IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel.,	§	
MIKE HUNTER,	§	
ATTORNEY GENERAL OF OKLAHOMA,	§	
	§	
Plaintiff,	§	
	§	
vs.	§	**Case No. CJ-2017-816**
	§	**Judge Thad Balkman**
(1) PURDUE PHARMA L.P.;	§	
(2) PURDUE PHARMA, INC.;	§	
(3) THE PURDUE FREDERICK COMPANY;	§	
(4) TEVA PHARMACEUTICALS USA, INC.;	§	**William C. Hetherington**
(5) CEPHALON, INC.;	§	**Special Discovery Master**
(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.	§	

NOTICE OF FILING OF THE STATE'S PROPOSED (1) FINAL JUDGMENT & (2) FINDINGS OF FACT AND CONCLUSIONS OF LAW

PART 1

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., MIKE HUNTER, ATTORNEY GENERAL OF OKLAHOMA,	§	
Plaintiff,	§	
vs.	§	**Case No. CJ-2017-816** **Judge Thad Balkman**
(1) PURDUE PHARMA L.P.; (2) PURDUE PHARMA, INC.; (3) THE PURDUE FREDERICK COMPANY; (4) TEVA PHARMACEUTICALS USA, INC.; (5) CEPHALON, INC.; (6) JOHNSON & JOHNSON; (7) JANSSEN PHARMACEUTICALS, INC.; (8) ORTHO-McNEIL-JANSSEN PHARMACEUTICALS, INC., n/k/a JANSSEN PHARMACEUTICALS, 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.,	§	**William C. Hetherington** **Special Discovery Master**
Defendants.	§	

NOTICE OF FILING OF THE STATE'S PROPOSED (1) FINAL JUDGMENT & (2) FINDINGS OF FACT AND CONCLUSIONS OF LAW

Pursuant to the July 31, 2019 deadline set by the Court following trial, the State of Oklahoma hereby submits the following to the Court as Exhibits hereto:

1. The States proposed Final Judgment (Exhibit 1 hereto); and

2. The State's proposed Findings of Fact and Conclusions of Law

For the reasons demonstrated at trial and set forth in detail in the State's proposed Findings of Fact and Conclusions of Law, the State respectfully requests the Court to enter judgment for the State.

Dated: July 31, 2019

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ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I certify that a true and correct copy of the above and foregoing was emailed on July 31, 2019 to:

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IN THE DISTRICT COURT OF CLEVELAND COUNTY
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STATE OF OKLAHOMA, ex rel., MIKE HUNTER, ATTORNEY GENERAL OF OKLAHOMA,	§	
Plaintiff,	§	
vs.	§	**Case No. CJ-2017-816**
	§	**Judge Thad Balkman**
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(5) CEPHALON, INC.;	§	**Special Discovery Master**
(6) JOHNSON & JOHNSON;	§	
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(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.	§	

FINAL JUDGMENT

Based upon the Court's Findings of Fact and Conclusions of Law attached hereto, the Court finds and enters judgment in favor of Plaintiff and against Defendants, Johnson & Johnson, Janssen Pharmaceuticals, Inc., Ortho-McNeil-Janssen Pharmaceuticals, Inc.,

n/k/a Janssen Pharmaceuticals, Inc., and Janssen Pharmaceutica, Inc., n/k/a Janssen Pharmaceuticals, Inc., ("Defendants") as follows:

1. A public nuisance, as defined by 50 OKLA. STAT. §§1, 2, exists in the State of Oklahoma.

2. Defendants unlawfully committed acts and omitted to perform duties, which have in the past and continue to:

a. Annoy, injure and endanger the comfort, repose, health and safety of others; and

b. Offend decency; and

c. Render Oklahomans insecure in life and in the use of property.

3. The nuisance in Oklahoma has affected and continues to affect at the same time entire Oklahoma communities and neighborhoods, as well as a considerable number of Oklahomans, although the extent of the harm inflicted upon individual Oklahomans may be unequal.

4. The public nuisance is the opioid crisis existing in the State of Oklahoma, which consists of, among other things, an artificially inflated demand for prescription opioids, an oversupply of prescription opioids, the overprescribing of prescription opioids, and the pervasive misinformation regarding the health risks and purported benefits of opioids; as well as the public health and societal conditions arising from that inflated demand, oversupply and misinformation including, but not limited to: opioid use disorder; accidental non-fatal and fatal opioid overdoses; neonatal-abstinence-syndrome births; youth misuse of prescription opioids; child removals within the child welfare system due

to parental opioid use or death; prescribing patterns caused by misinformation about the health risks and purported benefits of opioids that expose patients to an unjustified risk of addiction, overdose, or death; and diversion of prescription opioids and related criminality.

5. Defendants' acts and omissions were a contributing, and indeed substantial, factor in producing the public nuisance in Oklahoma.

6. Defendants' acts and omissions were a cause-in-fact of the public nuisance in Oklahoma.

7. Defendants' acts and omissions were a direct cause of the public nuisance in Oklahoma.

8. Defendants' acts and omissions were a proximate cause of the public nuisance in Oklahoma.

9. While neither negligence nor intent is a necessary element of the State's public nuisance claim under Oklahoma law, the Court finds that Defendants committed their acts and omissions willfully, wantonly, and intentionally.

10. Defendants are jointly and severally liable for the entirety of the nuisance and the remedy therefor.

11. The public nuisance caused by Defendants' acts and omissions has resulted in an indivisible injury to the State.

12. Defendants perpetrated their acts and omissions in concert with others.

13. The State has not asserted a claim arising in negligence. Thus, contributory negligence is not an available defense or otherwise at issue.

14. Because I find Defendants' acts were willful, wanton, and intentional, the defense of comparative negligence is unavailable.

15. Regardless of whether contributory or comparative negligence is available, I find that no act or omission by the State was a direct or proximate cause of the public nuisance in Oklahoma.

16. No act or omission on the part of any other actor was sufficient to supervene the acts of Defendants as a direct and proximate cause of the public nuisance in Oklahoma.

17. The State's claims are not preempted by federal law.

18. The acts and omissions Defendants committed are not protected or otherwise immunized from liability under Oklahoma law, federal law, or the U.S. Constitution.

19. The public nuisance can be abated.

20. The proper remedy for the public nuisance is equitable abatement.

21. The State's proposed abatement plan is reasonable and necessary to abate the public nuisance.

22. The State's abatement plan is adopted *in toto*, and shall be referred to from now on as the "Abatement Plan."

23. Under Oklahoma law, Defendants are entitled to a settlement credit in the amount of $355,000,000.00 to account for the settlements entered between the State and the former defendants who settled and were dismissed.

24. To facilitate the programs and services identified in the Abatement Plan as necessary to abate the public nuisance in Oklahoma, Defendants are hereby ordered to pay **$17,172,761,537.00** ($17,527,761,537.00 less the $355,000,000.00 settlement credit) into

a state account designated by the Court. Such account will be referred to from now on as the "Abatement Fund" and shall be directed and disbursed by further Order(s) of this court to accomplish the abatement of the public nuisance.

25. This equitable abatement award does not compensate the State for past, present or future damages.

26. This equitable abatement award does not impose a penalty on Defendants.

27. The equitable abatement award, and Defendant's being held jointly and severally liable for it does not violate the Oklahoma or the U.S. Constitution.

28. This matter, as an action to abate a public nuisance, was properly tried to the Court sitting in equity as factfinder.

29. To the extent any argument or objection set forth by Defendants in their Renewed Motion for Judgment, or any other Motion, filing or pleading, is not specifically addressed by the Court's Findings of Fact and Conclusions of Law, such argument and/or objection made by Defendants is hereby denied and overruled.

30. The Court retains jurisdiction over the parties and the Abatement Fund as a result of the Court's Final Judgment.

31. The Court will enter such further Orders pertaining to administration of the Abatement Fund and implementation of the Abatement Plan as necessary and in due course.

It is so ORDERED.

DATED this ___ day of _____, 2019.

_____

Honorable Thad Balkman, District Judge

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IN THE DISTRICT COURT OF CLEVELAND COUNTY
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STATE OF OKLAHOMA, ex rel., MIKE HUNTER, ATTORNEY GENERAL OF OKLAHOMA,	§	
Plaintiff,	§	
vs.	§	**Case No. CJ-2017-816**
	§	**Judge Thad Balkman**
(1) PURDUE PHARMA L.P.;	§	
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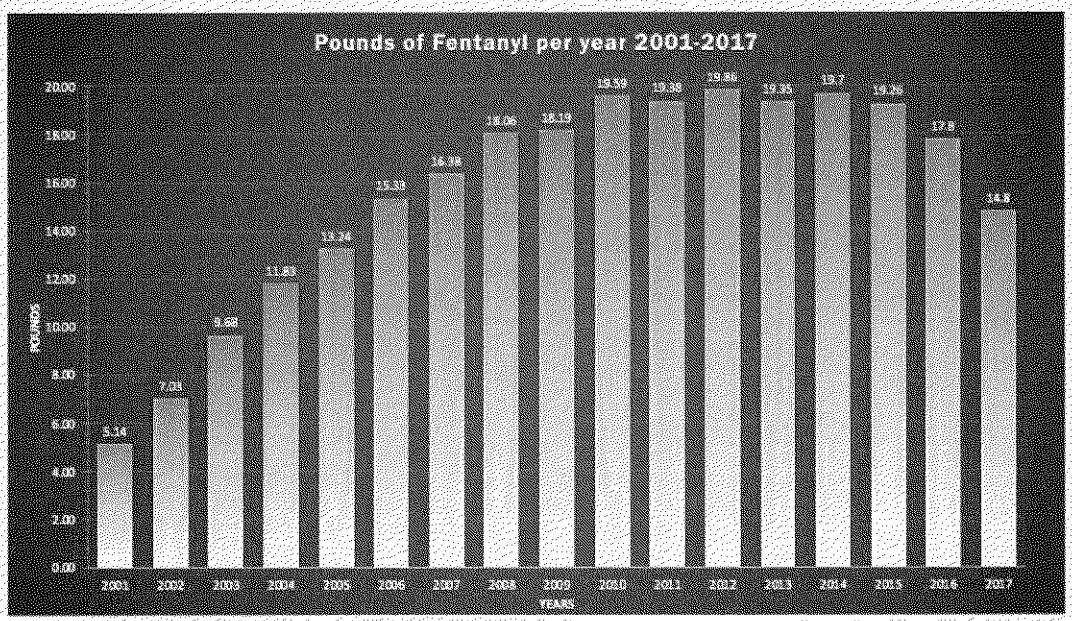
Defendants.	§	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Oklahoma is in crisis. It is a crisis that has washed over the State. A crisis that has wreaked more havoc than any oil spill or polluted stream. A crisis that rips families apart, causes people to lose their jobs, and destroys communities. A crisis that affects every aspect of life and does not discriminate amongst rich or poor, race, gender or age. The

source of this crisis is the flood of prescription opioids that has inundated Oklahoma for the past two decades. It is a man-made crisis. It was brought into being by the pharmaceutical industry, including Defendants. The harm it has wrought, and the threat it continues to pose to the health, safety and welfare of the State, make it the worst nuisance Oklahoma has ever known.

The evidence at trial was clear: when prescription opioids are oversupplied, people die. This fact is all too true in Oklahoma. From 1994 to 2006, prescription opioid sales increased fourfold. From 1997 to 2010, sales of prescription fentanyl—a drug 100-times more potent than morphine—increased elevenfold. In 2001, 5 pounds of prescription fentanyl came into Oklahoma. From 2010 to 2015, that number soared to 19 pounds *annually*:

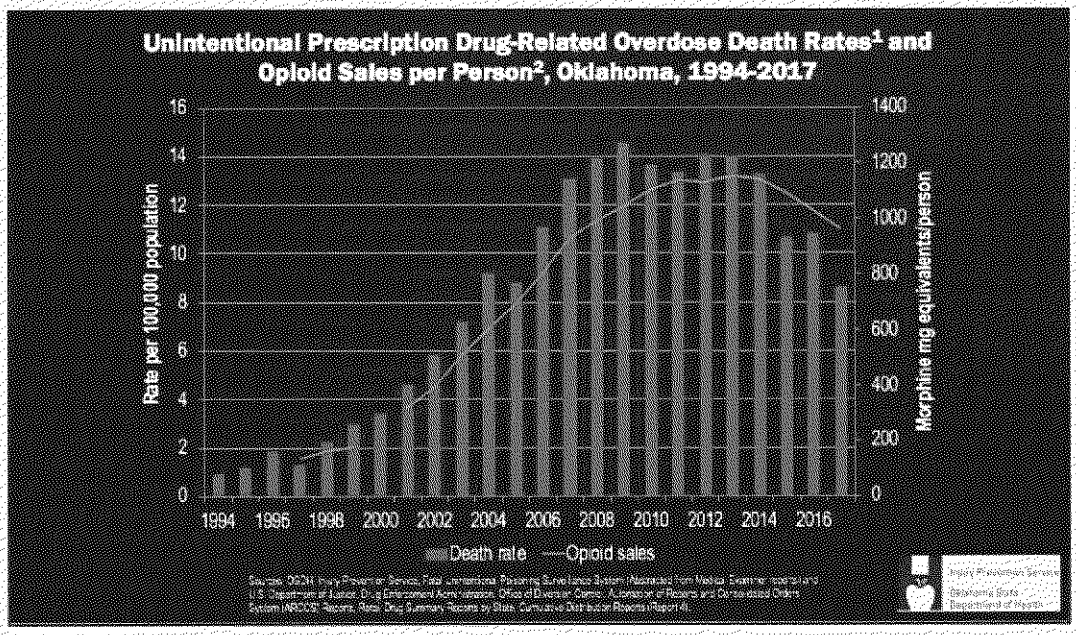


For the last 6 years, more fentanyl has come into Oklahoma per 100,000 people than in any other state.

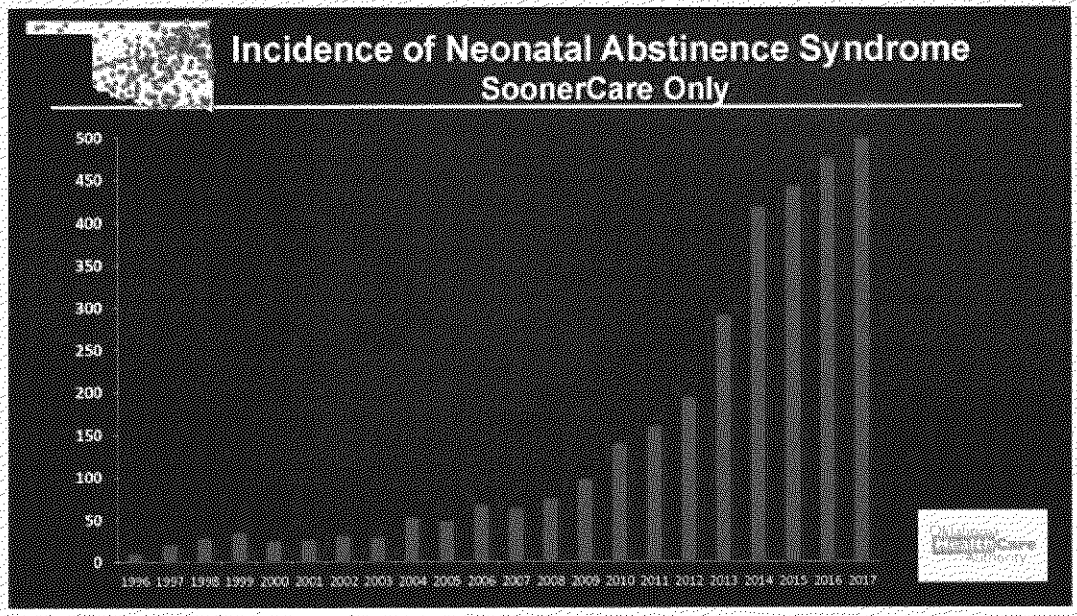
Over that same time, the rate of hydrocodone sales in Oklahoma has been nearly double that of the national average. According to the CDC, from 2006 through 2017, Oklahoma ranked between 4th and 8th in the nation in total opioid prescribing rates each year. In 2017, there were 479 opioid prescriptions dispensed every hour across the State. Enough opioids were prescribed that year for every adult in Oklahoma to have the equivalent of 156 ten-milligram hydrocodone tablets. Meanwhile, evidence shows that over 65% of opioids prescribed and dispensed in Oklahoma go unused and often end up being diverted.

Death soon followed this oversupply of prescription opioids. Since 2000, more than 6,000 Oklahomans have lost their lives from a prescription-opioid overdose. From 1994 to 2006, unintentional opioid overdose rates increased seven-fold. Between 2013 and 2017, an average of 32 Oklahomans died every month from an unintentional prescription-opioid overdose. From 1994 to 1996, there was only 1 unintentional overdose involving oxycodone. From 2012 to 2014, there were 484. From 2007 to 2012, two-thirds of all children who died from an unintentional poisoning died from a prescription opioid. Since 2011, more people have died from opioids in Oklahoma than from car accidents.

The trend is clear:



And for every Oklahoman who died from opioids, there are countless others in their wake suffering from addiction and other devastating effects of these drugs. In 2009, for example, 45 out of every 100,000 Oklahomans had to be admitted for opioid abuse treatment. In 2017, upwards of 500 Oklahoma babies were born suffering from the symptoms of opioid withdrawal (neonatal abstinence syndrome or "NAS"):



That same year, 16.4 percent of Oklahoma high school students reported misusing prescription opioids within the past year—that is a number roughly equal to one in six. A 2019 study showed that a child born to a parent who uses opioids for more than a year is twice as likely to attempt suicide.

The more prescription opioids that were supplied in this State, the more people died from them. Our country's and, indeed, the world's history with opioids taught the lesson that when one introduces such vast quantities of these drugs into society, that society deteriorates: its people become addicted; its communities unravel; and generations suffer. Put more simply, oversupply causes death, addiction and destruction. Defendants knew this fact and were reminded by their own scientific advisors. But, they chose to ignore those warnings. So, history repeated itself.

As a result, Oklahomans have died, Oklahomans are dying, and Oklahomans have and continue to become addicted. To date, the rapid increase in opioid prescribing in Oklahoma is estimated to have stolen 139,359 years of potential life—50,866,035 days of Oklahomans going to work and supporting and growing their communities.

In response to this ongoing public-health emergency, and after years of trying to combat the crisis outside of court, the State of Oklahoma brought this lawsuit against a group of opioid sellers and on behalf of its citizens to abate the nuisance that opioids impose upon the State. While this opioid crisis is unprecedented, this exercise of the State's power is not. Indeed, there are few examples of State governance that are as richly or deeply engrained in this nation's legal history as the duty of states to seek judicial redress for nuisances that threaten the health, safety and prosperity of their people. That power has

existed in Oklahoma since before statehood. It existed in each of the states since before there was a Constitution. And it has been invoked against nuisances that stifle the economic growth of communities, as well as those traditional nuisances where, like this one, the injury to public health and comfort is "graphic and direct."[1]

Contrary to Defendants' arguments at trial, the application of Oklahoma's specific public nuisance law to this crisis under the specific facts applicable to Oklahoma is not an expansion of the law. The public nuisance statute exists for precisely these types of wrongs. The public nuisance statute does not require that the conduct involve or impact property in any way. Nevertheless, if Oklahoma's public nuisance statute required the involvement of property, the evidence in this case demonstrated that Defendants utilized property upon which to carry out their marketing scheme and the impact of that scheme was, and is, felt in countless doctors' offices, hospitals, government buildings, public roads, private homes, parks, schools, playgrounds and fields to name a few. The Court is not concerned that the proper application of Oklahoma's public nuisance law to this case and these facts will have some type of broad impact on other cases. Unlike cases like those cited by Defendants dealing with global warming, for example, in this case, under these facts, there can be no credible or reasonable dispute about the source of the wrongs at issue or their impact. The evidence in this case was substantial and it all pointed to the pharmaceutical industry—and Defendants specifically—as the cause of the worst public health crisis in Oklahoma history.

[1] *See Alfred L. Snapp & Son v. Puerto Rico*, 458 U.S. 592, 604-606.

After two years of intensive litigation, this case arrived at trial—the *State of Oklahoma v. Johnson & Johnson, et al.*—the goal of which was two-fold: first, determine who is at fault; second, determine what must be done to abate the crisis.

The preponderance of the evidence showed that, at the root of this crisis was Johnson & Johnson, a company that literally created the poppy that became the source of the American opioid crisis and engaged in a decades-long revolutionary marketing campaign designed to convince doctors, patients, and the public that these drugs—which had for the last century been reserved as a last resort—should now be used for ordinary, every-day sprains and strains. Defendants sought to erode and replace the narcotic conservatism that had been built up to stem the previous opioid crisis in this country, with an aggressive, liberal understanding that made opioids a go-to, first-line treatment for everything from headaches to sprained ankles. Before this campaign, all the other ingredients for this crisis were in place and had been so for decades, yet no such crisis existed. Prescription opioid drugs existed, as did the doctors prescribing them, as did those who sought to abuse them should they be able to get their hands on them. The missing ingredient, as the evidence showed, was Defendants' aggressive push to expand these drugs into broader, more profitable markets. And once that piece was added, the crisis ensued.

Beyond simply ignoring the lessons of history, what made Defendants' promotional message so egregious was the fact that it was based on deception and misrepresentation. There was no revolutionary breakthrough that made these drugs markedly safer or less prone to abuse or that made the people taking them less prone to addiction and death. But the marketing messages from these Defendants and others was just that—that these drugs

are safe and should be taken at higher and higher dosages for longer and longer periods of time; that these drugs are not prone to abuse; and that they are rarely, if ever, addictive. Defendants intentionally targeted those doctors that were untrained in spotting and treating addiction, and Defendants promoted terms like "pseudoaddiction" in an effort quell those doctors' fears regarding classic signs of addiction and convince them to respond to those signs with less caution and more drugs. What once was reserved for those patients coming out of surgery or enduring the final days of their battle with cancer, was now touted as a one-drug-fits-all wonder-cure. The brand or the potency of the drug did not matter, and neither did the patient or the pain; Defendants told doctors that people were in pain and *opioids* were the solution.

Defendants did not target all doctors. To the contrary, they targeted those doctors that Defendants thought would be more likely to prescribe more opioids more liberally. They intensely focused upon primary care physicians in an effort to get them to prescribe more and more opioids for longer durations at higher doses. And they sought, successfully, to muddy the waters for doctors by misleading them about the risks of these drugs and the warning signs applicable to patients who were at risk for addiction or already addicted.

Defendants' marketing scheme was driven by a desire to make billions for their pain franchise. To do this, they developed and carried out a plan to directly influence and convince doctors to prescribe more and more opioids, despite the fact that Defendants knew increasing the supply of opioids would lead to abuse, addiction, misuse, death and crime. Yet, Defendants carried out this plan with deliberate and painstaking efforts. One of the

most concise examples of Defendants' plan, and how they attempted to secretly influence Oklahoma doctors was discussed at length in trial:

> The high deciled physicians continue to represent significant opportunity for DURAGESIC due to their high volume prescribing of chronic pain medications . . . Even though our deciling methods ha[ve] changed, the same 8,000 physicians that we focused on in 2000 are still those we will concentrate on in 2001, with even greater emphasis being placed on the top 1000 who account for 20% of all the dollars in the pain market. . . . In 2000, we conducted extensive market research to assess the effectiveness of our new promotional campaign. Physicians overwhelmingly stated that the 'Life, Uninterrupted' message was credible and compelling enough to cause them to prescribe DURAGESIC as a 1st choice for chronic pain. This positioning statement will continue to serve as the cornerstone for all brand related activities in 2001. Expand DURAGESIC Use in Non-malignant Pain. Physicians are becoming more comfortable using opioids in non-malignant pain. Our objective is to convince them that DURAGESIC is effective and safe to use in areas such as chronic back pain, degenerative joint disease, and osteoarthritis. It is important to remind physicians that the A[merican] P[ain] S[ociety], A[merican] A[cademy of] P[ain] M[edicine], and A[merican] G[eriatric] S[ociety] have all endorsed the appropriate use of opioids to manage chronic, non-malignant pain.

The "cornerstone" of this campaign—including the "Life, Uninterrupted" message—was false and misleading statements about the safety and efficacy of these dangerous drugs. And the testimony from one Oklahoma prescriber at trial demonstrated how this specific campaign was carried out by the sales representatives that called on him.

But influencing doctors was only part of Defendants' plan to reach their profits goals. Defendants also targeted the expansion of the market for opioids. They targeted men, women, veterans, the young, the elderly, and even people with a high risk of addiction.

The element of causation in this case is not complex. It is simple. Defendants intended to increase prescriptions of opioids as a class of drug by vastly broadening the

perceptions of prescribers, patients, and payors as to when, why, and for how long opioids should be prescribed. To do this, Defendants incessantly delivered targeted, false and misleading messages through countless channels—sales representatives, lunches, dinners, journal articles, key opinion leaders, advocacy groups, trade organizations, continuing medical education programs, speaking events, and others—for two decades in Oklahoma. As a result, opioid prescriptions skyrocketed in Oklahoma. And in lock-step with the rise in prescription opioids, Oklahoma experienced dramatic increases in opioid-related abuse, addiction, overdoses, and death, and related crimes. This is clear, common-sense causation of a public nuisance based on credible evidence.

Defendants' arguments that the labels on their opioid drugs, as well as others, warned doctors and patients of the risks of addiction are of no consequence. Defendants' marketing campaign was designed to influence doctors to prescribe, and patients to take, opioids despite these risks. Every time a patient went to her doctor in Oklahoma, Defendants wanted to make sure that they were there first to influence the conversation as well as the decision to prescribe and the decision to fulfill the prescription. Defendants did this through a relentless, aggressive campaign of direct and indirect marketing, branded and unbranded, for more than a decade and a half. That campaign understated and hid the risks of opioids, overstated their benefits, took data out of context, and omitted highly material information. And that campaign was not supported by scientific evidence.

Defendants had a particular interest in promoting the use of opioids generally. Their billion-dollar plan did not just include their branded drugs. To make their plan work, Defendants had to make sure that opioids were available, not feared, and widely used. So,

they marketed all opioids, not just their own, as more effective than they were and less dangerous and addictive than they were. Further, Defendants had another deep financial reason to market all opioids in this manner.

Until 2016, Johnson & Johnson owned poppy fields in Tasmania and processing plants on the east coast that were vital in supplying the active narcotic ingredients for other manufacturers' opioid products. Janssen invented fentanyl in the 1950s. And for years, Johnson & Johnson was the number-one supplier of oxycodone, hydrocodone, morphine, and codeine in the United States—accounting for more than 50% of the market for those drugs. Johnson & Johnson even developed a mutant poppy in order to meet the increase in demand they forecasted—before Purdue launched its new extended-release formulation of the compound known as OxyContin—because Johnson & Johnson began developing its poppy at the same time Purdue filed its New Drug Application for OxyContin—almost two years before OxyContin hit the market. Johnson & Johnson acknowledged that its newly created poppy enabled the national spike in the oxycodone consumption that followed. To Defendants' bottom line, it did not matter whose opioid was sold. The more opioids were sold, the more money Defendants made. Defendants marketed ALL OPIOIDS as more effective and safer than they were and charged the costs of such marketing to their entire pain franchise. In the rising tide that raised all boats, Defendants were not just another boat—they were also the tide.

Dr. Russell Portenoy, Defendants' foremost key opinion leader—the first place they turned to lend credibility to their statements—describes Defendants' campaign like this:

> [T]hey distilled from work that was created in the time frame of this problem evolving, all the positives, all the positive messages and packaged that into marketing without concurrently providing the medical community and the public with the context and the kinds of education related to risk to try to make sure that the patients who had access to this drug [opioids] were carefully selected to minimize risk, that they had been selective with this therapy only after other approaches of pain management had not worked, and that if this therapy was tried, it was tried according to guidelines that were published repeatedly during this period of time that pointed to the need to be cautious in dosing, to evaluate aberrant behavior, to react to aberrant behavior—all of that messaging about proper patient selection, about appropriate dosing, about monitoring of drug-related behavior, about dealing with problematic drug-related behavior, that messaging was not included in many – in much of the marketing work that was done by the companies during this period of time. And I have come to believe that that's in part what drove the kind of prescribing by a segment of the physician community that presumably could not select patients appropriately and led to a high risk for patients, including the risk of unintended overdose and mortality.

This testimony came from Defendants' own top Key Opinion Leader ("KOL")—someone they paid, heralded as honest, trustworthy, credible and the expert of all experts, and someone who blamed Defendants, Johnson & Johnson and Janssen, for being a cause of the crisis. And Dr. Aaron Gilson, another KOL whose work Defendants often cited, testified that Defendants compromised the integrity of his work and "manipulated" his research into misleading sales messages for their own commercial purposes.

