IN RE TAXOTERE LITIGATION

FILED
JUN 04 2019
Judge James F. Hyland

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION – MIDDLESEX COUNTY

CASE TYPE: MCL NO. 628
MASTER DOCKET NO.:
MID-L-4998-18-CM

CIVIL ACTION
IN RE TAXOTERE LITIGATION

CASE MANAGEMENT ORDER NO. ___
REGARDING PLAINTIFF FACT SHEET

THIS MATTER having been presented to the Court on consent of the parties, and for good cause shown;

IT IS on the 4th day of June, 2019,

ORDERED that the Plaintiff Fact Sheet attached hereto as Exhibit A will be adopted and the operable Plaintiff Fact Sheet in this matter.

Honorable James F. Hyland, J.S.C.

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PLAINTIFF FACT SHEET

This Fact Sheet must be completed by each plaintiff who has filed a lawsuit related to the use of Taxotere® by the plaintiff or a plaintiff's decedent. Please answer every question to the best of your knowledge. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. Approximations are an acceptable answer. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect.

In filling out this form, please use the following definitions: (1) "**healthcare provider**" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric, or psychological care or advice, and any pharmacy, weight loss center, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care, and/or treatment of the plaintiff or plaintiff's decedent; (2) "**document**" means any writing or record of every type that is in your possession, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phone-records, non-identical copies, and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

Information provided by plaintiff will only be used for purposes related to this litigation and may be disclosed only as permitted by the protective order in this litigation. This Fact Sheet is completed pursuant to the New Jersey Rules of Court.

I. CASE INFORMATION

Attorney Information

Please provide the following information for the civil action that you filed:

1. Caption:_____

2. Court and Docket No.:_____

3. MCL Docket No. (if different):_____

4. Date Lawsuit Filed:_____

5. Plaintiff's Attorney:_____

6. Plaintiff's Law Firm:_____

7. Attorney's Address:_____

8. Attorney's Phone Number:_____

9. Attorney's Email Address:_____

Plaintiff Information

Please provide the following information for the individual who was administered Taxotere or Docetaxel:

10. Name:_____

11. Street Address:_____

12. City:_____

13. State:_____

14. Zip code:_____

15. Date of Birth:_____

16. City and State of Birth:_____

17. Social Security Number (last 4 digits only):_____

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

_____

19. Sex: Male: ☐ Female: ☐

20. Race:

Race	
American Indian or Alaska Native	☐

Race	
Asian	☐
Black or African American	☐
Native Hawaiian or Other Pacific Islander	☐
White	☐
Other	☐

21. Ethnicity:

Ethnicity	
Hispanic or Latino	☐
Not Hispanic or Latino	☐

22. Primary Language:_____

Representative Information

If you are completing this questionnaire in a representative capacity (e.g., on behalf of the estate of a deceased person), please state the following:

23. Your Name:_____

24. Your Address:_____

25. Capacity in which you are representing the individual:_____

26. If you were appointed as a representative by a court, identify the State, Court and Case Number:

    a) State:_____

    b) Court:_____

    c) Case Number:_____

27. Relationship to the Person Administered Taxotere or Docetaxel:_____

28. Date of death for the individual who was administered Taxotere or Docetaxel:_

29. Indicate the State where the individual who was administered Taxotere or Docetaxel resided at the time of death:_____

30. Are you filling this questionnaire out on behalf of an individual who is deceased and on whom an autopsy was performed? Yes: ☐ No: ☐

If you are completing this questionnaire in a representative capacity, please respond to these questions with respect to the person whose medical treatment involved Taxotere® or Docetaxel.

II. PERSONAL INFORMATION

Relationship Information

1. Are you currently: Married: ☐ Single: ☐ Engaged: ☐ Significant other: ☐ Divorced: ☐ Widowed: ☐ Same sex partner: ☐

2. Have you ever been married? Yes ☐ No ☐

3. If yes, for EACH marriage, state the following:

Spouse's Name	Date of Marriage	Date Marriage Ended	Nature of Termination

Education

4. For each level of education you completed, please check below:

High School: ☐ Vocational School: ☐

College: AA: ☐ BA/BS: ☐ Masters: ☐ PhD: ☐ M.D.: ☐ Other: ☐

Employment

5. Are you currently employed? Yes ☐ No ☐

6. If yes, state the following:

   a) Current employer name:_____

   b) Address:_____

   c) Telephone number:_____

   d) Job title:_____

7. Are you making a claim for lost wages or lost earning capacity? Yes ☐ No ☐

8. Only if you are asserting a wage loss claim, please state the following for EACH employer for the last seven (7) years:

Name of Employer	Address of Employer	Dates of Employment	Annual Gross Income	Your Position

9. Only if you are asserting a lost wage claim, state the annual gross income you earned for each of the three (3) years before the injury you claim was caused by Taxotere® or Docetaxel.

Year	Annual Gross Income

10. Only if you are asserting a lost wage claim, state the annual gross income for every year following the injury or condition you claim was caused by Taxotere® or Docetaxel.

Year	Annual Gross Income

11. Have you ever been out of work for more than thirty (30) days for reasons related to your health in the last seven (7) years? Yes ☐ No ☐

12. If yes, please state the following:

Name of Employer	Dates	Health Reason

YOU MUST ATTACH TAX RETURNS, EMPLOYMENT AUTHORIZATIONS, AND IDENTIFY THE LOSS OF CONSORTIUM PLAINTIFF'S EMPLOYERS IF CLAIMING LOST WAGES OR LOST EARNING CAPACITY DAMAGES.

