MR. BECKWORTH: Well, it keeps happening. Why don't you -- you can complete an answer, despite the interruptions.

Q (By Ms. Patterson) Yeah. I'm not trying to -- you talk slowly and you do kind of stop at times, and so sometimes I think you're finished with your answer. And I'm not trying to cut you off.

MR. BECKWORTH: Well, good. Then

you won't mind her continuing.

THE WITNESS: And the -- I'm pausing because I just want to make sure that I'm really thorough in my answer.

I feel like there was another point in here where I also mentioned Eric Wayman. So Wayman also states, in a different point in the deposition, that the total prescription level is highly correlated to call activity.

And, again, he -- he is the -- he is the Oklahoma sales manager, so --

Q (By Ms. Patterson) Have you ever spoken to or interviewed Mr. Wayman?

A I have not.

Q Everything you know about what Mr. Wayman believes went on in Oklahoma is based on your review of his deposition. Is that fair?

A That's fair.

Q Okay. Other than the references to Mr. Wayman's deposition that appear in a couple of different places in Exhibit No. 8, can you point to me -- point me to any other discussion in Section B of your expert disclosure where you discuss any particular marketing tactic that was used by any of the defendants with any prescriber in the State of

Oklahoma?

A Again, information -- national information would not exclude Oklahoma and is relevant to Oklahoma.

I have not -- I -- to the best of my recollection, I have not included other information specific to marketing of opioids in Oklahoma specifically in this report.

Q Okay. Have you -- have you done any research to determine whether there is any particular marketing tactic or sales tactic that any of the defendants have employed in order to market opioids specific to the State of Oklahoma?

A Such research is unnecessary, given the information from the call notes of the drug reps --

Q So the answer is no, you haven't done it.

MR. BECKWORTH: Let --

THE WITNESS: -- for the --

MR. BECKWORTH: Hold on a second.

THE WITNESS: -- defendants.

MR. BECKWORTH: Excuse me.

Q (By Ms. Patterson) Have you done it?

MR. BECKWORTH: No. Objection. You're not going to keep interrupting her.

MS. PATTERSON: It's a yes-or-no question.

MR. BECKWORTH: It's not. She can answer it however she chooses. Your question was -- and you cut her off. You said, "Such research is necessary given the information from the call notes of the drug reps" --

MS. PATTERSON: I think she actually said it's unnecessary.

MR. BECKWORTH: I'm reading it, unnecessary.

You can finish your answers whenever you need to. Okay?

THE WITNESS: Call notes can be very important, because they reflect marketing messages that a company has given to the drug reps to convey to physicians.

We know there is an opioid use and overdose problem in Oklahoma. We know that there were many drug rep visits from -- from companies represented here to physicians in Oklahoma.

We have call notes from two of those companies that reflect marketing messages that were used nationally, and Oklahoma is not an exception to marketing tactics that would be used nationally.

that --

A Several factors.

Q Okay. And when you say that if a person -- you said, "If a person who dies from a street drug started off on prescription drugs, how do you count that? Do you count that as a street death or a drug death?"

Now, you're not saying that every person that dies from an overdose of street drugs necessarily started by taking a prescription opioid, are you?

A No, but there are data showing that four out of five heroin addicts started off on prescription opioids.

Q Okay. And do you have any data as to the percentage of those prescriptions that were made to those particular individuals were medically unnecessary?

A Ah, so that's a -- that's a great point. So some of those prescriptions would have been given to someone who then goes on for -- to -- to use heroin. The person may have been given them for pain at some point and became addicted to them. They might have been given to them at some point, saved some, started using them later. They may have been

prescribed a -- an inappropriate amount of opioids that then somebody else got into and started taking. So it might be -- it -- it might be a relative, a friend, a kid, a houseguest who's using a prescription opioid that they weren't actually prescribed.

But in all of those cases, the fact that over-prescribing occurred in the first place and that people have bottles of opioids in their medicine cabinets is contributing to opioid use disorder, opioid overdoses, and opioid death. All of those go back to over-prescribing.

MS. PATTERSON: Objection, nonresponsive.

Q (By Ms. Patterson) Is all prescribing of opioids, in your opinion, over-prescribing?

A No. We've already discussed that there are --

Q Okay.

A -- actually appropriate uses of -- of opioids.

Q Okay. And would you agree, Doctor, that different medical professionals disagree on the appropriate uses for opioids, the medically appropriate uses for opioids?

A Medical professionals may disagree on

this, but the science on it is quite clear.

Q Okay. All right. But you're not here to testify as an expert on that, are you?

A I'm not here to testify on what?

Q On the science behind what's -- what's appropriate -- an appropriate use of opioids, a medically appropriate use of opioids?

A I'm happy to testify that there is not evidence that opioids are effective for chronic pain. That's not --

Q Are you here to testify --

A -- my opinion. That is also the opinion of the U.S. Government in the form of CBC guidelines, the A/DOD guidelines, and --

Q So your -- well, let me make sure I understand. It's your testimony that the U.S. Government's position is that the prescription -- that the use of opioids for chronic pain is -- is inappropriate?

A That's not exactly what I said.

Q Okay. That's what I thought I heard, so you can clarify that.

MR. BECKWORTH: She said CBC and DOD. Just let's be clear. Her scope of her report is what it is. That's what she is being offered to

Q Have you interviewed or communicated with any patients in the State of Oklahoma about the opioid medications they've been provided or prescribed by their practitioners?

A No.

Q All right. And in terms of -- again, just to be clear, you have not spoken to or interviewed any of the doctors on any of the documents that you have been shown today -- any of the doctors in the State of Oklahoma about what, if anything, about pharmaceutical manufacturer or marketing materials has influenced their prescribing decisions?

A Although I have not interviewed physicians, that wouldn't -- that wouldn't be high yield, anyway. Physicians don't think that they're influenced by pharmaceutical marketing, but, in fact, they are, and there is robust academic literature on the fact that they are influenced, despite what they think.

Q All right.

A And there's lots of studies in social psychology literature that explains why that's true.

Q In your opinion, are there any legitimate prescriptions that have been made by any physicians in the State of Oklahoma for opioids, at

any time?

A As I stated before, there are legitimate reasons to prescribe opioids, in end-of-life care, in cancer-related pain, in acute pain.

There are several clinical scenarios in which it's absolutely appropriate to prescribe opioids.

Although I don't have specific information on opioid prescribing by physicians in Oklahoma, I would certainly hope that -- that some of the prescriptions that they write are actually appropriate.

Q Can you name for me any physician in the State of Oklahoma who has been influenced by pharmaceutical company marketing to over-prescribe Actiq or Fentora?

MR. BECKWORTH: Objection to form.

THE WITNESS: Well, we have evidence of influence by -- by sales reps for companies of opioids other than Actiq and Fentora. We do know that there were national --

Q (By Ms. Patterson) My question is specific to Actiq and Fentora. I'm asking you to name doctors.

MR. BECKWORTH: Hold on a second. If we're going to be interrupting the witness, we're not going to stick around.

So go ahead and finish your question -- your answer, Doctor.

THE WITNESS: There are certainly national marketing campaigns that would be expected to have influenced physicians in Oklahoma.

I'm certainly hoping that there will be call notes available from Cephalon reps, and I would be happy to analyze those.

Q (By Ms. Patterson) Do you know if those have been produced?

A I do not, but --

Q The documents that are in these folders that Mr. Beckworth marked, I think, as Exhibit 48, those are additional call notes, but you haven't looked at any of those documents yet; right?

A I have looked at some of them and not others.

Q And you have told us that you plan to look at additional documents that are provided by counsel for the State; correct?

A Yes. That's correct.

Q Do you plan to amend your disclosure

EXHIBIT 23

IN THE DISTRICT COURT OF CLEVELAND COUNTY

STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., MIKE HUNTER, ATTORNEY GENERAL OF OKLAHOMA, Plaintiff,	)	
-vs-	)	No. CJ-2017-816
PURDUE PHARMA, L.P.; et al., Defendants.	)	

* * * * *

VIDEOTAPED DEPOSITION OF MEL POHL, M.D., DFASAM

TAKEN ON BEHALF OF THE DEFENDANTS

IN OKLAHOMA CITY, OKLAHOMA

ON MARCH 8, 2019

COMMENCING AT 9:07 A.M.

* * * * *

instaScript, L.L.C.
101 Park Avenue, Suite 910
Oklahoma City, Oklahoma 73102
405.605.6880
schedule@instascript.net

REPORTED BY: BETH A. McGINLEY, CSR, RPR

A Other than the addiction-related medications?
Q (By Mr. Ercole) Yes.
A No.
Q Okay. With respect to that situation you just described, where you visited a pharmaceutical company at a booth during a -- a conference, do you recall any -- strike that.

With respect to that situation you just described, did you ever visit with any representatives for Cephalon at a conference?
A I can't recollect that I have.
Q So, sitting here today, you can't recall any communications that you had with Cephalon after -- well, strike that.

Sitting here today, can you recall any communications you've ever had with -- with Cephalon?
A No.
Q Sitting here today, can you recall any conversations you've ever had with Teva about opioid medicines, as we've defined it?
A No.
Q Sitting here today, are -- can you recall any conversations you had with any other -- that -- of the defendants in this case, about opioid medicines?
A Yes.

MR. CUTLER: Object to the form.

Q (By Mr. Ercole) Okay. How about -- have you ever heard of the company Actavis, LLC?

A No.

Q Have you ever heard of the company Watson Laboratories?

A I might have heard of them, but I couldn't tell you what they did.

Q Are there -- you don't recall having any convers- -- communications with that company?

A No.

Q Any communications you recall with Actavis, LLC?

A No.

Q Any communications that you can recall with -- strike that.

Have you ever heard of the company Actavis Pharma?

A No.

Q And are you -- in this case, you're not giving any opinions regarding Actavis Pharma, correct?

MR. CUTLER: Object to the form.

A Correct.

Q (By Mr. Ercole) And you're not giving any opinions with respect to Actavis, LLC?

MR. CUTLER: Object to the form.

A Correct.
Q (By Mr. Ercole) And you're not giving any opinions with respect to Watson Laboratories, correct?
MR. CUTLER: Object to the form.
A Correct.
Q (By Mr. Ercole) Okay. You've mentioned that you've used marketing materials in some of the presentations that you've given -- strike that.
You mentioned you've used mar- -- marketing materials from pharmaceutical companies in connection with presentations you've given on opioids --
A Yes.
Q -- is that fair?
A Yes.
Q Okay. With respect to those presen- -- strike that.
With respect to those marketing materials, have you ever utilized any marketing materials involving Cephalon?
A I think not.
Q Okay. Have you ever utilized any marketing materials regarding Teva, with respect to opioids, as we've defined it?
MR. CUTLER: Object to the form.
A I think not.

