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KATHRYN FLOR Plaintiff, v. MYLAN BERTEK PHARMACEUTICALS, INC., f/k/a BERTEK PHARMACEUTICALS, INC.; MYLAN PHARMACEUTICALS, INC.; MYLAN, INC. f/k/a MYLAN LABORATORIES, INC.; CARDINAL HEALTH 409, INC. f/k/a R.P. SCHERER CORPORATION; and GENPHARM Defendants	SUPERIOR COURT OF NEW JERSEY LAW DIVISION ATLANTIC COUNTY DOCKET NO. ATL-L-3795-07 CIVIL ACTION **APPLICABLE TO ALL CONSOLIDATED CASES** **ORDER RE COMPLETION OF FACT SHEET DOCUMENTS**

THIS MATTER, having come before the Court at recent Case Management Conferences, and all parties having been represented by Counsel, and for good cause shown,

IT IS on this 4th day of Dec, 2008,

ORDERED as follows:

I. PLAINTIFF'S FACT SHEET, PLAINTIFF'S CONFIDENTIAL FACT SHEET AND LIST OF TOPICS FOR ELECTRONIC DOCUMENTS FOR DISCOVERY

Each plaintiff alleging that his or her injuries were caused by one or more generic forms of isotretinoin shall complete, and comply with, the Plaintiff's Fact Sheet, Plaintiff's

Confidential Fact Sheet, List of Topics for Electronic Documents for Discovery, verifications and records release authorizations, all of which are attached to this Order (hereinafter collectively "Plaintiff's Fact Sheet Documents").

Plaintiff's Fact Sheet Documents shall be deemed served on all plaintiffs in cases filed prior to the entry of this Order (hereinafter "Initial Plaintiffs"). All other plaintiffs whose cases are subsequently filed (hereinafter "New Plaintiffs") shall be deemed served with the Plaintiff's Fact Sheet Documents at the time the first served generic isotretinoin defendant files its Answer or other responsive pleading.

II. DUE DATES FOR PLAINTIFF'S FACT SHEET, PLAINTIFF'S CONFIDENTIAL FACT SHEET, AND LIST OF TOPICS FOR ELECTRONIC DOCUMENTS FOR DISCOVERY

The Initial Plaintiffs shall provide completed Plaintiff's Fact Sheet Documents, together with any responsive documents and/or things, within 45 days of the entry of this Order.

Any Initial Plaintiff who previously completed and provided generic defendants with responses to the Plaintiff's Fact Sheet, Plaintiff's Confidential Fact Sheet, and List of Topics for Electronic Documents for Discovery previously approved for use in the New Jersey Accutane mass tort litigation is not required to complete the attached documents. Rather, defendants may request that a plaintiff provide information and documentation requested in the attached Plaintiff's Fact Sheet Documents that was not previously provided by the plaintiff in his or her Accutane Plaintiff's Fact Sheet responses and related documents. Initial Plaintiffs shall provide the requested information and/or documentation within 30 days of defendant's request.

All New Plaintiffs shall provide answers to Plaintiff's Fact Sheet Documents, together with executed verification and records release authorizations and any responsive documents

and/or things, within 45 days of filing by the first served generic defendant of its Answer or other responsive pleadings.

III. DEFENDANTS' FACT SHEET

Defendants shall complete the Defendants' Fact Sheet attached to this Order.

With respect to Initial Plaintiffs and New Plaintiffs, the Defendants' Fact Sheet shall be deemed served on the Defendants at the time each plaintiff serves their initial responses to the Plaintiff's Fact Sheet Documents. For those cases in which plaintiffs have previously served the Plaintiff's Fact Sheet approved for use in the New Jersey Accutane mass tort litigation, the Defendants' Fact Sheet shall be deemed served on the Defendants as of the date of the entry of this Order.

IV. DUE DATES FOR DEFENDANTS' FACT SHEETS

With respect to Initial Plaintiffs and New Plaintiffs, Defendants shall provide answers to the Defendants' Fact Sheet, together with an executed verification and any responsive documents and/or things, within 45 days of each Plaintiff's service of their completed Plaintiff's Fact Sheet Documents. For those cases in which plaintiffs have previously served the Plaintiff's Fact Sheet approved for use in the Accutane mass tort litigation, including executed verifications and records release authorizations, Defendants shall provide answers to the Defendants' Fact Sheet, together with an executed verification and any responsive documents and/or things, within 45 days of the entry of this Order.

Honorable Carol E. Higbee, P.J.Cv.

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KATHRYN FLOR Plaintiff, v. MYLAN BERTEK PHARMACEUTICALS, INC., f/k/a BERTEK PHARMACEUTICALS, INC.; MYLAN PHARMACEUTICALS, INC.; MYLAN, INC. f/k/a MYLAN LABORATORIES, INC.; CARDINAL HEALTH 409, INC. f/k/a R.P. SCHERER CORPORATION; and GENPHARM Defendants	:	SUPERIOR COURT OF NEW JERSEY LAW DIVISION ATLANTIC COUNTY DOCKET NO. ATL-L-3795-07 CIVIL ACTION **APPLICABLE TO ALL CONSOLIDATED CASES**

PLAINTIFF'S FACT SHEET

Plaintiff: _____
(name)

This Fact Sheet and the attached List of Medical Providers and Other Sources of Information must be completed by each plaintiff who has used isotretinoin or their personal representative. In filling out this form, please use the following definitions:

(1) **"Health care provider"** means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric, mental, emotional or psychological care or advice, and any pharmacy, counselor, dentist, X-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, therapist, nurse, herbalist, nutritionist, dietician or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you or your decedent;

(2) **"Document"** means any writing or record or any type, however produced and whatever the medium on which it was produced or reproduced, and includes, without limitation,

the original and any non-identical copy (whether different from the original because of handwritten notes or underlining on the copy or otherwise) and all drafts of papers, letters, telegrams, telexes, notes, notations, memoranda of conversations or meeting, calendars, diaries, minutes of meetings, interoffice communications, electronic mail, message slips, notebooks, agreements, reports, articles, books, tables, charts, schedules, memoranda, medical records, x-rays, advertisements, pictures, photographs, films, accounting books or records, billings, credit card records, electrical or magnetic recordings or tapes, or any other writings, recordings, or pictures of any kind of description.

(3) **"Isotretinoin"** means any and all forms of the prescription drug generically known as isotretinoin, including Claravis®, Sotret®, Amnesteem®, and other branded or non-branded versions or forms of isotretinoin, including, but not limited to, Accutane®.

(4) **"Primary care physician"** means the physician or health care provider whom you consult initially for diagnosis and treatment of any condition and upon whom you rely for referrals to specialists or other health care providers, including, but not limited to, physicians designated as your primary care physicians under any health or medical insurance plan.

I. CASE INFORMATION

A. Name of person completing this form: _____

B. Please state the following for the civil action which you filed:

1. Case Caption: _____

2. Case No.: _____

3. Please state the name, address, and telephone number of the principal attorney representing you:

_____
Name

_____
Firm

_____
City, State and Zip Code

_____
Telephone number

4. When did you first contemplate obtaining an attorney regarding any injury(ies) which you now allege is (are) associated with isotretinoin?

_____

_____

5. When did you first contact an attorney regarding any injury(ies) which you now allege is (are) associated with isotretinoin? (This question asks for the first contact with any attorney including, but not limited to, your present attorney.)

_____

_____

C. If you are completing this questionnaire in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following: If not, skip this question.

1. _____
Your name and Social Security Number

2. _____
Maiden or other names used or by which you have been known

3. _____

Street Address

4. _____

City, State and Zip Code

5. If you are in a representative capacity, state which individual or estate you are representing, and in what capacity you are representing the individual or estate:

_____

6. If you were appointed as a representative by a court, state the:

_____ _____

Court Date of Appointment

7. Your relationship to deceased or represented person or person claimed to be injured:

_____

8. If you represent a decedent's estate based on a decedent's death, state the date of death of the decedent and the address of the place where the decedent died:

_____

If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who used isotretinoin, unless the question instructs you otherwise. Those questions using the term "You" refer to the person who used the isotretinoin, unless you are instructed otherwise. If the individual is deceased, please respond as of the time immediately prior to his or her death, unless a different time period is specified.

D. Claim Information

1. What bodily injury(ies)/condition(s) do you claim resulted from your use of isotretinoin? If you state severe organ damage, please state specifically which organ and the alleged injury(ies). Be very specific about each and every injury claimed.

_____

_____

_____

2. When do you claim this injury(ies)/condition(s) first occurred?

_____

_____

3. Who diagnosed the condition(s)?

_____

_____

_____

4. Physician/healthcare provider(s) who related condition(s)/diagnosis(es) to isotretinoin.

_____

_____

_____

5. Date of diagnosis for each condition(s) alleged to have been caused by isotretinoin.

_____

_____

_____

6. Did you ever suffer this injury(ies) prior to the date set forth in answer to the prior question? If yes, when and who diagnosed the condition(s) at that time?

_____

_____

_____

7. Do you claim that your use of isotretinoin worsened a condition(s) that you already had or had in the past?

Yes_____ No _____ Don't Know _____

If yes, set forth the injury(ies) or condition(s), whether or not you had already recovered from that injury(ies) or condition(s) before you took isotretinoin, and the date of recovery, if any.

_____

_____

_____

8. Is there a family history of the same or similar condition(s) you claim resulted from your use of isotretinoin?

Yes_____ No _____

If so, who in your family had or has this or a similar condition (father, mother, brother, grandmother, etc.)?

_____

_____

_____

_____

_____

II. PERSONAL INFORMATION OF THE PERSON WHO USED ISOTRETINOIN

A. Last Name: _____
First Name: _____
Middle Name or Initial: _____

B. Maiden or other names used or by which you have been known:

_____

C. Social Security Number: _____

D. Present Street Address: _____

_____
City State Zip Code

E. Identify each other address at which you have resided during the last ten (10) years, and list when you started and stopped living at each one:

_____ From _____ To _____

_____ From _____ To _____

_____ From _____ To _____

_____ From _____ To _____

_____ From _____ To _____

F. Identify each grammar/grade school, high school, college, university or other educational institution you have attended, the dates of attendance, courses of study pursued, and diplomas or degrees awarded and when each was awarded:

_____

_____

G. Employment Information.

1. Current employer (if not currently employed, last employer):

Name

Address

Dates of Employment

Occupation/Job Duties

2. List the following for each employer you have had in the last ten (10) years:

Name

Address

Dates of Employment

Occupation/Job Duties

Name

Address

Dates of Employment

Occupation/Job Duties

Name

Address

_____

Dates of Employment

_____

Occupation/Job Duties

H. Driver's license number and State issuing license: [If you have had driver's licenses in more than one state, list response for each state.]

