P. Data from IMS Health show that the pharmaceutical industry, including PhRMA members and non-members, spent approximately $7.2 billion dollars on office promotion, hospital promotion, and journal advertising in 2006 (including all direct costs of marketing such as sales representatives' salaries and training). (PhRMA's First Amended Responses to Defs.' Requests for Admission at ¶ 54 (Ex. 8).)

Q. Data from IMS Health show that the pharmaceutical industry, including PhRMA members and non-members, spent $12 billion on all combined drug promotional activities (as defined by IMS) for 2006. (PhRMA's First Amended Responses to Defs.' Requests for Admission at ¶ 56 (Ex. 8).)

VIII. PHARMACEUTICAL SALES

A. In a March 8, 2007 news release, IMS Health reported that U.S. sales of prescription drugs in 2006 totaled $274.9 billion dollars. (PhRMA's First Amended Responses to Defs.' Requests for Admission at ¶ 114 (Ex. 8).)

B. In a March 2007 news release, IMS Health reported that sales of lipid regulators in 2006 totaled $21.6 billion dollars. (PhRMA's First Amended Responses to Defs.' Requests for Admission at ¶ 116 (Ex. 8).)

C. In a March 2007 press release, IMS Health reported that 2006 sales of Lipitor totaled $8.6 billion, and that 2006 sales of Zocor totaled $3.1 billion. (PhRMA's First Amended Responses to Defs.' Requests for Admission at ¶ 117 (Ex. 8).)

D. Some PhRMA members use subsidiaries or third parties to sell authorized generic versions of their drugs. (PhRMA's First Amended Responses to Defs.' Requests for Admission at ¶ 50 (Ex. 8).)

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prescriber data to improve their practices. Partners HealthCare has implemented a variety of systems to monitor the prescribing practices of doctors to ensure that members of Partners are prescribing according to current practices. These systems attempt to improve collectively the prescribing practices of all doctors participating as members of Partners HealthCare. In order to determine whether patients are getting appropriate care, Partners HealthCare needs to know not just what is prescribed by the doctor, but also what prescriptions actually are filled by the pharmacist. (Glaser ¶ 10). Partners HealthCare's systems therefore collects information about the drugs that member doctors are prescribing and about the prescriptions that are being filled. Partners HealthCare uses that information to help educate doctors about breakthrough drugs that have become available and that may offer their patients better alternatives to the drugs that are currently being prescribed, drugs that are more cost effective than the drugs that are being prescribed and drugs that are safer than the drugs that are being prescribed. (Glaser ¶ 11). This information about the prescribing practices of its physicians is collected through managed care organizations and depicts the drugs prescribed and drugs that the patient takes. Partners HealthCare regularly analyzes that information and then communicates directly with its members about alternative prescribing practices that might improve the health of patients in order to attempt to improve the quality, safety and cost effectiveness of the care delivered by its doctors. (Glaser ¶12-13). The potential for increased doctor income is also a critical consideration in the acceptability of this oversight. *Id.* Partners HealthCare's systems for analyzing the prescribing practices of individual members often are used to influence sales or market share of a pharmaceutical product and to influence and evaluate the prescribing behavior of an individual health care professional. (Glaser ¶15). Thus, the activities of Partners HealthCare and its use of prescriber identifiable data closely resemble the activities of pharmaceutical manufacturers, who

like physicians, are interested in improving the practice of medical care and increasing their profitability and do so with the use of prescriber identifiable data. Therefore, the Prescription Restraint Law's restrictions on the flow of prescribe-identifiable data has the potential of affecting a whole range of activities conducted by organizations other than pharmaceutical manufacturers.

Plaintiffs Seek Guidance as to Their Rights Under the Law

45. After passage of Prescription Restraint Law, IMS Health sought guidance from the Attorney General both in writing and in person on how the State would seek to interpret and enforce the law. Assistant Attorney General Richard Head tried to be helpful, but ultimately was unable to provide any assurance that the health information companies or their sources could not or would not be prosecuted if they continued their existing business practices. Asst. Atty. Gen. Head confirmed that the Attorney General would enforce all provisions of the law and defend its constitutionality if it were challenged. (Mahon Dec. ¶ 7-15).

46. The plaintiffs have concrete plans to engage immediately in activity which appears to be proscribed by the Prescription Restraint Law. Those concrete plans are to continue the purchasing and selling of patient-de-identified prescription information for commercial purposes that are ostensibly prohibited by the Prescription Restraint Law. The plaintiffs therefore have a reasonable fear that they will be prosecuted criminally for executing their plans and that an action for injunctive relief and damages will be brought against them by the Attorney General, a County Attorney or by private citizens if they execute those concrete plans. (Mahon ¶¶ 8-9).

The Health Information Companies Challenge the Prescriptions Restraint Law

47. On July 28, 2006, the health information companies filed a complaint for declaratory and injunctive relief and motion for preliminary injunction asking the Court to

invalidate the portions of the Prescription Restraint Law that criminalize the licensing, sale, transfer and use of prescriber-identifiable data for commercial purposes. The health information companies emphasized that they were not challenging the portions of the Prescription Restraint Law that addressed *patient*-identifiable data.

48. On August 7, 2006, the plaintiffs moved for an expedited status conference. At a status conference that took place on September 5, 2006, the plaintiffs asked the Court to schedule a an expedited hearing on the motion for preliminary injunction because the plaintiffs First Amendment rights were being affected with each day that the Prescription Law remained in effect. The Court decided to allow the State an opportunity to engage expert witnesses to defend the constitutionality of the statute and engage in discovery of the plaintiffs' witnesses.

