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24 SUPERIOR COURT OF THE STATE OF CALIFORNIA

25 IN AND FOR THE COUNTY OF ORANGE

26 THE PEOPLE OF THE STATE OF
27 CALIFORNIA, acting by and through Santa
28 Clara County Counsel Orry P. Korb and Orange
County District Attorney Tony Rackauckas,

Plaintiff,

v.

PURDUE PHARMA L.P.; PURDUE, INC.;
THE PURDUE FREDERICK COMPANY, INC.;
TEVA PHARMACEUTICAL INDUSTRIES,
LTD.; CEPHALON, INC.; JOHNSON &
JOHNSON; JANSSEN PHARMACEUTICALS,
INC.; ENDO HEALTH SOLUTIONS INC.;
ACTAVIS, PLC; AND DOES 1 THROUGH
100, INCLUSIVE,

Defendants.

No.

COMPLAINT FOR VIOLATIONS OF
CALIFORNIA FALSE ADVERTISING
LAW, CALIFORNIA UNFAIR
COMPETITION LAW, AND PUBLIC
NUISANCE, SEEKING RESTITUTION,
CIVIL PENALTIES, ABATEMENT, AND
INJUNCTIVE RELIEF

TABLE OF CONTENTS

Page

I. INTRODUCTION 1

II. JURISDICTION AND VENUE..... 6

III. PARTIES 7

 A. Plaintiff..... 7

 B. Defendants 7

IV. FACTUAL ALLEGATIONS..... 10

 A. Before Defendants’ Deceptive Marketing Campaign, Opioids Were Rarely Prescribed by Physicians Because of Their Known Serious Side Effects and Substantial Risk of Addiction..... 10

 B. Defendants’ Marketing of Opioids for Long-Term Use to Treat Chronic Non-Cancer Pain was False, Misleading, Imbalanced, and Unsupported by Science 11

 1. Defendants’ misrepresentations regarding the benefits of opioids for chronic pain. 13

 2. Defendants’ misrepresentations regarding the adverse outcomes and risks of opioids. 18

 a. Risk of addiction and abuse..... 18

 (1) Minimizing the risk of addiction. 19

 (2) Claiming the risk of addiction can be identified and managed..... 21

 (3) Deflecting attention to “undertreated” pain..... 23

 (4) Physical dependence vs. addiction. 24

 (5) Pseudoaddiction..... 27

 b. Other adverse effects. 30

 3. Misrepresentations regarding superiority. 34

 C. Defendants, Directly and Through Their Agents and Front Organizations, Made and Caused Their Misrepresentations to Be Made and Broadly Disseminated 35

 1. Method 1: Key opinion leaders (“KOLs”). 36

 2. Method 2: Co-opting of chronic pain advocacy and research groups to promote opioid use. 39

1	a.	American Pain Foundation.....	40
2	b.	American Academy of Pain Medicine.....	42
3	3.	Method 3: Treatment guidelines.....	43
4	4.	Method 4: Continuing medical education.....	47
5	5.	Method 5: Scientific articles.....	51
6	6.	Method 6: Patient education.....	52
7	(1)	Elderly patients.....	54
8	(2)	Veterans.....	55
9	D.	Defendants Often Acted Together in Promoting Opioids, Opposing Regulation, and Facilitating Supportive Standards to Approve Opioids.....	57
10	E.	Defendants Also Acted Individually to Deceptively Promote Their Opioids for Chronic Pain.....	59
11	1.	Cephalon fraudulently marketed Actiq and Fentora.....	60
12	a.	Cephalon launches its fraudulent marketing scheme of Actiq.....	60
13	b.	Cephalon engaged in deceptive, off-label marketing efforts to expand the use of Actiq.....	61
14	c.	Government investigations also confirm Cephalon’s deceptive marketing strategy.....	63
15	d.	Cephalon attempted to cover-up evidence of its deceptive, unlawful scheme.....	64
16	e.	Cephalon fraudulently marketed Actiq’s successor drug, Fentora.....	65
17	f.	October 1, 2006 – Cephalon launches Fentora and immediately begins deceptive marketing campaign.....	66
18	g.	September 2007 – Reports of death and serious side effects lead the FDA to issue a public health warning for Fentora.....	67
19	h.	Cephalon sponsored CMEs used to promote the off-label use of Actiq and Fentora – 2007-2008, in spite of the FDA warnings.....	68
20	i.	May 6, 2008 – The FDA rejects Cephalon’s request for expanded approval of Fentora.....	69
21	j.	March 26, 2009 – the FDA’s Division of Drug Marketing, Advertising and Communications (“DDMAC”) warned Cephalon about its misleading advertising of Fentora.....	70
22	k.	Cephalon continues to knowingly, deceptively, and illegally promote Fentora for off-label uses.....	71
23			
24			
25			
26			
27			
28			

1
2
3
4
5
6
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8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

2. Purdue’s role in deceptively promoting opioids for treatment of chronic pain. 72

 a. Purdue’s marketing of OxyContin was deceptive from the start. 72

 b. Purdue continued to engage in false marketing, misrepresenting OxyContin’s benefits and the risk of addiction when taken long-term for chronic pain..... 75

 c. Purdue was aware of, and has profited from, misuse and diversion of its opioids. 75

F. Defendants Knew That Their Marketing of Chronic Opioid Therapy Was False, Unfounded, and Dangerous and would Harm California Residents 77

G. Defendants Fraudulently Concealed their Misrepresentations..... 78

H. Defendants’ Fraudulent and Deceptive Marketing of Opioids Directly Caused Harm to California Communities 80

FIRST CAUSE OF ACTION FALSE ADVERTISING Violations of California Business and Professions Code Section 17500, *et seq.* 86

SECOND CAUSE OF ACTION UNFAIR COMPETITION Violations of the Unfair Competition Law, California Business and Professions Code Section 17200..... 91

THIRD CAUSE OF ACTION PUBLIC NUISANCE Violations of California Civil Code Section 3479, *et seq.*..... 94

V. PRAYER FOR RELIEF 97

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
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I. INTRODUCTION

1. A pharmaceutical manufacturer should never place its desire for profits above the health and well-being of its customers. When marketing a drug, a pharmaceutical manufacturer must tell the truth, which means ensuring that its marketing claims are supported by science and medical experience. Defendants broke these simple rules.

2. By the 1990s, Defendants had the ability to cheaply produce massive quantities of opium-like painkillers (“opioids”), but the market was small. Defendants knew that opioids were effective treatments for short-term post-surgical and trauma-related pain, and for palliative (end-of-life) care. They knew – and had known for years – that opioids were too addictive and too debilitating for long-term use for chronic non-cancer pain (pain lasting three months or longer),¹ particularly because their effectiveness waned with prolonged use and because of the substantial risk of significant side effects and addiction, especially with high-dose use.² They also knew that controlled studies of the safety and efficacy of opioids were limited to short-term use (not longer than 90 days), and in managed settings (*e.g.*, hospitals), where the risk of addiction and other adverse outcomes was much less significant.

3. Even the doctors who published articles suggesting that opioids might be useful for chronic pain treatment recognized the substantial concerns about long-term opioid use and counseled for “[a]stute ongoing assessment of functional outcomes if opioids are administered.”³

4. Prescription opioids, which include well-known brand-name drugs like OxyContin and Percocet, are narcotics. They are derived from or possess properties similar to opium and heroin – which is why they are regulated as controlled substances. Like heroin, prescription opioids work by binding to receptors on the spinal cord and in the brain, dampening the perception of pain. Opioids also can create a euphoric high, which can make them addictive. At certain doses, opioids can slow the user’s breathing, causing respiratory depression and, ultimately, death.

¹ Chronic pain, as used in this Complaint, refers to chronic non-cancer pain.

² R.K. Portenoy, *Opioid Therapy for Chronic Nonmalignant Pain: Current Status*, Progress in Pain Research and Management, Vol. 1, ed. H.L. Fields & John C. Liebeskind, IASP Press, Seattle, 1994.

³ *Id.*

1 5. In order to expand the market for opioids and realize blockbuster profits,
2 Defendants needed to create a sea-change in medical and public perception that would permit the
3 use of opioids for long periods of time to treat more common aches and pains, like lower back
4 pain, arthritis, and headaches. Opioid makers Purdue, Janssen, Endo, Cephalon, and Actavis,
5 through a common, sophisticated, and deeply deceptive marketing campaign that continues to the
6 present, set out to, and did, reverse the popular and medical understanding of opioids.

7 6. Beginning over 20 years ago, Defendants seized on anecdotal accounts of opioid
8 use to treat chronic pain to begin a reeducation campaign about opioids. They spent millions of
9 dollars funding, assisting, and encouraging doctors and front groups that would pioneer a new and
10 far broader market for their potent and highly addictive drugs – the chronic pain market.
11 Defendants persuaded doctors and patients that what they had long known – that opioids are
12 addictive drugs and unsafe in most circumstances for long-term use – was untrue, and quite the
13 opposite, that the compassionate treatment of pain *required* opioids. They overstated the benefits
14 of using opioids long-term to treat chronic non-cancer pain, promising improvement in patients’
15 function and quality of life, and dismissed or minimized the serious risks and adverse outcomes of
16 chronic opioid use, including the risk of addiction, overdose, and death. There was and is no
17 reliable scientific evidence supporting Defendants’ marketing claims at issue, and there is a wealth
18 of scientific evidence to the contrary. They also deceptively marketed the drugs for indications
19 and benefits that were prohibited by the drugs’ labels.

20 7. Defendants’ efforts were wildly successful; the United States is now awash in
21 opioids. In 2010, 254 million prescriptions for opioids were filled in the U.S. – enough to
22 medicate every adult in America around the clock for a month. Twenty percent of all doctors’
23 visits result in the prescription of an opioid (nearly double the rate in 2000).⁴ Opioids – once a
24 niche drug – are now the most prescribed class of drugs – more than blood pressure, cholesterol, or
25 anxiety drugs. While Americans represent only 4.6% of the world’s population, they have

26 _____
27 ⁴ Daubresse M, *et al.*, *Ambulatory Diagnosis and Treatment of Nonmalignant Pain in the United States, 2000-*
28 *2010*, *Medical Care*, 2013; 51(10):870-878.

1 consumed 80% of the opioids supplied around the world and 99% of the global hydrocodone
2 supply.⁵ Together, opioids generated \$8 billion in revenue for drug companies in 2010.

3 8. Roughly 87% of these prescriptions are for chronic opioid therapy – a prescribing
4 practice doctors previously considered not just ineffective, but even reckless given the substantial
5 risk of addiction chronic opioid use creates.

6 9. It was Defendants’ marketing – and not any medical breakthrough – that
7 rationalized prescribing opioids for chronic pain and opened the floodgates of opioid use and
8 abuse. The result has been catastrophic. According to the U.S. Centers for Disease Control and
9 Prevention (“CDC”), the nation has been swept up in an opioid-induced “public health epidemic.”
10 Prescription opioid use contributed to 16,651 overdose deaths nationally in 2010 – more than twice
11 as many deaths as heroin and cocaine combined and surpassing motor vehicle accidents as a cause
12 of death. In Orange County alone there is an opioid-related death every other day.⁶ For every
13 death, more than 30 individuals are treated in the emergency room. But even these alarming
14 statistics do not fully communicate the toll of prescription opioid abuse on patients and their
15 families.

16 10. The dramatic increase in opioid prescriptions to treat common chronic pain
17 conditions has resulted in a population of addicts who seek drugs from doctors or from the
18 secondary criminal market, and a pipeline of drugs that can be diverted to supply them. Sixty
19 percent of opioid abusers report that their drugs came originally from prescriptions.⁷ According to
20 the CDC, more than 12 million Americans age 12 or older have used prescription painkillers
21 without a prescription in the past year, and adolescents are abusing opioids in alarming numbers.

22 11. In addition, opioid abuse has triggered a resurgence in the use of heroin, which has
23 imposed additional burdens on the public and the state and local agencies that serve them. Heroin
24 produces a very similar high to prescription opioids, but is often cheaper. While a single opioid

25 ⁵ Manchikanti, *et al.*, *Therapeutic Use, Abuse, and Nonmedical Use of Opioids: A Ten-Year Perspective*, *Pain Physician*, 2010; 13:401-435.

26 ⁶ David Whiting, *Whiting: FDA Finally Starts to Tackle Opioid Epidemic*, ORANGE COUNTY REGISTER, Oct. 26,
27 2013, available at www.ocregister.com/articles/fda-533176-drug-country.html.

28 ⁷ Katz M, *Opioids After Thousands of Years, Still Getting to Know You*, *Clin J Pain* 2007; 23:303-306.

1 pill may cost \$10-\$15 on the street, users can obtain a bag of heroin, with multiple highs, for the
2 same price. It is hard to imagine the powerful pull that would cause a law-abiding, middle-aged
3 person started on prescription opioids for a back injury, to turn to buying, snorting, or injecting
4 heroin, but that is the dark side of opioid abuse and addiction.

5 12. Dr. Robert Dupont, former director of the National Institute on Drug Abuse and the
6 former White House drug czar, opines that opioids are more destructive than crack cocaine:

7 [Opioid abuse] is building more slowly, but it's much larger. And
8 the potential for death, in particular, [is] way beyond anything we
9 saw then. ... [F]or pain medicine, a one-day dose can be sold on the
10 black market for \$100. And a single dose can [be] lethal to a non-
11 patient. There is no other medicine that has those characteristics.
12 And if you think about that combination and the millions of people
13 who are using these medicines, you get some idea of the exposure of
14 the society to the prescription drug problem.

15 13. To shift medical convention and unleash this epidemic, Defendants engaged in a
16 campaign of deception that: (1) misrepresented the efficacy of opioids, (2) trivialized or obscured
17 their serious risks and adverse outcomes, and (3) overstated their superiority, compared with other
18 treatments. Defendants supported, encouraged, and directed employees, front groups, and doctors
19 they identified as "Key Opinion Leaders" ("KOLs") to publicize biased and misleading studies and
20 promotional materials and conduct thousands of medical education programs that were deceptive
21 and lacked balance. These "educational" efforts were designed not to present a fair view of how
22 and when opioids could be safely and effectively used, but rather to convince doctors and patients
23 that the benefits of using opioids to treat chronic non-cancer pain outweighed their risks and that
24 opioids could be used safely by most patients.

25 14. Defendants' representations regarding the benefits, risks, and relative superiority of
26 opioids were – and are – untrue and unsupported by competent scientific evidence. In fact, even
27 Defendants' KOLs initially were very cautious about whether opioids were safe and effective to
28 treat chronic pain. Some of these same KOLs have since recanted their pro-opioid marketing
messages and acknowledged that Defendants' marketing went too far. Yet despite the voices of
renowned pain specialists, researchers and physicians who have sounded the alarm on the long-

1 term use of opioids to treat chronic non-cancer pain, Defendants continue to disseminate their false
2 and misleading marketing claims even today.

3 15. Defendants' marketing not only ignored contrary evidence, but also failed to
4 acknowledge risks disclosed on their own labels and sometimes exceeded the approved
5 indications. Defendant Cephalon, for example, marketed its opioid, Fentora, for chronic non-
6 cancer pain even though it was approved *only* to treat cancer pain. Defendants also promised that
7 opioids would improve patients' ability to function, even though such benefits had not been proven
8 and were specifically disputed by the FDA.

9 16. Many of Defendants' strategies are modeled on the standard promotional activities
10 for prescription drugs that have been deemed unlawful, and for which the drug companies have paid
11 billions of dollars in settlements and judgments. What makes this effort particularly nefarious – and
12 dangerous – is that unlike most other prescription drugs, opioids are highly addictive controlled
13 substances. Defendants deceptively engaged a patient base that – physically and psychologically –
14 could not turn away from their drugs; many of whom were not helped by the drugs or were
15 profoundly damaged by them.

16 17. There are millions of Californians who suffer from chronic pain, which takes an
17 enormous toll on their health, their lives, and their families. These patients deserve both
18 appropriate care and the ability to make decisions based on accurate, complete information about
19 treatment risks and benefits. But Defendants' deceptive marketing campaign deprived California
20 patients and their doctors of the ability to make informed medical decisions and, instead, caused
21 important, sometimes life-or-death decisions to be made based not on science, but on hype.
22 Defendants deprived patients, their doctors, and health care payers of the chance to exercise
23 informed judgment, and subjected them to enormous suffering and costs.

24 18. Defendants' course of conduct, individually and collectively, has violated and
25 continues to violate one or more of the following laws of the State of California:

- 26 • California False Advertising Law, BUS. & PROF. CODE
27 § 17500, in that Defendants made and disseminated untrue,
28 false, or misleading statements about the use of opioids to
treat chronic non-cancer pain, or caused untrue, false, or

misleading statements about opioids to be made or disseminated to the public;

- California Unfair Competition Law, BUS. & PROF. CODE § 17200, in that Defendants engaged in unlawful, unfair, and fraudulent business acts and practices and deceptive, untrue, and misleading advertising in their promotion of opioids to treat chronic non-cancer pain; and
- California Public Nuisance Law, CAL. CIV. CODE §§ 3479, 3480, in that Defendants, through their untrue, misleading, false, fraudulent, and deceptive promotion of opioids, have created or assisted in the creation of a condition that is injurious to health and substantially interferes with the comfortable enjoyment of life and property of the people of Santa Clara and Orange County and the State of California.

19. To redress and punish these violations of law the People of the State of California, by and through Santa Clara County Counsel Orry P. Korb and Orange County District Attorney Tony Rackauckas, seek a judgment requiring Defendants to pay restitution, civil penalties, and attorneys' fees, costs, and expenses. The People also request that the Court issue an order requiring Defendants to cease their unlawful promotion of opioids, to correct their misrepresentations, and to abate the public nuisance they have created, in addition to granting any other equitable relief authorized by law.

II. JURISDICTION AND VENUE

20. This Court has subject matter jurisdiction over the People's claims for restitution, including disgorgement of profits, civil penalties, trebling of relief, injunctive relief, and other equitable relief under the California Unfair Competition Law (BUS. & PROF. CODE § 17200, *et seq.*), California False Advertising Law (BUS. & PROF. CODE § 17500, *et seq.*), and California Civil Code section 3345; and over the People's claim for abatement under the California Public Nuisance law (CAL. CIV. CODE §§ 3479, 3480).

21. This Court has personal jurisdiction over Defendants under California Code of Civil Procedure § 410.10. Defendants have submitted to jurisdiction by conducting and transacting business in Santa Clara and Orange Counties on a regular and continuous basis, by marketing and selling opioids to doctors, pharmacies, payers, and patients in Santa Clara and Orange Counties,

1 and by committing acts within Santa Clara and Orange Counties against their citizens and residents
2 that are in violation of the laws of California and the United States.

3 22. Venue as to each Defendant is proper in this judicial district, pursuant to California
4 Code of Civil Procedure §§ 395 and 395.5.

5 III. PARTIES

6 A. Plaintiff

7 23. Plaintiff is the People of the State of California, acting by and through Santa Clara
8 County Counsel Orry P. Korb and Orange County District Attorney Tony Rackauckas (“the
9 People”).

10 24. The People bring this action for violations of the Unfair Competition Law pursuant
11 to California Business and Professions Code Sections 17200, 17204, and 17206, and for violations
12 of the False Advertising Law pursuant to California Business and Professions Code Sections
13 17500, 17535, and 17536.

14 25. The People bring this action to abate a public nuisance pursuant to California Code
15 of Civil Procedure Section 731.

16 B. Defendants

17 26. Defendant Purdue Pharma L.P. is a limited partnership organized under the laws of
18 Delaware, Defendant Purdue, Inc. is a Delaware corporation with its principal place of business in
19 Stamford, Connecticut, and Defendant The Purdue Frederick Company, Inc. is a Delaware
20 corporation with its principal place of business in Stamford, Connecticut (collectively, “Purdue”).
21 Purdue is primarily engaged in the manufacture, promotion, and distribution of opioids, including
22 OxyContin, its largest selling opioid, in both California and the nation. Since 2009, Purdue’s
23 national annual sales of OxyContin have fluctuated between \$2.47 billion and \$2.99 billion.
24 OxyContin constitutes roughly 30% of the entire market for analgesic drugs (painkillers).

25 27. In 2007, Purdue settled criminal and civil charges against it for misbranding
26 OxyContin and agreed to pay the United States \$635 million – at the time, one of the largest
27 settlements with a drug company for marketing misconduct. Pursuant to its misbranding
28

1 settlement, Purdue operated under a Corporate Integrity Agreement with the Office of Inspector
2 General of the U.S. Department of Health and Human Services, which required the company, *inter*
3 *alia*, to ensure that its marketing is fair and accurate and to monitor and report on its compliance
4 with the Agreement.

5 28. Defendant Teva Pharmaceutical Industries, Ltd. is an Israeli corporation with its
6 principal place of business in Petah Tikva, Israel. In 2011, Teva Pharmaceutical Industries, Ltd.
7 acquired Cephalon, Inc. Defendant Cephalon, Inc. is a Delaware corporation with its principal
8 place of business in Frazer, Pennsylvania (Teva Pharmaceutical Industries, Ltd. and Cephalon, Inc.
9 are collectively referred to herein as “Cephalon”). Cephalon is in the business of manufacturing,
10 selling and distributing pharmaceutical drugs, including opioids Actiq and Fentora, nationally and
11 in California.

12 29. In November 1998, the FDA granted restricted marketing approval for Actiq,
13 limiting its lawful marketing to cancer patients experiencing pain “with malignancies who had
14 developed a tolerance to less dangerous therapies.” The FDA specified that Actiq should not be
15 marketed for off-label uses, stating that the drug “must not be used in opioid non-tolerant patients”
16 and must be prescribed solely to cancer patients by oncologists and pain specialists specifically
17 trained in the use of Schedule II opioids to treat pain in cancer patients. In 2008, Cephalon plead
18 guilty to a criminal violation of the Federal Food, Drug and Cosmetic Act for its misleading
19 promotion of Actiq and two other drugs and agreed to pay \$425 million.

20 30. Cephalon also entered into a five-year Corporate Integrity Agreement with the
21 Office of Inspector General of the U.S. Department of Health and Human Services. The
22 agreement required Cephalon to send doctors a letter advising them of the settlement terms and
23 giving them a means to report questionable conduct of sales representatives; to post payments to
24 doctors on its web site; and to regularly certify that the company has an effective compliance
25 program.

26 31. Defendant Janssen Pharmaceuticals, Inc. is a Pennsylvania corporation with its
27 principal place of business in Titusville, New Jersey, and a wholly owned subsidiary of Defendant
28

1 Johnson & Johnson, a New Jersey corporation with its principal place of business in New
2 Brunswick, New Jersey (Janssen Pharmaceuticals, Inc. and Johnson & Johnson are collectively
3 referred to herein as “Janssen”). Janssen manufactures, sells, and distributes a range of medical
4 devices and pharmaceutical drugs in California and nationally, including the opioids Duragesic,
5 Nucynta, Ultracet, and Ultram. Duragesic is the largest selling opioid of the group, with revenue
6 of \$1 billion in 2008, which dropped to \$589 million in 2011. Sales of Janssen’s opioids
7 collectively commanded between \$1.3 billion in revenue in 2009 and \$1.2 billion in 2012 – a total
8 of \$4.7 billion dollars over the four-year period.

9 32. Defendant Endo Health Solutions Inc. (“Endo”) is a Delaware corporation with its
10 principal place of business in Malvern, Pennsylvania. Endo develops, markets, and sells
11 prescription drugs, including opioids Opana, Percocet, and Percodan, in California and throughout
12 the U.S. These opioids made up roughly \$403 million of Endo’s overall revenues of \$3 billion in
13 2012. Opana yielded revenue of \$1.16 billion between 2008 and 2012, and alone accounted for
14 10% of Endo’s total 2012 revenue.

15 33. Defendant Actavis plc is a public limited company incorporated in Ireland with its
16 principal place of business in Dublin, Ireland. Actavis plc was established for the purpose of
17 facilitating the business combination between Actavis, Inc. and Warner Chilcott plc. Watson
18 Pharmaceuticals, Inc. acquired Actavis, Inc. in October 2012 and the combined company name
19 was changed to Actavis, Inc. as of January 2013, and then Actavis plc in October 2013.
20 Throughout the Complaint, “Actavis,” collectively refers to Actavis, Inc. and Actavis plc. During
21 the relevant time period, Actavis engaged in the business of marketing and selling opioids in
22 California and across the country, including the branded drug Kadian and generic versions of
23 Duragesic and Opana.

IV. FACTUAL ALLEGATIONS

A. Before Defendants' Deceptive Marketing Campaign, Opioids Were Rarely Prescribed by Physicians Because of Their Known Serious Side Effects and Substantial Risk of Addiction

34. Opioids have long been approved and accepted for the treatment of chronic cancer pain. Opioids are appropriate for this use given the severity of pain often associated with cancer and the recognition that the benefits of treating that pain outweigh the potential risk of addiction, especially for terminal patients. The same is not true for chronic non-cancer pain. Among other differences, the pathology responsible for cancer pain is distinct from the pathology that causes chronic pain. For patients with cancer, the source of their pain is likely to be the tumor and pressure on, or erosion of nerves or bones, which can be extremely painful, while chronic pain arises from multiple sources – including musculoskeletal (from joints, ligaments, or muscles), neuropathic (or nerve-related, occurring in diseases like diabetes or shingles), headache, or functional pain (arising from disease states such as irritable bowel) – that respond differently (or not at all) to opioids.