This theme in the testimony of Defendants' own KOLs was echoed consistently at trial. Defendants have described this case as "expert-driven" and, in that regard, the State's witnesses were convincing. Consisting largely of State employees who have lived this crisis and who were paid no more than their government salary, as well as a who's-who of national experts who have made it their life's work to research, combat and address the opioid crisis, the State's experts explained the following:

- Commissioner Terri White, head of Oklahoma's Department of Mental Health and Substance Abuse Services ("ODMHSAS"), leader in the State's fight to combat the opioid crisis, and the primary architect of the State's plan to abate the crisis, testified that Defendants' brand-specific, and unbranded promotion of opioids generally, caused the sales of opioids and their negative consequence to "rise rapidly and significantly" in the State of Oklahoma; that the crisis can be abated and will be through the measures identified in the State's abatement plan; and that, if the crisis is not abated, more Oklahomans will become addicted and die—Commissioner White is, and has been since 2007, the Commissioner of the ODMHSAS. Trial Tr. (6/25/19 a.m., Commissioner White) at 6:15-22, 13:14-21. In that role, she is "the highest-ranking public health official for the State of Oklahoma, responsible for overseeing the prevention and the treatment of mental health and addiction," including the use, abuse and addiction to substances. *Id.* at 6:23-7:5. Commissioner White is the longest serving commissioner of a state department of mental health and substance abuse services in the country. *Id.* at 13:25-14:6. She was the first woman in Oklahoma to serve as the State's Secretary of Health. *Id.* at 13:17-24. And, as ODMHSAS Commissioner, "the mantle of being the single State authority" for "the prevention [and] treatment of addiction, including substance abuse addiction in the State of Oklahoma, rests with" Commissioner White. *Id.* at 33:13-22. Commissioner White was professionally trained in the field of social work, which included professional training in "human development and human behavior, as well as social, economic, and organizational, and community organizations, and specifically, the culture of those organizations and how those work together with human development and human behavior and how you take all of that knowledge that you learn and put it into practice, specifically, to help people in need." *Id.* at 8:11-23;

- Dr. Jason Beaman, an Oklahoma physician and the head of the addiction-medicine department at Oklahoma State University, testified that the misinformation campaign of the opioid industry, including Defendants, caused the opioid epidemic in Oklahoma; and that the crisis can be abated and will be through the measures set forth in the State's abatement plan—Dr. Beaman is the current chair of psychiatry in behavioral sciences at the Oklahoma State Center for Health Sciences in Tulsa. *See* Trial Tr. (6/17/19 p.m., Beaman) at 27:18-21; S-4733. He holds Masters degrees in both pharmacology and public health and a Doctor of Osteopathic Medicine Degree, completed residencies in family medicine and psychiatry and a fellowship in forensic psychiatry, and is board certified in family medicine, general psychiatry, forensic psychiatry and addiction medicine. *See* Trial Tr. (6/17/19 p.m., Beaman) at 31:4-13, 32:5-33:22. His expertise in addiction and addiction medicine has been recognized nationally and in Oklahoma. *Id.*

at 27:18-49:23; S-4733. Dr. Beaman received his Doctor of Osteopathic Medicine Degree in 2007 from the Oklahoma State University Center for Health. *See id.* at 31:4-13. Dr. Beaman completed two medical residencies—in family medicine and psychiatry—in 2012. *See id.* at 32:5-18. Dr. Beaman is board certified in 4 areas: family medicine, general psychiatry, forensic psychiatry, and addiction medicine. *Id.* at 33:11-22. Dr. Beaman was previously on faculty at the University of Arkansas for Medical Sciences and is currently on the faculty at Oklahoma State University Center for Health Sciences and the Department of Psychiatry, which he runs. He is also national faculty for the National Board of Osteopathic Medical Examiners and is national faculty for the National Attorneys General Training Institute. *See id.* at 41:14-23. Dr. Beaman won the award for best resident teacher 4 years in a row and was recognized in Oklahoma's Top 40 under 40. *See id.* at 41:24-42:6. Dr. Beaman sees patients every day as the consulting psychiatrist at OSU Medical Center, supervises residents in the psychiatric clinic, and supervises residents in the addiction medicine clinic. *See id.* at 44:15-45:6;

- Dr. Andrew Kolodny, the man widely recognized as the nation's foremost expert on the opioid crisis, its causes, effects and solutions, and relied upon by federal and state leaders around the country—and who traveled at his own expense to Tasmania to see the root of the opioid crisis with his own eyes years before this litigation ever began, testified that Defendants' false and misleading marketing campaign was "a major cause" of Oklahoma's opioid crisis; and that the crisis can be abated and will be through the measures set forth in the State's abatement plan—Dr. Kolodny is board certified in psychiatry and addiction medicine. Trial Tr. (6/11/19 a.m., Kolodny) at 11:13-16. His main clinical focus has been treating opioid addicted patients, and he has worked extensively in the field of public health. *See, e.g., id.* at 8:04-11:12. Dr. Kolodny teaches a class on the opioid epidemic and has studied it extensively. *See id.* at 5:12-54:09. Dr. Kolodny is the Co-Director of the Opioid Policy Research Collaborative (OPRC) at Brandeis University. The goal of the OPRC is "to help policymakers, health officials, legislators, better address the opioid crisis." The OPRC "is studying interventions to bring the epidemic under control so that [they] can figure out what works, what doesn't work, and get that information out to stakeholders as quickly as possible so that they can more effectively address the epidemic." *Id.* at 12:11-13:04. Dr. Kolodny spent several years working for the New York Department of Health and Mental Hygiene. His primary assignment during that time was to reduce the number of people dying from drug overdoses. *Id.* at 13:05-14:21. Dr. Kolodny also spent several years at Maimonides Medical Center in New York, which is "one of the largest community-based teaching hospitals in the country where he was selected as the vice chair of the

department of psychiatry and, later, the chair of the same department." *Id.* at 27:22-28:21. Dr. Kolodny then left to spend several years at Phoenix House, a national, nonprofit addiction treatment agency where he became the chief medical officer at the New York City headquarters. *Id.* at 28:22-29:06. The Senate Finance Committee investigating the relationship between pharmaceutical companies and professional societies and patient advocacy group, led by Senators Grassley and Baucus, sought Dr. Kolodny's help in the investigation. *Id.* at 33:15-34:11. Dr. Kolodny personally traveled to Tasmania to learn more about the Tasmanian Alkaloids operation that Defendant Johnson & Johnson owned and operated, including speaking with a former managing director. *Id.* at 35:23-37:16. For the last several years, Dr. Kolodny has worked as a consultant for various government organizations dealing with the opioid crisis. *Id.* at 37:24-38:03. His work concerning the "Financial Conflicts of Interest and the Centers for Disease Control and Prevention's 2016 Guideline for Prescribing Opioids for Chronic Pain" was cited by the President's Commission on Combatting the Drug Addiction and Opioid Crisis. *Id.* at 38:14-39:16. Dr. Kolodny has been asked to work with different congressional offices to help address and investigate the opioid crisis and aggressive marketing, and he also testified as an expert witness to the U.S. Senate Caucus on International Narcotics Control and his testimony discussed the "campaign to encourage aggressive opioid prescribing that relied on deceptive information." *Id.* at 40:13-41:16. Dr. Kolodny was invited to speak at the World Health Organization in Switzerland about the opioid addiction epidemic in the U.S. *Id.* at 41:17-21. He has worked with the National Governors Association, National Association of Attorneys General, the National Judicial Opioid Task Force, and the National Center for State Courts. *Id.* at 41:22-42:17. Prior to serving as an expert witness in this case, Dr. Kolodny worked in Oklahoma and gave a talk at an event in 2015 organized by the DEA in Tulsa, Oklahoma. *Id.* at 45:18-23. Dr. Kolodny has also worked with the Department of Mental Health and Substance Abuse in Oklahoma to assist in opioid prescribing continuing medical education programs in the State. *Id.* at 45:24-46:04. Finally, Dr. Kolodny was invited to speak with the Oklahoma Opioid Commission and is cited within that Commission's final report. *Id.* at 46:05-11;

- Claire Nguyen, the State's lead epidemiologist at the Oklahoma State Department of Health ("OSDH"), testified that as prescription opioid sales increased, more and more Oklahomans died as a result of unintentional opioid overdose; that those levels reached epidemic proportions; that the epidemic was driven by prescription opioids and particularly deadly to women and Oklahomans between the ages of 35 and 54—Ms. Nguyen has worked for the OSDH as an epidemiologist for nearly ten years. Trial Tr. (6/7/19 a.m., Nguyen) at 42:18-20; 43:18-52:14. Ms. Nguyen is currently an

administrative program manager with the Injury Prevention Service ("IPS"), the lead injury and violence prevention program for the State, and a division of OSDH. *Id.* at 41:16-18; 42:1-4. As administrative program manager, Ms. Nguyen oversees all areas of unintentional injury within the IPS. She supervises two epidemiologists, who mainly focus on drug overdose, and two project coordinators focusing on child injury prevention, older adult falls and unintentional poisoning prevention. *Id.* at 42:7-14. Ms. Nguyen oversees all data collection, analysis, quality assurance, reports, review and presentations or other material related to unintentional injuries in Oklahoma. *Id.* at 42:15-17. Ms. Nguyen has a BS in Mathematics and an MS in Biostatistics from the University of Oklahoma. *Id.* at 42:21-25;

- Renzi Stone, a local marketing strategy firm owner, member of the Oklahoma Board of Regents, and an expert on how marketing works to influence behavior, testified that Defendants executed a well-orchestrated, multi-faceted marketing scheme designed to influence doctors and patients to generate more and more product sales—and that the campaign worked. Mr. Stone also testified regarding the necessity of a public media and counter-detailing campaign to reverse and correct the misinformation spread by Defendants' marketing—Mr. Stone's qualifications are further discussed below;

- Dr. Danesh Mazloomdoost, a Johns Hopkins-trained anesthesiologist and pain specialist, testified that Defendants' marketing influenced Oklahoma physicians and caused them to write more prescriptions for opioids, and that the campaign worked—so much so that it even influenced him to prescribe opioids more liberally and aggressively (a confession that was echoed by Dr. Beaman)—Dr. Mazloomdoost's qualifications are further discussed below;

- Dr. Julio Rojas, a Professor at the University of Oklahoma's Department of Psychiatry and Behavioral Sciences, testified that the effects of addiction are horrific, brain-altering and can follow a person for life—Dr. Rojas' qualifications are further discussed below;

- Dr. David Courtwright, the nation's foremost authority on the history of opioid abuse and epidemics in America testified that the natural and inevitable consequence of flooding a society with opioids is addiction, death, and deterioration. But he also testified that with a return to narcotic conservatism—the cautious and restrained use of opioids—these effects can be reversed; Dr. Courtwright's qualifications are further discussed below;

- Gary Mendell, one of the nations' foremost voices on how to revolutionize the way we think about and treat addiction, testified that the stigma around addiction is a powerful barrier to our ability to address it; but that once we remove that stigma and view addiction like any other disease, we can and will be able to combat it and save the lives of those suffering from it—Mr. Mendell's qualifications are further discussed below;

- Dr. Julie Croff, Executive Director of the Oklahoma State University Center for Wellness & Recovery and Professor at the College of Education's School of Applied Health and Educational Psychology, testified that the crisis can be abated with, among other things, measures designed to train and re-train doctors regarding how to properly prescribe opioids, programs designed to change the way we view and treat addiction, and research designed to better understand the crisis, its causes, effects, and solutions—As Executive Director of the Center, Dr. Croff interacts daily with the clinicians at the Center's addiction medicine clinic to ensure the Center is utilizing best practices and engaging in research such as nonpharmacological alternatives to opioid therapy for the treatment of pain, recovery for individuals with OUD, and effects and outcomes on children exposed to opiates in utero. Trial Tr. (6/20/19 a.m., Croff) at 7:20-8:9; 11:2-14:17; Trial Tr. (6/20/19 p.m., Croff) at 58:14-17. Dr. Croff provides CME to clinicians regarding the Oklahoma opioid crisis. Trial Tr. (6/20/19 a.m., Croff) at 10:21-11:1; 16:9-11; Trial Tr. (6/20/19 p.m., Croff) at 58:11-13. Dr. Croff was also a tenured assistant professor of health education and promotion at OSU in Stillwater. Trial Tr. (6/20/19 a.m., Croff) at 22:1-6. Dr. Croff founded the Masters of Public Health Program at OSU in 2014. *Id.* at 22:7-14; 22:20-23:11. Dr. Croff has taught courses in public health, epidemiology, health behavioral theory and principles of health education and promotion. *Id.* at 19:24-20:20:9. Dr. Croff also was Associate Director for Research for the Center for Family Resilience at OSU in Tulsa. Dr. Croff has 20 years of experience working on substance use, including drugs and alcohol as experienced and used by college students. *Id.* at 100:12-22; and

- Jessica Hawkins, the Senior Director of Prevention Services at the Oklahoma Department of Mental Health and Substance Abuse Services, testified regarding virtually every element of the State's abatement plan, detailing the necessity of measures designed to treat those currently suffering from the negative effects of these drugs, to prevent new cases of abuse and addiction, and to return prescribing rates and practices back to their pre-crisis levels. Ms. Hawkins provided invaluable and unrebutted testimony on what is needed in order to abate the opioid nuisance in Oklahoma— As senior director of prevention services at ODMHSAS, Ms. Hawkins is one of the architects of the State's Abatement Plan. Trial Tr. (6/20/19 p.m., Hawkins)

at 70:16-19, 106:3-9. Ms. Hawkins, who has been working in prevention services for about 20 years, oversees the State's portfolio of substance use prevention dollars, any additional discretionary grants, state appropriations and other sources of prevention funding. Trial Tr. (6/20/19 p.m., Hawkins) at 71:3-9; 89:15-17. Ms. Hawkins has specialized training as a substance abuse specialist and has a certification as an instructor in several evidence-based prevention programs. Trial Tr. (6/20/19 p.m., Hawkins) at 72:6-13. On a daily basis, Ms. Hawkins sets the strategic direction for prevention services including preparing funding proposals, overseeing and developing substance use and prevention programs, researching evidence-based programs, and presenting at conferences nationwide. Trial Tr. (6/20/19 p.m., Hawkins) at 78:24-80:10. Ms. Hawkins has developed several state-wide plans including two specifically around prescription drug abuse. Trial Tr. (6/20/19 p.m., Hawkins) at 86:11-22. Ms. Hawkins combats the nuisance daily, is involved in several workgroups focused on the nuisance and has worked on numerous committees focused on developing pain and opioid guidelines. Trial Tr. (6/20/19 p.m., Hawkins) at 90:23-91:17. This work resulted in an initiative that successfully accomplished a goal of reducing statewide unintentional opioid overdoses by 15% in five years. Trial Tr. (6/20/19 p.m., Hawkins) at 91:18-93:12. Due to the previous plan's success, Ms. Hawkins was a crucial part in initiating a 2016 follow up plan that added new items and addressed new ways to combat the nuisance. Trial Tr. (6/20/19 p.m., Hawkins) at 95:11-96:4.

Moreover, many of Defendants' witnesses agreed with the State.

- In 2014, *Pain Medicine* published an article co-authored by former Janssen employee and paid expert witness at trial, Dr. Bruce Moskovitz, in which Dr. Moskovitz stated that the relationship between expanding rates of opioid misuse, abuse, and fatal and nonfatal overdoses and the corresponding rise in opioid prescribing is "**more than circumstantial, as multiple investigations have been conducted to support the purported causal influence of increased opioid prescribing to higher rates of misuse, abuse, emergency room visits, and overdose**."

- In 2016, Janssen's paid expert witness, Dr. Timothy Fong, gave a presentation about the opioid epidemic, in which Dr. Fong described the advent of the opioid crisis as "**coupl[ing] physician anxiety about treating pain with a lot more choices prescribed with a pharmaceutical industry that was very aggressive in promoted pain management treatment. So dinners and lunches like this, golf trips, massages. The drug reps, all that – from 1998 onward till about mid-2000 saying, 'Hey, do me a favor. Prescribe this for me. I'll do you a solid.' So it was a combination of just**

what we saw in the housing industry – Right? – opportunity, greed, easy money, anxiety about losing what I have."

- In 2016, Defendants' paid expert, Dr. Terrell Phillips, gave a presentation to the Oklahoma State Medical Association, during which he stated: "**Everyone here knows how we got in this situation. They told us we were underprescribing. We need to prescribe more. It's the patient's rights to have pain medicine, so we all got on board. And when someone said they were hurting, we said, Okay, we are going to give you something. Now it's just the opposite. Not everyone deserves pain medicine**."

- A doctor who Defendants called at trial, Dr. Muchmore, testified that there is a 100% certainty of a patient getting addicted to opioids if on the drug long enough at a dose significant enough to treat moderate to severe pain, and it would be ridiculous for anyone to tell a doctor that a patient would not become addicted to opioids;

- A doctor who Defendants called at trial, Dr. Schick, testified that it would be wrong for Defendants to target veterans and women in the State of Oklahoma to try to get them to use more opioids so that Defendants could build a billion-dollar brand, that he became more "comfortable" prescribing opioids as a result of "sales reps being around"; and

- A doctor Defendants called at trial, Dr. Halford, testified that pharmaceutical sales representatives are not experts in pain management and holding them out as such is nonsense.

These are statements of Defendants' own witnesses and experts, long before they were hired to testify—and one of them, Dr. Moskovitz, was a career Janssen employee.

Learned, trustworthy voices around the country agree too. Many public institutions tasked with dealing with this crisis have repeatedly found that misrepresentations regarding the safety of opioid medications and the oversupply of such medications caused, at least in part, the opioid crisis decimating Oklahoma and states across the Union.

- On October 26, 2017, the President of the United States declared the opioid crisis a national public health emergency under federal law and established the President's Commission on Combating Drug Addiction and the Opioid Crisis ("U.S. Commission") to "develop[] recommendations to combat the

addiction crisis that is rampantly impacting our country." The U.S. Commission issued a report detailing causes of the opioid crisis and the actions necessary to reverse it, which found, among other things, that the origins of the current opioid crisis can be traced in part to the opioid pharmaceutical industry "**embrac[ing] and exploit[ing] . . . with aggressive marketing and 'educational outreach'" flawed claims that "opioid narcotics are safe to use universally for chronic pain**."

- On May 18, 2017, the Governor of Oklahoma signed into law a resolution forming the Oklahoma Commission on Opioid Abuse ("Oklahoma Commission") in response to Oklahoma's opioid epidemic. The Oklahoma Commission gathered recommendations to address the opioid crisis "from law enforcement officials, the medical community, business professionals, state legislators, and other stakeholders who came to the table to help" over the course of six meetings. In its findings regarding the rise of the opioid epidemic, the Oklahoma Commission found that: "**Opioid manufacturers became focused on enticing doctors to prescribe opioids for common chronic pain conditions. Doctors were told that opioid addiction is rare, that opioids are safe and effective, and that they are easily discontinued . . . . Drug companies engaged in multiple strategies including inundating doctors with scripted propaganda utilizing their peers in pain management, medical societies, hospitals, and medical boards**."

- In January 2019, the National Institute on Drug Abuse ("NIDA"), a federal-government research institute, whose mission is to "lead the Nation in bringing the power of science to bear on drug abuse and addiction," issued a revised summary of the opioid crisis that found the opioid crisis happened because: "**In the late 1990s, pharmaceutical companies reassured the medical community that patients would not become addicted to prescription opioid pain relievers, and healthcare providers began to prescribe them at greater rates**."

- The Centers for Disease Control and Prevention ("CDC") has found that the first wave of overdose deaths related to the opioid epidemic "**began with increased prescribing of opioids in the 1990s, with overdose deaths involving prescription opioids increasing since at least 1999**."

- In a 2017 report, the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control ("OBN") reported: "**By 2010, Oklahoma ranked first in the elicit use of prescription pain killers and second in overdoses per capita. In 2013, Oklahoma doctors prescribed patients enough hydrocodone to provide a 30-day supply to every man, woman, and child in the state –**

> **more than 200 million pills each year. Public health officials reported a spike of more than 800 overdose deaths the same year . . . . Officials believe the increase in prescriptions written for pain killers likely contributes to spikes in overdose deaths across the country**."

And these other bodies reached these conclusions without the benefit of a full evidentiary record containing many of the documents unveiled to the public for the first time at this trial.

Defendants admitted here that they do not know and have never known the rate of addiction for patients receiving prescription opioids and taking them as prescribed. Defendants also conceded they are not aware of any high-quality studies or evidence that show otherwise. These admissions come years after Defendants marketed their drugs, and ALL OPIOIDS, as having a low risk of addiction. Defendants agree there is an opioid crisis in Oklahoma. But they have done nothing to fix it.

Instead, Defendants continue to deny they played any role in causing this crisis.

The evidence says otherwise. The record is replete with evidence that confirms the opinions of the witnesses and public institutions set forth above. But, set aside, for a moment, the national voices, the voices of Defendants' experts, and even the voices of the State's witnesses. Perhaps the most telling evidence in the case that Defendants preyed upon and misled doctors in Oklahoma is Defendants' call notes—the records of what Defendants' sales force said to doctors when they visited them.

The State brought 35 over-sized boxes into this Court representing well over 140,000 records of Defendants' efforts to influence and convince Oklahoma physicians to become more and more comfortable prescribing more and more opioids. These notes show

that Defendants deployed their false and misleading messages in Oklahoma—including messages their own internal scientific advisors and the FDA explicitly warned them were false, misleading and dangerous. These call notes included examples of:

- Defendants misleading doctors about the risk of abuse in their branded medication:
    - "Started telling me about DUR[agesic] and nurses taking the old patches. I said how many more people do you think are abusing oral BC they are easier to get and get high from."
    - "Said that he is concerned with rx so much DUR and I reassured him that DUR has no street value and is least abused."
- Defendants offering incentives for writing more prescriptions:
    - "asked linda at the front desk to dispense the coupon and police the D[ispense]A[s]W[ritten]'s on each script. She gets a Power Aid Sonic when 5 coupons are gone."
- Defendants overcoming doctors' objections about abuse and addiction with misleading citations to unsupportive data:
    - "Asked him what he dislikes about CII drugs, he said that they are addictive. I showed him the DAWN Data and told him that was one of the benefits of Dur[agesic], the low abuse potential. I told him that when prescribing dur he doesn't have to worry about it when compared to other Rx . . . ."
    - "S[ai]d he finally had someone abuse Dur by eating it, ended up in hospital and almost died. Showed him DAWN and he agreed that it was rare people abuse it."
    - "Asked him to rx [Duragesic] for any O[steo]A[rthritis] who is on rc SAO. Mentioned 21yo who got hold of 100 mcg of cancer p[atien]t rel who died and had them. S[ai]d he OD'd on it. Shared DAWN in response to that and he agreed that Dur low abuse potential."
- Defendants misleadingly promoting the use of opioids as safe for use in every-day aches and pains:

- "I closed for strains/sprains p[a]t[ient]s from spring break. Nice weather, people become more active and skiing trips."

- "Ultracet spring break blitz. I talked to doctors and staff about ultracet w/proper dosing over lortab. P.A. told story about problem pt and using tramadol. I talked about using ultracet for pts because it is not a narcotic but will effectively relieve pain. I asked them to use ult instead of others."

- "2 ways to reduce Lortab in clinic, Ultracet for Spring Breaks, Sprains and Strain and when pain progress rx DUR DAW and educate pts to say no to generic since not a lot is known about them and eliminate hassel [*sic*] of paperwork on case fails generic."

- And Defendants showing that their misleading marketing strategy worked:

  - "Doctor said he would try more with these patients"

  - "She would try some nonmalignant patients"

  - "Dinner. Good call, uncover big objection to Dur[agesic] and that is abuse. For some reason thinks Dur[agesic] is abusable, talked about DAWN data. . . . Tried Dur[agesic] once and p[atien]t freaked out on it. . . . Talked about benefits of Dur[agesic]. Hit on conversion, bring him calculator, Allan and Simpson study. Closed for pat[ient] to be started on Dur[agesic] . . . ."

C.t Exs. 17 & 61 (excerpts from S-2481 through S-2492). And those are just a few examples from the years for which Defendants recorded their thoughts and impressions; from 2010 forward, those parts of the call notes are blank.

Further, these call notes evidence that Defendants engaged in a decades-long marketing approach designed to get Oklahoma doctors to be extremely aggressive in using opioids, to start patients on opioids first, to stay with opioids thus keeping patients on them for long durations and increase dosages—all of which is conduct that should never have occurred. Defendants used meals, snacks, trips to bars and an overwhelming array of

pressure sales techniques all designed—from corporate headquarters—to do one thing: influence doctors to prescribe more opioids more agressively. The call notes also show the callous, profit-driven attitude that fueled this crisis:

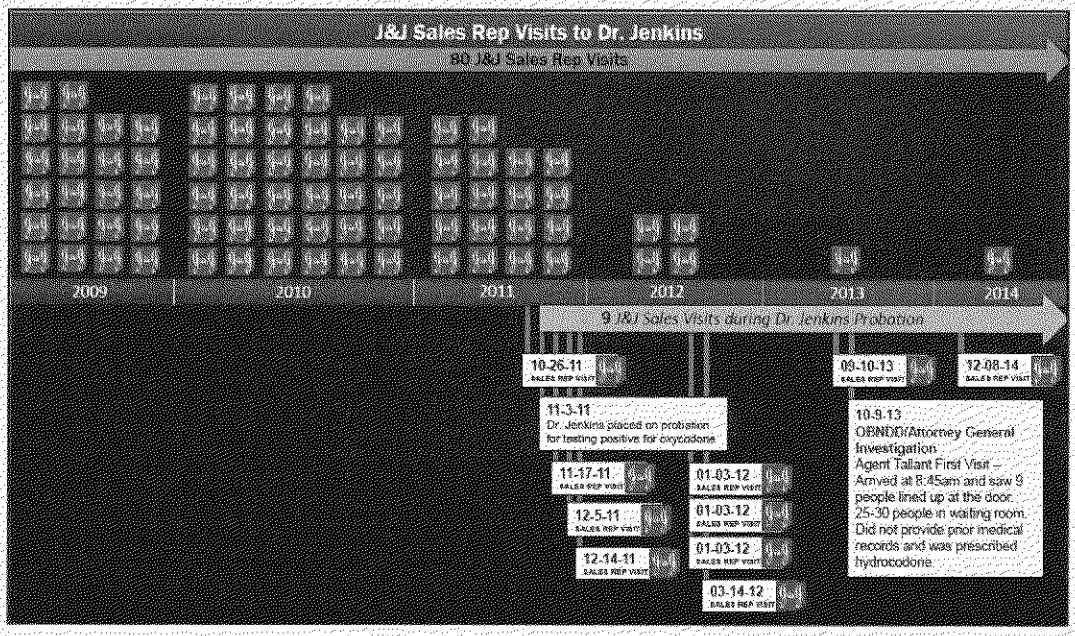
2/19/2004

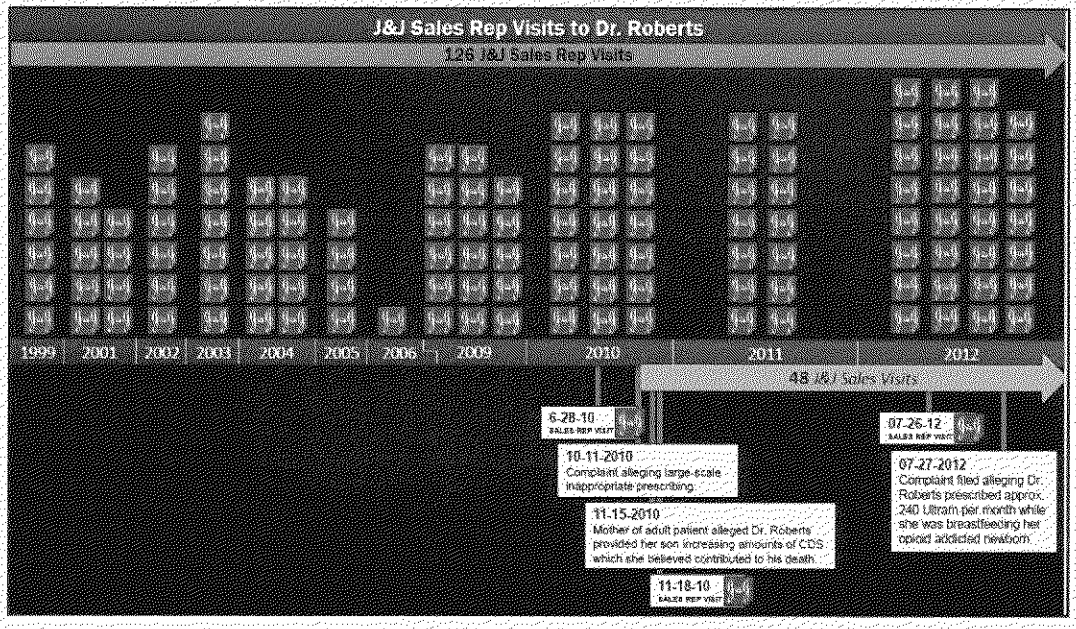
Sales Rep: Melinda Dickson
Dr. REDACTED
Tulsa

Saw him with Greg. Sd only thing we coudl do for him is bring him any info. on ways to divert Dur. I showed hin DAWN and sd it's no street value and low abuse potential. Greg suggested we could bring DEA agent to talk to him. Emphasized when someone does divert it's usually not repeated. Either fatal or they do not get affect they are looking for.

To these Defendants, the Oklahomans dying from prescription opioids were nameless and faceless afterthoughts—diversion was not a concern because many of those folks end up dying anyway.

Defendants even targeted high prescribing pill mills. For example, at trial Defendants attempted to blame the crisis on pill mills, such as clinics run by, among others, Drs. Harvey Jenkins and Dennis Roberts. However, the evidence demonstrated that Defendants' Oklahoma sales reps called on these doctors heavily both prior to and during investigations by the State—all as a part of Defendants' strategy to target and influence high-opioid-prescribing physicians in order to build Defendants' billion-dollar brand:





After claiming opioids were safe, effective and rarely addictive, after Defendants divested part of their pain franchise and recorded over $1.5 billion in proceeds for Johnson & Johnson, Defendants began to say something quite different about opioids. Indeed, Defendants now market their Tylenol, non-opioid, pain reliever as non-habit forming:

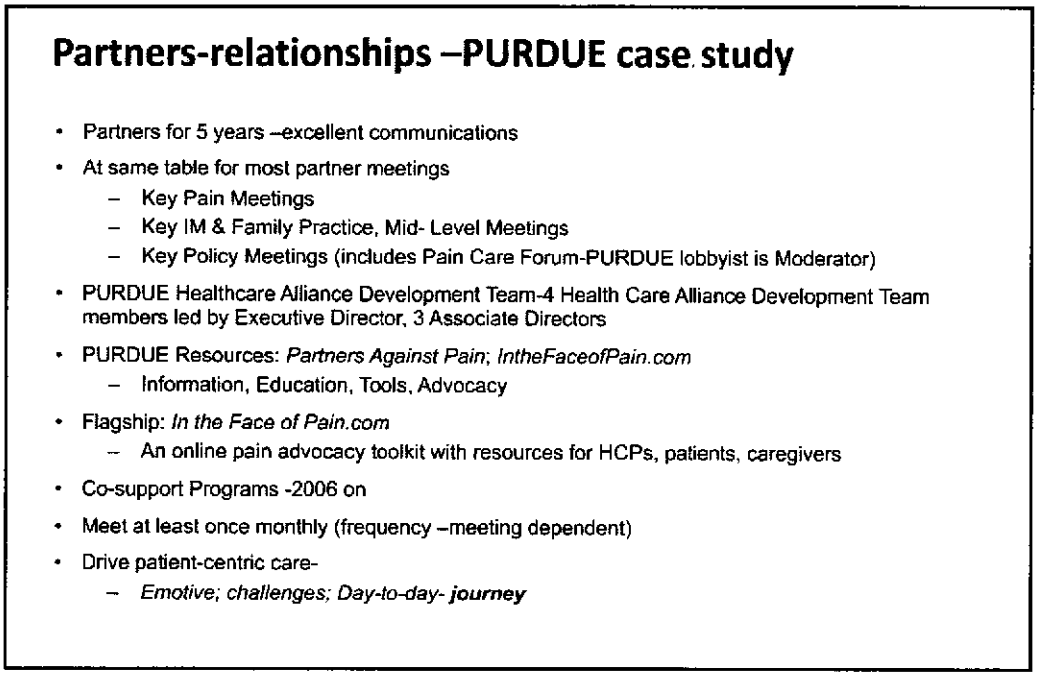
use only as directed

TYLENOL® Extra Strength Coated Tablets for Adults should be used to temporarily reduce fever and relieve minor aches and pains. Each extra strength pain relief coated tablet contains 500 milligrams of acetaminophen and can be a safe and effective post-surgery pain relief option when used as directed. From the #1 doctor-recommended over the-counter brand for post-surgical pain, these opioid-free tablets provide strong, fast relief without constipation, upset stomach, or habit forming side effects that are seen with opioids.

For adults and children 12 years of age and older

If Defendants truly believed their opioids, and all opioids generally, were safe and not addictive, they would not now be marketing their non-opioid products as safer than opioids because they are not "habit forming."