_____

_____

I. Date and place of birth: _____

J. Sex: Male _____ Female _____

K. Military Service Information

1. Have you ever served in any branch of the U.S. military?

Yes _____ No _____

If yes, please state:

1. What branch, the dates of service and highest rank achieved:

_____

2. Were you discharged for any reason relating to your physical, psychiatric or emotional condition(s)?

Yes _____ No _____

If yes, identify the condition(s):

_____

2. Have you ever been rejected from military service for any reason relating to your health or physical condition(s)?

Yes _____ No _____

If yes, identify the condition(s):

_____

3. Have you ever served in the military overseas?

Yes _____ No _____

If yes, state location(s) and dates:

_____

L. Insurance/Claim Information

1. Have you ever filed a worker's compensation claim?

Yes _____ No _____

If yes, please state:

1. Month and year when each claim was filed: _____
2. Court/State in which claim was filed: _____
3. Claim/ docket number, if applicable: _____
4. Nature of disability: _____
5. Period of disability: _____
6. Benefits received, if any: _____

[Attach additional sheets if necessary to provide all of the foregoing information for more than one claim]

2. Have you ever filed a social security disability claim (SSI or SSD)?

Yes _____ No _____

If yes, please state:

1. Year claim was filed: _____
2. Where claim was filed: _____
3. Nature of disability: _____
4. Period of disability: _____
5. Benefits received, if any: _____

[Attach additional sheets if necessary to provide all of the foregoing information for more than one claim]

3. Have you ever been denied life insurance or medical insurance for reasons relating to your medical or physical condition(s)?

Yes _____ No _____

If yes, state when, the name of the insurance company, the type or kind of policy involved, and the company's stated reason for denial:

_____

_____

4. ***(Answer this question if you are claiming damages for mental or emotional distress.)*** Have you ever been denied life insurance or medical insurance for reasons relating to your mental or emotional condition(s)?

Yes _____ No _____

If yes, state when, the name of the insurance company, the type or kind of policy involved, and the company's stated reason for denial:

_____

_____

_____

5. Has any insurance or other company provided medical coverage to you (either directly or through a group including any employer of yours) or paid medical bills on your behalf at any time, beginning ten (10) years before your alleged injury(ies) through the present?

Yes _____ No _____

If yes, then as to each company, separately state:

Name of the company: _____

Address of the company: _____

The account/policy number or designation: _____

The claim number, if any: _____

Dates of coverage: _____

When claim was made: _____

6. Have you ever been out of work for more than thirty (30) days for reasons related to your health? If yes, set forth when and the reason for each such occasion:

Yes _____ No _____

When: _____

Reason: _____

_____

7. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury(ies)?

Yes _____ No _____

If so, state the court in which such action was filed, the caption, case name and/or names of adverse parties, and the civil action or docket number assigned to each claim, action or suit, and a brief description of the claims asserted:

_____

_____

_____

M. Have you ever been convicted of a crime? If yes, set forth where, when and the crime, and, for each such instance, the penalty or sentence imposed and, if you were incarcerated, the name of the institution in which you were incarcerated:

Yes _____ No _____

_____

_____

_____

III. FAMILY INFORMATION

A. List for each marriage the name of your spouse; spouse's date of birth (for your current spouse only), spouse's occupation, date of marriage, date the marriage ended, if applicable, and how the marriage ended (e.g., divorce, annulment, death):

_____

_____

_____

_____

_____

B. List the names and ages of your parents and whether they are still married:

_____

_____

_____

C. List the names and ages of your paternal and maternal grandparents and whether they are still living. If deceased, list date and cause of death for each:

_____

_____

_____

D. To the best of your current knowledge or present recollection, has any parent, grandparent, child, or sibling ever been diagnosed with a condition(s) relating to the same organ or organ system identified in your answer to Section I(D)?

Yes _____ No _____ Don't Know _____

If yes, identify each such person below and provide the information requested:

1. Name: _____
   Current age (or age at death): _____
   Type of condition: _____
   If applicable, cause of death: _____

2. Name: _____
   Current age (or age at death): _____
   Type of condition: _____
   If applicable, cause of death: _____

3. Name: _____

Current age (or age at death): _____
Type of condition: _____
If applicable, cause of death: _____

E. If applicable, for each of your children, list his/her name, age, occupation and address:

_____
_____
_____
_____
_____

F. If you are bringing a survivor cause of action, state whether you have been appointed as the decedent's personal representative authorized to prosecute the decedent's claims, and, if so, when and by whom you were so appointed:

_____
_____
_____
_____
_____

IV. CURRENT MEDICAL CONDITION(S)

A. Do you currently suffer from any physical injuries, illnesses or disabilities other than those you have alleged are the result of your use of isotretinoin?

Yes _____ No _____

B. If the answer is yes, please state the following for each injury(ies), illness or disability:

1. Identify for each such injury(ies), illness or disability, their symptoms and date of onset:

_____
_____
_____
_____
_____

Date of onset: _____

2. By whom were you first diagnosed with this injury, illness or disability?

_____ _____
Name Address (if not otherwise provided)

_____

Date of diagnosis

Medical specialty of diagnosing physician: _____

V. MEDICAL HISTORY AND BACKGROUND

A. Height: _____

B. Current weight: _____
Weight at the time of the injury, illness or disability described in section I(D):

_____

C. Prescription Medications

1. To the best of your recollection, list each prescription medication, including but not limited to oral contraceptives (as applicable) you have taken **regularly** in the last ten (10) years, identifying the medication and the condition(s) for which it was prescribed:

_____
_____
_____
_____
_____
_____
_____
_____

2. To the best of your recollection, list each prescription medication you have taken **intermittently** in the last ten (10) years, identifying the medication and the condition(s) for which it was prescribed:

_____
_____
_____
_____
_____
_____

3. To the best of your recollection, state whether you used any of the following substances at any time ten (10) years prior to the date of the injury(ies) you allege in section I(D) through the present. Circle all medications you have used, state when you took the medication and how frequently, and, if a doctor prescribed or suggested the medication for your use, identify the doctor:

a. NSAIDS (such as):

Substance	When taken and how frequently	Name of prescribing doctor (if any)
Advil	_____	_____
Ibuprofen	_____	_____
Aleve	_____	_____
Naprosyn	_____	_____
Motrin	_____	_____
Orudis	_____	_____
Feldene	_____	_____
Indocin	_____	_____
Toradol	_____	_____
Daypro	_____	_____
Celebrex	_____	_____

b. Herbal remedies or supplements:

Substance	When taken and how frequently	Name of prescribing doctor (if any)
Kava	_____	_____
Ginseng	_____	_____
Ginko Bilboa	_____	_____
St. John's Wort	_____	_____
Sal Palmetto	_____	_____
Other	_____	_____

D. Smoking/tobacco use history (circle whichever is applicable):

1. Never used or smoked cigarettes/cigars/pipe tobacco or chewing tobacco/snuff.

2. Past user or smoker of cigarettes/cigars/pipe tobacco or chewing tobacco/snuff.
   Date on which smoking/tobacco use ceased: _____
   Amount smoked or used: _____ per day for _____ years.

3. Current user or smoker of cigarettes/cigars/pipe tobacco or of chewing tobacco/snuff.

Amount smoked or used: _____ per day for _____ years.

E. Drinking history:

1. Do you now drink or have you in the past drunk alcohol (beer, wine, whiskey, etc.)?

Yes _____ No _____

If no, go to Section F below. If yes, check the following box which represents your greatest alcohol consumption over an extended (6 months or greater) period within the last 10 years:

_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 11-14 drinks per week
_____ 15 or more drinks per week
_____ Other (describe) _____

Check the following box which represents your weekly alcohol consumption for the month prior to the first symptom (gastrointestinal or other symptoms related to your injury) you experienced:

_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 11-14 drinks per week
_____ 15 or more drinks per week
_____ Other (describe) _____

F. Caffeine and sugar intake history:

1. Do you now or have you in the past consumed caffeinated beverages (coffee, tea, sodas, etc.)?

Yes _____ No _____

If yes, check the following box which represents your greatest caffeine consumption over an extended (6 months or greater) period within the last 10 years:

_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 11-14 drinks per week
_____ 15 or more drinks per week
_____ Other (describe) _____

Check the following box which represents your weekly caffeine consumption for the month prior to the first symptom (gastrointestinal or other symptoms related to your injury) you experienced:

_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 11-14 drinks per week
_____ 15 or more drinks per week
_____ Other (describe) _____

2. Do you now or have you in the past consumed sugared beverages or desserts?

Yes _____ No _____

If yes, check the following box which represents your greatest sugar consumption over an extended (6 months or greater) period within the last 10 years:

_____ 1-5 items per week
_____ 6-10 items per week
_____ 11-14 items per week
_____ 15 or more items per week
_____ Other (describe) _____

Check the following box which represents your weekly sugar consumption for the month prior to the first symptom (gastrointestinal or other symptoms related to your injury) you experienced:

_____ 1-5 items per week
_____ 6-10 items per week
_____ 11-14 items per week
_____ 15 or more items per week
_____ Other (describe) _____

G. ***If you are claiming damages for mental or emotional distress as a consequence of isotretinoin***, state whether you have experienced or been treated for any psychological, psychiatric or emotional problem prior to the use of isotretinoin, including but not limited to, panic attacks, anxiety, post traumatic stress disorder, depression, thoughts of hurting yourself or other people, schizophrenia, bipolar disorder, personality disorders (e.g., obsessive compulsive, paranoid, borderline, histrionic, other), generalized anxiety disorder, social phobia/anxiety disorder, mania, poor sleep, poor concentration, suicidal thoughts/attempts, and drug abuse.

Yes _____ No _____

If yes, state:

1. Name and address of each health care provider who treated you:

_____
Name

_____
Address (if not otherwise provided)

_____

2. Condition(s) for which treated: _____

3. When treated: _____

4. Medications prescribed for such condition(s): _____

_____

H. To the best of your knowledge or understanding, have you ever experienced, or been told by a doctor or other healthcare professional, that you have, may have or had any of the following at any time in your life.