35. However, over the past twenty years, fueled by aggressive marketing from the pharmaceutical industry, opioid use for the management of chronic non-cancer pain has become commonplace. As set forth below, use of opioids for long-term non-cancer pain management is based on “unsound science and blatant misinformation ... and dangerous assumptions that opioids are highly effective and safe, and devoid of adverse events when prescribed by physicians.”⁸

36. As admitted in 1994 by Dr. Russell Portenoy, a KOL who went on to tirelessly promote opioid therapy for the treatment of chronic non-cancer pain (also called chronic nonmalignant pain), the medical consensus before Defendants' “reeducation” campaign was decidedly against the use of opioids to treat chronic non-cancer pain:

The traditional approach to chronic nonmalignant pain does not accept the long-term administration of opioid drugs. This perspective has been justified by the perceived likelihood of tolerance, which would attenuate any beneficial effects over time, and the potential for side effects, worsening disability, and addiction. According to conventional thinking, the initial response to an opioid

⁸ Available at <http://www.ncbi.nlm.nih.gov/pubmed/22786464?report>.

1 drug may appear favorable, with partial analgesia and salutary mood
2 changes, but adverse effects inevitably occur thereafter. It is
3 assumed that the motivation to improve function will cease as mental
4 clouding occurs and the belief takes hold that the drug can, by itself,
5 return the patient to a normal life. *Serious management problems
6 are anticipated, including difficulty in discontinuing a problematic
7 therapy and the development of drug seeking behavior induced by
8 the desire to maintain analgesic effects, avoid withdrawal, and
9 perpetuate reinforcing psychic effects.* There is an implicit
10 assumption that little separates these outcomes from the highly
11 aberrant behaviors associated with addiction.⁹

12 37. Dr. Portenoy left no doubt about the 1994 state of knowledge concerning the safety
13 and efficacy of opioid therapy for long-term chronic non-cancer pain:

14 At the present time, neither the medical literature nor clinical
15 experience provides compelling evidence that long-term opioid use
16 would be salutary for more than a very small number of patients with
17 chronic nonmalignant pain...¹⁰

18 38. But the lack of any credible science supporting opioid therapy for chronic non-
19 cancer pain did not stop Defendants from marketing opioid therapy for that use. Working with and
20 through KOLs like Dr. Portenoy, Defendants seized on anecdotal accounts of opioid efficacy in
21 limited populations and methodically, through numerous publications, programs, and
22 spokespeople, overstated the benefits and understated the risks of opioids in order to create and
23 defend a broad market for opioids that never should have and never would have come to exist
24 absent Defendants' concerted, deliberate, and patently misleading efforts.

25 **B. Defendants' Marketing of Opioids for Long-Term Use to Treat Chronic Non-Cancer
26 Pain was False, Misleading, Imbalanced, and Unsupported by Science**

27 39. For years, Defendants systematically violated state laws requiring that the
28 promotion of pharmaceutical drugs not be false or misleading. Defendants manipulated and
29 ignored scientific evidence to formulate and broadcast the misrepresentations described below,
30 each of which was instrumental in: (1) overcoming longstanding medical and legal barriers to
31 opioid therapy for chronic pain; and (2) making high-dose, long-term opioid use the new "gold
32 standard" of treatment of chronic non-cancer pain.

33 ⁹ Portenoy, R.K., *Opioid Therapy for Chronic Nonmalignant Pain: Current Status*, Progress in Pain Research and
34 Management, Vol. 1, p. 247, ed. H.L. Fields & John C. Liebeskind, IASP Press, Seattle, 1994 (emphasis added).

35 ¹⁰ *Id.* at 278 (emphasis added).

1 40. Defendants disseminated much of their false, misleading, imbalanced, and
2 unsupported statements through unbranded marketing materials – materials that generally
3 promoted opioid use but did not name a specific opioid drug name. Upon information and belief,
4 Defendants used these unbranded materials, which are not reviewed by the FDA, to disseminate
5 messages that were inaccurate, were inconsistent with their branded marketing materials and the
6 drugs’ labels and package inserts, and would not pass muster with the FDA. Had they relied on
7 branded materials, the FDA-required drug labels and package inserts would have been included to
8 more fully describe the risks and administration of opioids (such as OxyContin).

9 41. Defendants marketed directly to patients to: (1) encourage them to ask doctors for
10 opioids to relieve chronic pain; and (2) allay their well-founded concerns that opioids were
11 dangerous and addictive. Defendants targeted particularly vulnerable, but usually well-insured,
12 groups of patients, such as veterans and the elderly. Defendants leveraged and funded patient
13 organizations and communities – promoting opioids particularly for common conditions, such as
14 headaches, arthritis, fibromyalgia, and back pain. Unlike other direct-to-consumer marketing,
15 Defendants, as a group, focused on unbranded advertising – promoting opioids for chronic pain
16 knowing that the creation of a new, expansive market for opioids would benefit all manufacturers.

17 42. Doctors are the gatekeepers for all prescription drugs so, not surprisingly,
18 Defendants focused the bulk of their marketing efforts, and their multi-million dollar budgets, on
19 the professional medical community. Particularly because of barriers to prescribing opioids, which
20 are regulated as controlled substances, Defendants knew doctors would not treat patients with
21 common chronic pain complaints with opioids unless doctors were persuaded that opioids had real
22 benefits and minimal risks. Through misleading medical education programs, treatment
23 guidelines, and other efforts, Defendants “reeducated” general practitioners and family doctors,
24 knowing that these doctors reach the vast majority of patients with common chronic pain
25 complaints, but are less likely than specialists to have the time or knowledge to evaluate
26 Defendants’ deceptive messages or to closely monitor patients for signs of improvement or
27 adverse outcomes (such as addiction).

28

1 43. Individually and collectively, Defendants promoted a series of misrepresentations
2 aimed broadly at reversing the ultimately well-founded fears and beliefs of doctors and patients.

3 **1. Defendants’ misrepresentations regarding the benefits of opioids for chronic**
4 **pain.**

5 44. Defendants deceptively promoted opioids as improving chronic non-cancer pain
6 patients’ function by allowing them to get back to “normal” and reducing their pain long-term.
7 Defendants misrepresented the efficacy of opioids in an effort to persuade doctors and patients that
8 their benefits outweigh their risks.

9 45. Although opioids may initially improve patients’ function by providing pain relief
10 in the short term, there were – and are – no controlled studies of the use of opioids beyond 16
11 weeks and no evidence that opioids improve patients’ function in the long-term. Indeed, research
12 such as a 2008 study in *Spine* has shown that pain sufferers prescribed opioids long-term suffered
13 addiction that made them more likely to be disabled and unable to work. Despite this lack of
14 evidence, and evidence to the contrary, Defendants consistently promoted opioids as capable of
15 improving patients’ function and quality of life.

16 46. The FDA has recognized that claims that opioids improve patients’ function are
17 misleading. For example, a company claimed that its opioid “Improved Overall Function” and
18 offered “Long Lasting Improvements in Physical Function” and would enable patients to be better
19 able to engage in a list of daily activities, such as walking, standing, and climbing stairs. In a
20 warning letter sent March 24, 2008, the FDA publicly made clear “that [the claim that] patients
21 who are treated with the drug experience an improvement in their overall function, social function,
22 and ability to perform daily activities ... as not been demonstrated by substantial evidence or
23 substantial clinical experience.”

24 47. In marketing Kadian, Actavis made implied claims that the drug would allow
25 chronic pain patients to return to work, relieve “stress on your body and your mental health,” and
26 help them enjoy their lives. The FDA found the Actavis had misrepresented the scientific
27 evidence: “[W]e are not aware of substantial evidence or substantial clinical experience
28 demonstrating that the magnitude of the effect of the drug has in alleviating pain, taken together

1 with any drug-related side effects patients may experience ... results in any overall positive impact
2 on a patient's work, physical and mental functioning, daily activities, or enjoyment of life.”¹¹

3 48. Janssen also distributed a series of posters to doctors' offices that showed pictures
4 of people dressed for a variety of active professions suggesting that doctors prescribe Ultracet
5 because “Pain doesn't fit into their schedules.” Despite the lack of scientific evidence in support
6 of such a claim, the posters falsely implied that Ultracet was appropriate for help in maintaining an
7 active lifestyle. Several of the posters contained the tagline “Ultracet lets them perform.”

8 49. In spite of the complete lack of scientific basis, in 2011, Purdue sponsored the
9 *Policymaker's Guide*, published by the American Pain Foundation (“APF”), which asserted that
10 “multiple clinical studies” have shown that opioids are effective in improving daily function,
11 psychological health, and health-related quality of life for chronic pain patients. To support this
12 claim, APF cited *Opioids for chronic noncancer pain: a meta-analysis of effectiveness and side*
13 *effects*, a review published in 2006 in the Canadian Medical Association Journal. However, the
14 review concludes: “For functional outcomes, the other analgesics were significantly more
15 effective than were opioids.” The Purdue-sponsored *Guide* failed to disclose both this conclusion
16 and the fact that the review analyzed studies that lasted, on average, five weeks, and therefore
17 could not support the long-term use of opioids.

18 50. [REDACTED]
19 [REDACTED]
20 [REDACTED] In 2009, one of the
21 campaign's marquee components was a “first-of-its-kind Web-based series called the *Let's Talk*
22 *Pain* show hosted by veteran TV journalist Carol Martin. The resource brings together medical
23 doctors, nurses, psychologists, social workers and people with pain to discuss a host of issues from
24 managing health care for pain to exploring integrative treatment approaches to addressing the
25 psychological aspects associated with pain.”

26
27 ¹¹ Feb. 18, 2010 Warning Letter.
28

1 51. The *Let's Talk Pain* talk show [REDACTED]
2 [REDACTED] is still available online. In the very
3 first episode of this talk show, the following exchange took place:

4 **Teresa Shaffer (APF Action Network Leader):** As a person who
5 has been living with pain for over 20 years, opioids are a big part of
6 my pain treatment. And I have been hearing such negative things
7 about opioids and the risk factors of opioids. Could you talk with
8 me a little bit about that?

9 **Dr. Al Anderson (AAPM Board of Directors):** The general belief
10 system in the public is that the opioids are a bad thing to be giving a
11 patient. Unfortunately, it's also prevalent in the medical profession,
12 so patients have difficulty finding a doctor when they are suffering
13 from pain for a long period of time, especially moderate to severe
14 pain. And that's the patients that we really need to use the opioids
15 methods of treatment, because they are the ones who need to have
16 some help with the function and they're the ones who need to have
17 their pain controlled enough so that they can increase their quality of
18 life.

19 **Teresa Shaffer:** This is what has allowed me to continue to
20 function and is what has allowed me to have somewhat of a normal
21 life, is the opioids.¹²

22 There simply is no scientific evidence that opioids taken long-term improve function or quality of
23 life for chronic pain patients, and there is significant evidence that opioids impose significant risks
24 and adverse outcomes on long-term users.

25 52. Similarly, the National Initiative on Pain Control ("NIPC"), an APF initiative
26 [REDACTED], ran a facially unaffiliated website called www.painknowledge.org. NIPC
27 billed itself as "an integrated education initiative" and promoted its expert leadership team,
28 including "nationally respected experts in the pain management field." [REDACTED]
[REDACTED] Painknowledge.org
promised that, on opioids, "your level of function should improve; you may find you are now able
to participate in activities of daily living, such as work and hobbies, that you were not able to enjoy
when your pain was worse." Elsewhere, the website touted improved quality of life (as well as
"improved function") as benefits of opioid therapy.¹³

¹² Available at <http://www.youtube.com/watch?v=zeAIVAMRgsk> (0:35 to 1:09).

¹³ www.painknowledge.org_patiented_pdf_8679_PatientHandout_Final.

1 53. APF’s *Policymaker’s Guide*, supported and sponsored by Purdue and published
2 only two years ago, also includes claims that opioids “help alleviate pain, restore functioning and
3 improve quality of life.”

4 54. Defendants’ misrepresentations about increased function are particularly misleading
5 for specific indications for which they promoted opioids, such as migraines and low back pain.
6 For instance, research indicates that as many as 30% of patients who suffer from migraines have
7 used opioids to treat their headaches.¹⁴ Despite this, users of opioids had the highest increase in
8 headache days per month, scored significantly higher on the Migraine Disability Assessment
9 (MIDAS), and had higher rates of depression, compared to non-opioid users.¹⁵ A survey by the
10 National Headache Foundation found that migraine patients who used opioids were more likely to
11 experience sleepiness, confusion, and rebound headaches, and reported a lower quality of life than
12 patients taking other medications.¹⁶ Studies of the use of opioids long-term for chronic lower back
13 pain similarly have been unable to demonstrate an improvement in patients’ function.¹⁷

14 55. There also is evidence that, over the long-term, opioid therapy fails to lessen, and
15 sometimes increases, patients’ pain – important facts that Defendants fail to include in their
16 marketing literature. For example, Defendants have failed to disclose scientific evidence that
17 establishes that many patients on chronic opioid therapy continue to experience significant pain
18 and dysfunction.¹⁸ Defendants also have failed to disclose research and clinical experience
19 demonstrating that: (1) the analgesic (pain relieving) efficacy of opioids often declines over time;

20
21 ¹⁴ Buse D, *Opioid Use and Dependence Among Persons With Migraine: Results of the AMPP Study*, *Headache: The Journal of Head and Face Pain*, 2012, 52: 18-36.

22 ¹⁵ *Id.*

23 ¹⁶ Press Kits – Migraine Patients Taking Addictive Or Non Approved FDA Migraine Treatment, National Headache Foundation, http://www.headaches.org/press/NHF_Press_Kits/Press_Kits_-_Migraine_Patients_Taking_Addictive_Or_Non_Approved_FDA_Migraine_Treatments.

24 ¹⁷ Chaparro, *Opioids compared to placebo or other treatments for chronic low-back pain*, *Cochrane Database System Review*, 2013, available at <http://www.ncbi.nlm.nih.gov/pubmed/23983011>.

25 ¹⁸ Mark D. Sullivan, *et al.*, *Problems and concerns of patients receiving chronic opioid therapy for chronic non-cancer pain*, 149(2) *Pain* 345-353 (2010); Jørgen Erikson, *et al.*, *Critical issues on opioids in chronic non-cancer pain*, 125(1-2) *Pain* 172-179 (2006); *see also*, IOM, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research*, Comm. on Advancing Pain Research, Care, & Educ. Board on Health Sci. Policy, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*, Institute of Medicine (2011); Dillie KS, *et al.*, *Quality of life associated with daily opioid therapy in a primary care chronic pain sample*, *J Am Bd Fam Med*, 21:108-117 (2008).

1 (2) patients on opioids long-term may develop greater sensitivity to pain (“hyperalgesia”); and
2 (3) research showing that because they develop tolerance to the medication over time, many
3 chronic pain patients require ever higher doses of opioids to obtain relief and are on doses that
4 doctors have described as “frighteningly high.”¹⁹

5 56. Consistently, in their marketing, Defendants failed to disclose the lack of evidence
6 to establish that opioids are safe and effective long-term, as well as the growing body of evidence
7 that the risks of opioids increase and their benefits decline over time. The studies relied on by
8 Defendants in marketing their drugs are short-term, typically for less than 12 weeks. For example,
9 an ad run by Janssen in the October 2010 issue of *American Family Physician* included the claim:
10 “Opioid efficacy meets unexpected tolerability in patients with end-stage degenerative joint
11 disease of the hip or knee.” The study cited was only conducted over a five-day period, and thus
12 provided no support for long-term efficacy.

13 57. As one California pain specialist noted in an article titled, *Are We Making Pain*
14 *Patients Worse*, “opioids may work acceptably well for a while, but over the long term, function
15 generally declines, as does general health, mental health, and social functioning. Over time, even
16 high doses of potent opioids often fail to control pain, and these patients are unable to function
17 normally.” Instead, at higher doses, patients are much more likely to develop dependence or
18 addiction, experience pain deterioration due to hyperalgesia, and are three to nine times more
19 likely to die from opioid-related causes than those on low doses.²⁰ Additionally, epidemiological
20 data suggest that only a minority of patients on chronic opioid therapy benefit from the drugs and
21 most continue to suffer significant pain and limitations on their activities. Defendants have never
22 disclosed these facts.

23
24 ¹⁹ Katz M, *Long-term Opioid Treatment of Nonmalignant Pain: A Believer Loses His Faith*, Arch Intern Med
2010; 170(16):1422-1424.

25 ²⁰ Gomes, *Opioid dose and drug-related mortality in patients with nonmalignant pain*, Arch Intern Med
2011;171:686-691A; Dunn KM, *et al.*, *Opioid prescriptions for chronic pain and overdose: a cohort study*, Annals of
26 Int. Med. 2010;152:85-92. Most overdoses were medically serious and 12% were fatal. *Id.* See also, Braden JB,
27 Russo JE, Fan MY, Edlund MJ, Martin BC, DeVries A, Sullivan MD, *Emergency Department visits among recipients*
28 *of chronic opioid therapy*, Arch Intern Med, 2010; 170(16): 1425-1432 (finding that higher doses of opioids doubled
the risk of adverse drug events).

1 **2. Defendants’ misrepresentations regarding the adverse outcomes and risks of**
2 **opioids.**

3 58. In an effort to persuade doctors to prescribe opioids for chronic non-cancer pain,
4 Defendants deceptively overstated the safety and minimized the adverse outcomes, particularly the
5 risk of abuse and addiction, of using opioids long-term.

6 **a. Risk of addiction and abuse.**

7 59. Defendants’ fraudulent representation that opioids are rarely addictive is central to
8 Defendants’ scheme. To reach chronic non-cancer pain patients, Defendants had to overcome
9 doctors’ legitimate fears that opioids would addict their patients. The risk of addiction is an
10 extremely weighty risk – condemning patients to, among other things, dependence, compulsive
11 use, haziness, a lifetime of battling relapse, and a dramatically heightened risk of serious injury or
12 death. But for Defendants’ campaign to convince doctors otherwise, finding benefits from opioid
13 use for common chronic pain conditions sufficient to justify that risk would have posed a nearly
14 insurmountable challenge.

15 60. Remarkably, Defendants were able to do it. Even though opioids are controlled
16 substances – classified under the federal Controlled Substances Act as having “high potential for
17 abuse” and a “risk of severe psychological and physical dependence”²¹ Defendants: (1) brazenly
18 maintained that the risk of addiction for patients who take opioids long-term was low; and
19 (2) omitted the risk of addiction and abuse from the list of adverse outcomes associated with
20 chronic opioid use, even though the frequency and magnitude of the risk – and Defendants’ own
21 FDA labels – compelled disclosure.

22 61. Contrary to Defendants’ claims, numerous studies support that, though these
23 patients may not presently show signs of abuse or addiction, at least 15% and as many as 40% of
24 patients will become addicted to opioids.²² Research has shown that opioids are even more

25 ²¹ 21 U.S.C. § 812(b).

26 ²² *E.g.*, Boscarino, J, Risk factors for drug dependence among out-patients on opioid therapy in a large US health-
27 care system, *Addiction* 2010 (105): 1776-1782; Boscarino J, Prevalence of prescription opioid-use disorder among
28 chronic pain patients: comparison of the DSM-5 vs. DSM-4 diagnostic criteria, *J Addict Dis.* 2011, 30(3): 185-194;
Prescription Drugs: Abuse and Addiction, National Institute on Drug Abuse,
<http://www.drugabuse.gov/sites/default/files/rrprescription.pdf>.

1 addictive than cocaine and alcohol. One in three to five users who self-administer short-acting
2 opioids will become addicted, versus one in eight to 15 for users of cocaine or alcohol.²³

3 **(1) Minimizing the risk of addiction.**

4 62. In order to answer questions about increasingly well-publicized incidents of opioid
5 addiction, Defendants falsely reassured doctors and patients that, when taken properly under a
6 doctor's supervision, opioids are not addictive. Defendants' representations that opioid addiction
7 can be effectively managed by competent physicians not only had the effect of increasing the
8 number of opioid prescriptions, but also deflected the responsibility from Defendants' marketing
9 to doctors' prescribing and treatment practices.

10 63. Defendants' efforts to minimize the risk of addiction from taking opioids long-term
11 are evident in their unbranded materials, which dramatically understate or deny the risk of
12 addiction, as compared to their branded materials, overseen by the FDA, which include stronger
13 addiction warnings from the drugs' labels. Upon information and belief, Defendants took
14 advantage of this less regulated marketing channel to disseminate their deceptive messages
15 regarding the risk of addiction from long-term opioid use. For example (emphasis added):

[REDACTED]	What You Should Know About Treating Your Pain With Opioids (2012)	Opana ER Advertisement (2011/2012/2013)
[REDACTED]	unbranded patient education material created by Endo	branded Endo advertisement
[REDACTED]	"The risk of becoming addicted to your opioid medicine is reduced if you take your medicine exactly as prescribed by your healthcare provider.	"contains oxymorphone, an opioid agonist and Schedule II controlled substance with an abuse liability similar to other opioid agonists, legal or illicit." "All patients treated with opioids require careful monitoring for signs of abuse and addiction, since use of opioid analgesic products carries the risk of addiction even under appropriate medical use."

27 ²³ Kreek, et al., *Pharmacotherapy of Addictions*, 1:710-726, 2002.

1 64. Defendants also sought to deceptively downplay the risk of addiction to chronic
2 pain patients by defining opioid addicts as people who get the drugs illicitly and take them
3 improperly – not patients taking drugs they were prescribed. According to Defendants, patients
4 who take opioids prescribed to them are not addicted. A 2004 Endo patient education publication
5 edited by KOL Dr. Russell Portenoy titled *Understanding Your Pain: Taking Oral Opioid*
6 *Analgesics*, which is still available online, answers the hypothetical patient question: “What
7 should I know about opioids and addiction?” by focusing on explaining what addiction is (“a
8 chronic brain disease”) and is not (“Taking opioids for pain relief”). It goes on to explain that
9 “[a]ddicts take opioids for other reasons, such as unbearable emotional problems. Taking opioids
10 as prescribed for pain relief is not addiction.”

11 65. More graphically, a Purdue brochure, still provided to doctors today, makes the
12 point visually in advising doctors of *Indications of Possible Drug Abuse*; the brochure shows the
13 stigmata of injecting or snorting opioids – skin popping, track marks, or perforated nasal septa.²⁴
14 In fact, opioid addicts who resort to these extremes are uncommon; the far more typical reality is
15 patients who become dependent and addicted through oral use. Thus, these misrepresentations
16 wrongly reassured doctors that as long as they did not observe those signs, they need not worry
17 that their patients were becoming addicted to opioids.

18 66. These deceptive messages gave doctors and patients a false sense of security that as
19 long as patients are only taking opioids a doctor gives them – regardless of the dose or frequency
20 ingested – and not manipulating them, snorting, or injecting them, they are not addicted. That is
21 dangerously false. Many opioid users who become addicted to the drugs began using them when a
22 doctor prescribed them. Pain patients and opioid addicts are not separate universes, but
23 overlapping circles. As one study noted, “a potential side effect from chronic use can be abuse and
24 addiction ... [I]n fact, correct use and abuse of these agents are not polar opposites – they are
25 complex, inter-related phenomena.”²⁵ A review of studies of urine drug monitoring for opioid

26 ²⁴ *Providing Relief, Preventing Abuse*, p. 13.

27 ²⁵ Compton/Volkow, Major increases in opioid analgesic abuse in the United States: Concerns and Strategies
28 (2006), p 106.

1 patients showed that at least 11% of patients with chronic pain were misusing opioids and at least
2 12% were not taking their medication as prescribed.²⁶

3 67. Dr. Scott Fishman, another KOL previously funded by opioid makers,
4 acknowledged that data supporting the contention that addiction is rare “have been found to be
5 inadequate and seriously flawed. Although we currently do not know the exact rate of addiction in
6 patients legitimately prescribed opioids for pain or the rate of overall misuse, we know that rates
7 are high enough that they should be considered a significant potential adverse effect.”²⁷ Despite
8 these acknowledgements, Defendants continued to market opioids to doctors and patients as rarely
9 addictive and failed to disclose the significant risk of addiction.

10 **(2) Claiming the risk of addiction can be identified and managed.**

11 68. Defendants continue to maintain to this day that *most* patients can safely take
12 opioids long-term for chronic pain without becoming addicted. However, over time, needing to
13 explain why so many doctors encountered chronic pain patients addicted to opioids, Defendants
14 admitted that *some* patients *could* become addicted. Defendants claimed that if doctors use
15 screening tools or questionnaires with their patients to identify those with higher addiction risks
16 (stemming from personal or family histories of substance abuse, mental illness, or abuse), opioids
17 can be given safely and addiction can be avoided.²⁸

18 69. Dr. Russell Portenoy, a pro-opioid, Defendant-funded KOL described above,
19 appeared on *Good Morning America* in 2010 to discuss the use of opioids long-term to treat non-
20 cancer chronic pain. He claimed that, “Addiction, when treating pain, is distinctly uncommon. If
21 a person does not have a history, a personal history, of substance abuse, and does not have a
22

23
24 ²⁶ Katz N, *Prescription Opioid Abuse: Challenges and Opportunities for Payers*, AmJManagCare, April 19 2013,
25 p. 8, available at <http://www.ajmc.com/publications/issue/2013/2013-1-vol19-n4/Prescription-Opioid-Abuse-Challenges-and-Opportunities-for-Payers/.Katz>, AmJManagCare.

26 ²⁷ *Responsible Opioid Prescribing: A Clinician’s Guide* (2012).

27 ²⁸ The FDA’s Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics
28 directs doctors to “assess each patient’s risk of abuse.” However, it does not excuse drug companies’
misrepresentations that the screening tools allow them to prevent low-risk or high-risk patients from abusing or
becoming addicted to opioids.

1 history in the family of substance abuse, and does not have a very major psychiatric disorder, most
2 doctors can feel very assured that that person is not going to become addicted.”

3 70. A guide created by Cephalon, *Opioid Medications and REMS: A Patient’s Guide*,
4 similarly promised: “Some people are nervous about taking opioids because they are afraid they
5 will become addicted. However, patients without a history of abuse or a family history of abuse
6 do not commonly become addicted to opioids.”

