IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA ex rel. ALLEN JONES,	§	Civil Action No. 04cv1310
Plaintiffs,	§	JURY TRIAL DEMAND
v.	§	
JANSSEN PHARMACEUTICA PRODUCTS, L.P., JANSSEN PHARMACEUTICA, INC., JOHNSON & JOHNSON, INC.,	§	**FILED UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2) DO NOT PLACE IN PRESS BOX DO NOT ENTER ON PACER**
Defendants.	§	

FALSE CLAIMS ACT COMPLAINT AND DEMAND FOR JURY TRIAL

FISH & RICHARDSON P.C.
Thomas L. Halkowski
PA Bar No. 88854
919 N. Market Street, Suite 1100
Wilmington, DE 19899-1114
(302) 652-5070 (Telephone)
(302) 652-0607 (Telecopy)

Thomas M. Melsheimer
Texas Bar No. 13922550
1717 Main Street, Suite 5000
Dallas, TX 75201
(214) 747-5070 (Telephone)
(214) 747-2091 (Telecopy

WATERS & KRAUS, LLP
C. Andrew Waters
Charles Siegel
George Tankard
Susan Hays
3219 McKinney Ave.
Dallas, TX 75204
(214) 357-6244 (Telephone)
(214) 871-2263 (Telecopy)

JS 44 (Rev 3/99)

CIVIL COVER SHEET

The JS-44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON THE REVERSE OF THE FORM.)

I. (a) PLAINTIFFS
UNITED STATES OF AMERICA ex rel. ALLEN JONES
(b) County of Residence of First Listed Plaintiff
(EXCEPT IN U.S. PLAINTIFF CASES)

DEFENDANTS
JANSSEN PHARMACEUTICA PRODUCTS, L.P., JANSSEN PHARMACEUTICA, INC., JOHNSON & JOHNSON, INC.
County of Residence of First Listed Defendant: Mercer County, NJ
(IN U.S. PLAINTIFF CASES ONLY)
NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE LAND INVOLVED

(c) Attorneys (Firm Name, Address, and Telephone Number)
Thomas L. Halkowski
Fish & Richardson P.C.
919 N. Market St, Ste. 1100, Wilmington, DE 19899-1114
(302) 652-5070

Attorneys (If Known)

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)

- ☒ 1. U.S. Government Plaintiff
- ☐ 2. U.S. Government Defendant
- ☐ 3. Federal Question (U.S. Government Not a Party)
- ☐ 4. Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant)
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In this State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT (Place an "X" in One Box Only)

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excl. Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury

PERSONAL INJURY
- ☐ 362 Personal Injury- - - Med. Malpractice
- ☐ 365 Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth In Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

FORFEITURE/PENALTY
- ☐ 610 Agriculture
- ☐ 620 Other Food & Drug
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 630 Liquor Laws
- ☐ 640 R.R. & Truck
- ☐ 650 Airline Regs.
- ☐ 660 Occupational Safety/Health
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Mgmt. Relations
- ☐ 730 Labor/Mgmt. Reporting & Disclosure Act
- ☐ 740 Railway Labor Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Empl. Ret. Inc. Security Act

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☒ 830 Patent
- ☐ 840 Trademark

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS – Third Party 26 USC 7609

OTHER STATUTES
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce/ICC Rates/etc.
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 810 Selective Service
- ☐ 850 Securities/ Commodities/ Exchange
- ☐ 875 Customer Challenge 12 USC 3410
- ☐ 891 Agricultural Acts
- ☐ 892 Economic Stabilization Act
- ☐ 893 Environmental Matters
- ☐ 894 Energy Allocation Act
- ☐ 895 Freedom of Information Act
- ☐ 900 Appeal of Fee Determination Under Equal Access to Justice
- ☐ 950 Constitutionality of State Statutes
- ☒ 890 Other Statutory Actions

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

CIVIL RIGHTS
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 444 Welfare
- ☐ 440 Other Civil Rights

PRISONER PETITIONS
- ☐ 510 Motions to Vacate Sentence
- Habeas Corpus:
- ☐ 530 General
- ☐ 535 Death Penalty
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition

V. ORIGIN (PLACE "X" IN ONE BOX ONLY)

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from another district (specify) ☐ 6 Multidistrict Litigation ☐ 7 Appeal to District Judge from Magistrate Judgment

VI. CAUSE OF ACTION (Cite the U.S. Civil Statute under which you are filing and write brief statement of cause. Do not cite jurisdictional statutes unless diversity.)
31 U.S.C. §§ 3729 *et seq*; False Claims Act Complaint.

VII. REQUESTED IN COMPLAINT: ☐ CHECK IF THIS IS A CLASS ACTION UNDER F.R.C.P. 23 **Demand: $** CHECK YES only if demanded in Complaint
JURY DEMAND ☒ Yes ☐ No

VIII. RELATED CASE(S) IF ANY (See Instructions) JUDGE s DOCKET NUMBER

DATE
March 25, 2004

SIGNATURE OF ATTORNEY OF RECORD

TYPE NAME OF ATTORNEY
Thomas L. Halkowski

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

UNITED STATES DISTRICT COURT

APPENDIX F

FOR THE EASTERN DISTRICT OF PENNSYLVANIA — DESIGNATION FORM to be used by counsel to indicate the category of the case for the purpose of assignment to appropriate calendar.

Address of Plaintiff: Pennsylvania

Address of Defendant: Pennsylvania/New Jersey

Place of Accident, Incident or Transaction: Pennsylvania

(Use Reverse Side For Additional Space)

Does this civil action involve a nongovernmental corporate party with any parent corporation and any publicly held corporation owning 10% or more of its stock?

(Attach two copies of the Disclosure Statement Form in accordance with Fed.R.Civ.P. 7.1(a)) Yes☐ No☒

Does this case involve multidistrict litigation possibilities? Yes☐ No☒

RELATED CASE, IF ANY:

Case Number: _____ Judge _____ Date Terminated: _____

Civil cases are deemed related when yes is answered to any of the following questions:

1. Is this case related to property included in an earlier numbered suit pending or within one year previously terminated action in this court? Yes☐ No☒
2. Does this case involve the same issue of fact or grow out of the same transaction as a prior suit pending or within one year previously terminated action in this court? Yes☐ No☒
3. Does this case involve the validity or infringement of a patent already in suit or any earlier numbered case pending or within one year previously terminated action in this court? Yes☐ No☒

CIVIL: (Place ✔ in ONE CATEGORY ONLY)

A. *Federal Question Cases:*

1. ☐ Indemnity Contract, Marine Contract, and All Other Contracts
2. ☐ FELA
3. ☐ Jones Act-Personal Injury
4. ☐ Antitrust
5. ☐ Patent
6. ☐ Labor-Management Relations
7. ☐ Civil Rights
8. ☐ Habeas Corpus
9. ☐ Securities Act(s) Cases
10. ☐ Social Security Review Cases
11. ☒ All other Federal Question Cases (Please specify) Civil False Claims Act 31 U.S.C. Sec. 3729 et seq.

B. *Diversity Jurisdiction Cases:*

1. ☐ Insurance Contract and Other Contracts
2. ☐ Airplane Personal Injury
3. ☐ Assault, Defamation
4. ☐ Marine Personal Injury
5. ☐ Motor Vehicle Personal Injury
6. ☐ Other Personal Injury (Please specify)
7. ☐ Products Liability
8. ☐ Products Liability — Asbestos
9. ☐ All other Diversity Cases (Please specify)

ARBITRATION CERTIFICATION

(Check appropriate Category)

I, Thomas L. Halkowski, counsel of record do hereby certify:

☐ Pursuant to Local Civil Rule 53.2, Section 3(c)(2), that to the best of my knowledge and belief, the damages recoverable in this civil action case exceed the sum of $150,000.00 exclusive of interest and costs;

☒ Relief other than monetary damages is sought.

DATE: 3/25/03 Thomas L. Halkowski Pending

Attorney-at-Law Attorney I.D.#

NOTE: A trial de novo will be a trial by jury only if there has been compliance with F.R.C.P. 38.

I certify that, to my knowledge, the within case is not related to any case now pending or within one year previously terminated action in this court except as noted above.

DATE: 3/25/03 Thomas L. Halkowski Pending

APPENDIX I

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CASE MANAGEMENT TRACK DESIGNATION FORM

UNITED STATES OF AMERICA ex rel. ALLEN JONES	:	CIVIL ACTION
v.	:	
JANSSEN PHARMACEUTICA PRODUCTS, L.P., JANSSEN PHARMACEUTICA, INC., and JOHNSON & JOHNSON, INC.	:	NO.

In accordance with the Civil Justice Expense and Delay Reduction Plan of this court, counsel for plaintiff shall complete a case Management Track Designation Form in all civil cases at the time of filing the complaint and serve a copy on all defendants. (See § 1:03 of the plan set forth on the reverse side of this form.) In the event that a defendant does not agree with the plaintiff regarding said designation, that defendant shall, with its first appearance, submit to the clerk of court and serve on the plaintiff and all other parties, a case management track designation form specifying the track to which that defendant believes the case should be assigned.

SELECT ONE OF THE FOLLOWING CASE MANAGEMENT TRACKS:

(a) Habeas Corpus – Cases brought under 28 U.S.C. §2241 through §2255. ( )

(b) Social Security – Cases requesting review of a decision of the Secretary of Health and Human Services denying plaintiff Social Security Benefits ( )

(c) Arbitration – Cases required to be designated for arbitration under Local Civil Rule 53.2. ( )

(d) Asbestos – Cases involving claims for personal injury or property damage from exposure to asbestos. ( )

(e) Special Management – Cases that do not fall into tracks (a) through (d) that are commonly referred to as complex and that need special or intense management by the court. (See reverse side of this form for a detailed explanation of special management cases.) (XX)

(f) Standard Management – Cases that do not fall into any one of the other tracks. ( )

Thomas L. Halkowski

Thomas L. Halkowski	Plaintiff
Date	**Attorney-at-law**	**Attorney for**
(302) 652-5070	(302) 652-0607	halkowski@fr.com
Telephone	**FAX Number**	**E-Mail Address**

(Civ. 660) 10/02

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA ex rel. ALLEN JONES, Plaintiffs, v. JANSSEN PHARMACEUTICA PRODUCTS, L.P., JANSSEN PHARMACEUTICA, INC., JOHNSON & JOHNSON, INC., Defendants.	§ § § § § § § § § § § § §	Civil Action No. _____ JURY TRIAL DEMAND **FILED UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2) DO NOT PLACE IN PRESS BOX DO NOT ENTER ON PACER**

FALSE CLAIMS ACT COMPLAINT AND DEMAND FOR JURY TRIAL

Introduction

1. Allen Jones ("Jones" or "Relator") brings this action on behalf of the United States of America against defendants for treble damages and civil penalties arising from the defendants' false statements and false claims in violation of the Civil False Claims Act, 31 U.S.C. §§ 3729 *et seq.* Defendants persuaded state governments to adopt algorithms demanding the use of certain "new generation" drugs, in part by making payments to state employees to promote the program and by unauthorized marketing of pharmaceuticals for the treatment of psychiatric conditions. As a result, the defendants caused the submission of false claims for Medicaid reimbursement for "off-label" use and other irregular uses. The defendants persuaded the states that the drug in question was superior to other available treatments, despite the Food and Drug Administration ("FDA") explicitly prohibiting such claims.

2. The Relator has previously provided to the Attorney General of the United States and to the United States Attorney for the Middle District of Pennsylvania a statement of some material evidence and information relevant to this case. Relator has attached to this complaint, a full disclosure of substantially all material facts, as required by the False Claims Act, 31 U.S.C. §3730(b)(2). This disclosure statement is supported by material evidence known to Relator at his filing establishing the existence of defendants' false claims. Because the statement includes attorney-client communications and work product of Relator's attorneys, and is submitted to the Attorney General and to the United States Attorney in their capacity as potential co-counsel in the litigation, the Relator understands this disclosure to be confidential.

Jurisdiction and Venue

3. This action arises under the False Claims Act, 31 U.S.C. §§3729 *et seq.* This Court has jurisdiction over this case pursuant to 31 U.S.C. §§3732(a) and 3730(b). This court also has jurisdiction pursuant to 28 U.S.C. §1345 and 28 U.S.C. §1331.

4. Venue is proper in this District pursuant to 31 U.S.C. §3732(a), because acts proscribed by 31 U.S.C. §§3729 *et seq.* and complained of herein took place in this district, and is also proper pursuant to 28 U.S.C. §1391(b) and (c), because at all times material and relevant, defendants transact and transacted business in this District.

Parties

5. Relator Allen Jones is a citizen of the United States and a resident of the State of Pennsylvania. From May 2002 to the present, Relator has been an employee of the Office of the Inspector General ("OIG"), Bureau of Investigations of the

Commonwealth of Pennsylvania. The Relator brings this action based on his direct, independent, and personal knowledge and also on information and belief.

6. Relator is an original source of information underlying this Complaint and provided to the United States and underlying recent media reports on the defendants' scheme. *See* Ex. A, Melody Peterson, *Making Drugs, Shaping the Rules: Big Pharma is Eager to Help States Set Medication Guidelines*, NEW YORK TIMES at 3-10 (Feb. 1, 2004). He has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the Government before filing an action under the False Claims Act which is based on the information.

7. Defendant Janssen Pharmaceutica Products, L.P. ("Janssen L.P.") is organized under the laws of New Jersey and has its principal place of business in New Jersey, at 1125 Trenton-Harbourton Rd., Titusville, NJ 08560. Janssen L.P. is a wholly-owed subsidiary of Johnson & Johnson. Janssen L.P. manufactured and marketed the drug Risperidone known by the brand name Risperdal.

8. Defendant Janssen Pharmaceutica, Inc., ("Janssen, Inc.") is incorporated in Pennsylvania and has its principal place of business in New Jersey, at 1125 Trenton-Harbourton Rd., Titusville, NJ 08560. Janssen, Inc. is the general partner of Janssen L.P. and also manufactured and marketed the drug Risperidone known by the brand name Risperdal. The two defendants are collectively referred to as "Janssen" or "the defendants."

9. Defendant Johnson & Johnson, Inc. ("Johnson & Johnson") is incorporated in New Jersey and has its principal place of business in New Jersey at One

Johnson & Johnson Plaza, New Brunswick, NJ 08933. Johnson & Johnson is the parent company of Janssen, L.P. and Janssen, Inc.

Facts Common to All Counts

The FDA and Medicaid

10. The United States of America and the several states fund health care treatment for the poor and mentally ill through Medicaid. The Food, Drug, and Cosmetics Act only allows the promotion of a drug for a particular purpose, if the drug sponsor demonstrates that the drug is both safe and effective for each of its intended uses. 21 U.S.C.A. §§331(d), 355(a), (d). Medicaid reimbursement is available in most circumstances only for "covered outpatient drugs." 42 U.S.C.A. §1396b(i)(10). A covered outpatient drug is one that has been approved for both safety and effectiveness under the FDCA. 42 U.S.C.A. §1396r-8(k)(2)(A)(i). Coverage does not typically extend to uses that are not "medically accepted indications" or not supported by certain medical compendia. 42 U.S.C.A. §§1396r-8(d)(1)(B), (k)(6); *see* 42 U.S.C.A. §1396r-8(g)(1)(B)(i) (list of compendia). Thus, Medicaid reimbursement is not available for "off-label" use of drugs.

11. The states administer medical assistance programs, Medicare and Medicaid, with substantial reimbursement by the federal government. By statute and regulation, the federal government provides detailed provisions concerning reimbursement for prescription drugs, drug utilization review, price controls on prescription drugs, and drug manufacture rebate programs. Federal law requires a state formulary to include medically accepted uses of prescription drugs. *See* 42 U.S.C. §1396r-8.

12. State Medicaid programs do not intend to reimburse for prescriptions that are not medically necessary. However, states lack the ability to monitor individual prescriptions to identify whether uses are "off-label." Thus, while a particular drug may be approved for some uses, prescriptions written for other "off-label" uses may be inadvertently reimbursed. Moreover, aggressive marketing by drug companies may lead a state to adopt a formulary use that is not medically accepted, despite a state's intention not to do so.

Atypical schizophrenia drugs

13. Beginning in the early 1990s and through present day, drug companies developed new schizophrenia drugs are known as "Atypical Antipsychotics" ("Atypicals"). These drugs are also known as Second Generation Antipsychotics ("SGAs") or "New Generation" drugs. **Risperdal, Zyprexa,** and **Seroquel** are Atypicals. They are much more expensive than the older generation of drugs as they are still under patent.

14. The older drugs, first appearing in the 1960's, are known as "Typical Antipsychotics" ("Typicals"). All of these drugs are available in generic form today, and are therefore less expensive to consumers and state and federal governments that reimburse health care costs. These drugs are also known as First Generation Antipsychotics ("FGAs").

The Texas Program — TMAP

15. In the mid-1990s, the defendants and other pharmaceutical companies sought to persuade the State of Texas to adopt a protocol or "algorithm" requiring the prescription of certain drugs for the treatment of mental illness. The result was a "Model Program" known as the "Texas Medication Algorithm Project" or TMAP (pronounced

"T-Map"). Through TMAP, the drug industry methodically compromised the decision-making of elected and appointed public officials to gain access to captive populations of mentally ill individuals in prisons and state mental health hospitals. Schizophrenia and bipolar disorder were two principal conditions targeted by TMAP. TMAP resulted in the off-label use of drugs on children, the elderly, and the mentally retarded, both in off-label dosages and for unapproved diagnoses.

16. TMAP began in 1995 as an alliance of individuals from within the pharmaceutical industry and the Texas state university, mental health, and corrections systems. Start-up funds included a $1.8 million grant from the Robert Wood Johnson Foundation, a Johnson & Johnson-related foundation. Johnson & Johnson is the parent company of Janssen, L.P. and Janssen, Inc.

17. The group's goal was to develop a model mental health treatment program for incorporation into public mental health and prison systems. This model program would ensure that newer, expensive medications would be heavily used. But the drug industry had a problem: Clinical trials simply did not favor their new products. Alternative justification for favoring these drugs would have to be developed.

18. The pharmaceutical industry bypassed governmental safeguards and medical review by creating and marketing TMAP as a "treatment model" that was instituted as an *administrative* decision by a select few public officials. In Texas, **Dr. Steven Shon**, the Medical Director of the Mental Health and Mental Retardation Department, became the chief proponent of the adoption of TMAP. Dr. Shon, who had previously been the Deputy Commissioner for Mental Health Services, helped secure the

adoption of TMAP in Texas, then allowed himself to be used as the promoter of TMAP as a Model Program to other states, including Pennsylvania.

19. The treatment model accepted by these state officials had a fundamental requirement rooted deep within it: Doctors must first treat their patients with the newest, most expensive drugs patented by the pharmaceutical companies. The state doctors treating mental illness could choose which patented drug to use, but effectively could not choose to use less expensive generic drugs unless and until the patented drugs failed.

