IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

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

Plaintiff,

vs.

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

Defendants.

For Judge Balkman's Consideration

Case No. CJ-2017-816
Honorable Thad Balkman

William C. Hetherington
Special Discovery Master

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

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

—CONFIDENTIAL—
TO BE FILED ONLY UNDER SEAL

Part F

193

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,

because he had had a patient that suffered from the consequences that that drug was eventually removed from the market from, and that was pulmonary hypertension that damaged patients' lungs and some required -- some died and some required some lung transplants.

But I just remember him sitting me down early on in this process and saying, "You've got to be -- you've got to be careful, you know, when -- what the reps say. They're car salesmen" -- he probably used that exact term -- "you've got to do your own research, ask for studies, you know, and you have got to do it from peer-reviewed journals. You don't -- you don't accept some beautifully written research from some, you know, 501(c)(3) corporation or whatever," you know.

So I -- that stuck with me, and I think that's what I've tried to do throughout my career, and I think most physicians do that.

Q (By Mr. Hill) If you go back to Exhibit 12, Doctor, and flip to Page 6 of 16. Going on to Page -- starting with that February 11, 2000 -- I'm sorry -- February 10, 2011, entry and then bleeding over until the next page, do you see those four entries --

A Yes.
Q -- that go through February 28th, 2011?
A Yes.
Q Do you know, sitting here today, whether or not J&J representatives called on or contacted someone within your office every week in a given month, this one being February of 2011?
MR. BURNS: Object to the form.
MR. JOHNSON: Object to the form.
THE WITNESS: I don't know that for sure, but it wouldn't surprise me.
Q (By Mr. Hill) If you flip to Page 10 of 16, Doctor, you see there's entries from a report to be October of 2011, three in that month and two on this page for November of 2011 from two sales representatives, Elizabeth Hightower and Elizabeth Wakefield?
A Yes.
Q Do you recall a Ms. Hightower?
A Not with any specificity.
Q Exhibit 16 to your deposition is an e-mail thread with the Bates number JAN-OK 00133020. I'll direct you to the bottom e-mail that bleeds to the second page.
Do you see this is an e-mail from Beth

EXHIBIT 27

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

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

Case Number
CJ-2017-816

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

VIDEO DEPOSITION OF STEVEN ALAN CRAWFORD, M.D.

TAKEN ON BEHALF OF THE DEFENDANTS
ON FEBRUARY 13, 2019, BEGINNING AT 9:06 A.M.
IN OKLAHOMA CITY, OKLAHOMA

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

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

Q. Understood. 09:27

To the best of your recollection -- 09:27

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

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

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

Q. At least six months. 09:27

A. Yes, sir. 09:27

Q. And -- 09:27

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

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

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

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

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

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

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

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

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

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

A. Uh-huh. 09:28

Q. -- you've made the medical decision that the benefits of the medication outweigh the risk for the patient you're prescribing the medication for, correct? 09:28 09:29 09:29

MS. BALDWIN: Object to form. 09:29

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

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

MS. BALDWIN: Object to form. 09:29

THE WITNESS: Yes, sir. 09:29

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

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

MS. BALDWIN: Object to form. 09:29

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

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

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

MS. BALDWIN: Object to form. 09:29

THE WITNESS: Yes. 09:29

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

MS. BALDWIN: Object to form. 09:30

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

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

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

Q. Sure. 09:30

comments. 09:38
Q. And that is true for almost every 09:38
prescription medication, correct? 09:38
MS. BALDWIN: Object to form. 09:38
Q. (By Mr. Ehsan) Well, let me ask the question 09:38
slightly better. 09:38
All prescription medications carry risks, correct? 09:38
A. Yes, sir, all medications, whether they're 09:38
prescription or not. 09:38
Q. That's true. You can potentially do a lot of 09:38
harm with over-the-counter medications as well, 09:38
correct? 09:38
A. Yes, sir. 09:38
Q. So when you prescribe any medication, you 09:38
engage in a risk and benefit an -- assessment for the 09:39
patient receiving the medication, correct? 09:39
A. Yes, sir. 09:39
Q. So for -- specifically focusing on opioids. 09:39
Opioids have risk of respiratory depression, correct? 09:39
A. Yes, sir. 09:39
Q. They carry the risk of constipation, correct? 09:39
A. Yes, sir. 09:39
Q. They carry the risk of mental confusion or 09:39
fogginess, correct? 09:39
A. Yes, sir. 09:39