7 71. Pro-opioid KOL Lynn Webster developed a basic five-question risk screening tool
8 called the Opioid Risk Tool. In 2011, Dr. Webster presented, via webinar, a program sponsored
9 by the American Academy of Pain Management and defendant Purdue, titled, *Managing Patient’s*
10 *Opioid Use: Balancing the Need and the Risk*. Dr. Webster recommended use of risk screening
11 tools, urine testing, and patient agreements as a way to prevent “overuse of prescriptions” and
12 “overdose deaths.” This webinar was available to doctors in California during the relevant
13 limitations period.

14 72. An Endo-sponsored 2007 supplement to the *Journal of Family Practice* contained
15 an article, *Pain Management Dilemmas in Primary Care: Use of Opioids*, by a physician who was
16 on all of Defendants’ speakers bureaus, which recommends risk screening by use of the Opioid
17 Risk Tool (developed by another pro-opioid KOL, Dr. Lynn Webster), or the Screener and Opioid
18 Assessment for Patients with Pain. Medium to high-risk patients should be treated by “a
19 maximally structured approach” including toxicology screens and pill counts.

20 73. That same doctor also gave a Purdue-sponsored continuing medical education
21 presentation (“CME”) in 2012, *Chronic Pain Managing and Opioid Use: Easing Fears,*
22 *Managing Risks, and Improving Outcomes*, in which he discussed the treatment of a high-risk
23 chronic pain patient demonstrating aberrant behavior, recommending screening, reducing the
24 prescription fills, and also switching to a different opioid as management strategies – all to
25 maintain a course of chronic opioid therapy.

26 74. There are three fundamental flaws in Defendants’ assurances that doctors could
27 identify and manage the risk of addiction. First, there is no reliable scientific evidence that
28

1 screening alone substantially limits the risk of addiction. Second, there is no reliable scientific
2 evidence that high-risk patients can be given opioids safely, even with enhanced monitoring.
3 Third, there is no reliable scientific evidence that patients without red flags can take opioids long-
4 term without significant danger of addiction.

5 75. Defendants' misrepresentations regarding the risk of addiction from chronic opioid
6 therapy were particularly dangerous because they were aimed at general practitioners or family
7 doctors (collectively "GPs"), who treat many chronic conditions, but who lack the time and
8 expertise to closely manage patients on opioids by reviewing urine screens, counting pills, or
9 conducting detailed interviews to identify other signs or risks of addiction. Defendants have made
10 a concerted effort to reach GPs through continuing medical education programs ("CMEs"), office
11 visits, and literature specifically aimed at them, and most opioids are prescribed by primary care
12 physicians like GPs.²⁹

13 76. Further, GPs do not have the specialized training to fully address the needs of
14 patients taking opioids long-term for chronic non-cancer pain. Defendants put together training for
15 GPs on prescribing opioids to chronic pain patients, but provided no guidance on recognizing
16 opioid abuse or weaning patients off opioids. Since GPs are especially reliant on CMEs to equip
17 them to manage patients on opioids, this critical learning gap makes it even less likely that, once
18 on opioids, chronic pain patients will have the chance to get off them.

19 **(3) Deflecting attention to "undertreated" pain.**

20 77. Rather than honestly disclose the risk of addiction, Defendants attempted to portray
21 those who were concerned about that risk as unfairly denying treatment to needy patients. They
22 claimed that purportedly overblown worries about addiction caused pain to be under-treated and
23 opioids to be over-regulated and under-prescribed. One APF publication funded by Purdue, *A*
24 *Policymaker's Guide to Understanding Pain & its Management*, stated that: "[u]nfortunately, too
25 many Americans are not getting the pain care they need and deserve. Some common reasons for
26

27 ²⁹ Wolters Kluwer Health, *Sharp rise in opioid drugs prescribed for non-cancer pain*, ScienceDaily, Sept. 16,
28 2013, <http://www.sciencedaily.com/releases/2013/09/130916091218.htm>.

1 difficulty in obtaining adequate care include ... misconceptions about opioid addiction.” The
2 Purdue *Guide* further alleged that resulting regulatory constraints (like the FDA’s recently
3 mandated prescriber education program, or REMS (“Risk Evaluation and Mitigation Strategies”))
4 have a “chilling effect” on prescribing and that abuse of opioids injured and “jeopardize[d]
5 effective pain management by impeding patient access to opioids.”

6 78. Janssen-sponsored *Let’s Talk Pain* – a multi-media patient education campaign –
7 warned that “strict regulatory control has made many physicians reluctant to prescribe opioids.
8 The unfortunate casualty in all of this is the patient, who is often undertreated and forced to suffer
9 in silence.” The program went on to say, “[b]ecause of the potential for abusive and/or addictive
10 behavior, many healthcare professionals have been reluctant to prescribe opioids for their
11 patients ... This prescribing environment is one of many barriers that may contribute to the under
12 treatment of pain, a serious problem in the United States.”

13 79. For example, under the heading of “Protecting Access,” *In the Face of Pain*, a
14 Purdue website, complained through at least mid-2013 that policy governing the prescribing of
15 opioids was “at odds with” best medical practices by “unduly restricting the amounts that can be
16 prescribed and dispensed; “restricting access to patients with pain who also have a history of
17 substance abuse;” “requiring special government-issued prescription forms only for the
18 medications that are capable of relieving pain that is severe.”³⁰ This unsupported and untrue
19 rhetoric aimed to portray doctors who did not prescribe opioids as uncaring, protecting themselves
20 at the expense of their patients.

21 **(4) Physical dependence vs. addiction.**

22 80. In an effort to underplay the risk and impact of addiction, Defendants frequently
23 explain that, while patients become physically “dependent” on opioids, physical dependence is not
24 the same as addiction and can be addressed by gradually tapering patients’ dosage to avoid the
25 adverse effects of withdrawal.

26
27 ³⁰ Available at www.inthefaceofpain.com_content/uploads/2011_12_factsheet_ProtectingAccess.

1 physical dependence, a patient’s fear of the unpleasant effects of discontinuing opioids can cause
2 patients to seek the drugs.³³

3 85. Thus, ending opioid therapy is not, as Defendants claim, simply a matter of
4 gradually lowering a patient’s dosage over time. In fact, one of the significant risks in beginning
5 chronic opioid therapy is that, once patients become physically dependent, it will be difficult for
6 them to ever stop using opioids. According to one study, more than half of patients who
7 continuously use opioids for more than 90 days remain on opioids after more than five years.³⁴
8 Most patients who become physically dependent after long-term use will require opioid
9 maintenance (through methadone or buprenorphine) for years or decades.

10 86. A publication in Purdue’s current catalog of publications for providers, *Providing*
11 *Relief, Preventing Abuse*, cautions against the “common error” of confusing physical dependence
12 with addiction. It analogizes physical dependence on opioids to physical dependence on
13 antihypertensives (blood pressure medicine) or decongestants.

14 87. This analogy has no basis in fact. With non-addictive drugs, like blood pressure
15 medicine, patients may experience withdrawal symptoms, but they are rarely difficult to get over,
16 and there is no craving for the drug. However, with long-term use of opioids, even in the absence
17 of a formal diagnosis of addiction, patients often crave the drug long after they have discontinued
18 use. Patients on opioids long-term will often experience symptoms that arguably may not qualify
19 as full blown addiction, but are certainly not mere physical dependence. Defendants’ marketing
20 failed to acknowledge the spectrum of substance abuse disorders short of full blown addiction,
21 which are also cause for concern, and created the sense that doctors need only concern themselves
22 with signs of addiction.

23 88. As with the claimed low incidence of addiction, the misrepresentation that chronic
24 opioid therapy is easy to stop is important to Defendants’ fraudulent marketing scheme. Honestly
25

26 ³³ Ballantyne J., *New Addiction Criteria: Diagnostic Challenges Persist in Treating Pain With Opioids*, IASP,
2013 Dec.; 21(5), p. 2.

27 ³⁴ BC Martin, *Long-Term Chronic Opioid Therapy Discontinuation Rates from the TROUP Study*, J Gen Intern
28 Med 2011 Dec.; 26(12):1450-7, available at www.ncbi.nlm.nih.gov/pubmed/21751058.

1 describing the difficulty of removing patients from opioids after long-term use and the complexity
2 of patients' dependence would rebalance the risk-benefit analysis and stoke doctors' and patients'
3 well-grounded concerns that once on opioids, severe physical and psychological dependence
4 would make it extremely difficult for patients to ever stop their use. It might also motivate the
5 general practitioners to whom Defendants generally marketed opioids for long-term use to refer
6 patients requesting opioids to pain management specialists who would not so easily prescribe
7 them. Defendants also gave GPs a false sense of confidence that they could identify addiction,
8 distinct from physical dependence, which, again, allowed them to believe that they could continue
9 to responsibly prescribe opioids. Defendants chose not to tell the truth so that they could sell more
10 drugs.

11 **(5) Pseudoaddiction.**

12 89. Defendants needed a way to explain why so many chronic pain patients on opioids
13 seem to be addicted: they ask for drugs by name, seek refills earlier than their supplies should
14 have run out, hoard drugs, or self-escalate their doses. Defendants, led by Purdue, managed
15 masterfully to turn these recognized signs of addiction into a way to sell more opioids through the
16 concept of "pseudoaddiction."

17 90. Purdue discussed pseudoaddiction in a publication called *Providing Relief,*
18 *Preventing Abuse*, in which it falsely and misleadingly claimed that the concept of
19 pseudoaddiction had "emerged in the literature" "to describe the inaccurate interpretation of [drug-
20 seeking behaviors] in patients who have pain that has not been effectively treated." And Purdue
21 went even farther, saying that pseudoaddiction is unproblematic and may occur "occasionally even
22 with successful opioid therapy for pain." This gave doctors confidence that signs of addiction that
23 do not resolve when more opioids are prescribed might not be cause for concern. It also misled
24 doctors into believing that the proper response to pain that has not been "effectively treated"
25 through opioid prescriptions is *more* opioids. Purdue's unbranded website –
26 PartnersAgainstPain.com – also issued a pamphlet in 2005 titled, *Clinical Issues in Opioid*
27
28

1 *Prescribing*, that included a list of conduct including “illicit drug use and deception” as examples
2 of unproblematic pseudoaddiction-related behavior, not problematic addiction.

3 91. Defendants also managed to work the misleading concept of pseudoaddiction into
4 medical literature. In a 1994 article, Defendant-sponsored KOL Russell Portenoy described
5 common signs of addiction as potential signs of mere *therapeutic dependence* – which he likened
6 to a diabetic’s response to insulin – or *pseudoaddiction*.³⁵ Portenoy claimed that “*Pseudoaddiction*
7 describes a specific phenomenon that has also been observed in the population with cancer pain.”
8 But his authority for this statement was limited to a single citation to an article by another KOL
9 and later Purdue executive J. David Haddox.³⁶ Dr. Haddox’s article did not concern a population
10 study at all, but rather, simply reported the possible phenomenon in a single cancer (leukemia)
11 patient with pneumonia and chest wall pain.³⁷

12 92. Portenoy took the deception of pseudoaddiction one step farther, separating from a
13 list of commonly accepted signs of drug addiction those he claimed were “probably less predictive
14 of addiction.”³⁸ Portenoy’s “less predictive of addiction” list included:

- 15 i. Aggressive complaining about the need for more drugs;
- 16 ii. Drug hoarding during periods of reduced symptoms;
- 17 iii. Requesting specific drugs;
- 18 iv. Openly acquiring similar drugs from other medical sources;
- 19 v. Unsanctioned dose escalation or other noncompliance with
20 therapy on one or two occasions;
- 21 vi. Unapproved use of the drug to treat other symptoms;
- 22 vii. Reporting psychic effects not intended by the clinician; and
- 23 viii. Resistance to a change in therapy associated with ‘tolerable’
24 adverse effects with expressions of anxiety related to the
return of severe symptoms.

25 ³⁵ Portenoy, R.K., *Opioid Therapy for Chronic Nonmalignant Pain: Current Status*, pp. 266-67.

26 ³⁶ *Id.* at 267.

27 ³⁷ Haddox, J.D. and Weissman, D.E., *Opioid pseudoaddiction – an iatrogenic syndrome*, *Pain*, 36 (1989) pp. 363-
366.

28 ³⁸ Portenoy, R.K., *Opioid Therapy for Chronic Nonmalignant Pain: Current Status*, p. 267, Table III.

1 93. Portenoy cited no authority for his “less predictive of addiction” conclusion and is
 2 not himself a specialist or authority in addiction medicine. Yet his list encouraged doctors to
 3 ignore obvious signs of addiction and prescribe more opioids.

4 94. Similarly, in his book, *Responsible Opioid Prescribing* (2007), which was funded
 5 by Defendants Cephalon and Purdue and is still distributed in California, Dr. Scott Fishman
 6 asserts: “It may be tempting to assume that patients with chronic pain and a history of recreational
 7 drug use who are not adherent to a treatment regimen are abusing medications. But other causes of
 8 non-adherence should be considered before a judgment is made.” Thus, according to Defendants,
 9 even patients at high risk for opioid addiction should be given the benefit of the doubt (and more
 10 opioids).

11 95. Defendants’ common marketing messages and concerted efforts were evident in the
 12 nearly identical language they used to describe pseudoaddiction (emphasis added):

<i>Let’s Talk Pain</i> (2009)	<i>A Policymaker’s Guide</i> (2011)	<i>Clinical Issues in Opioid Prescribing</i> (2005)
funded by Janssen	funded by Purdue	funded by Purdue
“A related term is pseudoaddiction, which refers to patient behaviors that may occur when pain is under-treated ... Pseudoaddiction is different from true addiction because such behaviors can be resolved with effective pain management.”	“Pseudo-addiction describes patient behaviors that may occur when pain is undertreated ... Pseudo-addiction can be distinguished from true add[i]ction in that this behavior ceases when pain is effectively treated.”	“Pseudoaddiction is a term which has been used to describe patient behaviors that may occur when pain is undertreated ... Even such behaviors as illicit drug use and deception can occur in the patient’s efforts to obtain relief. Pseudoaddiction can be distinguished from true addition in that the behaviors resolve when the pain is effectively treated.”

21 96. Despite Defendants’ claims, pseudoaddiction has no scientific basis; there is no
 22 competent study documenting its existence. Indeed, the list of behaviors that Defendants
 23 identified as the symptoms of pseudoaddiction are the same symptoms of addiction. Based on a
 24 single cancer pain case observed by Purdue executive and KOL David Haddox, Defendants have
 25 counseled doctors to treat chronic pain patients on opioids who seem to be addicted *with more*
 26 *opioids*.

1 97. KOL Dr. Lynn Webster recommended just this course in his book, *Avoiding Opioid*
2 *Abuse While Managing Pain* (2007). He advised giving patients more medication when unsure
3 whether a patient is showing signs of addiction or untreated pain. He asserted that
4 pseudoaddiction was the cause “*in most cases and should be the clinician’s first response.*” Lynn
5 R. Webster, Beth Dove, *Avoiding Opioid Abuse While Managing Pain* (2007) (emphasis added).
6 Years later, Dr. Webster reversed himself, acknowledging that “[pseudoaddiction] obviously
7 became too much of an excuse to give patients more medication.... It led us down a path that
8 caused harm. It is already something we are debunking as a concept.”

9 **b. Other adverse effects.**

10 98. Defendants also misrepresent the risks of long-term opioid use by describing them
11 as minor and short-term. Defendants most frequently highlight the risk of constipation, which they
12 advise can be addressed with laxatives or other treatments. The other side effects Defendants
13 typically disclose are drowsiness, nausea and vomiting, mental clouding (sometimes disclosed),
14 and itching, though Defendants promise that these symptoms will go away in a matter of days.

15 99. Below is a representative example of how Defendants disclose potential side effects
16 from opioid use in unbranded material. This is taken from a 2009 patient education publication
17 distributed by the NIPC and funded by Endo and which was distributed in California during the
18 applicable limitations period:

19 **As with any medication, there are some side effects that are associated with**
20 **opioid therapy. The most common side effects that occur with opioid use**
21 **include the following:**

- 22 ▶ Constipation
- 23 ▶ Drowsiness
- 24 ▶ Confusion
- 25 ▶ Nausea
- 26 ▶ Itching
- 27 ▶ Dizziness
- 28 ▶ Shortness of breath

Your healthcare provider can help to address and, in some cases, prevent side effects that may occur as a result of opioid treatment. Less severe side effects, including nausea, itching, or drowsiness, typically go away within a few days without the need for further treatment. If you experience any side effects, you should let your healthcare provider know immediately.

1
2 100. Notably absent from this list are far more significant adverse outcomes linked to
3 long-term opioid use, including: hyperalgesia, immunologic and hormonal dysfunction,
4 respiratory depression, apnea, tolerance/loss of analgesic efficacy, endocrinopathies (most notably
5 testosterone depletion, which, among other impacts, may decrease pain tolerance and the
6 effectiveness of opioids),³⁹ cognitive impairment, dependence, and addiction. These adverse
7 outcomes can result in an increase in falls and fractures in the elderly (which can shorten the lives
8 of elderly patients), overuse, overdose, and death. Defendants also fail to disclose the risk that
9 infants born to pregnant women using opioids will be dependent on opioids as well, suffering a
10 condition called neonatal abstinence syndrome when they painfully withdraw from the drug after
11 birth.⁴⁰ In addition, though the labels for opioids contain numerous warnings about use of opioids
12 for patients who have certain conditions, are opioid naïve (new to opioids), or use other drugs,
13 Defendants’ marketing materials contain no similar cautions.

14 101. These omitted side outcomes are not, as Defendants claim, fleeting or minor. A
15 Cochrane Collaboration review of evidence relating to the use of opioids for chronic pain found
16 that 22% of patients in opioid trials dropped out before the study began because of the “intolerable
17 effects” of opioids.⁴¹ Defendants were aware of this high drop-out rate as they pushed the FDA to
18 allow them to exclude these patients from clinical trial data, a method of research known as
19 “enriched enrollment,” which allowed drug companies to study only those patients who could
20 tolerate opioids.

21 102. Janssen’s marketing campaign for Nucynta was particularly deceptive in that it
22 promoted Nucynta’s “tolerability,” which is completely at odds with and misrepresents its serious
23 side effects. In an ad that Janssen currently is running, including on its website, it claims that

24 _____
25 ³⁹ Daniell HW, *Hypogonadism in men consuming sustained-action oral opioids*, J Pain, 3:377-384 (2002);
Katz N, Mazer M, *Impact of opioids on the endocrine system*, Clin J Pain, 25:170-175 (2009).

26 ⁴⁰ The FDA now requires a boxed warning on all extended release and long acting opioids, cautioning that chronic
27 use of those drugs by pregnant women can result in neonatal opioid withdrawal syndrome (“NOWS”), which may be
28 life-threatening and require specialized care.

⁴¹ Noble M, *et al.*, *Long-term opioid management for chronic noncancer pain (Review)*, Cochrane Database of
Systematic Reviews, Issue 1, 2010.

1 Nucynta ER has “Efficacy you need, Tolerability you want.” However, each of the studies
 2 included in the drugs approval were only conducted over a 12-week period, using a pre-seeded
 3 patient group; thus none provide support for a claim of long-term efficacy in the population at
 4 large.

5 103. Defendants’ misleading treatment of the serious risks of opioid treatment in
 6 unbranded materials directly contradicts the disclosures they made on their own labels. The label
 7 for Purdue’s OxyContin, for example, acknowledges that its use may increase the risk of serious
 8 adverse reactions “including respiratory depression, apnea, respiratory arrest, circulatory
 9 depression, hypotension, or shock[.]” Likewise, the label for Janssen’s Duragesic includes the
 10 warning that “[r]espiratory depression is the chief hazard of” Duragesic, and it “has a narrow
 11 indication and should be prescribed only by healthcare professionals who are knowledgeable in the
 12 administration of potent opioids and management of chronic pain.” The labels even include
 13 warnings for interactions with substances as commonly used as alcohol, as in the Nucynta ER
 14 label, which says that the drug “may be expected to have additive effects when used in conjunction
 15 with alcohol ... [and] respiratory depression, hypotension, and profound sedation, coma or death
 16 may result.” Yet upon information and belief, these risks are not highlighted in the educational
 17 programs and marketing materials Defendants have sponsored and disseminated; materials that are
 18 much more widely read and relied on than the drug labels.

19 104. The table below (emphasis added) highlights the differences, described above,
 20 between how Defendants (in this instance, Janssen) disclosed side effects in unbranded materials
 21 and front-group materials versus how they disclosed side effects in their branded advertisements:

Finding Relief: Pain Management for Older Adults (2009)	Let’s Talk Pain Website (2009)	Nucynta IR Advertisement (2010)
unbranded publication funded by Janssen	APF website funded by Janssen	branded Janssen advertisement
“At first, the drugs can cause upset stomach or sleepiness . These side effects often go away as you get used to the drugs. Some other side effects, such as constipation , don’t lessen with time. Constipation can be	“The most common side effects of opioids include constipation, nausea and vomiting, sedation (sleepiness), mental clouding, and itching . Some people may also experience dizziness or difficulty urinating ... The good	Prescriber information in the ad states: “ Respiratory depression is the primary risk of mu-opioid agonists.”

prevented or lessened by taking a laxative on a regular basis.”	news is that most side effects go away after a few days. However, side effects may continue in some people. Constipation is likely to persist.”	
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105. In a 2008 warning letter, the FDA recognized that these strategies deceptively represented the side effects of opioids – in that case, Avinza. The FDA complained that one of the company’s marketing materials (a file card) lists common adverse effects “including constipation, nausea, and somnolence,” but omitted all of the other risks listed in the drug’s package insert.

According to the FDA, the file card with a page headed “Managing Side Effects”

creates the misleading impression that the risk information contained in that section is a comprehensive presentation of the risks associated with Avinza therapy and the steps needed to address those risks. The fact that the File Card contains no other disclosure of drug risks reinforces this misleading impression. Furthermore, the File Card – in direct contradiction of the [Package Insert] for Avinza – implies that no serious or life-threatening risks (e.g., risk of respiratory depression, overdose, or death) can be caused by Avinza, both by disclosing only ‘common adverse events’ (e.g., constipation, nausea, and somnolence) and by emphasizing the drug’s ‘proven safety and tolerability’ throughout the piece. Finally, by framing its discussion of common adverse reactions as one of ‘managing’ them, and by providing no disclosure to the contrary, the File Card misleadingly implies that common adverse reactions associated with the use of Avinza may ordinarily be alleviated or mitigated, and therefore do not pose a risk to patients.... Your minimization of the serious risk profile associated with your drug raises significant public health concerns.

106. In promoting their opioids, Defendants have engaged in the same marketing practices warned against by the FDA – highlighting only minor risks, emphasizing the ability to manage those risks, failing to disclose serious risks, and generally declaring the safety of their drugs. As the FDA made clear, that message is dangerously deceptive. By deliberately understating the risks of opioids, Defendants exposed patients to extremely dangerous adverse effects and deprived doctors and patients of the ability to make informed, appropriate choices about using opioids.

107. Defendants’ pattern of understating the risks of chronic opioid therapies marred the continuing medical education programs and studies they funded or sponsored and left providers with the impression that opioids were much safer than they are and should be used more

1 frequently. One study by a Georgetown University Medical Center professor compared the
2 messages retained by medical students who reviewed an industry-funded article on opioids versus
3 another group who reviewed a non-industry-funded article. The industry-funded article did not
4 mention opioid-related death once; the non-industry-funded article mentioned opioid-related death
5 26 times. A summary of the study notes that students who read the industry-funded article more
6 frequently cited the impression that opioids were underused in chronic pain. Those reading the
7 non-industry-funded article, in reporting their “take-aways,” mentioned the risk of death and
8 addiction much more frequently than the other group. Neither group could accurately identify
9 whether the article they read was industry-funded, making clear the difficulty providers have in
10 screening and accounting for source bias.⁴²

11 **3. Misrepresentations regarding superiority.**

12 108. Defendants’ deliberate misrepresentation of the risks of opioids is particularly
13 evident when compared to Defendants’ description of the risk of over-the-counter nonsteroidal
14 anti-inflammatory drugs (“NSAIDs”), such as ibuprofen (Advil, Motrin) or naproxen (Aleve).
15 While NSAIDs can pose significant gastrointestinal and renal risks, particularly for elderly
16 patients, Defendants’ exaggerated descriptions of those risks make their omissions regarding the
17 risks of opioids all the more striking and misleading. In the Cephalon and Purdue-sponsored 2007
18 *APF Treatment Options*, NSAIDs are described as “life threatening,” – a term never used in
19 connection with opioids – and are said to have caused 10,000 to 20,000 deaths each year. The
20 CDC reports that the actual number of deaths even possibly related to the use of NSAIDs in 2008,
21 the most recent year available, is roughly 3,400, and that number includes all gastrointestinal
22 bleeding deaths regardless of cause.⁴³ The Defendant-funded brochure, excerpted below, was
23 distributed to doctors and patients in California during the applicable limitations period:
24
25

26 ⁴² Fugh-Berman A, *Marketing Messages in Industry-Funded CME*, Pharmedout, June 25, 2010, available at
<http://pharmedout.org/conferencematerials.htm>.

27 ⁴³ John Fauber, *NSAID Bleeding Risk: Smoke But No Fire*, MedPage Today, May 30, 2012, available at
www.medpagetoday.com/Geriatrics/PainManagement/32971.