20. The centerpiece of this model is a set of algorithms that, together with text guidelines, guide a clinician in prescribing medications to schizophrenic patients and in changing or adjusting medications. Algorithms are flow charts that illustrate step-by-step movements in a process. The centerpiece of the algorithms is a formulary of approved and required medications. A formulary is like a menu in a restaurant, but it lists medications instead of food, in effect listing what medications a doctor may choose from. If a drug is not on the menu, a doctor may not prescribe it for a patient without a written justification. Exhibit B is a sample TMAP algorithm.

21. Drug companies marketed their newer, patented medications as safer and more effective than the older, generic brands. These drugs, they said, not only better treated the symptoms of mental illness, they did so without the troublesome side-effects often seen with conventional medications.

22. Proponents of TMAP secured funding to pay for the added expense of the Atypicals. With funding behind it, TMAP opened the doors of the Texas prison system, juvenile justice system, and mental health system to the unlimited influence of — and

profiting by — major pharmaceutical companies in expanding the usage and marketing of their most expensive drugs — all with the government and the taxpayers footing the bill.

"Expert Consensus Guidelines," "Retrospective Analysis," and other methods of bypassing clinical support for the Defendant's claims.

23. The TMAP consortium sought to legitimize the use of medications in the program by way of "Expert Consensus Guidelines" rather than clinical trials. Essentially, TMAP opted to "establish" new drugs as the best drugs for various illnesses by surveying the opinions of doctors and psychiatrists of TMAP's own choosing. No hard science, no patients, no study review, and no clinical trials — just the "Expert Opinions" of persons TMAP elected to survey.

24. The "Expert Consensus" process became TMAP's standard mechanism for creating the *appearance* of superiority for certain drugs and it was employed repeatedly from 1996 to 2003. The doctors who were surveyed included persons who had already published articles favoring the new drugs. The survey included doctors with strong ties to the drug industry.

25. They included **Dr. Jack Gorman** who received more than $140,000 from drug companies in a single year between April 1, 1997, and March 31, 1998. During that time Gorman received speaking fees, travel, board memberships and consulting deals from Janssen, Johnson & Johnson, Eli Lilly, Pfizer, and other drug companies.

26. TMAP formulated the questions to be posed to these physicians and formulated the structure of the responses permitted. No input aside from the survey questions was solicited. A total of only fifty-seven doctors and psychiatrists responded to the medication survey.

27. _TMAP concluded that the Atypical antipsychotic medications **Risperdal**, produced by Janssen, **Zyprexa,** produced by Eli Lilly, and **Seroquel**, produced by AustraZeneca, are the drugs of choice. TMAP concluded that all newer, patented anti-depressants were superior to generics, that the patented bi-polar drugs were superior to generic drugs, and that "Expert Consensus" established these drugs to be safer, more effective, better tolerated and relatively free of side effects when compared to the older, generic, medications.

28. TMAP then formulated separate algorithms and drug menus for the treatment of schizophrenia, depression, and bi-polar disorder. All of the new, patented drugs were incorporated into the TMAP algorithms. *See* Ex. B, sample TMAP algorithm.

29. State doctors following the algorithms were and are ***required*** to use these drugs. The ***administrative*** decision of Dr. Steven Shon and the Mental Health Program to adopt TMAP brought with it the ***clinical*** decision to use the recommended drugs on all patients in the state system. A state doctor may choose which patented drug to use, but he or she may not choose to use a generic drug until at least two, often three, patented drugs have failed.

30. Janssen funded the "Expert Consensus Guidelines" survey and analysis. Eli Lilly and AustraZeneca were also funding the project by the time the initial results were published in 1996. Pfizer, Novartis, Ortho-McNeil, GlaxoSmithKline, Abbott, Bristol Myers Squibb, Wyeth-Ayerst, Forrest Laboratories and U.S. Pharmacopeia have since joined them. All of these drug companies have patented drugs in one or more of the TMAP "menus."

31. The "Expert Consensus Guidelines" and resultant algorithms were adapted and Texas prisons, juvenile facilities and mental hospitals were made available for pilot projects for the TMAP algorithms — all with the federal and state government footing the bill for funding the drug purchases.

32. With the doors of the Texas prisons and mental hospitals open to TMAP, TMAP personnel were free to "mine" patient records in a process called "**Retrospective Analysis**." Essentially they could research files of those patients who had previously been treated with the newer medications and report on those cases that offered favorable results. TMAP personnel cherry-picked patient records for positive results so that the extent of any harmful side effects such as dramatic weight loss or onset of diabetes was concealed. Additionally, TMAP personnel were responsible for monitoring the usage of the drugs, gathering raw data, analyzing data and formulating reports.

33. Not surprisingly, TMAP "research" confirmed the "Expert Consensus." TMAP, funded by the drug companies, found **Risperdal**, **Zyprexa,** and **Seroquel** to be safer and more effective than generic drugs for the treatment of schizophrenia.

34. TMAP proponents began referring to the TMAP algorithms as being "Evidence Based" and "Evidence Based Best Practices."

The expansion of TMAP

35. Members of TMAP began publishing their "findings." TMAP co-directors and staff traveled widely, at the expense of pharmaceutical companies, to tout the wonders of the new drugs and to expand their guidelines and algorithms to other states — and to other nations. As early as 1997, TMAP members were traveling to China, Japan, and other nations to sell the TMAP agenda. The principal TMAP

spokesman is Dr. Steven Shon, who has lauded TMAP and pursued TMAP development under several titles at both state and national levels.

36. In 1997-98, TMAP, with pharmaceutical industry funding, began working on the Texas Children's Medication Algorithm Project. ("TCMAP"). An "Expert Consensus" panel was assembled at a meeting in Dallas in 1998 to determine which drugs would be best for the treatment of mental and emotional problems in children and adolescents.

37. The panel consisted almost exclusively of persons already involved in TMAP or associated with TMAP officials. A survey was not necessary. These persons simply met and decided that the identical drugs being used on adults should also be used on children. There were no studies or clinical trial results whatsoever to support this consensus that these psychiatric drugs should be used on children.

38. One of the members of the children's "expert consensus panel" was **Graham J. Emslie, M.D.**, Professor and Chair, Division of Child and Adolescent Psychiatry, University of Texas Southwestern Medical Center (a TMAP site), and Director, Bob Smith Center for Research in Pediatric Psychiatry, Dallas. Multiple drug companies have hired Emslie as a consultant or financially supported his research.

39. The TCMAP panel also included **Dr. Karen Dineen Wagner** who has received research support from Abbott, Bristol-Myers Squibb, Eli Lilly, Forest Laboratories, GlaxoSmithKline, Organon, Pfizer, and Wyeth-Ayerst; has served as a National Institute of Mental Health consultant to Abbott, Bristol-MyersSquibb, Cyberonics, Eli Lilly, Forest Laboratories, GlaxoSmithKline, Novartis, Otsuka, Janssen,

Pfizer, and UCB Pharma; and has participated in "speaker's bureaus" for Abbott, Eli Lilly, GlaxoSmithKline, Forest Laboratories, Pfizer, and Novartis.

The New Freedom Commission, TIMAP, and other networks designed to spread TMAP.

40. With TMAP and TCMAP in place, a Johnson & Johnson foundation provided a $300,000 grant to fund the implementation of the Texas Implementation of Medication Algorithms Project ("TIMAP") for the sole purpose of exporting TMAP and TCMAP to other states. Janssen also helped fund the expansion. As of 2002, ten states, including Pennsylvania, had implemented TMAP or were in the process of doing so.

41. The pharmaceutical industry influence on the development of TMAP was not limited to TMAP, TCMAP, and TIMAP funding. Janssen funded efforts of the newly created Research Committee of the National Association of State Mental Health Program Directors ("NASMHPD"). **Dr. Steven Shon**, a co-director of TMAP and Texas' State Medical Director authored reports and articles under the NASMHPD banner in which he lauded TMAP, the TMAP algorithms, and the TMAP medications.

42. Janssen's influence of state Mental Health Directors was not limited to NASMHPD funded events. Janssen also formed "Advisory Boards" comprised entirely of State Mental Health Directors and regularly treated these "Advisory Board" members to trips and conferences, with all expenses paid by Janssen. Janssen's influence of State Mental Health systems was not limited to deluxe treatment of state Directors. Janssen also funded trips and, through intermediaries, paid money, to other key state employees who were in a position to implement TMAP.

43. The New Freedom Commission ("NFC") was purportedly formed to examine issues and provide guidance to the United States president relative to mental

health treatment. However, the NFC is another "Expert Consensus" panel with a pre-set mission to create an aura of legitimacy for TMAP and to advance plans to further implement use of and payment for expensive mental health drugs. The NFC currently has 22 members many of whom have financial or other ties to the drug industry.

44. Another NFC member is **Michael F. Hogan** of Ohio. Hogan is the president of the NASMHPD Research Institute, an entity heavily supported by Janssen and other pharmaceutical company grants. Hogan was the Mental Health Program Director in Ohio when TMAP was implemented there. Hogan participated on a Janssen advisory Board along with **Steven Karp**, the Pennsylvania Director who implemented TMAP (more on Mr. Karp below). He serves with Dr. Shon in NASMHPD.

45. **Stephen W. Mayberg** of California is also a NFC member. Mayberg was the California State Mental Health Program Director when California implemented TMAP. Mayberg is a past president of NAMHPD and the NASMHPD research institute. Mayberg participated on a Janssen advisory board along with Michael Hogan and Steven Karp. He serves with Dr. Shon in NASMHPD.

46. **Larke Nahme Huang** is the NFC's link to yet another network for spreading TMAP. Huang was involved in the planning and formation of the National Asian American Pacific Islander Mental Health Association ("NAAPIMHA"). Dr. Shon who is a TMAP Director and major TMAP proponent heads this recently-formed group. Haung currently serves under Dr. Shon in NAAPIMHA.

47. On July 22, 2003 the New Freedom Commission issued its recommendations for redesigning the mental health network in each of our fifty states. Not surprisingly, TMAP is recommended as the model program for all states to follow.

The reality of TMAP drugs: expensive, ineffective, and dangerous.

48. However, these new "miracle" drugs did not live up to their hype. They have proven to not be substantively better than the generic Typicals. Most importantly, most of the new drugs have been found to cause serious, even fatal side-effects, particularly in children. In addition, the financial cost of TMAP drugs was taking its toll. By 1998, the Texas MHMR network was in severe financial trouble. A 2001 news report noted that the costs of treating schizophrenia, bipolar conditions, and depression had surpassed the costs for expenditure on physical ailments such as infections, high blood pressure, and diabetes. Texas reacted by appropriating an additional $67 million to pay drug companies for medications for patients in Texas prisons and the mental health system. In 2003, Texas suspended funding for all anti-psychotics for its children's health insurance program.

49. The drugs were not clinically certified as safe and effective for the proposed use in TMAP, such as Eli Lilly's highly touted new anti-psychotic, Zyprexa. In clinical trials averaging six weeks, Zyprexa was tested in 2,500 adults. The drug was linked to serious, in some cases life-threatening side effects requiring hospitalization in 22% of those tested. Acute weight gain of 50 to 70 lbs is usual, and with it the increased risk of diabetes. FDA data reveals a 65% drop out rate, and only 26% favorable response. During those six-week clinical trials there were 20 deaths, of which 12 were suicides. Much of this information was not revealed to the FDA. One non-TMAP researcher noted that the data from these trials "demonstrate . . . a higher death rate on Zyprexa than on any other antipsychotic ever recorded."

Pennsylvania adopts TMAP creating "PENNMAP."

50. The Pennsylvania Medication Algorithm Project ("PENNMAP") is a treatment model and regimen for the treatment of schizophrenia. It was adopted by the Pennsylvania Department of Public Welfare ("DPW"), Office of Mental Health and Substance Abuse Services ("OMHSAS") in 2002 and fully implemented in January of 2003.

51. Like TMAP, PENNMAP is a vehicle for an administrative decision to adopt an approach to the medical treatment of schizophrenia and other mental conditions. Also like TMAP, PENNMAP utilizes algorithms of Atypicals.

52. The designation of PENNMAP by OMHSAS as the required treatment methodology for all schizophrenic patients required that *all schizophrenic patients* coming in contact with the state hospital system be treated with Atypicals, *regardless* of patient history and regardless of past or current success with Typical medications.

53. During the phase-in of PENNMAP hundreds of mental patients had their medications switched ***in the absence of medical need or indication*** to comply with an administrative decision. This was an unethical practice instituted without regard for the rights of patients and in the absence of meaningful consent.

54. A number of state employees conspired to implement PENNMAP.

55. **Charles Currie** is an NFC member and was the Deputy Secretary for OMHSAS in Pennsylvania when PENNMAP was adopted. In Pennsylvania, Currie endorsed the TMAP agenda and permitted employees to solicit "educational grants" from drug companies who had a vital interest in TMAP and with the intent to promote the TMAP agenda. Currie has lauded TMAP in Substance Abuse and Mental Health Services Agency ("SAMHSA") speeches and SAMHSA documents.

56. Currie approved a slush fund and an off-the-books account that formed the basis of Relator Jones' initial OIG investigation. The OIG received reports that drug company sales representatives frequently and openly made gifts of meals and sporting event tickets to officials and state hospitals during Currie's tenure.

57. Following the start of the PENNMAP implementation process in Pennsylvania, Currie was appointed by President Bush to head the national SAMHSA. In that capacity, Currie has worked to further the expansion of TMAP, which is listed as one of his prime initiatives. SAMHSA had a $500,000 budget in FY 2002-03 for the express purpose of aiding TMAP development. Currie also serves on the New Freedom Commission, which seeks to expand the role of the insurance industry in more fully funding mental health services, including mental health medications.

58. **Steven J. Fiorello**, Director of Pharmacy Services, Office of Mental Health and Substance Abuse Services, played a key role in the implementation of PENNMAP. Fiorello describes himself as the point man in Pennsylvania for any drug company wishing to have their product placed on the state drug formulary. He is the Chairman of the Pennsylvania Formulary Committee that approves or disapproves drugs for the state "menu."

59. Fiorello solicited "educational grants" from pharmaceutical companies totaling at least $13,765. Part of this amount was spent to bring Dr. Shon to Pennsylvania to "sell" the TMAP agenda. Part of this amount was spent on trips to New Orleans for Fiorello and OMHSAS Psychiatric Services Physician Manager, Dr. Robert Davis, to meet with TMAP representatives and marketing representatives of Janssen.

60. Janssen documents list Janssen's purpose and goal in providing these "educational grants." Funds for these grants were drawn from a promotional account for the Janssen drug Risperdal. The stated purpose of one grant was to support "TMAP initiative to expand atypical usage and drive **Dr. Steven Shon's** expenses." Ex. C, payment records. Another grant lists the purpose of the grant as being "Pennsylvania OMH to meet with TMAP group" in New Orleans. The expected "deliverable" result was "Successful implementation of PENNMAP". This statement directly contradicts the "Letter of Agreement" between the Commonwealth and Janssen which states: "**Statement of Purpose**: The Program is for scientific and educational purposes only and is not intended to promote a JANSSEN product directly or indirectly."

61. Along with **Dr. Fredrick Maue**, Chief, Clinical Services Division, Pennsylvania Department of Corrections, Fiorello did a presentation on PENNMAP at a Janssen sponsored event in Hershey, Pennsylvania on April 17, 2002. He was paid a $2,000 honorarium for the presentation, which he delivered in his official state capacity. Fiorello noted that Maue was implementing a similar program in the state prison system.

62. A Janssen sub-contractor, **Comprehensive NeuroSciences**, ("CNS") arranged the Hershey event for Janssen. A Janssen sales representative attended the event. Documents indicate that CNS, as Janssen's sub-contractor, and Janssen personnel themselves, prepared and reviewed Fiorello's presentation materials. See Ex. D, CNS Check Request Form; related email; Ex. E, Fiorello presentation. CNS sent Fiorello Janssen slides from the previous year to use as a model. This Janssen involvement was in direct violation of AMA regulations and FDA *Guidelines for Industry.*

63. Fiorello's presentation explicitly urged the audience to avoid "Blind Adherence to PDR Dose Limits." See Ex. E. However, the Physician's Desk Reference is similar to other compendia that establish the medical standard — and thus trigger the reimbursement of drug costs under Medicaid — for drug use. By urging healthcare professionals to disregard standards in the PDR, the speaker is urging the prescription of non-standard uses.

64. Fiorello traveled to Philadelphia in late 2001, at the request of Janssen to do a PENNMAP presentation to community-based managed-care service providers to promote PENNMAP outside of the Pennsylvania State Hospital system. Fiorello went to Philadelphia as a pharmacy consultant to Janssen.

65. **Steven J. Karp**, D.O. is the Medical Director of the Office of Mental Health and Substance Abuse Services. He is a supervisor of Fiorello, authorized the slush fund account, and approved expenditures. He was thus aware of Fiorello's activities, including the gathering of patient data, and association with Jannsen. In December of 2000, Karp was appointed to the advisory board of *Mental Health Issues Today*, ("MHIT"). Janssen contracts with Parexel International Corporation ("Parexel"), a medical marketing company, to produce MHIT. See Ex. F, MHIT Newsletter.

66. As a result, Karp was invited, at Parexel's expense as reimbursed by Janssen, to attend periodic "advisory board meetings." On June 23-25, 2001, Karp attended a meeting at the Mayflower Park Hotel in Seattle, Washington. Janssen, via Parexel, provided airfare, lodging and sustenance in Seattle and reimbursed Karp for his expenses in getting to the BWI airport. Karp also attended a meeting at the Hyatt Regency Westshore in Tampa, Florida, on November 17-19, 2001. Again, Janssen, via

Parexel, covered his expenses. In June or July of 2002, Karp again attended an Advisory Board Meeting in Chicago with all expenses paid by Janssen, via Parexel.

67. Karp also belongs to NASMHPD along with Dr. Shon and NFC commissioner Michael Hogan. The growth of this organization paralleled the development of TMAP and was likewise heavily subsidized by Janssen.

68. **Robert H. Davis, M.D.**, Psychiatric Services Physician Manager, OMHSAS Medical Services Division, is also supervised by Karp. He attended the New Orleans meeting with Fiorello, with Janssen paying the expenses. He assisted in Fiorello's retrospective analysis of patient data.

69. **Frederic Maue**, Chief, Clinical Services Division, Pennsylvania Department of Corrections, is Karp's counterpart in the Department of Corrections. In April of 2002, Maue did three presentations at Janssen-funded events sponsored by Janssen's contractor, CNS, including one in Sacramento, California, and one in Orlando, Florida. According to CNS, Maue received a $2,000 honorarium plus all expenses for each of the three presentations.

70. The costs of PENNMAP and the widespread implementation of TMAP are exorbitant. For example, in 2003, the VA system spent $106.6 million on Zyprexa alone. Pennsylvania likely spent more than $75 million on schizophrenics in its institutions and public health systems in 2003. Janssen grossed $2.5 billion on Risperdal worldwide in 2003.

The Defendants' Acts Causing the Submission of False Claims

71. Drug industry money guided TMAP from conception through development and expansion to other states. The growth of TMAP began with misleading

science. Through the defendants' acts TMAP grew and expanded with the aid of compromised public officials.