Symptom/Condition	Yes	No	I don't know
Abdominal pain			
Allergic reaction to medication			
Anemia			
Arthritis			
Back pain and/or neck injury			
Bleeding/clotting disorders (hemophilia, Von Willebrand's disease, scurvy, other)			
Blood disorders			
Blood in stool or dark/black stools			
Blurry vision lasting more than a few days			
Bone fracture			
Bone problems/pain/disease			
Calcification of tendons and ligaments			
Cancer (lung, colon, liver, breast, testicular, other)			
Chest pain/angina (at rest or with exertion)			
Chronic Fatigue Syndrome			
Chronic obstructive pulmonary disease/COPD			

Symptom/Condition	Yes	No	I don't know
Colitis			
Congenital heart disease			
Congestive heart failure			
Corneal opacity			
Corneal ulcer			
Coronary artery disease			
Coronary heart disease			
Crohn's Disease			
Deep vein thrombosis/DVT/blood clot in lower legs			
Degenerative disc			
Dermatomyositis			
Diabetes			
Dizziness lasting more than a few days			
Drowsiness lasting more than a few days			
Elevated cholesterol			
Elevated liver enzymes			
Elevated triglycerides			
Esophagus problems (strictures, achalasia, esophagitis, Barrett's esophagus, difficulty swallowing, other)			
Eye hemorrhages			
Fibromyalgia			
Gall bladder problems (gall stones, other)			
Gastrointestinal problems			
Gout			
Headaches lasting more than a few days			
Heart attack/MI/myocardial infarction			
Heart problems (including but not limited to heart attack, heart murmurs, heart valve problems, heart palpitations, heart rate/rhythm problems, congestive heart failure, cor pulmonale, etc.)			
Heartburn/ reflux/ esophageal reflux disease/ GERD			

Symptom/Condition	Yes	No	I don't know
Hepatotoxicity			
Hernia (strangulated or incarcerated)			
High blood pressure/hypertension			
High triglycerides			
Hodgkin's disease/ non-Hodgkin's lymphoma			
Hypoxia (low oxygen saturation)			
Ileitis			
Inflammatory bowel disease			
Insomnia lasting more than a few days			
Intestinal hemorrhage			
Intestinal obstruction (not including constipation)			
Irregular heart rhythm			
Irritable bowel syndrome			
Itching (persistent lasting more than one week)			
Joint pain lasting more than a few days			
Keratitis			
Kidney problems (disease, infection, stones, protein in urine, etc.)			
Leukemia			
Liver disease (hepatitis B/C, cirrhosis, cysts, abnormal enzymes, etc.)			
Lupus			
Lymphadenopathy			
Measles			
Musculoskeletal problems			
Nausea (repetitive bouts lasting more than a few days)			
Night vision loss			
Obesity			
Optic neuritis			
Oral herpes (canker sores)			

Symptom/Condition	Yes	No	I don't know
Osteoarthritis			
Pancreatitis			
Paresthesias			
Peptic ulcer disease			
Peripheral vascular disease			
Premature epiphyseal closure			
Pseudotumor cerebri psychosis			
Pulmonary embolism/blood clot in the lung			
Pyoderma faciale			
Rectal bleeding			
Regional ileitis			
Rheumatic fever (as to you only, if applicable)			
Rhabdomyolysis			
Rheumatoid arthritis			
Scheuermann's Kyphosis			
Seizure disorder			
Shortness of breath not associated with vigorous exercise			
Silent MI			
Skeletal hyperostosis			
Sleep apnea			
Stomach problems (ulcers, perforations, bleeding)			
Stroke			
Swelling/edema/fluid in legs ankles (other than in pregnancy)			
Syncope			
Tendonitis			
Thyroid disorder and/or goiter			
Transient chest pain			
Transient ischemic attack/TIA			

Symptom/Condition	Yes	No	I don't know
Tuberculosis			
Ulcerative colitis			
Urogenital condition(s)s			
Vascular problems			
Vascular thrombotic disease			
Vasculitis			
Vision problems lasting more than a few days			
Vomiting lasting more than a few days			

I. If you responded "yes" to any of the above, please identify/state the condition(s), the date of onset, any medication prescribed to treat the condition(s), and the name and address of the physician or other person who made the diagnosis or informed you of the condition(s):

1. Condition(s): _____
   Onset date and medication: _____
   Name and address of physician or other person: _____
   _____

2. Condition(s): _____
   Onset date and medication: _____
   Name and address of physician or other person: _____
   _____

3. Condition(s): _____
   Onset date and medication: _____
   Name and address of physician or other person: _____
   _____

4. Condition(s): _____
   Onset date and medication: _____
   Name and address of physician or other person: _____
   _____

5. Condition(s): _____
   Onset date and medication: _____
   Name and address of physician or other person: _____
   _____

J. Please indicate whether you have ever received any of the following treatments or diagnostic procedures:

1. Surgeries, including but not limited to the following, and specify for what condition(s) the surgery was performed: open heart/bypass surgery, vascular surgery, intestinal surgery, etc.

Surgery and condition(s) for which it was performed: _____

_____

_____

When: _____

Treating physician: _____

_____

Hospital: _____

_____

2. Treatments/interventions for heart attack, angina (chest pain), or lung ailments, including but not limited to the following: cardiac catheterization, angioplasty (balloon), stenting, electroconversion.

Treatment/intervention: _____

_____

_____

When: _____

Treating physician: _____

_____

Hospital: _____

_____

3. Have you had any of the following tests performed: chest X-ray, CT scan, MRI, any other type of x-ray, colonoscopy, upper or lower GI, EKG, echocardiogram, bleeding scan, endoscopy, lung bronchoscopy, carotid duplex/ultrasound, or CT scan of the head. If so, answer the following:

Diagnostic test: _____

_____

When: _____

Treating physician: _____

_____

Hospital: _____

_____

Reason: _____

_____

K. Have you ever participated in any clinical trials or studies relating to any drugs or treatments for any medical condition(s)s?

Yes _____ No _____

If "Yes", please identify: _____

Name of the trial or study: _____

Sponsor of trial or study: _____

Drug or treatment studied: _____

Indicated use(s) of the drug or treatment studied: _____

Name and address of the investigator in charge of your care and treatment in the trial or study: _____

_____

The dates you participated in the trial or study: _____

L. To the best of your knowledge, have your parents, grandparents, children or siblings ever experienced or been diagnosed with, or been told by a doctor or other healthcare professional, that they have, may have or had any of the following (circle all that apply), set forth the name of the individual and their relationship to you next to each condition(s) circled:

Symptom/Condition	Name of Individual	Relationship
Gastrointestinal pain (repetitive bouts)		
Blood in stool or dark/black stools		
Bone pain/problems/disease		
Cancer (lung, colon, liver, breast, testicular, other)		
Depression/psychiatric disorders		
Diabetes		
Elevated cholesterol/lipids		
Heart problems of any kind including arthrosclerotic disease		
Any kind of bowel disease/disorder (including Crohn's, ulcerative colitis or irritable bowel syndrome)		
Kidney disease/stones		
Liver disease (hepatitis B/C, cirrhosis, cysts, other)		
Lupus		
Musculoskeletal disease/disorder		

Symptom/Condition	Name of Individual	Relationship
Pancreatitis		
Stroke		
Thyroid disease/disorder (goiter, etc.)		
Vision Disorder		

VI. ISOTRETINOIN PRESCRIPTION INFORMATION

PLEASE NOTE: With regard to each and every one of your answers in this section VI. "Isotretinoin Prescription Information" (subparts A through T), please provide separate and specific information for each and every brand or form of isotretinoin you took or were prescribed, including separate specific information relating to your use of and/or prescriptions for (1) Claravis®, (2) Sotret®, (3) Amnesteem® and (4) any or other branded or non-branded versions or forms of isotretinoin you took or were prescribed, such as Accutane®.

Which of the following brands of isotretinoin did you ingest:

Claravis®

Sotret®

Amnesteem®

Accutane®

Please complete the section(s) for each brand of isotretinion checked above.

A. CLARAVIS®

1. Who prescribed Claravis® for you?

_____

_____

_____

2. On which dates did you begin to take, and stop taking, Claravis®? If you took Claravis® more than once, list each start and stop date.

_____

_____

_____

3. For what condition(s) were you prescribed Claravis®?

_____

_____

_____

4. Did you renew your prescription for Claravis®? If yes, how many times?

_____

_____

_____

5. Where and with whom were you living when you took Claravis®?

_____

_____

6. Pharmacy Information. If you received a prescription for Claravis®, state for each prescription the name and address of the pharmacy where it was filled, and the number of times it was filled:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

7. Have you had discussions with any doctor about whether your claimed injury(ies) is (are) related to the use of Claravis®?

Yes_____ No_____

If yes, identify the doctor or doctors with whom you had such discussions.

_____

Name

_____

Address (if not otherwise provided)

[If discussed with more than one doctor, please copy and complete Part 2 for each.]

8. State whether you requested that any doctor or clinic provide you with Claravis® or a prescription for Claravis®.

   Yes _____ No _____

9. Were you given any written instructions or warnings regarding the use of Claravis®?

   Yes _____ No _____

   If yes, please state:

   a. When the written instructions or warnings were given to you:

   _____

   _____

   b. A description of the written warnings or instructions (e.g., package insert, patient product information; pharmacy handout, etc.):

   _____

   _____

   _____

   c. Identify each person or entity from whom you received the warnings or instructions:

   _____

   _____

   _____

   Approximate date you received the written instructions or warnings:

   _____

   _____

   Summary of instructions/warnings received:

   _____

   _____

10. What other medications (including aspirin), if any, were you taking at the same time you were taking Claravis®?

   _____

   _____

   _____

   _____

   _____

11. a. To the best of your recollection what other medications (other than those set

forth elsewhere in the Fact Sheet) including, but not limited to, oral contraceptives (as applicable) and over-the-counter medication, had you taken five (5) years before you took Claravis®, and when did you take them? Please also state how frequently you took the medication, and, if it was prescribed by a physician, the name and address of the physician.

_____
_____
_____
_____
_____

b. Do you believe you ever experienced gastrointestinal problems or other adverse side effects from any or all of these other medications? If yes, list the type of adverse side effect, the medication you were taking at the time, and the date(s) on which you experienced the adverse side effect.