<p>Non-steroidal anti-inflammatory drugs (NSAIDs) <i>NSAIDs</i> are a large family of medicines that work in a similar way to aspirin by relieving both pain and swelling. This class includes drugs such as ibuprofen, naproxen, and celecoxib. Some are available without a prescription.</p> <p><i>Advantages</i></p> <ul style="list-style-type: none"> • Relieve mild to moderate pain, fever, headaches, and swelling <p><i>Disadvantages</i></p> <ul style="list-style-type: none"> • Can cause stomach upset or bleeding in stomach or intestines • Can cause kidney or liver damage if taken at high doses or for a long time • May cause adverse reactions in people with asthma • Can increase the risk of heart attack and stroke 	<p>Opioid medications Medicines containing opioids have been used for centuries. <i>Opioids</i> are strong pain medicines for moderate to severe pain. Today, opioids come in many forms and strengths. Some work very quickly but don't last very long. Some give long-lasting pain relief. And some are less likely to be addictive.</p> <p>All opioids require a prescription. Talk to your doctor about what type of opioid would be best for you.</p> <p>Opioids usually produce side effects. At first, the drugs can cause upset stomach or sleepiness. These side effects often go away as you get used to the drugs. Some other side effects, such as constipation, don't lessen with time. Constipation can be prevented or lessened by taking a laxative on a regular basis.</p> <p>Used properly, opioid medications can make it possible for people with chronic pain to "return to normal"—get back to work, walk or run, play sports, and participate in other activities.</p>
<p>Topical anesthetics <i>Topical anesthetics</i> are used to numb the surface of a body part. They can be used to numb the front of the eye, the inside of the nose, the throat, the skin, the ear, the anus, and the genital area. Topical anesthetics are available in creams, ointments, aerosols, sprays, lotions, and jellies. They are used to relieve many types of pain and itching, such as that caused by sunburn, minor burns, insect bites or stings, nerve damage, or conditions such as hemorrhoids.</p>	<p>Opioid myths</p> <p>Myth: Opioid medications are always addictive. Fact: Many studies show that opioids are <i>rarely</i> addictive when used properly for the management of chronic pain.</p> <p>Myth: Opioids make it harder to function normally. Fact: When used correctly for appropriate conditions, opioids may make it <i>easier</i> for people to live normally.</p> <p>Myth: Opioid doses have to get bigger over time because the body gets used to them. Fact: Unless the underlying cause of your pain gets worse (such as with cancer or arthritis), you will probably remain on the same dose or need only small increases over time.</p>

1 - Finding Relief: Pain Management for Older Adults, sponsored by Defendant Janssen (2009)

109. As with the preceding misrepresentations, Defendants' false and misleading claims regarding the comparative risks of NSAIDs and opioids had the effect of shifting the balance of opioids' risks and purported benefits. While opioid prescriptions have exploded over the past two decades, the use of NSAIDs has declined during that same time.⁴⁴

C. Defendants, Directly and Through Their Agents and Front Organizations, Made and Caused Their Misrepresentations to Be Made and Broadly Disseminated

110. Defendants have polluted virtually every resource for information on the use of opioids to treat chronic non-cancer pain, and have created a deceptively solid foundation of core materials, cited and relied upon by others, to minimize the risks and overstate the benefits of using opioids to treat chronic pain. Both directly and indirectly – through doctors, medical education courses, seemingly independent patient advocacy groups, and professional societies – Defendants have ensured that their messages reach and expand the market for opioids. Upon information and belief, these strategies and players are deployed according to marketing plans that Defendants developed. Defendants have identified, encouraged, and compensated high profile KOLs to give

⁴⁴ Olfson M, et al., *National trends in the office-based prescription of schedule II opioids*, J Clin Psychiatry, 2013 Sept.; 74(9):932-9, available at <http://www.ncbi.nlm.nih.gov/pubmed/24107767>.

1 talks and advice and author books and articles. Defendants’ KOLs offer and serve on the program
2 committees that choose continuing medical education programs, and develop and promote
3 treatment guidelines that promote chronic opioid therapy. Many of these groups and KOLs have
4 been misled by Defendants in the same manner as general practitioners and family doctors.

5 111. Directly and through public relations firms they hire and advocacy groups and
6 professional societies they finance and influence, Defendants have funded, drafted, edited,
7 approved, published, and distributed websites, books, patient education brochures, videos, and
8 other materials that carry their misrepresentations to targeted groups of doctors (such as family
9 doctors), and patients – particularly veterans and the elderly. Defendants carry out their fraudulent
10 promotions both individually and in concert with industry front groups and each other, and make
11 and disseminate these misrepresentations throughout the State of California.

12 **1. Method 1: Key opinion leaders (“KOLs”).**

13 112. Defendants routinely rely on a small circle of doctors to promote the use of opioids
14 for the treatment of chronic pain. These doctors have been at the hub of Defendants’ promotional
15 efforts, presenting the appearance of unbiased and reliable medical research in order to support the
16 broad use of opioid therapy for chronic non-cancer pain. Known by industry shorthand as
17 “KOLs,” they have written, consulted on, edited, and lent their names to books and articles and
18 given speeches and continuing medical education programs supportive of chronic opioid therapy.
19 They served on committees that developed treatment guidelines that, even while acknowledging
20 the lack of evidence for their positions, strongly encourage the use of opioids to treat chronic pain.

21 113. Defendants’ KOLs have served on the boards of the advocacy groups and
22 professional societies that develop and offer continuing medical education programs and publish
23 patient education materials on opioids.

24 114. What Defendants and the KOLs rarely disclose is the substantial sums of money
25 Defendants have paid to the KOLs for consulting and speaking arrangements and to serve on
26 various panels and boards; as well as through purported “research grants.” Some KOLs have even
27 gone on to become direct employees and executives of Defendants. Dr. Haddox, for example, was
28

1 a KOL who, as a physician in private practice, promoted widespread opioid use for common non-
2 cancer chronic pain. He was a paid speaker and consultant for Purdue, then became a Purdue
3 employee and executive.

4 115. While some KOLs may initially have advocated for more permissive opioid
5 prescribing with honest intentions, Defendants cultivated and promoted only those KOLs who
6 could be relied on to help broaden the opioid therapy market. Defendants selected and funded
7 doctors whose public positions were unequivocal and supportive of using opioids to treat chronic
8 pain.⁴⁵ These doctor's professional reputations were then dependent on continuing to promote a
9 pro-opioid message, even in activities that were not directly funded by the drug companies.

10 116. The KOLs' association with Defendants provided not only money, but also
11 prestige, recognition, research funding, and avenues to publish. This positioned them to exert even
12 more influence in the medical community. Upon information and belief, using these KOLs is a
13 central part of Defendants' marketing plans and critical to persuading regulators and doctors – who
14 rely heavily and more uncritically on their peers – that the benefits of chronic opioid therapy
15 outweigh its risks.

16 117. Dr. Russell Portenoy, Chairman of the Department of Pain Medicine and Palliative
17 Care at Beth Israel Medical Center in New York, is one example of a KOL who Defendants
18 identified and co-opted to further their marketing campaign. With Defendants' support, Dr.
19 Portenoy was dubbed the "King of Pain" by Time Magazine. He co-authored *Chronic Use of*
20 *Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases (1986)*, which asserted, based
21 solely on 38 cases, that chronic opioid therapy was a safe and effective treatment for patients with
22 intractable non-malignant pain. His 1994 writings also strongly promoted opioid use long-term for
23 non-cancer pain, although even he suggested opioid therapy should be used for chronic pain only
24 as a last resort, after an initial limited trial period and with intense observation.⁴⁶

25 ⁴⁵ Opioid-makers were not the first to mask their deceptive marketing efforts in purported science. The tobacco
26 industry also used key opinion leaders in its effort to persuade the public and regulators that tobacco was not addictive
27 or dangerous. For example, the tobacco companies funded a research program at Harvard and chose as its chief
28 researcher a doctor who had expressed views in line with industry's views. He was dropped when he criticized low tar
cigarettes as potentially more dangerous, and later described himself as a pawn in the industry's campaign.

⁴⁶ Portenoy, R.K., *Opioid Therapy for Chronic Nonmalignant Pain: Current Status*, pp. 274-75, Table IV.

1 118. Dr. Portenoy thus helped to open the door for the use of opioids to treat chronic
2 pain. He served on the American Pain Society/American Academy of Pain Medicine Guidelines
3 Committee, which endorsed the use of opioids to treat chronic pain, and the FDA Anesthetic and
4 Life Support Drugs Advisory Committee, one of a host of FDA advisory committees that serve to
5 provide expertise and technical assistance to assist the FDA decision-making. While he held these
6 positions he also was receiving “research support,” consulting fees or honoraria from Cephalon,
7 Endo, Janssen, and Purdue (among others), and was a paid consultant to Cephalon and Purdue.

8 119. Another KOL, Dr. Lynn Webster, was the co-founder and Chief Medical Director
9 of Lifetree Clinical Research. He is a Senior Editor of the *Pain Medicine* Journal, which published
10 numerous articles supportive of chronic opioid therapy. He was President, and is a current board
11 member, of the American Academy of Pain Medicine, an ardent supporter of chronic opioid
12 therapy.

13 120. Dr. Webster is the author of numerous CME programs, sponsored by Defendants,
14 that contained virtually all of Defendants’ misrepresentations described above. At the same time,
15 Dr. Webster was receiving significant funding from Defendants.

16 121. Dr. Webster has been under investigation by the U.S. Drug Enforcement
17 Administration, which raided Dr. Webster’s clinic in 2010. More than 20 of Dr. Webster’s former
18 patients at the Lifetree Clinic died of opioid overdoses. Ironically, Dr. Webster created and
19 promoted an opioid risk tool, which purportedly allows a doctor to manage the risk that their
20 patient will become addicted to or abuse opioids.⁴⁷

21 122. In a striking blow to Defendants’ marketing campaign, Drs. Portenoy and Webster
22 recently acknowledged shortcomings in their pro-opioid positions. Dr. Webster has admitted that
23 the concept of pseudoaddiction – taking patients at their word and assuming they are not addicts,
24 but just need more pain relief “– obviously became too much of an excuse to give patients more
25 medication[.]”⁴⁸ Dr. Portenoy has admitted that he gave “innumerable lectures in the late 1980s

26 ⁴⁷ Stephanie Smith, *Prominent pain doctor investigated by DEA after patient deaths*, CNN HEALTH, Dec. 30,
27 2013, available at <http://www.cnn.com/2013/12/20/health/pain-pillar/>.

28 ⁴⁸ Silverman E, *Opioids & An Overdue Senate Probe: Kolodny Explains*, Pharmalot.com.

1 and '90s" in which he asserted that fewer than 1% of patients would become addicted to opioids
2 that "weren't true." Because the primary goal was to "destigmatize" opioids, he said, "we often
3 left evidence behind." Dr. Portenoy also conceded that "data about the effectiveness of opioids
4 does not exist."

5 **2. Method 2: Co-opting of chronic pain advocacy and research groups to**
6 **promote opioid use.**

7 123. A key component of Defendants' plans to promote the long-term use of opioids was
8 co-opting pain management organizations and societies and pain patient advocacy groups. Taking
9 a page from the tobacco industry's play book, which had created and used front groups to proclaim
10 tobacco was not harmful, Defendants harnessed and warped existing organizations to disseminate
11 their deceptive messages with the expectation that these messages would circulate among and
12 influence the conduct of prescribing physicians and other members of the medical community.
13 These front organizations appeared to be legitimate scientific and patient advocacy organizations
14 (and perhaps started out as such) and publicized seemingly scientific, balanced, and accurate
15 information on opioid use. In fact, the information was false and misleading and paid for and
16 encouraged by Defendants for the purpose of creating a vast market for the use of opioids for
17 chronic pain.

18 124. The role of these organizations in promoting opioid use and their ties to opioid
19 makers was highlighted when, on May 8, 2012, Senators Grassley and Baucus wrote to a half-
20 dozen of these organizations:

21 There is growing evidence pharmaceutical companies that
22 manufacture and market opioids may be responsible, at least in part,
23 for this epidemic [of opioid use and abuse] by promoting misleading
24 information about the drugs' safety and effectiveness. Recent
25 investigative reporting from the *Milwaukee Journal*
26 *Sentinel/MedPage Today* and *ProPublica* revealed extensive ties
27 between companies that manufacture and market opioids and non-
28 profit organizations such as the American Pain Foundation, the
American Academy of Pain Medicine, the Federation of State
Medical Boards, the University of Wisconsin Pain and Policy Study
Group, and the Joint Commission.

In a *ProPublica* story published in the *Washington Post*, the
watchdog organization examined the American Pain Foundation, a
"health advocacy" organization that received "nearly 90 percent of

1 its \$5 million funding from the drug and medical device industry.”⁴⁹
2 *ProPublica* wrote that its review of the American Pain Foundation’s
3 “guides for patients, journalists, and policymakers play down the
4 risks associated with opioids and exaggerate their benefits. Some of
5 the foundation’s materials on the drugs include statements that are
6 misleading or based on scant or disputed research.

7 According to the *Milwaukee Journal Sentinel/MedPage Today*, a
8 “network of national organizations and researchers with financial
9 connections to the makers of narcotic painkillers ... helped create a
10 body of dubious information” favoring opioids “that can be found in
11 prescribing guidelines, patient litigators, position statements, books
12 and doctor education courses.”⁵⁰

13 125. These front groups, aided by millions of dollars in grants from Defendants and
14 assistance from public relations firms hired by Defendants, spread the misrepresentations central to
15 Defendants’ fraudulent promotion of opioids. Indeed, Defendants influenced, if not outright
16 controlled, the messages disseminated by many of these front groups.

17 **a. American Pain Foundation.**

18 126. The most prominent of Defendants’ front groups was the American Pain
19 Foundation (“APF”), which received [REDACTED] in funding from Defendants from
20 2007 until it closed its doors in May 2012. [REDACTED]
21 [REDACTED]

22 127. APF issued education guides for patients, reporters, and policymakers that
23 promoted the benefits of opioids for chronic pain and trivialized their risks, particularly the risk of
24 addiction. APF also launched a campaign to promote opioids for returning veterans, described in
25 greater detail below; promotion of opioids to treat veterans has contributed to high rates of
26 addiction among our returning soldiers. APF engaged in a significant multimedia campaign –
27 through radio, television and the web – to educate patients about their “right” to pain treatment –
28 namely opioids. KOLs funded by Defendants, including Drs. Perry Fine, Scott Fishman and
Kathleen Foley, also served on APF’s Board of Directors.

⁴⁹ *ProPublica, The Champion of Painkillers*, Dec. 23, 2011, available at <http://www.propublica.org/article/the-champion-of-painkillers>.

⁵⁰ John Fauber, *Follow the Money: Pain, Policy, and Profit*, MILWAUKEE JOURNAL SENTINEL/ MEDPAGE TODAY Feb. 19, 2012, available at <http://www.medpagetoday.com/Neurology/PainManagement/31256>.

1 128. In 2009 and 2010, [REDACTED] APF's operating budget came from industry
2 sources. Including industry grants for specific projects, in 2009, APF received [REDACTED]
3 from industry sources out of total income of [REDACTED]; its budget for 2010 projected
4 receipts of [REDACTED] from drug companies, out of total income of [REDACTED]
5 [REDACTED]
6 [REDACTED].

7 129. But the control was even more direct than the money. [REDACTED]
8 [REDACTED]
9 [REDACTED]
10 [REDACTED]
11 [REDACTED]
12 [REDACTED]
13 [REDACTED]
14 [REDACTED]

15 130. [REDACTED] opioid "tool-kit" for the National Initiative
16 on Pain Control [REDACTED]
17 [REDACTED]
18 [REDACTED]
19 [REDACTED] included two of Defendants' key
20 misrepresentations:

- 21 • After starting opioid therapy, you may see the following
22 positive improvements: - Your pain level may decrease[;]
23 -Your level of function should improve: you may find you
24 are now able to participate in activities of daily living, such
25 as work and hobbies, that you were not able to enjoy when
26 your pain was worse[;] - Your sleep may improve.
- 27 • People who take opioids as prescribed usually do not become
28 addicted.

26 131. At a July 2007 hearing before the Senate Judiciary Committee, "evaluating the
27 propriety and adequacy of the oxycontin criminal settlement," APF aggressively defended Purdue,
28

1 repeatedly denying that patients prescribed opioids abuse or become addicted to the drugs. APF's
2 board chairman, Dr. James Campbell, described addiction as a "rare problem" for chronic pain
3 patients and asserted that "the scientific evidence suggests that addiction to opioids by legitimate
4 chronic pain patients without prior histories of substance abuse using the medication as directed is
5 rare. Furthermore, no causal effect has been demonstrated between the marketing of oxycontin
6 and the abuse and diversion of the drug."

7 132. Despite APF's unequivocal pro-opioid positions, [REDACTED]

8 [REDACTED]
9 [REDACTED]
10 [REDACTED]
11 [REDACTED]
12 [REDACTED]
13 133. On May 8, 2012, Senators Grassley and Baucus wrote the Chairman of APF
14 seeking information about the source of its funding and asked for a response by June 8, 2012. APF
15 shuttered its offices and dissolved before that deadline.

16 **b. American Academy of Pain Medicine.**

17 134. The American Academy of Pain Medicine, with the assistance, prompting,
18 involvement, and funding of Defendants, issued treatment guidelines and sponsored and hosted
19 medical education programs critical to Defendants' deceptive marketing of chronic opioid therapy.
20 Upon information and belief, the American Academy of Pain Medicine received significant
21 funding from opioid manufacturers in a two-year period.

22 135. The American Academy of Pain Medicine maintained a corporate relations council,
23 whose members paid \$25,000 a year (on top of other funding) to participate. The benefits included
24 allowing members to present educational programs at off-site dinner symposia in connection with
25 the American Academy of Pain Medicine's marquee event, its annual meeting in Palm Springs.

26 [REDACTED]
27 [REDACTED]
28 [REDACTED]

1 The American Academy of Pain Medicine describes the annual event as an “exclusive venue” for
2 offering education programs to doctors. Defendants Endo, Purdue, Cephalon, and Actavis were
3 members of the council and presented deceptive programs to doctors who attended this annual
4 event.

5 136. The American Academy of Pain Medicine and American Pain Society issued a
6 consensus statement in 1997, *The Use of Opioids for the Treatment of Chronic Pain*, that endorsed
7 opioids to treat chronic pain and claimed that the risk that patients would become addicted to
8 opioids was low. The co-author of the statement, Dr. Haddox, was at the time a paid speaker for
9 Defendant Purdue; three years later, he became Vice President for Health Policy at Purdue.
10 American Academy of Pain Medicine and APS revised their guidelines in 2009 and continued to
11 recommend the use of opioids to treat chronic pain. Fourteen of the 21 panel members who
12 drafted the guidelines, including KOL Dr. Portenoy, received support from Defendants Janssen,
13 Cephalon, Endo, and Purdue. Upon information and belief, the consensus statement remained on
14 The American Academy of Pain Medicine’s website until 2011, and was taken down only after a
15 doctor complained.

16 **3. Method 3: Treatment guidelines.**

17 137. Treatment guidelines have been particularly important in securing acceptance for
18 chronic opioid therapy. They are relied upon by doctors, especially the general practitioners and
19 family doctors targeted by Defendants, who are otherwise not experts in, nor trained in, the
20 treatment of chronic pain. Treatment guidelines used in making treatment decisions are cited
21 throughout the scientific literature and are referenced by third-party payers in determining whether
22 they should cover treatments for specific indications.

23 138. Initially, even Defendants’ KOLs were reasonably balanced and cautious in their
24 proposed guidelines. For example, Dr. Portenoy’s 1994 proposed guidelines stated as follows:

25 **Table IV**
26 **Proposed guidelines in the management of opioid maintenance**
therapy for nonmalignant pain

- 27 1. Should be considered only after all other reasonable attempts at
28 analgesia have failed.

2. A history of substance abuse, severe character pathology and chaotic home environment should be viewed as relative contraindications.
3. A single practitioner should take primary responsibility for treatment.
4. Patients should give informed consent before the start of therapy; points to be covered include recognition of the low risk of true addiction as an outcome, potential for cognitive impairment from the drug alone or from co-administration of sedative/hypnotics, likelihood that physical dependence will occur (abstinence possible with acute discontinuation), and understanding by female patients that children born when the mother is receiving opioid drugs will likely be physically dependent at birth.
5. After drug selection, doses should be given on an around-the-clock basis; several weeks should be agreed upon as the period of initial dose titration, and although improvement in function should be continually stressed, all should agree to at least partial analgesia as the appropriate goal of therapy.
6. Failure to achieve at least partial analgesia at relatively low initial doses in the non-tolerant patient raises questions about the potential treatability of the pain syndrome with opioids.
7. Emphasis should be given to attempts to capitalize on improved analgesia by gains in physical and social function; opioid therapy should be considered complementary to other analgesic and rehabilitative approaches.
8. In addition to the daily dose determined initially, patients should be permitted to escalate dose transiently on days of increased pain; two methods are acceptable: a) Prescription of an additional 4-6 "rescue doses" to be taken as needed during the month; b) Instruction that one or two extra doses may be taken on any day, but must be followed by an equal reduction of dose on subsequent days.
9. Initially, patients must be seen and drugs prescribed at least monthly. When stable, less frequent visits may be acceptable.
10. Exacerbations of pain not effectively treated by transient, small increases in dose are best managed in the hospital, where dose escalation, if appropriate, can be observed closely and return to baseline doses can be accomplished in a controlled environment.
11. Evidence of drug hoarding, acquisition of drugs from other physicians, uncontrolled dose escalation, or other aberrant behaviors must be carefully assessed. In some cases, tapering and discontinuation of opioid therapy will be necessary. Other patients may appropriately continue therapy within rigid guidelines. Consideration should be given to consultation with an addiction medicine specialist.
12. At each visit, assessment should specifically address:
 - a. Comfort (degree of analgesia)
 - b. Opioid-related side effects
 - c. Functional status (physical and psychosocial)

d. Existence of aberrant drug-related behaviors

13. Use of self-report instruments may be helpful but should not be required.
14. Documentation is essential and the medical record should specifically address comfort, function, side effects and the occurrence of aberrant behaviors repeatedly during the course of therapy.⁵²

139. The measured precaution evident in Dr. Portenoy's early guidelines was excluded from later guidelines funded and sponsored by Defendants. As noted above, in 2009 the American Pain Society, together with the American Academy of Pain Medicine, issued their *Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Non-cancer Pain*. Though Dr. Portenoy served on the panel, the Guidelines represented a marked departure from previous guidelines for the promotion of opioids. The APS/AAPM guidelines promote opioids as "safe and effective" for treating chronic pain, despite acknowledging limited evidence, and conclude that the risk of addiction is manageable for patients with and without past abuse histories. One member of the panel, Dr. Joel Saper, Clinical Professor of Neurology at Michigan State University and the founder of the Michigan Headache & Neurological Institute, resigned from the panel because of his concerns that the guidelines were influenced by contributions by Defendants to the sponsoring organizations and committee members. These guidelines have been a particularly effective channel of deception and have influenced not only treating physicians, but the body of scientific evidence on opioids; the APS/AAPM guidelines have been cited 732 times in academic literature that was disseminated in California during the applicable limitations period are still available on the internet, and were reprinted in the *Journal of Pain* in 2009.

140. In 2009, the American Geriatric Society ("AGS") revised its guidelines for the *Pharmacological Management of Persistent Pain in Older Persons*. Upon information and belief, these guidelines were funded by Defendants Purdue and Janssen, and included the following recommendations:

- "All patients with moderate to severe pain ... should be considered for opioid therapy (low quality of evidence, strong recommendation)."

⁵² Portenoy, R.K., *Opioid Therapy for Chronic Nonmalignant Pain: Current Status*, pp. 274-75, Table IV.

- “[Th]e risks [of addiction] are exceedingly low in older patients with no current or past history of substance abuse.”

These recommendations, which continue to appear on AGS’s website, are not supported by any study or other reliable scientific evidence and they are contrary to Dr. Portenoy’s 1994 guidelines which noted opioid therapy as a last resort and required disclosure of the risk of addiction and other significant risks of the therapy.

141. According to one news report, the American Geriatric Society received \$344,000 in funding from opioid makers since 2009.⁵³ Five of 10 of the experts on the guidelines panel disclosed financial ties to Defendants, including serving as paid speakers and consultants, presenting CMEs sponsored by Defendants, receiving grants from Defendants and investing in Defendants’ stock.⁵⁴

142. In contrast, treatment guidelines that did not receive industry backing are much more reserved and endorse chronic opioid therapy only in narrow circumstances. The 2012 *Guidelines for Responsible Opioid Prescribing in Chronic Non-Cancer Pain*, issued by the American Society of Interventional Pain Physicians, included a remarkable disclaimer that “[t]he recent revelation that the pharmaceutical industry was involved in the development of opioid guidelines as well as the bias observed in the development of many of these guidelines illustrate that the model guidelines are not a model for curtailing controlled substance abuse and may, in fact, be facilitating it.” The American Society of Interventional Pain Physicians Guidelines further advise that “therapeutic opioid use, specifically in high doses over long periods of time in chronic non-cancer pain starting with acute pain, not only lacks scientific evidence, but is in fact associated with serious health risks including multiple fatalities, and is based on emotional and political propaganda under the guise of improving the treatment of chronic pain.” They recommend long-acting opioids in high doses only “in specific circumstances with severe intractable pain ... with

⁵³ John Fauber, *Narcotic Painkiller Use Booming Among Elderly*, MILWAUKEE JOURNAL SENTINEL, May 30, 3012.

⁵⁴ The Institute of Medicine recommends that, to ensure an unbiased result, that fewer than 50% of the members of a guidelines committee should have financial relationships with drug companies.

1 continuous adherence monitoring, in well-selected populations, in conjunction with or after failure
2 of other modalities of treatments with improvement in physical and functional status and minimal
3 adverse effects.”

4 143. Similarly, the 2011 *Guidelines for the Chronic Use of Opioids*, issued by the
5 American College of Occupational and Environmental Medicine, recommended against “routine
6 use of opioids for treatment of chronic pain patients,” finding “at least moderate evidence that
7 harms and costs exceed benefits based on limited evidence,” while conceding there may be
8 patients for whom opioid therapy is appropriate.

9 144. Industry supported guidelines, in contrast, separate the strength of the
10 recommendation from the strength of evidence supporting the recommendation. For instance,
11 most of the “strong” recommendations of the APS/AAPM guidelines are backed by only weak
12 evidence. Further, the guidelines Defendants supported fail to adequately take into account the
13 potential adverse effects and specific label warnings that a physician should take into consideration
14 in deciding on a treatment for any medical condition. As a result, they present a distorted picture
15 of treatment options.