Worker's Compensation and Disability Claims

13. Within the last ten (10) years, have you ever filed for workers' compensation, social security, and/or state or federal disability benefits? Yes ☐ No ☐

14. If yes, then as to EACH application, please state the following:

Year Claim Filed	Court	Nature of Claimed Injury	Period of Disability	Award Amount

Military Service

15. Have you ever served in any branch of the military? Yes ☐ No ☐

16. If yes, state the branch and dates of service:

Branch	Date of Service

17. If yes, were you discharged for any reason relating to your health (whether physical, psychiatric, or other health condition)? Yes ☐ No ☐

18. If yes, state the condition:_____

Other Lawsuits

19. Within the last ten (10) years, have you filed a lawsuit, relating to any bodily injury, or made a claim, OTHER THAN the present suit? Yes ☐ No ☐

Computer Use

20. Apart from communications to or from your attorney, have you communicated via email, visited any chat rooms, or publicly posted a comment, message or blog entry on a public internet site regarding your experience with or injuries you attribute to Taxotere®, other chemotherapies, or alopecia/hair loss during the past ten (10) years? You should include all postings on public social network sites including Twitter, Facebook, MySpace, LinkedIn, or "blogs" that address the topics above. Yes ☐ No ☐

21. If yes, please state the following:

Forum Name	Screen Name or User Handle	Date of Post	Substance of Post

22. Are you now or have you ever been a member of an alopecia support group? Yes ☐ No ☐

a) If yes, identify the group by name:_____

b) When did you join the group?_____

III. PRODUCT IDENTIFICATION

1. Were you treated with brand name Taxotere®? Yes ☐ No ☐ Unknown ☐

Other Docetaxel

2. Were you treated with another Docetaxel or generic Taxotere®? Yes ☐ No ☐

3. If yes, select all that apply:

Name of Drug	
Docetaxel – Sanofi Aventis U.S. LLC d/b/a Winthrop US	☐
Docetaxel – McKesson Corporation d/b/a McKesson Packaging	☐
Docetaxel – Actavis LLC f/k/a Actavis Inc./ Actavis Pharma, Inc.	☐
Docetaxel – Pfizer Inc.	☐
Docetaxel – Sandoz Inc.	☐
Docetaxel – Accord Healthcare Inc.	☐
Docetaxel – Hospira Worldwide, LLC f/k/a Hospira Worldwide, Inc/ Hospira, Inc.	☐
Docefrez – Sun Pharma Global, FZE	☐
Docefrez – Sun Pharmaceutical Industries, Inc. f/k/a Caraco Pharmaceutical Laboratories, Ltd.	☐
Docetaxel- Teva Parenteral Medicines, Inc.	☐
Docetaxel- Dr. Reddy's Laboratories Limited	☐
Docetaxel – Eagle Pharmaceuticals, Inc.	☐
Docetaxel- Northstar Rx LLC	☐
Docetaxel – Sagent Pharmaceuticals	☐
Unknown	☐

4. **IF YOU SELECTED "UNKNOWN" YOU MUST CERTIFY AS FOLLOWS:**

I certify that I have made reasonable, good faith efforts to identify the manufacturer of the Docetaxel used in my treatment, including requesting records from my infusion pharmacy, and the manufacturer either remains unknown at this time or I am awaiting the records: ☐

IV. MEDICAL INFORMATION

Vital Statistics

1. Current Age:_____
2. Age at the time you were first diagnosed with Breast Cancer:_____
3. Age at the time of your alleged injury:_____
4. Current weight:_____
5. Current height:

   Feet:_____ Inches:_____

6. Weight at time of alleged injury:_____

Gynecologic and Obstetric History

7. Have you ever been pregnant? Yes ☐ No ☐

   a) Number of pregnancies:_____

   b) Number of live births:_____

8. If you have children, please state the following of EACH child:

Child's Name	Current Address	Date of Birth

9. Date of first period (menses):_____ Age:_____
10. Date of last period (menses): _____ Age:_____
11. Are you menopausal, perimenopausal or postmenopausal? Yes ☐ No ☐
12. For the period of seven (7) years before your first treatment with Taxotere® or Docetaxel to present, list who you saw for your annual gynecological exam for EACH of those years. Also indicate whether an annual exam was skipped or missed.

Doctor	Office	Year	Skipped or Missed
			☐
			☐
			☐
			☐

Doctor	Office	Year	Skipped or Missed
			☐
			☐
			☐

13. For EACH year after age 40, or before then if applicable, who did you see for your annual mammogram? Also indicate whether an annual mammogram was skipped or missed.