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

A. Yes, sir. 09:39

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

A. Yes, sir. 09:39

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

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

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

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

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

A. Yes, sir. 09:40

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

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

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

A. Yes, sir. 09:40

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

carry the risk of constipation? 09:40
A. Again, probably during medical school. 09:40
Q. And you've consistently held that view to present? 09:40
A. Yes, sir. 09:40
Q. How about the risk of opioids for addiction, abuse, or misuse, when did you first become aware of that risk? 09:40
A. During medical school. 09:40
Q. And that -- 09:40
A. Or --
Q. Go ahead. 09:40
A. Sorry.
Q. I'm sorry. 09:40
A. During medical school. 09:40
Q. And have you had -- and have you held that understanding to present? 09:40
A. No. 09:40
Q. Okay. How -- how has your understanding of the risk of -- of the fact that opioids have a risk of abuse and misuse -- let me strike that and ask the question differently. 09:41
Has there ever been a point in time where you believed that opioids didn't cause or didn't carry the risk of abuse or misuse? 09:41

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

A. A wide variety of information. 11:23

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

A. Labeling meaning the? 11:23

Q. Package insert. 11:23

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

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

A. Yes, sir. 11:23

Q. Do you rely on -- 11:23

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

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

A. Yes, sir. 11:23

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

A. Yes, sir. 11:23

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

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

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

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

A. Very limited now. 11:24

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

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

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

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

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

A. Yes, sir. 11:24

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

A. Yes, sir. 11:24

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

Did they also have conversations with you? 11:25

A. Yes, sir. 11:25

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

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

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

A. That is correct. 11:26

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

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

Q. Yes, sir. 11:26

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

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

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

A. Skilled.

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

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

not had a paper copy. 11:27

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

paginated. 11:27

A. Thank goodness. 11:27

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

A. Page 4.

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

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

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

that's underlined? 11:28

A. Yes, sir. 11:28

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

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

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

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

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

opioid use or addiction each year preceding an 11:28

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

licensee has demonstrated to the satisfaction of the 11:28

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

valid federal Drug Enforcement Administration 11:28

registration number," period. 11:28

Did I read that correctly? 11:29

A. Yes, sir. 11:29

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

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

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

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

A. Yes. 02:09

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

A. Yes, sir. 02:10

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

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

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

which is the active ingredient in Duragesic? 02:10

A. Yes, sir. 02:10

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

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

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

you recall that testimony? 02:11

A. Yes, sir. 02:11

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

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

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

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

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

A. Yes, sir. 02:11

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

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

that.

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

disregarded information in a product label based on 02:11

something a pharmaceutical representative told you; 02:11

is that correct? 02:11

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

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

that, no. 02:11

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

yourself doing that? 02:12

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

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

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

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

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

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

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

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

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

A. I believe I did. 03:38

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

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

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

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

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

A. That is -- 03:39

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

THE WITNESS: That is correct. 03:39

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

THE WITNESS: Okay. 03:40

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

(Break was taken.) 03:40

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

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

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

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

specific instance where you didn't make a prescribing decision in the best interest of your patient? 04:48

MS. BALDWIN: Object to form. 04:48

THE WITNESS: If I know what I do today, I probably would not have accelerated many of my patients with their opioid prescribing and tried my best to limit those, particularly to less than 90 MME, or even less, 50 MME. 04:48

Q. (By Mr. Ercole) Are you aware of any instance -- well, can you -- can you -- are you aware of any instance where you did not make a prescribing decision that was in the best interest of the patient based upon the science available at that time? 04:49

MS. BALDWIN: Objection to form. 04:49

THE WITNESS: Based on what I knew at the time, I thought I made the right decision at the time. 04:49