16 **4. Method 4: Continuing medical education.**

17 145. The millions of doctors and other health care professionals⁵⁵ who participate in
18 accredited CMEs constitute an enormously important audience for opioid reeducation. Defendants
19 have sponsored thousands of CME programs that promote chronic opioid therapy and support and
20 disseminate the deceptive and biased messages described in this Complaint. Upon information and
21 belief, Defendants’ grant making to fund and sponsor CMEs has been influenced by their
22 marketing strategies and harnessed to the goal of increasing opioid sales. Upon information and
23 belief, Defendants are more than passive funders of these programs, which reached tens of
24 thousands of doctors; they have influenced, if not outright controlled, the messages on topics and
25 in the fields of practice Defendants targeted.

26
27 ⁵⁵ Schwart, *et al.*, *Medical Communication Companies and Continuing Medical Education: Clouding the*
28 *Sunshine*, JAMA Intern Med., Dec. 18, 2012, p. 2507.

1 146. Defendants have long-standing relationships with the professional associations,
2 advocacy organizations, presenters, and CME development companies that select and develop
3 opioid-related CMEs. These organizations have depended upon Defendants’ financial support for
4 their activities and, in some cases, their very existence. It stands to reason that each of these
5 organizations and the individuals running them know and believe that future financial support
6 from Defendants depends upon producing programs that support the use of Defendants’ products.

7 147. Defendants are able to influence CMEs because they funded: (1) the KOLs who
8 serve on the program committees of the professional societies that select the presentations and
9 speakers and promote the views on which the presentations rely; (2) the KOLs who serve as
10 speakers for the CMEs; and (3) the professional societies that host the conferences at which the
11 presentations are given. Upon information and belief, many of these programs focus exclusively
12 on prescribing opioids, and do not fairly present reasonable alternative treatments (except to
13 discount them), nor do they fairly present (or present at all) the risks or benefits of chronic opioid
14 therapy, nor how to take patients off opioids, once prescribed.

15 148. Defendants’ sales representatives participated in these conferences, encouraged
16 doctors to attend the programs, and held auxiliary events that reinforced and amplified the
17 distorted messaging of the CMEs. The CMEs themselves, however, buttressed by printed
18 disclaimers by Defendants, were marketed to appear evidence-based and unbiased. In fact, like
19 KOLs, the CMEs are particularly effective for disseminating Defendants’ messages because
20 doctors rely on these peer-led professional events to deepen their understanding of clinical
21 issues.⁵⁶

22 149. *Path of the Patient, Managing Chronic Pain in Younger Adult at Risk for Abuse*, a
23 CME program sponsored, in part, by Purdue and edited by KOL Dr. Perry Fine, provides one
24 example of Defendants’ use of CMEs to spread deceptive messages supportive of chronic opioid
25 therapy. *Path of the Patient* aimed to educate primary care doctors about managing chronic pain
26

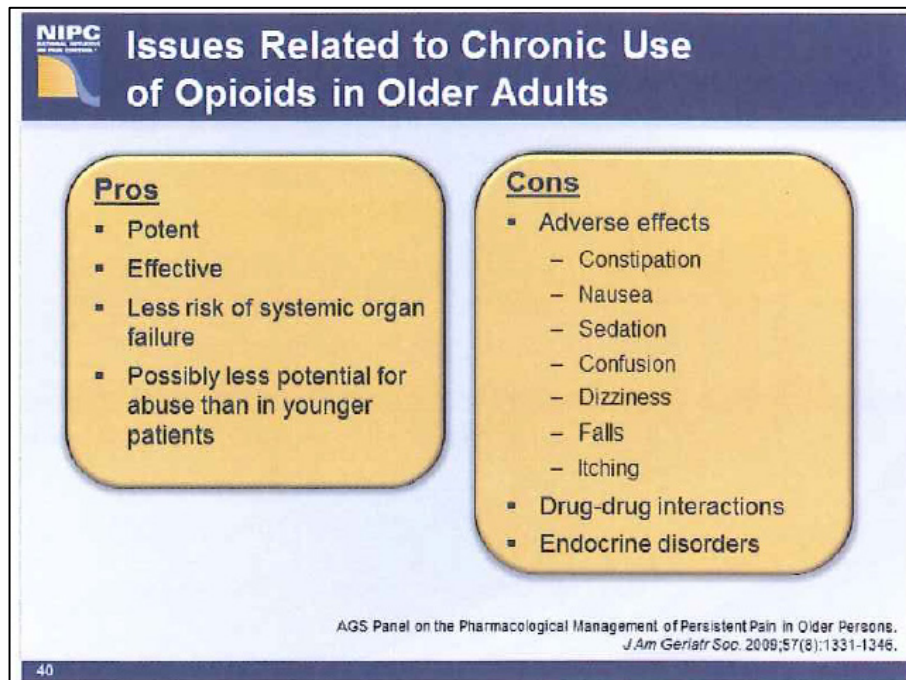
27 ⁵⁶ This is especially true in the Counties and State since all California-licensed physicians (except pathologists and
28 radiologists), beginning in 2001, have been required to take a full-day course on “pain management.”

1 with opioids. The presentation is devoted entirely to opioid prescribing and, despite its title,
2 presents *no other* potential treatments. Far from a therapy of last resort, as conventional medical
3 thought advised, *Path of the Patient* promotes opioid therapy as the only solution, even for
4 common chronic pain issues such as back pain. This CME was available on-line for California
5 physicians, and others, to view during the relevant statute of limitations period.

6 150. In a role play in *Path of the Patient*, a patient who suffers from back pain tells his
7 doctor that he is taking twice as many hydrocodone pills a day as directed. The doctor reports that
8 the pharmacy called him because of the patient's early refills. The patient has a history of drug
9 and alcohol abuse. Even given these facts, an authoritative narrator notes that, because of a
10 condition known as pseudoaddiction, the doctor should not assume his patient is addicted even if
11 he persistently asks for a specific drug, seems desperate, hoards medicine, or "overindulges in
12 unapproved escalating doses." The doctor in the role play treats this patient by prescribing a high-
13 dose, long-acting opioid.

14 151. An Endo-sponsored continuing medical education program put on by the American
15 Pain Foundation's National Initiative for Pain Control, *Persistent Pain in the Older Adult*, also
16 reprises several of Defendants' misrepresentations. The program was first made available on-line,
17 including to California residents, in 2011 and continued to be available during the relevant statute
18 of limitations period. The CME describes fear of addiction, safe use, and drug-drug interactions –
19 all factors relating to addiction, abuse, and overdose – as the most significant barriers to treating
20 "persistent" or chronic pain in the elderly. The presentation counsels that acetaminophen should
21 be used only short-term and includes five slides on the FDA's restrictions on acetaminophen and
22 its adverse outcomes, including severe liver injury and anaphylaxis (shock). Citing the American
23 Geriatric Society's treatment guidelines as its sole support, the CME describes the "chronic use of
24 opioids in older adults" as "effective" and notes "possibly less potential for abuse than in younger
25 patients." Its listed adverse outcomes simply omit addiction, overdose, respiratory depression, or
26 death, among others, and the slides note that tolerance to opioids more mild side effects (such as
27
28

1 dizziness or nausea) “develops within days to weeks.” The CME never discloses the heightened
2 risks opioids pose to elderly patients (see below).



15 152. In 2012, the American Academy of Pain Medicine offered a *Safe Opioid*
16 *Prescribing Course* in connection with its annual conference. The course promised that
17 participating doctors would “get the answers from the leading experts in pain” and offered up to 36
18 hours of CME credit. The course was sponsored by Defendants Purdue and Endo, and the faculty
19 included noted pro-opioid KOLs such as Drs. Fine, Fishman, Haddox and Webster. Indeed, Dr.
20 Webster, two other doctors from Dr. Webster’s clinic, and Dr. Haddox, a Purdue executive, all
21 served on the course program planning committee.

22 153. The course materials included a 560-page syllabus, which contained selected
23 studies, literature and slide decks from the presenters. The syllabus also contained numerous
24 misrepresentations including, for example: pseudoaddiction; risk of addiction can be managed
25 (use of screening tools; high-risk patients may be considered for chronic opioid therapy); taking
26

1 opioids long-term to treat chronic non-cancer pain improves quality of life and physical function;
2 promotion of the American Academy of Pain Medicine’s guideline recommendations.

3 154. Dozens of CMEs, that were and continue to be available to doctors in California
4 and during the relevant limitations period, also promoted the false concept that the risk of
5 addiction to opioids is low and that doctors can identify and manage patients at higher risk of
6 addiction. The programs train doctors to use specific risk training tools without disclosing that the
7 tools are unproven or the lack of evidence that high-risk – or any – patients can take opioids long-
8 term without becoming addicted.

9 **5. Method 5: Scientific articles.**

10 155. Defendants rely on misleading and deceptive citation of purported authorities to
11 overstate the benefits of chronic opioid therapy and minimize its serious risks and fail to disclose
12 contrary evidence. For instance, APF’s *Policymaker’s Guide* (2011) makes the particularly callous
13 representation that less than 1% of children prescribed opioids will become addicted. In support of
14 this contention it misleadingly cites a 1996 article by Dr. Kathleen Foley concerning cancer pain.
15 The purpose of the *Guide* was to support opioid therapy generally; it was not focused on or
16 restricted to cancer pain patients – the only population addressed in Dr. Foley’s article, which also
17 did not reference pediatric cancer patients or include *any* statistics on addiction rates. Defendants
18 funded and distributed the Guide with this misleading citation, knowing that there was no evidence
19 to support the general assertion that children will not become addicted to opioids, even when taken
20 long-term. The Guide was disseminated in the State of California within the applicable limitations
21 period.

22 156. Similarly, a 2003 scientific study funded by Purdue and co-authored by a Purdue
23 employee concluded that OxyContin is “effective and safe for the management of [chronic
24 diabetes-related pain] and improves QOL [quality of life].” The study asserts that there is
25 “evidence that the risk of psychological dependence or addiction is low in the absence of a history
26 of substance abuse.” The authors cite a single article by Porter and Jick, *Addiction Rare in*
27 *Patients Treated with Narcotics*, published in the prestigious New England Journal of Medicine.
28

1 What the authors fail to disclose is that the “evidence” is actually a letter to the editor, not a peer
2 reviewed article. Moreover, the letter describes not a study but a chart review of hospitalized
3 patients; if medical charts failed to note that the patients exhibited documented signs of addiction
4 while on opioids, the authors concluded that they were not addicted. Not only did the study not
5 support the authors’ assertion, but the authors’ misleading citation of it created a false impression
6 of its reliability. The Porter and Jick letter and the 2003 Purdue study have been cited 819 and 455
7 times, respectively, in the medical literature since 2008.

8 157. Practicing doctors, particularly the busy family doctors and general practitioners
9 targeted by Defendants, do not have the time to look behind seemingly authoritative sources,
10 particularly in scientific literature. They do – and must be able to – rely on citations to scientific
11 literature, a fact that Defendants use to their advantage. Moreover, the misleading use of studies –
12 to give them weight or meaning they do not have – is like a virus; once embedded in the literature,
13 it takes on a life of its own. Studies that assert addiction is rare, relying either on the Foley or
14 Porter-Jick analyses, themselves are cited for the proposition. Thus, with a few key manipulations
15 and deceptive citations, Defendants were able to seed a scientific consensus supportive of chronic
16 opioid therapy.

17 **6. Method 6: Patient education.**

18 158. Defendants reach chronic pain patients through written publications, websites, and
19 videos designed to present the purported “facts” about opioids in a simple, user-friendly manner.
20 As Defendants know, these materials are accessed by both patients doing their own research and
21 doctors, who read them when distributing them to patients. The materials Defendants produced
22 concerning opioids include numerous fraudulent representations, overstate the benefits of chronic
23 opioid therapy and fail to fully disclose its risks, particularly the risks of addiction.

24 159. For example, Janssen funded a patient education pamphlet produced by public
25 relations firm Conrad & Associates. The pamphlet, *Finding Relief: Pain Management for Older*
26 *Adults*, 2009 (also sponsored by AGS, and American Academy of Pain Medicine) is unbranded.

1 160. Because the piece is general and does not seem to promote a particular drug, and
2 because it is co-sponsored by a credible and seemingly neutral professional organizations (the
3 American Geriatric Society and the American Academy of Pain Medicine), patients are more
4 likely to read and credit it. The pamphlet was distributed in the State of California within the
5 applicable limitations period.

6 161. *Finding Relief* promises: “Used properly, opioid medications may make it possible
7 for people with chronic pain to “return to normal” – get back to work, walk or run, and play sports,
8 and participate in other activities.” *Finding Relief* describes opioids as “rarely addicting when
9 used properly for the management of chronic pain” and assures that “unless the underlying cause
10 of your pain gets worse ... you will probably remain on the same dose or only need small increases
11 over time.” As described above, these contentions are wholly lacking in scientific or clinical
12 support. Upon information and belief, Defendants were involved in developing and approving the
13 deceptive messages in patient education booklets such as this one.

14 162. Defendants created campaigns – including literature, websites, community groups,
15 and programs – related to chronic non-cancer pain from illnesses such as low back pain, shingles,
16 migraines, osteoarthritis, phantom limb pain, fibromyalgia and multiple sclerosis. These
17 conditions affect significant numbers of people, who have formed affinity groups and on-line
18 communities for support in seeking to address conditions that produce persistent pain and may
19 necessitate long-term treatment. Defendants used this community-building to promote the use of
20 opioids in the treatment of these conditions, despite the fact that there was little or no scientific
21 evidence supporting the use of opioids for these conditions, and little or no evidence supporting or
22 even suggesting that the use of opioids for these conditions would provide more benefit from pain
23 relief than harm from the many known and significant opioid treatment risks. None of these
24 conditions reflect indications approved to appear on Defendants’ drug labels, supporting the
25 inference that Defendants did not have evidence to obtain such approval.

26 163. In addition to their general marketing efforts, Defendants made special efforts to
27 market to two particularly vulnerable patient groups: the elderly and veterans. While obvious
28

1 markets for chronic pain medications, each of these patient populations has risk factors that make
2 long-term opioid use particularly dangerous.

3 **(1) Elderly patients.**

4 164. Elderly patients taking opioids have been found to suffer elevated fracture risks, a
5 greater risk for hospitalizations, and increased vulnerability to adverse drug effects and
6 interactions, such as respiratory depression, which, as Defendants acknowledge in their labels,
7 occurs more frequently in elderly patients.⁵⁷ A 2010 paper in the Archives of Internal Medicine
8 reported that elderly patients who used opioids had a significantly higher rate of death, heart
9 attacks, and strokes than users of NSAIDs. Defendants’ targeted marketing to the elderly and the
10 absence of cautionary language in its promotional materials flies in the face of scientific evidence
11 and even their own labels.

12 165. In their effort to reach elderly patients, who experience pain associated with
13 arthritis and other aging-related conditions, Defendants supported the American Geriatric Society,
14 which produced the treatment guidelines discussed at ¶¶ 140-41 and education materials focused
15 on elderly patients. *Finding Relief: Pain Management for Older Adults*, a 2009 publication
16 sponsored by Janssen, repeated the same unsubstantiated, deceptive statements that opioids are
17 “rarely addictive” and increase patients’ function, allowing them to get back to work or participate
18 in recreational activities.

19 166. Defendants also promoted the notion – also without adequate scientific foundation –
20 that the elderly are particularly unlikely to become addicted to opioids. The American Geriatric
21 Society’s 2009 Guidelines, for example, described addiction rates as “exceedingly low in older
22 patients with no current or past history of substance abuse.” Yet, a 2010 study that examined
23 overdoses among long-term opioid users found that the largest number of patients among those with
24 serious overdoses were 65 or older.⁵⁸

25
26 ⁵⁷ Saunders/Dunn, *et al.*, *Relationship of opioid use and dosage levels to fractures in older chronic pain patients*,
J Gen Intern Med 2010; 25:310-5.

27 ⁵⁸ Dunn, *et al.*, *Opioid Prescriptions for Chronic Pain and Overdose: A Cohort Study*, Annals of Internal
28 Medicine. 2010, available at http://www.rsds.org/2/library/article_archive/pop/DunnKM_AnnInternMed_2010.pdf.

1 170. Defendants have targeted veterans with fraudulent and unproven representations.
2 As early as 2001, a Purdue promotional plan described spending hundreds of thousands of dollars
3 to target the Veterans Administration and admitted that it was using “education” for what was
4 actually marketing.⁶¹ “Corporate initiatives and partnering efforts were very successful with the
5 Veterans Administration. In addition to building sales for OxyContin Tablets, it also positioned
6 Purdue as the leader in pain management education.”⁶²

7 171. *Exit Wounds*, a 2009 publication [REDACTED]
8 [REDACTED] promoted as a personal narrative by one veteran writing to others,
9 describes opioids as “under-used” and the “gold standard of pain medications” and fails to disclose
10 the risk of addiction, overdose, or injury. It notes that opioid medications “*increase* your level of
11 functioning” (emphasis in original) and that “[I]ong experience with opioids shows that people
12 who are not predisposed to addiction are very unlikely to become addicted to opioid pain
13 medications.” The book also asserts that “denying a person opioid pain medications because he or
14 she has a history of substance abuse or addiction is invalid and contrary to the guidelines for the
15 prescription of opioids published by the U.S. Federation of State Medical Boards.” The U.S.
16 Federation of State Medical Boards itself received support from Defendants during the time it
17 created and published its guidelines for prescription of opioids. Upon information and belief, *Exit*
18 *Wounds* was disseminated in the State of California within the applicable limitations period.

19 172. *Exit Wounds* minimizes the risks from chronic opioid therapy and does not disclose
20 the risk that opioids may cause fatal interactions with anti-anxiety medications taken by a
21 significant number of veterans. [REDACTED]
22 [REDACTED]
23 [REDACTED]

26 ⁶¹ *Critics say pharmaceutical firms spurred the increase in prescriptions for narcotic painkillers*,
STATESMAN.COM, Sept. 29, 2012, available at <http://www.statesman.com/news/news/local-military/critics-say-firms-spurred-painkiller-prescriptions/nSPNL/>.

27 ⁶² *Id.*

1 [REDACTED]
2 [REDACTED]
3 173. The deceptive nature of *Exit Wounds* is made obvious in comparing it to guidance
4 on opioids published by the VA and Department of Defense (“DOD”) in 2010 and 2011. The
5 VA’s *Taking Opioids Responsibly* describes opioids as “dangerous.” It cautions against taking
6 extra doses or using multiple doctors for prescriptions and mentions the risk of overdose and the
7 dangers of interactions with alcohol. The list of side effects from opioids includes decreased
8 hormones, sleep apnea, hyperalgesia, addiction, immune system changes, birth defects and death –
9 none of which are disclosed in *Exit Wounds*. *Clinical Guidelines on Management of Opioid*
10 *Therapy for Chronic Pain*, issued by the DOD, discloses that its review “revealed the lack of solid
11 evidence based research on the efficacy of long-term opioid therapy. Almost all of the randomized
12 trials of opioids for chronic non-cancer pain were short-term efficacy studies. Critical research
13 gaps ... include: lack of effectiveness studies on long-term benefits and harms of opioids ...;
14 insufficient evidence to draw strong conclusions about optimal approaches to risk stratification ...;
15 lack of evidence on the utility of informed consent and opioid management plans ...; and treatment
16 of patients with chronic noncancer pain at higher risk for drug abuse or misuse.” These
17 disclosures are missing from Defendants’ marketing to veterans.

18 **D. Defendants Often Acted Together in Promoting Opioids, Opposing Regulation, and**
19 **Facilitating Supportive Standards to Approve Opioids**

20 174. As laid out above, Defendants supported, assisted, encouraged and/or facilitated the
21 same front groups and KOLs to disseminate the same deceptive messages about the use of opioids
22 to treat chronic pain. In fact, the similarity of their messages, language, and even their formatting
23 (*e.g.*, the myth/fact formulation) suggests that Defendants participated in a common scheme to
24 disseminate misleading information about opioids.

25 175. This inference is supported by Defendants’ cooperation in other activities to
26 promote opioids, including successful efforts to set standards for measuring and treating pain,
27 training and regulating doctors, and approving new opioids.

1 176. Defendants’ efforts to shift the paradigm on opioids and pain treatment began soon
2 after their branded opioids were launched. In 2000, the Joint Commission on Accreditation of
3 Healthcare Organizations (“JCAHO”), in conjunction with the University of Wisconsin Pain and
4 Studies Group, declared that pain was the “5th Vital Sign” and required all healthcare practitioners
5 to make pain assessment and management a priority in daily practice.

6 177. Upon information and belief, the impetus behind the new pain standard began with
7 June Dahl, then a professor of pharmacology at the University of Wisconsin-Madison. Dr. Dahl
8 approached JCAHO with a proposal and helped identify pain management experts and key
9 organizations to act as advisors to JCAHO, as well as promoters of Pain as the 5th Vital Sign.
10 Those experts and key organizations are many of the same heavily funded KOLs and front groups
11 that ultimately helped bring about the change in attitudes towards opioids and, subsequently, the
12 rise in opioid prescribing. Purdue was one of two companies that paid for programs across the
13 country to educate hospital physicians and staff about complying with the new pain standards and
14 had exclusive rights to distribute certain education materials to JCAHO members.⁶³

15 178. Once health practitioners were required to consider a patient’s pain along with other
16 vitals, the next step was to convince practitioners that all pain must be treated – preferably with
17 opioids. In 2004, the Federation of State Medical Boards revised and updated its Model Policy for
18 the Use of Controlled Substances for the Treatment of Pain. In support of those efforts, noted
19 KOL Dr. Scott Fishman was tapped to author a companion piece, titled *Responsible Opioid*
20 *Prescribing: A Physician’s Guide*.

21 179. The Guide was sponsored by Defendants Endo and Purdue, and was distributed to
22 state medical boards, healthcare regulatory boards, medical organizations, hospitals and physicians
23 across the country, including in California. The 2007 *Physician’s Guide* contained many of the
24 misrepresentations described above, notably the concept of “pseudoaddiction” and the claim that
25 opioids improve function.

27 ⁶³ GAO, *OxyContin Abuse and Diversion*, Dec 2003, available at <http://www.gao.gov/htext/d04110.html>.

1 180. Defendants also worked together to promote opioids through the Pain Care Forum,
2 which is comprised of representatives from opioid manufacturers and distributors (including each
3 of the Defendants); doctors and nurses in the field of pain care; health care professional
4 organizations (*e.g.*, the American Academy of Pain Management, APS, and American Society of
5 Pain Educators); patient advocacy groups (*e.g.*, APF, American Chronic Pain Association, and the
6 Northern California Pain Initiative); and other like-minded organizations (*e.g.*, Federation of State
7 Medical Boards and Wisconsin Pain & Policy Studies Group), almost all of which received
8 substantial funding from Defendants. Upon information and belief, the Pain Care Forum was
9 started, and continues to be run, by Defendant Purdue's in-house lobbyist Burt Rosen, previously
10 in conjunction with APF. [REDACTED]

11 [REDACTED]
12 181. Upon information and belief, Defendants collaborated on a common campaign to
13 build a market for opioids for chronic non-cancer pain.

14 **E. Defendants Also Acted Individually to Deceptively Promote Their Opioids for**
15 **Chronic Pain**

16 182. In addition to participating in a shared campaign to expand the market for opioids
17 by reaching chronic pain patients and conditions, each Defendant acted on its own to deceptively
18 market its specific opioids for chronic pain and to capture a larger share of the chronic pain
19 market. Separately, in their branded materials and on seemingly independent websites, they each
20 overstated the benefits and understated the risks of their drugs (including the risk of addiction) in
21 the various ways described above, often causing the FDA to formally admonish them. On top of
22 this, Cephalon engaged in additional unlawful conduct, marketing its opioid Fentora for
23 unapproved chronic pain uses despite only recently settling a case involving almost identical
24 activities with respect to its predecessor, Actiq. Likewise, Purdue also quickly began to violate a
25 consent judgment with the federal government and State of California by continuing to
26 misrepresent the risks and benefits of OxyContin and its other opioids.

1 **1. Cephalon fraudulently marketed Actiq and Fentora.**

2 183. Cephalon also engaged in a distinctive effort to market its opioids for chronic pain
3 despite having labels that specifically limited their use to cancer pain. As a result of its successful
4 marketing efforts, Cephalon reaps significant revenue from selling its opioids for treatment of
5 chronic pain. However, neither of its two opioid drugs – Actiq or Fentora – is approved for this
6 purpose. Instead, both have indications that are very clearly and narrowly defined to limit their use
7 to a particular form of cancer pain. Despite this restriction and in order to claim its piece of the
8 broader chronic pain market, Cephalon deceptively and unlawfully marketed Actiq and then
9 Fentora for patients and uses for which they were not safe, effective, or allowed, causing
10 prescriptions to be written and paid and, grievously, patients to be injured and die.

11 **a. Cephalon launches its fraudulent marketing scheme of Actiq.**

12 184. Cephalon’s Actiq is a powerful opioid narcotic that is delivered to the bloodstream
13 by a lollipop lozenge that dissolves slowly in the mouth. As described by one patient, Actiq
14 “tastes like the most delicious candy you ever ate.”⁶⁴

15 185. Actiq is appropriately used only to treat “breakthrough” cancer pain that cannot be
16 controlled by other medications. Breakthrough pain is a short-term flare of moderate-to-severe
17 pain in patients with otherwise stable persistent pain. Actiq is a rapid onset drug that takes effect
18 within 10-15 minutes but lasts only a short time. It is also an extremely strong drug, considered to
19 be at least 80 times more powerful than morphine. Fentanyl, a key ingredient in Actiq, has been
20 linked to fatal respiratory complications in patients. Actiq is not safe in any dose for patients who
21 are not opioid tolerant, that is, patients who have taken specific dosages of opioids for a week or
22 longer and whose systems have acclimated to the drugs.