Doctor	Office	Year	Skipped or Missed
			☐
			☐
			☐
			☐
			☐
			☐
			☐

Other Risk Factors

14. Have any family members been diagnosed with breast cancer?

Family Member	Diagnosed	Age at Diagnosis
Mother	☐	
Sister	☐	
Daughter	☐	
Paternal grandmother	☐	
Maternal grandmother	☐	

15. Have you ever been diagnosed as having genes or gene mutations that carry an increased cancer risk (e.g., BRCA1, BRCA2)? Yes ☐ No ☐

    a) If yes, which?_____

16. Did you receive radiation treatments or exposure to radiation before the age of 30? Yes ☐ No ☐

    a) If yes, describe the areas of your body which received radiation treatment or exposure and the years of this treatment or exposure:

_____

Tobacco Use History

For the ten (10) year period before your use of Taxotere® or Docetaxel up to the present, check the answer and fill in the blanks applicable to your history of tobacco use, including cigarettes, cigars, pipes, and/or chewing tobacco/snuff.

17. I currently use tobacco: Yes ☐ No ☐

18. I have never used tobacco: Yes ☐ No ☐

19. I used tobacco in the ten (10) years before Taxotere® or Docetaxel treatment: Yes ☐ No ☐

20. Identify types of tobacco use:

Type	Used	Average Per Day	Duration of Use (Years)
Cigarettes	☐		
Cigars	☐		
Pipes	☐		
Chewing tobacco/snuff	☐		

Prescription Medications

21. Apart from chemotherapy, are there prescription or over-the-counter medications that you took on a regular basis or more than three (3) times in the seven (7) year period before you first took Taxotere®? Yes ☐ No ☐

For purposes of this question, "regular basis" means that you were directed by a healthcare provider to take a medication for at least forty-five (45) consecutive days.

22. If yes, please provide the following for EACH prescription medication:

Medication	Prescriber	Dates Taken

V. CANCER DIAGNOSIS AND TREATMENT

Cancer Diagnosis & Treatment Generally

1. Have you ever been diagnosed with any type of cancer? Yes ☐ No ☐

2. Were you diagnosed with cancer more than once, meaning either two forms of cancer or a cancer recurrence? Yes ☐ No ☐

3. Did you undergo any of the following for any type of cancer?

Treatment	Treated
Surgery	☐
Radiation	☐
Chemotherapy	☐

4. For surgery, specify:

Type of Surgery	Treated
Double mastectomy	☐
Left-side mastectomy	☐
Right-side mastectomy	☐
Lumpectomy	☐
Prostate Removal	☐
Head/Neck Surgery to Remove Cancer	☐
Other:_____	☐

5. Please state the following for EACH cancer diagnosis:

Type of Cancer	
Date of Diagnosis	
Primary Oncologist	Name: Address: Dates of Treatment: Treatment:
Primary Oncologist	Name: Address: Dates of Treatment: Treatment:
Primary Oncologist	Name: Address: Dates of Treatment: Treatment:
Treatment Facility	Name: Address: Dates of Treatment: Treatment:
Treatment Facility	Name: Address: Dates of Treatment: Treatment:
Treatment Facility	Name: Address: Dates of Treatment: Treatment:

Type of Cancer	
Date of Diagnosis	
Treatment Facility	Name: Address: Dates of Treatment: Treatment:

Type of Cancer	
Date of Diagnosis	
Primary Oncologist	Name: Address: Dates of Treatment: Treatment:
Primary Oncologist	Name: Address: Dates of Treatment: Treatment:
Primary Oncologist	Name: Address: Dates of Treatment: Treatment:
Treatment Facility	Name: Address: Dates of Treatment: Treatment:
Treatment Facility	Name: Address: Dates of Treatment: Treatment:
Treatment Facility	Name: Address: Dates of Treatment: Treatment:
Treatment Facility	Name: Address: Dates of Treatment: Treatment:

Particulars of Chemotherapy

6. When were you first diagnosed with the condition for which you were prescribed Taxotere® or Docetaxel?_____

7. What was the diagnosis for which you were prescribed Taxotere® or Docetaxel?

Diagnosis	Diagnosed
Breast cancer	☐
Non-small cell lung cancer	☐
Prostate cancer	☐
Gastric adenocarcinoma	☐
Head and neck cancer	☐
Other:_____	☐

8. For breast cancer, specify:

   a) Tumor size:

Tumor Size	Yes
TX	☐
T0	☐
Tis	☐
T1	☐
T2	☐
T3	☐
T4 (T4a, T4b, T4c, T4d)	☐

   b) Metastasis:_____

   c) Node involvement:

Node	Yes
Node + NX	☐
Node + N0	☐
Node + N1	☐
Node + N2	☐
Node + N3	☐
Node – (negative)	☐

   d) HER2: + (positive): ☐ - (negative): ☐

   e) Estrogen receptor: Positive (ER+): ☐ Negative (ER-): ☐

   f) Progesterone receptor: Positive (PR+): ☐ Negative (PR-): ☐

9. Was Taxotere® or Docetaxel the only chemotherapy treatment that you ever received? Yes ☐ No ☐ Unknown ☐

10. Have you ever been treated with other chemotherapy drugs, either alone or in combination with or sequentially with Taxotere® or Docetaxel? Yes ☐ No ☐ Unknown ☐