Q (By Mr. Ercole) Okay. Just give me one second, if that's okay.

I'm trying to figure out a way of streamlining things because there are numerous defendants in this case and I want to make sure that I'm trying to get you out of here as quickly as we can, so --

A Understood.

Q Dr. Pohl, since you've never reviewed any marketing materials involving Cephalon -- correct?

MR. CUTLER: Object to the form, mischaracterizes --

MR. ERCOLE: Sorry.

MR. CUTLER: -- his testimony.

Q (By Mr. Ercole) Have you reviewed any marketing materials disseminated, involving Cephalon?

MR. CUTLER: Same objection.

A No, not that I recall.

Q (By Mr. Ercole) Because you're -- you haven't reviewed any, you're not giving an opinion about any of those materials, correct?

MR. CUTLER: Object to the form, mischaracterizes his testimony and mischaracterizes his disclosure.

A Correct.

Q (By Mr. Ercole) Okay. And you haven't -- I

MR. CUTLER: Object to the form.

A Yes.

Q (By Mr. Ercole) And some doctors may not consider medical literature; is that fair to say?

MR. CUTLER: Object to the form.

A It is. I -- I wanted to go back to --

Q (By Mr. Ercole) Yeah.

A -- the doctor who chooses to prescribe based on prior experience.

Q Yeah.

A That's the least valuable of all the lists that you've just enumerated, because that's just anecdotal, related to, you know, small circumstances. Ideally, we base our decisions on large circumstances, such as a medical article.

Q And when you say "small" -- so --

A So if you have -- you -- you've prescribed this medicine for 10 patients, that's an N of 10. You know, you -- you -- you'd really rather see an N of 2,000.

Q Sure.

A You know, how does it work in a large number of patients compared to a small number of patients.

Q Well, and let me -- let me -- just for the sake of, you know, intellectual discussion, let me push back on that just a little bit, if it's fair.

So with -- would you agree, though, that a prescriber that has had success with a particular medicine for a number of patients, over an extended period of time, may want to -- and -- and -- may want to consider that experien- -- a positive experience with the medicine in writing a prescription?

MR. CUTLER: Objection, form, completely speculative, vague.

A I think that's what we do as physicians, but I wouldn't say it's nearly as valuable as a controlled study.

Q (By Mr. Ercole) Would you agree that in terms of controlled studies and what's actually published in the medical literature, that that lags behind, in some instances, what's actually going on in practice?

MR. CUTLER: Object to the form, calls for speculation, outside the scope of his testimony.

A Yeah, I'd suspect the answer is maybe.

Q (By Mr. Ercole) Okay. Just de- -- just depends?

A It does.

MR. CUTLER: Same objections.

Q (By Mr. Ercole) Would you -- Dr. Pohl, would you agree that if chronic pain patients are screened for potential substance abuse issues and then monitored appropriately by prescribers, that the benefits of opioids

can outweigh the risks?

MR. CUTLER: Object to the form, calls for speculation, vague.

A I think that they can outweigh the risks, on -- on occasion, yes.

Q (By Mr. Ercole) And just depends on the particular circumstances at issue?

A On all the variables --

MR. CUTLER: Object to the form.

A -- yes.

Q (By Mr. Ercole) Yeah. And those circumstances are individualized; would you agree with that?

MR. CUTLER: Object to the form.

A I would agree with that.

MR. ERCOLE: What -- what time is it? Do we have a time?

THE WITNESS: 12:08.

MR. ERCOLE: Okay. You -- I'm happy to keep going. You let me know when you want to stop for lunch.

THE WITNESS: I'm ready anytime.

MR. CUTLER: If we can stop now, I'd -- I could use a break, anyway, if -- if you all are fine stopping now.

THE WITNESS: That would be good.

MR. ERCOLE: Yeah, I'm going to -- I was going

to move on to a -- another topic, so this is as good a time as any --

THE WITNESS: Okay.

MR. ERCOLE: -- so let's go off the record now.

THE VIDEOGRAPHER: Off the record at 12:07 p.m., end of Media No. 2.

(Recess was had from 12:07 p.m. to 1:05 p.m.)

THE VIDEOGRAPHER: We are back on the record, this is Media No. 3, at 1:05 p.m.

Q (By Mr. Ercole) Good afternoon, Dr. Pohl.

A Good afternoon.

Q Earlier today, we were discussing some of the presentations that you've given at various times regarding opioids. Do you recall that?

A Yes.

Q Okay. And you mentioned, in -- in some of your presentations, you've referred to or used marketing materials from pharmaceutical manufacturers. Do you recall that testimony?

A Yes.

Q Which specific companies' marketing materials have you used?

A Purdue Pharma, particularly, and ads for -- excuse me -- OxyContin. And I don't know that it's specific to any pharmaceutical company, but the

back one more.

With respect to the patients you see, the patients you see have all become addicted to some type of substance, correct?

A Correct.

MR. CUTLER: Object to the form.

Q (By Mr. Ercole) Okay. So you have not actually monitored patients who are not addicted to opioid medicines, for --

MR. CUTLER: Object --

Q (By Mr. Ercole) -- decades, correct?

MR. CUTLER: Object to the form.

A That's correct.

Q (By Mr. Ercole) And so based upon your personal experience, then, you would not know whether or not patients are benefiting or not benefiting from chronic opioid therapy until they come to you and, in that instance, they're -- they've suffered some type of addiction, correct?

A You know --

MR. CUTLER: Object to the form, vague, compound, mischaracterizes his earlier testimony.

A And I would say that, you know, I've based my opinions on the broad efficacy of opioids on -- on the literature that I've referenced here.

Q (By Mr. Ercole) And -- and the literature you're referencing would be the -- is it "Efficacy of Long-Acting Opioids with Respect to Chronic Pain"?

MR. CUTLER: Object to the form.

A Yes.

Q (By Mr. Ercole) Okay. And you're not giving an opinion with respect to the efficacy of opioids with respect to treating -- strike that.

You're not giving an opinion with respect to the efficacy of -- of short-acting opioids to treat immediate or acute pain, correct?

MR. CUTLER: Object to the form.

A No, but I have -- I have an opinion about that. I mean, the -- the data that is quoted in the CDC study that I also reference suggests that short-term use of an opioid can result in long-term reliance on that opioid. So I'm of the opinion that minimizing the use of opioids in acute pain would be appropriate.

Q (By Mr. Ercole) And you used the word "minimizing the use of opioids with respect to acute pain." You would agree with me that opioids can be effective in treating acute pain, correct?

A Well --

MR. CUTLER: Object to the form, vague.

A Opioids are effective in treating acute pain

because it's short-lived and all of the problems, the -- the harms are minimized in that, so there -- they are beneficial -- the -- they are effective in treating pain. Whether they're beneficial or not is really a -- a different issue, because some people -- I mean, I can't tell you how many patients tell me that they got 60 pills from a surgeon for a wisdom tooth being pulled and they took one and didn't like the way they felt and didn't take any more, so that's a trend in our country that is also problematic for acute pain.

Q (By Mr. Ercole) And at least -- and I think you used the word -- I think your -- your testimony talks about -- uses the word "rarely be -- be used daily for the treatment of chronic painful conditions." Do you see that?

A Where are we looking?

Q Sure. In your disclosure, the -- what I just -- what we just looked at, "rarely be used daily" --

A On the second page?

Q Ye- -- it's on the first page, still.

A Just -- just help me find the sentence and I'll --

Q Yeah, sure. It says --

A I just want to confirm.

Q It's what we were talking about before --

A Oh, yeah.
Q -- "Opioids should rarely be used daily for the treatment of chronic painful conditions."
A I would agree with that, yes.
Q Okay. And there are -- there are instances, correct, where -- strike that.
Are you aware of -- of instances where patients have benefited from the long-term use of opioid therapy for chronic non-cancer pain?
MR. CUTLER: Object to the form.
A And I -- I think that I -- I would wonder if any patient really benefits from chronic use of opioids. I think that people perceive that they suffer less when they take an opioid, but, in actual fact, whether they're benefiting, whether it -- it -- it helps them, as an organism, have a better life, have a better functional life, is in question, in my mind.
Q (By Mr. Ercole) Have you spoken with doctors that have talked to you about benefits that their patients have had with respect to long-term chronic pain?
MR. CUTLER: Object to the form.
A Yeah, I -- I mean, I've heard from people, when I lecture or when I discuss this topic, and, you know, I read the -- the -- for the response to the CDC guidelines, you know, there are people who affirm that they have been

is --

A Absolutely. Absolutely. False and misleading. I think that the company that created that ad knew that that was false and misleading.

Q So what is the basis for your opinion that the advertisement was false and misleading?

A Because there's no data to suggest that opioids made life better and they claimed that opioids made life better. Where -- where was the data to support that contention? You know, the -- and the fact that you couldn't get addicted if you had chronic pain, where was the data for that, other than in the Porter and Jick letter to the editor of The New England Journal? So, yeah.

Q Doctor, have you conducted a -- let me start over.

Doctor, have you conducted a systematic review of the literature on the risks of addiction associated with opioids?

MR. CUTLER: Object to the form.

A I'm sorry, say the question again.

Q (By Mr. Tam) Have you conducted a systematic review of the medical literature on the risks of addiction associated with opioids?

A "Systematic review" is probably not an accurate

way to characterize it. I've reviewed reams of literature on this topic. I -- I read voraciously about everything, but it's not done in a systematic way.

Q Certainly, as, you know, an addiction specialist, you've conducted research; I get that.

So just to make my question clear: As to the issue of the risk of addiction associated with opioids, you have not done a systematic review of the literature, have you?

A And I'll --

MR. CUTLER: Object to the form.

A -- state again that I've reviewed a lot of literature, depending -- I mean, I guess I need a definition of "systematic review." I -- I don't want to exaggerate the systematic nature of my review, but I've reviewed reams of literature on this topic.

Q (By Mr. Tam) Can you identify any study at the time -- let me start over.

Can you -- at the time you saw these advertisements in The Journal of the Medical -- let me start over.

At the time you saw the advertisements in The Journal of the American Medical Association, can you i- -- identify any study that demonstrated that the advertisement was false or misleading?

MR. CUTLER: Object to the form.

A You're saying at --

MR. CUTLER: Asked and answered.

A At the time that I saw this ad, were there -- did I -- the studies didn't exist. The studies that I'm referencing now weren't available. I mean, those have come since that time. Were there studies at that time? None that I'm aware of, I...