49. On September 21, 2006, the Court approved the parties' discovery plan and schedule the case for trial to commence on January 25, 2006. On October 13, 2006, the Court amended the trial period to commence on January 29, 2006.

The State's Experts

50. Pursuant to the parties' discovery plan, the State identified five witnesses whom it intends to call at trial. The depositions that have been completed of the State's witnesses reveal the State's intention to engage in post-hoc attempts to justify the Prescription Restraint Law through their experts. The State's expert witnesses Drs. Jerry Avorn and Gary A. Sobelson testified that they were not consulted by the state of New Hampshire prior to the passage of the law and had no input in the drafting of the legislation. (Avorn Dep. at 7; Sobelson Dep. 12-13).

51. Notably, the testimony of the State's experts showed that the Prescription Restraint Law will do little, if anything, to stop doctors from prescribing branded drugs when generic drugs become available because there are a number of factors, other than pharmaceutical

detailing, that affect a physician's decision to prescribe a branded drug when a generic drug is available. Dr. Gary A. Sobelson, for example, acknowledged that he prescribes branded drugs when generic drugs are available not necessarily because of pharmaceutical detailing but because branded names are easier to remember, he is not always aware of the existence of generic equivalents or simply because he relies on pharmacies to dispense available generic drugs even he prescribes branded drugs. (Sobelson Dep. 141-43).

52. Moreover, none of the State's experts were able to point to the existence of any studies showing that restricting the free flow of prescriber-identifiable data will result in an increase of prescriptions of generic drugs in the state of New Hampshire. Dr. Jerry Avorn acknowledged that although he has 25 years of experience in the filed of pharmacoepidemiology and pharmacoeconomics, he had never previously advocated imposition of a restriction on the dissemination of prescriber-identifiable data as a means of increasing the likelihood that a prescriber would prescribe a generic drug in lieu of a branded drug. (Avorn Dep. at 21, 103).

53. He testified that although he has advocated for many years the curb of excessive influence of pharmaceutical promotion, he never advocated the enactment of legislation of the type at issue in this case. (Avorn Dep. at 13-14).

54. Dr. Avorn's testimony brought to light the many different alternatives that the New Hampshire could have pursued to achieve its objectives that do not involve the restriction of speech. For example, Dr. Avorn acknowledged that any suboptimal prescribing practices that are caused by the effectiveness of the marketing conducted by detailers can be counteracted through the implementation of "academic detailing" whereby doctors are exposed to science-based information about drug performances. (Avorn Dep. 54-57). This approach, which has been implemented in the state of Pennsylvania, advocates more, not less, information to be made

available to doctors to help them drive decisions. (Avorn Dep. 58). Yet the state of New Hampshire does not appear to have attempted to implement an academic detailing program at any time prior to the passage of the Prescription Restraint Law. (Avorn Dep. 64).

55. Other alternatives that Dr. Avorn advocates to counteract suboptimal prescription practices include: (a) a the requirement of prior authorization from the payor the drugs before a doctor could prescribe a branded drug for which a less costly generic is available, modification (Avorn Dep. 64-69); a differential co-payment system whereby patients are required to pay for the difference between a branded and a generic drug when they choose to purchase the branded drug; (Avorn Dep. 73-4); modification of existing patents law to make more difficult for pharmaceutical companies to manufacture new drugs that have result in minimal or no improvement over existing drugs (75-6); and drug importation whereby patients could feely purchase cheaper drugs from other nations outside the United States. (Avorn Dep. 77-79).

56. Dr. Avorn and Dr. Sobelson both acknowledged that not all pharmaceutical detailing results in costlier or suboptimal prescribing and that there are instances in which such detailing could be useful to the medical community. (Avorn Dep. 44, 48-49; Sobelson Dep. 82-83). Yet they believe that the Prescription Restraint law is a step in the right direction because it would make it more difficult for manufacturers to present their messages to prescribers. (Avorn Dep. 228; Sobelson Dep. 150-51).

57. In late October, the Attorney General hired for the flat fee of $5,000, Shahram Ahari (Ahari Dep. 16), an Eli Lilly sales representative for a year and a half (Ahari Dep. 148), to testify concerning how he and others employed by manufacturers used prescriber identifiable data more than six years ago. He testified that the information allowed sales representatives to identify the prescribers to whom they would direct their messages and that the messages that

they delivered were always truthful. (Ahari Dep. 78). He testified he resigned as a sales representative in June 2000 because he came to believe that even truthful messages led some prescribers to make less than optimal decisions. (Ahari Dep. 148-52). He testified he could not, consistent with his own morality, continue to work for Eli Lilly, although he did not tell Eli Lilly this when he resigned. (Ahari Dep. 151). He also testified, however, that when he could not find other employment, that he applied to become a sales representative with Novartis, another manufacturer, but that company rejected his employment application. (Ahari 191). He explained that his current knowledge of detailing practices is based largely on his recent contact with "Jenna," an "acquaintance" and current employee of Eli Lilly whose last name, telephone number, and e-mail address he could not recall during his deposition. (Ahari Dep. 163-64). Today Mr. Ahari is a temporary employee of the University of California at San Francisco. He tries to identify cases of poisonings that may have adverse public health consequences. He expects that employment to terminate in April 2007. (Dep. Ahari 203-04).

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing was served by electronic filing on November 30, 2006, to:

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