11. If yes, check which of the following chemotherapy drugs you took:

Drug	Yes
5-Fluorouracil (Eludex)	☐
Actinomycin	☐
Altretamine (Hexalen)	☐
Amsacrine	☐
Bleomycin	☐
Busulfan (Busulfex, Myleran)	☐
Cabazitaxel: Mitoxantrone	☐
Carboplatin (Paraplatin)	☐
Carmustine (BiCNU, Gliadel)	☐
Cetuximab (Erbitux)	☐
Chlorambucil (Leukeran)	☐
Cisplatin (Platinol)	☐
Cyclophosphamide (Neosar)	☐
Cytarabine (Depocyt)	☐
Dacarbazine	☐
Daunorubicin (Cerubidine, DaunoXome)	☐
Doxorubicin (Adriamycin, Doxil)	☐
Epirubicin (Ellence)	☐
Erlotinib (Tarceva)	☐
Etoposide (Etopophos, Toposar)	☐
Everolimus (Afinitor, Zortress)	☐
Faslodex (Fulvestrant)	☐
Gemcitabine (Gemzar)	☐
Hexamethylmelamine (Hexalen)	☐
Hydroxyurea (Hydrea, Droxia)	☐
Idarubicin (Idamycin)	☐
Ifosfamide (Ifex)	☐
L-asparginase (crisantaspase)	☐
Lomustine (Ceenu)	☐
Melphalan (Alkeran)	☐
Mercaptopurine (Purinethol, Purixan)	☐
Methotrexate (Trexall, Rasuvo)	☐
Mitomycin	☐
Mitoxantrone	☐
Nab-paclitaxel (Abraxane): Mitoxantrone	☐
Nitrogen mustard	☐
Paclitaxel (Taxol)	☐
Panitumumab (Vectibix)	☐

Drug	Yes
Procarbazine (Matulane)	☐
Sorafenib (Nexavar)	☐
Teniposide (Vumon)	☐
Thioguanine (Tabloid)	☐
Thiotepa (Tepadina)	☐
Topotecan (Hycamtin)	☐
Vemurafenib (Zelboraf)	☐
Vinblastine	☐
Vincristine (Mariqibo, Vincasar)	☐
Vindesine	☐
Vinorelbine (Alocrest, Navelbine)	☐
Unknown	☐

12. Please provide the following information regarding Taxotere® or Docetaxel:

    a) Number of cycles:_____

    b) Frequency: Every week ☐ Every three weeks ☐ Other:_____

    c) First treatment date:_____

    d) Last treatment date:_____

    e) Dosage:_____

        (1) Combined with another chemotherapy drug: ☐

        (2) Sequential with another chemotherapy drug: ☐

        (3) If so, describe the combination or sequence:_____

13. Prescribing Physician(s):

Prescribing Physician	Address
	Street: City: State: Zip:
	Street: City: State: Zip:

Prescribing Physician	Address
	Street: City: State: Zip:

14. Treatment Facility:

Prescribing Physician	Address
	Street: City: State: Zip:
	Street: City: State: Zip:
	Street: City: State: Zip:

15. Identify EACH state where you resided when you began and while taking Taxotere® or Docetaxel:

State	From Date	To Date

16. Was your Taxotere® or Docetaxel treatment part of a clinical trial? Yes ☐

No ☐ Unknown ☐

17. If yes, please provide the name and location of the trial site:

a) Name of trial site:_____

b) Location of trial site:_____

VI. CLAIM INFORMATION

Current Status

1. Are you currently taking Taxotere® or Docetaxel? Yes ☐ No☐

2. Are you currently cancer-free? Yes ☐ No ☐

3. If no, check those that apply to your CURRENT status:

Current Status	Yes
In remission	☐
Currently receiving chemotherapy	☐
Currently receiving radiation therapy	☐
Currently hospitalized for cancer or cancer- related complications	☐
Currently in home health or hospice care for cancer or cancer-related complications	☐
Cancer returned after taking Taxotere® or Docetaxel	☐

4. When was the last (most recent) date you consulted with an oncologist:_____

Alleged Injury

5. State the injury you allege in this lawsuit and the dates between which you experienced the alleged injury. Check all that apply:

Alleged Injury	Yes	No	From	To
Persistent total alopecia – No hair growth on your head or body after six (6) months of discontinuing Taxotere® or Docetaxel treatment	☐	☐		
Persistent alopecia of your head – No hair growth on your head after six (6) months of discontinuing Taxotere® or Docetaxel treatment. Hair is present elsewhere on your body	☐	☐		
Permanent/Persistent Hair Loss on Scalp	☐	☐		
Diffuse thinning of hair: partial scalp Top Sides Back Temples Other:_____	☐	☐		
Diffuse thinning of hair: total scalp Top Sides Back Temples Other:_____	☐	☐		
Significant thinning of the hair on your head after six (6) months of discontinuing Taxotere®	☐	☐		

Alleged Injury	Yes	No	From	To
or Docetaxel treatment – There are visible bald spots on your head no matter how you style your hair				
Moderate thinning of the hair on your head after six (6) months of discontinuing Taxotere® or Docetaxel treatment – There is noticeable hair loss but if you brush or style your hair, the hair loss is less evident	☐	☐		
Small bald area in the hair on your head	☐	☐		
Large bald area in the hair on your head	☐	☐		
Multiple bald spots in the hair on your head	☐	☐		
Change in the texture, thickness or color of your hair after Taxotere® or Docetaxel treatment	☐	☐		
Other:_____	☐	☐		
Permanent/Persistent Loss of Eyebrows	☐	☐		
Permanent/Persistent Loss of Eyelashes	☐	☐		
Permanent/Persistent Loss of Body Hair	☐	☐		
Permanent/Persistent Loss of Genital Hair	☐	☐		
Permanent/Persistent Loss of Nasal Hair	☐	☐		
Permanent/Persistent Loss of Ear Hair	☐	☐		
Permanent/Persistent Loss of Hair in Other Areas Describe:_____	☐	☐		