72. Janssen operates a specialty sales division devoted to public sector marketing. Janssen was the most aggressive of the companies in developing this model and in directly compromising and influencing public officials. Other drug companies contributed funding to the effort.

73. To implement TMAP and its offspring around the country, Janssen made claims that its Atypical, Risperdal, is safer and more effective than existing drugs. However, FDA raw data on the Atypical drug trials and the FDA's review of the trials, do not support industry claims that the Atypicals were safer or more effective than existing generic drugs. In fact, in the approval letter to Janssen regarding their drug Risperdal, the FDA specifically stated:

> We would consider any advertisement or promotion labeling for RISPERDAL false, misleading or lacking fair balance under section 502 (a) and 502 (n) of the ACT if there is a presentation of data that conveys the impression that Risperidone is superior to haloperidol [a generic antipsychotic] or any other marketed antipsychotic drug product with regard to safety or effectiveness.

Thus, from the beginning, the FDA specifically ordered Janssen to not market Risperdal as superior to other drugs.

74. Janssen, however, ignored this initial directive from the FDA. Janssen marketed Risperdal as superior to generic antipsychotics resulting in the creation of TMAP which requires the use of Atypicals, for which there are no generics, rather than the cheaper Typicals. Janssen's acts did not go without notice from the FDA. In 1999, the FDA issued a letter after review of Janssen marketing materials by the FDA's Division of Drug Marketing, Advertising and Communications ("DDMAC"). The

DDMAC determined that Janssen marketing materials were "false, misleading and/or lacking in fair balance" and in violation of the Food, Drug, and Cosmetic Act and its regulations. See Ex. G, Jan. 5, 1999 FDA Letter. The letter specifically states that:

> Materials that state or imply that Risperdal has superior safety or efficacy to other antipsychotics due to its receptor antagonist profile are false or misleading because the mechanism of action of Risperdal is unknown, as is the correlation of the specific receptor antagonism to the clinical effectiveness and safety of the drug.

Thus, even as Janssen and state employees benefiting from Janssen's funding were selling Risperdal to Texas and Pennsylvania as a superior anti-psychotic, the FDA was instructing Janssen to stop this marketing practice that the FDA had forbade from the beginning.

75. Janssen made direct payments of money to state officials for representing Janssen products. The remuneration was far in excess of "reasonable value" ($2,000 for a ½ day presentations) and was made to officials who were in a position to influence the state drug formulary.

76. Janssen funded travel and expenses for Commonwealth and other governments' employees to represent Janssen in the employee's official state capacities.

77. Janssen provided trips, entertainment, and meals directly to the persons who were in key positions to accept or reject Janssen's product in the state formulary.

78. Janssen selected speakers for "educational grant" funded symposiums and paid travel expenses and honorariums to these speakers.

79. Janssen influenced, to the point of control, the content and materials of presentations in which Janssen had provided "educational grant" funding. In particular, Janssen representatives delivered a Powerpoint presentation to a grant recipient

instructing that recipient to merely change the "look" (but not the content) of the material.

80. Janssen, through these symposiums and through direct contact with Pennsylvania officials, encouraged doctors to prescribe drugs in dosages that were not FDA approved.

81. Janssen, through these symposiums and through direct contact with Pennsylvania officials, encouraged doctors to prescribe medications for non-FDA approved or "off-label" indications.

82. Janssen conspired with Commonwealth employees to obtain data generated from the non-FDA approved activities.

83. These acts, along with others, caused Texas and Pennsylvania to adopt TMAP and its resulting false claims for "off-label" use.

The Pennsylvania OIG shuts down the investigation.

84. Relator Jones uncovered facts underlying this complaint while conducting an investigation for OIG. But once his investigation began to turn up payments by the defendant drug companies to state employees in Pennsylvania and Texas, Jones' supervisors shut down his investigation. After Jones discovered payments from drug companies through state accounts to state employees, Jones began to "follow the money."

85. Jones made a trip to Janssen headquarters in Titusville, NJ, to seek explanations for the payments made to state agencies and employees. "Janssen" representatives, an attorney and sales department representatives, presented Jones with business cards indicating that they worked for Johnson & Johnson. The day after his on-site interviews with these personnel, Jones's supervisor told him that the investigation

would not cover drug companies, and should focus on Fiorello, a fairly low-level state employee. Jones kept pressing to investigate the full scope of any wrongdoing. In retaliation, his supervisors removed him as lead investigator on the case and limited his access to case documents.

86. When Jones pressed for an explanation for the limited nature of the investigation and the retaliation he was facing, one of his managers told him that: **"Drug companies write checks to politicians — they write checks to politicians on both sides of the aisle."** Thus, Pennsylvania employees made it clear to Relator Jones that political pressures brought on by drug company influence prevented the OIG from doing its job and safeguarding taxpayer funds.

87. As a result of defendants' acts, Pennsylvania citizens and taxpayers are saddled with an expensive treatment model for the treatment of schizophrenics and other mentally ill persons who are in the care of the Commonwealth. This model is part of a large pharmaceutical marketing scheme designed to infiltrate public institutions and influence treatment practices. Pennsylvania is paying tens of millions of dollars for patented drugs that have no proven advantage over cheaper generic drugs.

88. The pharmaceutical industry has methodically compromised the political system at all levels and has systematically infiltrated the mental health service delivery system of this nation, via TMAP, its progeny, and now the NFC. The pervasive manipulation of clinical trials, the non-reporting of negative trials and the cover-up of debilitating and deadly side effects render meaningful informed consent impossible by persons being treated with these drugs.

COUNT I

FEDERAL FALSE CLAIMS ACT VIOLATIONS (31 U.S.C. §3729)

89. Relator re-alleges and incorporates the allegations in paragraphs 1-88 as if fully set forth herein.

90. Defendants each knowingly made or used false or fraudulent statements, or caused false or fraudulent statements to be made or used, for the purpose of obtaining or aiding in obtaining the payment or approval of false Medicaid claims by the United States, the State of Texas, and the Commonwealth of Pennsylvania.

91. Defendants submitted or caused to be submitted false or fraudulent claims to the the Medicaid program via the state prison and mental health programs for payment of services that were fraudulent because the prescriptions were "off label" and not subject to reimbursement. Further, defendants made false statements about the safety and efficacy of the drugs in order to persuade state officials to adopt algorithms requiring the prescription of the drugs.

92. By touting Risperdal as superior to other anti-psychotics, the defendants avoided price controls imposed by federal law. *See* 42 U.S.C. §1396r-8. Because the less expensive Typicals are capable of conferring the same benefit on Medicaid recipients for a much lesser amount, the state and federal governments would have achieved the same benefits for less money, had the defendants marketed their product within the parameters set by the FDA, as they believed the Atypicals to be more effective.

93. The United States made payment upon the false or fraudulent claims and was therefore damaged.

COUNT TWO

CONSPIRACY TO SUBMIT FALSE CLAIMS, 31 U.S.C. § 3729(A)(3)

94. Relator re-alleges and incorporates the allegations in paragraphs 1-88 as if fully set forth herein.

95. Defendants combined, conspired, and agreed together to defraud the United States by knowingly causing false claims to be submitted to the United States for the purpose of having those claims paid and ultimately profiting from those false claims. Defendants committed other overt acts set forth above in furtherance of that conspiracy, all in violation of 31 U.S.C. § 3729(a)(3), causing damage to the United States.

COUNT THREE

VIOLATION OF THE ANTI-KICKBACK STATUTE, 42 U.S.C. § 1320A-7

96. Relator re-alleges and incorporates the allegations in paragraphs 1-88 as if fully set forth herein.

97. Through an organized system of "speakers bureaus," consultant payments, honoraria, advisory board memberships, and other titles disguising payments intended to influence "scientific" findings and administrative decisions that resulted in wide scale prescription of and governmental reimbursement for Risperdal, the defendants established a system of kickbacks. The kickbacks took the form of honoraria, travel benefits, and other benefits.

98. These kickbacks had the effect of greatly increasing the amount of Risperdal prescriptions and consequently the amount of state and federal governmental money spent to cover the drug's costs. The payment of these kickbacks represents the inducement of federal payments through a pattern of fraudulent conduct, and constitutes a false claim within the meaning of 31 U.S.C. §3729.

COUNT FOUR

COMMON LAW FRAUD

99. Relator re-alleges and incorporates the allegations in paragraphs 1-88 as if fully set forth herein.

100. Defendants have engaged in a pattern and practice whereby they caused claims to be submitted when they knew or should have known that these claims were false, and intended to induce Medicaid to rely on them to pay for these "off-label" drug prescriptions.

101. The United States paid these false or fraudulent claims because of the acts of Defendants.

102. By reason of these payments, the United States has been damaged in an amount to be determined at trial exclusive of interest and costs.

COUNT FIVE

UNJUST ENRICHMENT

103. Relator re-alleges and incorporates the allegations in paragraphs 1-88 as if fully set forth herein.

104. Defendants' conduct has unjustly enriched them with monies which in good conscience they should not be allowed to retain.

105. Defendants have been unjustly enriched to the detriment of the United States.

106. By reason of the overpayments described above, the United States is entitled to damages in an amount to be determined at trial exclusive of interest and costs.

COUNT SIX

FRAUD IN THE INDUCEMENT

107. Relator re-alleges and incorporates the allegations in paragraphs 1-88 as if fully set forth herein.

108. Defendants made material, false representations to the government, namely that Atypical drugs were more effective than the cheaper Typicals. Defendants knew this representation was false or made it recklessly.

109. Defendants made the representation with the intent that the governments rely upon it. The State of Texas and the Commonwealth of Pennsylvania did in fact rely on this representation in adopting TMAP and PENNMAP respectively.

110. The representation cause injury to the government in the form of exponentially higher prescription drug costs.

PRAYER FOR RELIEF

WHEREFORE, Relator respectfully requests this Court to enter judgment against defendants, as follows:

(a) That the United States be awarded damages in the amount of three times the damages sustained by the United States because of the false claims and fraud alleged within this Complaint, as the Civil False Claims Act, 31 U.S.C. §§ 3729 *et seq.* provides;

(b) That civil penalties of $10,000 be imposed for each and every false claim that defendant presented to the United States;

(c) That pre- and post-judgment interest be awarded, along with reasonable attorneys' fees, costs, and expenses which the Relator necessarily incurred in bringing and pressing this case;

(d) That the Court grant permanent injunctive relief to prevent any recurrence of violations of the False Claims Act for which redress is sought in this Complaint;

(e) That the Relator be awarded the maximum percentage of any recovery allowed to him pursuant the False Claims Act, 31 U.S.C. §3730(d)(1),(2);

(f) For Counts Four, Five, and Six above, the United States seeks recovery of all damages it has sustained, in amounts to be determined at trial, together with such other and further relief to which it may show itself entitled; and

(h) That this Court award such other and further relief as it deems proper.

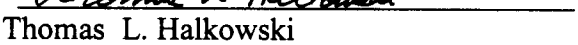
DEMAND FOR JURY TRIAL

Relator, on behalf of himself and the United States, demands a jury trial on all claims alleged herein.

Dated: March 25, 2004

Respectfully submitted,

FISH & RICHARDSON P.C.

By: 

Thomas L. Halkowski
PA Bar No. 88854
(Admitted to E. Dist. of PA
919 N. Market Street, Suite 1100
Wilmington, DE 19899-1114
(302) 652-5070 (Telephone)
(302) 652-0607 (Telecopy)

Thomas M. Melsheimer
Texas Bar No. 13922550
1717 Main Street, Suite 5000
Dallas, TX 75201
(214) 747-5070 (Telephone)
(214) 747-2091 (Telecopy

WATERS & KRAUS, LLP
C. Andrew Waters
Charles Siegel
George Tankard
Susan Hays
3219 McKinney Ave.
Dallas, TX 75204
(214) 357-6244 (Telephone)
(214) 871-2263 (Telecopy)

INDEX OF EXHIBITS

Melody Peterson, *Making Drugs, Shaping the Rules: Big Pharma is Eager to Help States Set Medication Guidelines,* New York Times at 3-10 (Feb. 1, 2004) ..... Ex. A

Sample TMAP Algorithm ..... Ex. B

Payment Records ..... Ex. C

CNS Check Request Form; related e-mail ..... Ex. D

A Study of Combination Antipsychotic Medication Usage (Fiorello presentation) ..... Ex. E

Mental Health Issues Today Newsletter, Vol. 6, No. 3 ..... Ex. F

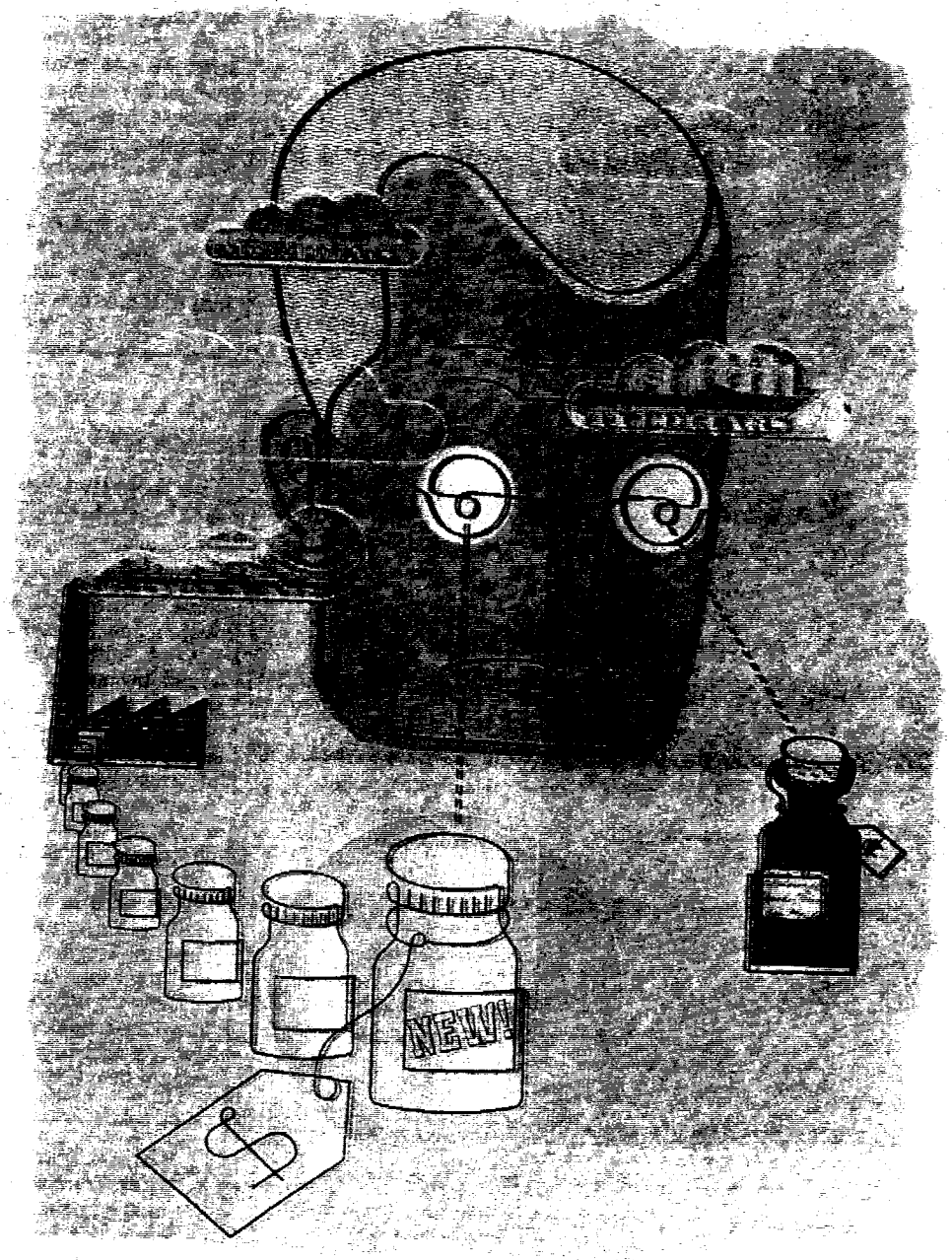
Jan. 5, 1999 FDA Letter ..... Ex. G

A

Making Drugs, Shaping the Rules

Big Pharma Is Eager To Help States Set Medication Guidelines

By MELODY PETERSEN



Otto Steninger

THE drug industry has created vast markets for products like Viagra, Celebrex and Vioxx by spending billions of dollars on consumer advertising.

But to sell medicines that treat schizophrenia, the companies focus on a much smaller group of customers: state officials who oversee treatment for many people with serious mental illness. Those patients — in mental hospitals, at mental health clinics and on Medicaid — make states among the largest buyers of antipsychotic drugs.

For Big Pharma, success in the halls of government has required a different set of marketing tactics. Since the mid-1990's, a group of drug companies, led by **Johnson & Johnson**, has campaigned to convince state officials that a new generation of drugs — with names like Risperdal, Zyprexa and Seroquel — is superior to older and much cheaper antipsychotics like Haldol. The campaign has led a dozen states to adopt guidelines for treating schizophrenia that make it hard for doctors to prescribe anything *but* the new drugs. That, in turn, has helped transform the new medicines into blockbusters.

Ten drug companies chipped in to help underwrite the initial effort by Texas state officials to develop the guidelines. Then, to spread the word, Johnson & Johnson, **Pfizer** and possibly other companies paid for meetings around the country at which officials from various states were urged to follow the lead of Texas, according to documents and interviews that are part of a lawsuit and an investigation in Pennsylvania.

How did this play out? In May 2001, as Pennsylvania was weighing whether to adopt the Texas guidelines, Janssen Pharmaceutica, a Johnson & Johnson subsidiary that sells Risperdal, paid $4,000 to fly two state mental health officials to New Orleans, where they dined at an elegant Creole restaurant in the French Quarter, visited the aquarium and met with company executives and Texas officials, according to documents. Janssen also paid two Pennsylvania officials $2,000 each for giving speeches at company-sponsored educational seminars for doctors and nurses working in the state's prisons.