_____
_____
_____
_____
_____

c. Do you believe you experienced any of the adverse side effects listed in your answer to the preceding question while taking Claravis®? If so, set forth which adverse side effect you experienced, when, what treatment you received for the adverse side effect, and who prescribed that treatment.

_____
_____
_____
_____
_____

B. SOTRET®

1. Who prescribed Sotret® for you?

_____
_____
_____

2. On which dates did you begin to take, and stop taking, Sotret®? If you took Sotret® more than once, list each start and stop date.

_____
_____

_____

3. For what condition(s) were you prescribed Sotret®?

_____
_____
_____

4. Did you renew your prescription for Sotret®? If yes, how many times?

_____
_____
_____

5. Where and with whom were you living when you took Sotret®?

_____
_____

6. Pharmacy Information. If you received a prescription for Sotret®, state for each prescription the name and address of the pharmacy where it was filled, and the number of times it was filled:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

7. Have you had discussions with any doctor about whether your claimed injury(ies) is (are) related to the use of Sotret®?

Yes _____ No _____

If yes, identify the doctor or doctors with whom you had such discussions.

_____
Name

_____
Address (if not otherwise provided)

[If discussed with more than one doctor, please copy and complete Part 2 for each.]

8. State whether you requested that any doctor or clinic provide you with Sotret® or a prescription for Sotret®.

   Yes _____ No _____

9. Were you given any written instructions or warnings regarding the use of Sotret®?

   Yes _____ No _____

   If yes, please state:

   a. When the written instructions or warnings were given to you:

   _____

   _____

   b. A description of the written warnings or instructions (e.g., package insert, patient product information; pharmacy handout, etc.):

   _____

   _____

   _____

   c. Identify each person or entity from whom you received the warnings or instructions:

   _____

   _____

   _____

   Approximate date you received the written instructions or warnings:

   _____

   _____

   Summary of instructions/warnings received:

   _____

   _____

10. What other medications (including aspirin), if any, were you taking at the same time you were taking Sotret®?

   _____

   _____

   _____

   _____

   _____

11. a. To the best of your recollection what other medications (other than those set

forth elsewhere in the Fact Sheet) including, but not limited to, oral contraceptives (as applicable) and over-the-counter medication, had you taken five (5) years before you took Sotret®, and when did you take them? Please also state how frequently you took the medication, and, if it was prescribed by a physician, the name and address of the physician.

_____
_____
_____
_____
_____

b. Do you believe you ever experienced gastrointestinal problems or other adverse side effects from any or all of these other medications? If yes, list the type of adverse side effect, the medication you were taking at the time, and the date(s) on which you experienced the adverse side effect.

_____
_____
_____
_____
_____

c. Do you believe you experienced any of the adverse side effects listed in your answer to the preceding question while taking Sotret®? If so, set forth which adverse side effect you experienced, when, what treatment you received for the adverse side effect, and who prescribed that treatment.

_____
_____
_____
_____
_____
_____

C. AMNESTEEM®

1. Who prescribed Amnesteem® for you?

_____
_____
_____

2. On which dates did you begin to take, and stop taking, Amnesteem®? If you took Amnesteem® more than once, list each start and stop date.

_____

_____

_____

3. For what condition(s) were you prescribed Amnesteem®?

_____

_____

_____

4. Did you renew your prescription for Amnesteem®? If yes, how many times?

_____

_____

_____

5. Where and with whom were you living when you took Amnesteem®?

_____

_____

6. Pharmacy Information. If you received a prescription for Amnesteem®, state for each prescription the name and address of the pharmacy where it was filled, and the number of times it was filled:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

7. Have you had discussions with any doctor about whether your claimed injury(ies) is (are) related to the use of Amnesteem®?

Yes_____ No_____

If yes, identify the doctor or doctors with whom you had such discussions.

_____

Name

_____

Address (if not otherwise provided)

[If discussed with more than one doctor, please copy and complete Part 2 for each.]

8. State whether you requested that any doctor or clinic provide you with Amnesteem® or a prescription for Amnesteem®.

   Yes _____ No _____

9. Were you given any written instructions or warnings regarding the use of Amnesteem®?

   Yes _____ No _____

   If yes, please state:

   a. When the written instructions or warnings were given to you:

   _____

   _____

   b. A description of the written warnings or instructions (e.g., package insert, patient product information; pharmacy handout, etc.):

   _____

   _____

   _____

   c. Identify each person or entity from whom you received the warnings or instructions:

   _____

   _____

   _____

   Approximate date you received the written instructions or warnings:

   _____

   _____

   Summary of instructions/warnings received:

   _____

   _____

10. What other medications (including aspirin), if any, were you taking at the same time you were taking Amnesteem®?

   _____

   _____

   _____

   _____

   _____

11. a. To the best of your recollection what other medications (other than those set forth elsewhere in the Fact Sheet) including, but not limited to, oral contraceptives (as applicable) and over-the-counter medication, had you taken five (5) years before you took Amnesteem®, and when did you take them? Please also state how frequently you took the medication, and, if it was prescribed by a physician, the name and address of the physician.

_____
_____
_____
_____
_____

b. Do you believe you ever experienced gastrointestinal problems or other adverse side effects from any or all of these other medications? If yes, list the type of adverse side effect, the medication you were taking at the time, and the date(s) on which you experienced the adverse side effect.

_____
_____
_____
_____
_____

c. Do you believe you experienced any of the adverse side effects listed in your answer to the preceding question while taking Amnesteem®? If so, set forth which adverse side effect you experienced, when, what treatment you received for the adverse side effect, and who prescribed that treatment.

_____
_____
_____
_____
_____

D. ACCUTANE®

1. Who prescribed Accutane® for you?

_____
_____
_____

2. On which dates did you begin to take, and stop taking, Accutane®? If you took Accutane® more than once, list each start and stop date.

_____
_____

_____

3. For what condition(s) were you prescribed Accutane®?

_____
_____
_____

4. Did you renew your prescription for Accutane®? If yes, how many times?

_____
_____
_____

5. Where and with whom were you living when you took Accutane®?

_____
_____

6. Pharmacy Information. If you received a prescription for Accutane®, state for each prescription the name and address of the pharmacy where it was filled, and the number of times it was filled:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

7. Have you had discussions with any doctor about whether your claimed injury(ies) is (are) related to the use of Accutane®?

Yes _____ No _____

If yes, identify the doctor or doctors with whom you had such discussions.

_____
Name

_____
Address (if not otherwise provided)

[If discussed with more than one doctor, please copy and complete Part 2 for each.]

8. State whether you requested that any doctor or clinic provide you with Accutane® or a prescription for Accutane®.

   Yes _____ No _____

9. Were you given any written instructions or warnings regarding the use of Accutane®?

   Yes _____ No _____

   If yes, please state:

   a. When the written instructions or warnings were given to you:

   _____

   _____

   b. A description of the written warnings or instructions (e.g., package insert, patient product information; pharmacy handout, etc.):

   _____

   _____

   _____

   c. Identify each person or entity from whom you received the warnings or instructions:

   _____

   _____

   _____

   Approximate date you received the written instructions or warnings:

   _____

   _____

   Summary of instructions/warnings received:

   _____

   _____

10. What other medications (including aspirin), if any, were you taking at the same time you were taking Accutane®?

   _____

   _____

   _____

   _____

   _____

11. a. To the best of your recollection what other medications (other than those set

forth elsewhere in the Fact Sheet) including, but not limited to, oral contraceptives (as applicable) and over-the-counter medication, had you taken five (5) years before you took Accutane®, and when did you take them? Please also state how frequently you took the medication, and, if it was prescribed by a physician, the name and address of the physician.

_____

_____

_____

_____

_____

b. Do you believe you ever experienced gastrointestinal problems or other adverse side effects from any or all of these other medications? If yes, list the type of adverse side effect, the medication you were taking at the time, and the date(s) on which you experienced the adverse side effect.

_____

_____

_____

_____

_____

c. Do you believe you experienced any of the adverse side effects listed in your answer to the preceding question while taking Accutane®? If so, set forth which adverse side effect you experienced, when, what treatment you received for the adverse side effect, and who prescribed that treatment.

_____

_____

_____

_____

_____

E. FIRST SYMPTOMS AND MEDICAL CARE, WAGE LOSS, MEDICAL EXPENSES

1. On what date, and in what city and state, did you first experience any symptoms you believe are related to the injury(ies) alleged in your complaint, and what were those symptoms?

_____

2. Were there any witnesses to the symptoms identified above? If so, state their names, addresses, phone numbers and relationships to you.

_____

_____

_____

3. When did you first contact a doctor or healthcare professional concerning this injury(ies)? Whom did you contact?

_____

_____

4. If you were taken to a doctor or health care facility for the injury(ies) alleged in your complaint, state the name and address of the persons, police department, fire department, emergency medical workers, or ambulance company that took you to the doctor or health care facility.

_____

_____

5. Wage Loss Claims. ***Answer these questions if you claim or expect to claim that you lost earnings or impairment of earning capacity as a result of any condition(s) that you believe was caused by your use of isotretinoin: [If you are not claiming lost wages, skip this section.]***

a. State the total amount of time you have lost from work as a result of any condition(s) that you claim or believe was caused by your use of isotretinoin and the amount of income that you lost.

_____

_____

b. State your total earned income (including salary, bonus, and benefits) for each of the last 10 years.

Year	Income
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____

6. Have you paid or incurred any medical expenses that are related to any condition(s) that you claim or believe was caused by your use of isotretinoin and for which you seek recovery in the action you have filed?

Yes_____ No _____

If yes, state the total amount of such expenses at this time: $ _____

7. Has your insurer, or any other entity or person, paid or incurred any medical expenses that are related to any condition(s) that you claim or believe was caused by your use of isotretinoin and for which you seek recovery in the action you have filed?

Yes _____ No _____

If yes, state the total amount of such expenses at this time: $ _____

8. Emotional Distress Claims. ***If you are claiming damages for mental or emotional distress***, describe the kind of injury(ies) you allege and when you allegedly suffered it, and list all individuals from whom you received treatment for such injury(ies) and the dates on which treatment was received.

_____
_____
_____
_____
_____

9. Please identify all person who you believe possess information relevant to your claims in this matter and, for each, state his or her name, relationship address, telephone number and a description of the relevant information you believe he or she possesses.