Q. (By Mr. Ercole) Have you ever heard of the company Cephalon? 04:49

A. I've heard of it. 04:49

Q. Do you know whether that company manufactures opioid medicines? 04:49

A. I think I am now. I wouldn't -- if you had asked me, you know, a year ago, I probably wouldn't. It's a relatively smaller company from what I know, 04:49

but don't know much more about it than that. 04:49
Q. Sure. 04:49
So is it -- is it -- is it fair to say, then, that 04:49
you were -- you never -- since you didn't know of 04:49
Cephalon until about a year ago, you never interacted 04:49
with any Cephalon sales representative? 04:50
A. Not -- not that I'm aware of. I can't 04:50
remember any Cephalon sales reps. 04:50
Q. And it's fair to say that you're not aware of 04:50
any false or misleading statements that -- that any 04:50
representatives of Cephalon ever made to you? 04:50
A. At the time, no. I don't know if -- if I -- 04:50
anyway, no, not at the time. 04:50
Q. Well, I guess, sitting here today, can you -- 04:50
can you identify -- 04:50
A. Even -- even today, I don't know of any 04:50
specific Cephalon-related materials that would be 04:50
considered something that would be out of the pail as 04:50
it were. 04:50
Q. Sitting here today, are you aware of any 04:50
Cephalon-related materials that you would have 04:50
received? 04:50
MS. BALDWIN: Object to form. 04:50
THE WITNESS: No. 04:50
Q. (By Mr. Ercole) Sitting here today, are you 04:51

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

MS. BALDWIN: Object to form. 04:51

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

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

A. That is correct. 04:51

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

A. Vaguely, yes. 04:51

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

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

Q. Fair enough. 04:52

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

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

A. No, sir. 04:53

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

A. Yes. 04:53

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

MS. BALDWIN: Object to form. 04:53

THE WITNESS: No, sir. 04:53

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

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

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

A. Proton pump inhibitor. 04:53

Q. Okay. 04:53

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

manufacturers of one of those drugs. That's the -- the only thing I vaguely recall of Teva. 04:53 04:53

Q. And just so my notes are clear, that's -- sitting here, that's the only product you ever recall being discussed with you by any representative of Teva; is that correct? 04:54 04:54 04:54 04:54

A. That's all that I can vaguely recall, and it's a distant memory. 04:54 04:54

Q. And that -- that particular PPI product may have been actually manufactured by a -- a different company? 04:54 04:54 04:54

A. Could. Could. But I -- I don't know. I wouldn't put a lot of money on my memory on that one. 04:54 04:54

Q. And it's -- it's been some time, correct? 04:54

A. Yes. 04:54

Q. Can you -- 04:54

MR. ERCOLE: Can we go off the record for one minute? 04:54 04:54

VIDEO TECHNICIAN: We're going off the record at 4:55 p.m. 04:54 04:54

(Break was taken.) 04:54

VIDEO TECHNICIAN: We're back on the record at 5:02 p.m. 05:02 05:02

Q. (By Mr. Ercole) Doctor, we were talking about the PPI inhibitor. Do you recall that? 05:02 05:02

A. Yeah. 05:02

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

interaction with, perhaps, a Teva representative 05:02

regarding a PPI inhibitor, correct? 05:02

A. Right. 05:03

Q. Any statements from Teva Pharmaceuticals 05:03

regarding opioids that you ever recall receiving? 05:03

A. No, sir. 05:03

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

from Teva Pharmaceuticals that you recall being 05:03

disseminated in Oklahoma at all? 05:03

MS. BALDWIN: Object to form. 05:03

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

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

can't identify any, correct? 05:03

A. No, sir. 05:03

MS. BALDWIN: Object to form. 05:03

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

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

any sales representative for any drug manufacturer 05:03

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

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

mislead -- misleading statement any sales 05:03

representative for any drug manufacturer ever made to 05:03

you? 05:04

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

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

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

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

Q. Sure. 05:04

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

A. Yes. 05:05

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

Sitting -- 05:05

A. Okay. 05:05

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

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

comfortable with now. 05:10

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

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

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

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

Q. Uh-huh. 05:11

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

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

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

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

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

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

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

A. I -- I -- 05:12

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

A. Right. 05:12

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

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

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

THE WITNESS: At this point, no, I can't -- I -- I don't recall any particular patient. There's patients that came to me who were already on opioids that I would attempt more aggressively to reduce their dose, but -- and that I've continued on that -- the higher dose that I'm now trying to reduce because of the change in belief of the use of chronic long-term high-dose opioids. 05:12

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

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

A. And shorter -- 05:13

MS. BALDWIN: Object to form. 05:13

THE WITNESS: -- duration. 05:13

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

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

A. Yes, sir. 05:14

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

MS. BALDWIN: Object to form. 05:14

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

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

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

Q. Give me one second. 05:15

A. Sure. 05:15

EXHIBIT 28

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

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

Case Number
CJ-2017-816

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

Defendants.