23 186. In 1995, the FDA approved Actiq “**ONLY** for the management of breakthrough
24 cancer pain in patients with malignancies who are already receiving and who are tolerant to opioid
25 therapy for their underlying persistent cancer pain.” (Emphasis in FDA document.) Because of
26 Actiq’s dangers, wider, off-label uses – as the FDA label makes clear – are not permitted:

27 ⁶⁴ See John Carreyrou, *Narcotic ‘Lollipop’ Becomes Big Seller Despite FDA Curbs*, WALL STREET JOURNAL,
28 Nov. 3, 2006.

1 Because life-threatening hypoventilation could occur at any dose in
2 patients not taking chronic opiates, *Actiq* is contraindicated in the
management of acute or postoperative pain. This product **must not**
be used in opioid non-tolerant patients.”

3 *Actiq* is intended to be used only in the care of cancer patients and
4 only by oncologists and pain specialists who are knowledgeable of
and skilled in the use of Schedule II opioids to treat cancer pain.

5 (Emphasis in original.) Unlike other drugs, where off-label uses are permitted but cannot be
6 promoted by the drug maker, *Actiq* is so potent that off-label use to opioid naïve patients is strictly
7 forbidden.

8 187. Notwithstanding the drug’s extreme potency and related dangers and the FDA’s
9 explicit limitations, Cephalon actively promoted *Actiq* for chronic pain – an unapproved, off-label
10 use. Cephalon marketed *Actiq* as appropriate for the treatment of various conditions including
11 back pain, headaches, pain associated with sports related injuries, and other conditions not
12 associated with cancer for which it was not approved, appropriate, or safe.

13 188. *Actiq*’s initial sales counted in the tens of millions of dollars, corresponding to its
14 limited patient population. But by 2005, *Actiq* sales reached \$412 million, making it Cephalon’s
15 second highest selling drug. As a result of Cephalon’s deceptive, unlawful marketing, sales
16 exceeded \$500 million by 2006.

17 **b. Cephalon engaged in deceptive, off-label marketing efforts to expand**
18 **the use of *Actiq*.**

19 189. Cephalon knew that *Actiq*’s market potential for the treatment of breakthrough
20 cancer pain in opioid-tolerant patients with malignancies was limited. Rather than seek FDA
21 approval for a broader set of indications, Cephalon launched an illegal marketing campaign to
22 capture the lucrative chronic pain market. Cephalon also actively concealed the illegal means that
23 it used to market the drug.

24 190. Despite the FDA’s mandate that *Actiq* be prescribed only by oncologists or pain
25 specialists skilled in the use of Schedule II opioids to treat cancer pain, Cephalon implemented a
26 marketing scheme aimed at a wide range of doctors, including general practitioners, neurologists
27 and sports medicine specialists. Cephalon failed to disclose the fact that *Actiq* was not approved
28

1 or safe for the treatment of general aches and pains and is inappropriate for anything besides
2 persistent cancer pain in certain opioid-tolerant cancer patients.

3 191. Cephalon drove Actiq prescriptions by providing coupons to doctors in this wide
4 range of specializations. According to the WALL STREET JOURNAL, an ImpactRx survey showed
5 that Actiq sales visits to non-cancer physicians increased six-fold between 2002 and 2005. The
6 surveyed doctors reported more than 300 Actiq sales visits in both 2004 and 2005. One general
7 practitioner reported that a Cephalon sales representative visited his office once a month,
8 delivering 60 to 70 coupons for free Actiq at a time. Each coupon was good for six Actiq
9 lollipops. A package of 30 Actiq lollipops, each containing 200 micrograms of fentanyl, would
10 otherwise cost about \$500.

11 192. Within two years, Cephalon's off-label marketing campaign had borne fruit.
12 According to data from NDCHealth, a health-care information company, Actiq prescriptions in the
13 United States rose from 77,478 in 2001 to 321,463 in 2003. By 2003, 26% of Actiq prescriptions
14 were written by family-practice doctors or internists – five times the number written by that same
15 group in 2001. During the first six months of 2006, 99% of the prescriptions for Actiq filled by
16 retail pharmacies were prescribed by non-oncologists. According to one physician survey, 80% of
17 patients who were prescribed Actiq between June 2004 and October 2006 were non-cancer
18 patients.⁶⁵

19 193. Cephalon even targeted workers' compensation programs, which usually handle
20 relatively few cases of cancer. By 2003, Actiq catapulted to 15th on The Hartford Financial
21 Services Group's list of total medication costs in workers' compensation claims. Just two years
22 earlier, it ranked 66th.

23 194. A June 16, 2007 report by Prime Therapeutic LLC, a company dedicated to
24 providing pharmacy solutions for third-party payers, also confirm the off-label marketing scheme.
25 The study analyzed a Midwestern commercial health plan's Actiq claims for April through June
26 2005. Of the 95 patients who received prescriptions for Actiq during that period, only 21 had a

27 ⁶⁵ According to Cephalon, at its peak, there were 9,000 Actiq prescriptions filled per week.

1 diagnosis of cancer or AIDS. And only 10 of 21 patients were taking a long-acting opioid
2 painkiller (opioid tolerant). Altogether, 84 of the 95 Actiq prescriptions – nearly 90% – were for
3 off-label purposes. The study also found that more than 15% of Actiq prescriptions exceeded the
4 FDA’s recommended 120 lollipops per month, signaling widespread overuse of the drug.

5 **c. Government investigations also confirm Cephalon’s deceptive**
6 **marketing strategy.**

7 195. Internal company documents uncovered during an investigation by the State of
8 Connecticut revealed that:

- 9 a. Cephalon instructed its sales representatives to ask non-cancer
10 doctors whether they had the potential to treat cancer pain. Even if
11 the doctor answered “no,” the Cephalon-created decision tree
12 instructed the sales representatives to give the physician free Actiq
13 coupons to distribute to their patients.
- 14 b. Cephalon encouraged neurologists to prescribe Actiq to patients
15 with migraine headaches. An internal document titled *Actiq in*
16 *Migraine*, instructed salespersons to tout the berry-flavored
17 narcotic as “an ER on a stick.”
- 18 c. Outside pain management specialists were enlisted to pitch Actiq
19 to non-cancer physicians. A retained “independent” pain
20 management specialist would accompany the Cephalon
21 salesperson on sales calls to non-cancer physicians. The
22 “independent” pain management specialist would deceptively
23 assure the physician that Actiq did not cause patients to feel “high”
24 and, unlike other narcotic painkillers, carried a low risk of
25 diversion toward recreational use.
- 26 d. Cephalon set sales quotas for its sales and marketing
27 representatives that could be met only by promoting Actiq for off-
28 label uses.
- 29 e. Cephalon encouraged physicians to ignore the label’s maximum
30 dosage, which limited new patients to six lollipops containing a
31 200-microgram dose of fentanyl, and instead encouraged
32 physicians to start patients with 24 lollipops containing 400
33 micrograms.
- 34 f. Cephalon promoted Actiq by funding and controlling CME
35 seminars that promoted and misrepresented the efficacy of the drug
36 for nonmalignant pain. CME topics included “Opioid Use in
37 Headache” and “Use of Actiq in Opioid-Naïve Patients.”
- 38 g. Cephalon paid speakers’ fees and expenses to present topics
39 promoting off-label uses for Actiq at these conferences.

1 h. Cephalon also funded, promoted, and distorted studies to promote
2 Actiq for noncancer pain. The methodologies used in the studies
3 would not pass scientific muster. For example, two Cephalon-
4 touted studies tested fewer than 28 patients and had no control
5 group. One of the doctors involved in the studies pitched
6 Cephalon products in paid speaking engagements; another received
7 help from Cephalon with conducting his study. At least one of the
8 studies was published in the medical journal "Headache."

9 196. Actiq's widespread use led the FDA's Office of Criminal Investigations and the
10 U.S. Attorney for the Eastern District of Pennsylvania to investigate Cephalon's marketing
11 practices. That investigation found that from 2001 through at least 2006, Cephalon promoted
12 Actiq off-label to treat migraines, back pain, and even injuries. The investigation also confirmed
13 that Cephalon had structured its sales quotas and bonuses such that a sales representative could
14 only reach sales goals by selling the drug for chronic non-cancer pain. In 2008, Cephalon entered
15 a criminal plea for its off-label promotion of Actiq.

16 **d. Cephalon attempted to cover-up evidence of its deceptive, unlawful**
17 **scheme.**

18 197. The FDA conditioned its approval of Actiq upon Cephalon's agreement to
19 conditions enumerated in the FDA's Risk Management Program. This Program required Cephalon
20 to: (1) make sure that informational packets describing the limited uses for Actiq were given to
21 everyone who was prescribed Actiq; (2) conduct patient surveys and spot check pharmacies to
22 ensure that the informational packets were being distributed; (3) monitor prescribing physicians to
23 make sure only appropriate patients received Actiq; and (4) if it turned out that more than 15% of
24 the prescriptions were written by doctors who should not have been prescribing Actiq, Cephalon
25 was to report that fact to the FDA and embark on a physician training program to stop and prevent
26 physicians from prescribing Actiq for broader use.

27 198. But a report drafted by a compliance auditor hired by Cephalon revealed that
28 Cephalon was failing to meet the Program's conditions. Rather than come into compliance,
Cephalon buried the report.⁶⁶ The report was submitted to the company in October 2003, and

⁶⁶ The allegations in this section are made on information and belief based on the allegations in the Second Amended Complaint filed on April 7, 2005 in the lawsuit *David Brennan v. Cephalon, Inc.*, No. 4 CV 3241 (D.N.J.).

1 various management members directed the auditor to remove from the report his conclusion that
2 Cephalon was not in compliance with the Program. He refused and was terminated.

3 **e. Cephalon fraudulently marketed Actiq’s successor drug, Fentora.**

4 199. Actiq was set to lose its patent protection in September 2006. To replace the
5 revenue stream that would be lost once generic competitors came to market, Cephalon purchased a
6 new opioid drug, Fentora, from Cima Labs and, in August 2005, submitted a New Drug
7 Application (NDA) to the FDA for approval.

8 200. Like Actiq, Fentora is an extremely powerful opioid. It is administered by placing a
9 tablet in the mouth until it disintegrates and is absorbed by the mucous membrane that lines the
10 inside of the mouth. Like Actiq, Fentora is a rapid onset opioid.

11 201. On September 25, 2006, the FDA approved Fentora, like Actiq, only for the
12 treatment of breakthrough cancer pain in cancer patients who were already receiving and were
13 tolerant to around-the-clock opioid therapy for their underlying persistent cancer pain.

14 202. Fentora’s inherent danger is confirmed by the unusually strong and detailed black
15 box warning label – the most serious medication warning required by the FDA. The warning
16 makes clear that, among other things:

17 Reports of serious adverse events, including deaths in patients
18 treated with *FENTORA* have been reported. Deaths occurred as a
19 result of improper patient selection (e.g., use in opioid non-tolerant
20 patients) and/or improper dosing. The substitution of *FENTORA* for
21 any other fentanyl product may result in fatal overdosing.

22 *FENTORA* is indicated only for the management of breakthrough
23 pain in patients with cancer who are already receiving and who are
24 tolerant to around-the-clock opioid therapy for their underlying
25 persistent cancer pain.

26 *FENTORA* is contraindicated in the management of acute or
27 postoperative pain including headache/migraine. Life-threatening
28 respiratory depression could occur at any dose in opioid non-tolerant
patients. Deaths have occurred in opioid non-tolerant patients,”

...

FENTORA is intended to be used only in the care of opioid tolerant
cancer patients and only by healthcare professionals who are
knowledgeable of and skilled in the use of Schedule II opioids to
treat cancer pain.

1 (Emphasis in original.)

2 **f. October 1, 2006 – Cephalon launches Fentora and immediately begins**
3 **deceptive marketing campaign.**

4 203. When Cephalon launched Fentora on October 1, 2006, it picked up the playbook it
5 developed for Actiq and simply substituted in Fentora. Cephalon immediately shifted 100 general
6 pain sales representatives from selling Actiq to selling Fentora to the very same physicians for uses
7 that would necessarily and predictably be off-label.

8 204. Cephalon’s marketing of Actiq “primed the market” for Fentora. Cephalon had
9 trained numerous KOLs to lead promotional programs for Fentora, typically including off-label
10 uses for the drug. Cephalon billed Fentora as a major advance that offered a significant upgrade in
11 the treatment of breakthrough pain generally – not breakthrough cancer pain in particular – from
12 Actiq.

13 205. On February 12, 2007, only five months after the launch, Cephalon CEO Frank
14 Baldino told investors:

15 [W]e’ve been extremely pleased to retain a substantial portion,
16 roughly 75% of the rapid onset opioid market. We executed our
17 transition strategy and the results in our pain franchise have been
18 better than we expected. With the successful launch of FENTORA
19 and the progress in label expansion program, we are well positioned
20 to grow our pain franchise for many years to come.⁶⁷

21 206. On May 1, 2007, just seven months after Fentora’s launch, Cephalon’s then-
22 Executive Vice President for Worldwide Operations, Bob Roche, bragged to financial analysts that
23 Fentora’s reach would exceed even Actiq’s. He described the company’s successful and
24 “aggressive” launch of Fentora that was persuading physicians to prescribe Fentora for ever
25 broader uses. He identified two “major opportunities” – treating breakthrough cancer pain and:

26 The other opportunity of course is the prospect for FENTORA
27 outside of cancer pain, in indications such as breakthrough lower
28 back pain and breakthrough neuropathic pain....

We believe that a huge opportunity still exists as physicians and
patients recognize FENTORA as their first choice rapid onset opioid

⁶⁷ See <http://seekingalpha.com/article/26813-cephalon-q4-2006-earnings-call-transcript> (last visited Jan. 28, 2014).

1 medication.... Noting that opioids are “widely used in the treatment
2 of ... non-cancer patients,” Roche continued:

3 Of all the patients taking chronic opioids, 32% of them take that
4 medication to treat back pain, and 30% of them are taking their
5 opioids to treat neuropathic pain. In contrast only 12% are taking
6 them to treat cancer pain, 12%.

7 We know from our own studies that breakthrough pain episodes
8 experienced by these non-cancer sufferers respond very well to
9 FENTORA. And for all these reasons, we are tremendously excited
10 about the significant impact FENTORA can have on patient health
11 and wellbeing and the exciting growth potential that it has for
12 Cephalon.

13 In summary, we have had a strong launch of FENTORA and
14 continue to grow the product aggressively. Today, that growth is
15 coming from the physicians and patient types that we have identified
16 through our efforts in the field over the last seven years. In the
17 future, with new and broader indications and a much bigger field
18 force presence, the opportunity that FENTORA represents is
19 enormous.⁶⁸

20 **g. September 2007 – Reports of death and serious side effects lead the
21 FDA to issue a public health warning for Fentora.**

22 207. On September 10, 2007, Cephalon sent letters to doctors warning of deaths and
23 other “serious adverse events” connected with the use of Fentora and indicating that “[t]hese
24 deaths occurred as a result of improper patient selection (*e.g.*, use in opioid non-tolerant patients),
25 improper dosing, and/or improper product substitution.” The warning did not acknowledge
26 Cephalon’s deliberate role in the “improper patient selection.”

27 208. Two weeks later, the FDA issued its own Public Health Advisory. The FDA
28 emphasized, once again, that Fentora only should be prescribed for approved conditions and that
dosage guidelines should be carefully followed. The FDA Advisory made clear that several
Fentora-related deaths had occurred in patients who were prescribed the drug for off-label use.
The FDA Advisory warned that Fentora should not be used for any off-label conditions, including
migraines, post-operative pain or pain due to injury, and that it should be given only to patients
who have developed opioid tolerance. The Advisory reiterated that because Fentora contains a

⁶⁸ See <http://seekingalpha.com/article/34163-cephalon-q1-2007-earnings-call-transcript> (last visited Aug. 23, 2010).

1 much greater amount of fentanyl than other opiate painkillers, it is not a suitable substitute for
2 other painkillers.

3 **h. Cephalon sponsored CMEs used to promote the off-label use of Actiq**
4 **and Fentora – 2007-2008, in spite of the FDA warnings.**

5 209. Cephalon also used the CME programs it sponsored to promote the off-label use of
6 their Actiq and Fentora. In 2007 and 2008, Cephalon sponsored three CMEs that each positioned
7 Actiq and Fentora, and only Actiq and Fentora, as “rapid onset opioids” that would provide
8 effective analgesia within the time period during which “breakthrough pain” was at its peak
9 intensity. Although the CMEs only use the generic names of the drugs, the description of the
10 active ingredient and means of administration means that a physician attending the CME would
11 know to prescribe Actiq or Fentora.

12 210. The CMEs each taught attendees that there was no sound basis for the distinction
13 between cancer and non-cancer “breakthrough pain,” and one instructed patients that Actiq and
14 Fentora were commonly used in non-cancer patients, thus effectively endorsing this use.
15 *Optimizing Opioid Treatment for Breakthrough Pain*, offered by Medscape, LLC from
16 September 28, 2007, through December 15, 2008, was prepared by KOL Dr. Lynn R. Webster and
17 M. Beth Dove. It recommends prescribing a “short-acting opioid” (e.g., morphine,
18 hydromorphone, oxycodone) “when pain can be anticipated,” or a rapid onset opioid when it
19 cannot. The only examples of rapid onset opioids then on the market are oral transmucosal
20 fentanyl citrate (*i.e.*, Actiq) or fentanyl effervescent buccal tablet (*i.e.*, Fentora): “Both are
21 indicated for treatment of [breakthrough pain] in opioid-tolerant cancer patients *and are frequently*
22 *prescribed to treat [breakthrough pain] in noncancer patients as well.”* (Emphasis added.)

23 211. Similarly, *Breakthrough Pain: Improving Recognition and Management*, offered
24 between March 31, 2008, and March 31, 2009, by Medscape, LLC completely omitted tolerance
25 limitations, cited examples of patients who experienced pain from accidents, not from cancer, and,
26 like the “Optimizing Opioid Treatment” CME, taught that Actiq and Fentora were the only
27 products on the market that would take effect before the breakthrough pain episode subsided.
28 Lastly, KOL Dr. Fine authored a CME, sponsored by Cephalon, *Opioid-Based Management of*

1 *Persistent and Breakthrough Pain*, with Dr. Christine A. Miaskowski, Professor and Associate
2 Dean for Academic Affairs, Department of Physiological Nursing, University of California – San
3 Francisco. They instruct their audience, “Clinically, broad classification of pain syndromes as
4 either cancer- or noncancer-related has limited utility,” and recommend “rapid onset opioids” for
5 “episodes that occur spontaneously” or unpredictably, including “oral transmucosal fentanyl,” *i.e.*,
6 Actiq, and “fentanyl buccal tablet,” *i.e.*, Fentora, including specifically in patients with chronic
7 non-cancer pain.⁶⁹

8 212. Dr. Miaskowski disclosed in 2009, in connection with the APS/AAPM Opioid
9 Treatment Guidelines that she served on Cephalon’s speakers’ bureau. Dr. Fine and Dr. Webster
10 also received funding from Cephalon for consulting services, and upon information and belief,
11 Drs. Fine and Webster continued to receive funding from other opioid manufacturers, too.

12 **i. May 6, 2008 – The FDA rejects Cephalon’s request for expanded**
13 **approval of Fentora.**

14 213. Cephalon filed a supplemental new drug application, (sNDA), asking the FDA to
15 approve Fentora for the treatment of non-cancer breakthrough pain. To support its application,
16 Cephalon admitted that Fentora already had been heavily prescribed for non-cancer pain, but
17 argued that such widespread use demonstrated why Fentora should be approved for these wider
18 uses.⁷⁰ Cephalon argued for the expanded approval even though, as it acknowledged, “[t]o date,
19 no medication has been systematically evaluated in clinical studies or approved by the FDA for the
20 management of [breakthrough pain] in patients with chronic persistent non-cancer-related pain.”

21 *Id.*

22 214. The FDA presented data showing that 95% of all Fentora use was for treatment of
23 non-cancer pain.⁷¹ By a vote of 17-3, the relevant Advisory Committee – a panel of outside

24 _____
⁶⁹ See *Opioid-Based Management of Persistent and Breakthrough Pain*, Aug. 20, 2008, pp. 9-10.

25 ⁷⁰ See Joint Meeting: Anesthetic and Life Support Drugs, Advisory Committee and Drug Safety and Risk
26 Management Advisory Committee, May 6, 2008, *available at*, <http://www.fda.gov/ohrms/dockets/ac/08/briefing/2008-4356b2-02-Cephalon.pdf> (last visited Aug. 17, 2010).

27 ⁷¹ See Review of Fentora® and Actiq® Adverse Events from the Adverse Event Reporting System (“AERS”)
28 Database, May 6, 2008, *available at*, [http://www.fda.gov/ohrms/dockets/ac/08/slides/2008-4356s2-02-FDA-
corepresentations.ppt#289.1](http://www.fda.gov/ohrms/dockets/ac/08/slides/2008-4356s2-02-FDA-corepresentations.ppt#289.1) (last visited Aug. 17, 2010).

1 experts – voted against recommending approval of Cephalon’s sNDA for Fentora, citing the
2 potential harm from broader use. On September 15, 2008, the FDA denied Cephalon’s application
3 and requested, in light of its already off-label use, that Cephalon implement and demonstrate the
4 effectiveness of proposed enhancements to Fentora’s Risk Management Program. In December
5 2008, the FDA followed that up with a supplemental request, asking that the company submit a
6 Risk Evaluation and Mitigation Strategy for Fentora as well.

7 j. **March 26, 2009 – the FDA’s Division of Drug Marketing, Advertising
8 and Communications (“DDMAC”) warned Cephalon about its
9 misleading advertising of Fentora.**

10 215. Undeterred by the rejection of its sNDA, Cephalon continued to use its general pain
11 sales force to promote Fentora off-label to pain specialists as an upgrade over Actiq for the
12 treatment of non-cancer breakthrough pain. Deceptively and especially dangerously, Cephalon
13 also continued to promote Fentora for use by all cancer patients suffering breakthrough cancer
14 pain, and not simply those who were opioid tolerant.

15 216. On March 26, 2009, the DDMAC issued a Warning Letter to Cephalon, telling
16 Cephalon that its promotional materials for Fentora amounted to deceptive, off-label promotion of
17 the drug. Specifically, the Warning Letter asserted that a direct-to-patient advertisement found on
18 the internet was improper because it “misleadingly broaden[ed] the indication for Fentora by
19 implying that any patient with cancer who requires treatment for breakthrough pain is a candidate
20 for Fentora therapy ... when this is not the case.” DDMAC emphasized that Fentora’s label was
21 limited to cancer patients with breakthrough pain **“who are already receiving and who are
22 tolerant to around-the-clock opioid therapy for their underlying persistent cancer pain.”**

23 (Emphasis in original.) DDMAC explained that the advertisement was “especially concerning
24 given that Fentora **must not** be used in opioid non-tolerant patients because life-threatening
25 hypoventilation and death could occur at any dose in patients not on a chronic regimen of opioids.”

26 (Emphasis in original.) DDMAC also warned Cephalon that, based on a review of Cephalon-
27 sponsored links for Fentora on internet search engines, the company’s advertisements were
28 “misleading because they make representations and/or suggestions about the efficacy of Fentora,

1 but fail to communicate **any** risk information associated with the use” of the drug. (Emphasis in
2 original.)

3 **k. Cephalon continues to knowingly, deceptively, and illegally promote**
4 **Fentora for off-label uses.**

5 217. Cephalon’s own market research studies confirm that its Fentora promotions were
6 not focused on the physicians who treat breakthrough cancer pain. Cephalon commissioned
7 several market research studies to determine whether oncologists provided an “adequate” market
8 potential for Fentora. These studies’ central goal was to determine whether oncologists treat
9 breakthrough cancer pain themselves, or whether they refer such patients to general pain
10 specialists. The first study, completed in 2007, reported that 90% of oncologists diagnose and treat
11 breakthrough cancer pain themselves, and do not refer their breakthrough cancer pain patients to
12 pain specialists. The second study, completed in 2009, confirmed the results of the 2007 study,
13 this time reporting that 88% of oncologists diagnose and treat breakthrough cancer pain
14 themselves and rarely, if ever, refer those patients to general pain specialists. (One reason that
15 general pain specialists typically do not treat oncological pain is that the presence of pain can, in
16 itself, be an indicator of a change in the patient’s underlying condition that should be monitored by
17 the treating oncologist.)

18 218. Yet Cephalon continued to use its general pain sales force (which numbered over
19 110 representatives) to promote Fentora to general pain specialists. This only makes sense
20 because the off-label sales are so vast that missing out on 90% of the potential on-label market is
21 inconsequential to Cephalon’s bottom line.

22 219. Cephalon-set sales quotas for its general pain sales force would be unattainable if
23 they did not deceptively promote Fentora off-label. The general pain sales representatives have,
24 from the outset, been required to adhere to call lists that include numerous pain doctors and other
25 physicians who do not, and would not, prescribe Fentora on-label. These same call lists contain
26 few, if any, oncologists.

1 220. A 2009 PowerPoint presentation by Kathy Roman, Cephalon’s Associate Director
2 of Oncology for Strategic Analysis & Planning, reported that only 4% of Fentora prescriptions
3 were written by oncologists.

4 221. Cephalon’s conduct in marketing Actiq and Fentora for chronic pain, despite their
5 clear (and deadly) risks and unproved benefits, was an extension of, and reaped the benefits of,
6 Cephalon’s generally deceptive promotion of opioids for chronic pain.

7 **2. Purdue’s role in deceptively promoting opioids for treatment of chronic pain.**

8 222. Like Cephalon, Purdue also undertook its own separate campaign to deceptively
9 market opioids. Purdue is the maker of OxyContin, which, over time, has been the most used and
10 abused opioid. Today, with one exception, all of the drugs marketed by Purdue are opioids.