_____
_____
_____
_____
_____

VII. DOCUMENTS AND THINGS

Attach copies of the following non-privileged documents and things to this declaration to the extent that such materials are currently in your possession, custody, or control, in the possession, custody, or control of your parents, guardians or spouse, or in the possession, custody, or control of your lawyers.

A. A copy of all prescriptions for isotretinoin, any unused isotretinoin you received as a result of such prescriptions, receipts, physician or office records, drug containers, packaging and other records that show the period during which you have taken isotretinoin, the dosage of isotretinoin and the frequency with which you took isotretinoin.

B. All documents that refer or relate to isotretinoin obtained from the Food and

Drug Administration or other government agencies.

C. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.

D. Copies of all documents from physicians, hospitals, clinics, or any type of health care provider relating to your medical or mental health history. This includes, but is not limited to, hospital records, diagnostic test or test results, lab work, rehab records, doctor's office charts, etc.

E. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, consent forms, pharmacy handouts or other materials distributed or provided to you when your prescriptions for isotretinoin were filled.

F. Copies of all advertisements or promotional materials for isotretinoin received or reviewed before filing this action.

G. Executed authorizations for the release of medical, employment, educational and other records.

H. If you claim you have suffered loss of earnings or earning capacity, all documents that evidence your income/earnings for each of the last ten (10) years.

I. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider, and statements and explanations of benefits from your health care insurer or plan.

J. Copies of letters testamentary, letters of administration, powers of attorney, guardianship or guardian *ad litem* orders or other documents relating to your status as plaintiff if you are suing on behalf of another individual.

K. Decedent's death certificate (if applicable).

L. Report of autopsy, medical examiner, coroner, pathology, toxicology, or other police or investigative reports (if applicable);

M. Copies of all documents concerning your education including, but not limited to, records of and from all schools attended including but not limited to report cards, progress reports, attendance records, disciplinary reports, transcripts, guidance or counseling records and any class yearbooks.

N. All documents authored by you which document, record or reflect your physical or mental condition or state of mind before, during and after isotretinoin use, including but not limited to diaries or journals, suicide notes,

and written or electronic communications.

CERTIFICATION

I certify under penalty of perjury that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, that I have completed the List of Medical Providers and Other Sources of Information appended hereto, which is true and correct to the best of my knowledge, that I have supplied all the documents requested in part VII of this declaration to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____
Print Name

_____ _____
Signature Date

_____
Print Name
(Loss of Consortium Plaintiff)

_____ _____
Signature Date

LIST OF MEDICAL PROVIDERS
AND OTHER SOURCES OF INFORMATION

EACH PLAINTIFF IS REQUIRED TO FULLY AND ACCURATELY TO THE BEST OF THEIR RECOLLECTION COMPLETE THIS FORM LISTING MEDICAL CARE PROVIDERS AND OTHER SOURCES OF INFORMATION AS REQUESTED.

List the name and address of each of the following:

A. Your current family and/or primary care physician:

_____
Name

_____
Street Address

_____
City, State, Zip Code

B. To the best of your ability, identify each of your primary care physicians for the last ten (10) years. [See definition as set forth on page 2 of the Fact Sheet]

_____ _____
Name Approximate Dates

_____
Last Known Address

_____
City, State, Zip Code

_____ _____
Name Approximate Dates

_____
Last Known Address

_____
City, State, Zip Code

_____ _____
Name Approximate Dates

_____
Last Known Address

_____

City, State, Zip Code

Name | Approximate Dates

Last Known Address

City, State, Zip Code

Name | Approximate Dates

Last Known Address

City, State, Zip Code

C. Each hospital, clinic, or healthcare facility where you have received impatient treatment during the last ten (10) years.

Name

Street Address

City, State, Zip Code

Dates of Admission

Reason for Admission

Name

Street Address

City, State, Zip Code

Dates of Admission

Reason for Admission

Name

Street Address

City, State, Zip Code

Dates of Admission

Reason for Admission

Name

Street Address

City, State, Zip Code

Dates of Admission

Reason for Admission

Name

Street Address

City, State, Zip Code

Dates of Admission

Reason for Admission

D. Each hospital, clinic, or healthcare facility where you have received outpatient treatment (including treatment in an emergency room) during the last ten (10) years.

_____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Admission

_____
Reason for Admission

_____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Admission

_____
Reason for Admission

_____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Admission

_____
Reason for Admission

Name

Street Address

City, State, Zip Code

Dates of Admission

Reason for Admission

Name

Street Address

City, State, Zip Code

Dates of Admission

Reason for Admission

E. Each physician or healthcare provider from whom you have received treatment in the last ten (10) years.

Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment

Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment

Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment

Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment

Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment

Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment

Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment

Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment

Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment

Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment

F. Each pharmacy where you filed or obtained prescription medication in the last ten (10) years.

_____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Name

_____
Street Address

_____
City, State, Zip Code

G. If you have submitted a claim for social security disability benefits in the last ten (10) years, state the name and address of the office which is most likely to have records concerning your claim.

_____
Name

_____
Street Address

_____
City, State, Zip Code

H. If you have submitted a claim for worker's compensation benefits, state the name and address of the entity which is most likely to have records concerning your claim.

_____
Name

_____
Street Address

_____
City, State, Zip Code

PLAINTIFF'S
CONFIDENTIAL FACT SHEET
NOT TO BE RELEASED

A. Illicit Drugs

1. a) Have you ever used (even one time) any illicit drugs of any kind within one (1) year before, or any time after, you first experienced your alleged isotretinoin-related injury(ies)?

   Yes _____ No _____

   b) If "Yes", identify each substance and state when you first and last used it.

   _____
   _____
   _____
   _____
   _____

B. To the best of your knowledge, have you ever experienced, or been told by a doctor or other healthcare professional, that you have, may have or had any of the following at any time in your life (circle all that apply)?

Symptom/Condition	Yes	No	Unsure
Alcoholism			
Depression			
Eating disorders (anorexia, bulimia, etc.)			
Hepatitis			
HIV/AIDS			
Mental disorders			
Oral Herpes (canker sores), Herpes Zoster, Shingles			
Psychiatric problems			
Suicidal ideation			
Syphilis			

C. (*If you are claiming psychiatric injuries as a consequence of isotretinoin*): To the best of your knowledge, have you ever experienced, or been told by a doctor or other healthcare professional, that you have, may have or had any of the following at any time in your life (circle all that apply)?

Symptom/Condition	Yes	No	Unsure
Anorexia			
Anxiety			
Bulimia			
Catatonic behavior			
Decrease or increase in appetite, lasting more than a few days			
Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)			
Delusions			
Depersonalization (being detached from oneself)			
Depressed mood, lasting more than a few days			
Derealization (feelings of unreality)			
Difficulty concentrating or mind going blank, lasting more than a few days			
Diminished ability to think or concentrate, or indecisiveness, lasting more than a few days			
Disorganized speech			
Distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli), lasting more than a few days			
Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)			
Fatigue or loss of energy, lasting more than a few days			
Fear of losing control or going crazy			
Feelings of hopelessness			
Feelings of worthlessness or excessive or inappropriate guilt (not merely self-reproach or guilt about being sick), lasting more than a few days			

Symptom/Condition	Yes	No	Unsure
Flat Affect			
Flight of ideas or subjective experience that thoughts are racing			
Hallucinations			
Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation			
Inflated self-esteem or grandiosity			
Insomnia, lasting more than a few days			
Intense fear of gaining weight or becoming fat, even though underweight			
Irritability, lasting more than a few days			
Low self-esteem, lasting more than a few days			
Marked and persistent fear of social or performance situations together with either intense anxiety during such situations or the avoidance of such situations			
Markedly diminished interest or pleasure in all, or almost all activities, lasting more than a few days			
More talkative than usual or pressure to keep talking, lasting more than a few days			
Panic attacks			
Phobias			
Psychomotor agitation or retardation			
Psychosis or psychotic			
Recurrent thoughts of death (not just fear of dying)			
Restlessness or feeling keyed up or on edge together with anxiety			
Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month)			
Sleep disturbance (difficulty following or staying asleep , or restless unsatisfying sleep), lasting more than a few days			
Suicidal ideation			
Suicide attempt or a specific plan for committing suicide			

D. (*If you are claiming psychiatric injuries as a consequence of isotretinoin*): If you responded "yes" to anything in C. above, please identify/state the condition(s), the date of onset, any medication prescribed to treat the condition(s), and the name of the physician or other person who made the diagnosis or informed you of the condition(s) and their address if not otherwise herein provided.

Condition(s): _____
Onset date and medication: _____
Name and address of physician or other person: _____
_____

Condition(s): _____
Onset date and medication: _____
Name and address of physician or other person: _____
_____

Condition(s): _____
Onset date and medication: _____
Name and address of physician or other person: _____
_____

Condition(s): _____
Onset date and medication: _____
Name and address of physician or other person: _____
_____

E. (*If you are claiming psychiatric injuries as a consequence of isotretinoin*): To the best of your knowledge, have your parents, grandparents, children or siblings ever experienced or been diagnosed with, or been told by a doctor or other healthcare professional, that they have, may have or had any of the following (circle all that apply), set forth the name of the individual and their relationship to you next to each condition(s) circled?

Symptom/Condition	Name of Individual	Relationship
Depression		
Schizophrenia		
Bipolar Disorder		
Manic Depression		
Psychosis		
Suicide		
Suicide Attempt		

Symptom/Condition	Name of Individual	Relationship
Eating Disorder (Anorexia/Bulimia)		
Anxiety		
Panic Attacks		
Personality Disorder		
Dissociative Disorder		
Mood Disorder		
Post-traumatic stress disorder		
Obsessive compulsive disorder		
Phobias		

CERTIFICATION

I certify under penalty of perjury that all of the information provided in this Confidential Fact Sheet is true and correct to the best of my knowledge, that I have completed the List of Medical Providers and Other Sources of Information appended hereto, which is true and correct to the best of my knowledge, that I have supplied all the documents requested in part VII of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____
Print Name

_____ _____
Signature Date

_____
Print Name
(Loss of Consortium Plaintiff)

_____ _____
Signature Date

LIST OF TOPICS FOR ELECTRONIC DOCUMENTS FOR DISCOVERY FROM PLAINTIFFS' COMPUTERS FOR PLAINTIFFS ALLEGING SYSTEMIC INJURIES

In the context of these requests, "isotretinoin" means any and all forms of the prescription drug generically known as isotretinoin, including Claravis®, Sotret®, Amnesteem® and other branded or non-branded versions or forms of isotretinoin, including but not limited to Accutane®.