Defendants' arguments that they only had a small share of the opioids market is to no avail. First, market share is not a factor under Oklahoma's public nuisance statute. Second, market share is not relevant under Oklahoma's joint and several liability law. Oklahoma clearly affords joint and several liability in nuisance cases such as this one where the State is a party. Third, Defendants' evidence at trial ignored the fact that Defendants marketed all opioids generally as more effective and less dangerous than they really were. Defendants' own witness admitted that such marketing had the potential to increase sales of all opioids. This unbranded marketing of "all opioids" benefitted Defendants, as well as their partners, like Purdue—a company that: (i) Defendants supplied with API to make OxyContin; (ii) Defendants entered into a co-promotion agreement to promote opioids with; and (iii) Defendants internally referred to as their "partner" with whom Defendants sat at the "same table for most partner meetings":



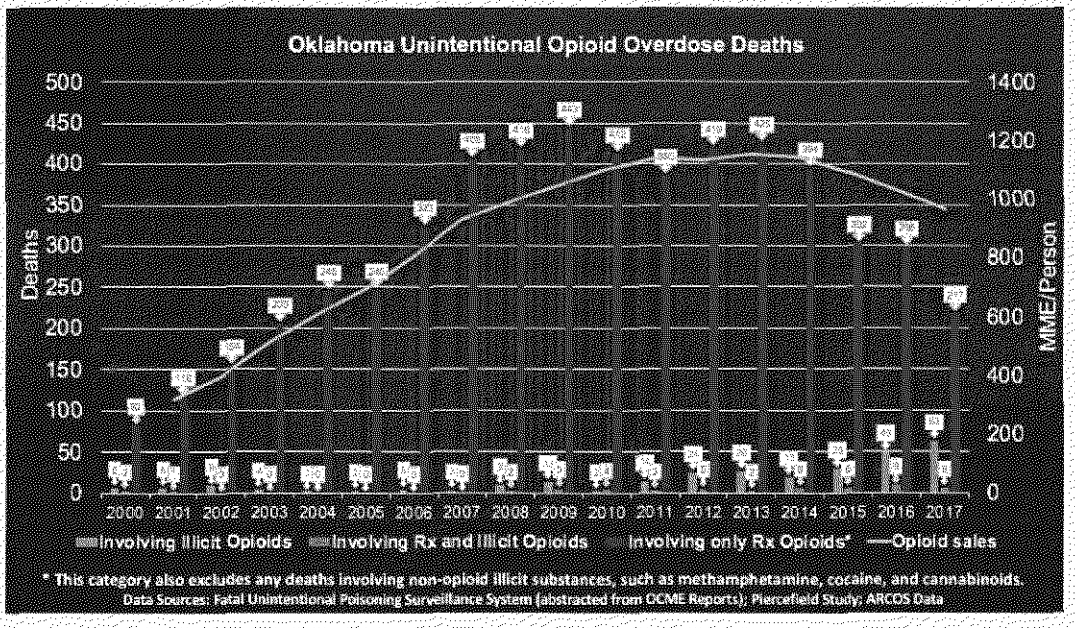
Defendants' marketing of all opioids in this manner was pervasive and continued on the internet until the beginning of trial. Defendants' own marketing expert admitted that he was never asked to analyze the impact of such marketing on the overall market for prescription opioids and he agreed that the market share for all opioids (which is what Defendants' unbranded marketing focused on) is 100% of the market. Further, Defendants also omitted any discussion of the market for its unscheduled opioids such as Tylenol with codeine, Tylox and Tylenol 3.

Contrary to Defendants' arguments, none of this conduct was excused by regulatory agencies and none of the State's claims are preempted by federal law. The United States Food and Drug Administration ("FDA") and the Drug Enforcement Agency ("DEA") undoubtedly allowed Defendants to make active pharmaceutical ingredients, make prescription opioids, and market them. And the DEA set quotas and the FDA imposed

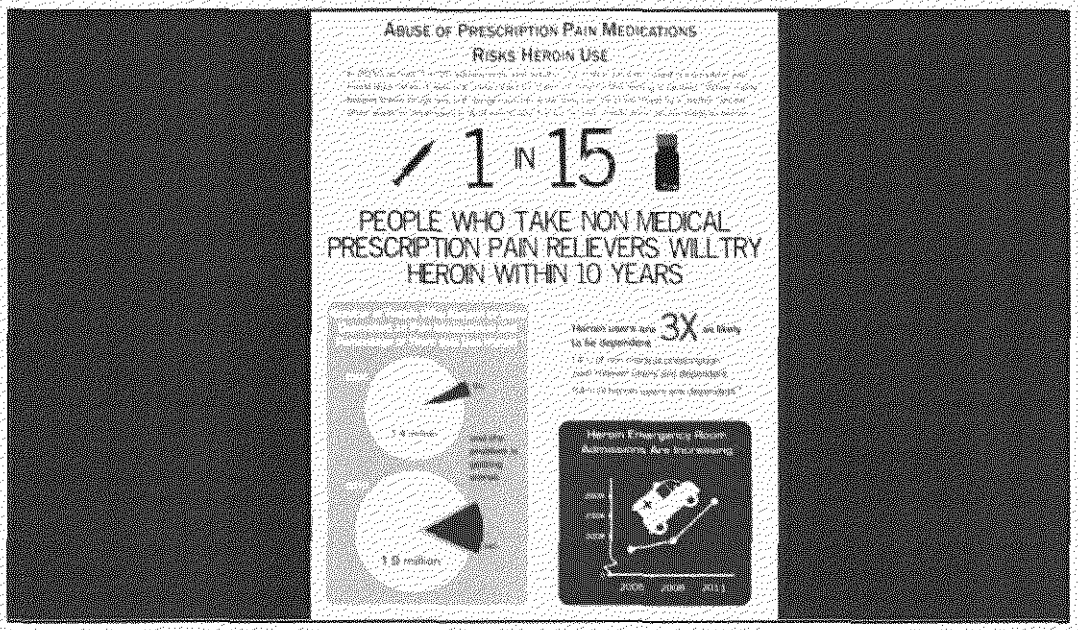
label requirements. But neither agency, nor federal law, sanctioned the false and deceptive marketing campaign these Defendants engaged in for almost twenty years.

And as such, the State of Oklahoma is fully within its right to seek to enforce its laws to provide an abatement remedy for its people.

Defendants' efforts to blame the crisis on illegal diversion of opioids and trafficking of illicit opioids also is unavailing. The evidence at trial demonstrated that Oklahoma did not have a serious illicit opioid problem until well into the middle of the crisis:



The evidence also demonstrated that the diversion and illicit opioid use that has occurred was a result of the pharmaceutical industry, including Defendants', aggressive and misleading marketing designed to increase the supply of opioids—as demonstrated by the presentation materials from Defendants' own expert, Dr. Fong:



Signs of the Opioid Epidemic: Increased Heroin Use

- Past month heroin use, past year heroin use, and heroin addiction have all since increased among 18-25 year olds since 2000
- More heroin available on the street
- 80% of heroin initiates used prescription opiates previously

Similarly unavailing is Defendants' effort to blame the State of Oklahoma for Defendants' conduct. As a threshold matter, Oklahoma law does not allow a defendant to blame the State in a non-negligence nuisance case such as this. However, assuming *arguendo* that Defendants could legally assert a contributory negligence claim against the State, any such claim is belied by the evidence in this case. Defendants sought to influence

and mislead the State of Oklahoma at every turn. Commissioner White's testimony in this regard is particularly relevant:

> [W]hat was occurring in Oklahoma in 2001 was a host of intense marketing by [Defendants] pushing and pushing and pushing for doctors to prescribe more opioids while it appears that we have some of the State agencies stepping up to try to say, this is a problem, this is a problem. But there's no way we could win a tug-of-war when you drop $30 million into [Defendants' marketing] and that doesn't include your sales force. So if what you're trying to say to me with this yesterday and today, is that somehow [it is] the State's fault when [Defendants] were shooting bullets at the State of Oklahoma, that we didn't invest enough or act fast enough to buy Oklahomans enough bulletproof vests, or when you were dropping bombs on the State of Oklahoma that we didn't work fast enough or hard enough to build bomb shelters to save peoples' lives, I find that offensive and I completely disagree with it. . . . I find it incredibly offensive that what you would stand here and suggest is that as [Defendants] unleashed a series of bombs, as I have described to you already, across the United States of America that landed squarely in Oklahoma, that killed over 6,000 Oklahomans, without you telling us that you were going to do this, without you still accepting any responsibility today, that as we have worked as hard as we have worked and we are the only reason, the only reason that lives are being saved in this State, that what you say to us is, You didn't build bomb shelters fast enough, you didn't purchase enough bulletproof vests, you couldn't run from us fast enough. . .

The record is clear: Oklahoma's opioid crisis was manufactured; and Defendants played a "major" and substantial role in causing it.

This Court has been asked to sit in equity to do justice under the facts presented. To be clear, no one—including the State—seeks to eliminate these drugs as a tool for treating pain. Nor does the State fail to empathize with the many Oklahomans who suffer from chronic debilitating pain. To the contrary, the State and its experts agree that these drugs play an important role in medicine and should remain available for those patients who need them. This Court agrees. That said, however, the deadly consequences of Defendants'

campaign to rapidly expand the role these drugs played in the treatment of pain show that Defendants abandoned all standards of responsible corporate conduct in their blind resolve to make money from their drugs. Oklahoma has proven for over a century that its citizens can coexist, and even thrive, with opioid medications without sacrificing thousands of lives. The remedy the State seeks here—abatement of the public nuisance—is designed to restore that harmony once again.

The Court finds the State is entitled to such a remedy and the Defendants, based on their actions and omissions that gave rise to this public nuisance, are responsible for providing it. Below the Court sets forth the basis for its decision.

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I. Procedural History

This matter was tried to the Court in an extensive public bench trial from May 28, 2019, through July 15, 2019. This trial was conducted following nearly two years of comprehensive fact and expert discovery, a removal to federal court, a remand back to this Court, motion-to-dismiss hearings, a writ to the Oklahoma Supreme Court in an effort to continue the trial date, two arguments at the Supreme Court resulting in a denial of the writ, summary-judgment hearings, at least 35 pretrial and motion-in-limine hearings, a two-hour hearing on Defendants' Motion for Judgment as a Matter of Law, fairness hearings on the State's settlements with the Purdue and Teva defendants followed by entry of separate consent judgments governing each settlement, dozens of hearings conducted by Special Discovery Master, the Honorable William Hetherington, and numerous appeals of certain of the Special Discovery Master's orders. This bench trial involved, *inter alia*, the testimony of 43 witnesses, the admission of 935 exhibits, frequent evidentiary hearings, and the opening and closing arguments of counsel for the parties.

The pre-trial and trial record generated in this matter is voluminous and unprecedented. The Court, the Court's staff, the four (4) separate special masters that the Court appointed at various stages of the litigation, and numerous others, including the parties and their counsel, have dedicated substantial time and resources to ensuring the fair, orderly and expedient resolution of this matter. A detailed summary of this procedural history follows:

1. The State of Oklahoma initiated this action by filing its Petition on June 30, 2017 against Purdue Pharma L.P., Purdue Pharma, Inc., The Purdue Frederick Company

("Purdue"), Teva Pharmaceuticals USA, Inc., Cephalon, Inc., Watson Laboratories, Inc., Actavis, LLC, Actavis Pharma, Inc. ("Teva"), Johnson & Johnson, Janssen Pharmaceuticals, Inc., Ortho-McNeil-Janssen Pharmaceuticals, Inc., and Janssen Pharmaceutica, Inc. ("Defendants"). To be clear, throughout this document, the Court uses the term "Defendants" to refer only to Johnson & Johnson, Janssen Pharmaceuticals, Inc., Ortho-McNeil-Janssen Pharmaceuticals, Inc., and Janssen Pharmaceutica, Inc.—the Defendants against whom this case was tried. Where the Court uses the term "defendants," the Court is referring both the Defendants (Johnson & Johnson and related entities), as well as the settling defendants, Purdue and Teva.[2]

2. On July 24, 2017, the parties stipulated to a 60-day extension (to September 22, 2017) for defendants to answer the State's Petition. Included in the stipulation, defendants agreed that they "will not remove the above-caption case, based upon Plaintiff's Original Petition, to Federal Court."

3. On September 15, 2017, defendants moved to for a protective order staying discovery until the Court ruled on defendants' then-forthcoming motions to dismiss.

4. On September 22, 2017, Defendants, Teva and Purdue separately filed motions to dismiss for failure to state a claim, jointly filed a motion to dismiss for failure to state a claim, and jointly filed a motion to stay under the primary jurisdiction doctrine and the Court's inherent authority. Collectively, defendants' motions sought dismissal of

[2] Allergan, PLC was also named in the Petition but was never served.

each of the State's causes of action based on pleading deficiencies, failure to sufficiently allege elements of the asserted causes of action, and federal preemption.

5. On November 14, 2017, after briefing and oral argument, the Court denied defendants' motion for protective order seeking to stay discovery until resolution of their motions to dismiss.

6. On December 6, 2017, after briefing and oral argument, the Court granted-in-part and denied-in-part defendants' motions to dismiss and motion to stay under the primary jurisdiction doctrine and the Court's inherent authority. The Court dismissed with prejudice the State's cause of action under the Oklahoma Consumer Protection Act, and denied the remainder of defendants' motions to dismiss and motion to stay.

7. On January 5, 2018, defendants served their Answers to the State's Petition.

8. On January 25, 2018, the Court found that appointment and referral of a special discovery master was "necessary in the administration of justice due to the nature, complexity, and volume of the discovery materials involved in this multiparty litigation[.]" Accordingly, the Court appointed Judge William C. Hetherington, Jr. as Discovery Master "in the interests of judicial economy, to address and resolve all pretrial discovery matters arising between the Plaintiff and [d]efendants, and to facilitate the effective and timely resolution thereof." Judge Hetherington brought decades of judicial experience to the role of Discovery Master. A graduate of the University of Oklahoma and Oklahoma City University School of Law, Judge Hetherington served a total of 28 years in the Judiciary—21 years as a Cleveland County general jurisdiction trial judge, and seven years on the Court of Civil Appeals (elected Chief Judge in 2015). As a trial judge, he presided over

400 jury trials, including complex class action and mass tort cases, such as the State of Oklahoma's tobacco litigation. In discharging his duty as Discovery Master, Judge Hetherington conducted dozens of hearings and issued dozens of rulings on discovery matters. The parties appealed a number of these rulings to the Court, which ruled on those appeals *de novo*. Additionally, Discovery Master Hetherington personally attended a number of depositions at the request of defendants.

9. On January 29, 2018, the Court entered a Scheduling Order establishing a trial date of May 28, 2019. Additionally, the Scheduling Order established, *inter alia*, that parties had until March 30, 2018, to file motions to join additional parties (*no such motion was ever filed*); June 29, 2018, to file motions to amend pleadings (the State never amended its Petition); November 1, 2018, for Plaintiffs to file their expert reports and November 29, 2018, for defendants to file their expert reports; January 31, 2019, to complete fact discovery; January 25, 2019 to complete expert discovery; March 8, 2019, for *Daubert* hearings; and March 29, 2019, to file dispositive motions. The Court maintained the trial date of May 28, 2019, and at all times indicated to the parties its intent to do so, absent a showing of good cause. As set forth below, the Court subsequently extended certain other dates in the Scheduling Order in response to developments in the litigation and at the request of the parties.

10. On March 20, 2018, the Court and the Discovery Master entered an Amended Protective Order to facilitate discovery in recognition of long-established Oklahoma jurisprudence that "the plaintiff's right to prepare for trial and to avoid delay in the evidentiary process should be *balanced* against the defendant's legitimate claim to

privacy." *See* Amended Protective Order at 1-2. The Court subsequently amended this protective order on April 16, 2018.

11. On March 29, 2018, the Court found that "the circumstances of this case warrant the early appointment of a Settlement Master to begin conducting and administering settlement conferences in this litigation." Accordingly, the Court appointed Settlement Master Judge Layn Phillips "to facilitate, administer, and oversee the settlement negotiations and procedure in this action." Judge Phillips brought experience as both a former United States Attorney and a former United States District Judge to the role of Settlement Master. Judge Phillips served as a federal prosecutor in the Central District of California and as the United States Attorney for the Northern District Oklahoma. In 1987, Judge Philips was commissioned to the United States District Court for the Western District of Oklahoma where he presided over numerous trials. He also sat by designation on the United States Court of Appeals for the Tenth Circuit in Denver, Colorado. As Settlement Master in this litigation, Judge Phillips was conferred authority to take actions necessary to "facilitate the meaningful resolution of all or any part of this action" and was specifically charged with conducting "a settlement meeting or other conference with the parties and their counsel each month during the pendency of this action." In discharging his duty as Settlement Master, Judge Phillips conducted multi-day settlement meetings over many months during the pendency of the litigation and successfully facilitated settlement between the State and the Purdue defendants, as well as between the State and the Teva defendants.

12. On April 11, 2018, the Discovery Master entered an Agreed Qualified Protective Order for Protected Health Information to facilitate the discovery and transmission of Protected Health Information. The Discovery Master subsequently amended this protective order on September 27, 2018.

13. On June 13, 2018, Purdue, with the consent of all defendants, removed this case to federal court on the basis of "federal question" jurisdiction.

14. On August 3, 2018, the United States District Court for the Western District of Oklahoma held that federal jurisdiction was lacking and remanded the case back to this Court.

15. On August 10, 2018, the State moved to bifurcate the trial into two phases and stay discovery regarding the second phase: Phase I consisting of a jury trial on (1) the State's public nuisance claims, (2) the State's claim for fraud, (3) the State's claim for unjust enrichment, and (4) the State's claim for punitive damages; Phase II consisting of a separate, subsequent jury trial of the State's remaining claims for violations of the Oklahoma Medicaid False Claims Act and Oklahoma Medicaid Program Integrity Act.

16. On August 13, 2018, the Court extended the deadline to file motions to amend pleadings to August 30, 2018.

17. On August 22, 2018, at the request of The Oklahoma Publishing Company and after consideration of input from both defendants and the State, the Court held that digital cameras may be present in the courtroom during the trial in this matter.

18. On August 30, 2018, Defendants moved to amend their Answer to the State's Petition.

19. On August 30, 2018, after briefing and oral argument, the Court denied the State's Motion for Separate Trials and to Stay Discovery and Proceedings as to Phase II and ordered all claims be tried together.

20. On September 11, 2018, the Court entered an Amended Scheduling Order. The Amended Scheduling Order extended a number of deadlines including, *inter alia*, the deadlines for Plaintiff's expert reports and defendants' expert reports to December 21, 2018, and January 21, 2019, respectively (defendants were subsequently granted three additional extensions of their expert-report deadline); the fact discovery deadline to March 15, 2019; the expert discovery deadline to March 22, 2019 (subsequently extended to April 1, 2019); the deadline for *Daubert* hearings to April 18, 2019; and the dispositive-motions deadline to April 19, 2019.

21. Pursuant to the Court-issued protective orders and scheduling orders, the parties engaged in extensive discovery over the course of this litigation. The Court understands that the parties collectively took over 200 depositions and produced over 90 million pages of documents.

22. On September 21, 2018, the Court granted Defendants' Motion to Amend Answer and Defendants' Amended Answer was filed.

23. On February 28, 2019, defendants filed a Motion for Continuance requesting the Court reschedule the trial to begin September 16, 2019 and grant a 100-day continuance of all pre-trial deadlines other than the close of fact discovery.

24. On March 8, 2019, after briefing and oral argument, the Court denied defendants' Motion for Continuance.

25. On March 11, 2019, defendants petitioned the Oklahoma Supreme Court to assume original jurisdiction and to issue a writ of prohibition and/or mandamus to direct this Court to move the trial date.

26. On March 25, 2019, the Supreme Court of the State of Oklahoma denied defendants' application to assume original jurisdiction.

27. On March 22, 2019, the Defendants filed a Motion for Severance asking that Defendants receive a separate trial.

28. On March 26, 2019, with the agreement of the State and Purdue, the Court entered Consent Judgment as to Purdue, pursuant to which Purdue agreed to pay $270 million (including $20 million in medication-assisted-treatment drugs), and all claims asserted by the State against Purdue were dismissed with prejudice.

29. On April 4, 2019, the State filed a Notice of Voluntary Dismissal of Certain Claims Without Prejudice, dismissing all claims except for its public nuisance claim seeking abatement.

30. On April 11, 2019, the Court, after briefing and oral argument, found that the State's sole claim seeking abatement of a public nuisance is an equitable claim for which there is no right to jury trial.

31. On April 16, 2019, the Court entered an Administrative Order setting forth policies and procedures governing the use of cameras in the courtroom.

32. On April 18, 2019, the Court entered an Updated Scheduling Order setting dates for pre-trial matters, including *Daubert* briefing and argument, motions *in limine* briefing and argument, exchange of witness and exhibit lists, and deposition designations.

33. Between April 16 and April 23, 2019, Defendants filed 18 *Daubert* motions to exclude the State's expert witnesses from testifying at trial.

34. The Court heard oral argument on defendants' *Daubert* motions over the course of several days. After briefing and oral argument, the Court denied defendants' *Daubert* motions.

35. On April 23, 2019, Defendants filed a Motion for Summary Judgment on the State's public nuisance claim. Defendants argued that the State's claim fails as a matter of law because, among other things, Oklahoma's public nuisance law is limited to cases involving real property, there is no nuisance to abate because Defendants no longer market opioids, and that the State has failed to establish a triable issue of causation.

36. On April 26, 2019, Defendants filed 14 motions *in limine* and joined in five others filed by Teva. On May 15, 2019, Defendants filed three additional motions *in limine*.

37. The Court heard oral argument on defendants' motions *in limine* over the course of several days. After briefing and oral argument, the Court denied-in-part and granted-in-part defendants' motions *in limine*.

38. On May 13, 2019, after briefing and several hours of oral argument, the Court denied Defendants' Motion for Summary Judgment.

39. On May 16, 2019, after briefing and oral argument, the Court denied Defendants' Motion to Sever.

40. On May 28, 2019, this case proceeded to trial against Defendants.

41. On June 24, 2019, with the agreement of the State and Teva, the Court entered Consent Judgment as to Teva, pursuant to which Teva agreed to pay $85 million, and all claims asserted by the State against Teva were dismissed with prejudice.

42. At trial, the Court heard evidence from 43 witnesses, admitted 935 exhibits into evidence, and presided over numerous hearings.

43. On July 3, 2019, after the State rested its case, Defendants filed a Motion for Judgment arguing that the State identified no actionable conduct, failed to prove Defendants caused the opioid crisis, failed to prove entitlement to abatement, that Defendants cannot be held responsible for the entire Oklahoma opioid crisis, and that the State itself is responsible for causing the opioid crisis.

44. On July 8, 2019, after briefing and over two hours of oral argument, the Court denied Defendants' Motion for Judgment.

45. On July 12, 2019, Defendants, after resting their case, renewed their Motion for Judgment.

46. On July 12, 2019, the Court took Defendants' Renewed Motion for Judgment under advisement. On July 31, 2019, the State filed its response to Defendants' Renewed Motion for Judgment, incorporating in full the findings of fact and conclusions of law that followed. Defendants' Motion is denied for the reasons set forth herein.

II. Standards Governing the Court's Decision

The Court has used, among other things, the following standards to guide the Court's evaluation and weighing of the evidence presented at trial in order to reach the Court's findings of fact set forth below.

Under Oklahoma law, the party with the burden of proof must prove a proposition "by the greater weight of the evidence," which means that, based on all of the evidence presented in the case, "the proposition . . . is more probably true than not true. The greater weight of the evidence does not mean the greater number of witnesses testifying to a fact, but means what seems to [the Court to be] more convincing and more probably true." Oklahoma Uniform Jury Instruction ("OUJI") No. 3.1.

Moreover, under Oklahoma law:

> "Direct evidence" is the testimony of a person who asserts actual, personal knowledge of a fact, such as the testimony of an eyewitness. "Direct evidence" may also be an exhibit such as a photograph which demonstrates the existence of a fact. It is proof which points immediately to a question at issue and which proves the existence of a fact without inference or presumption.
>
> "Circumstantial evidence" is the proof of facts or circumstances which gives rise to a reasonable inference of other connected facts.
>
> The law makes no distinction between the weight to be given to either direct or circumstantial evidence. . . .

OUJI No. 3.25. The Court has "consider[ed] circumstantial evidence together with all the other evidence in the case in arriving at" the Court's factual findings.

In making determinations about the credibility of witnesses and the value to be given to their testimony, the Court has taken into consideration the: (i) "witness's means of knowledge, strength of memory and opportunities for observation"; (ii) "reasonableness and consistency or inconsistency of the testimony"; and (iii) "bias, prejudice, or interest, if any, the witness may have in the outcome of the trial, the conduct of the witness upon the witness stand, and all other facts and circumstances that affect the believability of the witness." OUJI No. 3.13.

III. Findings of Fact

2. The Court has considered, analyzed and reviewed in detail the wealth of evidence presented to the Court over nearly two months of trial in this matter. The Court had the benefit of extensive legal briefing and argument of many of the legal issues raised during trial over the course of the last two years. Further, because this trial was to the Court, the Court had the benefit of both questioning witnesses and observing firsthand their demeanor and ability to answer questions during live examination. Thus, as factfinder in this matter, the Court has considered and weighed the credibility of each of the witnesses and all conflicting evidence and/or reasonable inferences therefrom. Based on the Court's comprehensive analysis of all of the evidence submitted, the Court enters the following findings of fact. To the extent any evidence in the record conflicts with one of the facts found below, the Court has weighed the competing evidence and found that the preponderance of the evidence weighs in favor of the facts set forth below.

A. The Parties

3. The State of Oklahoma, by and through Attorney General Mike Hunter, is referred to herein as "**Plaintiff**" or the "**State.**"

4. Johnson & Johnson, Janssen Pharmaceuticals, Inc., Ortho-McNeil-Janssen Pharmaceuticals, Inc., n/k/a Janssen Pharmaceuticals, Inc., and Janssen Pharmaceutica, Inc., n/k/a Janssen Pharmaceuticals, Inc., are collectively referred to herein as "**Defendants.**"

5. Purdue Pharma L.P., Purdue Pharma, Inc., and The Purdue Frederick Company are collectively referred to herein as "**Purdue.**" Purdue, formerly a defendant in

this matter, was dismissed from this action following the Court's approval of a settlement between the State and Purdue in the amount of $270 million (including $20 million in medication-assisted-treatment drugs) on March 26, 2019.

6. Teva Pharmaceuticals USA, Inc., Cephalon, Inc., Watson Laboratories, Inc., Actavis LLC, and Actavis Pharma, Inc., f/k/a Watson Pharma, Inc., are collectively referred to herein as "**Teva**" and/or "**Cephalon**." Teva, formerly a defendant in this matter, was dismissed from this action following the Court's approval of a settlement between the State and Teva in the amount of $85 million on June 24, 2019.

B. Prescription Opioids

7. The State of Oklahoma is currently experiencing an opioid crisis and epidemic. *See, e.g.*, Trial Tr. (6/25/19 a.m., Commissioner White) at 62:10-73:25, 105:14-108:3; Trial Tr. 6/26/19 p.m., Commissioner White) at 45:13-46:4, 47:17-48:19, 53:20-56:22, 65:17-22[3]; Trial Tr. (5/29/19 p.m., J&J: Deem-Eshleman) at 15:18-16:04; Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 36:21-22; Trial Tr. (6/5/19 a.m., J&J: Deem-Eshleman) at 80:08-13, 81:19-23[4]; Trial Tr. (7/2/19 p.m., Diesselhorst) at 30:23-33:15; Trial Tr. (5/29/19 a.m., Courtwright) at 22:15-18.

[3] Commissioner White's qualifications were set forth *supra*. Based on the evidentiary foundation laid at trial, the Court accepted Commissioner White as an expert witness in her fields of expertise. *See* Trial Tr. (6/25/19 a.m., Commissioner White) at 37:23-38:6, 39:22-40:2; *see also* S-4735.

[4] Kim Deem-Eshleman was designated to testify as Defendants' corporate representative, speak on behalf of Defendants, answer questions in the capacity of Defendants, and serve as the "face of [Defendants] for purposes of this trial." Trial Tr. (5/29/19 p.m., J&J: Deem-Eshleman) at 14:17-15:17.

8. This current stage of the crisis was started by and still primarily involves prescription opioids. *See, e.g.*, Trial Tr. (6/11/19 a.m., Kolodny) at 74:11-15; Trial Tr. (5/29/19 a.m., Courtwright) at 22:19-21; Trial Tr. (6/6/19 a.m., Mazloomdoost) at 22:15-23; Trial Tr. (6/3/19, a.m. J&J: Deem-Eshleman) at 126:16-18.

9. "Opioids" is a term that encompasses naturally existing "opiates," including codeine, morphine, thebaine and other molecules. Trial Tr. (6/11/19 a.m., Kolodny) at 63:10-65:06. These opiates can be manipulated to create semisynthetic opioids such as heroin, oxycodone, hydrocodone, and hydromorphone. Trial Tr. (6/11/19 a.m., Kolodny) at 63:10-65:06. There are also synthetic opioids such as fentanyl, tramadol and tapentadol that do not require opium to make. Trial Tr. (6/11/19 a.m., Kolodny) at 63:10-65:06. "Tramadol is an opioid analgesic and opioid activity is the overriding contributor to its pharmacological effects. Abuse and adverse events of tramadol are similar to those of other opioid analgesics." S-2384; *see* Trial Tr. (6/12/19 p.m., Kolodny) at 37:20-42:10.

10. Opioids can be addictive, highly dangerous and fatal drugs. Trial Tr. (5/28/19 p.m., Rojas) at 55:4-17, 78:19-21, 94:24-95:6; Trial Tr. (6/17/19 p.m., Beaman) at 59:11-60:1.[5]

11. Opioids are scheduled narcotics according to the U.S. Drug Enforcement Administration ("DEA") and Department of Justice ("DOJ") regulations regarding controlled substances. *See, e.g.*, 21 C.F.R. §1308. In particular, most opioids—as well as

[5] Dr. Beaman's qualifications were set forth *supra*. Based on the foundation laid at trial, the Court recognized Dr. Beaman as an expert witness in the fields of addiction, addiction science, treatment of addiction, opioid addiction and treatment thereof, as well as the opioid epidemic. *See* Trial Tr. (6/17/19 p.m., Beaman) at 50:25-51:11.

the narcotic raw materials used to manufacture them (*i.e.*, opium, opiates, the opium poppy, poppy straw, concentrate of poppy straw, morphine, oripavine, and thebaine)—are Schedule II narcotics. *See* 21 C.F.R. §1308.12.

12. Although all opioids are not the same, all Schedule II opioids have a "high potential for the risk of addiction." *See* Trial Tr. (6/27/19 p.m., Moskovitz) at 129:13-23; *see also, e.g.*, Trial Tr. (6/27/19 a.m., Moskovitz) at 54:10-11; Trial Tr. (6/28/19 a.m., Moskovitz) at 108:02-14. "All Schedule II opioids are considered to have the highest potential for abuse and misuse." *See* Trial Tr. (6/28/19 p.m., Moskovitz) at 93:03-07.

13. This risk of addiction for Schedule II opioids exists even when used appropriately. J-2769; Trial Tr. (6/5/19 a.m., J&J: Deem-Eshleman) at 90:08-12.