Q (By Mr. Tam) And you can't identify any doctor in Oklahoma who saw that advertisement, can you?

MR. CUTLER: Object to the form.

A No.

Q (By Mr. Tam) And you cannot identify any Oklahoma doctor who relied on that advertisement in writing a prescription for OxyContin, can you?

MR. CUTLER: Object to the form --

A I can't, but I can assume that people in Oklahoma read the same medical journals that I do. The Journal of the American Medical Association is a nationally-distributed journal to all members of the AMA, so I -- I would assume that they saw it, but I -- I haven't spoken to any Oklahoma doctors to confirm that.

Q (By Mr. Tam) Even if you assume that some doctors in Oklahoma may have seen that advertisement, you don't know whether any of those Oklahoma doctors relied on

EXHIBIT 24

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

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

Defendants.
_____/

VIDEOTAPED DEPOSITION OF WAYNE ARTHUR VAN ZEE, M.D.
TAKEN ON BEHALF OF THE DEFENDANTS
ON FEBRUARY 26, 2019, BEGINNING AT 9:07 A.M.
IN OKLAHOMA CITY, OKLAHOMA

VIDEOTAPED BY: Gabe Pack
REPORTED BY: D. Luke Epps, CSR, RPR

certification for that.

Q (BY MR. HOFFMAN) Do you consider yourself to be or do you hold yourself out as a marketing expert?

A I hold myself as somebody knowledgeable about the marketing of OxyContin.

Q Okay. And other than the 2009 article, which we're going to talk about in a moment, have you published on the topics of either pharmaceutical marketing or the marketing of OxyContin at any other point in time?

A No.

Q And you -- you are currently employed at the Stone Mountain Health Services. I guess it's the St. Charles Clinic; is that right?

A Correct.

Q Okay. And what do you do there?

A I'm a primary care general internist.

Q And you mentioned this a moment ago, but just tell me briefly, what kinds of patients do you see on a -- on a daily basis?

A Well, as a general internist, they're -- they're virtually all adults over age 18, and you see a variety of chronic medical problems from hypertension, diabetes, COPD, black lung cancer,

chronic renal insufficiency, so those are common medical problems. I've been a prescriber of buprenorphine since 2003, so that's 16 years now, and about 20 percent of my practice is taking care of patients with opioid use disorder.

Q Okay. If you can estimate, approximately how many patients do you see per day?

A I would see between 16 and 20 patients a day.

Q And do you currently prescribe opioids for patients who have chronic pain?

MR. PATE: Object to form.

THE WITNESS: I --

MR. PATE: Ask you asking -- hold on. You're asking him how he prescribes opioids?

MR. HOFFMAN: I'm just asking if he -- if he prescribes opioids currently for patients who have chronic pain.

MR. PATE: Patients in his own practice?

MR. HOFFMAN: Correct.

THE WITNESS: Yes. I prescribe opioids for some of my patients with chronic pain.

Q (BY MR. HOFFMAN) How many, approximately, patients do you believe you have who are in chronic pain for whom you prescribe opioids?

A 200 to 250.

Q And for some of those patients, do you currently prescribe OxyContin?

A I do not.

Q None of those patients, none of the 200 to 250, you don't prescribe OxyContin for any of them?

A I do not.

Q What --

A I prescribe oxycodone, which is a short-acting oxycodone, but no sustained-release oxycodone.

Q What other opioids do you prescribe to these approximately 200 to 250 patients who are in chronic pain?

A Short-acting oxycodone, short-acting hydrocodone, fentanyl patches on occasion, morphine, both immediate release and sustained release, and methadone.

Q So you mentioned with morphine, you prescribe both the immediate release or IR as well as the controlled-release, which is also sometimes referred to as extended-release or long-acting; is that right?

A Correct.

Q You mentioned earlier you do not prescribe

A Well, that's -- that's the primary one. I was a volunteer medical -- volunteer medical director at a nonprofit residential drug treatment facility for several years, and no medications were used in that situation, but the current practice is that, no, I don't use other things besides behavioral health interventions, 12-step treatment, 12-step programs and buprenorphine treatment.

Q Okay. You do use, you mentioned earlier, several different types of opioids to treat chronic pain; is that right?

A I do.

Q So based upon that, I take it you would agree that opioids can be safe and effective when used according to the FDA-approved labeling?

A No. I don't agree with that. I think there are -- I think they can be safe, but they're not always safe, and I don't -- I think it's almost misnomered to say that opioids are safe because opioids can inherently be addictive, and there are safer ways to prescribe opioids than others, but I don't know any situation where I could feel completely safe in.

Q Okay. And my question was -- was specific. I said would you agree that opioids can

be safe and effective when used according to the FDA-approved labeling, and I think that's a clarification you just gave me is that they can be; is that right?

MR. PATE: Objection. Misstates his testimony. He answered your question.

Q (BY MR. HOFFMAN) Would you agree that they can be safe and effective when used according to the FDA-approved labeling?

MR. PATE: Object to form. Asked and answered.

Q (BY MR. HOFFMAN) You can go ahead and answer.

MR. PATE: You can also look at your prior answer if you need to because you've already answered this question.

Q (BY MR. HOFFMAN) He hasn't answered it, but even if he has, I want to clarify. So do you know which question you're answering now, Doctor?

A You asked me if opioids can -- prescription opioids can be safe and effective.

Q When used according to the FDA-approved labeling.

A They can be.

Q And that's why you've prescribed them to

200 to 250 of your current patients; right?

A Right.

Q Okay. I don't think we've marked your article yet, so let's go ahead and mark your article. I guess I need another exhibit sticker. My plan for marking them in advance has failed miserably, so let me remark this. Let me just -- I'll mark your copy, Doctor, and I'll give it back to you. We'll mark as Exhibit 3 your article -- the copy of your article that you've brought with you here today. It's entitled "The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health," excuse me, "Tragedy," and you are the sole author; is that right?

(Exhibit 3 marked for identification.)

A Correct.

Q And as we mentioned earlier, there's some highlighting and some notes on here, and those were all placed on the document by you?

A Those are -- those were put -- those are my handwriting. Those are my notes.

Q Okay. Let me hand that back to you and I'll provide copies.

MR. PATE: I have it.

MR. HOFFMAN: You have it?

MR. PATE: Exhibit 3?

Q (BY MR. HOFFMAN) Correct. Now, this -- this article, which is Exhibit 3, this was published in the American Journal of Public Health; is that right?

A That's correct.

Q Did you submit this article to any other journals?

A I submitted an earlier version to other journals, yes.

Q Which journals did you submit to?

A Annals of Internal Medicine.

THE COURT REPORTER: I'm sorry?

THE WITNESS: Annals of Internal Medicine. A-N-N-A-L-S of Internal Medicine, a much earlier version.

Q (BY MR. HOFFMAN) Any other -- excuse me. Any other journals to which you submitted an earlier version?

A I don't think so.

Q So what happened with the earlier version that you submitted to the Annals of Internal Medicine? Did they reject it?

A They did.

Q Did they tell you why?

EXHIBIT 25

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

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

Plaintiff,

vs. No. CJ-2017-816

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

VIDEOTAPED DEPOSITION
OF TEVA 3230(C)(5) WITNESS
JOHN HASSLER
TAKEN ON BEHALF OF THE PLAINTIFFS
ON JANUARY 30, 2019, BEGINNING AT 9:08 A.M.
IN OKLAHOMA CITY, OKLAHOMA

VIDEOTAPED BY: Gabriel Pack

REPORTED BY: Lacy Antle, CSR, RPR

[redacted]

Q (BY MR. DUCK) Sometimes Teva funds or sponsors or even conducts clinical studies itself after FDA approval for purposes of marketing, right?

MR. FIORE: Object to form and scope.

THE WITNESS: I don't look at it quite that way. The company will fund studies that look at specific attributes of the product that we want to better understand and characterize which can have a beneficial effect in terms of promoting those branded products.

Q (BY MR. DUCK) Teva does what it can to understand physicians' concerns with any of its products, right?

A Yes.

MR. FIORE: Object to form.

Q (BY MR. DUCK) And if Teva identifies a concern that is preventing physicians from prescribing its drugs, Teva will perform research into that concern, right?

MR. FIORE: Object to form and scope.

THE WITNESS: At times.

Q (BY MR. DUCK) And if the research yields favorable results for Teva, Teva can then use those result to promote its drugs and overcome those

concerns, correct?

MR. FIORE: Object to form and scope.

THE WITNESS: Only if that trial qualifies and is recognized by the FDA in order to incorporate the outcomes of the trial into the label, so in order to use the material promotionally, it has to be part of the label.

Q (BY MR. DUCK) Is it true that the only clinical studies or research that Teva references in promotion are those that have been submitted to the FDA as part of the label?

MR. FIORE: Object to the form and scope.

THE WITNESS: In a proactive manner, for our sales force to use data and messaging proactively, it has to be PARC approved and PARC approved materials have to be consistent with the product labeling.

Q (BY MR. DUCK) What does PARC approved mean?

A That that material has been submitted through a review process where regulatory, medical, legal and marketing assess the piece to be consistent with the label, accurate, fair balanced and compliant with laws and regulations. Once it's been approved, then it can be used promotionally.

Q Is the FDA involved in that approval

process at all?

MR. FIORE: Object to the form.

THE WITNESS: The FDA receives all of the branded PARC-approved materials after they've been approved when they're being used in the field, except for Actiq, which required presubmission of all promotional materials to the FDA prior to their use.