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

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

PAGES 1 - 327

correct? 09:59

A. No. 09:59

MR. LEONOUDAKIS: Objection, form, outside the scope. 09:59

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

Q. (By Ms. Laurendeau) So if I understand you correctly, if there's no benefit, then the risk-benefit analysis should always be no 10:00 10:00 10:00

prescription of opioids, correct? 10:00

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

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

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

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

A. No. 10:02

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

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

THE WITNESS: Absolutely. 10:02

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

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

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

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

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

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

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

MR. LEONOUDAKIS: Objection, form. 03:01

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

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

MR. LEONOUDAKIS: Objection, form. 03:02

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

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

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

MR. LEONOUDAKIS: Objection, form. 03:03

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

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

A. Yes. 03:03

MR. LEONOUDAKIS: Objection, form. 03:03

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

MR. LEONOUDAKIS: Objection, form. 03:04

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

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

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

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

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

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

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

A. Yes. 03:05

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

A. Yes. 03:05

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

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

EXHIBIT 29

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

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

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

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

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

A Correct. 09:51:32

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

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

for the transcript. 09:51:37

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

Page 33 of this document. 09:51:42

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

sentence? 09:51:53

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

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

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

that statement. 09:52:03

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

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

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

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

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

then I agree with that. 09:52:23

Patient education on the risks and 09:52:27

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

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

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

compared with other analgesic options. 09:52:44

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A Yes. 09:56:13

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

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

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

A No. 09:56:32

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

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

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

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

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

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

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

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

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

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

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

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

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

A True. 01:44:47

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

A Perfect, yes. 01:44:58

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

A Uh-huh. 01:45:04

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

A Uh-huh. 01:45:06

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

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

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

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

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

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

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

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

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

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

EXHIBIT 30

BEFORE THE DISTRICT COURT OF CLEVELAND COUNTY

STATE OF OKLAHOMA

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

Plaintiff,

VS. CASE NO: CJ-2017-816

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

Defendants.

VIDEOTAPED DEPOSITION OF MELANIE ROSENBLATT, MD

ON BEHALF OF THE PLAINTIFF

ON MARCH 28TH, 2019

IN OKLAHOMA CITY, OKLAHOMA

REPORTED BY: MARTINE MCLAUGHLIN BUCK, CSR, CLR

line test is?

A I do not.

Q You've never heard that phrase?

A No.

Q Have you ever heard the phrase litmus test?

A Yes.

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

A Okay.

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

MR. ERCOLE: Objection to form.

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

BY MR. WHITTEN:

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

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

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

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

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

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

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

MR. ERCOLE: Objection to form.

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

BY MR. WHITTEN:

Q Look, I'm shocked --

A -- in every medical decision that I make.

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

A Sure.

MR. ERCOLE: Objection to form.

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

BY MR. WHITTEN:

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

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

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

Do you know what objective versus subjective means?

A Yes.

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

A Right.

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

A Generally speaking, yes.

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

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

THE WITNESS: I would imagine so.

BY MR. WHITTEN:

Q Do you have children?

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

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

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

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

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

MR. ERCOLE: Mr. Whitten --

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

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

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

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

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

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

MR. ERCOLE: Okay.

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

BY MR. WHITTEN:

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

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

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

A Okay.

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

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

MR. ERCOLE: Objection to form;

vague.

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

BY MR. WHITTEN:

Q Great. We're making progress.

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

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

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

MR. ERCOLE: Objection to form.

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

BY MR. WHITTEN:

Q Well, did you ask?

A It seems to me it's arbitrary.

MR. ERCOLE: Objection.

THE WITNESS: I'm sorry?