11 **a. Purdue’s marketing of OxyContin was deceptive from the start.**

12 223. OxyContin was approved by the FDA in 1995 for “management of moderate to
13 severe pain where use of an opioid analgesic is appropriate for more than a few days.” Purdue
14 immediately began promoting OxyContin as less addictive than other opioids. The drug’s
15 extended-release mechanism, according to Purdue, meant it was less likely to provide a euphoric
16 high, and therefore was less likely to be abused, create addiction, or cause withdrawal. However,
17 Purdue “did not have, and did not provide the FDA with any clinical studies demonstrating that
18 OxyContin was less addictive, less subject to abuse and diversion, or less likely to cause tolerance
19 and withdrawal than other pain medications.” When crushed, dissolved in water, or injected,
20 OxyContin’s extended-release mechanism could be bypassed to produce a heroin-like high. In
21 fact, OxyContin was more likely than other opioids to be abused and diverted because it had more
22 oxycodone than other non-controlled release opioids (and oxycodone already is twice as potent as
23 morphine).

24 224. Purdue’s marketing persuaded primary care physicians that it was safe to prescribe
25 OxyContin for chronic pain. By 2003, according to the Government Accountability Office
26 (“GAO”), general practitioners represented half of all OxyContin prescribers. A GAO report
27 noted that, between 1997 and 2002, OxyContin prescriptions for non-cancer pain increased nearly
28

1 ten-fold, from 670,000 to 6.2 million, versus an increase in prescriptions for treatment of cancer
2 pain from 250,000 to 1 million; non-cancer prescriptions represented 85% of total OxyContin
3 prescriptions. At the same time, Purdue doubled the number of its sales representatives, who
4 received bonuses based on sales quotas and were directed to target the most prolific opioid
5 prescribers. Total sales bonuses in 2001 were \$40 million, up from \$1 million in 1996. Purdue
6 also used speakers bureaus, which put on programs at resort locations, starter coupons to attract
7 new patients, funded new front group websites, and, even distributed plush toys and hats, which
8 the Drug Enforcement Administration (“DEA”) says had never been done before for a controlled
9 substance. The DEA blamed Purdue’s “aggressive marketing of OxyContin” for “fuel[ing]
10 demand for the drug and exacerbat[ing] the drug’s diversion.

11 225. In 2001, the FDA required Purdue to narrow its approved indication to “moderate to
12 severe pain when a continuous, around-the-clock analgesic is needed for an extended period of
13 time” and added new warnings relating to the drug’s potential for misuse and abuse. In August of
14 that year, the FDA wrote to Purdue to make clear that all promotional materials should
15 prominently disclose the new label information. Yet, not 18 months later, in January 2003, in
16 response to two ads Purdue ran in the Journal of the American Medical Association, the FDA
17 issued a sharply worded warning letter to Purdue:

18 Your advertisements thus grossly overstate the safety profile of
19 OxyContin by not referring in the body of the advertisements to serious,
20 potentially fatal risks associated with OxyContin, thereby potentially
21 leading to prescribing of the product based on inadequate consideration of
22 risk. In addition, your journal advertisements fail to present in the body of
23 the advertisements critical information regarding limitations on the
24 indicated use of OxyContin, thereby promoting OxyContin for a much
25 broader range of patients with pain than are appropriate for the drug. The
26 combination in these advertisements of suggesting such a broad use of this
27 drug to treat pain without disclosing the potential for abuse with the drug
28 and the serious, potentially fatal risks associated with its use is especially
egregious and alarming in its potential impact on the public health.⁷²

⁷² January 17, 2003 Warning Letter from Thomas W. Abrams, Director, Division of Drug Marketing, Advertising, and Communications, U.S. Food and Drug Administration, to Michael Friedman, Executive Vice President and Chief Operating Officer, Purdue Pharma L.P.

1 226. The FDA’s strong language seemed to have little impact on Purdue’s behavior. In
2 2007, Purdue entered into a \$635 million settlement with the federal government to resolve civil
3 and criminal allegations relating to its marketing of OxyContin. This is a drop in the bucket
4 compared to the \$27 billion in sales revenue generated since the introduction of OxyContin in
5 1996.⁷³ News reports assert that federal prosecutors originally intended to charge the company
6 with multiple felonies, including conspiracy, mail and wire fraud and money laundering, but that
7 the Department of Justice agreed to allow Purdue to plead guilty to a single felony count of
8 misbranding. Purdue’s chief executive officer, chief medical officer, and general counsel
9 individually pled guilty to misdemeanor counts of misbranding and subsequently left the company.
10 Purdue admitted in its plea that its promotion of OxyContin was misleading and inaccurate,
11 misrepresented the risk of addiction, and was unsupported by science.

12 227. As part of its settlement, Purdue entered into a Corporate Integrity Agreement with
13 the United States Department of Health and Human Services-Office of Inspector General (“HHS-
14 OIG”). Purdue agreed to refrain from deceptively marketing OxyContin, to train its employees
15 regarding compliance with the Agreement, monitor its own compliance, and report its compliance
16 (both independently and through an independent review organization or “IRO”) to HHS-OIG.

17 228. In 2007, Purdue also agreed to pay \$19.5 million to 26 states, including California,
18 to settle these states’ consumer protection claims which likewise stemmed from Purdue’s
19 promotion and marketing of OxyContin. As part of the consent judgment with California and the
20 other states (“Consent Judgment”), Purdue likewise agreed to, among other things, refrain from
21 deceptively marketing OxyContin; to refrain from providing to health care professionals written
22 information describing off-label use of OxyContin; to disclose any educational or research grants
23 relating to OxyContin; and to refrain from sponsoring any event that will discuss off-label use.

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27 ⁷³ See <http://www.latimes.com/opinion/la-ed-oxycontin-overprescribing-database-20130-001-photo.html>.

1 severe withdrawal or overdoses, hundreds of deaths, and increases in drug treatment admissions
2 for individuals on OxyContin. Since 2000, there have been countless news reports, lawsuits, and
3 government and other data describing the rising toll of addiction, overdose, and death from
4 OxyContin specifically and opioids generally.

5 232. In 2010, Purdue reformulated OxyContin to reduce tampering and make it less
6 subject to abuse. The new OxyContin cannot be reduced to a powder and does not dissolve; when
7 water is added to it, it becomes gelatinous and cannot be injected.

8 233. While an important step, Purdue knew that even the reformulation of OxyContin
9 did not resolve issues of abuse and addiction. A recent article in the LOS ANGELES TIMES revealed
10 that Purdue – since 2002 – has kept a database of 1,800 doctors suspected of inappropriately
11 prescribing its drugs, but did not alert law enforcement or medical authorities to all but a few of
12 these doctors.⁷⁴ This database, according to the news report, was whittled down from 3,200
13 doctors reported as suspicious by Purdue’s sales representatives (conduct that must have been so
14 egregious that the sales representatives forewent the chance to earn commissions on the doctors’
15 prescriptions).

16 234. Purdue did not use its database of problem doctors to reduce OxyContin abuse, to
17 rein in dangerous doctors, or to stop the potentially unlawful distribution of a controlled substance.
18 Instead, the company presented the evidence of rogue prescribing in an effort to persuade the FDA
19 that generic drug makers should not be allowed to copy the earlier, non-tamper resistant version of
20 OxyContin – the same OxyContin that Purdue originally promoted as less addictive – as it is too
21 subject to abuse.

22 235. As Dr. Mitchell Katz, director of the Los Angeles County Department of Health
23 Services said in the LOS ANGELES TIMES article, “Any drug company that has information about
24 physicians potentially engaged in illegal prescribing or prescribing that is endangering people’s
25 lives has a responsibility to report it.” Instead, on information and belief, Purdue continued to
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27 ⁷⁴ Scott Glover and Lia Girion, *Oxycontin maker closely guards is list of suspect doctors*, LA TIMES, Aug. 11,
28 2013.

1 profit from the prescriptions of these suspicious prescribers. Psychologist, researcher, and
2 Stanford University professor Keith Humphreys noted, “[t]hose doctors are a gold mine for Purdue
3 Pharma. And the whole time they’re taking the money, knowing that something is wrong, and not
4 telling anyone until it gives them a market advantage to do so. That is really disgusting.”⁷⁵

5 **F. Defendants Knew That Their Marketing of Chronic Opioid Therapy Was False,
6 Unfounded, and Dangerous and would Harm California Residents**

7 236. Defendants made, promoted, and profited from their misrepresentations –
8 individually and collectively – knowing that their statements regarding the risks, benefits, and
9 superiority of opioids for chronic pain were untrue and unproven. The history of opioids, as well
10 as research and clinical experience over the last 20 years, established that they were deeply
11 addictive and responsible for a long list of very serious adverse outcomes. The FDA and other
12 regulators warned Defendants of this, and Cephalon and Purdue entered into settlements in the
13 hundreds of millions of dollars to address nearly identical conduct. Defendants had access to
14 scientific studies, detailed prescription data, and reports of adverse events, including reports of
15 addiction, hospitalization, and deaths – all of which made clear the significant adverse outcomes
16 from opioids and that patients were suffering from addiction, overdoses, and death in alarming
17 numbers.

18 237. Moreover, Defendants knew and should have known about the harm that their
19 efforts had caused. Defendants closely monitored their sales and the habits of prescribing doctors,
20 which allowed them to see sales balloon, overall, in individual practices, and for specific
21 indications. Their sales representatives, who visited doctors and attended continuing medical
22 education programs, knew what types of doctors were receiving their messages and how they were
23 responding. Moreover, Defendants had access to and also watched carefully government and other
24 data that tracked the explosive rise in opioid use, addiction, injury, and death. They knew – and,
25 indeed, intended – that their misrepresentations would persuade doctors to prescribe and patients to
26 use their opioids for chronic pain.

27 ⁷⁵ *Id.*

1 238. Defendants’ actions are not permitted or excused by the fact that their labels (with
2 the exception of the Actiq/Fentora labels) may have allowed or did not exclude the use of opioids
3 for chronic non-cancer pain. However, the FDA’s approval did not give Defendants license to
4 misrepresent the risks, benefits, or side effects of opioids; if that were the case, there would be few
5 limits on what a drug company could say about its product and little use for the FDA’s rules on
6 fair promotion.

7 239. Nor is Defendants’ causal role broken by the involvement of doctors, professionals
8 with the training and responsibility to make individualized medical judgments for their patients.
9 Defendants’ marketing efforts were ubiquitous and highly persuasive. Their deceptive messages
10 tainted virtually every source doctors could rely on for information and prevented them from
11 making informed treatment decisions. Defendants also were able to harness – and indeed hijack –
12 what doctors wanted to believe – namely, that opioids represented a means of relieving their
13 patients’ suffering and of practicing medicine more compassionately.

14 **G. Defendants Fraudulently Concealed their Misrepresentations**

15 240. At all times relevant to this Complaint, Defendants took steps to avoid detection of
16 and fraudulently conceal their deceptive marketing and conspiratorial behavior.

17 241. First, and most prominently, Defendants disguised their own roles in the deceptive
18 marketing of chronic opioid therapy by funding and working through patient advocacy and
19 professional front organizations and KOLs. Defendants purposefully hid behind the assumed
20 credibility of the front organizations and relied on them to vouch for the accuracy and integrity of
21 Defendants’ untrue and unsupportable statements about opioid use for chronic pain.

22 242. Upon information and belief, while Defendants were listed as sponsors of many of
23 the publications described in this Complaint, they never disclosed their role in shaping, editing,
24 and approving their content. Upon information and belief, Defendants exerted their considerable
25 influence on these promotional and “educational” materials in emails, correspondence, and
26 meetings with key opinion leaders, front groups, and public relations companies that were not, and
27 have not yet become, public.

1 243. Contrary to their competitive interest in promoting their own opioid products,
2 Defendants disseminated their deceptive messages through websites that were unbranded (did not
3 promote a specific drug) and therefore could not easily be tied to a particular drug company
4 sponsor. Unbranded messaging created the appearance of neutrality and gave Defendants'
5 marketing messages the appearance of neutral medical science. [REDACTED]

6 [REDACTED]
7 [REDACTED] Upon information and belief, Defendants, including Purdue and
8 Janssen, ran similar websites that masked their own direct role in developing the content.

9 244. Upon information and belief, Defendants also obscured their participation by
10 extensively using the public relations companies they hired to work with front groups to produce
11 and disseminate deceptive materials. Also upon information and belief, Defendants may have
12 created their own seemingly independent public relations or marketing companies to create
13 campaign and education materials for opioids.

14 245. Much of Defendants' deceptive marketing occurred at medical conferences and
15 through continuing medical education programs that were open only to registered medical
16 professionals. Therefore, the People would have had no access to or awareness of their content.

17 246. Further, in addition to hiding their own role in the deceptive conduct, Defendants
18 manipulated their promotional materials to make it appear that they were accurate, truthful, and
19 supported by substantial scientific evidence. Defendants distorted the meaning or import of
20 studies they cited and offered them as evidence for propositions the studies did not support. The
21 true lack of support for Defendants' deceptive messages was not apparent to the medical
22 professionals who relied upon them in making treatment decisions, nor could they have been
23 detected by the People. Only in recent months have some of the KOLs whom Defendants relied
24 upon and promoted to spread their deceptive messages acknowledged the lack of support for their
25 positions.

26 247. Important elements of Defendants' unlawful conduct are only now becoming
27 known. Revelations, for example, of Defendants' role in paying third parties for access to the
28

1 FDA and a voice in formulating standards for the clinical trials for approving new opioid drugs
2 and indications was revealed only recently in an article in the WASHINGTON POST.⁷⁶ Defendants
3 were well-aware of their activities, intent, and impact, but hid their influence from the public and
4 from law enforcement and regulatory agencies.

5 248. Thus, while the opioid epidemic was evident, Defendants, in furtherance of their
6 marketing strategy, intentionally concealed their own role in causing it. Defendants successfully
7 concealed from the medical community, patients, and health care payers facts sufficient to arouse
8 suspicion of the existence of claims that the People now assert. The People were not alerted to the
9 existence and scope of Defendants' industry-wide fraud and could not have acquired such
10 knowledge earlier through the exercise of reasonable diligence. Through their public statements,
11 marketing, and advertising, Defendants' deceptions deprived the People of actual or presumptive
12 knowledge of facts sufficient to put them on notice of potential claims.

13 **H. Defendants' Fraudulent and Deceptive Marketing of Opioids Directly Caused Harm**
14 **to California Communities**

15 249. Defendants' misrepresentations prompted doctors to prescribe, patients to take, and
16 payers to cover opioids for the treatment of chronic pain. Defendants set out to overcome barriers
17 to widespread prescribing of opioids – and succeeded – through a series of deceptive messages
18 designed to address fears that opioids were dangerous for long-term use and addictive.

19 250. Defendants' fraudulent marketing caused consumers to purchase and use opioids
20 believing they were safe and effective. In addition, consumers have had to bear the costs of the
21 immediate and foreseeable results of chronic opioid therapy, including addiction treatment,
22 emergency department admissions, intensive care treatment for infants born addicted to opioids,
23 and other hospitalizations.

24 251. Defendants' deceptive marketing caused the use of opioids to explode.
25 Approximately 20% of the population between the ages of 30 and 44 and nearly 30% of the

26 ⁷⁶ Peter Whoriskey, *Pharmaceutical firms paid to attend meetings of panel that advises FDA*, THE WASHINGTON
27 POST, Oct. 6, 2013, available at http://www.washingtonpost.com/business/economy/pharmaceutical-firms-paid-to-attend-meetings-of-panel-that-advises-fda-e-mails-show/2013/10/06/a02a2548-2b80-11e3-b139-029811dbb57f_story.html.

1 population over 45 have used opioids.”⁷⁷ Indeed, “[o]pioids are the most common means of
2 treatment for chronic pain; 20% of office visits now include the prescription of an opioid, and 4
3 million Americans per year are prescribed a long-acting opioid.”⁷⁸ A study of 7.8 million doctor
4 visits found that prescribing for pain increased by 73% between 2000 and 2010 even though the
5 number of office visits in which patients complained of pain did not change; prescribing of non-
6 opioid pain medications decreased over the same time.⁷⁹ For back pain alone – one of the most
7 common chronic pain conditions – the percentage of patients prescribed opioids increased from
8 19% to 29% between 1999 and 2010, even as the use of NSAIDs or acetaminophen declined and
9 referrals to physical therapy remained steady.⁸⁰ This increase corresponds with, and was caused
10 by, Defendants’ marketing push.

11 252. The sharp increase in opioid use has led directly to a dramatic increase in opioid
12 abuse, addiction, overdose, and death throughout the United States. Scientific evidence
13 demonstrates a very strong correlation between therapeutic exposure to opioid analgesics, as
14 measured by prescriptions filled, and their abuse.⁸¹ “Deaths from opioid overdose have risen
15 steadily since 1990 in parallel with increasing prescription of these drugs.”⁸² Opioids are involved
16 in 40% of fatal drug overdoses – including overdoses due to illegal drugs.⁸³ Contrary to
17 Defendants’ misrepresentations, most of the illicit use stems from *prescribed* opioids; in 2011,
18 71% of people who abused prescription opioids got them through friends or relatives, not from
19 drug dealers or the internet.⁸⁴ According to the CDC, the 80% of opioid patients who take low-

20 ⁷⁷ Stagnitti, M.N., *Trends in Outpatient Prescription Analgesics Utilization and Expenditures for the U.S. Civilian*
21 *Noninstitutionalized Population, 1996 and 2006*, Statistical Brief #235, Agency for Healthcare Research and Quality,
Fig. 6 (Feb. 2006).

22 ⁷⁸ Grady D, *et al.*, *Opioids for Chronic Pain*, 171 Arch. Intern. Med. 1426, 1426 (Sept. 2011).

23 ⁷⁹ Daubresse M, *et al.*, *Ambulatory Diagnosis and Treatment of Nonmalignant Pain in the United States, 2000-*
2010, *Med. Care* 2013; 51(10):870-78.

24 ⁸⁰ Mafi J, *Worsening Trends in Management and Treatment of Back Pain*, *JAMA Intern Med.*, 2013;
173(17):1573-1571.

25 ⁸¹ Cicero T, *Relationship between therapeutic use and abuse of opioid analgesics in rural, suburban, and urban*
locations in the United States, *Pharmacoepidemiology and Drug Safety*, 2007; 16:827-840.

26 ⁸² Grady D, *et al.*, *Opioids for Chronic Pain*, 171 Arch. Intern. Med. 1426, 1426 (Sept. 2011).

27 ⁸³ Margaret Warner, Ph.D., Li Hui Chen, M.S., Ph.D., & Diane M. Makuc, Dr. P.H., *Increase in Fatal Poisonings*
Involving Opioid Analgesics in the United States, 1999-2006, U.S. Dep’t of Health & Human Servs., 2 (Sept. 2009),
available at www.cdc.gov/nchs/data/databriefs/db22.pdf.

28 ⁸⁴ U.S. Dep’t of Health & Human Servs., *2011 National Survey on Drug Use and Health* (Sept. 2012).

1 dose opioids from a single prescriber (in other words, who are not illicit users or “doctor-
2 shoppers”) account for 20% of all prescription drug overdoses.⁸⁵ In 2009, there were more than
3 twice as many deaths from prescription opioid overdoses (15,597) than from cocaine (4,350) and
4 heroin (3,278) put together.

5 253. In California, the numbers are equally dramatic. There were just over 10 deaths
6 from opioids for every 100,000 California residents in 2008, amounting to roughly 4,000 people.⁸⁶
7 That is almost double the number of homicides in the state (2,143) in the same year.⁸⁷ Santa Clara
8 and Orange Counties have not been spared from this rise in opioid-related deaths. Indeed, in
9 Orange County prescription opioids are responsible for a death every other day.⁸⁸

10 254. Death statistics represent only the tip of the iceberg. According to 2009 data, for
11 every overdose death that year there were nine abuse treatment admissions, 30 emergency
12 department visits for opioid abuse or misuse, 118 people with abuse or addiction problems, and
13 795 non-medical users.⁸⁹ Recent analysis by the CDC has documented increased rates of opioid
14 abuse and addiction among women; nationally, every three minutes a woman goes to the
15 emergency department for prescription painkiller misuse or abuse.⁹⁰ Every year since 2005,
16 opioid use has caused 1,000 additional emergency room visits in California.⁹¹ Nationally, there
17 were more than 488,000 emergency room admissions for opioids other than heroin in 2008 (up
18 from almost 173,000 in 2004).⁹²

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20 ⁸⁵ Paulozzi L, et al., *CDC Grand Rounds: Prescription Drug Overdoses, a U.S. Epidemic*, Morbidity and
Mortality Weekly Report, Jan. 13, 2012; 61(1):10-13.

21 ⁸⁶ *Opioid Analgesics in California: Relieving Pain, Preventing Misuse, Finding Balance*, CMA, June 2013, at p.
4.

22 ⁸⁷ Edmund G. Brown, Jr., Attorney General, *Homicide in California 2008*, California Department of Justice, 1
(March 2010), ag.ca.gov/cjsc/publications/homicide/hm08/preface.pdf.

23 ⁸⁸ David Whiting, *Whiting: FDA Finally Starts to Tackle Opioid Epidemic*, ORANGE COUNTY REGISTER, Oct. 26,
2013, available at www.ocregister.com/articles/fda-533176-drug-country.html.

24 ⁸⁹ Wilson M. Compton, M.D., M.P.E., *Prescription Drug Abuse: It's Not What the Doctor Ordered*, Nat'l Inst.
On Drug Abuse, 11 (May 3, 2013), available at www.apa.org/about/gr/science/spin/2013/05/prescription-drug-abuse.pdf.

25 ⁹⁰ CDC, Prescription overdose deaths are a growing problem among women, available at
26 <http://www.cdc.gov/vitalsigns/PrescriptionPainkillerOverdoses/>.

27 ⁹¹ Substance Abuse and Mental Health Services Administration [SAMHSA], Treatment Episode Data Set [TEDS]
2000-2010, State Admissions to Substance Abuse Treatment Services, Table 1.9.a.

28 ⁹² See http://www.samhsa.gov/data/dawn/nations/Nation_2011_NMUP.xls.

1 255. The deceptive marketing and overprescribing of opioids also have had a significant
2 detrimental impact on children in California. The overprescribing of opioids for chronic pain has
3 given young children access to opioids, nearly all of which were prescribed for adults in their
4 household. One study documented over 9,000 children nationally exposed to prescription opioids,
5 with a median age of two years old; the number of exposures in young children correlated to the
6 number of prescriptions in the area.⁹³ In addition, surveys of adolescents have shown that an
7 alarming percentage of California teenagers have used prescription painkillers illicitly. The most
8 recent California State Survey, conducted by the Attorney General, found that 12% of 9th graders
9 and 19% 11th graders had used an opioid without a prescription and finds that opioids are “the
10 most popular class of drugs after marijuana among high school students.” Four percent and 7% of
11 students, respectively, reported using opioids seven or more times.⁹⁴ Other research has found that
12 more than half of the teenagers obtained the drugs from their own home and report that the drugs
13 are easy to obtain.⁹⁵ A significant percentage of adolescents’ suicide attempts are carried out with
14 opioids.

15 256. Even infants have not been immune to the impact of opioid abuse. There has been
16 a dramatic rise in the number of infants who are born addicted to opioids due to prenatal exposure
17 and suffer from neonatal abstinence syndrome (“NAS,” also known as neonatal opioid withdrawal
18 syndrome, or “NOWS”). These infants painfully withdraw from the drug once they are born and
19 cry nonstop from the pain and stress of withdrawal, experience convulsions or tremors, have
20 difficulty sleeping and feeding, and suffer from diarrhea, vomiting, and low weight gain, among
21 other serious symptoms. The long-term developmental effects are still unknown, though research
22 in other states has indicated that these children are likely to suffer from continued, serious
23 neurologic and cognitive impacts, including hyperactivity, attention deficit disorder, lack of
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26 ⁹³ Bailey, JE, Campagna, E, Dart, RC, *The under recognized toll of prescription opioid abuse on young children*,
Ann. Emerg. Med., 2009 Apr. 53(4), 419-24.

27 ⁹⁴ See http://www.wested.org/online_pubs/hhdp/css_13th_highlights.pdf.

28 ⁹⁵ See http://www.adp.ca.gov/director/pdf/PDM_Tips_for_Educators.pdf.

1 impulse control, and a higher risk of future addiction.⁹⁶ When untreated, NAS can be life-
2 threatening.⁹⁷ In 2009, more than 13,000 infants in the United States were born with NAS, or
3 about one every hour.⁹⁸ According to data from Tennessee, which has most closely studied the
4 issue, 52% of mothers of NAS newborns used only drugs prescribed to them; another 20% used a
5 mix of their own prescriptions and illicitly obtained drugs.⁹⁹

6 257. Opioid addiction is the primary reason that individuals seek substance abuse
7 treatment at California facilities, and admissions into treatment facilities more than doubled from
8 2006-07 to 2010-11.¹⁰⁰ Nationally, in 2012, nearly 8 billion prescriptions of the two drugs
9 commonly used to treat opioid addiction – buprenorphine and naltrexone – were written and paid
10 for. Studies estimate the total medical and prescription costs of opioid addiction and diversion to
11 public and private healthcare payers at \$72.5 billion.¹⁰¹

12 258. Defendants’ creation through false and misleading advertising of a virtually
13 limitless opioid market has imposed significant burdens on the community at large. Defendants’
14 success in extending the market for opioids to new patients and chronic conditions has created an
15 abundance of drugs available for criminal use and fueled a new wave of addiction, abuse, and
16 injury. Defendants’ scheme supplied both ends of the secondary market for opioids – providing
17 both the inventory of narcotics to sell and the addicts to buy them. One researcher who has closely
18 studied the public health consequences of opioids has found, not surprisingly, that “substantial
19 increases in the nonmedical use of opioids is a predictable adverse effect of substantial increases in
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22 ⁹⁶ Roland Gray presentation to FDA; *See* citations in FDA decision on Docket Nos. FDA-2013-P-1288 and FDA-2013-P-1289.