14. Since at least the mid-1990s, Defendants have marketed, promoted and sold opioid drugs in Oklahoma. *See, e.g.*, Ct. Ex. 0092 (Mashett) at 401:4-16. During this time period, Defendants specifically manufactured and sold certain of their own branded opioid drugs as a part of its pain franchise, including: (i) Duragesic—a transdermal patch made out of the active pharmaceutical ingredient ("API"), fentanyl; (ii) Ultram and Ultram Extended Release ("ER")—tablets made out of the API, tramadol; (iii) Ultracet—tablets made out of the APIs, tramadol and acetaminophen; (iv) Nucynta and Nucynta ER—tablets made out of the API, tapentadol; (v) Tylenol with Codeine—tablets made out of the APIs, acetaminophen and codeine; (vi) Tylox—capsules made out of the APIs, acetaminophen and oxycodone. *See, e.g.*, S-1073 at 10; J-2769 at 1; Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 43:4-9; Trial Tr. (6/27/19 a.m., Moskovitz) at 21:7-22:13; Trial Tr. (6/11/19 a.m., Kolodny) at 108:5-7.

15. Dr. Paul Janssen originally invented fentanyl in the 1950s. Trial Tr. (6/3/19 p.m., J&J: Deem-Eshleman) at 67:17-23; Trial Tr. (6/5/19 a.m., J&J: Deem-Eshleman) at 80:17-20. Fentanyl is a highly addictive opioid. Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 47:02-05. Fentanyl can always be abused. Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 47:06-12. As a Schedule II opioid comprised of fentanyl, Defendants' Duragesic "has the highest potential for abuse." *See* Trial Tr. (6/28/19 p.m., Moskovitz) at 93:03-07.

16. As part of its "pain management franchise," from the 1990s through at least 2016, Defendant Johnson & Johnson also wholly owned two subsidiaries that, together, supplied other opioid manufacturers with opioid APIs to be used in opioid drugs. *See, e.g.*, S-0340; S-1048; S-0006. First, Johnson & Johnson owned a subsidiary based in Tasmania, Tasmanian Alkaloids Pty Limited ("**Tasmanian Alkaloids**"), which cultivated and processed opium poppy plants to manufacture narcotic raw materials that were imported into the U.S. to be processed and made into APIs necessary to manufacture opioid drugs. *See, e.g.*, S-0340; S-1048; S-0006. Second, Johnson & Johnson owned a subsidiary based in the U.S., Noramco, Inc. ("**Noramco**"), which imported the narcotic raw materials produced by Tasmanian Alkaloids, processed these materials into APIs, then sold these APIs to other opioid manufacturers in the U.S. *See, e.g.*, S-0340; S-1048; S-0006.

17. In approximately 2015, Defendants elected to drop pain as a therapeutic area of focus for their business. Trial Tr. (6/4/19 a.m., J&J: Deem-Eshleman) at 44:21-45:05. Upon doing so, in 2016, Johnson & Johnson sold Nucynta and sold the Noramco/Tasmanian Alkaloids business and recorded the earnings for these transactions

to have totaled approximately $1.65 billion to the company in its Form 10-Q filed with the U.S. Securities and Exchange Commission and signed by Johnson & Johnson's CEO, Alex Gorsky. *See* Trial Tr. (6/3/19 p.m., J&J: Deem-Eshleman) at 58:13-61:15; *see also, e.g.*, Ct. Ex. 220 (Martin) at 9:25-10:8.[6]

18. Up until 2016, Tasmanian Alkaloids and Noramco were "sister companies," as "both of them were" members of Defendants' "family of companies." Ct. Ex. 220 (Martin) at 9:17-23, 12:17-13:8, 104:5-107:2.[7] Testimony from Noramco at trial demonstrated that Noramco employees did not believe Noramco maintained its own bank accounts, separate from Defendants' treasury. Ct. Ex. 220 (Martin) at 101:19-24. Defendants, Noramco and Tasmanian Alkaloids shared employees and resources that were "required to operate the business." S-1048 at 9. Noramco employees, including Mr. Martin, physically worked at Defendants' facilities in New Jersey at various times. Ct. Ex. 220 (Martin) at 8:20-9:1. Noramco employees "were with Johnson & Johnson." Ct. Ex. 220 (Martin) at 9:17-18, 9:21-23. Further, employees simultaneously held positions at multiple

[6] In an email dated March 23, 2016, Defendants' employees circulated a news report that included a report about the U.S. Food and Drug Administration ("FDA") setting new limits on the use of immediate-release opioids and also noted a recent warning from the U.S. Centers for Disease Control and Prevention ("CDC"). *See* S-0703 at 1; Trial Tr. (6/3/19 p.m., J&J: Deem-Eshleman) at 55:19-57:04. In response, one of Defendants' employees said: "Looks like we sold at the right time…" S-0703; Trial Tr. (6/3/19 p.m., J&J: Deem-Eshleman) at 55:19-57:04. Another of Defendants' employees replied: ":-) Yep." S-0703 at 1; Trial Tr. (6/3/19 p.m., J&J: Deem-Eshleman) at 55:19-57:04.

[7] Excerpts of the videotaped deposition of Matthew Martin were played at trial on July 12, 2019. *See* Trial Tr. (7/12/19 a.m.) at 80:23-81:19. A transcript of the excerpts of the videotaped deposition testimony of Mr. Martin was marked, provided to, and accepted by the Court as Court Exhibit 220 ("Ct. Ex. 220"). Citations to Mr. Martin's testimony will, thus, be to this transcript, Ct. Ex. 220 (Martin). Mr. Martin was a Noramco employee from 2002 through 2016. Ct. Ex. 220 (Martin) at 7:22-8:19.

companies within the Johnson & Johnson Family of Companies at times. *See, e.g.*, Trial Tr. (6/11/19 p.m., Kolodny) at 15:11-20 ("I'm aware of testimony to Congress from Johnson & Johnson International's vice president, who at the time that he testified before Congress, was the president of Noramco and who, in his testimony, stated that the managing director of Tasmanian Alkaloids reported directly to him."). During this time, Noramco and Tasmanian Alkaloids were key parts of Defendants' "pain management franchise" or "pain franchise." Ct. Ex. 0092 (Mashett) at 75:3-11; S-0340. This "pain franchise" included all of Defendants' pain products and "was an important part of [Defendants'] business from the mid 1990s to after 2010." Ct. Ex. 0092 (Mashett) at 75:1-11.

19. Defendants, through these subsidiaries, supplied at least the following opioid APIs to other drug manufacturers in the U.S., including Purdue and Teva: oxycodone, hydrocodone, morphine, codeine, fentanyl, sufentanil, buprenorphine, hydromorphone, and naloxone. *See, e.g.*, S-0340 at 4; S-1048 at 7, 10, 22; S-0006 at 6-7; Ct. Ex. 220 (Martin) at 155:2-162:15, 184:24-185:16; Ct. Ex. 0092 (Mashett) at 219:18-220:8, 230:8-24.[8] By 2015, Defendants' "Noramco World Wide Narcotics Franchise," comprised of

[8] Excerpts of the videotaped deposition testimony of Frank Mashett, taken on January 30, 2019 and March 12, 2019, were played on June 19, 2019. *See* Trial Tr. (6/19/19 p.m.) at 68:18-20. A transcript of the excerpts of the videotaped deposition testimony of Mr. Mashett was marked, provided to and accepted by the Court as Court Exhibit 92 ("Ct. Ex. 0092"). Herein, citations to Mr. Mashett's testimony will be to this transcript: Ct. Ex. 0092 (Mashett). At the time of his deposition, Mr. Mashett was the director of trade operations for Janssen Pharmaceutica and had been employed by Johnson & Johnson for 34 years. Ct. Ex. 0092 (Mashett) at 9:12-13, 11:7-12. Mr. Mashett was designated to testify as 'Defendants' corporate representative regarding "relationships with industry associations and other opioid manufacturers." *Id.* at 10:24-11:6.

Noramco and Tasmanian Alkaloids, had become "the **#1 supplier of Narcotic APIs** in the United States, the world's largest market." S-1048 at 6 (emphasis in original).

20. That is, through various subsidiaries and sister companies that comprised their pain management franchise, Defendants were in the business of producing and selling all three types of opioids: (i) natural opium (*e.g.*, codeine, morphine, thebaine); semisynthetics (*e.g.*, oxycodone and hydrocodone); and Defendants' own branded synthetics (*e.g.*, fentanyl, tramadol and tapentadol). *See, e.g.*, Trial Tr. (6/11/19 a.m., Kolodny) at 68:13-69:02[9]; Trial Tr. (6/26/19 a.m., Commissioner White) at 109:3-23, 110:6-20.

21. Defendants knew that: (1) all Schedule II opioids have high abuse potential; (2) one Schedule II opioid pill can potentially lead to death; and (3) one Schedule II opioid patch can potentially lead to death. Trial Tr. (6/5/19 a.m., J&J: Deem-Eshleman) at 89:17-90:07. At all times, Defendants were aware of, but chose to ignore, that opioids have a history with mankind of problems with abuse and addiction going back to at least 300 B.C. *See* Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 56:18-22; *see also, e.g.*, S-0035; S-0006.

C. Opioid Use in Medicine Prior to the Late 1990s

[9] Based on the foundation laid at trial, Court recognized Dr. Kolodny as an expert witness in a number of fields and areas in which he possesses specialized education, knowledge, training and skill. *See* Trial Tr. (6/11/19 a.m., Kolodny) at 5:12-54:09.

22. The current opioid crisis in Oklahoma is not "the first epidemic of medical opioid addiction in the United States[.]" Trial Tr. (5/29/19 a.m., Courtwright) at 22:22-24.[10]

23. It is important to understand the history of opioids and the addiction crises they have caused in America because the country has "learned important lessons about how to prevent epidemics of medical opiate addiction[,]" including "knowledge" that "became part of medical culture[.]" Trial Tr. (5/29/19 a.m., Courtwright) at 22:5-13. Indeed, history has a way of "repeating itself." *See* Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 95:23-25.

24. Opioids are not new. *See, e.g.*, S-0035 at 9. Opium has been associated with problems throughout human history. *See* S-0006; Trial Tr. (6/11/19 a.m., Kolodny) at 105:3-20. Some of the earliest civilizations, including the "ancient Sumerians, Egyptians, and Chinese," documented the benefits and consequences of their use in medicine. *See* S-0035 at 9. As Defendants' own paid scientific advisors warned in 2001:

> The Greeks (c. 300 B.C.) noted harmful effects of opioids, including addiction. . . . By the late 17th-18th centuries, opium abuse was reported, while growing of opium in India was encouraged and China was forced to accept opium imports (Opium Wars), leading to widespread addiction. In

[10] Dr. David Courtwright is a Professor Emeritus at the University of North Florida in Jacksonville, Florida. Trial Tr. (5/29/19 a.m., Courtwright) at 16:21-23. He has taught history for over 40 years, focusing primarily on medical and U.S. history. *Id.* at 16:24-17:3. In obtaining his Ph.D., Dr. Courtwright wrote his dissertation on the history of opiate addiction in the U.S. *Id.* at 18:2-11. Dr. Courtwright's dissertation ultimately was published by the Harvard University Press in 1982 as a book entitled, *Dark Paradise: A History of Opiate Addiction in America*, and a second edition of the book was reprinted by Harvard Press in 2001. *Id.* at 18:6-15. Dr. Courtwright published many other books and articles demonstrating his specialized knowledge in the history of opiate addiction in America. *See id.* at 19:7-21:1; S-4731. The Court accepted Dr. Courtwright as an expert witness on the history of opioid addiction in America. Trial Tr. (5/29/19 a.m., Courtwright) at 21:21-22:3.

> 1803, Serturner synthesized morphine and, within decades, it was widely employed medicinally. Morphine addiction became a severe problem during the American Civil War.[11]

25. The severe morphine addiction problem surrounding the American Civil War referenced by Defendants' advisors represented the first significant opiate addiction epidemic in the U.S. *See* S-0035 at 9; Trial Tr. (5/29/19 a.m., Courtwright) at 23:2-88:20. It arose in the late 19th century, in particular the 1870s through the 1890s, following a nationwide tripling of the per capita consumption of medicinal opiates in the years before. Trial Tr. (5/29/19 a.m., Courtwright) at 23:2-12. This 19th century opioid addiction epidemic in the U.S. was "primarily driven by medical addiction." Trial Tr. (5/29/19 a.m., Courtwright) at 23:2-12.

26. Medical addiction, or addiction caused by medication prescribed by a physician, is termed "iatrogenic addiction." Trial Tr. (5/29/19 a.m., Courtwright) at 23:20-24:4. The late 19th century U.S. opioid addiction epidemic was primarily an epidemic of iatrogenic addiction. Trial Tr. (5/29/19 a.m., Courtwright) at 24:2-7. This epidemic affected people in all different social classes. Trial Tr. (5/29/19 a.m., Courtwright) at 24:14-23. The "liberal prescribing and use of opioids to treat pain by physicians" was "the primary cause" of this first U.S. epidemic. Trial Tr. (5/29/19 a.m., Courtwright) at 23:13-19.

27. A catalyst of this first opioid epidemic was physicians' widespread use of a new medical technology at the time—the hypodermic syringe—to administer opioids

[11] S-0035 at 9. S-0035, an Executive Summary of Defendant's' November 30, 2011 Chronic Pain Scientific Advisory Board Meeting, was admitted into evidence with no objection. *See* Trial Tr. (5/30/19 a.m.) at 94:4-95:21.

(primarily morphine) by intravenous injection. Trial Tr. (5/29/19 a.m., Courtwright) at 34:1-20. After first reaching the U.S. in 1856, the hypodermic syringe became so commonplace in the medical community by the end of the 1870s that "virtually every American physician had" one to use in administering opioids. Trial Tr. (5/29/19 a.m., Courtwright) at 34:10-20.

28. Prior to this general acceptance of the hypodermic syringe, opioids were typically administered orally. Trial Tr. (5/29/19 a.m., Courtwright) at 34:21-23. According to medical literature at the time, physicians understood that taking opioids orally could lead to addiction. Trial Tr. (5/29/19 a.m., Courtwright) at 35:2-6. With the advent of the hypodermic syringe, however, doctors did not initially understand the dangers of injecting morphine using a hypodermic syringe. Trial Tr. (5/29/19 a.m., Courtwright) at 35:7-9. In fact, physicians referred to this new technique as the "Holy Grail of pain relief"—a technique that "instantly and safely eliminate[d] pain." Trial Tr. (5/29/19 a.m., Courtwright) at 37:16-25.

29. For example, an article authored by a physician, Dr. William Green, and published in the *Atlanta Medical and Surgical Journal* in 1867, described the hypodermic injection of morphine as follows: "I now enter the chamber of suffering knowing that I have in my possession an unfailing remedy for pain. Relieve me of my pain, Doctor, is the cry of the sufferer. With a hypodermic syringe, this agonizing cry can be promptly, and without injury, hushed." Trial Tr. (5/29/19 a.m., Courtwright) at 35:12-37:12. The author-physician's statement that morphine could be administered intravenously "without injury"

indicated the then-common belief that no bad effects would follow from "using the drug in this way." Trial Tr. (5/29/19 a.m., Courtwright) at 37:13-15.

30. The medical community soon learned that injecting morphine was not as safe as physicians initially thought. Trial Tr. (5/29/19 a.m., Courtwright) at 38:1-3. Documented cases of opioid addiction in patients receiving morphine injections began to appear in medical journals and medical literature by at least the 1870s. Trial Tr. (5/29/19 a.m., Courtwright) at 38:6-22, 39:20-40:20. Cases of addiction in these patients had begun "piling up in the medical literature in the late 19th century[,]" as it became "more and more common" for physicians to write cautionary reports about their encounters with "patients who ha[d] become terribly addicted to hypodermic injections of morphine" in medical journals. Trial Tr. (5/29/19 a.m., Courtwright) at 40:21- 41:3.

31. Around 1870, and accelerating into the 1880s, while problems related to this "opiate-based technology" materialized, a debate in the medical literature ensued over whether to use opioids to treat chronic nonmalignant pain. Trial Tr. (5/29/19 a.m., Courtwright) at 47:1-8.

32. Both medical journal literature and medical text books during this time period increasingly reflected physicians informing their colleagues of these cases of medical addiction to morphine in what Dr. Courtwright described as physicians' "warning literature" because it indicated the "dangers of medical narcotic addiction in the late 19th century," and the "growing alarm about the effects of the hypodermic use of morphine." Trial Tr. (5/29/19 a.m., Courtwright) at 40:21-42:7.

33. For example, a medical textbook entitled *Drugs That Enslave*, which was published in 1881 and authored by Dr. Harry Hubbell Kane,[12] reported:

> There is no proceeding in medicine that has become so rapidly popular, no method of allaying pain so prompt in its action and permanent in its effect, no plan of medication that has been so carelessly used and so thoroughly abused. And no therapeutic discovery that has been so great a blessing and so great a curse to mankind as the hypodermic injection of morphia.[13]

34. This 19th century medical textbook continued:

> Those not acquainted with the truth in this matter will be surprised to learn that there are today thousands of educated and respectable people in all countries and among all classes confirmed habitues, slaves to a habit that is more exacting than the hardest task master, that they loathe beyond all else, and yet that binds them in chains that they are wholly unable to break. Everything must give way to this vice. Businesses neglected or but imperfectly performed; family ties are sundered; hope, ambition, happiness, self-respect are meaningless words; the one thing that fills the mind is the gratification of this passion, which they loathe, but from which they cannot break. Thus from day to day, week to week, year to year, they go on; not living – simply existing. Each day, each hour, each minute binds them more firmly until at last they feel their own inability to cope with the demon that has overpowered them, and abandoned themselves hopelessly, listlessly to the vise. Repentance comes too late. The momentary pleasure, the short period of excitement, the hour of the vivacity bears fruit to a thousandfold; fruit, the bitter taste of which must last them a lifetime. That which at first gave them pleasure has now become the veriest tyrant, enforcing long hours of pain and anguish, gloom and despondency. They do not continue its use because it gives them pleasure, but simply because it is the only thing that, in increasing doses, can save them from the torment it has itself imposed; because without it they are sunk into a living hell.[14]

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[12] Over no objection to its use as a learned treatise, the Court allowed portions of this 1881 medical publication to be read into the record. *See* Trial Tr. (5/29/19 a.m., Courtwright) at 41:4-46:10. This medical and historical literature regarding the use of opioids and the history of opioid addiction in the U.S., including the materials relied upon by Dr. Courtwright in his research, are publicly available and accessible. *Id.* at 75:11-77:12, 80:3-25.

[13] Trial Tr. (5/29/19 a.m., Courtwright) at 43:22-44:5. The term "morphia" was synonymous with "morphine" in the 19th century. *Id.* at 44:6-8.

[14] Trial Tr. (5/29/19 a.m., Courtwright) at 45:4-46:8.

35. Cautionary medical literature about the liberal use of morphine to treat pain continued to accumulate over the late 19th century. Trial Tr. (5/29/19 a.m., Courtwright) at 46:18-25. As the "controversy" over whether to use opioids to treat chronic nonmalignant pain in the 1870s and 1880s "erupt[ed,]" this building body of medical literature eventually helped "persuade doctors to be more conservative with respect to [opioid] drugs." Trial Tr. (5/29/19 a.m., Courtwright) at 46:18-25, 47:1-8. That is, in direct response to the first opioid addiction epidemic in the late 1800s, the debate over whether to use opioids to treat chronic nonmalignant pain was resolved "in favor of the conservative physician." Trial Tr. (5/29/19 a.m., Courtwright) at 47:1-10.

36. The U.S. learned some "important lessons from" this 19th century opioid addiction epidemic. Trial Tr. (5/29/19 a.m., Courtwright) at 25:3-5. According to early accounts, one of those lessons was that it is "a bad idea to overly prescribe" opioid "drugs to treat chronic noncancer pain" because of the risk of addiction. Trial Tr. (5/29/19 a.m., Courtwright) at 25:3-13. This approach to prescribing narcotics conservatively, as opposed to liberally, is called "narcotic conservatism." Trial Tr. (5/29/19 a.m., Courtwright) at 25:14-26:6.

37. In exercising narcotic conservatism, medical professionals particularly began looking for substitutes for opioids in the late 19th century. Trial Tr. (5/29/19 a.m., Courtwright) at 47:11-13. For example, an article published by Dr. James Adams in the

Boston Medical and Surgical Journal in 1889[15] illustrated the establishment of narcotic conservatism in the medical community during this era, stating:

> Opium is the most conspicuous article in the pharmacopeia. Its extraordinary efficacy in relieving pain, the versatility of its powers, and its reliability in emergencies, gives it a pre-eminence standing. It is generally recognized by the medical profession as the most indispensable of drugs. But, while surpassing other remedies in its beneficent effects, it is alike remarkable in its power for harm. Hence, its medical use requires a degree of caution not less than that with which the surgeon handles his scalpel. When to administer and when to withhold it, constitute one of the gravest of medical problems. There are times when the dangers and disadvantages of this most brilliant of drugs seem wholly out of portion to its benefits. A growing dissatisfaction with opium is the motive of the present paper, which is designed as an argument in favor of restricting the use of opiates to a greater degree than has hitherto been the prevailing custom.[16]

38. Beyond the published medical literature, other developments in medical science pushed the medical community towards narcotic conservatism in the late 19th century and continuing into the 1900s. Trial Tr. (5/29/19 a.m., Courtwright) at 50:13-20. An "evolution in medical education" ensued over this period in which medical education "became longer, more scientific, more standardized" and more "rigorous." Trial Tr. (5/29/19 a.m., Courtwright) at 50:21-25. This evolution included the development of surgical improvements and techniques, public health reform, diagnostic procedures, and safer options for pain reliever medications—each of which served to solidify narcotic

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[15] The *Boston Medical and Surgical Journal* was the precursor to the *New England Journal of Medicine*. Trial Tr. (5/29/19 a.m., Courtwright) at 47:19-48:2. Over no objection, the Court allowed portions of Dr. Adams' 1889 article, entitled *Substitutes for Opium in Chronic Diseases*, to be discussed and read into the record as a learned treatise relied upon by Dr. Courtwright. *See* Trial Tr. (5/29/19 a.m., Courtwright) at 47:16-50:11.

[16] Trial Tr. (5/29/19 a.m., Courtwright) at 49:20-50:11.

conservatism in the U.S. medical community and eliminate the need for opioids that existed in prior decades. Trial Tr. (5/29/19 a.m., Courtwright) at 51:1-52:9.

39. By exercising narcotic conservatism in the late 19th and early 20th centuries, the U.S. was able to end the country's first opioid addiction epidemic. Trial Tr. (5/29/19 a.m., Courtwright) at 26:7-27:24. Narcotic conservatism, thus, served "as a barrier" or "a dam that prevented another wave of medical opiate addiction from sweeping over the country." Trial Tr. (5/29/19 a.m., Courtwright) at 26:7-27:24. This medical outlook of narcotic conservatism acted as a barrier to overprescribing and overconsumption of opioids during this period. Trial Tr. (5/29/19 a.m., Courtwright) at 27:25-28:4, 29:10-22.[17]

40. Both the "goal and a result of this new approach" of narcotic conservatism by physicians was primary prevention—essentially, preventing a disease or condition (opioid addiction) from developing in the first place. Trial Tr. (5/29/19 a.m., Courtwright) at 28:5-23. Narcotic conservatism resulted in fewer prescriptions written for opioids, and if a person is never exposed to opioids, they cannot become addicted to them. Trial Tr. (5/29/19 a.m., Courtwright) at 28:17-23.

[17] The Court accepted as Court's Exhibit 1 an illustration created by Dr. Courtwright, which demonstrated this concept of narcotic conservatism serving as a barrier or dam that stymied the overprescribing and overconsumption of opioids. *See* Ct. Ex. 1; Trial Tr. (5/29/19 a.m., Courtwright) at 26:15-16, 27:6-28:4. Herein, the Court occasionally refers to or cites to this and other demonstrative materials used to illustrate or depict data and concepts that were used at trial by the parties and accepted as Court Exhibits. The Court does so for the same reason the parties used such demonstrative exhibits: to depict and/or illustrate points the substantive evidence established. For the purposes of finding facts and reaching conclusions of law, the Court relies on the substantive evidence admitted at trial.

41. This change in the prescribing practices of the medical community is illustrated by a 1923 advertisement in the *Carter Express* newspaper in Oklahoma for aspirin. Trial Tr. (5/29/19 a.m., Courtwright) at 53:2-54:22. Aspirin was introduced as a commercially available pain medication in 1899. Trial Tr. (5/29/19 a.m., Courtwright) at 52:10-53:1. In this 1923 advertisement, aspirin was promoted to treat colds, pain, headache, toothache, neurologia, neuritis, lumbago and rheumatism. Trial Tr. (5/29/19 a.m., Courtwright) at 54:10-20. However, prior to 1923 and the rise of narcotic conservatism, these conditions (with the exception of colds) would have been treated with opioids. Trial Tr. (5/29/19 a.m., Courtwright) at 54:13-20.

42. Another example is heroin. *See* Trial Tr. (5/29/19 a.m., Courtwright) at 54:23-57:22. Heroin was introduced as a prescription opioid drug in the U.S. in 1898, and primarily marketed as a cough reliever. Trial Tr. (5/29/19 a.m., Courtwright) at 54:23-55:8, 56:10-17. However, despite the potency of heroin, "there was no epidemic of iatrogenic heroin addiction in the way that there had been an epidemic of iatrogenic morphine addiction" beginning in the 1870s, because heroin "was marketed relatively narrowly and responsibly" during this time period and "physicians had become much more wary of prescription opioids by 1889 and by the early 1900s." Trial Tr. (5/29/19 a.m., Courtwright) at 56:18-57:3. The fact that there "was not a wave of medical heroin addiction like medical morphine addiction" in the prior decades indicated that narcotic conservatism "had taken hold." Trial Tr. (5/29/19 a.m., Courtwright) at 57:4-14. Out of "several hundred cases of medical addiction [documented in] different sources in the early 20th century" that Dr. Courtwright collected, "only 1.7 percent of the cases" involved patients who became

addicted to opioids by starting with heroin. Trial Tr. (5/29/19 a.m., Courtwright) at 57:4-22. Virtually all of the other cases began with morphine. Trial Tr. (5/29/19 a.m., Courtwright) at 57:4-22. History shows that narcotic conservatism worked for prescription heroin in the early 20th century. Trial Tr. (5/29/19 a.m., Courtwright) at 58:5-7.

43. Narcotic conservatism also affected the use of "patent medications." Trial Tr. (5/29/19 a.m., Courtwright) at 58:10-12. Patent medications were nostrums that were secret proprietary formulas, which often contained opiates or other potentially habit-forming drugs and were marketed for a variety of cures—the quintessential "snake oil medicine" with undisclosed and unidentified ingredients that "often contained narcotics." Trial Tr. (5/29/19 a.m., Courtwright) at 58:13-59:8.

44. Prior to 1906, makers of patent medications were not required to disclose the fact that their drugs contained narcotics. Trial Tr. (5/29/19 a.m., Courtwright) at 60:10-15. However, following enactment of the Pure Food and Drug Act in 1906, these manufacturers were required to list opiates and certain other potentially habit-forming ingredients on the labels of their drugs. Trial Tr. (5/29/19 a.m., Courtwright) at 60:13-61:5. One example of a patent medication was "Mrs. Winslow's Soothing Syrup," a drug that contained morphine and was widely advertised for treating teething babies. Trial Tr. (5/29/19 a.m., Courtwright) at 59:12-60:9. Another was "Red Cherry Cough Syrup," for which post-1906 advertisements disclosed morphine sulfate as an ingredient in the patent medication. Trial Tr. (5/29/19 a.m., Courtwright) at 61:10-62:5.

45. Once manufacturers were forced to disclose that opioids were contained in these patent medications, the public responded "wearily and sales of these medications

declined." Trial Tr. (5/29/19 a.m., Courtwright) at 62:6-10. As the public learned about the "opioid epidemic of the late 1800s" and discovered that many of these patent medications "they had been using for years" contained opioids, the public alarm caused sales of patent medications to fall and "makers of these products [to] either" stop selling these drugs "altogether" or reduce "the amount of the [opioid] drug in the formula." Trial Tr. (5/29/19 a.m., Courtwright) at 62:6-20, 63:1-25. Patent medication manufacturers proceeded to capitalize on the public's increasing rejection of opioids by advertising medications on the basis that they were not narcotics and did not contain opium or morphine. Trial Tr. (5/29/19 a.m., Courtwright) at 64:1-65:23. That "not having a narcotic drug" had become a "selling point" for medications illustrated "the growing consumer awareness of the dangers of these drugs in the early 20th century." Trial Tr. (5/29/19 a.m., Courtwright) at 65:23-66:2.

46. Following the rise of narcotic conservatism, "exposure to addiction through patent medicines" fell and the "percentage of prescriptions [written by doctors] containing opiates" also declined "during this time period." Trial Tr. (5/29/19 a.m., Courtwright) at 66:3-12. In short, by the early 20th century, narcotic conservatism had been adopted by the public and the medical community, and the philosophy was even incorporated into medical training provided and textbooks used in U.S. medical schools. Trial Tr. (5/29/19 a.m., Courtwright) at 66:13-18, 67:6-68:25 (providing examples of early textbook references). Thus, "by the early 20th century," overreliance "on opioids to treat everyday pain" had come to be viewed as an out-of-date and inappropriate practice. Trial Tr. (5/29/19 a.m., Courtwright) at 70:5-7. Narcotic conservatism enabled the medical community to "put an

end to the first opioid addiction epidemic in this country" by causing "the overall level of addiction" to opioids "to go down." Trial Tr. (5/29/19 a.m., Courtwright) at 70:8-19.

47. The practice of narcotic conservatism remained in place and grew stronger throughout the vast majority of the 20th century, until the 1990s. Trial Tr. (5/29/19 a.m., Courtwright) at 28:24-29:15. New doctors continued to be taught that they should be conservative in their approach to using opioids throughout the 1960s, 1970s and 1980s. Trial Tr. (5/29/19 a.m., Courtwright) at 73:15-75:4. Thus, by the early 1980s, narcotic conservatism had become a "standard part of the medical curriculum" taught to U.S. doctors, such that the concept had become firmly established in the U.S. medical community. Trial Tr. (5/29/19 a.m., Courtwright) at 75:5-16. By 1980, "based on the information that was . . . widely available to everyone at th[at] time," "the consequences of an in increase in supply" of opioids "and the reversal of the ethic of narcotic conservatism would have been apparent, and an epidemic would have been foreseeable." Trial Tr. (5/29/19 a.m., Courtwright) at 83:20-24.

