SEEGER WEISS LLP
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Plaintiff Liaison Counsel

In re: ACCUTANE LITIGATION	: SUPERIOR COURT OF NEW JERSEY : LAW DIVISION : ATLANTIC COUNTY
(This Order applies to all actions.)	: Civil Action
	: Case No.271
	: **ORDER**

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 30 day of Oct, 2008,

ORDERED as follows:

I. PLAINTIFF'S SUPPLEMENTAL FACT SHEET

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

Plaintiff's Supplemental Fact Sheet 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 Supplemental Fact Sheet at the time the first served generic isotretinoin defendant files its Answer or other responsive pleading.

Plaintiff's Supplemental Fact Sheet shall be completed in conjunction with, and as a supplement to, the primary Plaintiff's Fact Sheet approved for use by the Court in cases involving only Accutane® use ("Primary PFS"). To avoid unnecessary duplication of effort by plaintiff, it is understood and agreed to by all parties that in cases where Plaintiff's Supplemental Fact Sheet is required, the following questions set forth in the Primary PFS that make reference to the word "Accutane" will be understood to mean "isotretinoin" more generally: all questions in section III; all questions in section IV(G); and all questions in sections V(P), V(Q), and V(R).

II. PLAINTIFF'S CONFIDENTIAL FACT SHEET

To avoid the need for an additional and/or supplemental Plaintiff's Confidential Fact Sheet, in cases where Plaintiff's Supplemental Fact Sheet is required, all references to Accutane® contained in Plaintiff's Confidential Fact Sheet, as approved for use by the Court in cases involving only Accutane® use, will be understood to mean "isotretinoin" more generally.

III. LIST OF TOPICS FOR ELECTRONIC DISCOVERY

To avoid the need for an additional and/or supplemental list of topics for potential electronic discovery, it is understood and agreed to by all parties that in cases where Plaintiff's Supplemntal Fact Sheet is required, all references to Accutane® or "Accutane® User" contained in the List of Topics For Electronic Documents For Discovery From Plaintiffs' Computers For Plaintiffs Alleging Systemic Injuries approved for use by the Court in cases involving only Accutane® use, will be understood to mean "isotretinoin" or "isotretinoin user" more generally.

IV. DUE DATES FOR PLAINTIFF'S SUPPLEMENTAL FACT SHEET

The Initial Plaintiffs shall provide answers to Plaintiff's Supplemental Fact Sheet, together with executed verification and records release authorizations and any responsive documents and/or things, as follows:

a) In those cases in which a generic defendant has filed an answer and/or other responsive pleading as of the date of this Order, within 45 days of entry of this Order;

b) In those cases in which no generic defendant has filed an answer or other responsive pleading as of the date of this Order, within 45 days of filing by the first served generic defendant of its Answer or other responsive pleading.

All New Plaintiffs shall provide answers to Plaintiff's Supplemental Fact Sheet 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.

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

In Re: ACCUTANE LITIGATION	)	**SUPERIOR COURT OF NEW JERSEY LAW**
	)	**DIVISION: ATLANTIC COUNTY**
	)	
	)	**Case Code No._____**
	)	
	)	**PLAINTIFF'S SUPPLEMENTAL**
	)	**FACT SHEET**
	)	
	)	**Plaintiff: _____**

In cases where forms of isotretinoin other than Accutane® were used, this Supplemental Plaintiff's Fact Sheet ("Supplemental PFS") must be completed by plaintiff or plaintiff's personal representative. It is to be completed in conjunction with, and as a supplement to, the primary Plaintiff's Fact Sheet approved for use by the Court in cases involving only Accutane® use ("Primary PFS"). To avoid unnecessary duplication of effort by plaintiff, it is understood and agreed to by all parties that in cases where this Supplemental PFS is required, the following questions set forth in the Primary PFS that reference to the word "Accutane" will be understood to mean "isotretinoin" more generally: all questions in section III; all questions in section IV(G); and all questions in sections V(P), V(Q), and V(R).

To avoid the need for an additional and/or supplemental Plaintiff's Confidential Fact Sheet, all parties further understand and agree that in cases where this Supplemental PFS is required, all references to Accutane® contained in Plaintiff's Confidential Fact Sheet, as approved for use by the Court in cases involving only Accutane® use, will be understood to mean "isotretinoin" more generally.