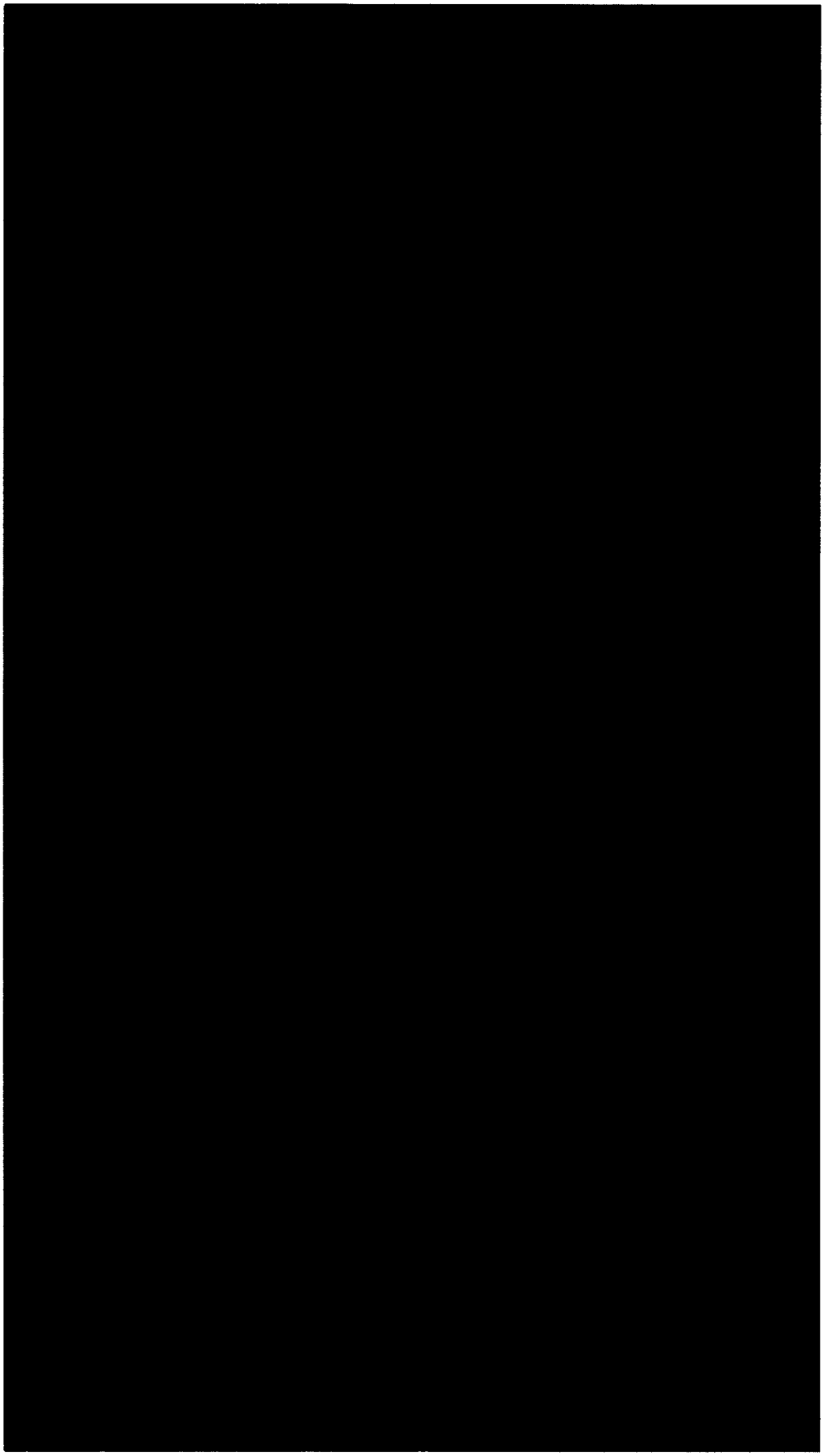
Q (BY MR. DUCK) Why the difference?

A Actiq was approved under a regulation that's called Subpart H and it allows for an expedited FDA review, but more stringent and restricted controls on what -- what can be done with the product in the marketplace following review.

Q Why was Actiq approved under Subpart H?

MR. FIORE: Object to form and scope.

THE WITNESS: I don't know the specific criteria that Subpart H represents. My understanding is that is for products that have a very important unmet need that the FDA feels an urgency to prioritize the evaluation and move the product to market, but I don't know that that's accurate, that's just my understanding, based on what I've heard. I'm not particularly familiar with Subpart H.



Q Now, by this time was Actiq also being made in a generic form by Teva?

A Yes.

Q Does this include any of its sales and marketing expended for the generic form of Actiq?

MR. FIORE: Object to form.

THE WITNESS: No, there aren't any sales and marketing initiatives. There are product announcements initiatives for the generic products and there's allocation of expenses for generic products, but they're not -- they're not allocated to a specific product. So it's all lumped together for all of Teva's generics, they're not split out for any specific product.

Q (BY MR. DUCK) Do the amounts we see for sales and marketing on this Exhibit 2 include amounts expended on non-branded marketing?

MR. FIORE: Object to form.

THE WITNESS: For the branded product, any expenses related to sales and marketing, which would include any medical affairs expenses as well, would be included in these numbers that were attributed back to the brand.

Q (BY MR. DUCK) So yes, these numbers do include non-branded marketing?

MR. FIORE: Object to form.

THE WITNESS: If there was any.

Q (BY MR. DUCK) Well, Teva and Cephalon have conducted non-branded marketing related to opioids, true?

A Yes.

MR. FIORE: Object to form and scope.

Q (BY MR. DUCK) Teva and Cephalon have -- new question.

Teva and Cephalon have conducted non-branded marketing about the problem of pain generally, right?

MR. FIORE: Object to form and scope.

THE WITNESS: Yes.

Q (BY MR. DUCK) And when Teva does non-branded marketing about opioids generally or pain generally, Teva does not mention its products, true?

MR. FIORE: Object to form and scope.

THE WITNESS: If it's non-branded promotion that the company controls, then it cannot mention a product.

Q (BY MR. DUCK) Otherwise the FDA would have to take a look at the information, because branded marketing is regulated by the FDA?

A It would be submitted --

MR. FIORE: Object to form. Lacks foundation. Assumes facts not in evidence and scope.

THE WITNESS: It would be submitted to the FDA and if it included Actiq specific information it would be submitted prior to use.

Q (BY MR. DUCK) But non-branded marketing is not submitted to the FDA, true?

MR. FIORE: Same objection.

THE WITNESS: That's correct. It still goes through the PARC-approval process if Teva or Cephalon controls the content, but it is not submitted to the FDA.

Q (BY MR. DUCK) And Teva makes generic opioids, right?

MR. FIORE: Object to form.

THE WITNESS: Yes.

Q (BY MR. DUCK) Generic opioids are used to treat pain, correct?

MR. FIORE: Object to the form and scope.

THE WITNESS: Yes.

Q (BY MR. DUCK) And between the years 2013 and 2016, you'd agree with me that Teva in fact conducted non-branded marketing about opioids and

pain?

MR. FIORE: Object to form and scope.

THE WITNESS: Yes.

Q (BY MR. DUCK) So even though Teva may not mention its generic products in this non-branded marketing, Teva's generic products do benefit from non-branded marketing about opioids and pain that Teva conducts, true?

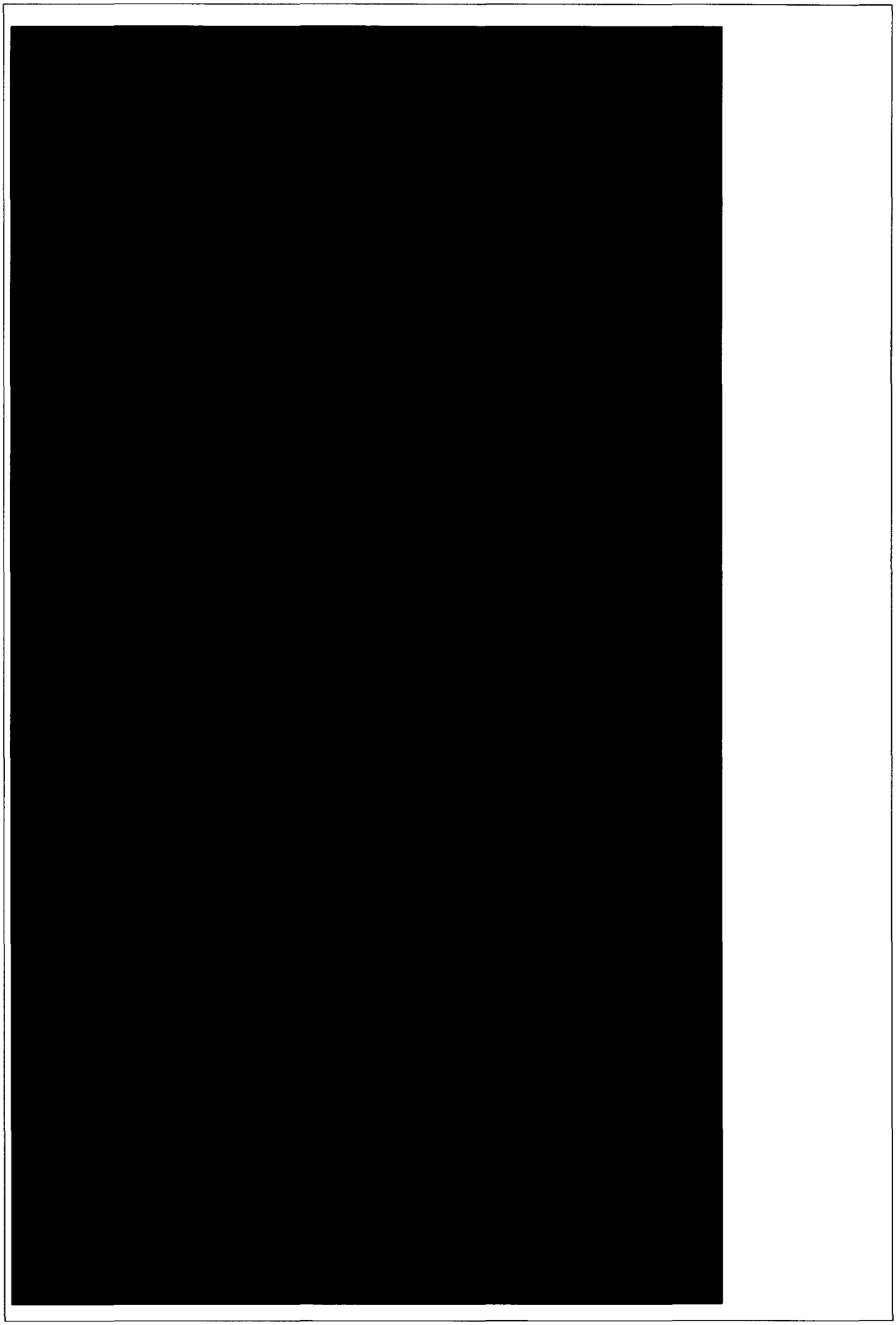
MR. FIORE: Object to form and scope.

THE WITNESS: It can if there's application for use of those products in managing that disease state, it -- those non-branded disease state materials also may recommend other approaches, other therapies that are not related to Teva.

Q (BY MR. DUCK) Well, Teva conducts non-branded marketing with the intent to further its business, right?

MR. FIORE: Object to form and scope.