"Isotretinoin user" is defined to mean each Plaintiff that ingested isotretinoin and is alleging systemic injuries.

"Documents" is defined to include all documents and correspondence of any kind, including letters, notes, e-mails, instant messages, stories, poems, word processing files (including Word, WordPerfect, and Lotus Notes files), Excel files, PowerPoint files, and image files (including .tif, .pdf and .jpeg files). Defendants request these documents regardless of whether they are located on a hard drive, disk, CD-ROM, any other electronic storage format, or in a printout. URL or web addresses should be provided where available.

All requests shall be interpreted to exclude privileged communications between plaintiffs and their attorneys.

I. Identify each and every computer used by the Plaintiffs by providing:

a. the name of the individual that owns the computer
b. the current location of the computer
c. approximate dates or timeframe Plaintiff used the computer
d. whether the computer was searched for the information requested below.
e. If the computer was not searched for the information requested below, provide the reason that it was not searched.

Owner	Location	Dates of Use	Whether Searched	Reasons Not Searched

II. <u>Isotretinoin User's Electronic Documents and Correspondence</u>

Request
1. All college applications and essays (including drafts) written for college applications by the isotretinoin user.

2. A printout of the isotretinoin user's website "favorites" (websites frequently visited or book-marked), redacted for non-users favorites.
3. All diaries, journals, calendars, kept by the isotretinoin user.
4. All photographs in which the isotretinoin user appears, whether alone or with friends and/or family for the time period beginning one year prior to Plaintiff's(s') first or only prescription of isotretinoin and ending two years after diagnosis of Plaintiff's(s') alleged injuries.

III. Other Documents and Correspondence in Plaintiffs' Possession, Custody, or Control

A. Isotretinoin and other Medications

Request
1. All documents referring to isotretinoin, **excluding those post-dating retention of counsel**.
2. All documents referring to ingestion of isotretinoin, prescriptions for isotretinoin, potential side effects of isotretinoin, research performed regarding isotretinoin, isotretinoin warnings or labeling information, or adverse events experienced by users of isotretinoin, excluding those post-dating retention of counsel.
3. All documents referring to treatment for acne or acne in general, excluding those post-dating retention of counsel.
4. All correspondence with any person who has taken isotretinoin or that person's family or friends referring to isotretinoin or this lawsuit, excluding those post-dating retention of counsel.

5. All documents referring to the isotretinoin user's communications with physicians, family, or friends about isotretinoin.
6. All documents referring to any medication – whether prescription or over-the-counter – taken by the isotretinoin user, including medications taken before, during, or after isotretinoin use within the last ten years.
7. All documents referring to natural or organic supplements or vitamins taken by the isotretinoin user within the last ten years.
8. All documents referring to creatine use by the isotretinoin user within the last ten years.
9. All documents referring to steroid use by the isotretinoin user within the last ten years.
10. All documents referring to any other supplements taken by the isotretinoin user.
11. All chat room postings regarding isotretinoin, including potential side effects from isotretinoin, isotretinoin warnings or labeling information, or adverse events experienced by users of isotretinoin, excluding those post-dating retention of counsel.
12. All documents (including correspondence) exchanged with Liam Grant or Congressman Bart Stupak, excluding those post-dating retention of counsel.
13. All documents referring to Liam Grant or Congressman Bart Stupak, excluding those post-dating retention of counsel.
14. All information downloaded or otherwise obtained from any website regarding isotretinoin, including potential side effects from isotretinoin, isotretinoin warnings or labeling information, or adverse events experienced by users of isotretinoin, excluding those post-dating retention of counsel.

15. All newspaper articles, journal articles, studies or research regarding acne, isotretinoin, potential side effects from isotretinoin, isotretinoin warnings or labeling information, or adverse events experienced by users of isotretinoin, excluding those post-dating retention of counsel.
16. All documents referring to Defendants, including correspondence with Defendants, excluding those post-dating retention of counsel.
17. All documents referring to any physical, emotional or other condition experienced by the isotretinoin user that is alleged to have been caused by his or her ingestion of isotretinoin.
18. All documents referring to the causes of the isotretinoin user's alleged condition.
19. All prescriptions the isotretinoin user or someone on his or her behalf filled on-line or attempted to fill on-line, within the last ten years.
20. All documents referring to the isotretinoin user's visits to or communications with physicians.

B. <u>Alcohol and Drug Use</u>

Request
1. All documents referring to the use of alcohol (or alcoholism) by the isotretinoin user or his or her family, within the last ten years.
2. All documents referring to the use of tobacco by the isotretinoin user or his or her family, within the last ten years.
3. All documents referring to the use of illegal drugs by the isotretinoin user or his or her family, within the last ten years.

C. Financial Information

Request
1. All documents referring to the isotretinoin user's feelings, concerns, or worries about his or her finances or ability to pay any bill. The time frame for this request is six months prior to the date of first ingestion to the present.

D. Educational Information

Request
1. All documents referring to the isotretinoin user's education, including grades, schoolwork, homework, testing, violations of school rules, disciplinary problems, delinquency, suspensions, expulsions, truancy, or absences (excused or unexcused). The time frame for this request is two years prior to the date of ingestion to the present.
2. All documents referring to the isotretinoin user's participation in extra-curricular, school, or after-school activities, including sports, clubs, newspaper staff, yearbook staff, service organizations, or social organizations. The time frame for this request is two years prior to the date of ingestion to the present.
3. All documents referring to the isotretinoin user's visits to or communications with school counselors or guidance counselors. The time frame for this request is two years prior to the date of ingestion to the present.
4. All school papers or projects (including drafts) about acne, isotretinoin and any gastrointestinal or autoimmune disease, symptoms, conditions or disorders.

5. All documents referring to the isotretinoin user's selection of colleges, the isotretinoin user's applications to colleges, the isotretinoin user's plans for college, the isotretinoin user's feelings or concerns about college (including going away to college), or the isotretinoin user's feelings or concerns about his or her ability to get into college.
6. All documents referring to the isotretinoin user going to college or leaving college.

E. Employment information

Request
1. All documents referring to the isotretinoin user's employment, whether paid or unpaid, temporary or permanent, including salary, promotion, demotion, changes in hours, hiring, firing, quitting, performance reviews, absences (excused or unexcused), violations of workplace rules, suspensions, and altercations, disagreements or fights with co-workers or supervisors. The time frame for this request is two years prior to the date of ingestion to the present.
2. All documents referring to the isotretinoin user changing employment. The time frame for this request is two years prior to the date of ingestion to the present.
3. All documents referring to the isotretinoin user's participation in work-related or career-related clubs or organizations. The time frame for this request is two years prior to the date of ingestion to the present.

4. All documents referring to any workplace accident suffered by the isotretinoin user or his or her claim for worker's compensation. The time frame for this request is two years prior to the date of ingestion to the present.
5. All documents referring to the isotretinoin user seeking or obtaining disability insurance (including failure to obtain disability insurance). The time frame for this request is two years prior to the date of ingestion to the present.
6. All documents referring to the isotretinoin user seeking or obtaining unemployment benefits (including failure to obtain unemployment benefits). The time frame for this request is two years prior to the date of ingestion to the present.
7. All documents referring to the isotretinoin user's plans for future employment. The time frame for this request is two years prior to the date of ingestion to the present.

F. Psychological information

Request
1. All documents relating to any preexisting psychological problems. The time frame for this request is two years prior to the date of ingestion to the present.
2. All documents relating to psychological impact of claimed medical condition. The time frame for this request is two years prior to the date of ingestion to the present.

G. Interaction With Law Enforcement or Weapons

Request
1. All documents referring to the isotretinoin user being arrested, charged with or convicted of any offense. The time frame for this request is two years prior to the date of ingestion to the present. This is subject to confidential treatment.
2. All documents referring to the isotretinoin user being the victim of any crime (including theft, rape, assault, or other violent act), whether or not the perpetrator was charged with a crime. The time frame for this request is two years prior to the date of ingestion to the present. This is subject to confidential treatment.
3. All documents referring to the isotretinoin user experiencing an emotionally, mentally or physically traumatic events such as rape or physical violence. The time frame for this request is two years prior to the date of ingestion to the present. This is subject to confidential treatment.

H. Relationships/Social activities

Request
1. All documents referring to the isotretinoin user's relationship with his or her parents, including any expressions of feeling or emotion, any arguments, any fights, or any insults. The time frame for this request is six months prior to the date of first ingestion to the present.

2. All documents referring to the isotretinoin user's relationships with his or her friends or romantic interests, including any expressions of feeling or emotion, any arguments, any fights, or any insults. The time frame for this request is six months prior to the date of first ingestion to the present.
3. All documents referring to pressure the isotretinoin user felt to succeed in school, sports, extracurricular activities or work. The time frame for this request is six months prior to the date of first ingestion to the present.
4. All documents referring to pressure the isotretinoin user felt to conform or be accepted by peers. The time frame for this request is six months prior to the date of first ingestion to the present.
5. All documents referring to the isotretinoin user's family responsibilities, including chores, housework, and care for siblings or other family members. The time frame for this request is six months prior to the date of first ingestion to the present.
6. All documents referring to conflicts in the isotretinoin user's interpersonal relationships with family, friends, acquaintances, teachers, physicians, co-workers, or supervisors. The time frame for this request is six months prior to the date of first ingestion to the present.
7. All documents referring to the isotretinoin user's hobbies or things he or she liked to do in his or her spare time. The time frame for this request is six months prior to the date of first ingestion to the present.

I. Miscellaneous

Request
1. All documents referring to the isotretinoin user's travel or vacation plans. The time frame for this request is six months prior to the date of first ingestion to the present.