Finally, to avoid the need for an additional and/or supplemental list of topics for potential electronic discovery, it is understood and agreed to by all parties that in cases where this Supplemental PFS is required, all references to Accutane® or "Accutane® User" contained in the List of Topics For Electronic Documents For Discovery From Plaintiffs' Computers For Plaintiffs Alleging Systemic Injuries approved for use by the Court in cases involving only Accutane® use, will be understood to mean "isotretinoin" or "isotretinoin user" more generally.

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®, Amnesteem®, and other forms of isotretinoin, excluding 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, 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, 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 the 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(s) 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(s) 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 _____ Don't Know _____

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

II. ISOTRETINOIN PRESCRIPTION INFORMATION

PLEASE NOTE: With regard to each and every one of your answers in this Section II. "Isotretinoin Prescription Information," please provide separate and specific information for each and every form of isotretinoin you took or were prescribed, including separate specific information relating to your use of and/or prescriptions for (1) Claravis®, (2) Amnesteem®, (3) Sotret® and (4) any other forms of isotretinoin you took or were prescribed, excluding Accutane®.

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 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(s) with whom you had such discussions.

_____

Name

_____

Address (if not otherwise provided)

[If discussed with more than one doctor, please copy and complete Item 7 for each.]

8. State whether you requested that any doctor or clinic provide you with Claravis® or with 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:

_____

_____

_____

d. Approximate date you received the written instructions or warnings:

_____

_____

_____

e. 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 Supplemental Fact Sheet) including, but not being 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. 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 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(s) with whom you had such discussions.

_____

Name

_____

Address (if not otherwise provided)

[If discussed with more than one doctor, please copy and complete Item 7 for each.]

8. State whether you requested that any doctor or clinic provide you with Amnesteem® or with 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:

_____

_____

_____

d. Approximate date you received the written instructions or warnings:

_____

_____

_____

e. 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 Supplemental Fact Sheet) including, but not being 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.

C. 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 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(s) with whom you had such discussions.

Name

Address (if not otherwise provided)

[If discussed with more than one doctor, please copy and complete Item 7 for each.]

8. State whether you requested that any doctor or clinic provide you with Sotret® or with 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:

_____

_____

_____

d. Approximate date you received the written instructions or warnings:

_____

_____

_____

e. 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 Supplemental Fact Sheet) including, but not being 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.

D. OTHER FORMS OF ISOTRETINOIN

1. Who prescribed isotretinoin for you?

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

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

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

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

6. Pharmacy Information. If you received a prescription for isotretinoin, 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 isotretinoin?

Yes _____ No_____

If yes, identify the doctor(s) with whom you had such discussions.

_____

Name

_____

Address (if not otherwise provided)

[If discussed with more than one doctor, please copy and complete Item 7 for each.]

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

Yes _____ No_____

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

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:

d. Approximate date you received the written instructions or warnings:

e. Summary of instructions/warnings received:

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

11.

a. To the best of your recollection, what other medications (other than those set forth elsewhere in the Supplemental Fact Sheet) including, but not being limited to, oral contraceptives (as applicable) and over-the-counter medication had you taken five (5) years before you took isotretinoin, 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 isotretinoin? 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.

_____

_____

_____

_____

III. DOCUMENTS AND THINGS

Attach copies of the following unprivileged documents and things to this declaration to the extent that such materials currently are in your possession, custody, or control, in the possession, custody, or control of your parents, guardians or spouse, or in the possession, custody, and 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, or 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 any brand of isotretinoin used by plaintiff, excluding Accutane®, that were obtained from the Food and Drug Administration or other government agencies.

C. 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 any brand of isotretinoin were filled.

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

E. 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 Supplemental Fact Sheet is true and correct to the best of my knowledge and that I have supplied all the documents requested in Section III of this Supplemental Fact Sheet 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 Supplemental Fact Sheet. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____

Print Name
(Plaintiff)

_____ _____

Signature Date

_____

Print Name
(Loss of Consortium Plaintiff)

_____ _____

Signature Date

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY

In re: ACCUTANE® LITIGATION

Case No. _____

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:

_____

_____

_____

_____

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY

In re: ACCUTANE® LITIGATION

Case No. _____

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:

_____

_____

_____

_____

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY

In re: ACCUTANE® LITIGATION

Case No. _____

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:

_____

_____

_____

_____

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).

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- 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