THE WITNESS: It conduct -- it conducts non-branded marketing with the intent of improving management of specific disease states. Where it's appropriate to use a Teva product, it would benefit from that use, but in managing the disease state, there may be many other options and choices that a physician would make that Teva would support as part



Q (BY MR. DUCK) Did Cephalon ever engage in any nonbranded marketing in conjunction with another opioid manufacturer?

MR. FIORE: Objection to form and scope.

THE WITNESS: How -- can you describe what you're looking for in any more detail?

Q (BY MR. DUCK) Sure. Let's -- there's a few different things that I'm thinking of, but first, did Teva and another opioid manufacturer ever work together to create material that would be disseminated that was nonbranded information about opioids?

MR. FIORE: Objection to form and scope.

THE WITNESS: There were instances when third parties would submit requests for support from

multiple companies to create disease state management materials and Cephalon or Teva would have donated money to address those requests, which may have been made by others, but I don't categorize that as nonbranded marketing, so much as educational grants to provide educational information on disease state.

I'm not aware -- nothing comes to mind right now of initiatives where Cephalon and another company controlled the content of a marketing piece that was nonbranded and distributed, I'm not thinking of any.

Q (BY MR. DUCK) What about Teva and another opioid manufacturer?

MR. FIORE: Same objection.

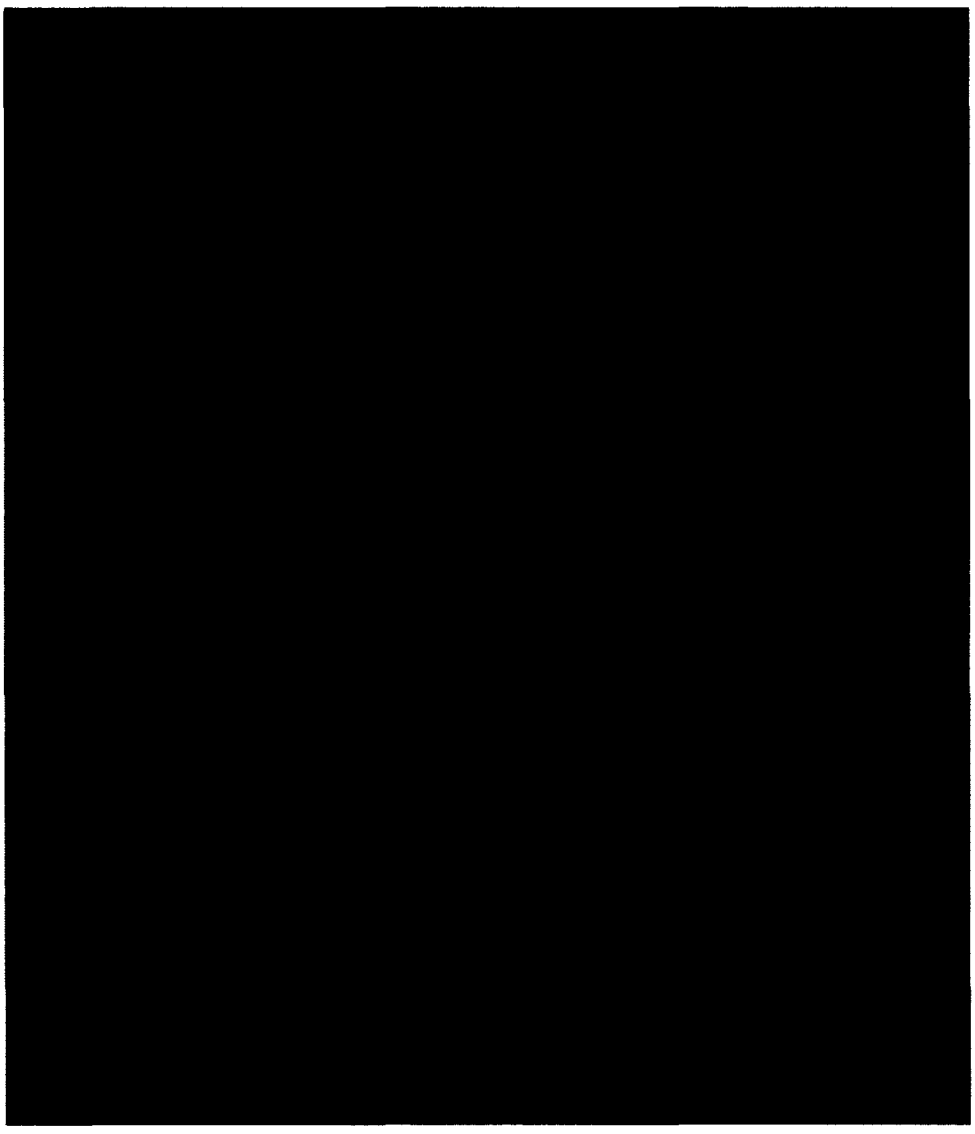
THE WITNESS: Nothing comes to mind.

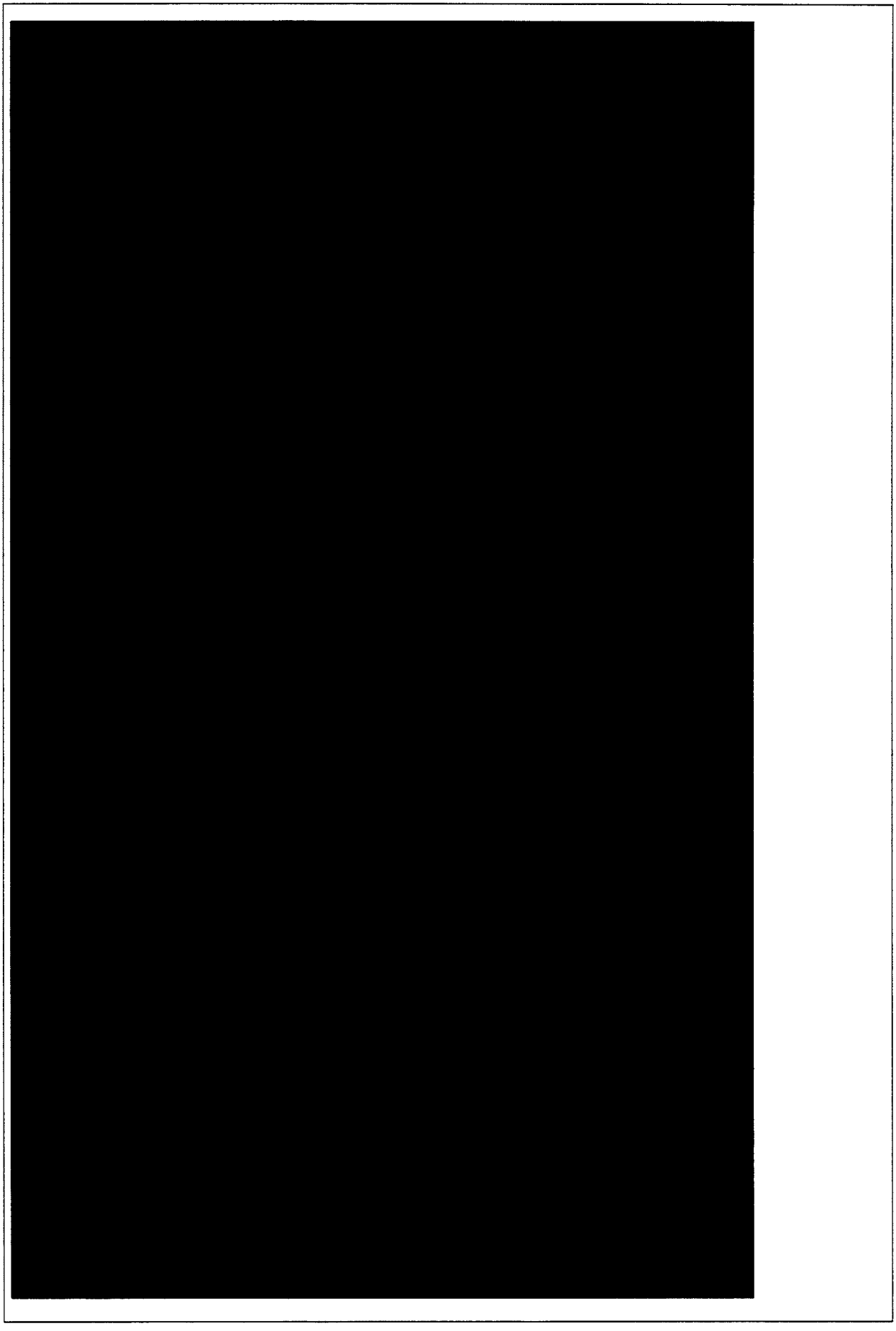
Q (BY MR. DUCK) But the situation you described, for example, may be where an association like the American Academy of Pain Medicine solicits requests for funding from multiple opioid manufacturers, is that the situation you were envisioning, you were thinking of?

MR. FIORE: Objection to form and scope.

THE WITNESS: Any company that would be involved in pain management that has -- would have

an interest in furthering education in that regard could be approached by a third-party organization to produce materials and Teva or Cephalon could have issued a grant in support of the those materials that provided partial funding, but at that time may not and probably would not have known whether other companies, or which other companies, or philanthropes or foundations would have been contributing to that project as well.