48. Consistent with how the debate had been resolved a century earlier, prior to 1995, opioids were prescribed only for palliative care, cancer pain and in acute settings for things like surgery. Ct. Ex. 2 (Portenoy) at 163:21-164:1.[18] They were not broadly used for

[18] Excerpts of the videotaped deposition testimony of Dr. Russell Portenoy, taken in New Hampshire, were played on May 29, 2019. *See* Trial Tr. (5/29/19 a.m.) at 89:1-16, (5/29/19 p.m.) at 5:1-5, 12:23-13:9. A transcript of the excerpts of the videotaped deposition testimony of Dr. Portenoy was marked, provided to and accepted by the Court as Court Exhibit 2 ("Ct. Ex. 2"). Citations to Dr. Portenoy's specific testimony herein will, thus, be to that transcript: Ct. Ex. 2 (Portenoy). As of 2019, Dr. Portenoy had been the executive director and chief medical officer of the Metropolitan Jewish Health System Hospice and Palliative Care in New York City since 2014. Ct. Ex. 2 (Portenoy) at 10:18-22, 11:8-21; *see also* S-0878 (Dr. Portenoy's CV). Dr. Portenoy is a medical doctor, who has treated and continues to treat pain patients. Ct. Ex. 2 (Portenoy) at 20:16-

chronic pain, like low back pain, due to concerns about negative consequences that can occur from the use of opioids, including tolerance, addiction, physical dependence, and the risk of abuse, misuse and diversion. Ct. Ex. 2 (Portenoy) at 164:2-24; *see also, e.g.*, S-0879 at ¶6 ("Prior to, and then during the 1980s, opioids were disfavored for use in chronic, non-cancer pain because of concerns that patients using opioids would develop tolerance and physical dependence, and be at risk for abuse, misuse, addiction and diversion.").[19]

49. For example, a 1986 paper that Dr. Portenoy co-authored recommended "that opioid therapy be considered only after 'all reasonable attempts at pain control have failed and persistent pain is the major impediment to improved function.' Contrary to how some drug companies later used this article, it was never intended as a report of high-quality evidence, or as support for broad adoption of opioid therapy; it was a description of anecdotal information accompanied by a brief narrative review of the literature, and was intended to suggest that the role of long-term opioid therapy needed re-thinking, and more research . . ." S-0879 at ¶7.[20]

21:1. He spent his career treating and researching chronic pain, palliative care and cancer care. *Id.* at 39:10-20. And, as discussed *infra*, he was a very influential speaker on issues related to the treatment of pain in the U.S. *Id.* at 39:10-40:9.

[19] Based on his personal knowledge, his professional experience and his direct interactions with the pharmaceutical industry, including Defendants, as well as Purdue and Cephalon, Dr. Portenoy signed a sworn declaration attesting to many facts. Ct. Ex. 2 (Portenoy) at 25:15-22, 26:13-21, 26:24-27:11, 27:22-24, 28:2-4. Dr. Portenoy testified that the statements in his declaration were true to the best of his knowledge. *Id.* at 35:23-36:10, 36:14-37:3. Over no objection, Dr. Portenoy's sworn declaration was admitted into evidence as S-879. *See* Trial Tr. (5/30/19 p.m.) at 8:9-14.

[20] Dr. Portenoy testified in his deposition as an independent third-party witness represented by his own counsel. Ct. Ex. 2 (Portenoy) at 18:5-19:2. He testified that the State had no control over him and nothing prevented him from saying things that may have been adverse to the State's case. *Id.* at 18:18-19:2. Prior to his deposition, Dr. Portenoy had never met with the State's attorneys or anyone representing the State of Oklahoma about this lawsuit. *Id.* at 21:20-22:18. There was no

50. The U.S. did not "have a public health problem" related to opioids in 1995 and 1996. Ct. Ex. 2 (Portenoy) at 190:2-4.

51. Prior to the late 1990s, there was neither "an oversupply of opioids in the State of Oklahoma" nor an opioid epidemic in Oklahoma. Trial Tr. (6/25/19 a.m., Commissioner White) at 71:5-7; Trial Tr. (6/26/19 p.m., Commissioner White) at 109:17-18. For approximately fifty (50) years after Dr. Janssen originally invented fentanyl, there was not an opioid public health crisis in Oklahoma or the U.S. Trial Tr. (6/5/19 a.m., J&J: Deem-Eshleman) at 80:17-20, 81:16-23.

52. During this time, there remained substantial fears about prescribing opioids to treat non-cancer chronic pain. Ct. Ex. 2 (Portenoy) at 263:8-13.

53. For more than a century, narcotic conservatism prevented another medical opioid addiction epidemic from occurring in the U.S. Trial Tr. (5/29/19 a.m., Courtwright) at 29:16-30:2, 77:13-78:1. In this sense, narcotic conservatism acted as a dam or barrier to overprescribing and overconsumption of opioid narcotics in this country for over a hundred years. Trial Tr. (5/29/19 a.m., Courtwright) at 77:13-78:1

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proffer agreement or formal settlement agreement between Dr. Portenoy and the State. *Id.* at 35:15-22, 36:14-37:22, 161:15-162:23. However, Defendants argued about Dr. Portenoy's financial situation and his understanding that the State of Oklahoma would not take any action against him in "any of the opioid litigation" if he testified truthfully at his deposition and in his written deposition. *See id.* at 278:5-286:14. The Court thoughtfully considered this information when considering the weight to attribute to Dr. Portenoy's testimony. After hearing and seeing Dr. Portenoy testify, the Court (as factfinder) found Dr. Portenoy's testimony to be relevant, credible and important to the issues at stake in this litigation, as well as corroborated by other evidence, notwithstanding Defendants' suggestions about his credibility.

54. Prior to 1996, Dr. Portenoy was unaware of any drug company encouraging the use of an opioid for chronic non-cancer pain by physicians who were not pain specialists. Ct. Ex. 2 (Portenoy) at 189:19-23.

55. However, Dr. Courtwright testified that removing or undermining this barrier to overprescribing and overconsumption of opioids established over the prior century would put a company "in a position to make a lot of money." Trial Tr. (5/29/19 a.m., Courtwright) at 78:13-24.

D. Defendants Laid the Groundwork for the Current Opioid Epidemic

56. Under longstanding U.S. law, narcotic raw materials may only be imported into the U.S. from certain authorized countries, which include Australia. *See* S-0006; 21 C.F.R. §1312.13(f)-(g). Specifically, a Drug Enforcement Agency ("DEA") regulation, often called the "80/20 Rule," provides that narcotic raw materials may only be imported into the U.S. by: (i) two historically "traditional suppliers" of narcotic raw materials, India and Turkey, must be the source of at least 80 percent of the narcotic raw materials imported by the U.S.; while (ii) five "non-traditional supplier" countries—Australia, France, Hungary, Poland and Yugoslavia—may be the source of not more than 20 percent of the narcotic raw materials imported by the U.S. *See, e.g.*, S-0006; 21 C.F.R. §1312.13(f)-(g).

57. DEA and other regulatory quotas on the amount of drugs that manufacturers may produce represent the "ceiling" or the maximum amount of a drug the manufacturer may produce. Trial Tr. (5/29/19 a.m., Courtwright) at 82:21-83:1, 86:20-23. Drug manufacturers do not "have to make all of" the drugs in the quota to fulfill this maximum ceiling level. Trial Tr. (5/29/19 a.m., Courtwright) at 86:24-25. The supply of opioid drugs

in the U.S. has been regulated since "before 1922." Trial Tr. (5/29/19 a.m., Courtwright) at 86:1-13. Despite this regulation of supply of opioid drugs, the U.S. did not experience a "medical opioid addiction epidemic" for "the vast majority of the 20th century[.]" Trial Tr. (5/29/19 a.m., Courtwright) at 86:15-19.

58. In the 1980s, Johnson & Johnson acquired and formed two companies, Tasmanian Alkaloids and Noramco, in order to ensure a "reliable source of [narcotic] raw materials" and "security of supply" for its Tylenol with Codeine range of pain medications. *See* S-0006 at 3; S-1048 at 13; Trial Tr. (6/11/19 a.m., Kolodny) at 108:13-17.

59. Tasmanian Alkaloids, located off the coast of Australia, cultivates and processes opium poppy plants, grown in Tasmania, to produce the narcotic raw materials necessary to manufacture APIs used in opioid drugs. *See* S-0006. Specifically, Tasmanian Alkaloids separates poppy seed from poppy straw, then extracts alkaloids from the poppy straw to produce concentrate of poppy straw ("CPS"). *See* S-0006. Once produced, CPS is then sold as the narcotic raw material necessary to manufacture the APIs in opioids. *See* S-0006. The principal alkaloids extracted from CPS include morphine, thebaine and oripavine. *See* S-0006.

60. Noramco, located in the U.S., imports the narcotic raw materials produced by Tasmanian Alkaloids, like morphine or thebaine, into the U.S., processes them into API, then sells them to drug manufacturers in the U.S. *See, e.g.*, S-340, S-1048. As a key part of Defendants' "pain franchise," Noramco was "an important part of J&J's business" from the mid-1990s until at least after 2010. Ct. Ex. 0092 (Mashett) at 75:3-11. Johnson & Johnson's ownership of these subsidiaries uniquely positioned its pain management

franchise to provide U.S. drug manufacturers, including J&J itself, with "Security of Supply"—"Direct Access to Narcotic Raw Material – From Our Fields to Your Formulations." S-1048 at 11-13. Through its subsidiary, Noramco, Johnson & Johnson supplied oxycodone API to other drug manufacturers. *See* Trial Tr. (5/29/19 p.m., J&J: Deem-Eshleman) at 36:22-37:01, 44:02-04; *see also, e.g.*, Trial Tr. (6/11/19 a.m., Kolodny) at 63:10-65:06, 100:1-134:11.

61. However, the scope of operations at these Johnson & Johnson subsidiaries changed dramatically in the 1990s due to a "transformational technology" developed by Defendants' scientists at Tasmanian Alkaloids. *See* S-340 at 7.

62. Because the U.S. 80/20 Rule is calculated based solely on the amount of morphine alkaloid contained in the narcotic raw material, but not the thebaine alkaloid content of these materials, the importation of thebaine is not restricted by the 80/20 Rule. *See* S-0006; *see also, e.g.*, Trial Tr. (6/11/19 p.m., Kolodny) at 14:25-15:24.

63. "Thebaine is not itself used in therapy, but [it] is an important raw material in the manufacture of several opioids," including oxycodone. *See* S-0006 at 2. Oxycodone is the opioid API contained in brand name opioids such as OxyContin. *See* S-0006; S-1048; *see also, e.g.*, Trial Tr. (6/11/19 a.m., Kolodny) at 106:4-115:8.

64. Until 1996, Tasmania was a "small producer" of thebaine. *See* S-0006.

65. In 1994, however, Defendants, in concert with subsidiary, Tasmanian Alkaloids, "anticipated demand" for oxycodone. *See* S-0006 at 6; Trial Tr. (5/29/19 p.m., J&J: Deem-Eshleman) at 59:19-24; Trial Tr. (6/11/19 a.m., Kolodny) at 113:2-13.

66. Specifically, Defendants' scientists at Tasmanian Alkaloids began a project "in 1994 in order to develop a high thebaine poppy variety to meet the anticipated demand." S-0006 at 6. The result of Defendants' research project was the creation of a mutant "high thebaine" poppy, called the "Norman Poppy," which Defendants internally described as "a transformational technology that enabled the growth of oxycodone." *See* S-0006 at 6-7; S-340 at 7; Trial Tr. (5/29/19 p.m., J&J: Deem-Eshleman) at 42:14-62:02; Trial Tr. (6/11/19 a.m., Kolodny) at 106:4-111:18. In 1994, Purdue filed its new drug application ("NDA") for OxyContin. *See* Trial Tr. (6/11/19 a.m., Kolodny) at 113:2-13.

67. Defendants later honored their scientist, Dr. A.J. Fist, who developed this "transformational" Norman Poppy by awarding him the "Johnson Medal." S-340 at 7; Trial Tr. (5/29/19 p.m., J&J: Deem-Eshleman) at 68:07-13. This was not a Noramco or Tasmanian Alkaloids medal; it was the Johnson Medal. *See id.*

68. Through Noramco, Defendants met the anticipated opioid demand by selling API, including oxycodone, to Purdue. Ct. Ex. 0092 (Mashett) at 222:3-16; *see also, e.g.*, S-1788; Trial Tr. (5/29/19 p.m., J&J: Deem-Eshleman) at 42:14-62:02; Trial Tr. (6/11/19 a.m., Kolodny) at 109:9-115:8.

69. By 1998, Defendants' subsidiary, Noramco, had been discussing a long-term supply agreement with Purdue for "many years." S-0494 at 2.

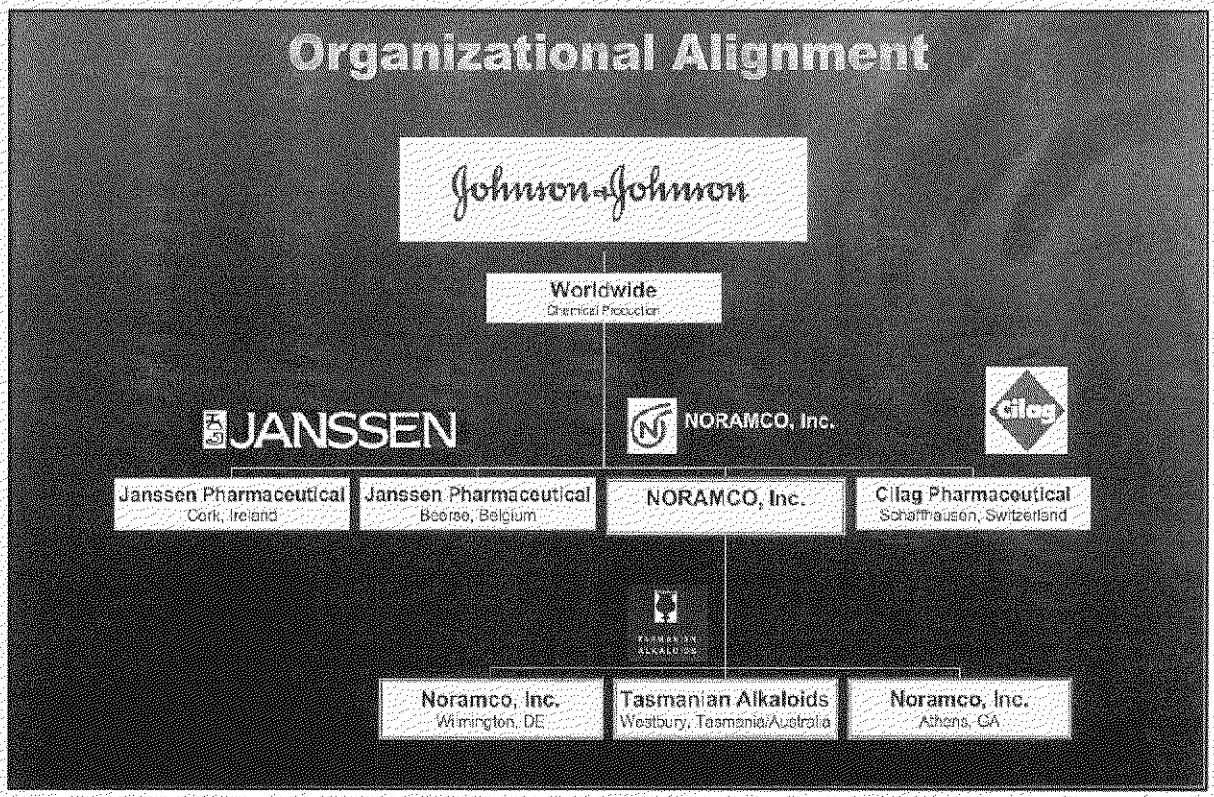
70. Noramco expressed a desire to secure Purdue's entire world-wide API supply requirements. S-0494; Trial Tr. (5/29/19 p.m., J&J: Deem-Eshleman) at 42:14-62:02. This was "not a minor point." S-0494 at 2; Trial Tr. (5/29/19 p.m., J&J: Deem-Eshleman) at 42:14-62:02. According to an internal Purdue memorandum, the "principal barrier to a

higher sales achievement before year end [wa]s product supply." S-2373 at 1; Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 39:17-41:24.

71. Noramco entered a long-term supply agreement with Purdue, under which Defendants, through Noramco, supplied opioid API, including oxycodone to be used in OxyContin, to Purdue. S-1788; *see also, e.g.*, Trial Tr. (6/11/19 a.m., Kolodny) at 106:4-115:8.

72. Defendants' "Franchise Strategy" for their "Noramco Worldwide Narcotics Franchise" included partnering with the "best-cost technology focused manufacturers" of narcotics and participating "in growth through partnerships." Ct. Ex. 0092 (Mashett) at 112:15-113:24; S-1048 at 16.

73. Noramco and Tasmanian Alkaloids were an important part of Defendants' "pain management franchise." S-0340. In 2003, a Noramco Vice President sent a presentation to one of Defendants' employees with "a short presentation summarizing [Noramco's] involvement in the pain management franchise." S-0340. The presentation includes an "organizational alignment" chart that depicts the relationship between the entities as follows:

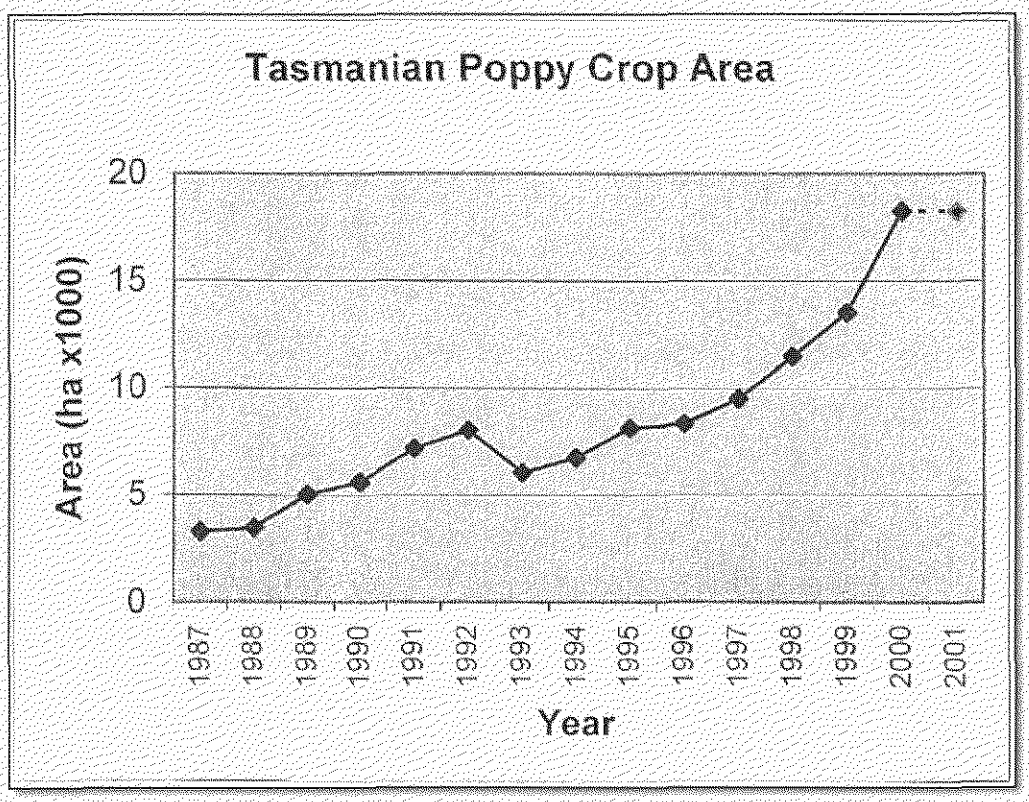


S-0340 at 2. This corporate structure reflects the significance of Noramco's role in Defendants' "pain management franchise" or "pain franchise," as Noramco is listed next to (and underneath) Janssen. *See* S-0340 at 2; *see also, e.g.*, Ct. Ex. 0092 (Mashett) at 75:1-11 (agreeing that Defendants' "pain franchise" included Noramco). The "pain franchise" included all of Defendants' pain products and "was an important part of [Defendants'] business from the mid 1990s to after 2010." Ct. Ex. 0092 (Mashett) at 75:1-11. This presentation also stated that Noramco played "a significant role influencing INCB, DEA policies." S-0340 at 3.

74. Through Noramco, Defendants supplied API to other opioid manufacturers, including Teva. Ct. Ex. 0092 (Mashett) at 219:18-220:8, 230:8-24. Noramco sold the majority of its "controlled substance" via "long-term agreements" and had such agreements

"with all 7 of the top US generic companies." S-1048 at 18. Through Noramco, Defendants supplied other U.S. opioid manufacturers with opioid APIs, including: oxycodone, hydrocodone, morphine, codeine, buprenorphine, hydromorphone and naloxone. *See, e.g.*, S-1048; Trial Tr. (6/11/19 a.m., Kolodny) at 127:4-134:11.

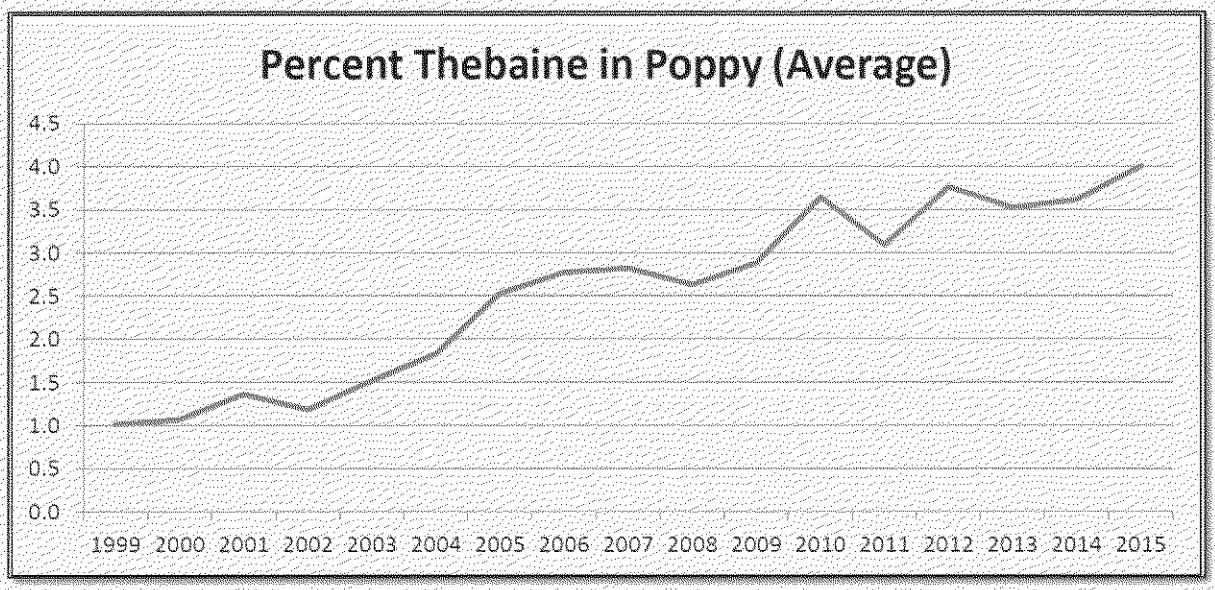
75. To meet the rising demand that continued to climb over the years, Defendants' subsidiary, Tasmanian Alkaloids, had to increase its poppy acreage in Tasmania. S-0006. Between 1996 and 2001, Tasmanian Alkaloids increased its crop area sown to the thebaine-focused, mutant Norman Poppy at a rate of 50-100% per year:



S-0006 at 3. For the consumption of oxycodone to increase at the rate and volume it did in the U.S., Defendants had to develop the high thebaine poppy and increase its poppy production, as Defendants did. *See, e.g.*, Trial Tr. (6/11/19 a.m., Kolodny) at 109:9-111:18;

see also id. at 131:15-23 ("The sharp increase in oxycodone consumption in the United States would not have been possible according to [Defendants], without the Norman poppy, the thebaine rich poppy").

76. Following the development and commercial production of the Norman Poppy, Tasmanian Alkaloids managed to "increase[] the alkaloid content" in its poppies by at least "300%" from 1999 through 2015—an "unparalleled" increase in the drug industry:



S-1048 at 48; Trial Tr. (6/11/19 p.m., Kolodny) at 13:24-14:18.

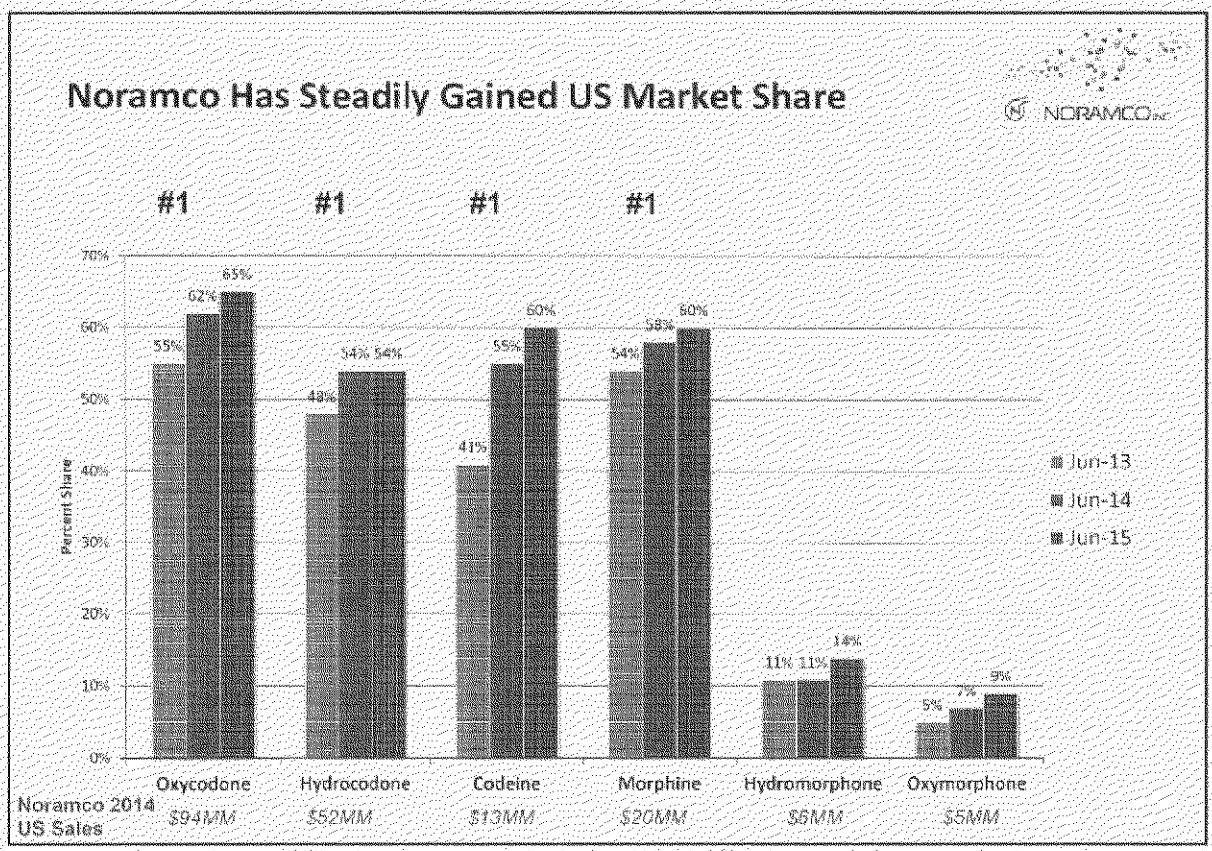
77. By 2015, Defendants' subsidiary, Tasmanian Alkaloids, produced 300 tons of narcotic raw materials annually, which represented "over 40% of the world's supply of Narcotic Raw Materials," including "77%" of the world's thebaine. S-1048 at 28, 35.

78. Between 2006 and 2011, the volume of APIs that Defendants produced through Noramco doubled. *See* S-1048 at 33. Demand for Noramco's APIs increased at such a rate during this time period that Noramco had reached production capacity by 2014,

necessitating the investment of millions of dollars into new facilities to expand its production capacity. S-1048 at 33-34.

79. According to Defendants' documents, by 2015, the U.S. consumed: 82% of the world's supply of oxycodone; 99% of the world's supply of hydrocodone; 79% of the world's supply of hydromorphone; and 61% of the world's supply of morphine. S-1048.

80. Defendants' subsidiary, Noramco, grew to become the No. 1 narcotic API supplier of oxycodone, hydrocodone, codeine and morphine in the United States:



S-1048; Trial Tr. (5/29/19 p.m., J&J: Deem-Eshleman) at 70:09-75:16.

81. During the relevant time period, Defendants' subsidiary, Noramco, owned a large percentage of the market for both oxycodone and hydrocodone. Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 38:05-14.

82. As shown above, for several years, Defendants' subsidiary, Noramco, was the No. 1 supplier in the world and the U.S. for: oxycodone, hydrocodone, morphine, and codeine. *See* S-1048; Trial Tr. (6/11/19 a.m., Kolodny) at 134:4-11.

E. Defendants' Code of Conduct

83. Johnson & Johnson is supposed to operate its business according to the Johnson & Johnson Code of Business Conduct, which includes the company's "Credo." *See* S-1044; Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 81:11-89:07; Ct. Ex. 92 (Mashett) at 12:19-14:6.

84. The entire company and all of Defendants' family of companies are supposed to hold itself to Defendants' Code of Conduct, and the entire company is required to live up to and adhere to the Defendants' Credo, including in conducting business in Oklahoma. Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 82:05-23; Ct. Ex. 0092 (Mashett) at 13:14-14:24, 21:14-17; *see also, e.g.*, Ct. Ex. 220 (Martin) at 104:5-107:2 (testifying that J&J's Credo applied to Noramco while J&J owned Noramco). Defendants' Code of Conduct "applies to all [of Defendants'] employees in every aspect" of their employment at Defendants' family of companies. *See* Ct. Ex. 0092 (Mashett) at 12:25-13:3.

85. Defendants' Credo states:

> We are responsible to the communities in which we live and work and to the world community as well. We must be good citizens – support good works and charities and bear our fair share of taxes. We must encourage civic improvements and better health and education. We must maintain in good order the property we are privileged to use, protecting the environment and natural resources.

Ct. Ex. 0092 (Mashett) at 14:7-18; S-1044 at 2. Defendants' "responsib[ility] to the communities in which [they] live and work" includes the State of Oklahoma. Ct. Ex. 0092 (Mashett) at 15:3-8; *see also* S-1044 at 2.

86. Among other things, Defendants' Code of Conduct states:

- "The values and principles spelled out in Our Credo serve as our compass. The Code of Business Conduct . . . is the road map that helps us stay on course with those values." Ct. Ex. 0092 (Mashett) at 19:17-22; S-1044 at 5;

- "The Code sets basic requirements for business conduct and serves as a foundation for our company policies, procedures and guidelines, all of which provide additional guidance on expected behaviors." Ct. Ex. 0092 (Mashett) at 19:25-20:6; S-1044 at 5;

- "Whenever we become aware of a violation of the Code, company policy or the law, we will act to address the problem and prevent future occurrences." Ct. Ex. 0092 (Mashett) at 20:15-20; S-1044 at 5;

- "You [Defendants' employees] have a responsibility to speak up when you are in a situation or are aware of a situation that you believe may violate or lead to a violation of the code, company policy or the law." Ct. Ex. 0092 (Mashett) at 21:7-13; S-1044 at 5;

- "Individuals and companies conducting business on our behalf must also follow our Code of Business Conduct." Ct. Ex. 0092 (Mashett) at 22:13-17; S-1044 at 6;

- "Applicable provisions of this Code should be included in the contracts of third-party suppliers, manufacturers, contractors, vendors and distributors doing business on behalf of the Johnson & Johnson Family of Companies." Ct. Ex. 0092 (Mashett) at 22:18-25; S-1044 at 6; and

- "We aspire to bring the highest standards and level of integrity" to the "[d]evelopment, approval, manufacture, sales and marketing of pharmaceuticals, medical devices, diagnostics, and consumer products and services" by "**[f]ollowing all laws and regulations regarding the promotion, marketing and sales of our products, including ensuring that what we say is truthful, not misleading, and is consistent with**

regulatory approvals for our products." Ct. Ex. 0092 (Mashett) at 23:3-5, 23:11-24:4; S-1044 at 12 (emphasis added).