BY MR. WHITTEN:

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

A Yeah.

Q Is that what you said?

A Yes.

EXHIBIT 31

IN THE DISTRICT COURT OF CLEVELAND COUNTY

STATE OF OKLAHOMA

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

Plaintiff,

vs. Case No. CJ-2017-816

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

Defendants.

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

VON AHN ASSOCIATES, INC., a U.S. LEGAL SUPPORT COMPANY
Registered Professional Reporters
2271 McGregor Boulevard, Second Floor
Fort Myers, Florida 33901
Phone: (239) 332-7443 FAX: (239) 332-4066
Offices in Naples * South Fort Myers * Punta Gorda

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

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

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

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

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

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

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

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

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

with these drugs.

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

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

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

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

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

Would those regulators include state officials?

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

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

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

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

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

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

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

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

MR. DUCK: Objection to form.

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

BY MR. BARTLE:

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

A. That is correct, yes.

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

MR. DUCK: Objection to form.

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

BY MR. BARTLE:

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

MR. DUCK: Objection to form.

BY MR. BARTLE:

Q. Correct?

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

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

A. Well, among other things --

MR. DUCK: Doctor, just a second.

BY MR. BARTLE:

Q. Doctor, you gotta wait. No worries.

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

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

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

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

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

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

BY MR. BARTLE:

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

MR. DUCK: Same objections.

THE WITNESS: Correct.

BY MR. BARTLE:

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

MR. DUCK: Same objections.

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

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

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

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

BY MR. BARTLE:

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

MR. DUCK: Objection. Form.

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

BY MR. BARTLE:

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

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

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

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

Do you see that?

A. Yeah.

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

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

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

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

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

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

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

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

EXHIBIT 32

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

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

Plaintiff,

vs. No. CJ-2017-816

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

Defendants.

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

VIDEOTAPED BY: C.J. Shelton

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

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

A Yes. Obviously.

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

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

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

I don't know where else to take that.

Q Sure. That's fine.

A That's just what they do.

Q Sure. So opioids can be addictive?

A Absolutely.

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

A Yes.

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

A I guess medical school or even before.

Q Okay.

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

Q Was that something that was taught in medical school?

A Sure, yeah.

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

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

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

A Yes.

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

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

Q Okay. Then let me take a little sidetrack

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

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

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

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

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

A Not very much.

Q Okay. That wasn't --

A I was doing mostly inpatient rehab.

Q Okay.

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

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

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

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

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

A Yes.

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

A Absolutely.

Q And a risk/benefit profile for that patient?

A Yes.

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

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

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

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

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

Q Why is that important?

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

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

A Absolutely.

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

A No.

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

A Absolutely not.

Q Would you agree that each patient's needs

are -- and medical issues are unique?

A Yes.

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

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

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

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

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

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

opioid is. I mean, it's pain.

Q Right.

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

Q Do you see SoonerCare patients, Doctor?

A Rarely.

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

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

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

A I don't really care.

Q Okay.

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

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

A No.

Q Okay. Why not?

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

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

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

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

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

MR. ANGELOVICH: Objection. Form.

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

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

we haven't talked about.

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

A I do not.

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

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

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

A Yes.

Q Describe your personal involvement with pharmaceutical sales representatives?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A With the drug reps?

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

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

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

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

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

A No.

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

A Yes.

Q Why?

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

Q What do you mean by that, polymedication?

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

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

Q To make an individualized decision?

A Yes.

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

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

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

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

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

A Right.

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

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

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

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

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

A Would it surprise me?

Q Does that surprise you?

A No.

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

A No.

Q Would it surprise or offend you to know that

they classify you and other doctors based on prescribing habits?

A No.

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

A I don't think so.

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

A No.

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

A I don't think so.

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

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

Q Is that anything you concern yourself with?

A No.

Q Why not?

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

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

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

Q And -- oh, I'm sorry.

A I was just -- that's oxycodone.

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

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

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

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

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

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

Q Do you know why?

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

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

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

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

A No.

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

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

MR. CURRAN: Object to the form.

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

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

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

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

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

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

MR. CURRAN: Object to the form.

THE WITNESS: No.

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

MR. CURRAN: Object to the form.