6. Have you ever received treatment for the injury you allege in this lawsuit? Yes ☐ No ☐

Name of Treating Physician	Dates of Treatment	Treatments

7. Were you diagnosed by a healthcare provider for the injury you allege in this lawsuit? Yes ☐ No ☐

Name of Treating Physician	Dates of Diagnosis	

8. Have you discussed with any healthcare provider whether Taxotere® or Docetaxel caused or contributed to your alleged injury? Yes ☐ No ☐

Name of Treating Physician	Dates of Discussion	

Name of Treating Physician	Dates of Discussion	

Statement Information

9. Were you ever given any written instructions, including any prescriptions, packaging, package inserts, literature, medication guides, or dosing instructions, regarding chemotherapy, Taxotere® or Docetaxel? Yes ☐ No ☐ Do not recall ☐

10. If yes, describe the document(s) you received regarding chemotherapy, Taxotere® or Docetaxel.

Description of Document	I Have the Documents	I Do Not Have the Documents
	☐	☐
	☐	☐
	☐	☐

11. Were you given any oral instructions from a healthcare provider regarding chemotherapy or your use of Taxotere® or Docetaxel? Yes ☐ No ☐

12. If yes, please identify each healthcare provider who provided the oral instructions:

Name of Healthcare Provider

13. Have you ever seen any advertisements (e.g., in magazines or television commercials) for Taxotere® or Docetaxel? Yes ☐ No ☐ Do not recall ☐

14. If yes, identify the advertisement or commercial, and approximately when you saw the advertisement or commercial:

Type of Advertisement or Commercial	Date of Advertisement or Commercial

15. Other than through your attorneys, have you had any communication, oral or written, with any of the Defendants or their representatives? Yes ☐ No ☐

16. If yes, please identify:

Date of Communication	Method of Communication	Name of Representative	Substance of Communication

17. Have you filed a MedWatch Adverse Event Report to the FDA? Yes ☐ No ☐

Other Claimed Damages

18. Mental or Emotional Damages: Do you claim that your use of Taxotere® or Docetaxel caused or aggravated any psychiatric or psychological condition? Yes ☐ No ☐

19. If you claim you sustained mental or emotional damage, did you seek treatment for the psychiatric or psychological condition? Yes ☐ No ☐

Provider	Date	Condition Treated

20. Medical Expenses: Do you claim that you incurred medical expenses for the alleged injury that you claim was caused by Taxotere® or Docetaxel? Yes ☐ No ☐

21. If you claim that you incurred medical expenses, list all of your medical expenses, including amounts billed or paid by insurers and other third-party payors, which are related to any alleged injury you claim was caused by Taxotere® or Docetaxel:

Provider	Date	Condition

22. Out-of-Pocket Expenses: Are you making a claim for lost out-of-pocket expenses? Yes ☐ No ☐

23. If yes, please identify and itemize all out-of-pocket expenses you have incurred:

Expense	Expense Amount

Expense	Expense Amount

VII. HAIR LOSS INFORMATION

Background

1. Did you ever see a healthcare provider for hair loss BEFORE taking Taxotere® or Docetaxel? Yes ☐ No ☐
2. Did your hair loss begin during chemotherapy treatment? Yes ☐ No ☐
3. If yes, did you FIRST experience hair loss:
   a) After treatment with another chemotherapy agent: ☐
   b) After treatment with Taxotere® or Docetaxel: ☐
4. At any time before or during the hair loss were you:

Condition	Yes	Description
Pregnant	☐	
Seriously ill	☐	
Hospitalized	☐	
Under severe stress	☐	
Undergoing treatment for any other medical condition	☐	

5. When did you FIRST discuss with or see a healthcare provider about your hair loss?_____
6. Have you started any special diets at any time before or during the hair loss? Yes ☐ No ☐ Describe:_____

Hair Loss History

Question	No	Yes	Name of Healthcare Provider
Have you had a biopsy of your scalp to evaluate your hair loss problem?	☐	☐	
Have you had blood tests done to evaluate your hair loss problem?	☐	☐	
Have your hormones ever been checked to evaluate your hair loss problem?	☐	☐	
Have you ever been told by a doctor that you have a thyroid condition?	☐	☐	

Question	No	Yes	Name of Healthcare Provider
Have you ever been treated with thyroid hormone?	☐	☐	
Have you ever been told by a doctor that you have a low iron level?	☐	☐	

7. Have you ever been on endocrine or hormonal therapy, either before or after chemotherapy with Taxotere® or Docetaxel? Yes ☐ No ☐

8. If yes, please identify:

Treating Physician	Dates of Treatment	Treatment

9. To your knowledge, have you ever been diagnosed with any autoimmune diseases? Yes ☐ No ☐

10. If yes, check the following which describes you:

Autoimmune Disease	Yes
Lupus	☐
Rheumatoid arthritis	☐
Celiac disease	☐
Type 1 diabetes	☐
Sjogrens disease	☐
Vitiligo	☐
Hashimoto's	☐
Other:_____	☐