87. Defendants' Code of Conduct, including its requirement that Defendants ensure what the company says is "truthful, not misleading, and . . . consistent with regulatory approvals for [Defendants'] products" in its "promotion, marketing and sales," applies to both Defendants' branded and unbranded marketing. Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 88:18-89:07.

88. Defendants' Code of Conduct applies to and "covers a wide variety" of Defendants' "partners." Ct. Ex. 0092 (Mashett) at 23:3-10. Defendants' Code of Conduct "applies to anyone with whom" Defendants did business, including other opioid manufacturers with whom Defendants partnered. Ct. Ex. 0092 (Mashett) at 230:1-232:6.

F. The Paradigm Shift – Expanding Opioid Use in Medicine

89. From at least the 1920s through the mid-1990s, there were doctors, patients and opioids in the State of Oklahoma, but there was no opioid epidemic. Trial Tr. (6/26/19 p.m., Commissioner White) at 29:15-18, 66:25-67:6; *see also, e.g.*, Trial Tr. (6/17/19 p.m., Beaman) at 73:8-19. Defendants' expert, Dr. Fong, agreed the three primary risk factors for opioid use disorder ("OUD")—biological, psychological, and social—all existed prior to the mid-1990s and most likely since "the dawn of human kind." Trial Tr. (7/1/19 p.m., Fong) at 11:9-13:11.

90. Something changed, however, in in the late 1990s. Defendants decided to act in concert with "a host of their key partners" to embark on a major campaign in which they used branded and unbranded marketing to disseminate the messages that pain was

being undertreated and "there was a low risk of abuse and a low danger" of prescribing opioids to treat chronic, non-malignant pain. Trial Tr. (6/26/19 p.m., Commissioner White) at 29:15-31:9, 67:13-68:9, 82:7-21; *see also, e.g.*, Trial Tr. (6/10/19 p.m., Stone) at 27:15-40:8.[21] As a result of their actions, prescriptions and, thus, sales of opioids spiked. *See* Sections G, H *infra.*

91. Beginning in the late 1990s, and continuing even today, Defendants executed a campaign to undermine and understate the risk associated with, and overstate the efficacy of, opioids as a class of drug. *See, e.g.*, Trial Tr. (6/13/19 p.m., Kolodny) at 11:25-12:05, 17:2-23:13; Trial Tr. (6/17/19 a.m., Kolodny) at 109:4-25.

1. Defendants and Purdue Begin Aggressively and Misleadingly Marketing Opioids for Long-Term Use for Chronic, Non-Cancer Pain

92. Purdue took OxyContin to market in the U.S. in December of 1995. Ct. Ex. 2 (Portenoy) at 263:14-17. This was one year after Purdue filed its NDA and when, almost contemporaneously, Johnson and Johnson had developed the Norman poppy in anticipation of the growth of Oxycodone (the API for Oxycontin).

93. In December 2003, the U.S. General Accounting Office ("GAO") issued a Report to Congressional Requesters, titled "*PRESCRIPTION DRUGS – OxyContin Abuse and Diversion and Efforts to Address the Problem*" (herein, the "2003 GAO Report"). *See*

[21] Until the production of discovery in this lawsuit, the State, its witnesses and the public had no access to Defendants' confidential marketing materials. Trial Tr. (6/25/19 a.m., Commissioner White) at 40:10-17, 45:25-46:11.

S-1067[22]; *see also, e.g.*, Ct. Ex. 0092 (Mashett) at 232:7-10. Among other things, the 2003 GAO Report found that:

- "Purdue conducted an extensive campaign to market and promote OxyContin using an expanded sales force and multiple promotional approaches to encourage physicians, including primary care specialists, to prescribe OxyContin as an initial opioid treatment for noncancer pain." Ct. Ex. 0092 (Mashett) at 233:1-10; S-1067 at 2;

- "DEA has expressed concern that Purdue's aggressive marketing of OxyContin focused on promoting the drug to treat a wide range of conditions to physicians who may not have been adequately trained in pain management." Ct. Ex. 0092 (Mashett) at 233:24-234:5; S-1067 at 2;

- "Purdue has been cited twice by FDA for using potentially false or misleading medical journal advertisements for OxyContin that violated the Federal Food, Drug, and Cosmetic Act including one advertisement that failed to include warnings about the potentially fatal risk associated with OxyContin use." Ct. Ex. 0092 (Mashett) at 234:10-18; S-1067 at 9;

- "In its written comments, DEA agreed that the data on abuse and diversion are not reliable, comprehensive, or timely, as we reported. DEA reiterated its previous statement that Purdue's aggressive marketing of OxyContin fueled demand for the drug and exacerbated the drug's abuse and diversion." Ct. Ex. 0092 (Mashett) at 237:15-22; S-1067 at 48–49;

- "DEA also stated that Purdue minimized the abuse risk associated with OxyContin." Ct. Ex. 0092 (Mashett) at 237:23-238:1; S-1067 at 49; and

- "We agree with DEA that Purdue conducted an extensive campaign to market and promote OxyContin using an expanded sales force and multiple promotional approaches to encourage physicians, including primary care specialists, to prescribe OxyContin as an initial opioid treatment for noncancer pain, and that these efforts may have contributed to the problems with abuse and diversion by increasing the availability of

[22] S-1067, the 2003 GAO Report, was admitted into evidence at trial on June 19, 2019. *See* Trial Tr. (6/19/19 p.m.) at 73:15-74:10.

the drug in the marketplace." Ct. Ex. 0092 (Mashett) at 238:1-11; S-1067 at 49.[23]

94. On the heels of Purdue's 1996 launch of Oxycontin for chronic non-cancer pain, in 1997, Defendants followed suit by re-launching Duragesic for chronic non-cancer pain and expanding Defendants' marketing and promotion for that broader type of use. S-2355; *see also* Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 78:07-81:05; Trial Tr. (6/3/19 p.m., J&J: Deem-Eshleman) at 25:01-03; Trial Tr. (6/13/19 p.m., Kolodny) at 16:15-25.

95. Defendants used a sales force for opioids in Oklahoma between 1991 and 1996 after Duragesic was originally released and marketed for chronic cancer and end-of-life pain. *See* Trial Tr. (6/3/19 p.m., J&J: Deem-Eshleman) at 24:01-08. However, there was not an opioid crisis in Oklahoma between 1991-1996. *See id.* at 24:09-11.

96. Defendants acted in concert with other opioid manufacturers to expand the use of opioids—***all opioids***—including but in no way limited to Defendants' branded drugs like Duragesic, through marketing opioids for long-term use in treating chronic non-cancer pain. Expanding opioid use in this way became the focus of Defendants' business plans after 1997. *See, e.g.*, S-2357; S-2358; S-2359; S-1358; S-2364; S-1246; S-1372; S-1844; S-3961; S-3960; S-0881; S-0903; S-0510; S-1364.

97. In a March 2018 email among members of the Sackler family (the owners of Purdue) discussing how an organization was considering removing the Sacklers' name

[23] The 2003 GAO Report also states that Purdue received the opportunity to review and comment on the Report and "in general, they thought the report was fair and balanced." S-1067 at 49.

from an award, Jonathan Sackler wrote: "Points to make to Governor Castle include the fact that Janssen, another big Research!America supporter, is the world's largest purveyor of fentanyl dispensed for the treatment of pain, which it marketed aggressively in the US and for which it is now subject to the same lawsuits that have troubled Purdue. If they sever their relationship with us, they will be called upon to do the same with Janssen." S-2369 at 2; *see* Trial Tr. (6/12/19 p.m., Kolodny) at 70:19-73:12.

98. By August 2000, Defendants' business plans identified the "[n]on-malignant market" as the "growth opportunity" for Defendants, although Defendants acknowledged that Duragesic data was "non-existent." S-2357 at 1, 19. The same business plan identified Defendants' "Key Strategies" to include, among other things: (i) "Expand DURAGESIC use in non-malignant pain"; and (ii) "Position DURAGESIC as 1st opioid choice for chronic A.T.C. [around the clock] pain." S-2357 at 21, 23-24.

99. Again, in 2001, a "Key Strateg[y]" for Defendants' Pain Franchise was to: "Drive Duragesic business in key 'non malignant' segments." S-2358 at 35; Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 145:02-146:02, 147:23-148:12. The plan identified "evidence-based prescribing" of opioids as a "threat" to its business. S-2358 at 31; *see also, e.g.*, Trial Tr. (6/11/19 a.m., Kolodny) at 89:12-90:3.

100. At the conclusion of their 2001 Pain Franchise plan, Defendants summarized that they viewed the pain market as "highly attractive" and there was a need to "build and protect the 'Franchise.'" S-2358 at 42; Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 148:13-19.

101. Defendants' 2003 Duragesic Business Plan Summary echoed these same principal strategies, stating, among other things:

- "The brands continued growth would primarily result from increasing acceptance of opioid therapy for the management of chronic non-malignant and malignant pain as well as the increasing acceptance that DURAGESIC can be used as a first line agent. By increasing call frequency and by continuing to target the appropriate high-decile Pain Specialists and primary Care Physicians, the brand will continue to grow." S-1358 at 3;

- "To help accelerate the brand's growth, DURAGESIC's promotional platform also evolved in 2002. Extensive market research initiatives were completed and provided the foundation for refining the brand's positioning. For the first time in the pain category, the DURAGESIC promotional efforts will focus the core message on improvements in physical and social functioning as a key benefit. The brand will continue to leverage it's [sic] competitive advantage of 72 hours of continuous pain relief but will define this benefit in the context of efficacy, the most important attribute of selecting a chronic pain mediation according market research findings. Functionality was also rated high on the physician's attribute importance index and therefore will represent the cornerstone of the brand's promotional campaign." S-1358 at 3;

- "DURAGESIC success in 2003 will be a function of the total teams' ability to direct all sales and marketing resources at those opportunities that afford the greatest potential return. It is important to deliver a consistent message around functionality to reinforce brand identity of DURAGESIC . . ." S-1358 at 4;

- A "Key Business Strategy" continued to be to "[e]xpand DURAGESIC use in chronic non-malignant pain (back, OA)." S-1358 at 13;

- "DURAGESIC will succeed in 2003 by ensuring that the brand's refined positioning is cemented into the marketplace and is perceived as believable by the brands customers. . . . Nothing is more important to our future success than maximizing the effectiveness of our sales force." S-1358 at 15.

102. Defendants' business plans similarly focused on "keep[ing] patients on Duragesic longer" and "[e]xtending patient duration" on opioids as "an opportunity for incremental sales." *See, e.g.*, S-2359 at 4, 9 (again describing the "acceptance of opioids for non-malignant pain (CBP [chronic back pain], OA [osteoarthritis])" as a "Growth

Driver"); S-3960 and S-3961 at 3 (describing 2003 research efforts to reduce patient drop off rates and identifying non-cancer market as the "high value" market); Trial Tr. (6/11/19 p.m., Kolodny) at 81:3-18, 87:12-23; Trial Tr. (6/12/19 p.m., Kolodny) at 19:17-24:23. As explained *infra* in Sections F.3 and F.4, Defendants knew that keeping patients on opioids long-term for non-cancer chronic pain was unsafe.

103. These business plans and many other of Defendants' internal documents outline the strategies and tactics Defendants used to carry out a comprehensive, multi-faceted, and decades-long campaign to convince physicians to liberally write more opioid prescriptions. *See, e.g.*, Trial Tr. (6/10/19 p.m., Stone) at 27:15-20.[24]

2. Keys to Defendants' Marketing Campaign to Expand the Use of Opioids

104. Defendants' marketing and promotional efforts were designed to reach Oklahoma doctors through multiple means and at multiple times over the course of the doctor's professional education and career in Oklahoma. *See* Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 63:01-66:20. Examples of such marketing and promotion include, among other things, alleged "education" from Defendants' sales representatives, literature funded by Defendants in medical journals and publications, materials from professional societies/patient advocacy groups, continuing medical education funded by Defendants, unbranded marketing materials, and Defendants' paid speakers. *See* Trial Tr. (5/30/19

[24] Based on the foundation laid at trial, the Court recognized Mr. Renzi Stone as an expert in the fields of marketing, communications, PR, sales, and advertising, and the Court further found Mr. Stone was qualified to offer an expert opinion about these topics with respect to abatement. Trial Tr. (6/10/19 p.m., Stone) at 25:21-23, 113:24 – 114:1.

a.m., J&J: Deem-Eshleman) at 63:01-66:20. Other avenues included dinners and presentations where doctors spoke to other doctors, partnering with third-party advocacy groups or academic groups to hold seminars, symposiums and conferences. Ct. Ex. 2 (Portenoy) at 40:24-41:11.

105. Though many of the Defendants' sales and marketing plans and strategies were designed to reach a national (and even global) audience, Defendants executed all of them according to plan in Oklahoma. *See, e.g.*, Trial Tr. (6/10/19 p.m., Stone) at 48:8-13; Trial Tr. (6/11/19 a.m., Kolodny) at 93:17-94:03; Trial Tr. (6/13/19 a.m., Kolodny) at 35:19-24.

106. All of these many different efforts, discussed in detail below, were intended to influence the prescribing behavior of physicians and, thus, increase Defendants' profits from opioids. *See, e.g.*, Ct. Ex. 2 (Portenoy) at 43:8-19; Trial Tr. (6/13/19 p.m., Kolodny) at 11:25-12:5, 17:2-23:13; Trial Tr. (6/13/19 a.m., Kolodny) at 63:2-64:04; S-2364; S-1246; S-1372; S-1844; S-3961; S-3960; S-881; S-903; S-510; S-1163; S-1780.

a. Removing Barriers to Opioid Prescribing

107. In order to expand the use of opioids into the chronic pain market, removing "barriers" to opioid prescribing, like narcotic conservatism, was a fundamental focus of Defendants' opioid marketing and sales campaign. *See, e.g.*, Trial Tr. (6/11/19 a.m., Kolodny) at 75:08-77:13. Defendants reframed the reasons to be cautious with opioids as "barriers to compassionate pain care" and through a "brilliant multifaceted campaign" convinced doctors that there is "opiophobia," fears of addiction were "overblown," and patients can stop taking opioids "easily." Trial Tr. (6/11/19 a.m., Kolodny) at 75:08-77:13.

108. Defendants were in the "drug space"—*i.e.*, the manufacturing side of the opioid drug business—in order to make money from the sale of the branded opioid drugs that Defendants made. Ct. Ex. 0095 (Ponder) at 74:7-9.[25] And, Defendants were in the drug "supply space"—*i.e.*, importing narcotic raw materials and making APIs to be used in other companies' opioid drugs—to make money off of selling those APIs. Ct. Ex. 0095 (Ponder) at 74:10-14.

109. If fewer prescriptions for opioids are written, then fewer opioid drugs are sold. *See, e.g.*, Ct. Ex. 0095 (Ponder) at 70:24-71:23. If "less opioids in general [we]re sold," then Defendants would "probably" lose money. *See* Ct. Ex. 0095 (Ponder) at 72:8-11. If barriers to physicians' writing of prescriptions for opioids existed, such that lower amounts of opioid prescriptions were written, Defendants "would make less money." Ct. Ex. 0095 (Ponder) at 74:15-19. Thus, from "a business standpoint" for Defendants, "lower prescriptions and less sales" represented "a double whammy," due to its interest on both the manufacturing and supplying side of the business. Ct. Ex. 0095 (Ponder) at 280:7-21.

110. In order to accomplish their profit goals, Defendants used "both unbranded and branded marketing." Trial Tr. (6/10/19 p.m., Stone) at 39:17–40:8; *see also, e.g.*, Trial Tr. (6/26/19 p.m., Commissioner White) at 24:10-14.

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[25] Excerpts of the videotaped deposition testimony of Richard Ponder, taken on November 9, 2018, were played at trial on June 20, 2019. *See* Trial Tr. (6/20/19 a.m.) at 5:3-17. A transcript of the excerpts of the videotaped deposition testimony of Mr. Ponder was marked, provided to and accepted by the Court as Court Exhibit 95 ("Ct. Ex. 0095"). Citations to Mr. Ponder's testimony herein will be to this transcript: Ct. Ex. 0095 (Ponder). Mr. Ponder was 'Defendants' Director of State Government Affairs for Oklahoma, Texas, and Arkansas. Ct. Ex. 0095 (Ponder) at 7:24-8:6. His job required him to "lobby and conduct advocacy for policies and regulations related to pain care treatment in the state of Oklahoma." Ct. Ex. 0095 (Ponder) at 59:11-15.

111. Unbranded marketing promotes the sale of all manufacturers' opioids, not just Defendants', following the philosophy that "a rising tide lifts all ships." Trial Tr. (6/10/19 p.m., Stone) at 39:12-24, 80:6-16, 158:6-11. While branded marketing focuses on a specific branded drug, like Duragesic or Nucynta, unbranded marketing focuses on an entire class of drugs, here all opioids in general, because increased sales of all opioids (a "rising tide") "will raise your boat as well." Trial Tr. (6/26/19 p.m., Commissioner White) at 83:15-84:18.[26] However, it "is impossible" to "separate out whether the rising tide lifted one ship versus another." Trial Tr. (6/10/19 p.m., Stone) at 158:6-11.

112. Defendants used unbranded marketing to market opioids generally as a class of drugs. *See, e.g.*, Trial Tr. (6/11/19 a.m., Kolodny) at 100:1-13.

113. Defendants have been using unbranded marketing since their earliest days of marketing opioids. For example, in 2000, Defendants were training their sales representatives repeatedly to emphasize the acceptance of "opioids" for treatment of chronic, non-cancer pain and use materials from groups that Defendants funded and partnered with—materials that Defendants adopted, ratified, and disseminated, such as the 1997 Consensus Statement, discussed below—to convince physicians that Defendants' statements were supported. *See, e.g.*, S-1246. Defendants created press kits in 2003 and other information from Duragesic.com that included unbranded marketing about all opioids in general as a class of drug. *See, e.g.*, S-0760. At that same time, Defendants created media response documents with prepared answers about "opioids." *See, e.g.*, S-

[26] As an example of well-known unbranded marketing, Mr. Stone alluded to the "Got Milk" advertising campaign for the dairy industry. *See, e.g.*, Trial Tr. (6/10/19 p.m., Stone) at 39:17-40:8.

0037. By 2003, Defendants had created unbranded opioid CME programs, such as NPEC (discussed below). *See, e.g.*, S-1358 at 10, 13.

114. Internally, Defendants acknowledged that advocating for and supporting policies that did "not restrict access" to opioids would "float all the ships" and enable all opioid manufacturers to "benefit." *See, e.g.*, S-0353; Trial Tr. (6/12/19 p.m., Kolodny) at 125:19-131:6.

115. When Defendants engaged in unbranded marketing for "opioids" generally as a class of drugs, Defendants knew these promotional efforts had the potential to sell other drug manufacturers' opioids. Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 64:25-65:03.

116. A key element in Defendants' opioid marketing strategy to overcome barriers to liberal opioid prescribing was its promotion of the concept that chronic pain was undertreated (creating a problem) and increased opioid prescribing was the solution. *See, e.g.*, Trial Tr. (6/10/19 p.m., Stone) at 83:17-22; S-1239 at 4-6; S-0982; Trial Tr. (6/12/19 p.m., Kolodny) at 46:23-47:5.

117. This kind of create-the-need, sell-to-the-need strategy is something that all marketers use: "You want to establish that there's a problem, and then you want to support the problem with your marketing messages. And then you want to introduce a solution to the problem that you talked about existing at the beginning." Trial Tr. (6/10/19 p.m., Stone) at 83:17-22.

118. For example, Defendants' unbranded marketing campaigns frequently focused on "[h]eightening awareness of the under treatment of pain and its consequences." *See, e.g.*, S-0223 at 1; S-1239 at 5-6; S-2358.

119. Defendants described the undertreatment of pain and its consequences as "the hook." *See, e.g.*, S-0223 at 2.

120. "The hook is the most compelling message you can deliver to – to change behavior. That's what a hook is." Trial Tr. (6/10/19 p.m., Stone) at 30:20-22.

121. Ms. Deem-Eshleman testified that she would define a marketing hook as "exactly what we talked about, is the fishing hook." Trial Tr. (5/31/19 p.m., J&J: Deem-Eshleman) at 48:03-07.

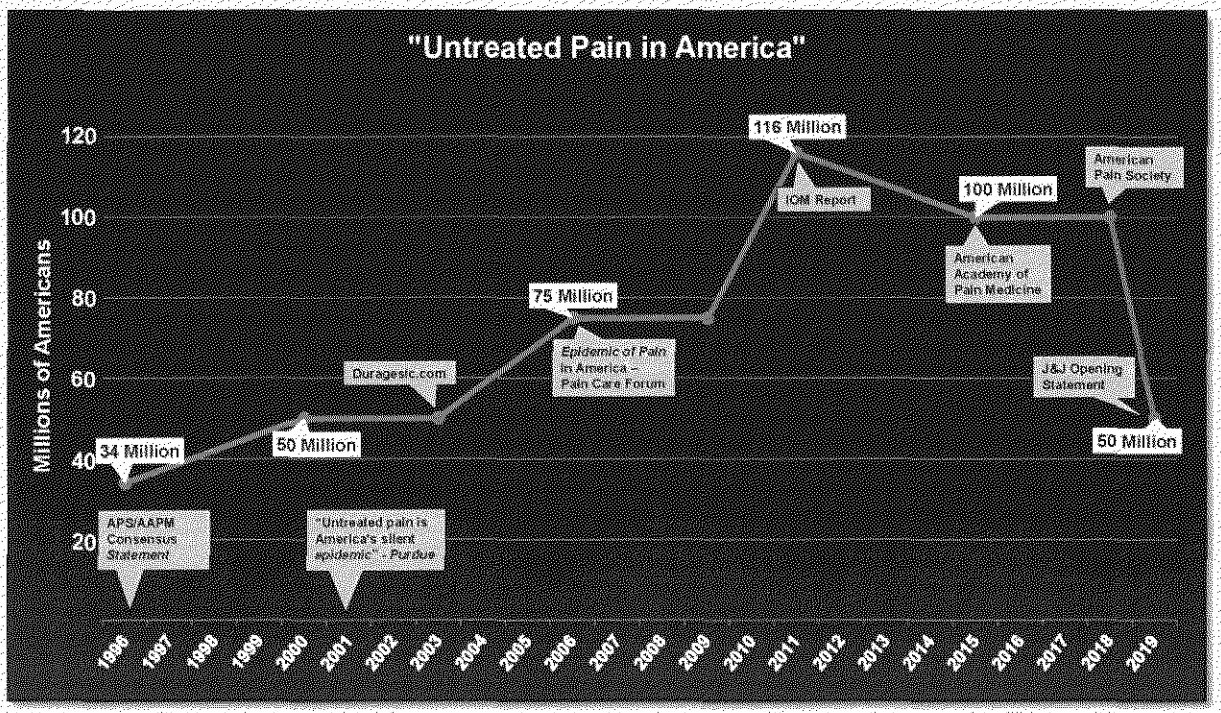
122. Defendants trained their Oklahoma sales representatives on how to use these campaigns, including through the use of "emotional selling" for opioids by convincing physicians that undertreated pain was harming patients. *See, e.g.*, S-0223 at 3; Section F.4 *infra.*

123. However, despite Defendants' focus on promoting the message that pain was undertreated, one of Defendants' Oklahoma sales representatives did not know if pain was, in fact, undertreated or if there was, in fact, widespread undertreatment of pain in the U.S. *See* Trial Tr. (7/2/19 p.m., Diesselhorst) at 39:4-5, 39:13-17, 40:23-24[27]; *see also, e.g.*, S-

[27] Drue Diesselhorst was one of Defendants' sales representative in Oklahoma for nine (9) years. *See* Trial Tr. (7/2/19 p.m., Diesselhorst) at 8:22-23; 11:7-9. Ms. Diesselhorst testified that she was good at selling opioids. Trial Tr. (7/2/19 p.m., Diesselhorst) at 51:2-11, 109:10-11.

1239 at 5 (identifying Defendants' first "Unbranded Message" to be that "Pain is mismanaged and under-treated").

124. The numbers of American patients allegedly suffering from untreated chronic pain that Defendants disseminated and reported as parts of their marketing-hook strategy continually increased over time:



Ct. Ex. 55 (illustrating timeline based on different statements in evidence); *see also, e.g.*, Trial Tr. (6/13/19 p.m., Kolodny) at 11:5-7, 61:13-65:14.

125. Defendants consistently identified the "fear of addiction, fear of diversion, fear of regulatory scrutiny," and "knowledge gaps" related to pain management as barriers to their opioid sales. *See, e.g.*, S-0635 at 1-2; Ct. Ex. 0095 (Ponder) at 276:2-17; Trial Tr. (6/11/19 a.m., Kolodny) at 75:8-77:13; Trial Tr. (6/11/19 p.m., Kolodny) at 68:12-69:07; S-2359 at 4 (identifying "opiophobia" as a sales "Growth Inhibitor").

126. For example, under the "SWOT" (strengths, weaknesses, opportunities, and threats) analysis for the Pain Franchise in 2001, the strengths Defendants noted included: "pain emanates from a wide variety of diseases/causes" and "LTC/ElderCare presence." S-2358 at 30; Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 139:16-140:04. The weaknesses Defendants noted included: "limited clinical data." S-2358 at 30. The opportunities Defendants noted included: "large sustainable market growth"; "recognition of undertreatment of chronic pain"; "growing acceptance of opioid usage for non-malignant pain"; "promotionally responsive market"; and "significant market opportunities." S-2358 at 31. And, the threats Defendants noted included: "move towards evidence-based prescribing"; and "risk of negative 'incident' higher in non-malignant indications." S-2358 at 31; *see also* Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 25:04-26:17.

127. Defendants conducted research into the effectiveness of their various unbranded marketing messages, including the "undertreatment of pain," in order to determine which messages most effectively caused a "behavior change" by doctors. *See* S-1163 at 16; *see also* S-1780; Trial Tr. (6/11/19 p.m., Kolodny) at 127:18-137:10.

128. Another unbranded marketing message Defendants used to accomplish the "[b]ehavior [c]hange" of "increase[d] opioid use" was that undertreated acute pain inevitably would turn into chronic pain. *See* 1163 at 17; S-1780; Trial Tr. (6/11/19 p.m., Kolodny) at 127:18-137:10.

129. Defendants emphasized these messages in their marketing materials that promoted opioids generally as a class of drug. *See, e.g.*, S-0760; Trial Tr. (6/3/19 a.m., J&J:

Deem-Eshleman) at 54:20-63:25. For example, in one such document that Defendants published online, Defendants stated:

- "Opioids are the major class of pain relievers used in managing moderate to severe chronic pain. These medications are called 'opioids' because they work in much the same way as pain relievers that come from the opium poppy, although many of these medications are now created synthetically." *See* S-0760 at 2.

- "Some patients have concerns about using strong medications like opioids to manage their pain, including a fear of addiction. This fear may prevent patients from receiving the treatment they need to manage their pain." *See* S-0760 at 2.

- "There are important differences between 'physical dependence,' 'tolerance' and 'addiction.' Because of a misunderstanding of these terms, pain is often under-treated and patients may be inappropriately stigmatized because of their use of opioids for medical purposes." *See* S-0760 at 2.

- "Most physicians who specialize in pain medicine agree that patients treated with opioid pain medication over a long period of time usually develop physical dependence and sometimes develop tolerance. However, the actual likelihood is unknown and varies between patients." *See* S-0760 at 2.

- "The leading medical societies for pain management...attribute confusion regarding the treatment of pain, including concerns about addiction, to unnecessary suffering and an economic burden to society." S-0760 at 3.

- "Concerns about addiction should not deter physicians from using adequate amounts of opioids in the management of moderate to severe pain when such use is medically indicated." S-0760 at 3.

- According to the document: "All information taken from www.duragesic.com unless otherwise noted." S-0760 at 3.

130. This document also is one of many documents that Defendants used and disseminated to actively promote the "Consensus Statement" issued in 1996 by groups that Defendants funded, ratified and sent out (in whole or part) in its own documents as discussed below. *See* S-0760; *see also* Section F.2.b(2), *infra*.

131. This document also actively promoted the concept of "pseudoaddiction" and emphasized the supposed stark differences between "physical dependence" and "addiction," portraying "physical dependence as totally benign." *See* S-0760; Trial Tr. (6/11/19 a.m., Kolodny) at 69:16-72:23.

132. "Pseudoaddiction" was another message Defendants used to minimize the risk of addiction to prescription opioids, claiming that "pseudoaddiction" "differs from true addiction because the behavior ends when pain is effectively treated." *See* S-0760 at 3; *see also, e.g.*, Trial Tr. (6/11/19 a.m., Kolodny) at 87:3-88:6; S-0954; S-0740. Defendants repeatedly promoted the concept of "pseudoaddiction" in various publications over time. *See, e.g.*, S-954 at 2; S-0740 at 6; S-0760 at 3.

133. Pseudoaddiction is a term that was invented and coined by individuals, including David Haddox—an individual who went on to work for Purdue for many years. Ct. Ex. 2 (Portenoy) at 215:24-216:10; *see also, e.g.*, Trial Tr. (6/11/19 p.m., Kolodny) at 41:8-16.

134. Defendants used this coined phrase, "pseudoaddiction," to convince doctors that patients who exhibited signs of addiction—e.g., asking for "higher and higher doses" of opioids or returning to the doctor "early" before a prescription should have run out—were not actually suffering from addiction, but from the undertreatment of pain; and the solution, according to Defendants' marketing, was to prescribe the patient more opioids. *See, e.g.*, Trial Tr. (6/11/19 a.m., Kolodny) at 87:3-88:6; Trial Tr. (6/13/19 a.m., Kolodny) at 74:25-89:11; Trial Tr. (6/6/19 a.m., Mazloomdoost) at 35:21-36:5, 44:7-45:4; Ct. Ex. 2 (Portenoy) at 215:24-219:8.

135. Defendants' marketing of the concept of "pseudoaddiction" was particularly dangerous, as Dr. Kolodny testified:

> Pseudoaddiction is an exceptionally dangerous concept. So the message for a prescriber should be that if you think there's any chance at all that your patient might be addicted, Doctor, you need to stop, take a deep breath, talk with that patient's family members because the patient may not want to tell you that they're addicted. The patient may either be ashamed or is afraid you won't write the prescription and doesn't want to go home to withdrawal . . . The concept of pseudoaddiction was really to tell prescribers to do the exact opposite. Doctor, if you think your patient might be addicted because they're asking for higher and higher doses or they're coming in early, you should give them more opioids. The problem, Doctor, . . . [is] [y]ou're not giving them enough opioids. You're undertreating their pain. . . . Giving someone who's opioid addicted more opioids is a very dangerous thing to do.