The payments were discovered a little more than a year ago by Allen L. Jones, an

Continued on Page 10

Big Pharma Is Eager to Help States Set Drug Rules

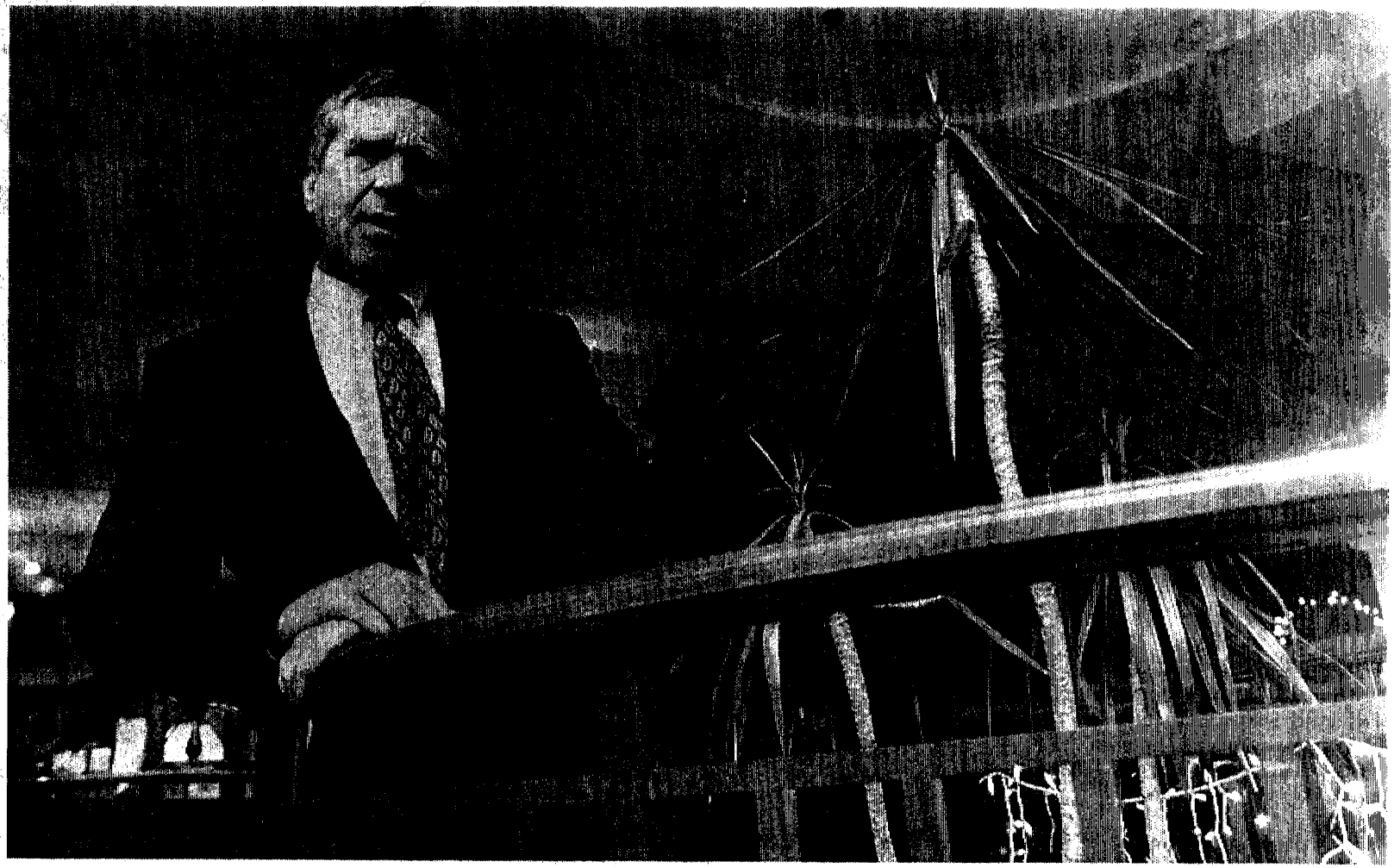
Continued From Page 1

investigator in the inspector general's office in Pennsylvania, who stumbled upon them when he was looking into why state officials had set up a bank account to collect grants from pharmaceutical companies.

With the help of his congressman in Pennsylvania, Mr. Jones, who is 49 and a former parole officer, brought the information to the attention of federal health officials — after, he says, his superiors removed him from the investigation, citing the political influence of the drug industry. The Department of Health and Human Services has asked the health care fraud unit of the Federal Bureau of Investigation to determine whether any laws were broken, according to letters Mr. Jones has received from federal officials.

DETAILS of the drug companies' efforts, recorded in Mr. Jones's investigative files and confirmed in part by drug companies and state officials, offer a glimpse inside the drug industry's behind-the-scenes efforts to promote the new-generation antipsychotics, called atypicals because their action in the body is unlike that of earlier drugs.

There is no proof that drug-industry money changed any state official's opinion about the drugs. And compared with the billions of dollars spent marketing to doctors from their first days as medical students — or the billions spent to underwrite and publish research — the dollar amounts are small.



Kalim A. Bhatti for The New York...

Allen L. Jones, an investigator in the inspector general's office in Pennsylvania, looked into drug company payments to two state officials.

But questions have multiplied about the many ways that the drug industry tries to influence the medical information that determines its products' success or failure. Last month, for example, some senators sharply criticized the National Institutes of Health for allowing its scientists to accept consulting fees and stock options from drug and biotechnology companies. Officials of the agency said that its top-level scientists were no longer accepting such compensation.

Sales of the new antipsychotics totaled $6.5 billion last year, according to an estimate by Richard T. Evans, an analyst at Sanford C. Bernstein & Company. About a third of those sales were to state Medicaid programs, whose costs have ballooned with their adoption of the new medications. Texas, for example, says it spends about $3,000 a year, on average, for each patient on the new drugs, versus the $250 it spent on older medications. The escalating costs have prompted a few states to try to limit access to the new antipsychotics — efforts that drug makers have opposed vigorously.

The Texas guidelines advise doctors to choose Risperdal or one of four other new antipsychotics — Zyprexa from **Eli Lilly**, Seroquel from **AstraZeneca**, Geodon from Pfizer or Abilify from **Bristol-Myers Squibb** — unless they can explain in writing why an older drug would be better. If a patient does poorly on the first medication, doctors at state hospitals and mental health clinics are advised to try another of the new drugs next. Texas officials said such guidelines were simply a road map for doctors, who can explain to the state on written forms why they are not prescribing a recommended drug.

The drug companies deny doing anything untoward. They say it was appropriate for them to help pay for the development of guidelines aimed at giving patients the best care. The ones for schizophrenia, they say, were written by medical experts and Texas officials without industry interference.

"Janssen did not participate in nor influence the content or the development of the guidelines," said Doug Arbesfeld, a spokesman for Janssen Pharmaceutica. Officials in some states asked the company for financial grants so that they could learn about the guidelines, he said.

Dr. Steven P. Shon, who as medical director of the Texas mental health department led the work on the guidelines, said the effort was not the drug companies' idea. Rather, he said, state officials decided that guidelines were needed because of the wide variations in prescriptions being written for patients.

Dr. Shon said that the condition of many patients had improved when their care followed the guidelines. Even without them, he added, doctors in Texas would have prescribed the new drugs. "Everyone wants to use the new thing," he said.

WHEN work on the Texas guidelines began in 1995, only two of the new-generation drugs were approved for sale: Risperdal and Clozaril, a medicine from **Novartis** that doctors were uncomfortable prescribing because of its known potential to cause a life-threatening blood disorder.

At the time, Janssen had little research on which to base its claims that Risperdal represented a medical advance. In fact, when federal regulators approved the drug, they forbade the company from claiming in marketing materials that it was better than the older drugs.

Now, doctors widely prefer the new medications, saying that the older drugs cause a higher incidence of side effects like stiffness, trembling and uncontrollable jerks that can stigmatize patients and prompt them to stop taking the drugs.

But some recent studies have complicated the picture for doctors by showing that the new medicines have potentially serious side effects, too, including the development of diabetes in some patients. On Tuesday, four medical groups, including the American Psychiatric Association, warned that the new drugs could increase a patient's risk of obesity, diabetes and high cholesterol — which can all lead to heart disease. Some leading experts on schizophrenia, after reviewing the accumulated scientific evidence, have developed a set of guidelines that clash with the Texas policy. These recommendations, produced entirely with federal government financing, say that physicians should not consistently choose the new drugs over the older medications.

"You choose the one that seems the best for the patient," said Dr. Anthony F. Lehman, the chairman of the psychiatry department at the University of Maryland School of Medicine. Dr. Lehman was the leader of the panel, called the Patient Outcomes Research Team, that put together the alternate guidelines under a grant from the National Institute of Mental Health. The guidelines are expected to be published this spring.

As early as 1999, physicians were raising questions about the drug industry's financing of the Texas guidelines. In an article that year in The Journal of Practical Psychiatry and Behavioral Health, Dr. Peter J. Weiden and Dr. Lisa Dixon argued that corporate financing created a potential conflict of interest that could hurt the project's credibility.

Dr. Weiden, professor of psychiatry at the State University of New York Downstate Medical Center in Brooklyn, said in an interview last month that he believes the new drugs have benefits over the older ones. But he continues to worry, he said, that the industry controls too much of what doctors learn in psychiatry. For example, Dr. Weiden said, industry-sponsored educational events focus on medications, while subjects like how to talk to patients to motivate them to get better fall through the cracks.

"The industry drives education right now," Dr. Weiden said. "Across the board, there has been a shifting of education toward psychopharma," meaning drug treatment.

Mr. Arbesfeld, the Janssen spokesman, said that the company disagreed with the recommendations of Dr. Lehman's panel. A growing body of evidence, Mr. Arbesfeld said, shows the benefits of the new drugs. He pointed to a 2002 study that found that patients treated with Risperdal had a lower risk of relapse than those treated with Haldol. He also noted that the National Institute for Clinical Excellence, part of the National Health Service of the British government, recommends the new drugs as a first-choice treatment for schizophrenia.

Other companies say it is important that they help educate doctors about the intricacies of their drugs. "There is no one who knows more about our products than we do," said Mariann Caprino, a spokeswoman for Pfizer. The company, like many others, gives financial grants for educational events but says that it is not involved in writing the instruction materials.

Industry financing of the Texas guidelines began in 1996, when Janssen agreed to help pay for a survey of dozens of experts about the best way to treat schizophrenia, according to the article by Dr. Weiden and Dr. Dixon.

Texas officials relied on the experts' conclusions to help them write the guidelines, which were first applied to patients in 1997. The initial ones called for doctors to use either Risperdal or one of the earlier generation of antipsychotics. Three years later, Janssen and five other companies helped underwrite an update of the consensus; Texas, in turn, used it in updating the guidelines. The 1999 version established a preference for the new drugs.

Dr. Shon said 11 drug companies had given Texas a total of $285,000 for the project. The effort produced guidelines for treating schizophrenia as well as for treating bipolar disorder and major depressive disorder in adults, and attention deficit hyper-

Marty Katz for The New York Times

Dr. Anthony F. Lehman, led a panel that wrote alternate guidelines for treating schizophrenia. The project had no financing from drug makers.

activity disorder and major depression in children.

In all, Texas has spent about $6 million on the guidelines and on educating doctors about how to use them, Dr. Shon said. In addition to the drug industry support, the state has received help from the federal government, universities and nonprofit foundations. The largest grant, $2.4 million, came from the Robert Wood Johnson Foundation, a leading backer of health care research, which was established by the estate of a longtime chief executive of Johnson & Johnson.

David J. Morse, a vice president of the foundation, said that it made the grant because one of its goals is to help find the best possible medical treatments. The foundation has about 50 percent of its financial assets invested in Johnson & Johnson stock, he said, and has former company executives on its board. But it is "completely independent" of Johnson & Johnson, Mr. Morse said.

IN May 2002, a manager in Pennsylvania's public health department reported to state investigators that mental health officials had created a bank account to collect grants from drug companies.

Mr. Jones said the inspector general's office soon dispatched him to look into the report. Pennsylvania's ethics law covering state workers bars them from accepting honorariums and gifts if they are made to influence officials' decisions; ethics officials say the ban can also extend to accepting reimbursements for travel in some cases. Violators can be punished by fines and criminal penalties.

Mr. Jones said he began to believe that drug companies were trying to buy the loyalty of state officials. "The more research I did, the more alarmed I became," he said in an interview.

As he reconstructed the flow of deposits into the account, he interviewed drug company executives and state officials. Pennsylvania mental health officials, he determined, were beginning to express interest in the Texas guidelines by October 2000. Janssen paid twice for Dr. Shon to fly to Pennsylvania, according to notes from an interview Mr. Jones conducted with Janssen executives in September 2002. Janssen made the grant covering Dr. Shon's travel expenses "to expand atypical usage," according to a company document that was given to Mr. Jones.

On April 17, 2002, Janssen paid for an educational seminar on the guidelines for doctors and nurses working in Pennsylvania's prisons. Each of the speakers — including Steven J. Fiorello, the top pharmacist in Pennsylvania's mental health office, and Dr. Frederick R. Maue, clinical services director of the state's Department of Corrections — was paid $2,000, according to Mr. Jones's interviews and documents he obtained. Comprehensive NeuroScience, a marketing company in White Plains working for Janssen, provided Mr. Fiorello with slides to use as a model for his talk, according to an e-mail message that Comprehensive NeuroScience sent to Mr. Fiorello. In the message, Comprehensive NeuroScience asked him to personalize the slides and then send them back for Janssen's review.

Sandra Forquer, vice president for educational services at Comprehensive NeuroScience, said in an interview that Mr. Fiorello had written his own speech. She also said that Mr. Fiorello had requested that his $2,000 payment be given to charity, but that her company sent it to him directly by mistake. According to Mr. Jones's interview notes, Mr. Fiorello described several instances in which drug companies gave him honorariums but said he was unsure about which ones he had kept and which ones he had given to charity.

Stephanie Suran, a spokeswoman for the Department of Public Welfare in Pennsylvania, said Mr. Fiorello was not available for comment. She said that she could not comment on Mr. Jones's findings because of a continuing investigation.

Mr. Jones's interview notes show that Ms. Forquer also told him that Janssen, through Comprehensive NeuroScience, paid Dr. Maue $2,000 for each of two other speeches, in Orlando, Fla., and Sacramento. A spokeswoman for Dr. Maue said that he had turned over any honorariums he received to the state; state officials confirmed that he had sent the money to the state's general fund.

But Mr. Jones learned that Janssen nurtured other ties to state officials. It named Dr. Steven J. Karp, medical director of Pennsylvania's mental health office, to the advisory board of a newsletter, Mental Health Issues Today, that a marketing firm created for Janssen. Janssen paid to fly Dr. Karp, as well as top officials from other states, to advisory board meetings in Seattle, Washington, D.C., and Tampa, Fla.

ACCORDING to Mr. Jones's interview notes, Dr. Karp said he eventually became uncomfortable about attending the meetings because a Janssen executive was always present. Ms. Suran, the spokeswoman for the Department of Public Welfare, said that Dr. Karp was not available for comment.

The records that Mr. Jones compiled in his investigation are now part of a lawsuit he filed against his supervisors in the Pennsylvania inspector general's office after they removed him from the inquiry. Mr. Jones said he did not know if the inspector general's office had investigated the matter further.

Mr. Jones contends in the lawsuit, which has been transferred to the United States District Court in Scranton, Pa., that his bosses violated his rights by trying to hide the evidence he found.

"I was told that drug companies write checks to politicians on both sides of the aisle," said Mr. Jones, who still works as an investigator in the inspector general's office.

W. Scott Foster, a spokesman for the inspector general's office, said that the office did not comment on lawsuits or its investigations. In court, lawyers for the state health officials have argued that the officials did nothing wrong and did not violate the rights of Mr. Jones.

Pennsylvania officials believe that the schizophrenia guidelines, adopted by the state in 2001, are saving money, Ms. Suran said. In the past, many doctors prescribed more than one drug for schizophrenia patients, the mental health office found. The guidelines, however, rarely allow multiple prescriptions. Preliminary data also show that the mental health of some patients has improved, Ms. Suran said.

Before he was pulled off the investigation, Mr. Jones said, he learned that Janssen was not the only drug company that had made payments to Pennsylvania officials involved in adopting the guidelines. According to Mr. Jones's interview notes, Mr. Fiorello said that Pfizer had paid twice for him to travel to its Manhattan headquarters from Harrisburg for meetings of "an elite group of pharmacists," put him up at one of the Millennium hotels in Manhattan and paid him an honorarium of less than $1,300 for each meeting.

According to the notes, Mr. Fiorello also told Mr. Jones that Pfizer had paid for him to travel with a Pfizer sales representative to Maryland to meet with a mental health official from that state and discuss Pennsylvania's use of the guidelines. Pfizer paid him an honorarium, he said, but he could not remember how much.

Ms. Caprino, the Pfizer spokeswoman, said the company finances development of treatment guidelines to ensure that patients get the best possible medications. The company, she said, plays no role in writing the guidelines. In addition, Ms. Caprino said, Pfizer often hires medical professionals as consultants and pays them for their time.

Pfizer cooperated with Pennsylvania officials as they investigated the payments, she said, and the officials later told the company that it had not acted inappropriately.

SOME payments went to patient groups instead of directly to state officials. In 2002, Janssen gave the Olympia, Wash., chapter of the National Alliance for the Mentally Ill a grant of $15,000 to fly Dr. Shon and other Texans to speak to Washington state legislators about the guidelines, according to Bill Pilkey, the chapter's former treasurer. Each speaker, he said, was paid $1,500.

Dr. Shon said that he gave the $1,500 to the Texas mental health department. In all, he said, he has traveled to more than a dozen states to talk about the guidelines, with most of the trips paid for by grants from either the Robert Wood Johnson Foundation or the federal government.

When he asked the drug industry to cover various expenses, Dr. Shon said, it was because of a lack of state money. "It was the only source of funding to complete or do all the things we wanted to do," he said.

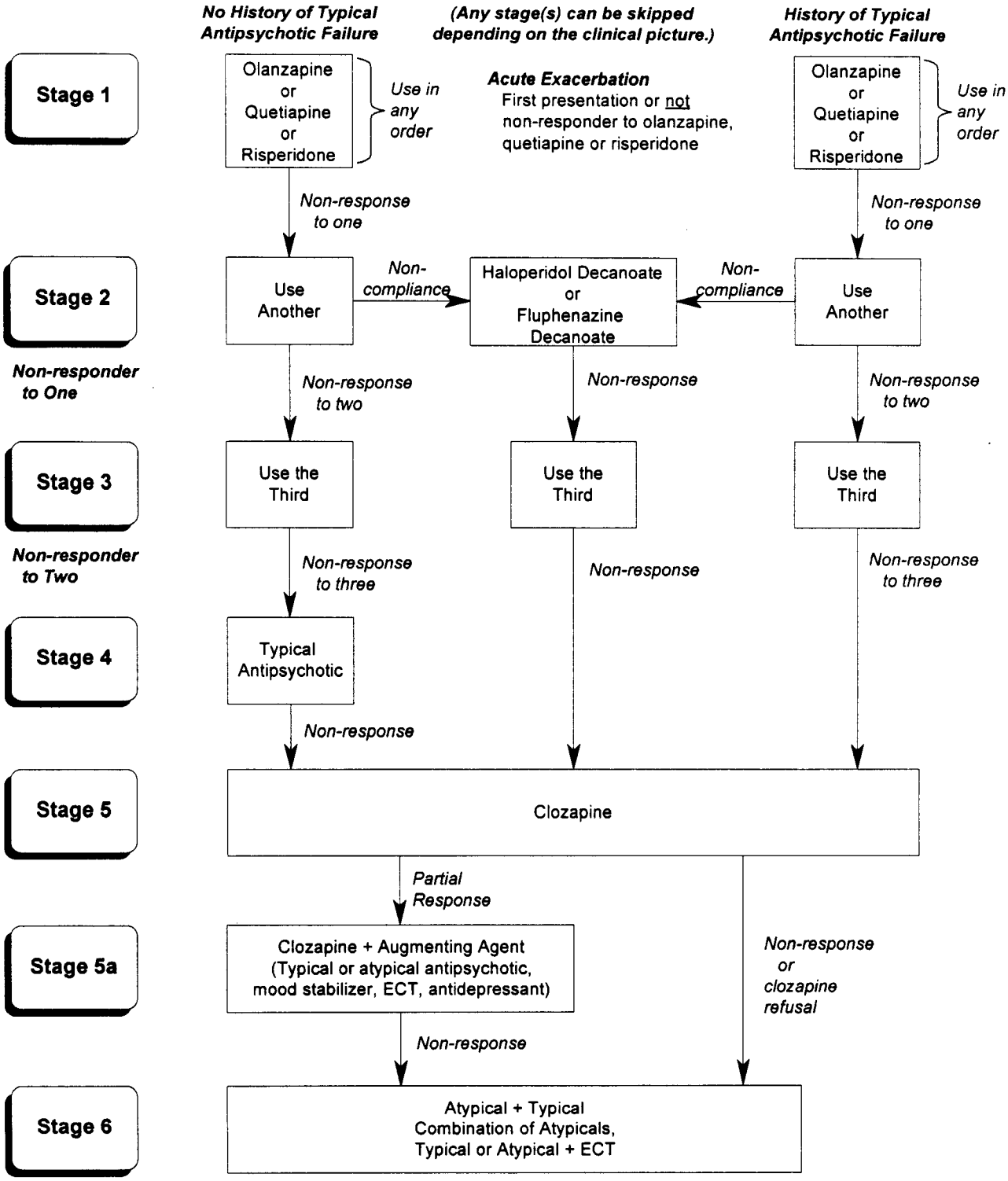
Dr. Shon said he was working with three more states —Alabama, Hawaii and Wyoming — to help them adopt the guidelines.