11. Were you taking any medications when your hair loss began? Yes ☐ No ☐

Medication

Hair Care

12. How often do you wash/shampoo your hair? Every _____ days

13. Check any of the following that apply to you currently or that have in the past:

Hair Treatment	Yes	Period of Time	Frequency
Hair chemically processed or straightened (relaxers, keratin, Brazilian blowout, Japanese straightening, other)	☐		☐ Never ☐ Once a week ☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year
Hair heat processed or straightened (blow drying/ flat ironing, curling)	☐		☐ Never ☐ Once a week ☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year
Hair dyed	☐		☐ Never ☐ Once a week ☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year
Hair highlighted	☐		☐ Never ☐ Once a week ☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year
Braids	☐		☐ Never ☐ Once a week ☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year
Weaves	☐		☐ Never ☐ Once a week ☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year
Tight hairstyles (ponytails)	☐		☐ Never ☐ Once a week

Hair Treatment	Yes	Period of Time	Frequency
			☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year
Extensions	☐		☐ Never ☐ Once a week ☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year
Other:_____	☐		☐ Never ☐ Once a week ☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year

14. Have you ever used the following?

Hair Treatment	Yes
WEN Cleansing Conditioners	☐
Unilever Suave Professionals Keratin Infusion	☐
L'Oréal Chemical Relaxer	☐

15. Has your hair care regimen been different in the past? Yes ☐ No ☐

a) If yes, describe: _____

Hair Loss Treatment

16. Did you use any other methods to prevent hair loss during chemotherapy?

Hair Treatment	Yes
Folic Acid supplementation	☐
Minoxidil	☐
Other:_____	☐

17. Did you wear a cool cap during chemotherapy treatment? Yes ☐ No ☐

18. If yes, which cooling cap did you wear:_____

19. Have you used any over-the-counter medications, supplements, or cosmetic aides for your hair loss? Yes ☐ No ☐

20. If yes, please state the following:

Treatment	When was it tried?	How long did you try it?	Did it help?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

21. Has anything helped your hair loss? Yes ☐ No ☐

22. If yes, please specify:

Type of Product	Dates of Use	Place of Purchase	Results of Use

23. As of the date you verify your PFS, how long have you had alopecia or incomplete hair re-growth?_____

24. Has any hair regrowth occurred? Yes ☐ No ☐

25. Have you ever worn a wig to conceal your hair loss? Yes ☐ No ☐

26. Specify:

Dates Used	Period of Use	Place Purchased	Cost of Item

VIII. RECORD HOLDER IDENTIFICATION

Healthcare Providers:

1. Identify each physician, doctor, or other healthcare provider who has provided treatment to you for any reason in the past eight (8) years and the reason for consulting the healthcare provider or mental healthcare provider.

YOU MUST INCLUDE YOUR ONCOLOGIST, RADIOLOGIST, DERMATOLOGIST, DERMATOLOGIST-PATHOLOGIST, HAIR LOSS SPECIALIST, GYNECOLOGIST, OBSTETRICIAN, AND PRIMARY CARE PHYSICIAN, ALONG WITH ANY OTHER HEALTHCARE PROVIDERS IDENTIFIED ABOVE.

Name	Area or Specialty	Address	Dates	Reason for Consultation

Hospitals, Clinics, and Other Facilities:

2. Identify each hospital, clinic, surgery center, physical therapy or rehabilitation center, or other healthcare facility where you have received inpatient or outpatient treatment (including emergency room treatment) in the past eight (8) years:

YOU MUST INCLUDE THE LOCATIONS FOR SURGERIES, RADIOLOGY, IMAGING, BIOPSIES, CHEMOTHERAPY, CHILD BIRTHS, GYNECOLOGIC PROCEDURES OR TREATMENT, ALONG WITH ANY OTHER HEALTHCARE FACILITIES.

Name	Address	Dates	Reason for Treatment

Laboratories:

3. Identify each laboratory at which you had medical tests run in the past ten (10) years:

Name	Address	Dates	Test	Reason for Tests

Pharmacies:

4. To the best of your recollection, identify each pharmacy, drugstore, and/or other supplier (including mail order) where you have had prescriptions filled or from which you have ever received any prescription medication within three (3) years prior to and three (3) years after your first treatment with Taxotere:

Name	Address	Dates	Medications

Name	Address	Dates	Medications

Retailers:

5. Identify each pharmacy, drugstore, and/or other retailer (including mail order) where you have purchased over-the-counter medications, or hair products in the past ten (10) years:

Name	Address	Dates	Product Purchased

Insurance Carriers:

6. Identify each health insurance carrier which provided you with medical coverage and/or pharmacy benefits for the last ten (10) years:

Carrier	Address	Name & SSN of Insured	Policy Number	Dates of Coverage

IX. DOCUMENT REQUESTS AND AUTHORIZATIONS

Please state which of the following documents you have in your possession. If you do not have the following documents but know they exist in the possession of others, state who has possession of the documents: Produce all documents in your possession (including writings on paper or in electronic form) and signed authorizations and attach a copy of them to this PFS.