Trial Tr. (6/11/19 a.m., Kolodny) at 87:3-88:6; *see also, e.g.*, Trial Tr. (6/6/19 a.m., Mazloomdoost) at 35:21-36:5, 44:7-45:4; Ct. Ex. 2 (Portenoy) at 215:24-219:8. As explained *infra* in Sections F.3 and F.4, this concept was not based in legitimate scientific evidence, and Defendants' use of the concept to promote and market opioids was deceptive and misleading.

136. Defendants' unbranded messaging documents also used the "Porter and Jick" letter and other studies, including Dr. Portenoy's (this letter and these studies are discussed *infra* at Section F.3), as supposed support for statements that the risk of a patient becoming addicted to opioids was 1%, 2.6%, or lower. *See, e.g.*, S-1710; S-1364; Trial Tr. (6/13/19 a.m., Kolodny) at 69:16-72:20.

137. Defendants ran a website called Prescribe Responsibly as a form of unbranded marketing. S-0974; Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 90:17-91:07; *see also* S-0954; Trial Tr. (6/11/19 p.m., Kolodny) at 139:1-147:25.

138. The website was accessible to anyone on the Internet. S-0974; *see* Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 90:17-91:17, 102:23-103:08. Defendants appeared to take this site down only a few weeks before trial began. *See* S-3958; Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 101:21-102:9.

139. Defendants displayed articles on their Prescribe Responsibly website that Defendants funded and that were authored by key opinion leaders ("KOLs") who Defendants used to disseminate their messaging, as discussed below. *See, e.g.*, Trial Tr. (6/11/19 p.m., Kolodny) at 139:1-147:25; *see also* Section F.2.b(2), *infra*. For example, one such article related to the "Use of Opioid Analgesics in Pain Management." S-0974; *see* Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 90:17-101:10. The author of this article was listed as "Keith Candiotti, MD," who had "received compensation from Janssen Pharmaceuticals, Inc." for his contribution to the website. S-0974; *see* Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 91:19-92:02. Dr. Candiotti was one of Defendants' KOLs. *See* Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 91:21-91:23.

140. This article on Defendants' unbranded website addressed opioids generally, not any one of Defendants' specific branded opioid products. *See* S-0974; *see* Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 90:17-101:10. The article states, among other things:

- "[N]o single class of agent has replaced or reached the same level of usefulness for the treatment of moderate to severe pain as have opioid analgesics." S-0974 at 1;
- "Opioid analgesics, for example, have no true 'ceiling dose' for analgesia and do not cause direct organ damage[.]" S-0974 at 1; and

- "Practitioners are often concerned about prescribing opioid analgesics due to potential legal issues and questions of addiction. By the same token, patients report similar concerns about developing an addiction to opioid analgesics. While these concerns are not without some merit, it would appear that they are often overestimated. According to clinical opinion polls, true addiction occurs only in a small percentage of patients with chronic pain who receive chronic opioid analgesics analgesic therapy." S-0974 at 2.

141. The article on Defendants' unbranded website includes a brief history of opioid use by the Ancient Greeks. S-0974. It omits all material information related to the risks, history of opioid use and addiction provided internally to Defendants in 2001 through Defendants' Scientific Advisory Board. *See* S-0035; S-0974; Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 93:06-97:08.

142. Information on Defendants' unbranded Prescribe Responsibly website promoted Defendants' messaging that the solution to "pseudoaddiction" was "to prescribe more opioids." *See* S-0954; Trial Tr. (6/11/19 p.m., Kolodny) at 139:1-147:25. And, the website inaccurately defined "iatrogenic addiction" to give the appearance that it only applied to high-risk patients and did not apply to medical use. *See* S-0954 at 3; *see also, e.g.*, Trial Tr. (6/11/19 p.m., Kolodny) at 139:1-147:25.

143. Another unbranded marketing initiative that Defendants employed was the dissemination of a brochure, titled "*Finding Relief.*" *See* S-1247; Trial Tr. (6/11/19 p.m., Kolodny) at 40:6-14. The *Finding Relief* brochure, which was widely disseminated, did not differentiate between opioids and discussed them as a class of drugs without reference to any of the differences between them. *See* S-1247; Trial Tr. (6/28/19 a.m., Moskovitz) at 108:02-110:09, 112:12-113:02.

144. The *Finding Relief* brochure actively promoted the concept that pain was undertreated. *See* S-1247; Trial Tr. (6/11/19 p.m., Kolodny) at 40:6-14. While it prominently and deceptively emphasized the risk of nonsteroidal anti-inflammatory drugs ("NSAIDs"), like aspirin or ibuprofen, the *Finding Relief* brochure misleadingly downplayed any risks associated with opioids. *See, e.g.*, Trial Tr. (6/11/19 p.m., Kolodny) at 98:17-99:22.

145. For the launch of their opioid, Nucynta, Defendants developed tactical unbranded marketing strategies in 2007. *See* S-1239; Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 64:04-79:16. Defendants' stated "objectives" for this unbranded campaign were to:

- "Disrupt the Marketplace";
- "Heighten awareness of the under-treatment of pain and its consequences";
- "Solidify rep training on disease and market";
- "Establish reps as pain experts";
- "Profile targeted HCPs [health care providers] in preparation of launch"; and
- "Pave the way for tapentadol launch."

See S-1239 at 4.

146. According to the planning document, the campaign included use of flashcards, webinars, reprint carriers, e-detailing, and iPod video clips. *See* S-1239.

147. When the planning document discussed the "preliminary message points" and discussed the "side effects," it did not mention addiction. *See* Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) 77:22-78:18; S-1239.

148. This document also discussed strategies aimed at "changing prescribing behaviors" and "reducing pseudoaddiction." *See* Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 79:01-09; S-1239.

149. Even as Defendants' surveillance programs reported rising rates of abuse and adverse events for several opioid compounds, Defendants continued their unbranded marketing of opioids. *See* Trial Tr. (6/28/19 p.m., Moskovitz) at 96:15-98:09. Defendants continued marketing opioids based on the "undertreatment of pain" in 2007, while opioid use continued to increase in the years since Defendants released Duragesic and then re-launched its promotion and marketing of the drug to expand its use in the chronic, non-cancer pain market. *See, e.g.*, Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 76:05-77:15; S-1239.

150. For example, Defendants' strategic plans in 2007 stated that the "fear of addiction contributes to the under-use of opioid analgesia." *See* S-1780 at 4; *see also, e.g.*, Trial Tr. (6/11/19 p.m., Kolodny) at 122:25-127:17.

151. In 2011, Defendants provided support for and promoted a website referred to as "Growing Pains" that was directed towards adolescents dealing with chronic pain. *See* S-1168; Trial Tr. (6/5/19 a.m., J&J: Deem-Eshleman) at 72:21-78:07. The "Janssen" logo appeared on this website. *See* S-1168; Trial Tr. (6/5/19 a.m., J&J: Deem-Eshleman) at 72:21-78:07.

152. In August 2012, Defendants' employees circulated an updated "National Advocacy Business Planning" document for 2013, which continued to strategize about promoting the "undertreatment of chronic pain." *See* S-1217; Trial Tr. (6/12/19 p.m., Kolodny) at 60:11-69:22. The document compared the advocacy support for opioid manufacturers and ranked Purdue in first place, followed by Defendants in second place. S-1217; Trial Tr. (6/12/19 p.m., Kolodny) at 60:11-64:8. A common trait that Defendants identified between these and other "top companies" was the willingness to engage in unbranded marketing for opioids. S-1217; Trial Tr. (6/12/19 p.m., Kolodny) at 64:9-25.

153. Defendants frequently used market research to identify certain patient populations to target with Defendants' marketing. *See, e.g.*, S-1163; S-1780; Trial Tr. (6/11/19 p.m., Kolodny) at 127:18-137:10; S-3960; S-3961; Trial Tr. (6/12/19 p.m., Kolodny) at 19:17-24:23; S-1253; S-3962.

154. At various times, Defendants targeted the elderly population with its marketing. *See* Trial Tr. (6/11/19 p.m., Kolodny) at 96:1-13. Defendants also used "media hooks" to target veterans and women with their marketing. *See* Trial Tr. (6/11/19 p.m., Kolodny) at 110:8-111:17. Defendants' former sales representative, Ms. Diesselhorst, testified it would be wrong for Defendants to target veterans and women with their marketing. *See* Trial Tr. (7/2/19 p.m., Diesselhorst) at 25:2-9. A witness Defendants called at trial, Dr. Schick, testified it would be wrong for Defendants to target women and veterans in the State of Oklahoma to try to get them to use more opioids so that Defendants could build a billion-dollar brand. *See* Trial Tr. (6/28/19 p.m., Schick) at 199:10-20. But that is precisely what Defendants did.

155. For example, in one 2012 PR program document for Defendants' "Pain Franchise," Defendants identified "Media Opportunities" that they could seize by using news "hooks," including: "Women are feeling the pain, study says—what every woman needs to know"; "Veterans—tools for dealing with chronic pain"; and "The long road home—Iraq/Afghanistan troops the next gen of chronic pain patients." S-2375 at 10-11.

156. The PR Program further identified a marketing campaign, entitled "Relief Interrupted" and identified ways to "Educate/Influence to Maintain Physician and Patient Access." S-2375 at 17; *see also* Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 134:02-23. The "Rationale" listed was "Laser-focus on states where access is threatened." S-2375 at 20; *see also* Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 134:02-23.

157. Many other examples of the marketing and sales efforts that Defendants utilized to disseminate these messages are discussed below.

b. Using Marketing Messaging to Influence Opioid Prescribing

158. Defendants used a variety of strategies and tactics to execute its business plans and disseminate its misleading and dangerous marketing messages through an extensive sales force, as well as numerous third-party doctors, researchers and organizations, nationally and in Oklahoma.

159. As part of Defendants' marketing and advocacy programs aimed at increasing opioid prescriptions, in addition to influencing doctors, Defendants employed strategies to influence a wide range of governmental agencies, including Oklahoma's medical and pharmacy boards and law enforcement agencies, through messages aimed at "optimizing the benefits of prescription opioids for pain management [and] minimizing

their risks," including the risk of addiction, abuse and diversion. *See, e.g.*, Trial Tr. (6/26/19 p.m., Commissioner White) at 57:21-61:4; S-1161 at 10; Trial Tr. (6/26/19 p.m., Commissioner White) at 110:2-111:8; Trial Tr. (6/10/19 p.m., Stone) at 36:3-37:22; Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 83:24-90:13. In doing so, Defendants successfully exerted influence on practically every phase of the decision-making process that ultimately causes a prescription to get filled at a pharmacy. *See, e.g.*, Trial Tr. (6/13/19 p.m., Kolodny) at 6:14-7:04.

160. Defendants used internal "influencer" maps depicting all the different "stakeholders" Defendants considered part of the "value proposition" for Defendants' products. *See, e.g.*, S-1161 at 10; Trial Tr. (6/10/19 p.m., Stone) at 36:3-37:22; Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 83:24-90:13. One example of such an influence map that Defendants used was a "Multidisciplinary Partnerships Influencers Mapping" related to the "Nucynta IR/ER Value Proposition." S-1161 at 10; *see* Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 88:24-89:04.

161. The document states: "Advocacy Program—Lead by Influence." S-1161 at 3. It does not state "lead by education." S-1161 at 3; Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 84:24-85:04.

162. One of the focuses listed was to: "Engage a multidisciplinary group of partners, stakeholders focused on optimizing the benefits of prescription opioids for pain management, minimizing their risks, including abuse and diversion." S-1161; *see* Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 85:14-86:12.

163. One of the objectives was to "deter discussions away from abuse and toward appropriate use." S-1161 at 3; *see* Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 87:13-87:17.

164. The document identified a number of Defendants' "Key Advocacy Partner Organizations" including the American Pain Society, American Academy of Pain Management, and American Academy of Pain Medicine (discussed *infra* at Section F.2.b(2)). *See* S-1161 at 4.

165. "[I]nfluence is the core of marketing. . . . [T]hat's what marketing is; it's influence." Trial Tr. (6/10/19 p.m., Stone) at 31:1-3. The purpose of marketing is to influence your target audience to get them to move "from A to B." *Id.*

166. According to Mr. Stone, "[T]he best kind of influence is when a purchase decision has been made, and you didn't realize that you had been influenced." Trial Tr. (6/10/19 p.m., Stone) at 32:9-11.

(1). Selling Drugs Through Defendants' Sales Force in Oklahoma

167. Defendants used a sales force in Oklahoma to promote, market and sell various types of opioids, including the branded opioid drugs that Defendants, themselves, manufactured: Duragesic, Ultram, and Nucynta. *See* Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 43:10-16.

168. "Nothing" was "more important" to Defendants' ability to succeed in selling opioids "than maximizing the effectiveness of [Defendants'] sales force." S-1358 at 15.

169. Defendants sent memoranda out to their sales force for Duragesic regarding the prescription sales and dollar volumes achieved. *See, e.g.*, S-1246; Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 59:06-24.

170. These memoranda, at times, directly attributed the success and increasing volume of sales and dollars from opioids to the sales force. *See, e.g.*, S-1246; Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 59:22-60:08.

171. These memoranda discussed marketing campaigns such as the "Life, Uninterrupted" campaign which, according to Defendants, was: "credible and compelling enough to cause [physicians] to prescribe DURAGESIC as a 1st choice for chronic pain." S-1246 at 1; Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 65:16-66:01.

172. A "Strategic Focus" listed for the sales force was to "Expand DURAGESIC Use in Non-malignant Pain." S-1246 at 1. Defendants' sales memorandum plainly states Defendants' primary objective for their sales force: "Physicians are becoming more comfortable using opioids in non-malignant pain. Our objective is to convince them that DURAGESIC is effective and safe to use in areas such as chronic back pain, degenerative joint disease, and osteoarthritis. It is important to remind physicians that the APS, AAPM, and AGS have all endorsed the appropriate use of opioids to manage chronic, non-malignant pain." S-1246 at 1; *see also* S-0510 at 3; S-2365 at 1.

173. According to Defendants' expert, Defendants' marketing materials were "not science." Trial Tr. (7/9/19 p.m., De La Garza) at 130:14-131:2; *see also id.* at 126:10-11.

174. Members of Defendants' sales force were not licensed doctors and were not required to be any sort of trained health care professional. *See* Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 43:17-44:02.

175. They were required to have either a Bachelor of Arts or Bachelor of Science degree. *See* Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 43:17-44:02.

176. Defendants trained sales representatives in Oklahoma using materials from Dr. Portenoy. *See* S-1364; Trial Tr. (5/29/19 p.m., J&J: Deem-Eshleman) at 30:14-33:11. This is the same Dr. Portenoy who, as discussed *infra*, testified that Defendants are responsible for being a cause of the opioid crisis in Oklahoma. *See* Trial Tr. (5/29/19 p.m., J&J: Deem-Eshleman) at 34:02-12; *see also* Section H, *infra*; Ct. Ex. 2 (Portenoy) at 270:7-271:18.

177. Defendants' training of their sales representatives in Oklahoma included teaching sales representatives to avoid the so-called "addiction ditch"—*i.e.*, to avoid the negatives (addiction) and emphasize the positives (supposed efficacy) in sales calls—and to use a study from Dr. Portenoy "to create dialogue about Opiophobia as a barrier." S-1364 at 16; Trial Tr. (5/29/19 p.m., J&J: Deem-Eshleman) at 30:14-33:11; *see also* Trial Tr. (7/2/19 p.m., Diesselhorst) at 46:10-16; S-1162.

178. As part of this training, Defendants trained their sales representatives that there was a 2.6% or lower risk of addiction when using opioids prescribed by a doctor. *See* S-1364; Trial Tr. (5/29/19 p.m., J&J: Deem-Eshleman) at 30:14-33:11.

179. As part of this same training, Defendants trained sales representatives to "establish that moderate to severe acute pain continues to be undertreated." S-1364 at 10; Trial Tr. (6/3/19 p.m., J&J: Deem-Eshleman) at 7:02-14.

180. As part of this same training, Defendants trained their sales representatives to address "barriers" to pain management, including for example, instructing sales representatives as follows: "Although many physicians are reluctant to prescribe controlled substances, the risks (for both patient addiction/misuse and physician disciplinary action) are much smaller than commonly believed." S-1364 at 14-15; Trial Tr. (6/3/19 p.m., J&J: Deem-Eshleman) at 8:07-9:16. The "[e]xecution tip" that Defendants provided to their sales representatives for addressing this particular "barrier" was to use Dr. Portenoy's study in their interaction with any reluctant physician. *See* S-1364 at 16; Trial Tr. (6/3/19 p.m., J&J: Deem-Eshleman) at 14:11-23. Defendants' "goal" was to "create dialogue that leads to 'Changing the Course.'" S-1364 at 18; Trial Tr. (6/3/19 p.m., J&J: Deem-Eshleman) at 15:07-16:03.

181. Defendants trained their sales force on various types of property and conducted Defendants' business on property in Oklahoma. *See* Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 44:13-46:17, 51:07-09. Defendants' Oklahoma sales representatives always conducted business on property, including doctors' offices, hospitals, and restaurants, and used numerous types of property provided to them by Defendants, including company cars (used on Oklahoma state and county roads) and computers or tablets. *See* Trial Tr. (7/2/19 p.m., Diesselhorst) at 168:10-170:4.

182. Defendants' corporate representative was not aware of any training provided to Defendants' sales force in Oklahoma on the disease of addiction. *See* Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 46:19-51:06.

183. Nor was Defendants' corporate representative aware of any training provided to the sales force related to the history of opioid use and epidemics in the U.S. or human history. *See* Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 46:19-51:06.

184. Defendants did not provide training on addiction because they were not marketing and selling a product for treating addiction. *See* Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 50:20-51:04.

185. Defendants' sales force "targeted" doctors in Oklahoma and elsewhere for promotion of opioids. *See* Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 52:20-53:10.

186. Defendants trained their sales representatives to "close" a sale by getting a commitment from their target doctor to write a prescription for the opioid they were selling. *See, e.g.*, Trial Tr. (5/31/19 p.m., J&J: Deem-Eshleman) at 92:22-93:09.

187. Defendants tracked the prescribing habits of doctors in Oklahoma using data Defendants purchased from a company called IMS. *See* Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 69:10-70:07. These detailed prescription data enabled Defendants to monitor precisely how well their sales calls were working to increase specific physicians' prescribing. *See* S-1774; Trial Tr. (6/13/19 a.m., Kolodny) at 93:09-95:14. These data demonstrated to Defendants that the sales tactics were effective in causing Oklahoma doctors to prescribe more opioids.

188. Defendants used these and other data to evaluate the impact of Defendants' marketing strategies on prescribing. *See, e.g.*, S-2364; Trial Tr. (6/13/19 a.m., Kolodny) at 63:02-64:04 ("The research can be used to identify how prescribing may change by segment due to competitive activity or other market factors. Message development and testing can be conducted to determine which messages have the most impact for each segment. These messages can then be communicated to the sales team to be used in the field.").

189. Defendants' testing of their promotional messages was "sophisticated enough that they were constantly refining their message to be able to deliver the best message at the best time to their target audience, this high-decile writer." Trial Tr. (6/10/19 p.m., Stone) at 53:20-54:17; S-0510.

190. Defendants specifically instructed their Oklahoma sales representatives to go to doctors' offices and told Oklahoma sales representatives what they could and could not say. *See* Trial Tr. (7/2/19 p.m., Diesselhorst) at 67:21-68:9.

191. Defendants chose which doctors and pharmacies their Oklahoma sales representatives called on and visited. *See* Trial Tr. (7/2/19 p.m., Diesselhorst) at 126:2-5.

192. Defendants trained their sales reps to target high-opioid-prescribing physicians, including pain specialists and primary care physicians. *See* S-2514; S-2515; S-2538; Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 116:04-152:25. Defendants particularly targeted primary care physicians with their opioid marketing, identifying them as "Key Customer[s]" for Defendants' pain franchise. S-2358 at 15 (defining "Prescribers" as a "Key Customer Segment"); Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 129:20-

130:23; Trial Tr. (6/12/19 p.m., Kolodny) at 115:10-14; *see also, e.g.*, Ct. Ex. 2 (Portenoy) at 213:25-214:10 (testifying that after 1996, the pharmaceutical industry targeted primary care physicians with their marketing efforts in order to convince these doctors to prescribe opioids for chronic non-cancer pain).

193. Defendants focused on high prescribers "because they prescribe tremendous amounts of opioid therapy." S-1844 at 12; Trial Tr. (6/12/19 p.m., Kolodny) at 25:06-31:03.

194. According to Defendants' documents, 63% of Duragesic prescriptions were written by primary care physicians as of 2001. S-2358; Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 133:14-22.

195. By 2003, primary care physicians continued to comprise the greatest proportion of Defendants' Duragesic business. *See* Trial Tr. (6/11/19 p.m., Kolodny) at 82:6-12.

196. Defendants' 2003 business plans included a strategic objective of "driv[ing] share with targeted Pain Specialists & PCPs [primary care physicians]." S-2359 at 26; Trial Tr. (6/11/19 p.m., Kolodny) at 87:12-23; *see also, e.g.*, S-1780; Trial Tr. (6/11/19 p.m., Kolodny) at 122:25-127:17.

197. Defendants internally tracked the "Promotion Response Curve" of Duragesic by measuring the number of incremental Duragesic prescriptions a targeted pain specialist wrote after the physician was called-on by Defendants' sales representatives. *See* S-2357 at 11. Defendants' analysis established the relationship between number of sales calls a pain specialist received from Defendants and the amount of incremental Duragesic

prescriptions the physician wrote: the more sales calls a physician received, the more Duragesic prescriptions the physician wrote. *See* S-2357 at 11; *see also* S-2357 at 12 (showing 10% and 14% increases in prescriptions written by "Decile 9 Physicians" after receiving an increased amount of Defendants' sales calls in a fiscal quarter). As such, by August 2000, Defendants had internally identified the conclusions that (i) Duragesic was "promotionally responsive" and, thus, (ii) investing Defendants' resources in targeting the "highest RX'ers [prescribers] pays off," were "[l]essons" that Defendants had "[l]earned." S-2357 at 17.

198. Defendants also targeted nurses and published information directed at nurses in pain management. *See* S-2354; Trial Tr. (6/11/19 p.m., Kolodny) at 148:09-158:25. According to one of the articles in the publication, the use of opioids was identified as an area where more education was needed for nurses. *See* S-2354; Trial Tr. (6/11/19 p.m., Kolodny) at 148:09-158:25.

199. The publication further claimed that "nurses overestimate the safety of NSAIDs." *See* S-2354 at 3; Trial Tr. (6/11/19 p.m., Kolodny) at 148:09-158:25. The publication suggested it is improper for 20% of nurses to feel uncomfortable prescribing opioids for over a year for chronic low back pain. *See* S-2354; Trial Tr. (6/11/19 p.m., Kolodny) at 148:09-158:25. Additionally, the brochure claimed that only 5% of patients taking opioids for over a year develop an addiction disorder. *See* S-2354; Trial Tr. (6/11/19 p.m., Kolodny) at 148:09-158:25.

200. Defendants trained and instructed their sales force to use studies that Defendants referred to as the "Allan Study," "Milligan Study," and "Simpson Study" in

interactions with physicians. *See, e.g.*, S-2522; S-2516; Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 91:23-94:11.

201. Defendants provided their sales force with various "visual aids" and other sales tools to use during their sales calls for Duragesic. *See, e.g.*, S-2514; S-2515; S-2538; S-2525; S-2517; S-2521; S-2523; Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 116:04-152:25.

202. These "visual aids" and other "promotional materials" were designed to help the sales force "drive home" the message with physicians that opioids were "safe and effective." Trial Tr. (6/10/19 p.m., Stone) at 53:2-19; S-0510.

203. Included as part of these sales tools were the Milligan, Allan, and Simpson Studies. *See* S-2514; S-2515; S-2538; S-2525; S-2517; S-2521; S-2523; Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 116:04-152:25.

204. Also included in the visual aids were messages about functionality and low abuse rates based on Drug Abuse Warning Network ("DAWN") data. *See* S-2514; S-2515; S-2538; S-2525; S-2517; S-2521; S-2523; *see also, e.g.*, S-1769; S-2510; S-2511.Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 116:04-152:25.

205. Defendants used this marketing material in Oklahoma. *See* S-2514; S-2515; S-2538; S-2525; S-2517; S-2521; S-2523; Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 116:04-152:25. Specifically, Defendants' Oklahoma call notes document that sales representatives distributed visual aids citing the Allan, Simpson and Milligan studies at least thousands of times, including, at a minimum: (i) 726 times between June 2002 and December 2002; (ii) 1,683 times in 2003; and (iii) 754 times in 2004. *See* S-2481 – S-

2492; *see also* Ct. Ex. 223 (illustrating data). Defendants' Oklahoma call notes further document their sales representatives using the Allan, Simpson and Milligan studies over 1,000 times in sales visits to Oklahoma doctors between 1998 and 2004. *See* S-2481 – S-2492; *see also* Ct. Ex. 223 (illustrating data).

206. The representations in these marketing materials related to functionality and low abuse rates, DAWN data, and the Milligan, Allan, and Simpson Studies, were later described as false and misleading by the FDA. *See, e.g.*, S-0038; *see also* Section F.3, *infra.* Defendants funded each of these studies. S-2517; S-2521; S-2523; Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 152:23-152:25.

207. Defendants did not educate or specifically train their sales representatives on addiction to opioids. Trial Tr. (5/31/19 p.m., J&J: Deem-Eshleman) at 133:02-05; *see also, e.g.*, Trial Tr. (7/2/19 p.m., Diesselhorst) at 53:1-2.

208. One of Defendants' former Oklahoma opioid sales representatives, who sold Ultram ER, did not know or remember: (i) what the risk of addiction for Ultram ER was; (ii) if Ultram ER fixed the underlying problem of pain; (iii) whether Ultram ER carried a risk of tolerance, abuse or dependency; (iv) what the rate of iatrogenic addiction to opioids is; and (v) whether an opioid can cure chronic back pain. *See* Trial Tr. (7/2/19 p.m., Diesselhorst) at 56:23-57:3, 57:6-14, 60:9-12, 91:6-18, 93:8-17. Ms. Diesselhorst also did not recall Defendants ever telling her about a conservative approach to pain management. *See* Trial Tr. (7/2/19 p.m., Diesselhorst) at 47:17-48:2.

209. Defendants' sales representatives were not experts in addiction or the coined concept of "pseudoaddiction." Trial Tr. (5/31/19 p.m., J&J: Deem-Eshleman) at 133:14-15.

210. Defendants' sales representatives were not experts in the "abuse" of opioid drugs. Trial Tr. (5/31/19 p.m., J&J: Deem-Eshleman) at 133:16-17.

211. Defendants' sales representatives were not pain experts. *See, e.g.*, Trial Tr. (7/2/19 p.m., Diesselhorst) at 48:15-17; S-1162; S-0223; *see also, e.g.*, Trial Tr. (7/8/19 p.m., Halford) at 56:11-19 (testifying that pharmaceutical sales representatives are not experts in pain management and holding them out as such is nonsense).

212. Defendants did not train their sales representative regarding red flags that could indicate a "pill mill," including, for example, pain clinics with patients lined up out the door or patients passed out in the waiting room. *See* Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 29:07-09; Trial Tr. (7/2/19 p.m., Diesselhorst) at 86:22-87:7, 170:6-172:6.

213. Defendants trained their sales representatives to visit pharmacies to ensure the pharmacies stocked the drugs the representatives were marketing and promoting. *See* Trial Tr. (7/2/19 p.m., Diesselhorst) at 121:19-122:18.

214. Defendants tracked the results of their opioid sales force (*i.e.*, through prescriptions written and ultimately filled in Oklahoma). *See* Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 68:10-69:09.

215. Sales representatives were ranked based on either market share or volume of prescriptions. *See* Trial Tr. (5/29/19 p.m., J&J: Deem-Eshleman) at 31:08-12.

216. Defendants' sales representatives' compensation went up or down depending on the prescribing behavior of their target doctors. *See* Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 69:10-70:07. Defendants' former Oklahoma sales representative, Ms. Diesselhorst, testified that if the Oklahoma doctors she called on "wrote a prescription, [she] would get a bonus." Trial Tr. (7/2/19 p.m., Diesselhorst) at 167:23-168:3; *see also* S-0106.

217. Defendants paid their sales force based on an incentive-based compensation structure. *See* Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 59:09-23. Bonus compensation increased based on the amount of prescriptions, and it did not matter if those prescriptions were appropriate or inappropriate. *See* Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 59:09-23.

218. Defendants' sales representatives' compensation was based on the number of prescriptions written, sold and paid for. *See* Trial Tr. (7/2/19 p.m., Diesselhorst) at 126:12-16, 135:19-25. Defendants' sales representatives did not get credit for a prescription unless their target doctor prescribed the drug and the pharmacy filled the prescription. *See* Trial Tr. (7/2/19 p.m., Diesselhorst) at 125:23-126:1. The prospect of Defendants paying them bonus money motivated Oklahoma sales representatives to sell more opioid prescriptions. *See, e.g.*, Trial Tr. (7/2/19 p.m., Diesselhorst) at 131:6-132:7; S-3955; S-0106.

219. Defendants' former Oklahoma sales representative, Ms. Diesselhorst, testified that Defendants' sales representatives visited Oklahoma doctors' offices to educate, sell and inform. *See* Trial Tr. (7/2/19 p.m., Diesselhorst) at 109:12-15. If a doctor

wrote a prescription for the drug that one of Defendants' sales representative was promoting, then the sales representative correctly did their job and "educated" the doctor. *See, e.g.*, Trial Tr. (7/2/19 p.m., Diesselhorst) at 98:2-22 (testifying that based on her training from Defendants, "if a doctor wrote a script, . . . then he learned something from [Ms. Diesselhorst]").

220. Defendants also relied on consultant companies like McKinsey & Company ("McKinsey") at times to develop marketing strategies for Defendants' sales force. *See* Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 26:18-27:01; S-1252; S-1253.

221. Defendants worked with McKinsey to identify "priority growth opportunities" for Duragesic in the chronic pain market and to develop strategies for growth. *See* Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 27:08-28:20.

222. In a presentation provided by McKinsey while acting as Defendants' consultant, the document investigated: "Are we properly targeting and influencing prescription behavior in the pain clinic?" S-1253; Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 35:19-36:11. The presentation discusses different ways to influence prescribing behavior. S-1253; *see, e.g.*, Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 40:19-47:21. Defendants' corporate representative testified that Defendants' marketing strategies were geared towards "education." *See, e.g.*, Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 46:16-19. This "education" could include, among other sources: (1) visits from Defendants' sales representatives; (2) speaking events from Defendants' paid speakers; (3) research articles funded by Defendants; and (4) KOLs paid by Defendants. Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 43:15-44:14.

223. One of the strategies listed to "increase share of patients shifting from immediate-release to sustained-release opioids captured by Duragesic" was to "target high abuse-risk patients (e.g., males under 40)." S-1253.