Referring to the effort to draw up state guidelines that began in 1995, he said, "None of us ever imagined it would grow into what it has become." □

B

❖ The Algorithms

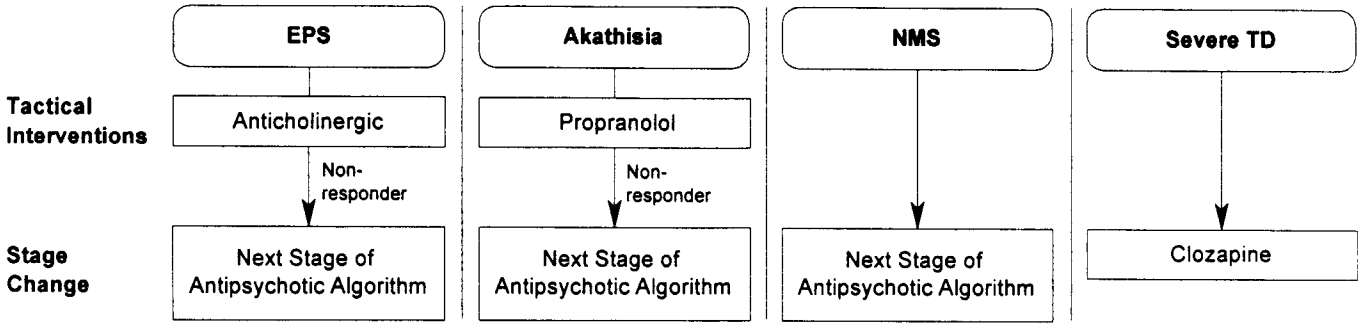
Antipsychotic Algorithm



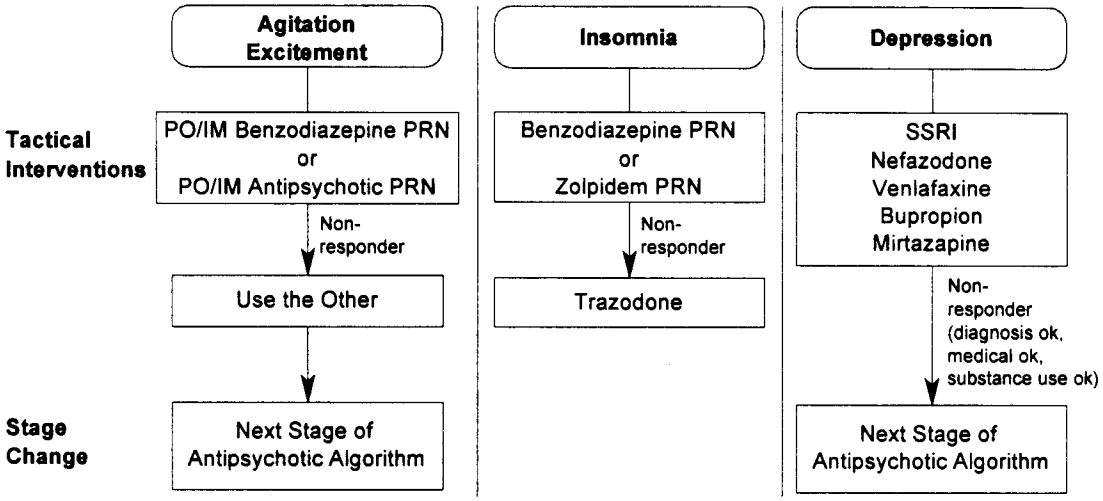
5/3/99

Side Effects and Co-existing Symptoms Algorithms

Side Effects Algorithms



Co-existing Symptoms Algorithms



C

Invoice No.	Date	Vcher	Att	Gross Amt	Discount	Net Amount	CHECK NUMBER	3375041
				Expenses 3/13-15/01/VALPREDA				
Q6315529	031901	H15529	Y	1,765.75		1,765.75		

Query? Call 877-557-4487 or write JANSSEN PHARMACEUTICA PRODUCTS, Box 16529, NEW BRUNSWICK NJ 08906
VENDOR#: 108790502 VENDOR: HARRISBURG STATE HOSP TOTAL: 1,765.75
Please Validate Tax Id # ==> EIN 23-2172299

TACH HERE

JANSSEN PHARMACEUTICA PROD, LP

Johnson & Johnson

SERVICES, INC.
AS PAYING AGENT

THE CHASE MANHATTAN BANK, N.A.
SYRACUSE, NEW YORK

CHECK NO: 3375041

50-937
213

PAYABLES CHECK

DATE	CHECK AMOUNT
03 22 01	$*******1,765.75

PAY EXACTLY: ONE THOUSAND SEVEN HUNDRED SIXTY FIVE AND 75/100 DOLLARS **********

TO THE ORDER OF: HARRISBURG STATE HOSPITAL
CAMERON & MACLAY STREETS
ATTN ACCOUNTING OFFICE
HARRISBURG PA 17105-1300

Johnson & Johnson

OCUMENT 8/03 Rev. 2

PUBLIC SECTOR & INSTITUTIONAL BUSINESS GRANT/FUNDING REQUEST FORM

FOR HOME OFFICE USE ONLY
REQ #: 6315529
CHECK #: 3375041

EDUCATION GRANTS Independent Education(CME) 97	RESEARCH GRANTS Drop Down Choice FREE GOODS/SERVICES Drop Down Choice ** Discuss with Manager	CONSULTING & SERVICES Drop Down Choice * T&E Form Enclosed
Market Segment: D/OMH	**RISPERDAL** ☒ **Check One** **REMINYL** ☐	
REASON FOR SUPPORT:	OMH TMAP initiative to expand atypical usage and drive Steve Shon's expenses	
DELIVERABLE:	Successful program with solid attendance and quality attendees. CNS follow-up with attendees .	

AMOUNT REQUESTED: 1765.75			EVENT DATE: March 13-15, 2001		
MAKE CHECK PAYABLE TO: Harrisburg State Hospital					
SEND CHECK TO THE ATTENTION OF: (Only use this if check is being sent directly to vendor)					
ADDRESS:			Cameron and Maclay streets		
			Harrisburg State Hospital		
CITY:	Harrisburg	STATE:	PA	ZIP	17105
SOCIAL SECURITY # OR FEDERAL TAX ID #			752-367-25		
501 (C)(3)	☐ YES ☑ NO				
TELEPHONE: 717-705-8331					

☐ SEND CHECK DIRECTLY TO THE VENDOR – Default check will go to requester
(No paperwork accompanies the check – will the vender know what this is for?)

- ☒ **CUSTOMER SUPPORT REQUEST ENCLOSED**
- ☒ **APPROPRIATE HEALTH CARE COMPLIANCE CHECKLIST ENCLOSED**
- ☒ **APPROPRIATE HEALTH CARE CUSTOMER AGREEMENT ENCLOSED**
- ☒ **IF REQUIRED, DETAILED BUDGET ENCLOSED**
- ☐ **CHARITABLE ORGANIZATION SUPPORT REQUEST ENCLOSED (e.g., NAMI, NMHA)**

REQUESTING MANAGER/DIRECTOR: Laurie Snyder	DATE SUBMITTED: March 8, 2001
AUTHORIZATION: Yolanda Roman	DATE APPROVED: 3/8/01
AUTHORIZATION SIGNATURE:	DATE ENTERED INTO PACT:
SID FRANK/PACT SIGNATURE:	DATE APPROVED: 3/22/01

JANSSEN • PHARMACEUTICA • • RESEARCH FOUNDATION •

Educational Grant
Letter of Agreement

Between Janssen Pharmaceutica Products, L.P., 1125 Trenton-Harbourton Road, Titusville, New Jersey 08560 ("JANSEN") and **Harrisburg State Hospital**

Title of Program

Promoting Best Practice for Schizophrenia Treatment

Date, Location & Time of Program: March 13, 14, and 15, 2001 10:30-2:30pm
Mayview, Norristown and Harrisburg State Hospital respectively

Institution has requested support for the above-named Program in the form of an educational grant in the amount of $ 1765.75 . It is the intent of this Agreement to ensure that the Program is conducted in a manner consistent with the Food and Drug Administration's Policy Statement on Industry Supported Scientific and Educational Activities, AMA Guidelines on Gifts to Physicians, and the Accreditation Counsel for Continuing Medical Education (ACCME)

To that end, Institution and JANSSEN agree as follows:

1. **Statement of Purpose**: The Program is for scientific and educational purposes only and is not intended to promote a JANSSEN product directly or indirectly.

2. **Control of Content & Selection of Presenters & Moderators:** Institution is responsible for control of content and selection of presenters and moderators. JANSSEN agrees not to direct the content of the program. JANSSEN, or its agents, may provide suggestions of presenters or sources of possible presenters. JANSSEN may suggest more than one name (if possible) and provide speaker qualifications.

3. **Disclosure of Financial Relationships**: Institution will ensure meaningful disclosure to the audience, at the time of the Program of (a) JANSSEN funding and (b) any significant relationship between the Institution and JANSSEN (e.g. grant recipient) or between individual speakers or moderators and JANSSEN.

4. **Involvement in Content**: There will be no "scripting," emphasis, or direction of content by JANSSEN or its agents.

5. **Ancillary Promotional Activities**: No promotional activities will be permitted in the same room or obligate path as the Program. No product advertisement will be permitted in the Program room.

6. **Objectivity & Balance**: Institution will make every effort to ensure that data regarding JANSSEN's products (or competing products) are objectively selected and presented, with favorable and unfavorable information and balance discussion of prevailing information on the product(s) and/or alternative treatments.

7. **Limitations on Data**: Institution will ensure, to the extent possible, meaningful disclosure of limitations of data, e.g. ongoing research, interim analyses, preliminary data, or unsupported opinion.

8. **Discussion of Unapproved Uses**: Institution will require that presenters disclose when a product is not approved in the United States for the use under discussion.

9. **Opportunities for Debate**: Institution will ensure meaningful opportunities for questioning or scientific debate.

10. No party shall use the other party's or its affiliate's name or trademarks for publicity or advertising purposes without the prior written consent of the other party.

11. Payment will be directed as follows:

Payee: Harrisburg State Hospital

In Care Of: Steve Fiorello, RPh

Address Harrisburg State Hospital
Cameron and Maclay Streets
Harrisburg PA 17105

Tax ID. # 752-367-25

THIS AGREEMENT IS NOT EFFECTIVE AND NO GRANT MONIES SHALL BE PAID UNTIL SIGNED BY AN AUTHORIZED REPRESENTATIVE OF JANSSEN AND Institution.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the last of the respective dates below.

Institution:

Name (Print) Steve Fiorello, Rph
Signature [signature]
Title OMHSAS Pharmacy Director
Date: March 1, 2001

JANSSEN:

Name (Print) Laurie P. Snyder
Signature [signature]
Title PHS&R Manager
Date: March 1, 2001

```
TRC                              Check Requisition                  15:48:59 03/19/01
     req # 6315529                    model req #                Status PY MGR WAIT
 user index RIS GRANTS                                             Date 03/19/01
+ Commodity 00990001  CHECK REQ ONLY,GRANTS,HONORARI
Description Expenses 3/13-15/01      (Description will appear on the check stub)
    comment OMH TMAP initiative to expand atypical usage and drive Steve
            Shon's expenses.

   Subtotal 1,765.75                 freight                    tax
  Total Amt 1,765.75       + currency code USD     + tax code E  + send check to R
    Pay to: + supp pay pt 108790502      + alt supv
       name HARRISBURG STATE HOSPITAL                          phone 999-555-1212
    address CAMERON & MACLAY STREETS                           tax id 23-2172299
            ATTN ACCOUNTING OFFICE
     + city HARRISBURG                          St PA      + zip code 17105 1300
postal zone                  district       + country US     certified? N
                                                          domestic wire? N
 originator RUTH          M VALPREDA                  609-730-2120 JP10 A22101
+ Bus Unit 174P      + franchise                    d/l              Dept 40000
       Acct 613006                               subcode M3111       ref LS

EZGL026I Send request initiated
F1=Help      F2=View      F3=Exit      F4=Prompt    F5=AcctDist  F6=Index
             F8=WireData  F9=Send      F10=RptPay   F11=InvcReq  F12=Cancel
```

Invoice No.	Date	Vcher	Att	Gross Amt	Discount	Net Amount
				Harrisburg ST Hospi/VALPREDA		
Q6337434	051001	H37434	Y	4,000.00		4,000.00

CHECK NUMBER: 3430202

Query? Call 877-557-4487 or write JANSSEN PHARMACEUTICA PRODUCTS, Box 16529, NEW BRUNSWICK NJ 08906
VENDOR#: 108790503 VENDOR: HARRISBURG STATE HOSP TOTAL: 4,000.00
Please Validate Tax Id # ==> EIN 23-6003113

DETACH HERE

JANSSEN PHARMACEUTICA PROD. LP
Johnson & Johnson
SERVICES, INC.
AS PAYING AGENT

THE CHASE MANHATTAN BANK, N.A.
SYRACUSE, NEW YORK

CHECK NO: 3430202 50-937/213

[redacted]

PAYABLES CHECK

DATE	CHECK AMOUNT
05 14 01	$*****4,000.00

PAY EXACTLY: FOUR THOUSAND AND NO/100 DOLLARS *****

TO THE ORDER OF: HARRISBURG STATE HOSPITAL
CAMERON & MACLAY STREETS
HARRISBURG PA 17105-1300

Johnson & Johnson.

CRC Check Requisition 10:25:38 05/10/01

req # 6337434 model req # Status PY MGR WAIT

user index RIS GRANTS Date 05/10/01

+ Commodity 00990001 CHECK REQ ONLY,GRANTS,HONORARI

Description Harrisburg ST Hospit (Description will appear on the check stub)

comment PA OMH to meet with TIMA group. Sepcifically Dr. Trevedi to assist on implementation of algorithm

Subtotal 4,000.00 freight tax

Total Amt 4,000.00 + currency code USD + tax code E + send check to R

Pay to: + supp pay pt + alt supv

name HARRISBURG STATE HOSPITAL phone 717-705-8331

address CAMERON & MACLAY STREETS tax id 23-6003113

+ city HARRISBURG St PA + zip code 17120

postal zone district + country US certified? N

domestic wire? N

originator RUTH M VALPREDA 609-730-2120 JP10 A22101

+ Bus Unit 174P + franchise d/l Dept 40000

Acct 613006 subcode M3111 ref LS

EZGL026I Send request initiated

F1=Help F2=View F3=Exit F4=Prompt F5=AcctDist F6=Index

F8=WireData F9=Send F10=RptPay F11=InvcReq F12=Cancel

PUBLIC SECTOR & INSTITUTIONAL BUSINESS GRANT/FUNDING REQUEST FORM

FOR HOME OFFICE USE ONLY

REQ #: 6337434

CHECK #: 3430202

EDUCATION GRANTS Customer Sponsored (Non CME) 97	RESEARCH GRANTS Drop Down Choice FREE GOODS/SERVICES Drop Down Choice ** Discuss with Manager	CONSULTING & SERVICES Drop Down Choice * T&E Form Enclosed

Market Segment: D/OMH	**RISPERDAL** ☒ **Check One** **REMINYL** ☐
REASON FOR SUPPORT:	Pennsylvania OMH to meet with TIMA group. Specifically Dr. Trevedi to assist on implementation of algorithm
DELIVERABLE:	Successful implementation of PennMap

AMOUNT REQUESTED: $4000.00			EVENT DATE: May 8, 2001		
MAKE CHECK PAYABLE TO: Harrisburg State Hospital					
SEND CHECK TO THE ATTENTION OF: (Only use this if check is being sent directly to vendor)			Steve Fiorello, Rph		
ADDRESS:			Harrisburg State Hospital Cameron and MacClay Streets		
CITY:	Harrisburg	STATE:	PA	ZIP	17120
SOCIAL SECURITY # OR FEDERAL TAX ID #			236003113		
501 (C)(3)	☐ YES ☒ NO				
TELEPHONE: 717-705-8331					

☐ SEND CHECK DIRECTLY TO THE VENDOR – Default check will go to requester
(No paperwork accompanies the check – will the vender know what this is for?)