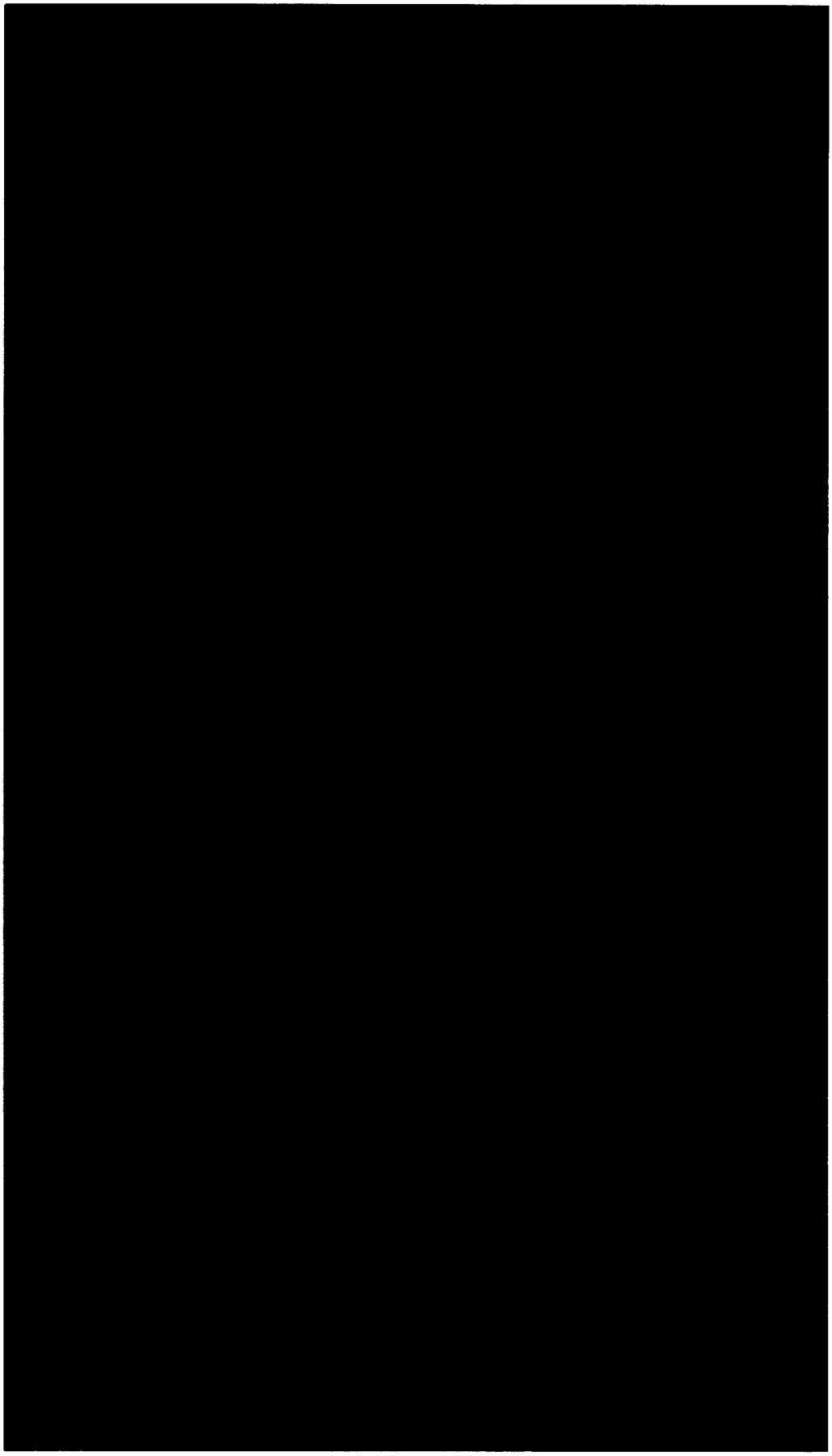


EXHIBIT 26

IN THE DISTRICT COURT OF CLEVELAND COUNTY

STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., MIKE HUNTER, ATTORNEY GENERAL OF OKLAHOMA,	)	
Plaintiff,	)	
-vs-	)	No. CJ-2017-816
PURDUE PHARMA, L.P., et al.,	)	
Defendants.	)	CONFIDENTIAL

VIDEO DEPOSITION OF JEFFREY LEON HALFORD, D.O.

TAKEN ON BEHALF OF THE DEFENDANTS

IN TULSA, OKLAHOMA

ON FEBRUARY 22, 2019

COMMENCING AT 10:19 A.M.

INSTASCRIPT, LLC
101 PARK AVENUE, SUITE 910
OKLAHOMA CITY, OKLAHOMA 73102
(405) 605-6880
www.instascript.net

REPORTED BY: KIM GLOVER, CSR, RPR, RMR, CLR

MR. HILL: Objection, form.
THE REPORTER: I'm sorry.
MR. HILL: I'm going to object. This is undisclosed expert testimony.
THE REPORTER: Thank you.
THE WITNESS: Opioids are a category of medications that bind to and activate what we call opioid receptors in the brain. There's three commonly recognized opioid receptors in a brain: the mu, the delta and the kappa.
The opioid receptors -- we have opioid receptors throughout our body, a lot of them in our GI system. But certainly in our brain to help mitigate pain responses.
Those receptors respond to both endogenous opioid or opiate-like substances and commonly known as endorphins. But they also respond to exogenous or artificial or synthetic sources of medication commonly referred to as opioids or opiates.

Q (By Mr. Curran) To your knowledge and in your practice, have you found that opioids are potentially addictive?

A To my knowledge, yes, they are certainly addictive.

Q Do they come with certain risks?

A Yes.

Q Okay. Are those risks to your knowledge disclosed on the labels of the individual opioids that you have had occasion to prescribe?

MR. HILL: Objection, form.

THE WITNESS: Yeah. It's disclosed on labels. It's common knowledge in medicine and medical school and residency and all of our training.

Q (By Mr. Curran) Okay. When did you first learn about the risks commonly associated with opioids?

A Well, it's something you sort of learn about as an child. I grew up in the '80s, Nancy Reagan saying "Just Say No" to most medication, illegal drugs certainly.

So it's something that's part of the culture, but in medical school you learn about it more specifically, more data. Learn about it a lot more in internship and residency with much more specificity because we're actually prescribing the medication with our name on the prescription.

In medical school it's all sort of theory and woo woo. When you first write, you know, that prescription, you have to take it very seriously.

And so, you know, it's just a growing knowledge base throughout my career. I still learn about these topics and these kinds of things every day.

Q To your understanding are all doctors taught that?

MR. HILL: Objection, form.

THE WITNESS: Taught what?

Q (By Mr. Curran) About the relative potential for addiction resulting from opioids.

MR. HILL: Objection, form. It's for all doctors.

THE WITNESS: Well, yeah. I mean, I would imagine that all doctors are taught, you know, as part of basic science and basic clinical medicines the associated risks of not only opioids but every medication we prescribe.

Most doctors -- I don't know if the general public knows this or understands it, but most doctors when we prescribe anything -- doesn't matter if it's aspirin, or a high blood pressure drug or an opiate, we read about it. We read about it from multiple sources.

Drugs that I prescribe 10,000 times many -- almost every time I prescribed it, I

will pull up on my little database on my iPhone the associated mechanism of action, the associated common side effects because I want to inform the patient, things that might happen, whether it's nausea or rash or whatever, and I want to prepare them for that and, you know, explain to them what might happen so it's not a surprise to them when they suddenly stop the truck.

I will always -- or commonly look at the associated, you know, consequences of taking any drug I prescribe.

Q Which leads me to ask: How do you use and prescribe opioids in your practice?

MR. HILL: Objection, form.

THE WITNESS: Well, approximately -- and I don't have the exact number here, but I'm guessing it's 95% plus of my patients that come to us at Pain Management of Oklahoma have been treated chronic -- treated for their chronic pain, again 95% of them with opiates for probably an average of five years.

It is a rare patient indeed at our practice that comes having never taken an opioid or hasn't taken one in the past -- hasn't been prescribed one in the past year. I would guess that that makes

But if it's something I'm particularly interested in, a new drug or a new, you know, medical device or whatever, and it's, you mean, germane to my current practice, I will reluctantly schedule a 30 minute or so lunch with this person.

And they may, during that period, offer me their typical, you know, marketing stuff which usually ends up in the trash. But I'll read it politely in there and listen to their pitch and ask questions. Almost always ask for subsequent literature, medical literature references that validate anything they might be saying.

Q Why?

A Because I don't trust anything they would say. I take it with a very small grain of salt. I usually just sort of think of what they are telling me as sort of an introduction and then I need to go and validate or refute and research and learn about, you know, whatever this is I'm interested in, if I'm going to incorporate it into my practice at all.

Q Do you or does your office keep track of who or how many sales reps visit you in any given period of time?

A Not keeping track per se but, you know, it may be on our calendar. I don't know.

Q Okay. Do you keep track of how often they may bring in lunch or how much that lunch costs?

A Do I keep track of it, no. I would say half the time when I do accept an engagement with a rep, they are providing lunch and then maybe 50% of the time there is no lunch.

Q Okay. How often --

A I don't require a lunch, for example.

Q I understand. You recall them ever providing anything else in the form of -- anything else, items -- promotional items, any sort of --

A Pens?

Q That kind of stuff.

A Sticky notes?

Q Right.

A Beyond that, no.

Q Did you ever make a decision to prescribe an opioid medication based upon what a sales rep did or what they told you?

A No.

MR. HILL: Form.

Q (By Mr. Curran) Do you have any personal knowledge as to any of Teva's -- and by Teva, I mean Teva and Cephalon, Watson and Actavis, do you have any personal knowledge of any of Teva's or any

other company sales or marketing practices or efforts in Oklahoma?

A Repeat that, please.

Q Sure. Do you have any personal knowledge into any pharmaceutical manufacturer's sales or marketing practices in Oklahoma?

A Yes.

Q Okay. Other than sales reps visiting you?

A Well, I see advertisements in journals, for example.

Q Okay. But do you have any knowledge as to where they decide to advertise or who they decide to target or visit?

A No.

Q Okay. Would it surprise you to know that as a pain management physician you are targeted by opioid manufacturers for visits?

A No.

Q Do you have any personal knowledge as to how any sales representative from any pharmaceutical manufacturer is paid?

A No.

Q Is that anything you concern yourself with?

time to bring her some dessert. I don't usually learn that much.

But I can think of, you know, less than a handful, maybe two or three of those that I have attended in my career.

One in particular I can remember was when Nucynta came out. I was interested in Nucynta. It was a novel opioid, synthetic type drug. Never heard of it, supposedly unlike other opioids and I was interested.

So I went to that particular lecture. And I don't consider that CME.

Q Right.

A That's just a marketing lecture, introduction to a drug.

Q Do you recall hearing any false or misleading statements of any of those marketing lectures as you call them?

A No. I don't recall --

MR. HILL: Form.

THE WITNESS: -- much about it.

Q (By Mr. Curran) I think I know the answer to this, but let me ask. Have you ever had any consulting relationship with Teva USA or Cephalon or Watson or Actavis about opioids?

A No.
Q Or about anything else?
A No.
Q If I use the term "preceptorship," do you know what that is?
A Only as it perhaps relates to a medical student.
Q Okay. Then let me just follow up. Have you ever agreed to do a preceptorship with any Cephalon or Teva sales rep?
A No.
Q Or Watson or Actavis?
A No.
Q Have you ever received any funds, items, meals or anything of value that you can recall from any Cephalon or Teva or Watson or Actavis sales representative?
A Not that I'm aware of.
Q Same question as to any sales rep from any pharmaceutical company?
MR. HILL: Objection, form.
THE WITNESS: Any meals?
Q (By Mr. Curran) Yes.
A Yes, I have received meals.
Q Are those the lunches you're talking

about?

A Lunches and/or the evening -- dinner talk.

Q Anything other than what we've just discussed?

A No.