224. Defendants utilized a coupon program as a marketing tool for Duragesic. S-2366; Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 66:18-79:08; *see also* S-0582. One of Defendants' Oklahoma sales representatives for described Defendants' coupon program as a "great marketing tool," and an "excellent opportunity to change the opinions of physicians that do not write much Duragesic." S-2366.[28]

225. Defendants further described coupons as a great way to "start new patients on Duragesic." S-1844; Trial Tr. (6/12/19 p.m., Kolodny) at 25:06-31:03.

226. Defendants described the coupon program as a way to motivate doctors to begin using Duragesic on new patients. *See* S-1844; Trial Tr. (6/12/19 p.m., Kolodny) at 25:06-31:03.

227. According to the Coupon Program Study Guide & FAQs, "The DURAGESIC Coupon Program was introduced in the first cycle of 2000 as an innovative approach to targeted selling. Those representatives who have implemented it with their targeted (chronic pain decile 5.0 to 9.0) high prescribers have seen their patient start with

[28] Defendants' corporate representative, Ms. Deem-Eshleman, testified that she disagreed with the characterization of the coupon program as investment upon which they expected a "return." Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 69:17-19, 70:15-23. However, Defendant's' "Tactical Review" for the year 2002 specifically stated that Defendants had analyzed a "13 to 1" "Return On Investment" for the "sample voucher program." S-0582; *see also* Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 71:11-72:19.

one free box of DURAGESIC, the Coupon Program gives doctors the opportunity to experience first-hand the best DURAGESIC has to offer." S-1844.

228. Defendants similarly used sample voucher programs, in which a sales representative delivered to a physician a "sample voucher for a box of 25mcg or 50mcg patches redeemed at pharmacy for a free 15-day trial of DURAGESIC." S-1358 at 14. The objective of this sample voucher program was to "[i]nitiate trials of DURAGESIC earlier in the chronic pain treatment continuum." S-1358 at 14. One of the measures for the success of the program was "incremental TRx's [total prescriptions] per targeted physician." S-1358 at 14. In 2003, Defendants stated that one of the "[l]essons [l]earned" was that this sample voucher program "br[ought] in new patient starts and should be continued." S-1358 at 11. Between March 2001 and March 2002, the program had yielded: (i) "1.53 Rx/physician"; and (ii) "$44MM sales." S-1358 at 11.

229. As a corollary to their efforts to "start" patients on Duragesic, including by using coupons, Defendants' 2003 Duragesic Business Plan, dated July 2002, identified as a strategic initiative the need to "[r]educe gap in patient drop-off" or retain patients on Duragesic. *See* S-2359. It further states that "[e]xtending patient duration on DURAGESIC represents an opportunity for incremental sales." S-2359; Trial Tr. (6/11/19 p.m., Kolodny) at 81:3-18. To do so, the business plan identifies the message: "Starting and Staying on DURAGESIC." S-2359.

230. Defendants' sales force specifically conducted market research to generate strategies for reducing the rate of patients dropping off Duragesic within the first two

months of treatment—*i.e.*, how to keep patients on fentanyl for a longer duration. S-3962; Trial Tr. (5/30/19 p.m., J&J: Deem-Eshleman) at 51:17-52:01.

231. The marketing message, "Start With, Stay With," was successfully used decades before by the tobacco industry and was "recycled" by the opioid industry, including both Defendants and Purdue. *See* Trial Tr. (6/10/19 p.m., Stone) at 63:1-66:14; S-1213. Defendants' corporate representative, Ms. Deem-Eshleman, stated she had no knowledge of the company using the "Start with, Stay with" slogan for the company's opioids. Trial Tr. (5/31/19 a.m., J&J: Deem-Eshleman) at 72:17-25. However, in a November 2002 Purdue document in which a Purdue sales team evaluated Defendants' Duragesic marketing in their area, the Purdue sales team complained about and objected to the fact that Defendants had been using the "start with, stay with" messaging for Duragesic. *See* S-1802; Trial Tr. (6/11/19 p.m., Kolodny) at 55:09-58:17; *see also, e.g.*, S-2359 (July 2002 Duragesic Business Plan, stating, "Starting and Staying on DURAGESIC").

232. Another program Defendants utilized to reduce the patient drop off rate for Duragesic was called "making connections." *See* S-3960, 3961; Trial Tr. (6/12/19 p.m., Kolodny) at 19:17-24:23. This program specifically identified ways to market in order to keep patients on continued opioid therapy for the first 90 days after their first use. *See* S-3961; S-3960; Trial Tr. (6/12/19 p.m., Kolodny) at 19:17-24:23.

233. Research demonstrates that if a patient takes an opioid every day for 90 days, then more than half of those patients will still be on opioids five years later. *See* Trial Tr. (6/12/19 p.m., Kolodny) at 19:17-24:23. Defendants' marketing to keep patients on Duragesic longer than 90 days was dangerous. *See id.*

234. Defendants also paid for their sales representatives to bring lunch to Oklahoma doctors and their staff and discuss the drug the representatives were promoting. *See* Trial Tr. (7/2/19 p.m., Diesselhorst) at 164:16-25; *see also* S-1161. Defendants' Oklahoma sales representatives brought breakfast, lunch, coffee and snacks to Oklahoma doctors' offices and used speaker programs as part of their sales strategies. *See* Trial Tr. (7/2/19 p.m., Diesselhorst) at 184:1-185:19; *see also* S-4497 (collection of excerpts from Ms. Diesselhorst's Oklahoma call notes).

235. Defendants' sales representatives called on Oklahoma medical professionals hundreds of thousands of times while selling opioids. *See* S-2481 – S-2492. The State introduced into evidence 35 boxes of call notes from Defendants' Oklahoma sales representatives over the last two decades. *See* S-2481 – S-2492. The substance of these 100,000-plus interactions between Defendants' sales representatives and Oklahoma medical professionals is discussed in detail below. *See* Section F.4, *infra*. Suffice it to say, however, Defendants' opioid sales representatives flooded the State of Oklahoma to sell their drugs.

236. The goal of the false and misleading statements and omissions made by these representatives and in the materials they referenced was to try to get doctors more comfortable prescribing more opioids generally and to influence their behavior by convincing them to increase the number of opioids prescribed. This aggressive promotion was misleading and flies in the face of the conservative nature in which opioids should be utilized and what is stated in their labels. At all times, Defendants trained, paid, incentivized, dictated call plans for, set targets for, imposed quotas on, and provided all

data and promotional materials that were to be used by, its sales representatives in Oklahoma. *See* Trial Tr. (5/31/19 p.m., J&J: Deem-Eshleman) at 134:05-136:17.

(2) Leveraging Third Parties, KOLs and Advocacy Groups to Sell Drugs

237. Another effective way to influence through marketing is to have trusted third-parties deliver a message or make recommendations. Trial Tr. (6/10/19 p.m., Stone) at 32:14-33:6. This is also called "word of mouth" advertising. Trial Tr. (6/10/19 p.m., Stone) at 32:14-33:6.

238. Because sales messages delivered by sales representatives to physicians would sometimes lack credibility, Defendants leveraged seemingly independent third parties to help deliver Defendants' sales messages. Ct. Ex. 2 (Portenoy) at 251:11-253:16; *see also, e.g.*, S-904 at 2. In particular, Defendants used KOLs and various advocacy groups to market opioids. *See, e.g.*, Trial Tr. (6/10/19 p.m., Stone) at 32:14-33:6; Ct. Ex. 2 (Portenoy) at 251:11-253:16; Trial Tr. (6/12/19 p.m., Kolodny) at 42:24-43:6.

239. Defendants worked with KOLs and advocacy groups, as well as other third parties over whom they have exerted significant influence, to change the culture of opioid prescribing in the United Sates. *See* Trial Tr. (6/13/19 a.m., Kolodny) at 31:13-32:03.

240. Defendants used KOLs and advocacy groups as part of their marketing plan for the commercial purpose of increasing sales of their opioid products and opioids generally. *See, e.g.*, S-0982; Trial Tr. (6/12/19 p.m., Kolodny) at 44:15-45:03. For example, in an internal email, one of Defendants' employees, when discussing how to

categorize KOLs, asked whether "a sweetie who just isn't putting out for you shouldn't qualify as an advocate?" S-0461; *see* Trial Tr. (6/12/19 p.m., Kolodny) at 52:09-55:02.

241. Defendants "leverage[ed]" KOLs and advocacy groups to dispel fears surrounding opioid addiction. S-0982; *see* Trial Tr. (6/12/19 p.m., Kolodny) at 47:10-47:25.

242. For example, a presentation entitled "Duragesic KOL Mapping Analysis" that was provided to Defendants by their consultant stated the following business objective: "to target the most influential physicians in Pain management, and to maximize DURAGESIC prescribing that is produced by physicians who are influenced by thought leaders." S-1372; *see* Trial Tr. (6/12/19 p.m., Kolodny) at 55:14-57:05. As indicated by the title, "thought leaders" refers to KOLs.

243. Opioid manufacturers, including Defendants, often provided support and funding indirectly to these third parties by working through PR firms or other agencies. Trial Tr. (6/12/19 p.m., Kolodny) at 96:13-104:20.

244. Defendants' use of KOLs and advocacy groups was a key component of Defendants' multifaceted marketing campaign because it included eminent pain specialists, professional societies and all areas of the field. Trial Tr. (6/11/19 a.m., Kolodny) at 77:16-78:21.

245. As part of their marketing strategy, Defendants also used these doctors and groups, among many others, to put on "speaker bureaus and programs," including in Oklahoma. *See* Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 61:05-61:22. "That would be a peer-to-peer speaker program." Trial Tr. (5/31/19 a.m., J&J: Deem-Eshleman)

at 25:16-19. A member of a "speaker program" or "speaker bureau" is a doctor who is paid to give talks on behalf of the pharmaceutical company. *See* Trial Tr. (6/13/19 a.m., Kolodny) at 89:15-90:04. Defendants controlled the content of these speaker bureau programs—Defendants created the presentations, provided the materials and trained the speakers on the materials to be used during the programs. *See, e.g.*, Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 61:5-61:22.

246. At these speaker programs, Defendants would often provide dinners, lunches, and similar things. *See* Trial Tr. (5/30/19 a.m., J&J: Deem-Eshleman) at 62:12-22. Defendants paid for a multitude of meals, lunches and other promotional items and speaking engagements in Oklahoma. *See* S-3080; Trial Tr. (6/13/19 a.m., Kolodny) at 92:13-25.

247. Indeed, Defendants made thousands of payments to Oklahoma doctors by way of speaker fees, gifts, honoraria, and meals. *See* S-3080 (extensively listing examples of such payments by Defendants in Oklahoma).

248. Defendants also directly and indirectly paid significant funds to KOLs, including Charles Argoff, Keith Candiotti, Perry Fine, Scott Fishman, Kathleen Foley, Bill McCarberg, Steven Passik, Richard Payne, Russell Portenoy, and Lynn Webster. *See* S-1350; *see also, e.g.*, Trial Tr. (5/29/19 p.m., J&J: Deem-Eshleman) at 20:05-14.[29]

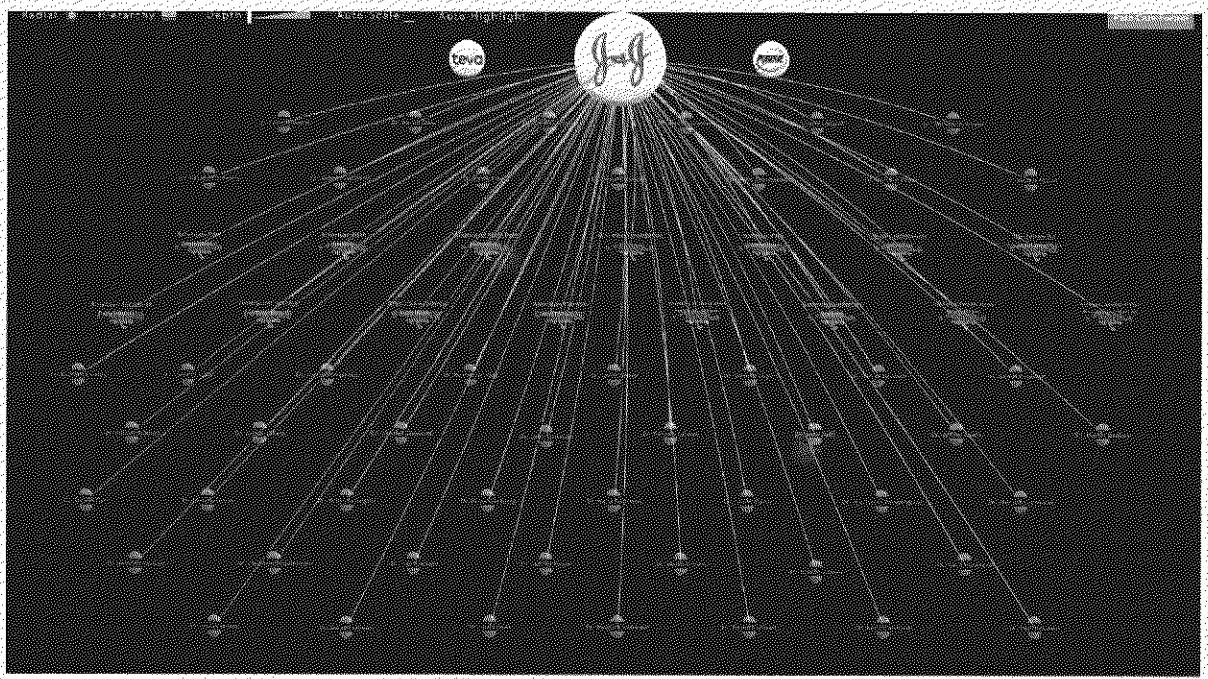
249. Defendants also made substantial payments of money to a variety of different pain advocacy groups and organizations, including the American Academy of Pain

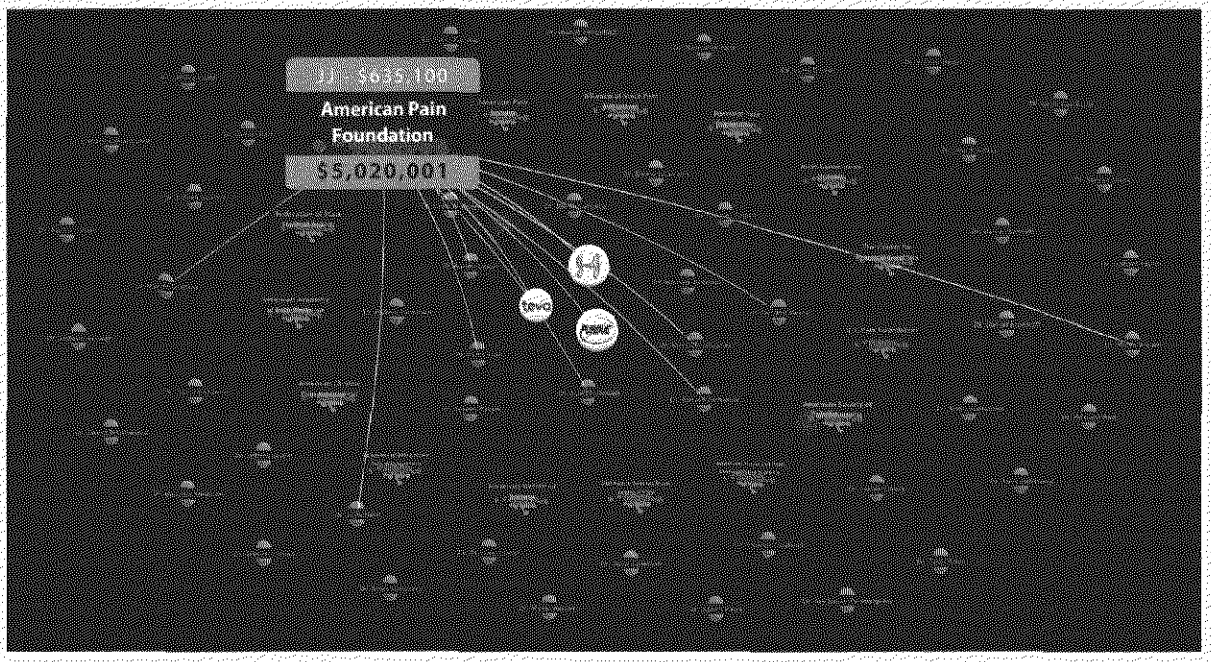
[29] Defendants acknowledged that they did not list all of their paid KOLs in S-1350. *See* Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 123:01-124:10

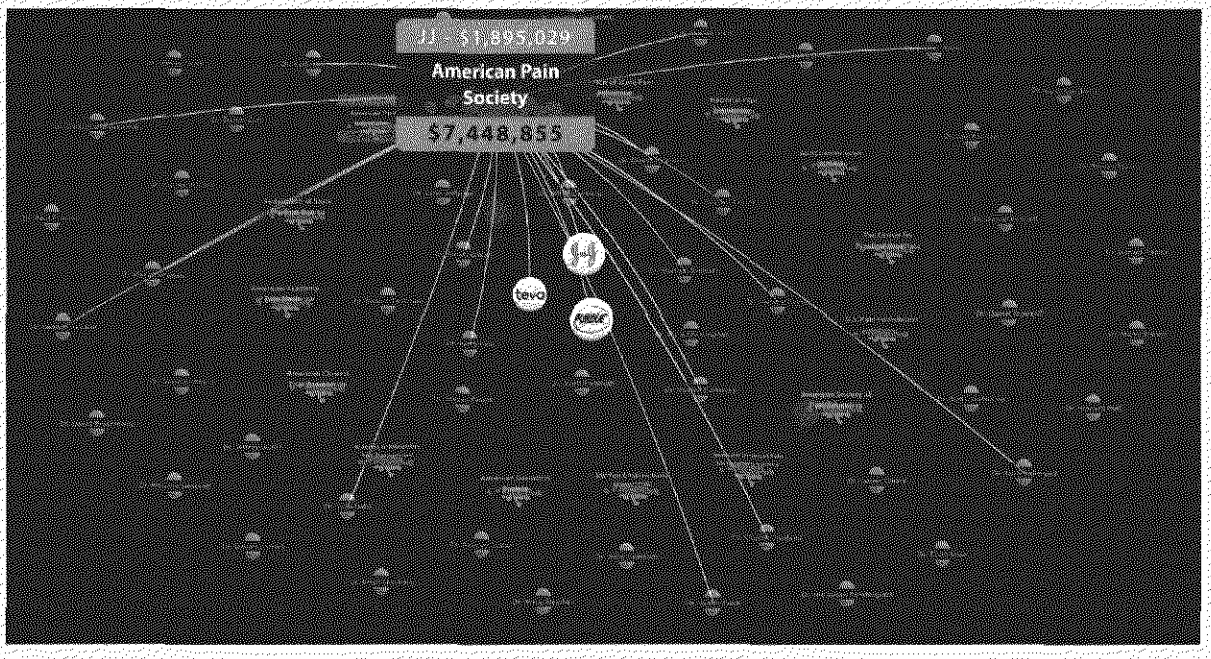
Medicine ("AAPM"), American Pain Society ("APS"), American Pain Foundation ("APF"), American Geriatrics Society, American Chronic Pain Association, National Pain Foundation, Pain and Policies Study Group ("PPSG"), Pain Care Forum, American Society of Pain Management Nursing, American Academy of Pain Management/Academy of Integrative Pain Management ("AIPM"), Center for Practical Bioethics, and Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). *See, e.g.*, S-1349 (listing payments). Defendants identified at least the following payments or contributions they made to these organizations:

Organization	**Payment / Contribution**
American Academy of Pain Medicine	$ 573,570.00
American Pain Society	$ 1,895,029.00
American Pain Foundation	$ 635,100.00
American Geriatrics Society	$ 605,626.00
American Chronic Pain Association	$ 100,000.00
The National Pain Foundation	$ 805,000.00
Pain and Policies Study Group	$ 155,840.00
American Society of Pain Management Nursing	$ 329,824.00
Academy of Integrative Pain Management	$ 265,855.00
The Center for Practical Bioethics	$ 23,000.00
The Joint Commission	$ 545,244.00

See S-1349. At trial, the State illustrated the ties between Defendants and the many third parties Defendants leveraged for marketing purposes through a graphic that presented data regarding each third party and their ties with others upon a touch of the screen (*see* Ct. Ex. 58, discussed in Trial Tr. (6/12/19 p.m., Kolodny) at 153:21-161:4; Trial Tr. (6/13/19 a.m. Kolodny) at 5:6-32:3):







250. Dr. Russell Portenoy was Defendants' No. 1 ranked, top-listed KOL. *See* S-0967; Trial Tr. (5/29/19 p.m., J&J: Deem-Eshleman) at 19:10-12.

251. Throughout his career, Dr. Portenoy was "involved in a lot of work funded by" Defendants, as well as Purdue and Teva. Ct. Ex. 2 (Portenoy) at 120:2-8. For example,

Dr. Portenoy was paid to be a speaker or advisor to many pharmaceutical companies that make opioid products, including Defendants, Purdue and Cephalon. Ct. Ex. 2 (Portenoy) at 14:17-15:13. In particular, Defendants paid Dr. Portenoy to serve as a speaker in relation to programs related to Defendants' opioid drug, Duragesic. Ct. Ex. 2 (Portenoy) at 138:12-15. When doctors were paid by these drug companies to deliver messages at "speakers bureaus[,]" those messages would favor the drugs "created by those drug companies." Ct. Ex. 2 (Portenoy) at 72:23-73:7. For example, in describing their opioid drug, Nucynta, as "[h]ighly promotionally sensitive" in their marketing materials and business plans, Defendants acknowledged that such "[s]peaker programs often trigger[ed] first use" of Nucynta by physicians. S-0880 at 8;[30] *see also* Ct. Ex. 2 (Portenoy) at 75:18-23. Defendants' acknowledgement that first use of their opioids could be triggered by speakers that Defendants paid is consistent with Dr. Portenoy's understanding that these speaker programs were put on by drug companies, like Defendants, "to help them sell more drugs[.]" Ct. Ex. 2 (Portenoy) at 77:3-22.

252. Dr. Portenoy understood his relationship with "pharma companies to be one in which they would use [his] expertise to expand educational opportunities." Ct. Ex. 2 (Portenoy) at 239:1-3. He was not aware of any "vision" by these companies to use Key Opinion Leaders ("KOLs") like himself "in marketing strategies," and he believed "it is wrong to do" so. Ct. Ex. 2 (Portenoy) at 239:4-10, 260:6-261:15. A company "that sells a

[30] S-0880, 'Defendants' "Nucynta & Nucynta ER 2012 Business Plan," was admitted into evidence over no objection. *See* Trial Tr. (5/30/19 p.m.) at 8:15-21.

drug cannot and should not use a KOL or speaker for the intended purpose of selling more of that company's drugs," according to Dr. Portenoy. Ct. Ex. 2 (Portenoy) at 239:12-17.

253. Dr. Portenoy was involved with the APS, having served on the APS board and a term as the president of APS. Ct. Ex. 2 (Portenoy) at 15:17-16:1; S-0879 at ¶37. Defendants and other opioid manufacturers provided funding to APS. Ct. Ex. 2 (Portenoy) at 16:2-6.

254. Dr. Portenoy also was involved with the APF and served on the APF board. Ct. Ex. 2 (Portenoy) at 19:3-7; S-0879 at ¶37. Defendants and other opioid manufacturers provided funding to APF. Ct. Ex. 2 (Portenoy) at 19:8-11.

255. The APF began with seed funding from Purdue and received funding from Defendants and other opioid manufacturers within its first year of operations. Trial Tr. (6/12/19 p.m., Kolodny) at 43:13-44:11. The APF depended on funds from opioid manufacturers, including Defendants, to operate. Ct. Ex. 2 (Portenoy) at 61:8-17. From 2000 through 2012, while Dr. Portenoy was a board member of the APF, the APF was funded primarily by pharmaceutical company grants. Ct. Ex. 2 (Portenoy) at 199:2-13. In or around 2012, a committee of the U.S. Senate requested information from APF about the sources of its funding. Ct. Ex. 2 (Portenoy) at 61:18-21. Following the receipt of this request, APF stopped taking money from opioid manufacturers. Ct. Ex. 2 (Portenoy) at 61:22-62:1. Without this funding, APF thereafter was no longer able to exist. Ct. Ex. 2 (Portenoy) at 62:2-4; S-0879 at ¶38. The APF did not respond to the U.S. Senate inquiry and went out of business soon after receiving the inquiry. Ct. Ex. 49 (Rosen) at 236:11-240:3.

256. The APF also was a member of the Pain Care Forum and received funding from Teva and Purdue, in addition to Defendants. APF worked with a number of KOLs, including June Dahl and Aaron Gilson from PPSG. *See* Trial Tr. (6/12/19 p.m., Kolodny) at 157:18-161:04; Trial Tr. (6/13/19 a.m., Kolodny) at 5:20-6:14.

257. Internally, Defendants identified the APF as Defendants' "Go to Partner." S-1224; S-1191; Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 104:05-105:23. The document also lists several other pain groups and advocacy partners to whom Defendants provided funding. S-1191; Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 104:05-107:06; *see also* S-1349.

258. Defendants worked with the APF to support and promote materials that encouraged patients to seek out a doctor who would prescribe what the patient wanted if another doctor refused. *See* S-1227; Trial Tr. (6/12/19 p.m., Kolodny) at 73:24-77:24. For example, the brochure includes a section entitled "Setting the Record Straight on Addiction" which states: "Many people living with pain—and even some healthcare providers—falsely believes opioids are universally addictive. Studies and clinical practice have shown that the risk of addiction is small when these medications are appropriately prescribed and taken as directed." S-1227; Trial Tr. (6/12/19 p.m., Kolodny) at 78:21-79:17. The brochure further states: "Unless you have a past or current history of substance abuse, the chance of addiction is low when these medications are prescribed properly and taken as directed." S-1227; Trial Tr. (6/12/19 p.m., Kolodny) at 81:04-16.

259. The APF did not focus on, or pursue activities or projects focused on, the rising problem of opioid overdose. Ct. Ex. 2 (Portenoy) at 199:19-22; S-0879 at ¶38. The

APF's dependence on funding from opioid manufacturers "influenced the types of projects that could be pursued" and "may have constrained the ability of APF to take positions that would be disadvantageous to industry." S-0879 at ¶38; Ct. Ex. 2 (Portenoy) at 200:17-22.

260. For example, one of Defendants' sales and marketing memoranda for the year 2001 advised Defendants' sales representatives that "[i]t is important to remind physicians that APS, AAPM, and AGS have all endorsed the appropriate use of opioids to manage chronic nonmalignant pain." S-903 at 1.

261. The idea that information created by Dr. Portenoy or APS "for education were also being used for marketing without appropriate caveats and statements of risk" and in order to "sell more drugs" made Dr. Portenoy "very uncomfortable" and was "wrong" and "improper." Ct. Ex. 2 (Portenoy) at 246:22-249:14.

262. In December 2010, Defendants requested permission to reproduce and disseminate several APF "TARGET Chronic Pain" materials, including a "Notebook," "Provider Card" and "Top 10 Tips." *See* S-1249; Trial Tr. (6/12/19 p.m., Kolodny) at 81:24-86:18. The Provider Card states "When prescribed by a healthcare professional and taken as directed, opioids are safe, effective and rarely lead to addiction." S-1249; Trial Tr. (6/12/19 p.m., Kolodny) at 81:24-86:18. The document also directs doctors to the Responsible Opioid Prescribing book authored by another KOL, Scott Fishman, and discussed further below. *See* S-1249.

263. At times, Defendants would use links on the APF's website to ultimately link back to their own opioid websites. *See* S-0973; Trial Tr. (6/12/19 p.m., Kolodny) at 87:10-90:08.

264. Two organizations that Defendants funded, the AAPM and APS, issued a "Consensus Statement" in 1996 that was drafted by a committee that included Robert Angarola, an attorney who at one time represented Defendants on opioid-related issues. *See* S-0900; Trial Tr. (6/11/19 p.m., Kolodny) at 20:10-39:8. Specifically, the Consensus Statement was written by a committee including David Haddox (former Purdue Pharma medical director), David Joranson (founder of PPSG), Richard Payne (KOL, co-leader of Defendants' NPEC program, discussed below), Matthew Midcap (who had a financial relationship with Defendants), Daniel Carr (who had a financial relationship with Defendants), and Robert Angarola (outside counsel to Defendants in 1990 related to thebaine imports from Tasmania). Dr. Portenoy consulted on the Consensus Statement as well. Trial Tr. (6/11/19 p.m., Kolodny) at 41:03-44:24.

265. The Consensus Statement suggests that pain is undertreated and doctors should prescribe more opioids. S-0900; Trial Tr. (6/11/19 p.m., Kolodny) at 20:10-39:08.

266. The Consensus Statement described a fear of addiction, regulatory action and diversion as "impediments" to the use of opioids. S-0900; Trial Tr. (6/11/19 p.m., Kolodny) at 20:10-39:08.

267. The Consensus Statement states that "Studies indicate that de novo development of addiction when opioids are used for the relief of pain is low." S-0900; Trial Tr. (6/11/19 p.m., Kolodny) at 20:10-39:08.

268. The Consensus Statement states that "Fear of inducing respiratory depression is often cited as a factor that limits the use of opioids in pain management. It is not accepted by practitioners of the specialty of pain medicine that respiratory depression induced by

opioids tends to be a short-lived phenomenon, generally occurs only in the opioid-naïve patient, and is antagonized by pain. Therefore, withholding the appropriate use of opioids from a patient who is experiencing pain on the basis of respiratory concerns is unwarranted." S-0900; Trial Tr. (6/11/19 p.m., Kolodny) at 20:10-39:08.

269. The Consensus Statement states that "It was previously thought that the development of analgesic tolerance limited the ability to use opioids efficaciously on a long-term basis for pain management. Tolerance, or decreasing pain relief with the same dosage over time, has not proven to be a prevalent limitation to long-term opioid use. Experience with treating cancer pain has shown that what initially appears to be tolerance is usually progression of the disease. Furthermore, for most opioids, there does not appear to be an arbitrary upper dosage limit, as was previously thought." S-0900; Trial Tr. (6/11/19 p.m., Kolodny) at 20:10-39:08.

270. Defendants actively promoted the Consensus Statement, ratifying and repeating its statements in Defendants' own marketing. *See, e.g.*, S-0760 ("According to the *Consensus Document* referenced above, studies indicate that the de novo development of addiction when opioids are used for the relief of pain is low.")

271. After AAPM and APS issued the Consensus Statement, Defendants' contributions to APS increased by almost eight hundred percent in 1996 and then increased again in 1997. *See* S-1349; Trial Tr. (6/3/19 a.m., J&J: Deem-Eshleman) at 118:05-10. Defendants' payments to APS increased from $10,000 in 1995 to $480,000 in 1998. *See* S-1349; Trial Tr. (6/11/19 p.m., Kolodny) at 47:05-17. In total, Defendants paid approximately $1.895 million to the APS. Similarly, from 1995 to 1997, Defendants'

payments to AAPM increased from $875 to $43,000. *See* S-1349; Trial Tr. (6/11/19 p.m., Kolodny) at 47:05-17.

272. The State illustrated the increase in Defendants' payments to these organizations following their issuance of the Consensus Statement (Ct. Exs. 53-54):