☒ **CUSTOMER SUPPORT REQUEST ENCLOSED**
☒ **APPROPRIATE HEALTH CARE COMPLIANCE CHECKLIST ENCLOSED**
☒ **APPROPRIATE HEALTH CARE CUSTOMER AGREEMENT ENCLOSED**
☒ **IF REQUIRED, DETAILED BUDGET ENCLOSED**
☐ **CHARITABLE ORGANIZATION SUPPORT REQUEST ENCLOSED (e.g., NAMI, NMHA)**

REQUESTING MANAGER/DIRECTOR: Laurie Snyder	DATE SUBMITTED: April 18, 2001
AUTHORIZATION: Yolanda Roman	DATE APPROVED: 5/3/01
AUTHORIZATION SIGNATURE:	DATE ENTERED INTO PACT:
SID FRANK/PACT SIGNATURE:	DATE APPROVED: 5/11/01

Provider / Patient Education Materials

EDUCATIONAL GRANT

Checklist

To meet Janssen Health Care Compliance guidelines, a program must meet all of the following criteria:

	Criteria Met
Grant will be used to develop provider or patient educational material and not To subsidize customer's ordinary business overhead.	☑
Janssen will receive the rights to use educational materials developed with Janssen's funds.	☑
Amount of grant will be limited to items specifically identified in the customer's Budget and consistent with fair market value of those items.	☑
Support is unrelated to Janssen product commitments.	☑
Customer is not financially committed to providing this service under an existing capitated agreement.	☑
Written agreement used to document terms of the Grant.	☑

Describe Deliverable: Successful TIMA implementation for Penn Map

Tracking Procedure: __Measurement of State Hospital data via Power play

Internal Sponsor-Name:__Laurie P. Snyder_____ Signature: Laurie Snyder
(or Sales Representative)

Department: _PHS&R__ Date:__4/19/2001_____

Final Approval – Name:_____ Signature:_____

Department: _____ Date:_____

JANSSEN • PHARMACEUTICA • • RESEARCH FOUNDATION •

Educational Grant
Letter of Agreement

Between Janssen Pharmaceutica Products, L.P., 1125 Trenton-Harbourton Road, Titusville, New Jersey 08560 ("JANSEN") and **Harrisburg State Hospital**

Title of Program ___Implementation Strategies for TMAP.

Date, Location & Time of Program May6 and 8 6-8 pm. New Orleans

Institution has requested support for the above-named Program in the form of an educational grant in the amount of $ 4000.00 . It is the intent of this Agreement to ensure that the Program is conducted in a manner consistent with the Food and Drug Administration's Policy Statement on Industry Supported Scientific and Educational Activities, AMA Guidelines on Gifts to Physicians, and the Accreditation Counsel for Continuing Medical Education (ACCME)

To that end, Institution and JANSSEN agree as follows:

1. **Statement of Purpose:** The Program is for scientific and educational purposes only and is not intended to promote a JANSSEN product directly or indirectly.

2. **Control of Content & Selection of Presenters & Moderators:** Institution is responsible for control of content and selection of presenters and moderators. JANSSEN agrees not to direct the content of the program. JANSSEN, or its agents, may provide suggestions of presenters or sources of possible presenters. JANSSEN may suggest more than one name (if possible) and provide speaker qualifications.

3. **Disclosure of Financial Relationships:** Institution will ensure meaningful disclosure to the audience, at the time of the Program of (a) JANSSEN funding and (b) any significant relationship between the Institution and JANSSEN (e.g. grant recipient) or between individual speakers or moderators and JANSSEN.

4. **Involvement in Content:** There will be no "scripting," emphasis, or direction of content by JANSSEN or its agents.

5. **Ancillary Promotional Activities:** No promotional activities will be permitted in the same room or obligate path as the Program. No product advertisement will be permitted in the Program room.

6. **Objectivity & Balance:** Institution will make every effort to ensure that data regarding JANSSEN's products (or competing products) are objectively selected and presented, with favorable and unfavorable information and balance discussion of prevailing information on the product(s) and/or alternative treatments.

7. **Limitations on Data:** Institution will ensure, to the extent possible, meaningful disclosure of limitations of data, e.g. ongoing research, interim analyses, preliminary data, or unsupported opinion.

8. **Discussion of Unapproved Uses:** Institution will require that presenters disclose when a product is not approved in the United States for the use under discussion.

9. **Opportunities for Debate:** Institution will ensure meaningful opportunities for questioning or scientific debate.

10. No party shall use the other party's or its affiliate's name or trademarks for publicity or advertising purposes without the prior written consent of the other party.

11. Payment will be directed as follows:

Payee: **Harrisburg State Hospital**

In Care Of: **Steve Fiorello, Rph**

Address **Harrisburg State Hospital**

Cameron and McClay Streets, Harrisburg PA 17120

Tax ID. # **2360031131**

THIS AGREEMENT IS NOT EFFECTIVE AND NO GRANT MONIES SHALL BE PAID UNTIL SIGNED BY AN AUTHORIZED REPRESENTATIVE OF JANSSEN AND Institution.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the last of the respective dates below.

Institution:

Name (Print) Steve Fiorello, RPh
Signature Steven J. Fiorello RPh, MS
Title OMH SAS Planning Director
Date: April 9, 2001

JANSSEN:

Name (Print) Laurie Snyder
Signature Laurie Snyder
Title Manager, Public Health Systems
Date: April 9, 2001

D

Check Request Form

CNS

○ White Plains - CNS ○ Maryland - CNS ○ D.C. - CBR

DATE: 4/4/02

Vendor Information:

Name: Stephen Florello

Street: 1113 Darlene Avenue
(Only if New Vendor)

City: Harrisburg

State: PA Zip: 17015

Approvals:

Requested By: C. Butler 17-Apr
Date Needed

Accounting Approval: / /
Date

Administrative Approval: / /
Date

Expenditure Information:

Protocol: (If applicable)

Date(s) of Visit(s): (If applicable)

Invoice Sponsor ☐ Check if reimbursable from sponsor

Purpose of Expenditure:

Janssen 02 Schizophrenia Faculty Honoraria $2000 per meeting

Hershey, PA +$2000 706-5413-83

Total Expenditure per Category:	Amount ($)	Accounting Use Only: G/L Account
Study Related:		
Hospital		500
Physician		5204
Testing		5206
Patient Transportation		5103
Patient Payments		5102
Other		
Non-Study Related:		
Furniture		1706
Computer Hardware		1702
Computer Software		1700
Office Supplies		690
Other		
	$2,000.00 Total	

COMPREHENSIVE NEUROSCIENCE, INC.

7678

DATE	INVOICE NO	COMMENT	AMOUNT	DISCOUNT	NET AMOUNT
04/04/2002	4/4/02	Jans Honoraria meeting	2,000.00	0.00	2,000.00

CHECK 007678	06/14/2002	Stephen Fiorello	CHECK TOTAL:	2,000.00

61N328 (2/02) 172971

Sandra Forquer

From: Ann Boughtin [aboughtin@comcast.net]
Sent: Monday, August 12, 2002 12:25 PM
To: Forquer Sandy
Subject: Fw: Slides for April 17

PEAFOR~1.PPT

This was my confirming e-mail to him. If you need something more, please let me know.

----- Original Message -----
From: "Ann Boughtin" <aboughtin@comcast.net>
To: <sfiorello@state.pa.us>
Cc: <Sforquer@cnsclinicaltrials.com>; "Chantel Butler (E-mail)" <cbutler@cnsclinicaltrials.com>
Sent: Tuesday, March 19, 2002 4:35 PM
Subject: Slides for April 17

Dear Dr. Fiorello: I left you a voicemail earlier today, and thought I would follow up with an e-mail. Things are well underway for the upcoming symposia for the state Dept. of Corrections. As one of the presenters for the April 17 meeting in Hershey, that is led by Dr. Maue, we will need copies of your slides in advance of the session. Would you please send:

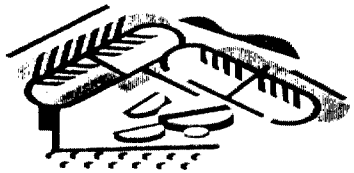
CV's: Please send your CV and bio for CE/CME purposes this week me. You can send it via e-mail or fax it to 615-771-0408.
Slides (Powerpoint) I have attached the slides that were used for last year's Janssen symposia series to use as a model for this year. We would like to make sure that this year's slides are similar in format and use the same color and design scheme. At each session we will discuss issues that are of interest to clinicians working with the special populations in the correctional system. This year, however, we are asking that each of you personalize your own slides relative to the session you are presenting. Please have your personalized set of slides (please send a maximum of 20-25 slides) back to me by March 21st. We will return any feedback CNS & Janssen might have on your slides to you by March 25 with final revisions due back to me from you by March 28.

Chantel Bulter (cbutler@cnsclinicaltrials) is handling administrative issues and she will send you copies of all communications, e.g. invitations, etc.
Please call me at 615-771-0908, if you have any questions. Thank you.

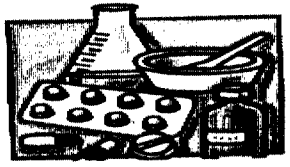
E

A Study of Combination Antipsychotic Medication Usage

Antipsychotic Combinations or 'Polypharmacy' at one Pennsylvania State Hospital



+



Combination Antipsychotic DUE

***In April 2000, 105 of 300 patients in HSH on a multiple anti-psychotic drug regimen.**

***41 of these 105 were on a combination of an atypical wi a low potency typical**

***These 41 were chosen for intensive chart reviews in July 2000**

***27 chart reviews were completed**

(14 patients were discharged or the medications were discontinued at the time of the reviews)

Combination Antipsychotic DUE

***In April 2000, 105 of 300 patients in HSH on a multiple anti-psychotic drug regimen.**

***41 of these 105 were on a combination of an atypical with a low potency typical**

***These 41 were chosen for intensive chart reviews in July 2000**

***27 chart reviews were completed**

(14 patients were discharged or the medications were discontinued at the time of the reviews)

WORKSHEET
COMBINATION ANTIPSYCHOTIC DUR

Patient _____ DOB _____ Med Rec # _____
Date of Review _____ Reviewer_____
Antipsychotic Medications: _____ _____
(typicals & atypicals) _____ _____

Patient is in drug therapy transition: (doses not stable>30 days) NO____ YES____-Drop from study
Note_____

Justification for each Antipsychotic drug Exists. NO____ YES____
Note_____

Patient had a 6-8 week Trial of an Atypical as monotherapy NO____ YES____
Note_____

Patient exhibits Sedation. NO____ YES____
Note_____

Patient participates in >70% of activities NO____ YES____
Note_____

Patient has a history of Aggression or agitation NO____ YES____
Note_____

COMMENTS:

DUE Chart Review Results:

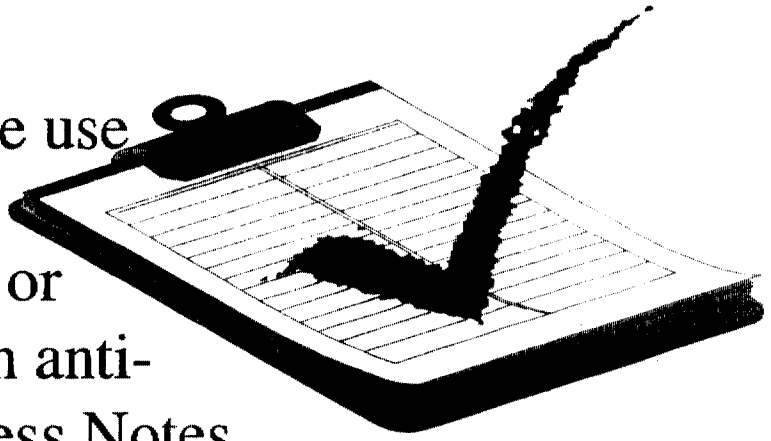
* Only 41% had an adequate atypical monotherapy trial

*Justification: *none, weak,* or *strong*

none = no documentation

weak = any note mentioning the use of each antipsyhcotic

strong=a documented rational or clinical reason for each anti-psychotic in the Progress Notes



Findings:

93% had no or weak justification;
only 7% has strong justification for combination therapy.

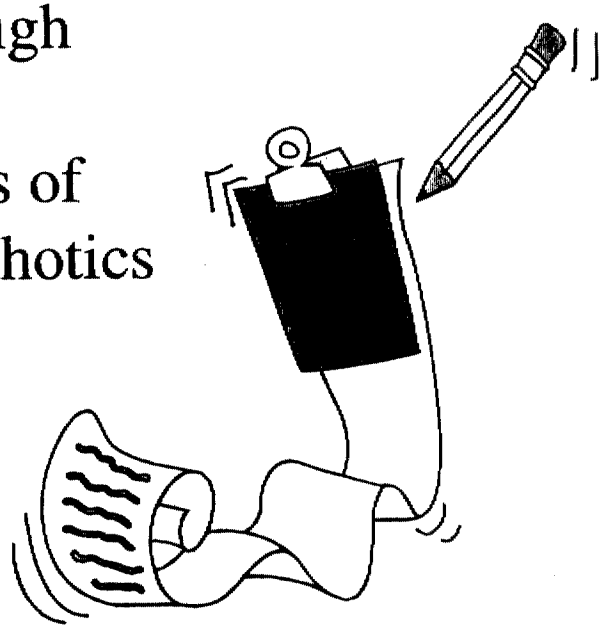
CONCLUSIONS:

*Use of Combination Therapy is too high

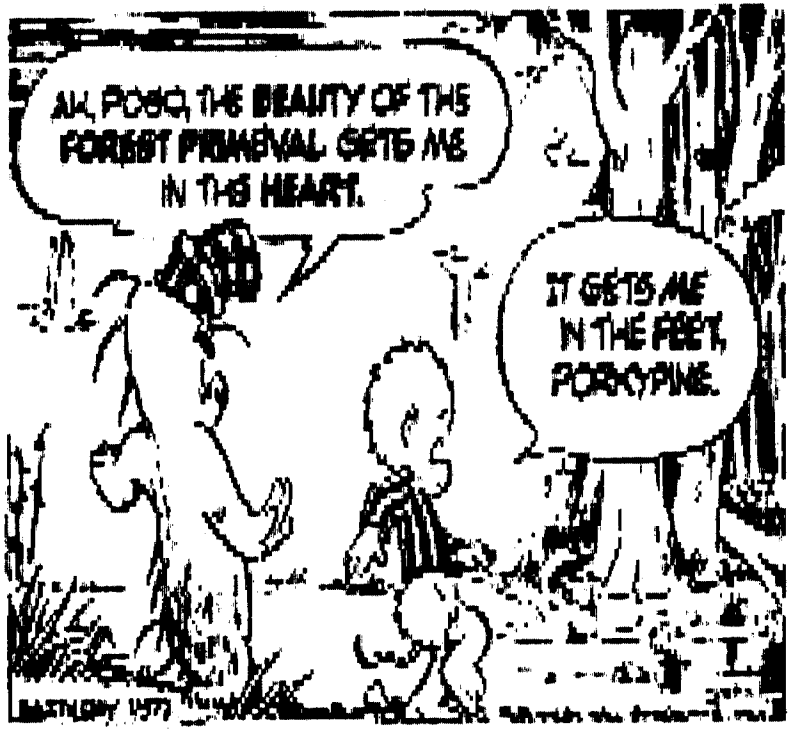
*Patients are not getting adequate trials of monotherapy with atypical antipsychotics

*Cross-tapering often leads to "psychopharmacology purgatory"

*There is a need for a more structured approach to treatment with antipsychotic medications.

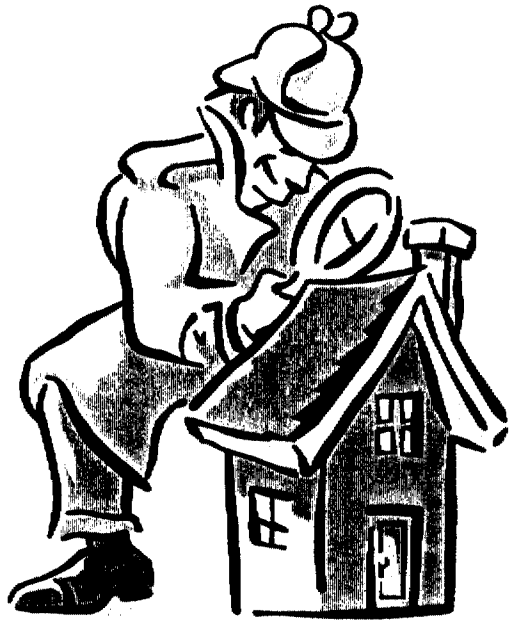


TMAPS can provide that approach.



Combination Therapy Study

Discussion



"These Are but Shadows of the Things That Have Been," Said the Ghost.

A Christmas Carol
Charles Dickens

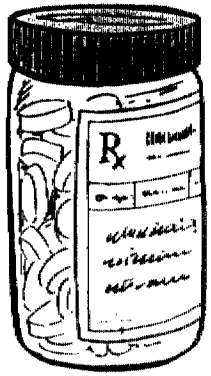
"Trifluoperazine has been prescribed with chlorpromazine in the treatment of patients who fail to respond to one or the other drug alone, where motor activity is desirable, or as a means of avoiding the toxic effects of high dosages of either drug when given alone"

Kolb
***Modern Clinical Psychiatry* (1973)**

"No combination of phenothiazines is more effective than Thorazine alone. Polypharmacy, with the possible exception of perphenazine-amitriptyline, is no more effective than a single drug, but can lead to more side effects, errors in taking medication, and problems in dose adjustment in case of toxicity or change in clinical state."

"The Fourth Psychoactive Usage Guide"
Appleton
Journal of Clinical Psychiatry

Polypharmacy



The use of two or more medications to treat the same condition, the use of two or more drugs of the same chemical class, or the use of two or more drugs with the same or similar pharmacological actions to treat different conditions.

Kingsbury, et al. Psychiatric Services 52:1033-37 (2001)

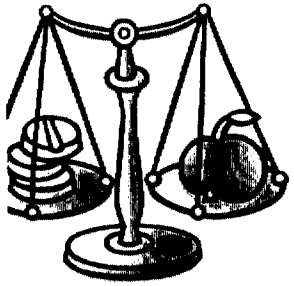
Rational v. Irrational Polypharmacy

and

Justifiable v. Unjustifiable Polypharmacy

Rational Polypharmacy

The use of a combination of medications to treat a condition or conditions that has a reasonable explanation based on the pharmacological actions of the medications and is supported by medical research or literature.

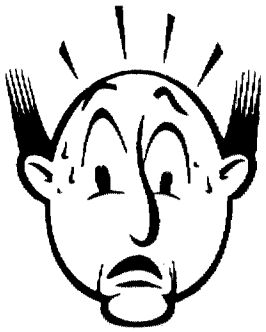


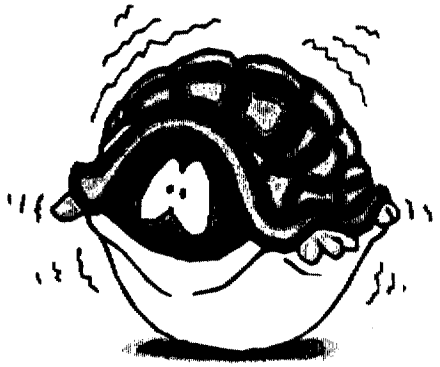
Justifiable Polypharmacy

The use of combinations of medications based on the
he clinical needs and response of the patient and a
reatment history that includes failure of response to
se of fewer medications despite adequate dose and
duration.