Requests

Type of Document(s)	Yes	No	If No, who has the document(s)?
Documents you reviewed to prepare your answers to this Plaintiff Fact Sheet. *Your attorney may withhold some documents on claims of attorney-client privilege or work product protection and, if so, provide a privilege log*	☐	☐	
Medical records or other documents related to the use of Taxotere® or Docetaxel at any time for the past twelve (12) years. This specifically includes any documentation identifying the manufacturer of your Taxotere® or Docetaxel.	☐	☐	

Type of Document(s)	Yes	No	If No, who has the document(s)?
Medical records or other documents related to your treatment for any disease, condition or symptom referenced above for any time in the past twelve (12) years.	☐	☐	
Laboratory reports and results of blood tests performed on you related to your hair loss.	☐	☐	
Pathology reports and results of biopsies performed on you related to your hair loss. *Plaintiffs or their counsel must maintain the slides and/or specimens requested in this subpart, or send a preservation notice, copying Defendants, to the healthcare facility where these items are maintained.*	☐	☐	
Documents reflecting your use of any prescription drug or medication at any time within the past eight (8) years.	☐	☐	
Documents identifying all chemotherapy agents that you have taken.	☐	☐	
Documents for any workers' compensation, social security or other disability proceeding at any time within the last five (5) years.	☐	☐	
Instructions, product warnings, package inserts, handouts or other materials that you were provided or obtained in connection with your use of Taxotere®.	☐	☐	
Advertisements or promotions for Taxotere®.	☐	☐	
Articles discussing Taxotere®.	☐	☐	
Any packaging, container, box, or label for Taxotere® or Docetaxel that you were provided or obtained in connection with your use of Taxotere®. *Plaintiffs or their counsel must maintain the originals of these items.*	☐	☐	
Documents which mention Taxotere® or Docetaxel or any alleged health risks related to Taxotere®. *Your attorney may withhold some legal documents, documents provided by your attorney, or documents obtained or created for the purpose of seeking legal advice or assistance on claims of attorney-client privilege or work product protection and, if so, provide a privilege log.*	☐	☐	
Documents obtained directly or indirectly from any of the Defendants.	☐	☐	
Communications or correspondence between you and any representative of the Defendants.	☐	☐	

Type of Document(s)	Yes	No	If No, who has the document(s)?
Photographs, drawing, slides, videos, recordings, DVDs, or any other media that show your alleged injury or its effect in your life.	☐	☐	
Journals or diaries related to the use of Taxotere® or Docetaxel or your treatment for any disease, condition or symptom referenced above at any time for the past twelve (12) years.	☐	☐	
Social media or internet posts to or through any site (including, but not limited to, Facebook, MySpace, LinkedIn, Google Plus, Windows Live, YouTube, Twitter, Instagram, Pinterest, blogs, and Internet chat rooms/message boards) relating to Taxotere® or Docetaxel or any of your claims in this lawsuit.	☐	☐	
If you claim you have suffered a loss of earnings or earning capacity, your federal tax returns for each of the five (5) years preceding the injury you allege to be caused by Taxotere® or Docetaxel, and every year thereafter or W-2s for each of the five (5) years preceding the injury you allege to be caused by Taxotere® or Docetaxel, and every year thereafter.	☐	☐	
If you claim any medical expenses, bills from any physician, hospital, pharmacy or other healthcare providers.	☐	☐	
Records of any other expenses allegedly incurred as a result of your alleged injury.	☐	☐	
If you are suing in a representative capacity, letters testamentary or letters of administration.	☐	☐	
If you are suing in a representative capacity on behalf of a deceased person, decedent's death certificate and/or autopsy report.	☐	☐	
Photographs of you that are representative of your hair composition **before** treatment with Taxotere® or Docetaxel.	☐	☐	
Photographs of you that are representative of your hair composition **during** treatment with Taxotere® or Docetaxel.	☐	☐	
Photographs of you that are representative of your hair composition **six months after conclusion** of treatment with Taxotere® or Docetaxel.	☐	☐	
Photographs of you that are representative of your hair composition **in present day**.	☐	☐	

Type of Document(s)	Yes	No	If No, who has the document(s)?
Signed authorizations for medical records related to any cancer treatment identified herein and all pharmacy records from three (3) years before and three (3) years after your first treatment with Taxotere in the forms attached hereto.	☐	☐	

X. DECLARATION

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that all of the information provided in connection with this Plaintiff Profile Form is true and correct to the best of my knowledge information and belief at the present time.

_____ _____

Signature Date

XI. AUTHORIZATIONS

See next page for Authorizations.

Please note, the following:

1. The authorization for Tax Returns, Employment and Worker's Compensation is only required if the individual who was administered Taxotere or Docetaxel was employed within the past ten (10) years and answered yes to Question II.7.

2. The authorization for Psychiatric, Psychological and/or Mental Health Treatment Notes/Records is only required if the individual who was administered Taxotere or Docetaxel answered yes to Question VI.18.

3. The authorization for Disability records is only required if the individual who was administered Taxotere or Docetaxel answered yes to Question II.13.