KATHRYN FLOR Plaintiff, v. MYLAN BERTEK PHARMACEUTICALS, INC., f/k/a BERTEK PHARMACEUTICALS, INC.; MYLAN PHARMACEUTICALS, INC.; MYLAN, INC. f/k/a MYLAN LABORATORIES, INC.; CARDINAL HEALTH 409, INC. f/k/a R.P. SCHERER CORPORATION; and GENPHARM Defendants	:	SUPERIOR COURT OF NEW JERSEY LAW DIVISION ATLANTIC COUNTY DOCKET NO. ATL-L-3795-07 CIVIL ACTION **APPLICABLE TO ALL CONSOLIDATED CASES**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS PURSUANT TO 45 C.F.R. § 164.508 (HIPAA)

Name: _____

Date of Birth: _____

Social Security Number: _____

I hereby authorize _____ to release all existing medical records and information regarding the above-named person's medical care, treatment, physical condition(s) and/or medical expenses revealed by observation or treatment past, present and future to the below law firm(s):

☐ Baker, Donelson, Bearman, Caldwell & Berkowitz, P.C., Post Office Box 14167, Jackson, MS 39236 (Counsel for Cardinal Health 409, Inc. n/k/a Catalent Pharma Solutions, Inc.) and Pietragallo, Gordon, Alfano, Bosick & Raspanti, LLP, One Oxford Center, 38th Floor, Pittsburgh, PA 15219 (Counsel for the Mylan Defendants).

- ☐ Ulmer & Berne, LLP, 600 Vine Street, Suite 2800, Cincinnati, OH 45202-2409 (Counsel for the Barr Defendants).

- ☐ Duane Morris, LLP, 30 South 17th Street, Philadelphia, PA, 19103-4196 (Counsel for the Ranbaxy Defendants).

These records shall be used solely in connection with the currently pending litigation involving the person named above. This authorization shall cease to be effective as of the date on which that litigation concludes.

I understand that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

This authorization also may include x-ray reports, CT scan reports, MRI scans, EEGs, EKGs, sonograms, arteriograms, fetal monitor strips, discharge summaries, photographs, surgery consent forms, informed consent forms regarding family planning, admission and discharge records, operation records, doctor and nurses notes (excluding psychotherapy notes maintained separately from the individual's medical records that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress), prescriptions, medical bills, invoices, histories, diagnoses, narratives, and any correspondence/memoranda and billing information. It also includes, to the extent such records currently exist and are in your possession, insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, etc.). This listing is not meant to be exclusive.

I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition(s) of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition(s) the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of the firm checked above.

Dated this _____ day of _____,200_

_____

[Signature of Plaintiff or Representative]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:

_____

_____

_____

_____

HIPAA COMPLIANT AUTHORIZATION FORM
FOR THE RELEASE OF EMPLOYMENT RECORDS
PURSUANT TO 45 C.F.R. § 164.508

Name or specific identification of the person(s), or class of person, authorized to make the requested disclosure:

_____

Employee Name: _____ A/K/A _____
Date of Birth: _____ Social Security Number: _____
Address: _____

I authorize disclosure of all protected employment or other confidential information for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities HIPAA identified above disclose full and complete protected medical information spanning the time period of _____ to present including the following:

- All employment information, records and reports, including all tax records, employee reviews, and payroll information.
- All medical information, records and reports, including disability employment applications and disability records.

Information about alcohol/substance abuse and HIV/AIDS may be disclosed as follows: (check all that apply)
__X__Yes, disclose HIV/AIDS information ____No, do NOT disclose HIV/Aids information
__X__Yes, disclose alcohol/substance abuse information ____No, do NOT disclose alcohol/substance abuse information

I authorize you to release the protected health information to:

Defendant(s) Counsel:

☐ Baker, Donelson, Bearman, Caldwell & Berkowitz, P.C., Post Office Box 14167, Jackson, MS 39236 (Counsel for Cardinal Health 409, Inc. n/k/a Catalent Pharma Solutions, Inc.) and Pietragallo, Gordon, Alfano, Bosick & Raspanti, LLP, One Oxford Center, 38th Floor, Pittsburgh, PA 15219 (Counsel for the Mylan Defendants).

☐ Ulmer & Berne, LLP, 600 Vine Street, Suite 2800, Cincinnati, OH 45202-2409 (Counsel for the Barr Defendants).

☐ Duane Morris, LLP, 30 South 17th Street, Philadelphia, PA, 19103-4196 (Counsel for the Ranbaxy Defendants).

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.

I acknowledge the right to revoke this authorization by writing to the above noted counsel at the above address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under 45 C.F.R. § 164.508.

I acknowledge the right to inspect the material to be released.

I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.
This authorization expires two years from the date below.

Signature: _____ Date: _____
Relationship to person who is the subject of the records:

Self: ___X___ Other: _____
Describe Authority

HIPAA COMPLIANT AUTHORIZATION FORM
FOR THE RELEASE OF EDUCATION RECORDS
PURSUANT TO 45 C.F.R. § 164.508

Name or specific identification of the person(s), or class of person, authorized to make the requested disclosure:

_____

Student Name: _____ A/K/A _____
Date of Birth: _____ Social Security Number: _____
Address: _____

I authorize disclosure of all protected medical or other confidential information for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities HIPAA identified above disclose full and complete protected medical information spanning the time period of _____ to present including the following:

- All attendance records, teachers' notes and reports and disciplinary records.
- All guidance counseling records, psychology records, drug and/or alcohol counseling records.
- All medical/school nurse/infirmary records.
- All medical records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians.
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
- All radiology films, mammograms, myelograms, CR scans, photographs, bones scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
- All pharmacy/prescription records include NDC numbers and drug information handouts/monographs.
- All billing records including all statements, itemized bills, and insurance records.

Information about alcohol/substance abuse and HIV/AIDS may be disclosed as follows: (check all that apply)
__X__Yes, disclose HIV/AIDS information ____No, do NOT disclose HIV/Aids information
__X__Yes, disclose alcohol/substance abuse information ____No, do NOT disclose alcohol/substance abuse information

I authorize you to release the protected health information to:

Defendant(s) Counsel:

☐ Baker, Donelson, Bearman, Caldwell & Berkowitz, P.C., Post Office Box 14167, Jackson, MS 39236 (Counsel for Cardinal Health 409, Inc. n/k/a Catalent Pharma Solutions, Inc.) and Pietragallo, Gordon, Alfano, Bosick & Raspanti, LLP, One Oxford Center, 38th Floor, Pittsburgh, PA 15219 (Counsel for the Mylan Defendants).

☐ Ulmer & Berne, LLP, 600 Vine Street, Suite 2800, Cincinnati, OH 45202-2409 (Counsel for the Barr Defendants).

☐ Duane Morris, LLP, 30 South 17th Street, Philadelphia, PA, 19103-4196 (Counsel for the Ranbaxy Defendants).

- I acknowledge the right to revoke this authorization by writing to the above counsel at the above address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under 45 C.F.R. § 164.508.
- I acknowledge the right to inspect the material to be released.
- I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.
- Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.
- This authorization expires two years from the date below.

Signature: _____ Date: _____
Relationship to person who is the subject of the records:
Self: ____X_____ Other: _____
Describe Authority

KATHRYN FLOR Plaintiff, v. MYLAN BERTEK PHARMACEUTICALS, INC., f/k/a BERTEK PHARMACEUTICALS, INC.; MYLAN PHARMACEUTICALS, INC.; MYLAN, INC. f/k/a MYLAN LABORATORIES, INC.; CARDINAL HEALTH 409, INC. f/k/a R.P. SCHERER CORPORATION; and GENPHARM Defendants	SUPERIOR COURT OF NEW JERSEY LAW DIVISION ATLANTIC COUNTY DOCKET NO. ATL-L-3795-07 CIVIL ACTION **APPLICABLE TO ALL CONSOLIDATED CASES**

AUTHORIZATION FOR RELEASE OF PSYCHOLOGICAL/PSYCHIATRIC RECORDS PURSUANT TO 45 C.F.R. § 164.508 (HIPAA)

Name: _____

Date of Birth: _____

Social Security Number: _____

I hereby authorize _____ to release all existing records and information regarding the above-named person's psychological or psychiatric care, treatment, condition(s) and/or expenses revealed by observation or treatment past, present and future to the below law firm(s):

☐ Baker, Donelson, Bearman, Caldwell & Berkowitz, P.C., Post Office Box 14167, Jackson, MS 39236 (Counsel for Cardinal Health 409, Inc. n/k/a Catalent Pharma Solutions, Inc.) and Pietragallo, Gordon, Alfano, Bosick & Raspanti, LLP, One Oxford Center, 38th Floor, Pittsburgh, PA 15219 (Counsel for the Mylan Defendants).

- ☐ Ulmer & Berne, LLP, 600 Vine Street, Suite 2800, Cincinnati, OH 45202-2409 (Counsel for the Barr Defendants).

- ☐ Duane Morris, LLP, 30 South 17th Street, Philadelphia, PA, 19103-4196 (Counsel for the Ranbaxy Defendants).

These records shall be used solely in connection with the currently pending litigation involving the person named above. This authorization shall cease to be effective as of the date on which that litigation concludes.

I understand that this authorization includes information regarding the diagnosis and treatment of psychiatric and psychological disorders, and that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

This authorization also may include x-ray reports, CT scan reports, MRI scans, EEGs, EKGs, sonograms, arteriograms, fetal monitor strips, discharge summaries, photographs, surgery consent forms, informed consent forms regarding family planning, admission and discharge records, operation records, doctor and nurses notes (excluding psychotherapy notes maintained separately from the individual's medical records that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress), prescriptions, medical bills, invoices, histories, diagnoses, psychiatric treatment and counseling records, psychological treatment and counseling records, narratives, and any correspondence/memoranda and billing information. It also includes, to the extent such records currently exist and are in your possession, insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, etc.). This listing is not meant to be exclusive.

I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition(s) of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition(s) the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of the firm checked above.

Dated this _____ day of _____,200_

_____

[Signature of Plaintiff or Representative]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:

_____

_____

_____

_____

KATHRYN FLOR Plaintiff, v. MYLAN BERTEK PHARMACEUTICALS, INC., f/k/a BERTEK PHARMACEUTICALS, INC.; MYLAN PHARMACEUTICALS, INC.; MYLAN, INC. f/k/a MYLAN LABORATORIES, INC.; CARDINAL HEALTH 409, INC. f/k/a R.P. SCHERER CORPORATION; and GENPHARM Defendants	SUPERIOR COURT OF NEW JERSEY LAW DIVISION ATLANTIC COUNTY DOCKET NO. ATL-L-3795-07 CIVIL ACTION **APPLICABLE TO ALL CONSOLIDATED CASES**

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES PURSUANT TO 45 C.F.R. § 164.508 (HIPAA)

Name: _____

Date of Birth: _____

Social Security Number: _____

I hereby authorize _____ to release all existing psychotherapy notes regarding the above-named person's medical care, treatment, physical/mental condition(s) and/or medical expenses revealed by observation or treatment past, present and future to the below law firm(s):

☐ Baker, Donelson, Bearman, Caldwell & Berkowitz, P.C., Post Office Box 14167, Jackson, MS 39236 (Counsel for Cardinal Health 409, Inc. n/k/a Catalent Pharma Solutions, Inc.) and Pietragallo, Gordon, Alfano, Bosick & Raspanti, LLP, One Oxford Center, 38th Floor, Pittsburgh, PA 15219 (Counsel for the Mylan Defendants).