Q Did any of those things ever influence your independent medical judgment as to whether to prescribe an opioid medicine for a patient?

MR. HILL: Objection, form.

THE WITNESS: Only in so much as it may be an introduction to a new medication.

Q (By Mr. Curran) Which you then followed up and investigated yourself?

MR. HILL: Objection, form.

THE WITNESS: Yes. And sometimes it's a new indication like I don't know if this is exactly accurate but Cymbalta, for example, comes out originally as an antidepressant and then it gets an indication for neuropathic pain.

I may be -- I may go to a dinner or have a lunch to learn about this new indication.

Q (By Mr. Curran) Okay. Have you always made your own decisions as to whether or not to prescribe opioids --

A Yes.
Q -- based upon your own independent medical judgment?
A Yes.
Q Have you ever considered or consulted any third party publications before you prescribed opioids?
A What do you mean third party publications?
Q Sure. Groups that put out articles on opioid or opioid-related subjects.
A When you say groups, do you mean the New England Journal of Medicine or what do you mean?
Q Sure. That's one of them. I was talking particularly about -- I had a list here that I could read you and you could tell me if you're familiar with them.
A Sure.
Q American Pain Foundation, the American Academy of Pain Medicine?
A Familiar with them, yes.
Q The American Pain Society?
A Yes.
Q The American Chronic Pain Association?
A Not familiar.

Q The American Geriatrics Society?
A Not familiar.
Q The National Pain Foundation?
A Not familiar.
Q The American Society of Pain Education?
A Don't know.
Q The Pain and Policy Studies Group?
A That sounds familiar.
Q Okay. Of the ones that sound familiar to you, do you recall reading anything in there that you felt was false or misleading?
MR. HILL: Objection, form.
THE WITNESS: I don't recall reading anything in particular from any of those groups.
Q (By Mr. Curran) Fair enough. Through the course of your education and career, have you noticed a change in the culture of opioid prescribing?
A Yeah. But I think --
Q How would you describe it?
A The most dramatic, as I read the medical literature and history and opinion pieces, the culture was changing pretty significantly before I entered medical school or about the time I entered medical school in '94 to '98 when I graduated.

further agency or certification body or administrative person in a hospital telling me that I needed to take pain more seriously. To me it was sort of annoying.

Q It being?

A The fact that we had to do further documentation to treat pain as a fifth vital sign.

Q Did you consider it to be an actual vital sign?

A No.

Q Why not?

A Because it's not vital. Vital indicates, you know, pulse, respiration, you know, circulatory system and breathing events.

Q Important perhaps but not vital?

A Yeah. That's reasonable.

Q Did it have any -- did that phrase or campaign have any influence on your prescribing habits?

MR. HILL: Object to the form.

THE WITNESS: Not overtly that I can say.

I can say that it prompted a lot of discussion about how we treat pain, you know, during my pretty influential training at Baylor and my residency. It was a topic -- is a common topic.

Older doctors sort of grumbling about, you know, the more liberalized use of opioids and younger doctors arguing, "Hey we got to take this more seriously, people are killing themselves because of under-treatment of chronic pain."

I remember a talk -- I wasn't even sure this was a real thing until I was recently putting together my lecture in October about this, that there was supposedly some big lawsuit in California where a doctor got sued for under-treatment of pain in a malpractice case, as I understand it.

I remember rumors about that as a young impressionable resident going, "Really, I cannot imagine we could get sued for under-treatment of pain."

Q So what, if any, effect did the fifth vital sign, the phrase, or the -- I don't know what you call it, the emphasis, what effect, if any, did that have on your prescribing?

MR. HILL: Objection, form.

THE WITNESS: I can't think of anything specific of how it influenced me.

Q (By Mr. Curran) To your knowledge, did it influence the way hospitals or administrators addressed the treatment of pain?

A I think it did.

Q How so to your knowledge?

A Well, yeah, to my knowledge, you know, from my reading of the medical literature and medical opinion pieces, you know, that phrase was adopted by the certifying body, the Joint Commission.

Q Joint Commission?

A Joint Commission, as I understand it -- I think it's called the Joint Commission as the certifying body for Medicare users to certify hospitals for appropriate Medicare payments.

And, you know, if you have ever spent any time working in a hospital, whether it's a janitor or a physician, you have to take the Joint Commission very seriously because your boss and your employer take the Joint Commission very seriously.

And if there is a mock survey, you take it very seriously. If there is a real survey you take it even more seriously And there's hours and hours of preparedness, again from the janitor to the nurses to the physicians to be able to respond to questions that the Joint Commission, you know, people may come and talk to you about on the spur of the moment.

Q How does that affect you, the pain management doctor?

reports. I would get them monthly, but I would get them quarterly and we would have meetings about it as the administrator -- physician administrator about, you know, Dr. Halford and the local administrator on the rehab unit. "Everything looks good, the place is clean, you guys are doing good with low infection rates, you guys are doing good with nobody is dying on the unit, you're doing good with all the statistics but your -- the perceived patient satisfaction with regard to pain management is not up to par."

And what that would commonly mean is, I might get an 80% satisfaction -- either very satisfied or excellent score as it relates to managing pain while the patient was in the hospital recovering from their hip fracture, but 80% is not good enough, you know.

And I don't remember the exact numbers, you know, but they had indicators that were driving them that said, you know, "We need to be better. We need to be higher. We need to treat patients more appropriately."

And so, you know, I was a contracted physician and I had a practice that I could rely if I left the hospital. And so if I wanted to tell St. Francis to go blow because I didn't like the pressure

they were putting on me to change the way I practice, I could do that.

Q Okay.

A But if you're an employed physician which most physicians are at St. Francis and your boss or your administrator is telling you you have got to get your pain scores up, you have got to get your pain scores up.

Q Okay. Is that something --

A And as a physician, getting your pain scores up may mean I got to give more pain medication.

Q Is that something you witnessed or saw while you were working at St. Francis?

A I can just say I felt the pressure directly from administrators to me. But I will not -- I do not believe that it significantly influenced how I practice medicine. I was pretty happy with the 80%.

Q Do you know of any legal way to obtain opioids other than by prescription?

A Legal way? No.

Q Can't be sold to the public without a prescription; correct?

A Correct.

Q Are there guidelines in Oklahoma for prescribing opioids for both acute and chronic pain?

A Yes.
Q Are you familiar with those?
A Yes.
Q Do you follow those guidelines?
A Yes.
Q Are all physicians to your knowledge supposed to follow those guidelines?
A Yes.
Q Have you ever had occasion to prescribe a drug by the name of Actiq or a drug by the name of Fentora?
A I can only think of one patient, maybe two, one or two patients in my career that I have ever prescribed Actiq to. I don't think I have ever prescribed Fentora.
Q Tell me about the Actiq prescription if you recall.
A The only time this may have occurred would be a patient -- let's say a patient in a chronic cancer situation, end-of-life situation.

And unfortunately, this is all too common where let's say a 50 year old lady who has been battling metastatic breast cancer for the last five or eight years is at the end stages of life but she has admitted to the hospital -- in this case it would be

St. Francis -- because she had a compression fracture in her spine that was very painful.

She may have multiple bony masses and she historically was taking high doses of pain medication, perhaps Actiq at home, prescribed by her oncologist perhaps or a pain doctor. She breaks her back from some relatively innocuous event in her life. Sometimes just sitting down because of the cancerous lesions in her spine, the vertebrae will crush and hurt a lot and may require surgery.

So those patients will be admitted and treated and then commonly will come to rehab for a relatively brief stay because the patient can't take care of themselves. They can't bathe or dress or toilet.

And so those patients may be admitted to my rehab unit at St. Francis in that decade that I was there and I would continue the same medication that they were on, you know, assess how it's working and how well it is and obviously try to keep the doses as low as possible, but continue under my name this medication. And then when the patient is dismissed, they would be dismissed from me because they are my patient for the last couple of weeks. I would dismiss them on that medication, the appropriate dose, and

track it to the minute and that they did and that they turned that data in to an overlay on the amount of times that they called you to see it as a return on their investment?

MR. CURRAN: Object to the form.

MR. BURNS: Object to the form.

MR. JOHNSON: Object to the form.

THE WITNESS: Yeah. I didn't it was that accurate.

Q (By Mr. Hill) Did you know that they were sitting outside of your office looking at a laptop that had the information of exactly how many prescriptions you wrote since the last time that they visited your office?

MR. CURRAN: Object to the form.

MR. BURNS: Object to the form.

MR. JOHNSON: Same objection.

THE WITNESS: I did not know that.

Q (By Mr. Hill) From conversations with your colleagues -- I don't mean specific to opioids -- in general, do you have a belief one way or the other as to whether prescribing behavior is correlated to sales representatives' call activity?

MR. BURNS: Object to form.

THE WITNESS: I think the --

Q (By Mr. Hill) I'm sorry. To make it easier for you. Do you have any understanding whether, from conversations with your colleagues or your experience, a physician's prescribing level is knowingly correlated with sales calls?

MR. CURRAN: Object to the form.

MR. BURNS: Object to the form.

Q (By Mr. Hill) By that I mean, do you know if physicians absolutely would be willing to come out and admit that, "The more somebody calls me, the more I'm going to prescribe"?

MR. CURRAN: Object to the form.

MR. BURNS: Object to the form.

MR. JOHNSON: Same objection.

THE WITNESS: I think we would admit with specificity that, if somebody introduces me or any physician to a new drug or even a variant of an old drug, and we researched it ourselves and made it a part of our practice to use it, that, yes, the sales calls of introducing us to that initially and then reminding us of it multiple times has an influence on how we prescribe.

But, for example, would it change significantly, in the case of opioids, how much I prescribe or how frequently I would prescribe it? It

wouldn't influence me.

Would it change -- could I add a new drug to my, you know, weapons in managing a patient's pain or impairments? If it's a new thing I'm interested in, yeah. It just makes sense that, if I'm introduced through marketing efforts to something new or different, I may incorporate that into my practice.

But is it going to substantially change how I practice? For me, no. Let me just go on just for a moment and give you an example of that.

In 2009, '10, '11, '12 region of my practice, Cymbalta got a new indication for pain. I don't remember if it was pain in general or neuropathic pain.

You know, typical of sales reps, young, cute girl, bubbly personality, just super nice, and I -- she was one of the few that I would let come to talk to me sort of in between patients and whatever. She would hang out, I would feel sorry for her, so I would talk to her for a few minutes, but I really enjoyed talking to her. We talked about her kids, we would talk about all kinds of non-medical stuff.