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03
(Excluding Psychiatric, Psychological, and Mental Health Treatment Notes/Records)

TO:
Patient Name:
DOB:
SSN:

I, _____, hereby authorize you to release and furnish to: Shook Hardy & Bacon LLP, DLA Piper LLP (US), Greenberg Traurig LLP, Stradley Ronon Stevens & Young, LLP, Dechert LLP, Riker Danzig Scherer Hyland & Perretti LLP, Tucker Ellis, LLP, Hinshaw & Culbertson LLP, Goldberg Segalla LLP, and Ulmer & Berne LLP and/or their duly assigned agents, copies of the following records and/or information **from the time period of twelve (12) years prior to the date on which the authorization is signed:**

* 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. Said medical records shall include all information regarding AIDS and HIV status.
* All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports. * All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.
****Notwithstanding the broad scope of the above disclosure requests, the undersigned does not authorize the disclosure of notes or records pertaining to psychiatric, psychological, or mental health treatment or diagnosis as such terms are defined by HIPAA, 45 CFR §164.501.**

1. To my medical provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants for the purpose of litigation. Yon are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition at a deposition or trial.**

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name:_____(plaintiff/representative)

Signature:_____Date

LIMITED AUTHORIZATION TO DISCLOSE EMPLOYMENT RECORDS AND INFORMATION (HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508)

TO: _____
Name of Employer

_____
Address, City State and Zip Code

RE: Employee Name: _____ AKA: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

I authorize the limited disclosure of my employment records including medical information protected by HIPAA, 45 CFR 164.508, for the purpose of review and evaluation in connection with a legal claim.

This authorization only authorizes release of records and/or information from the time period of seven (7) years prior to the date on which this authorization is signed. I expressly request that all entities identified above disclose full and complete records from the time period of seven (7) years prior to the date on which this authorization is signed, including the following:

This will authorize you to furnish copies of all applications for employment; resumes; records of all positions held; job descriptions of positions held; wage and income statements and/or compensation records; wage increases and decreases; evaluations, reviews and job performance summaries; W-2s; employee health files, and correspondence and memoranda regarding the undersigned.

I authorize you to release the information to:

_____
Name (Records Requestor)

_____
Street Address City State and Zip Code

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requestor at that time.

I acknowledge the right to revoke this authorization by writing to you at the above referenced 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. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

_____
Signature of Employee or Personal Representative Date Name of Employee or Personal Representative

_____
Description of Personal Representative's Authority to Sign for Employee (attach documents that show authority)

LIMITED AUTHORIZATION FOR RELEASE OF WORKERS' COMPENSATION RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all workers' compensation records of any sort **for any workers' compensation claims filed within the last ten (10) years**, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning:

_____
Name of Claimant

whose date of birth is _____and whose social security number is _____

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

Records Requestor _____
Representative Capacity (e.g., attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

This authorization only authorizes release of documents and records from the period of ten (10) years prior to the date on which this authorization is signed. This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date: _____ _____

Claimant Signature
[NAME]

Date: _____ _____

Witness Signature

LIMITED AUTHORIZATION FOR RELEASE OF
DISABILITY CLAIMS RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all records of disability claims of any sort **for any disability claim(s) filed within the last ten (10) years**, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning:

_____
Name of Claimant

whose date of birth is _____and whose social security number is _____

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

Records Requestor _____
Representative Capacity (e.g., attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

This authorization only authorizes release of documents and records from the period of ten (10) years prior to the date on which this authorization is signed. This authorization does not authorize you to disclose anything other than documents and records to anyone.

Date: _____ _____

Claimant Signature
[NAME]

Date: _____ _____

Witness Signature

FOR RELEASE OF
HEALTH INSURANCE RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all insurance claims applications and benefits, and all medical, health, hospital, physicians, nursing or allied health professional reports, records or notes, invoices and bills, in your possession that pertain to the named insured identified below. **This authorization only authorizes release of Health Insurance records and/or information from the time period of ten (10) years prior to the date on which this authorization is signed.**

_____
Name of Claimant

whose date of birth is _____and whose social security number is _____

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

Records Requestor _____
Representative Capacity (e.g., attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

This authorization only authorizes release of documents and records from the period of ten (10) years prior to the date on which this authorization is signed. This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requestor named above has executed the acknowledgement at the bottom of this authorization.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date: _____ _____

Claimant Signature
[NAME]

Date: _____ _____

Witness Signature

LIMITED AUTHORIZATION TO DISCLOSE PSYCHIATRIC, PSYCHOLOGICAL AND/OR MENTAL HEALTH TREATMENT NOTES/RECORDS
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO:
Patient Name:
DOB:
SSN:

I, _____, hereby authorize you to release and furnish to: hereby authorize you to release and furnish to: Shook Hardy & Bacon LLP, DLA Piper LLP (US), Greenberg Traurig LLP, Stradley Ronon Stevens & Young, LLP, Dechert LLP, Riker Danzig Scherer Hyland & Perretti LLP, Tucker Ellis, LLP, Hinshaw & Culbertson LLP, Goldberg Segalla LLP, and Ulmer & Berne LLP and/or their duly assigned agents, copies of the following records and/or information **from the time period of ten (10) years prior to the date on which the authorization is signed:**

- All "psychotherapy notes", as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501. Under HIPAA, the term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's record. This authorization does not authorize ex parte communication concerning same.

1. To my medical and/or mental health provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, mental health history, care, treatment, diagnosis, prognosis, information revealed by or in the medical or mental health records, or any other matter bearing on his or her medical, psychological, or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, mental health history, care, treatment, diagnosis, prognosis, information revealed by or in the medical or mental health records, or any other matter bearing on my medical, psychological, or physical condition at a deposition or trial.**

2. understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name: _____ (plaintiff/representative)

Signature: _____ Date