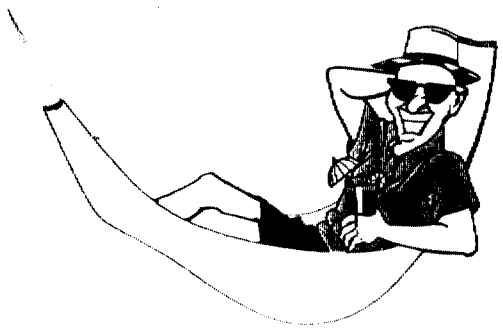
Causes of Polypharmacy

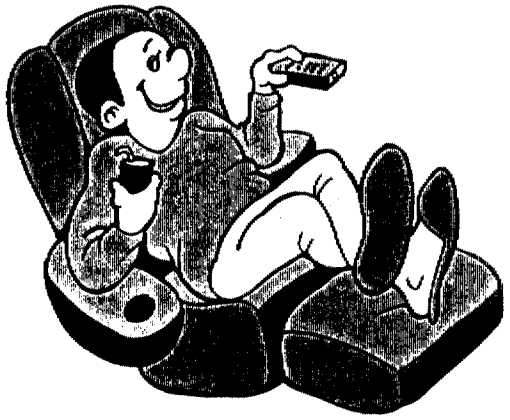
Irrational and Unjustifiable

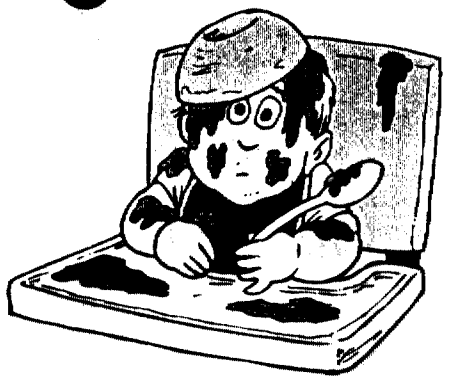




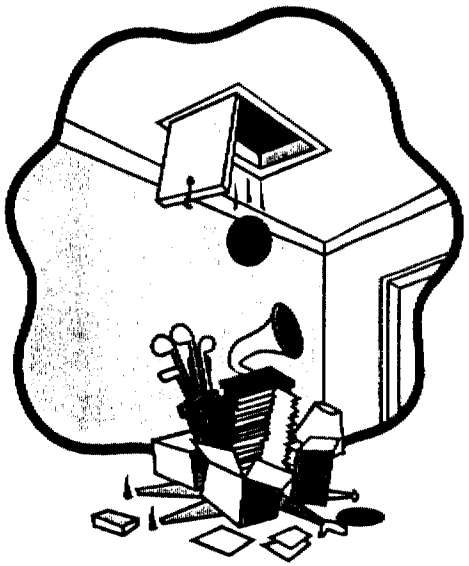
➢ Fear and Laziness

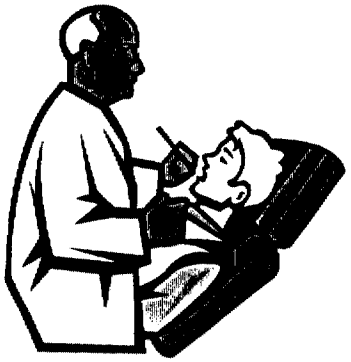






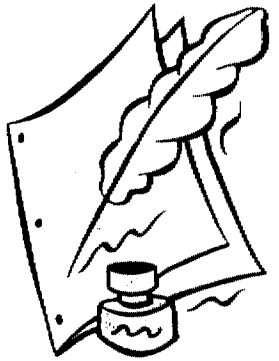
➢ Sloppy Diagnosis



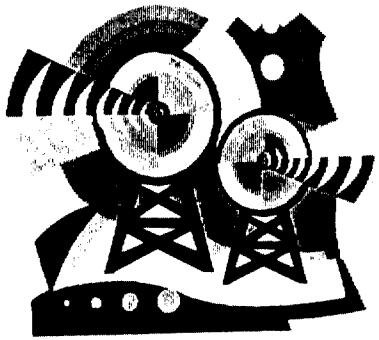


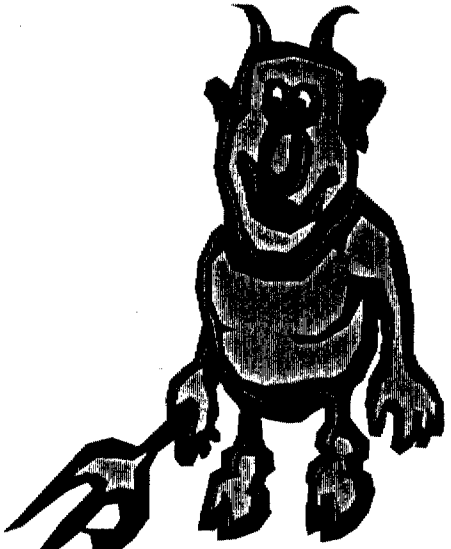
Osler's Rule: No matter how much you push and squeeze, give that patient one diease!

Poor Documentation

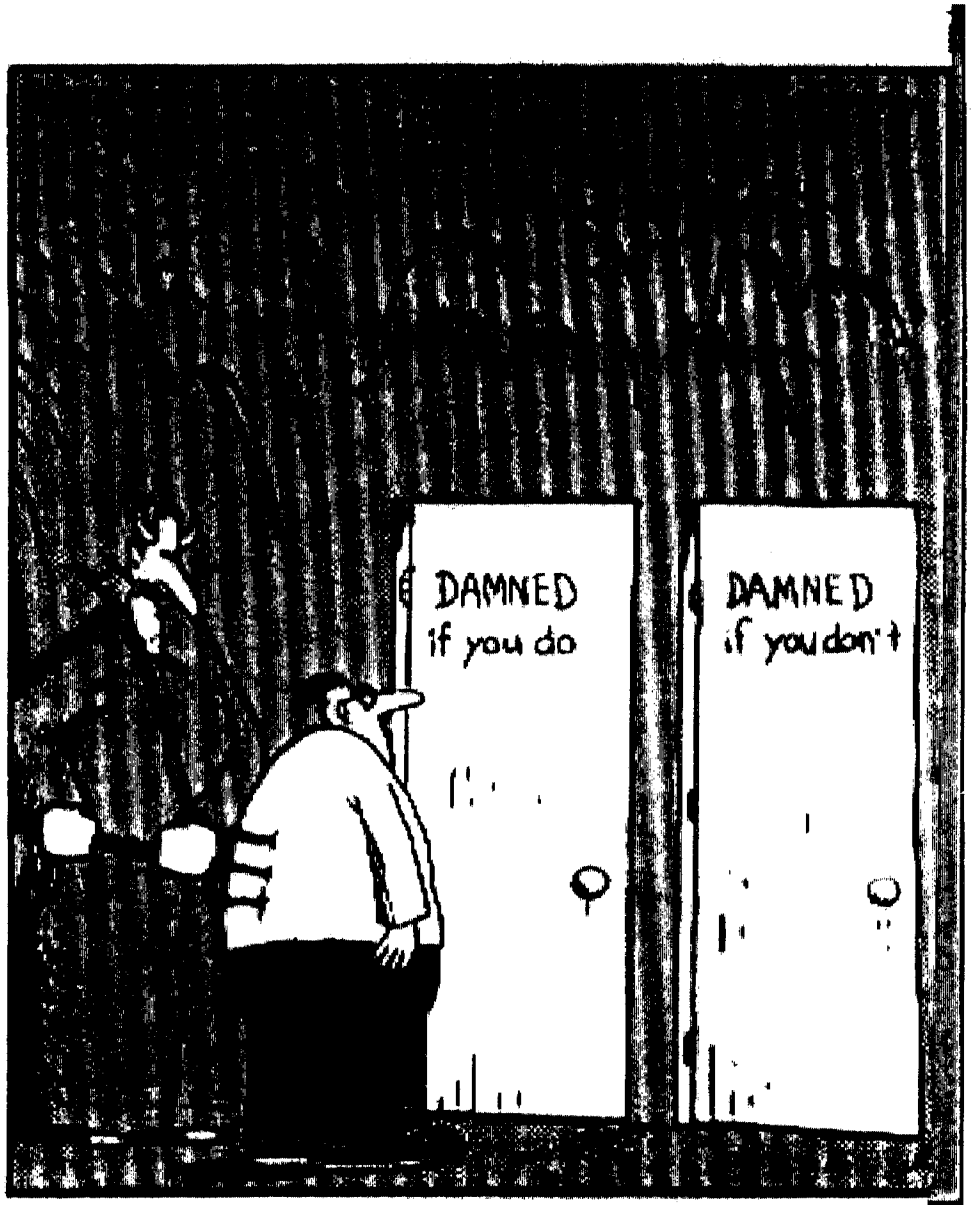


➢ Poor Communication



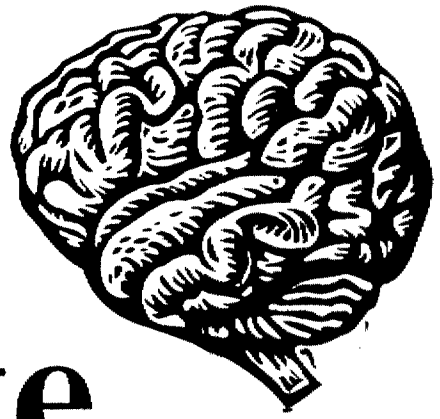


Transitional Purgatory

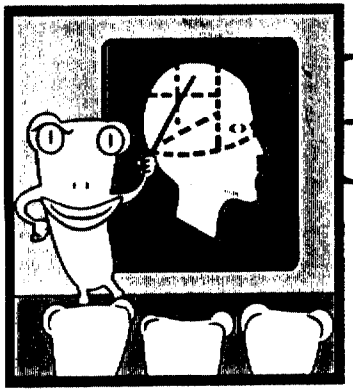


"C'mon, c'mon—it's either one or the other."

➢ Blind Adherence to PDR Dose Limits



Inadequate Knowledge of Receptor Pharmacology

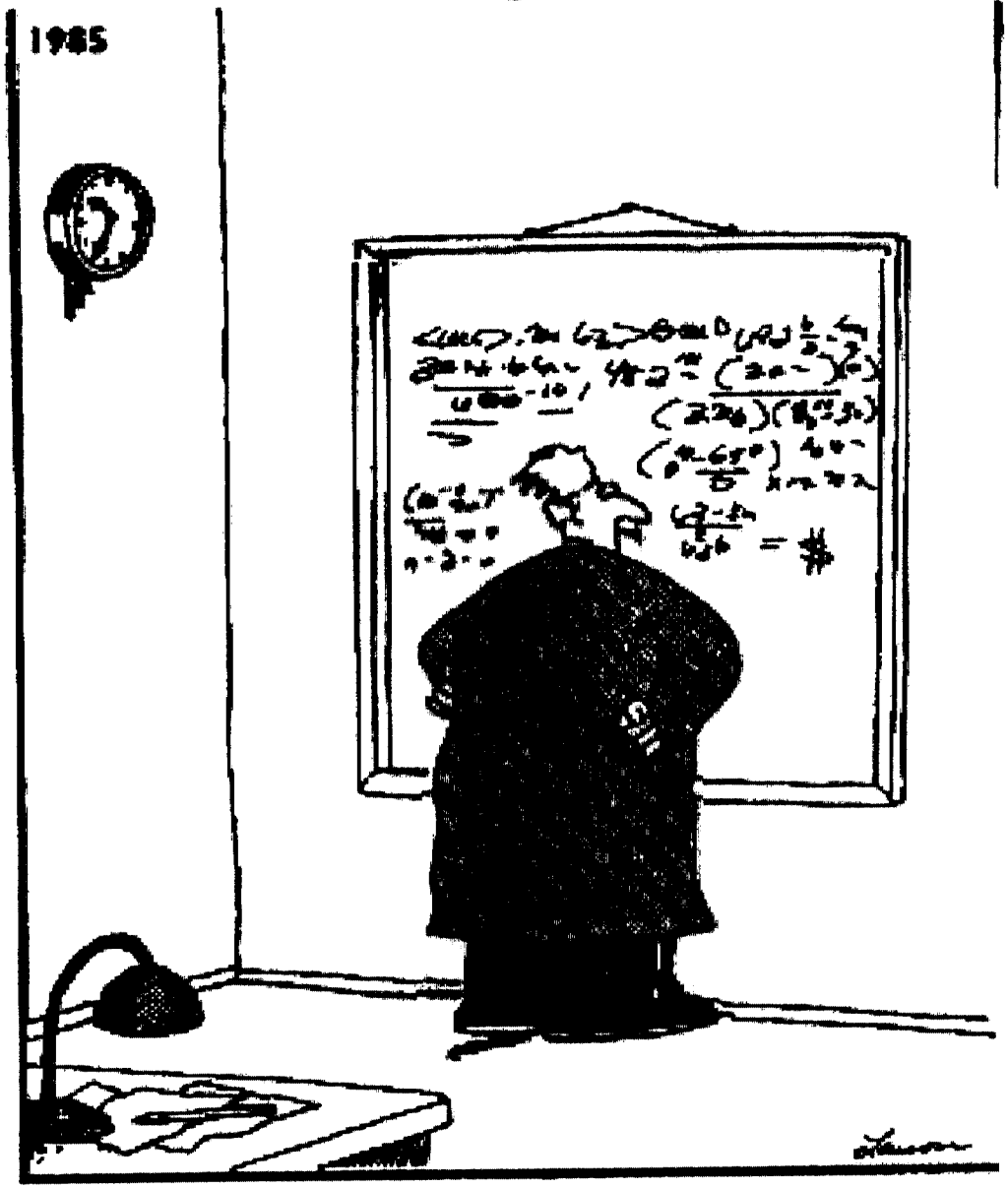


Need to Rush

- Busy Clinics/Hospitals

- Impatience

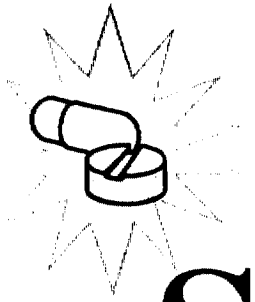
- Insurance/Managed Care



Einstein discovers that time is actually money.

Lunchtime Lecturer

➢ Magical Thinking

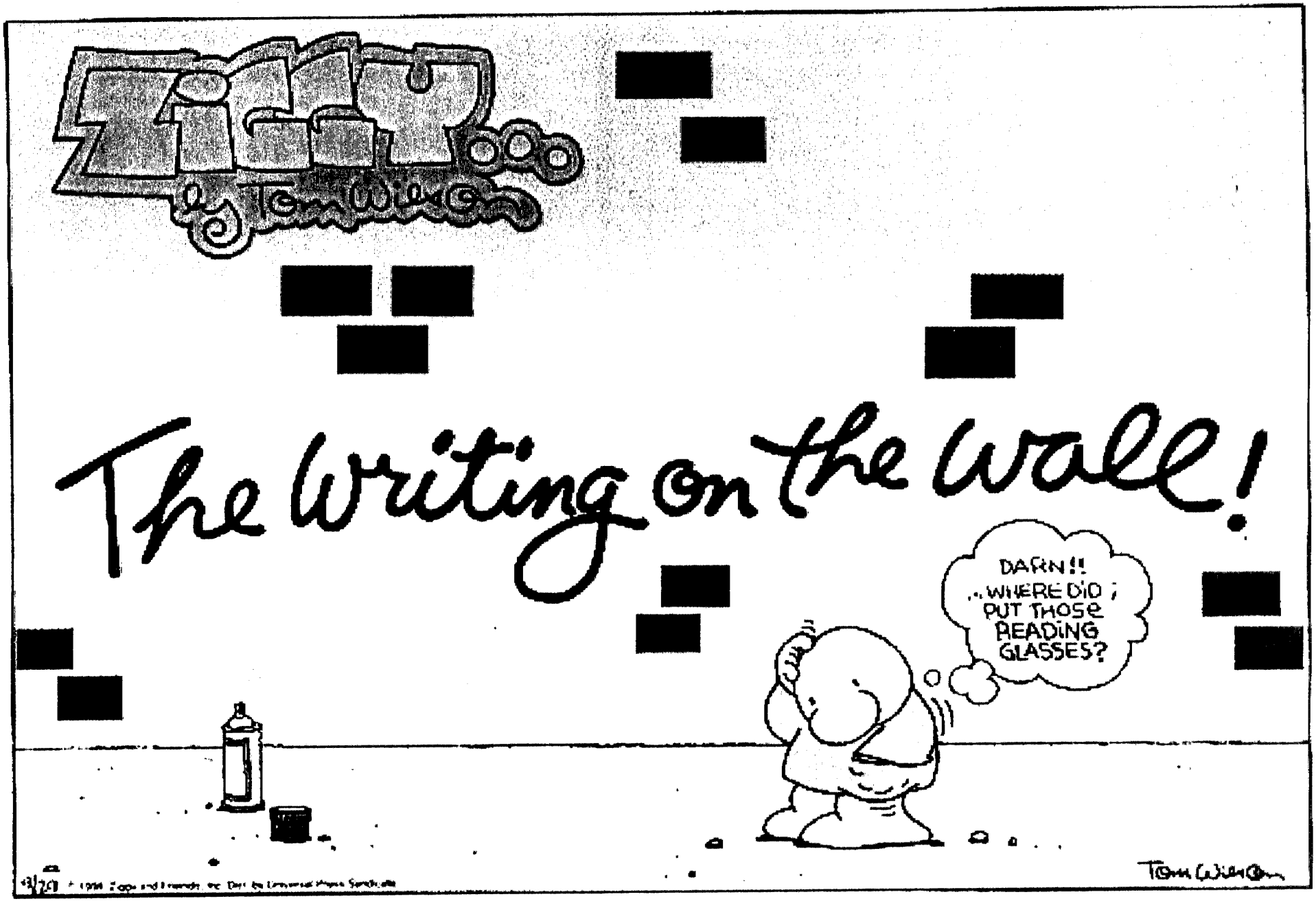


Substance Abuse: Drug Seeking Behavior

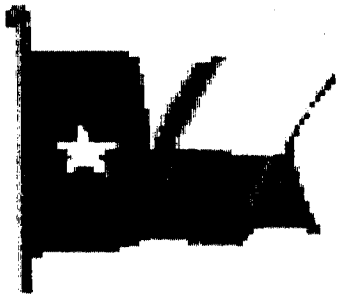
	Irrational	Rational
Unjustifiable	- -	- +
Justifiable	+ -	+ +

Less than half of the patients under Treatment for schizophrenia... are receiving proper doses of antipsychotic medications or appropriate psychosocial interventions.