☐ Ulmer & Berne, LLP, 600 Vine Street, Suite 2800, Cincinnati, OH 45202-2409 (Counsel for the Barr Defendants).

☐ Duane Morris, LLP, 30 South 17th Street, Philadelphia, PA, 19103-4196 (Counsel for the Ranbaxy Defendants).

These records shall be used solely in connection with the currently pending litigation involving the person named above. This authorization shall cease to be effective as of the date on which that litigation concludes.

I understand that this authorization includes all psychotherapy notes maintained separately from the above-named person's medical records that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress.

I understand that the health information being disclosed by these psychotherapy notes may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition(s) of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition(s) the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of the firm checked above.

Dated this _____ day of _____,200_

_____

[Signature of Plaintiff or Representative]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:

_____

_____

_____

_____

KATHRYN FLOR Plaintiff, v. MYLAN BERTEK PHARMACEUTICALS, INC., f/k/a BERTEK PHARMACEUTICALS, INC.; MYLAN PHARMACEUTICALS, INC.; MYLAN, INC. f/k/a MYLAN LABORATORIES, INC.; CARDINAL HEALTH 409, INC. f/k/a R.P. SCHERER CORPORATION; and GENPHARM Defendants	SUPERIOR COURT OF NEW JERSEY LAW DIVISION ATLANTIC COUNTY DOCKET NO. ATL-L-3795-07 CIVIL ACTION **APPLICABLE TO ALL CONSOLIDATED CASES**

Plaintiff: _____
(name)

DEFENDANTS' CASE PROFILE FORM

For each case, the Defendants must complete this Case Profile Form. This Case Profile Form must be completed and served on all counsel in the action identified in Section I below. Except as otherwise set forth in the Fact sheet order, this must be answered and served 45 days after the date that the Plaintiff's Fact Sheet has been served on the Defendants, provided the Plaintiff's Fact Sheet has provided a complete name and address for each prescribing physician.

You should attach additional sheets of paper if that is necessary to completely answer the following questions.

I. Case Information

This defendant fact sheet pertains to the following case:

Plaintiff Name: _____

Civil Action No. _____

MCN No. _____

II. Contacts With Dispensing Health Care Provider

A. Plaintiff identified persons or entities who prescribed or dispensed Isotretinoin to plaintiff (hereafter "Prescribing Health Care Provider"). For each Prescribing Health Care Provider, identify each "Dear Doctor" or "Dear Health Care Provider" letter that you contend was *actually sent* to that Provider. If known, please: a.) identify by date and/or by bates number the letter(s)sent; b.) state the date that each letter was actually sent; c.) state the person to whom each letter was actually sent, d.) state the address where it was sent, e.) identify the database or documents that demonstrate these facts.

Prescriber	Date/Bates No. of Letter	Date Sent	Recipient	Recipient's Address	Source

B. OTHER CONTACTS

For each Prescribing Health Care Provider identified, please identify the Isotretinoin sales representative(s), if any, provide his or her last known contact information, and current relationship, if any, with Defendant:

Prescribing Health Care Provider	Identity and last known address and telephone number of Isotretinoin sales representative	The current relationship, if any, between defendant and the sales representative

For each sales representative identified above, please state whether he/she is has been investigated or reprimanded for his/her Isotretinoin marketing practices by either Defendant or, if known, whether he/she is or has been investigated or reprimanded for his/her Isotretinoin marketing practices by some other governmental agency while at Defendant:

By Defendant:

Defendant's Sales Representative	Has the sales representative ever been investigated or reprimanded for his/her Isotretinoin marketing practices by Defendant? (Respond "Yes", "No" or "Unknown")	Is Defendant's investigation complete? If so, identify results of Defendant's investigation	Identify documents referring to Defendant's investigation/ reprimand

By a government agency:

Defendant's Sales Representative	**Has the sales representative ever been investigated or reprimanded for his/her Isotretinoin marketing practices by a governmental agency? (Respond "Yes", "No" or "Unknown")**	**Is the agency's investigation complete?** **If so, identify results of the agency's investigation**	**Identify documents referring to the agency's investigation/ reprimand**

III. **Consulting With Plaintiff's Dispensing Health Care Provider**

1. Plaintiff identified his/her Prescribing Health Care Provider(s). If you have ever retained any of plaintiff's Prescribing Health Care Providers as a "thought leader", a member of Defendant's Speaker Program, Defendant's Clinical Investigator, or a consultant in any other capacity on the subject of the treatment of acne, please state:

Prescribing Health	**Dates of Affiliation with**	**Annual Remuneration**

Care Provider	Defendant	for expenses, honoraria, fees

2. Please identify or produce all responsive consulting agreements and contracts with each Prescribing Health Care Provider identified in 1, above.

Prescribing Health Care Provider	Identify consulting agreement(s) and/or contract(s)

3. Has plaintiff's Prescribing Health Care Provider eve contacted you to request information concerning Isotretinoin, its indications, its effect and/or its risks?

_____ Yes _____ No

If your answer is "yes", please identify or produce any document which refers to your communication with plaintiff's Prescribing Health Care Provider.

Prescribing Health Care Provider	Identify document(s) referring to communication

IV. **Plaintiff's Prescribing Health Care Provider's Prescribing Practices**

In Plaintiff's fact sheet, plaintiff identified his/her Prescribing Health Care Provider(s). For each listed provider, please state and produce the following:

1. Do you have or have you had access to any database or information which purports to track any of plaintiff's Prescribing healthcare provider's prescribing practices with respect to Isotretinoin or any other prescription medication for acne (including, but not limited to the product(s), the number or prescriptions, the number of refills and the time frame when these products were prescribed or (re) filled)

_____ Yes _____ No

If your answer is "yes", please produce or identify the database or document which captures that information.

V. **Plaintiff's Medical Condition**

1. Have you been contacted by Plaintiff, any of his/her physicians, or anyone on behalf of plaintiff other than Plaintiff's counsel?

_____ Yes _____ No

If your answer is "yes", please a.) state the name of the person(s) who contacted you, b.) state the person(s) who were contacted including their name, address and telephone number and c.) produce (if not yet produced) or identify any and all documents which reflect any communication between any person and you, concerning plaintiff:

Identity of person(s) who contacted Defendant	Identity of person(s) contacted (name, address, telephone number)	Identify document(s) reflecting communication concerning plaintiff

VI. **Advertising**

1. Did you advertise Isotretinoin in the Media Market that plaintiff lived at the time that he/she took Isotretinoin?

_____ Yes _____ No

2. If your answer to the preceding question is "yes", please identify all such advertising stating the nature of the advertisement (i.e., in magazines, newspapers, television or other media), the identity of the media outlet, the dates that the advertisements ran, and the cost of the ad campaign

Identity of the Advertisement and intended media marketplace	Nature of media (print of television)	Identity of the media outlet	Dates that advertisement ran and cost of the campaign

Please provide or identify true and accurate copies of any advertisement identified above.

3. Did you advertise Isotretinoin in the Media Market that plaintiff's prescribing healthcare provider's office was located at the time that plaintiff took Isotretinoin?

_____ Yes _____ No

4. If your answer to the preceding question is "yes", please identify all such advertising stating the nature of the advertisement (i.e., in magazines, newspapers, television or other media), the identity of the media outlet and the dates that the advertisements ran.

Identity of the Advertisement and intended media marketplace	**Nature of media (print of television)**	**Identity of the media outlet**	**Dates that advertisement ran and cost of the campaign**

5. Did you conduct unbranded advertisement for acne products in the Media Market that plaintiff lived at the time that he/she took Isotretinoin?

_____ Yes _____ No

6. If your answer to the preceding question is "yes", please identify all such advertising stating the nature of the advertisement (i.e., in magazines, newspapers, television or other media), the identity of the media outlet, the dates that the advertisements ran, and the cost of the ad campaign

Identity of the Advertisement and intended media marketplace	**Nature of media (print of television)**	**Identity of the media outlet**	**Dates that advertisement ran and cost of the campaign**

Please provide or identify true and accurate copies of any advertisement identified above.

7. Did you conduct unbranded advertisement for acne products in the Media Market that plaintiff's prescribing healthcare provider's office was located at the time that plaintiff took Isotretinoin?

_____ Yes _____ No

8. If your answer to the preceding question is "yes", please identify all such advertising stating the nature of the advertisement (i.e., in magazines, newspapers, television or other media), the identity of the media outlet and the dates that the advertisements ran.

Identity of the Advertisement and intended media marketplace	**Nature of media (print of television)**	**Identity of the media outlet**	**Dates that advertisement ran and cost of the campaign**

Please provide or identify true and accurate copies of any advertisement identified above.

VII. **Drug Safety**

1. Please produce from the defendant's drug safety file for the plaintiff, if any, non-privileged material that predates filing of the instant lawsuit, and non-privileged material that postdates filing of the instant lawsuit except documents obtained through the litigation (e.g., complaints, answers, medicals and other records, and depositions or other discovery).

VIII. **Documents**

To the extent you have not already done so, please produce the following:

1. Any company records that refer to relate to plaintiff which has been provided to the company's outside defense counsel.
2. Any documents from plaintiff which can be retrieved by Defendants in a search of those files in the company where such documents are likely to be kept.

CERTIFICATION

I have read the foregoing answers to Defendant's Case Profile Form.

I hereby certify that the foregoing answers are the result of information either in my personal possession, or as acquired from company records and/or other individuals in the employ of Defendants and the answers were prepared by counsel.

I declare under penalty of perjury that the answers contained herein are true and correct to the best of my knowledge.

_____	_____	_____
Signature	Print name	Date

Defendants