23 ⁹⁷ *See*, FDA decision on Docket Nos. FDA-2013-P-1288 and FDA-2013-P-1289.

24 ⁹⁸ Patrick S, *et al.*, *Neonatal Abstinence Syndrome and Associated Health Care Expenditures, United States 2000-2009*, JAMA Intern Med. May 9, 2012; 307(18).

25 ⁹⁹ Jonel Aleccia, ‘*Just Flooding US*’: *Tenn. Spike in drug-dependent newborns is warning to nation*, NBC NEWS, October 11, 2013.

26 ¹⁰⁰ California Department of Alcohol and Drug Programs (ADP), Fact Sheet: Prescription Opioid Users in Treatment, Oct. 2012, at p. 2.

27 ¹⁰¹ Katz N, *Prescription Opioid Abuse: Challenges and Opportunities for Payers*, AmJManagCare, April 19 2013, p. 2, available at <http://www.ajmc.com/publications/issue/2013/2013-1-vol19-n4/Prescription-Opioid-Abuse-Challenges-and-Opportunities-for-Payers/>.

1 the extent of prescriptive use.”¹⁰² It has been estimated that 60% of the opioids that are abused
2 come, directly or indirectly, through doctors’ prescriptions.¹⁰³

3 259. In California counties like Orange County, the street value for a single tablet of
4 OxyContin may range from \$10 to \$15. These prices have given rise to a significant black market
5 in prescription opioids, which have not only created and supplied additional addicts, but fueled
6 other criminal activities. In Orange County, for example, rings of “cappers and handlers” prey on
7 homeless, indigent and seniors to buy their Medicare numbers or MediCal information to get
8 prescription opioids.

9 260. In addition, because heroin is cheaper than prescription painkillers, many
10 prescription opioid addicts migrate to heroin. According to one user interviewed by a local
11 television station, “If you’re doing 4, 5, 6, 7 Vicodin a day, you’re already spending \$30 or \$40 on
12 the pills. You know a bag of heroin is \$20.” Self-reported heroin use nearly doubled between
13 2007 and 2012, from 373,000 to 669,000 individuals and, in 2010, more than 3,000 people in the
14 U.S. died from heroin overdoses, also nearly double the rate in 2006; nearly 80% of those who
15 used heroin in the past year previously abused prescription opioids.¹⁰⁴ Patients become addicted to
16 opioids and then move on to heroin because these prescription drugs are roughly four times more
17 expensive than heroin on the street.” In the words of one federal Drug Enforcement Agency
18 official, “[w]ho would have ever thought in this country it would be cheaper to buy heroin than
19 pills and obtain them more easily. That is the reality we’re facing.”¹⁰⁵

20 261. The toll on patients who abuse or become addicted to opioids does not lend itself to
21 quantification, or even easy descriptions. Many of them will lose their jobs and some of them will
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23 ¹⁰² Alexander, *et al.*, *Rethinking Opioid Prescribing to Protect Patient Safety and Public Health*, JAMA Intern
Med., Nov. 14, 2012; 208(18):1865-66.

24 ¹⁰³ Katz N, *Prescription Opioid Abuse: Challenges and Opportunities for Payers*, AmJManagCare, April 19
25 2013, p. 5 (“The most common source of abused [opioids] is, directly or indirectly, by prescription.”), available at
<http://www.ajmc.com/publications/issue/2013/2013-1-vol19-n4/Prescription-Opioid-Abuse-Challenges-and-Opportunities-for-Payers>.

26 ¹⁰⁴ NPR Staff, *With Rise of Painkiller Abuse, A Closer Look At Heroin*, NPR, Nov. 2, 2013, available at
www.npr.org/2013/11/02/242594489/with-rise-of-painkiller-abuse-a-closer-look-at-heroin.

27 ¹⁰⁵ Matt Pearce and Tina Susman, *Philip Seymour Hoffman dies amid major comeback of heroin in the U.S.*, LA
28 TIMES, Feb. 3, 2014.

1 lose their homes and their families. Some of them will get treatment and fewer will successfully
2 complete it; many of those patients will relapse, returning to opioids or some other drug. As noted
3 above, some will become so desperate for drugs that they will switch to heroin – moving from
4 taking prescription drugs, to buying and even injecting illegal drugs. Of those who continue to
5 take opioids, some will overdose – some fatally, some not. Others will die prematurely from
6 related causes – falls, traffic accidents, or assaults or from premature heart or neurological disease
7 that hastens their death by 10 or 20 years.

8 **FIRST CAUSE OF ACTION**

9 **FALSE ADVERTISING**

10 **Violations of California Business and Professions Code Section 17500, *et seq.***
11 **Against all Defendants**

12 262. The People reallege and incorporate herein by reference each of the allegations
13 contained in the preceding paragraphs of this Complaint as though fully alleged in this Cause of
14 Action.

15 263. California Business and Professions Code Section 17500 (“Section 17500”) makes
16 it unlawful for a business to make, disseminate, or cause to be made or disseminated to the public
17 “any statement, concerning ... real or personal property ... which is untrue or misleading, and
18 which is known, or which by the exercise of reasonable care should be known, to be untrue or
19 misleading.”

20 264. At all times relevant to this Complaint, Defendants, directly or indirectly, violated
21 Section 17500 by making and disseminating untrue, false, and misleading statements about the use
22 of opioids to treat chronic non-cancer pain, or by causing untrue, false, and misleading statements
23 about opioids to be made or disseminated to the general public. In addition, Defendants repeatedly
24 failed to disclose material facts about the risks of opioids.

25 265. Defendant Purdue made and/or disseminated untrue, false and misleading
26 statements, including, but not limited to, the following:

- 1 • Endorsing and sponsoring patient education materials that contained misleading
2 statements;
- 3 • Posting misleading statements and pamphlets, concerning the risk of addiction and
4 the misleading concept of pseudoaddiction;
- 5 • Distributing brochures to doctors that included misleading statements concerning
6 the indicators of possible opioid abuse;
- 7 • Endorsing, directly distributed and assisted in the distribution of publications that
8 promoted the misleading concept of pseudoaddiction, even for high-risk patients;
- 9 • Providing significant financial support to pro-opioid key opinion leader doctors
10 who made untrue, false and misleading statements concerning the use of opioids to treat
11 chronic non-cancer pain;
- 12 • Providing significant financial support to pro-opioid pain organizations that made
13 untrue, false and misleading statements, including in patient education materials,
14 concerning the use of opioids to treat chronic non-cancer pain;
- 15 • Assisting in the distribution of guidelines that contained misleading statements
16 concerning the use of opioids to treat chronic non-cancer pain;
- 17 • Endorsing and assisting in the distribution of CME programs containing untrue,
18 false and misleading statements concerning the use of opioids to treat chronic non-cancer
19 pain;
- 20 • Assisting in the dissemination of scientific studies that misleadingly concluded
21 opioids are safe and effective for the long-term treatment of chronic non-cancer pain and
22 that opioids improve quality of life;
- 23 • Targeting veterans in disseminating patient education marketing materials that
24 contained untrue, false and misleading statements concerning the use of opioids to treat
25 chronic non-cancer pain; and
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1 • Exclusively disseminating misleading statements in education materials to
2 California hospital doctors and staff while purportedly educating them on new pain
3 standards created by JCAHO.

4 266. Defendant Endo made and/or disseminated untrue, false and misleading statements,
5 including, but not limited to, the following:

- 6 • Endorsing and sponsoring patient education materials and programs that contained
7 misleading statements;
- 8 • Facilitating the posting of misleading statements and pamphlets concerning the risk
9 of addiction, the misleading concept of pseudoaddiction and misleading claims that long-
10 term treatment of opioids improves function;
- 11 • Providing significant financial support to pro-opioid key opinion leader doctors
12 who made untrue, false and misleading statements concerning the use of opioids to treat
13 chronic non-cancer pain;
- 14 • Providing significant financial support to pro-opioid pain organizations – including
15 over \$10 million to the most egregious organization – that made untrue, false and
16 misleading statements, including in patient education materials, concerning the use of
17 opioids to treat chronic non-cancer pain;
- 18 • Assisting in the dissemination of scientific studies that misleadingly concluded
19 opioids are safe and effective for the long-term treatment of chronic non-cancer pain and
20 that opioids improve quality of life; and
- 21 • Targeting veterans in disseminating patient education marketing materials that
22 contained untrue, false and misleading statements concerning the use of opioids to treat
23 chronic non-cancer pain.

24 267. Defendant Janssen made and/or disseminated untrue, false and misleading
25 statements, including, but not limited to, the following:

- 26 • Endorsing and sponsoring patient education materials and programs that contained
27 misleading statements concerning the risk of addiction;

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- Facilitating the posting of misleading statements and pamphlets, concerning the risk of addiction, the misleading concept of pseudoaddiction and misleading claims that long-term treatment of opioids improves function;
- Assisting in the distribution of guidelines that contained misleading statements concerning the use of opioids to treat chronic non-cancer pain in the elderly;
- Providing significant financial support to pro-opioid key opinion leader doctors who made untrue, false and misleading statements concerning the use of opioids to treat chronic non-cancer pain;
- Providing significant financial support to pro-opioid pain organizations that made untrue, false and misleading statements, including in patient education materials, concerning the use of opioids to treat chronic non-cancer pain; and
- Targeting veterans in disseminating patient education marketing materials that contained untrue, false and misleading statements concerning the use of opioids to treat chronic non-cancer pain.

268. Defendant Cephalon made and/or disseminated untrue, false and misleading statements, including, but not limited to, the following:

- Endorsing and sponsoring patient education materials that contained misleading statements;
- Endorsing, directly distributing and assisting in the distribution of publications that promoted the misleading concept of pseudoaddiction, even for high-risk patients;
- Providing significant financial support to pro-opioid key opinion leader doctors who made untrue, false and misleading statements concerning the use of opioids to treat chronic non-cancer pain;
- Providing significant financial support to pro-opioid pain organizations that made untrue, false and misleading statements, including in patient education materials, concerning the use of opioids to treat chronic non-cancer pain;

- 1 • Endorsing and assisting in the distribution of CME programs containing untrue,
2 false and misleading statements concerning the use of opioids to treat chronic non-cancer
3 pain, and which did not concern cancer pain;
- 4 • Assisting in the dissemination of scientific studies that misleadingly concluded
5 Cephalon’s opioids (approved only for cancer pain) are safe and effective for the long-term
6 treatment of chronic non-cancer pain; and
- 7 • Targeting its marketing to a wide range of doctors, including general practitioners,
8 neurologists, sports medicine specialists and workers’ compensation programs.

9 269. Defendant Actavis made and/or disseminated untrue, false and misleading
10 statements, including, but not limited to, the following:

- 11 • Endorsing and sponsoring patient education materials that contained misleading
12 statements;
- 13 • Providing significant financial support to pro-opioid key opinion leader who made
14 untrue, false and misleading statements concerning the use of opioids to treat chronic non-
15 cancer pain; and
- 16 • Providing significant financial support to pro-opioid pain organizations that made
17 untrue, false and misleading statements, including in patient education materials,
18 concerning the use of opioids to treat chronic non-cancer pain.

19 270. Such omissions, which are deceptive and misleading in their own right, render even
20 Defendants’ seemingly truthful statements about opioids untrue, false, and misleading. All of this
21 conduct, separately and collectively, was likely to deceive California payers who purchased, or
22 covered the purchase of, opioids for chronic pain.

23 271. Defendants engaged in the widespread promotion of opioids for the treatment of
24 chronic pain directly through their own publications and employees, and indirectly through
25 seemingly independent thought-leaders, advocacy groups, and professional societies, by making,
26 funding, suggesting, editing, approving, and distributing untrue, false, and misleading statements
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1 and representations to doctors and patients. Defendants made untrue, false, and misleading
2 statements and representations about the benefits, risks, and superiority of opioids.

3 272. Defendants knew, or by the exercise of reasonable care should have known, at the
4 time of making or disseminating these statements, or causing these statements to be made or
5 disseminated, that such statements were untrue, false, or misleading and therefore likely to deceive
6 the public. In addition, Defendants knew or should have known that their marketing and
7 promotional efforts created an untrue, false, and misleading impression of the benefits, risks, and
8 superiority of opioids.

9 273. Pursuant to California Business and Professions Code Section 17535, Plaintiff
10 requests an order from this Court enjoining Defendants from any further violations of
11 Section 17500, *et seq.*;

12 274. Pursuant to California Business and Professions Code Section 17535, Plaintiff
13 requests restitution of any money acquired by Defendants' violations of Section 17500, *et seq.*;

14 275. Pursuant to California Business and Professions Code Section 17536, Plaintiff
15 requests an order assessing a civil penalty of two thousand five hundred dollars (\$2,500) against
16 Defendants for each violation of Section 17500, *et seq.*

17 **SECOND CAUSE OF ACTION**

18 **UNFAIR COMPETITION**

19 **Violations of the Unfair Competition Law**
20 **California Business and Professions Code Section 17200**
21 **Against all Defendants**

22 276. The People reallege and incorporate herein by reference each of the allegations
23 contained in the preceding paragraphs of this Complaint as though fully alleged in this Cause of
24 Action.

25 277. Each Defendant is named in this Count for its activities that occurred within four
26 years of the filing of this action.

27 278. California Business and Professions Code Section 17200 ("Section 17200")
28 prohibits any "unlawful, unfair or fraudulent business act or practices." Defendants have engaged

1 in unlawful, unfair and fraudulent business practices in violation of Section 17200 as set forth
2 above.

3 279. Defendants' practices as described in this Complaint are deceptive business
4 practices that violate Section 17200 because the practices are likely to deceive consumers in
5 California. Such practices include, but are not limited to, the following:

6 Defendants engaged in the widespread promotion of opioids for the
7 treatment of chronic pain directly through their own publications and
8 employees, and indirectly, through seemingly independent thought-
9 leaders, advocacy groups, and professional societies, by making,
10 funding, suggesting, editing, approving, and distributing untrue,
11 false, and misleading statements and representations to doctors and
12 patients. Defendants' untrue, false, and misleading statements and
13 representations involve overstating the benefits of opioids to treat
14 chronic pain and their superiority over alternate treatments and
15 minimizing their serious risks, including the risks of addiction,
16 overdose, and death.

12 280. Defendants knew, or by the exercise of reasonable care should have known, at the
13 time of making or disseminating these statements, or causing these statements to be made or
14 disseminated, that such statements were untrue, false, or misleading and therefore likely to deceive
15 the public. In addition, Defendants knew or should have known that their marketing and
16 promotional efforts created an untrue, false, and misleading impression of the risks of opioids.

17 281. Such omissions, which are deceptive and misleading in their own right, render even
18 Defendants' seemingly truthful statements about opioids false, and misleading. All of this
19 conduct, separately and collectively, was likely to deceive California payers who purchased, or
20 covered the purchase of, opioids for chronic pain.

21 282. Defendants' practices as set forth in this Complaint are also unlawful business
22 practices that violate Section 17200. These unlawful practices include, but are not limited to:

- 23 a. Defendants falsely advertised opioids in violation of the Sherman
24 Food, Drug, and Cosmetic Laws, CAL. HEALTH & SAFETY CODE
25 § 110390.
26 b. Defendants manufactured, sold, delivered, held, or offered for sale
27 opioids that had been falsely advertised in violation of the Sherman
28 Food, Drug, and Cosmetic Laws, CAL. HEALTH & SAFETY CODE
§ 110395.

- 1 c. Defendants advertised misbranded opioids in violation of the
2 Sherman Food, Drug, and Cosmetic Laws, CAL. HEALTH &
3 SAFETY CODE § 110398.
- 4 d. Defendants received in commerce opioids that were falsely
5 advertised or delivered or proffered for delivery opioids that were
6 falsely advertised in violation of the Sherman Food, Drug, and
7 Cosmetic Laws, CAL. HEALTH & SAFETY CODE § 110400.
- 8 e. Defendants manufactured, sold, delivered, held, or offered for sale
9 opioids that had been misbranded in violation of the Sherman
10 Food, Drug, and Cosmetic Laws, CAL. HEALTH & SAFETY CODE
11 § 111440.
- 12 f. Defendants misbranded opioids in violation of the Sherman Food,
13 Drug, and Cosmetic Laws, CAL. HEALTH & SAFETY CODE
14 § 111445.
- 15 g. Defendants received in commerce opioids that were misbranded in
16 violation of the Sherman Food, Drug, and Cosmetic Laws, CAL.
17 HEALTH & SAFETY CODE § 111450.
- 18 h. Defendants proffered for delivery opioids that were misbranded in
19 violation of the Sherman Food, Drug, and Cosmetic Laws, CAL.
20 HEALTH & SAFETY CODE § 111450.
- 21 i. Defendants failed to adopt a Comprehensive Compliance Program
22 in violation of CAL. HEALTH & SAFETY CODE § 19402.
- 23 j. Defendants represented that opioids had sponsorship, approval,
24 characteristics, ingredients, uses, or benefits which they did not
25 have in violation of the Consumer Legal Remedies Act, CAL. CIV.
26 CODE § 1770(a)(5).
- 27 k. Defendants represented that opioids were of a particular standard,
28 quality, or grade when they were of another in violation of
Consumer Legal Remedies Act, CAL. CIV. CODE § 1770(a)(7).
- l. Defendants disparaged the goods of another by false or misleading
representation of fact in violation of Consumer Legal Remedies
Act, CAL. CIV. CODE § 1770(a)(8).
- m. Defendants made or disseminated, directly or indirectly, untrue,
false, or misleading statements about the use of opioids to treat
chronic pain, or causing untrue, false, or misleading statements
about opioids to be made or disseminated to the general public in
violation of Section 17500.
- n. Defendants formed and operated a conspiracy, committed
wrongful acts pursuant to that conspiracy, and damaged the People
in violation of the California Common Law of Civil Conspiracy.
- o. Defendant Purdue continued to deceptively market OxyContin
after 2007, in violation of the terms of the 2007 Consent Judgment
with the State of California.

1 persons, although the extent of the annoyance or damage inflicted upon individuals may be
2 unequal.”

3 290. Pursuant to Section 731 of the California Civil Code, this action is brought by the
4 People to abate the public nuisance created by the Defendants.

5 291. Defendants, individually and in concert with each other, have contributed to, and/or
6 assisted in creating and maintaining a condition that is harmful to the health of Californians or
7 interferes with the comfortable enjoyment of life in violation of California Civil Code Sections
8 3479 and 3480.

9 292. The public nuisance created by Defendants’ actions is substantial and unreasonable
10 – it has caused and continues to cause significant harm to the community and the harm inflicted
11 outweighs any offsetting benefit. The staggering rates of opioid use resulting from Defendants’
12 marketing efforts have caused harm to the community, includes, but is not limited to:

- 13 a. Upwards of 30% of all adults have used them. These high rates of
14 use have led to unnecessary opioid abuse, addiction, overdose,
15 injuries, and deaths. In recent years, California deaths from
opioids have exceeded deaths by homicide by nearly a factor of
16 two.
- 17 b. Children too have been harmed by opioids. They have been
18 exposed to medications prescribed to family members or others,
19 resulting in injury, addiction, and death. Easy access to
20 prescription opioids has made opioids a recreational drug of choice
among California teenagers; opioid use among teenagers is only
21 outpaced by marijuana use. Even infants have been born addicted
22 to opioids due to prenatal exposure, causing severe withdrawal
23 symptoms and lasting developmental impacts.
- 24 c. Californians who have never taken opioids also have suffered the
25 costs of Defendants’ public nuisance. Many have endured both the
26 emotional and financial costs of caring for loved ones addicted to
27 or injured by opioids, and the loss of companionship, wages, or
28 other support from family members who have used, abused,
become addicted to, overdosed on, or been killed by opioids.
- d. More broadly, opioid use and misuse have driven Californians’
health care costs higher.
- e. Employers have lost the value of productive and healthy
employees who suffered from adverse consequences from opioid
use.

- 1 f. Defendants' success in extending the market for opioids to new
2 patients and chronic conditions has also created an abundance of
3 drugs available for criminal use and fueled a new wave of
4 addiction, abuse, and injury. Defendants' scheme created both
5 ends of a new secondary market for opioids – providing both the
6 supply of narcotics to sell and the demand of addicts to buy them.
- 7 g. This demand also has created additional illicit markets in other
8 opiates, particularly heroin. The low cost of heroin has led some
9 of those who initially become addicted to prescription opioids to
10 migrate to cheaper heroin, fueling a new heroin epidemic in the
11 process.
- 12 h. The diversion of opioids into the secondary, criminal market and
13 the increase in the number of individuals who abuse or are
14 addicted to opioids have increased the demands on emergency
15 services and law enforcement in the Counties.
- 16 i. All of this has caused significant harm to the community – in lives
17 lost; addictions endured; the creation of an illicit drug market and
18 all its concomitant crime and costs; unrealized economic
19 productivity; and broken families and homes.
- 20 j. These harms have taxed the human, medical, public health, law
21 enforcement, and financial resources of the People of California.
- 22 k. The Defendants' interference with the comfortable enjoyment of
23 life of a substantial number of people is entirely unreasonable
24 because there is little social utility to opioid use and any potential
25 value is outweighed by the gravity of the harm inflicted by
26 Defendants' actions.

27 293. Defendants knew or should have known that their promotion of opioid use would
28 create a public nuisance.

- 19 a. Defendants have engaged in massive production, promotion and
20 distribution of opioids for use by the People of the State of
21 California.
- 22 b. Defendants' actions created and expanded the market for opioids,
23 promoting its wide use for pain management.
- 24 c. Defendants misrepresented the benefits of opioids for chronic pain
25 and by fraudulently concealing, misrepresenting, and omitting the
26 serious adverse effects of opioids, including the addictive nature of
27 the drugs.
- 28 d. Defendants knew or should have known that their promotion
would lead to addiction and other adverse consequences and that
the larger community would suffer as a result.

29 294. Defendants' actions were, at the least, a substantial factor in opioids becoming
widely available and widely used. Defendants' actions were, at the least, a substantial factor in

1 doctors and patients not accurately assessing and weighing the risks and benefits of opioids for
2 chronic pain. Without Defendants' actions, opioid use would not have become so widespread, and
3 the enormous public health hazard of opioid overuse, abuse, and addiction that now exists would
4 have been averted.

5 295. The health and safety of the citizens of the jurisdictions, including those who use,
6 have used or will use opioids, as well as those affected by users of opioids, is a matter of great
7 public interest and of legitimate concern to the jurisdictions' citizens and residents.

8 296. The public nuisance created, perpetuated, and maintained by Defendants can be
9 abated and further reoccurrence of such harm and inconvenience can be prevented.

10 297. Defendants' conduct has affected and continues to affect a considerable number of
11 people within the Counties and is likely to continue to cause significant harm to chronic pain
12 patients who take opioids, their families, and the community at large.

13 298. Pursuant to California Code of Civil Procedure Section 731, Plaintiffs request an
14 order from the Court on behalf of the People of the State of California providing for abatement of
15 Defendants' ongoing violations of California Civil Code Sections 3479 and 3480, and enjoining
16 Defendants from future violations of California Civil Code Sections 3479 and 3480.

17 299. Each Defendant created or assisted in the creation of the epidemic of opioid use and
18 injury and each Defendant is jointly and severally liable for abating it.

19 **V. PRAYER FOR RELIEF**

20 THE PEOPLE pray that the Court:

21
22 300. Declare that Defendants have made, disseminated as part of a plan or scheme, or
23 aided and abetted the dissemination of false and misleading statements in violation of the False
24 Advertising Law.

25 301. Enjoin Defendants from performing or proposing to perform any further false or
26 misleading statements in violation of the False Advertising Law.

1 302. Order Defendants to pay restitution of any money acquired by Defendants' false
2 and misleading advertising, pursuant to Business and Professions Code sections 17500 and 17535
3 of the False Advertising Law.

4 303. Order Defendants to pay civil penalties for each act of false and misleading
5 advertising, pursuant to Business and Professions Code Sections 17500 and 17536 of the False
6 Advertising Law.

7 304. Declare that Defendants have engaged in unlawful, unfair, and deceptive business
8 acts and practices in violation of the Unfair Competition Law.

9 305. Enjoin Defendants from performing or proposing to perform any acts in violation of
10 the Unfair Competition Law.

11 306. Order Defendants to pay restitution of any money acquired by Defendants'
12 unlawful, unfair, and deceptive business practices, pursuant to Business and Professions Code
13 section 17203 of the Unfair Competition Law.

14 307. Order Defendants to pay civil penalties for each act of unfair and unlawful
15 competition, pursuant to Business and Professions Code section 17206 of the Unfair Competition
16 Law.

17 308. Order Defendants to pay civil penalties for each act of unfair and unlawful
18 competition perpetrated against senior citizens or disabled persons, pursuant to Business and
19 Professions Code section 17206.1 of the Unfair Competition Law.

20 309. Order Defendants to pay treble the amount of all relief awarded by the Court,
21 pursuant to California Civil Code section 3345.

22 310. Declare that Defendants have created a public nuisance in violation of California
23 Civil Code Sections 3479 and 3480.

24 311. Enjoin Defendants from performing any further acts in violation of California Civil
25 Code Sections 3479 and 3480.

26 312. Order Defendants to abate the public nuisance that they created in violation of
27 California Civil Code Sections 3479 and 3480.

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313. Order Defendants to pay the cost of the suit, including attorneys' fees.

314. Provide such further and additional relief as the Court deems proper.

DATED: May 21, 2014.

**OFFICE OF THE COUNTY COUNSEL
COUNTY OF SANTA CLARA**

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1 313. Order Defendants to pay the cost of the suit, including attorneys' fees.

2 314. Provide such further and additional relief as the Court deems proper.

3
4 DATED: May 21, 2014.

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