She tried so hard to get me to prescribe Cymbalta, and I rarely did it. And the

reason for that was because it wasn't effective in my experience and from my reading of the literature. It wasn't appropriate for my management of my patients, and I wanted it to be, because it's a non-opioid.

You know, wouldn't it be great if we just treated patient's depression and we got rid of their chronic pain and we had some non-opioid thing to help their chronic pain or have something that could lower their opioid dependence?

Man, I wanted that to be true, and she tried. She came every month, and probably multiple times a month.

You know, I rarely prescribed it, and my partners equally the same. We would have conversations about this. We were like, "We wish this drug would work."

My point is is that all the marketing effort in the world for Cymbalta, at least on me and my practice -- they could have spent one billion dollars on me marketing Cymbalta and it would not have changed my marketing practices one bit, and it did not.

Q And you think that's the way it's supposed to work; right?

A Yes.

Q So you certainly wouldn't at least want to acknowledge if in any way those marketing efforts did influence you in some way, shape, or degree; right?

MR. CURRAN: Object to the form.

MR. BURNS: Object to the form.

MR. JOHNSON: Same objection.

THE WITNESS: I don't mind agreeing that they influence me in some way, shape, or degree, but I don't -- I don't think they change fundamentally how I practice, me, personally. I can't speak about anybody else in particular.

Q (By Mr. Hill) You can set that document aside, Doctor.

Doctor, Exhibit 7 to your deposition has been placed in front of you. It begins with the Bates number PDD1782004399. It is identified as a November 6th, 2000, memorandum with the subject "Rationale for Partners Against Pain Spinoff."

Do you see that?

A Yes.

Q I told you I was going to do something, so I'm going to keep that statement and then we'll move to the specific things that I wanted to look at.

You saw a moment ago we looked at

Partners Against Pain Materials identified in one of the Purdue marketing plans. Do you remember that?

A Yes.

Q And we talked about how marketing directly -- advertising directly to patients influences those patients when it comes to drugs; right?

A Yes.

Q If you flip to the second page, Doctor.

A (Complies)

Q You see at the top of the page, reading from the first page, the document says, "The ultimate goal of Partners Against Pain is to positively impact Purdue Pharma's top line growth by creating quote 'pull through' end quote for pain management products among the 45 million Americans living in pain today. This can be accomplished through a concerted education effort to," and then it lists, going on to the next page, four separate things.

Do you see that?

A Yes.

MR. BURNS: Object to the form.

MR. CURRAN: Object to the form.

Q (By Mr. Hill) Do you see that, at the top of the second page, one of the concerted education

Norco or Lortab at the time or Oxycodone, with, you know, significant street values.

So I might have been persuaded to use those drugs, Butrans and Nucynta, more easily, because they didn't have street values and I perceived them as being safer, not because a rep told me that, but because I would just know that.

Q Sure. And, Doctor, my -- you know, I started with making some representations to you, telling you about what this lawsuit is about.

A Yeah.

Q I understand what you have told me today and, frankly, I respect it, and I know you're speaking for yourself about what was -- what could or couldn't influence you, knowingly, anyways.

But seeing what you have seen here and seeing what wasn't disclosed about who was doing what, do you also think it's reasonable to believe that maybe it wasn't you but some doctors who were super targets, or whatever the word is, that were called on over and over again, invited and paid to go to these programs, knowingly or unknowingly were influenced by the messages that these companies put forth?

MR. BURNS: Object to the form.

MR. CURRAN: Object to the form.

MR. JOHNSON: Object to the form, calls for speculation.

THE WITNESS: Yeah. I can't comment on how much they were influenced or not. I guess I would be surprised for -- for most -- for most doctors -- I was going to say reasonable doctors, but I think most doctors are reasonable.

To, again, begin any opioid on a patient, no matter how much marketing effort they put forward, on inappropriate patients -- they may do the conversion thing. They may be very -- my impression is the effects of marketing are very good at converting from one drug to another, but not necessarily, certainly in my case, changing how much I'm prescribing a patient in terms of morphine equivalents, which is the pertinent issue here, not whether or not we use a brand name or not. It's how much and how much associated risk is involved because of those dosages.

So I just don't think many doctors -- there's probably a few, but I just don't think the vast majority of doctors are going to be influenced to start any drug, much less an opioid, for inappropriate patients, no matter how good the meal was that they paid for or how cute the rep was or how many times

they came in the office or how many savings cards they brought or how good their literature was.

I just -- I just don't see that happening.

MR. HILL: I'm almost done and I'm making a mess. Just kidding.

Q (By Mr. Hill) Doctor, do you know whether physicians who are general practitioners, family practitioners, just general primary care physicians, have the training or specialty in pain management that someone like you has?

MR. CURRAN: Object to the form.

MR. BURNS: Object to the form.

THE WITNESS: Most of them do not get that as a primary part of their education in residency, like a rehab physician would or an anesthesiologist that has further pain training would.

Q (By Mr. Hill) Did you know that part of the plans, two-decade-long plans -- we've looked at some examples today -- in addition to targeting high prescribers were to target family practitioners and primary care physicians with these messages, as well?

A Yes.

MR. BURNS: Object to form.

Q (By Mr. Hill) The answer that you just

gave me about what you would expect yourself or others in your field, the likelihood of your being influenced to start a new drug -- pain drug with a patient, do you think that a doctor, like a primary care physician, who doesn't have the background and experience that you have would be more likely to be influenced by this type of marketing and the message that was sent out in it?

MR. CURRAN: Object to the form.

MR. BURNS: Object to the form.

MR. JOHNSON: Object to the form.

THE WITNESS: I can't say. I really don't know. I know that that is part of the underlying issue, I think, related to the opioid crisis. I think the access to well-trained physicians that do chronic pain -- the access is not there.

Most pain doctors in Tulsa, to this day, would prefer to spend their day in the procedure room, sticking long needles in people's backs and making a lot of money doing it, rather than worrying about how many morphine equivalents we're giving these patients.

So when a primary care physician is -- you know, has this group of patients that needs chronic pain medications, but yet they've either had

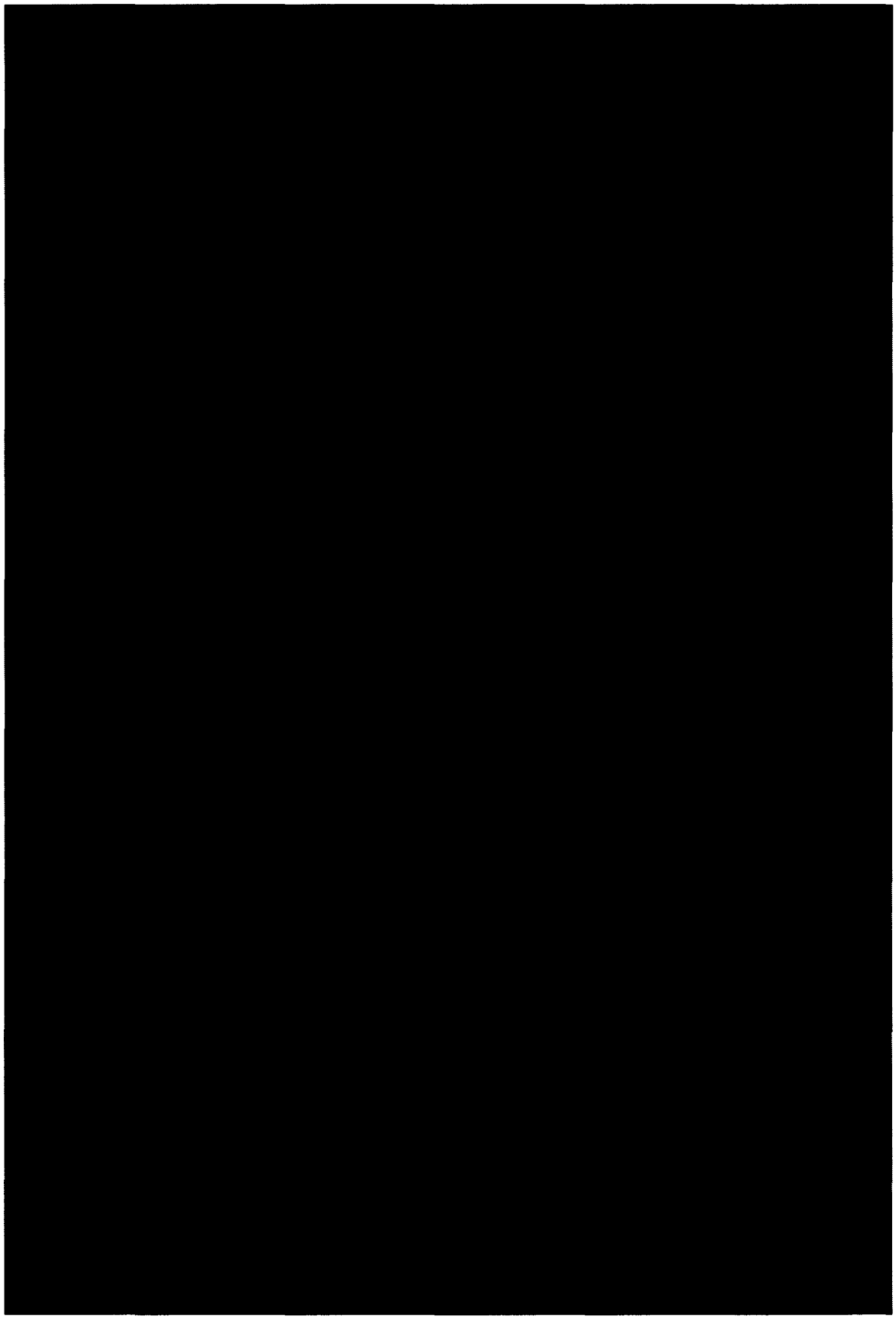
When I was a third-year medical student, I did a rotation -- a month-long rotation at Warren Clinic with Dr. James Hammerstein. He was trained at Mayo Clinic, internal medicine, and was the Health Department's medical director in Tulsa.

And I can't remember what his role there was, other than just being medical director, but a super smart guy. And he -- he taught me a lesson early in my career about -- about adopting medications early and believing reps.

And he told me this story about this drug called Redux that, in the late '90s, was a super popular drug for weight loss, and it was like related to the Fen-Phen combination. And he said, against his better judgment and typical patterns of practicing, he adopted that drug very early.

He didn't admit that it was as a result of marketing efforts from the pharmaceutical companies. It was because everybody else was doing it and -- and that patients seemed to be responding really well.

And he admitted later that he didn't do due diligence and research and he didn't, you know, adopt a new medication -- this medication slow enough into his practice and he was regretful,



[redacted]