NIMH Schizophrenia Bulletin 1998


Ziggy
by Tom Wilson
The writing on the wall!
DARN!! ..WHERE DID I PUT THOSE READING GLASSES?
TOM WILSON

Texas



Medication

Algorithm

Projects for

Schizophrenia

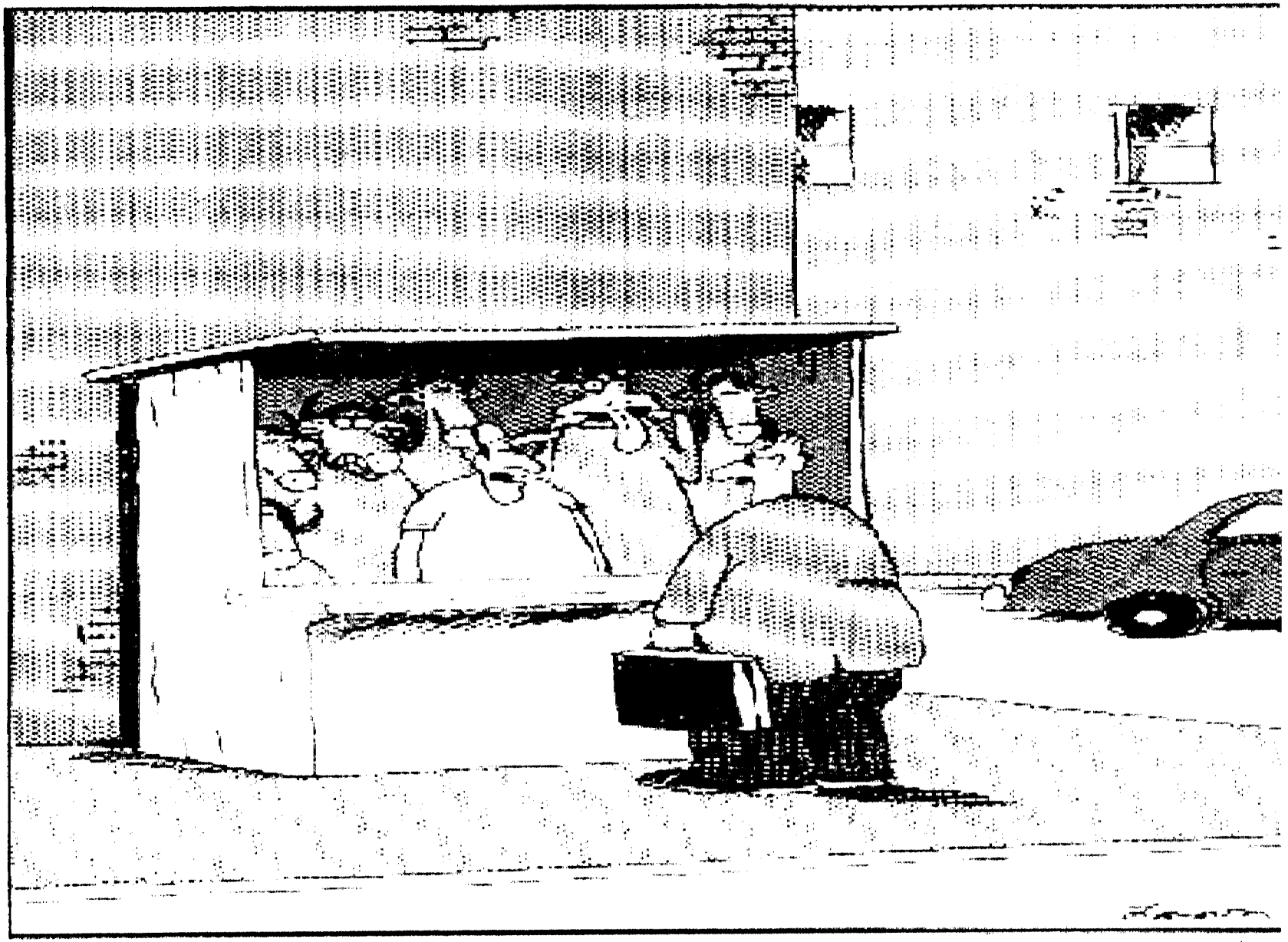
Penn

M

A

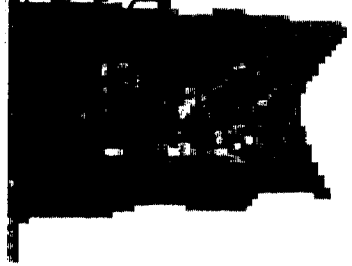
P

S



"Well, I've got good gnus and I've got bad gnus."

PENNSYLVANIA MEDICATION ALGORITHM PROJECT FOR SCHIZOPHRENIA (PennMAPS)

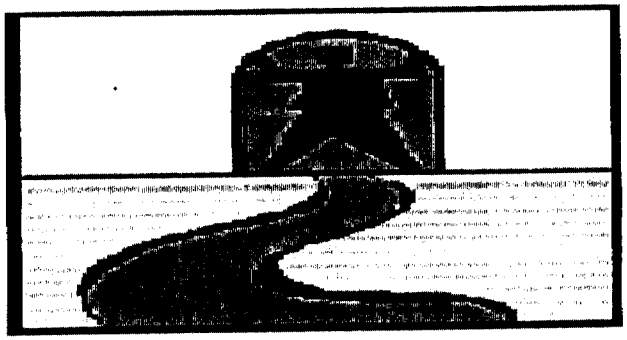


Developed from the

TEXAS MEDICATION ALGORITHM PROJECT FOR SCHIZOPHRENIA (TMAPS)

Websters Definition:

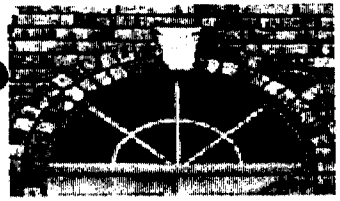
ALGORITHM:
A step-by-step procedure for solving a problem or accomplishing some end



PennMAPS is more than an algorithm—it encompasses all aspects of the treatment of Schizophrenia:

- ✓ Assessment
- ✓ Treatment planning
- ✓ Outcome measurement
- ✓ Patient education
- ✓ Family education
- ✓ Documentation
- ✓ Communication of information.

PennMAPS at-a-Glance

Algorithm: the **Keysto**  of Treatment

Weekly Assessment & Evaluation: Includes an 8 Point Rating Scale

Duration of Treatment: At lease 3 weeks at *therapeutic* doses
with new antipsychotic (3 mos with clozapine)

Response: Stages 1-4, positive symptom score < or = 6
negative symptom score < or = 12

Criteria for Medication Change: Defined in the manual

Medication Switching: taper over 1-3 weeks (or longer)
while titrating the 'new' medication

PennMAPS Forms

Clinical Inpatient Record
Progress Note

Final Version

Date and Time of Exam: _____

Patient seen and chart reviewed.
For: Medication _____
Progress Note _____

Level of Service ☐ Low ☐ Medium ☐ High
Duration_____

1. *SUBJECTIVE FINDINGS: (from Patient)*

Appetite:
☐ Normal ☐ Poor
☐ Good ☐ Overeating
☐ Fair

Sleep:
☐ Normal ☐ Poor
☐ Good
☐ Fair

Side Effects:
☐ None ☐ Involuntary Movements ☐ Appetite
☐ Tremors ☐ GI ☐ Sedation
☐ Akathisia ☐ Sexual ☐ Other: _____

Medication Efficacy:
☐ Excellent ☐ Poor
☐ Good ☐ Minimal
☐ Fair

Comments: _____

2. *OBJECTIVE FINDINGS:*

Orientation:
☐ Person
☐ Place
☐ Time
☐ Situation

Rapport:
☐ Appropriate
☐ Hostile
☐ Evasive
☐ Distant
☐ Inattentive
☐ Poor Eye Contact

Appearance:
☐ Appropriately Dressed
☐ Appropriately Groomed
☐ Poorly Dressed
☐ Poorly Groomed
☐ Dishevelled
☐ Body Odor

Mood:
☐ Euthymic
☐ Depressed
☐ Anxious
☐ Angry
☐ Irritable
☐ Elated

Affect:
☐ Appropriate
☐ Depressed
☐ Expansive
☐ Blunted
☐ Flat
☐ Labile

Speech:
☐ Coherent
☐ Appropriate
☐ Incoherent
☐ Loose Associations
☐ Circumstantial
☐ Tangential
☐ Poverty
☐ Pressured
☐ Loud
☐ Soft
☐ Preservation
☐ Clanging
☐ Word Salad
☐ Mute

Thought Content & Process:
☐ Appropriate
☐ Goal Directed
☐ Delusional
☐ Persecution
☐ Reference
☐ Thought Insertion
☐ Broadcasting
☐ Grandiose
☐ Obsessions
☐ Compulsions
☐ Phobias
☐ Suicidal Ideation
☐ Suicidal Plan
☐ Homicidal Ideation
☐ Homicidal Plan
☐ Hopelessness
☐ Worthlessness
☐ Loneliness
☐ Guilt
☐ Self Depreciation
☐ Hallucinations
Describe Hallucinations Below
___ Auditory ___ Visual ___ Command

Insight:
☐ Excellent
☐ Good
☐ Fair
☐ Poor
☐ Grossly Impaired

Judgement:
☐ Excellent
☐ Good
☐ Fair
☐ Poor
☐ Grossly Impaired

Cognitive:
☐ No Gross Cognitive Deficits
☐ Concentration Problems
☐ Concrete
☐ Abstract
☐ Easily Distracted

Psychomotor Activity:
☐ Normal
☐ Restless
☐ Retardation

Memory:

	Good	Fair	Impaired
Immediate	☐	☐	☐
Recent	☐	☐	☐
Past	☐	☐	☐

Pertinent Lab Data
_____
_____
_____

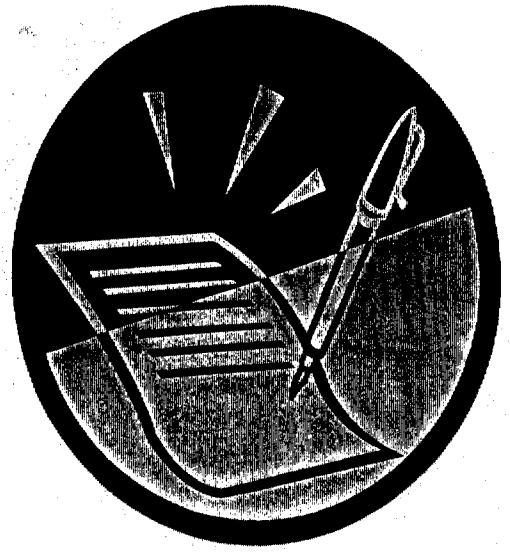
Comments:

3. *ASSESSMENTS:*

Psychiatric condition is generally: ☐ Improving ☐ Unchanged ☐ Deteriorating

_____
_____
_____

DIAGNOSIS: Unchanged _____



PennMAPS Clinical Inpatient Record
Progress Note

COMPLETE THIS SECTION IF PATIENT IS AN ALGORITHM CLIENT

Stage: _____ **Weeks in this stage:** _____

Patient Education Completed? ☐ Yes ☐ No

Primary Current Dx:(Check one) ☐ SCZ ☐ SCZ-A(BP) ☐ SCZ-A Other (specify) _____

Vital Signs: BP___/___ **Pulse**_____ **Temperature**_____ **Weight** _____

Use for all physician's ratings below: (0-10) 0 = No symptoms 5=Moderate 10=Extreme Leave blank if they do not app

Core Symptoms: ___ Mania ___ Depression ___ Positive Sx of Positive Psychosis ___ Ne

Other Symptoms: ___ Irritability ___ Mood Lability ___ Insomnia ___ Agitation ___ An
___ Appetite ___ Level of Interest ___ Energy Level ___ Other _____

Psychotropic Medication Information

Medication Name Document any new or discontinued medications or dosage changed of established medications.		Dosing Information Please provide information on titration, dose, dose frequency, duration the medication is to be start and stop date *(if applicable)* and any other pertinent information describing this medicat
☐ New ☐ Change ☐ D/C		
☐ New ☐ Change ☐ D/C		
☐ New ☐ Change ☐ D/C		
☐ New ☐ Change ☐ D/C		
☐ New ☐ Change ☐ D/C		
☐ New ☐ Change ☐ D/C		
☐ New ☐ Change ☐ D/C		

☐ **Medication unchanged from before**

S=Meds Targeted at core syndrome OS=Meds targeted at other symptoms SE=Meds for side effects of S or SO

Deviation from medication algorithm recommended? ☐ Yes ☐ No (If yes, check all that apply)

☐ Patient previously failed next step ☐ Next step not acceptable ☐ Next step not available at this site
☐ Next step not medically safe for this patient ☐ No options left ☐ Other _____

Reason for Medication Choice: ☐ SE Profile ☐ Pattern of Associated SX ☐ Past Response
☐ Other _____

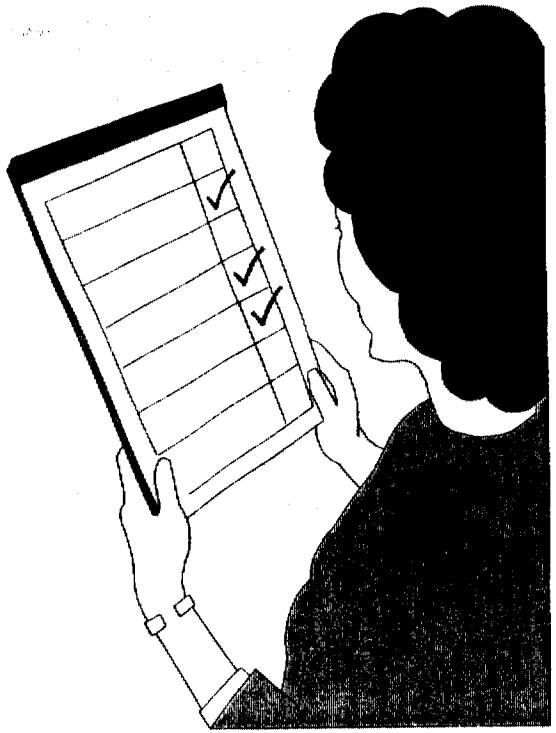
Patient Global Self Report (0-10) 0=No symptoms 5=Moderate 10=Extreme

Symptoms Severity: _____ **Side Effects:** _____

Clinical Rating Scales

Depressive Scale _____ POS SX _____ NEG SX _____ Other _____

Physician Signature _____ Date _____



ALLENTOWN STATE HOSPITAL

PennMAPS Score Sheet

Addressograph

BRIEF POSITIVE AND NEGATIVE SYMPTOMS RATING SCALE

Patient's Name _____ **Hospital #** _____

Attending Psychiatrist _____

4-Item Positive Symptoms Rating Scale:

Week of:								
A. Suspiciousness: Does it seem as though others are watching you? Or trying to hurt you... Specify: _____ _____								
1 (not present)	1	1	1	1	1	1	1	1
2 (very mild -pt. seems on guard)	2	2	2	2	2	2	2	2
3 (mild -occasional or no preoccupation)	3	3	3	3	3	3	3	3
4 (moderate - incident<1 per week, some preoccupation)	4	4	4	4	4	4	4	4
5 (moderately severe - >1episodes per week)	5	5	5	5	5	5	5	6
6 (severe - delusional most of the time)	6	6	6	6	6	6	6	6
7 (extremely severe - tends to act on beliefs)	7	7	7	7	7	7	7	7
B. Unusual Thought Content: Do you feel that people are messing with your mind? Like controlling or reading your mind, putting thoughts into your head or stealing your thoughts? Do you feel that you have special power or talent which makes you different than others? Specify:_____ _____								
1 (not present)	1	1	1	1	1	1	1	1
2 (very mild - some doubt)	2	2	2	2	2	2	2	2
3 (mild - same as 2 but more severe, without full conviction)	3	3	3	3	3	3	3	3
4 (moderate - delusion present, without functional impairment)	4	4	4	4	4	4	4	4
5 (moderately severe - full delusions with some dysfunctions)	5	5	5	5	5	5	5	5
6 (severe - full delusions, with many dysfunctions in multiple areas)	6	6	6	6	6	6	6	6
7 (extremely severe - total preoccupation and acting out	7	7	7	7	7	7	7	7

PennMAPS ALGORITHM

- Represents a systematic approach to treatment.
- Assures a patient will receive the same level of care at any site.
- Algorithms has key stages.
- Stages are numbered and used to document treatment and assure continuity of care.

LENNY DISCOVERS THE SOURCE OF ALL OUR PROBLEMS..
GOVERNMENT CENTER TO SOLVE ALL OUR PROBLEMS
WILEY@NON-SEQUITUR.COM
WWW.NON-SEQUITUR.COM

F

Mental Health Issues Today

Volume 6 Number 3

Polypharmacy of Psychotropic Drugs: A Critical Discussion

"He arose at the crack of dawn when he began to take his secret medicines, bromide to raise the spirits, salicylates for the aches in his bones when it rained, ergosterol drops for vertigo, belladonna for sound sleep. But in his pocket he always carried a little pad of camphor that he inhaled deeply when no one was watching, to calm his fear of so many medicines mixed together."

GABRIEL GARCIA MARQUEZ
Love in the Time of Cholera

In 21st Century American medicine, we are fortunate enough to have a large selection of prescription drugs available to treat disease. However, the advantage of multiple treatment options can be detrimental, especially when patients see multiple physicians and take numerous medications. Polypharmacy, the concurrent use of multiple medications, is a growing concern in all areas of medicine, but it is an especially delicate matter in psychiatry where there are increased opportunities and risks when physicians use a combination of medications.

Lack of a standard definition notwithstanding, polypharmacy is often perceived, at worst, as dangerous, and at least, as potentially wasteful.

The latest resurgence in the long psychiatric polypharmacy debate was precipitated by the introduction of atypical antipsychotic medications and selective serotonin reuptake inhibitors (SSRI) for the treatment of depression. With the influx of new options for medical treatment, the issue of polypharmacy has become even more complex as prescribers try different combinations of the new agents, experimenting to pinpoint the formula that produces the most successful response with the fewest side effects.

Supported by an educational grant from Janssen Pharmaceutica L.P., a member of the Johnson & Johnson family of companies

Despite the clinical opportunity it represents, polypharmacy is often considered taboo in psychiatry, often implying inappropriate use of multiple medications to treat one condition. In fact, even the term is controversial; advocates will often refer to it as "combination therapy." Because "polypharmacy" can refer to a variety of therapeutic situations, it is difficult to capture the practice in one definition. According to a technical report by the National Association of State Mental Health Program Directors (NASMHPD), the term polypharmacy can be divided into at least 5 categories:

Lack of a standard definition notwithstanding, polypharmacy is often perceived, at worst, as dangerous, and at least, as potentially wasteful. While the primary concern related to polypharmacy in any area of medicine is the increased potential for drug-drug interactions that may lead to morbidity and iatrogenic complications, adherence and fiscal constraints are also important considerations in psychiatry.

Apart from issues of safety, combination therapies that are very complicated or produce intolerable side effects will often result in the patient disengaging from treatment, a possibility that must be considered by prescribers. In addition, both public and private payers are concerned about unnecessary expenses related to inappropriate polypharmacy and are taking steps to curb its use.

In this issue of *Mental Health Issues Today* we will examine whether polypharmacy is inherently a wasteful practice that implies a duplicative and even dangerous use of multiple psychotropic medications, or if it is an invaluable tool in the in art of psychiatry. We will also describe ongoing state efforts to reduce polypharmacy and how programs such as the Texas Medication Algorithm Project (TMAP) can assist physicians in rational polypharmacy.

Mental Health Issues Today

ADVISORY BOARD

Carlos Brandenburg, Ph.D., Administrator, Division of Mental Health and Developmental Disabilities, Department of Human Services — Nevada

George Glintoll, State Director, Office of Mental Health — South Carolina

Michael Hogan, Ph.D., Director, Department of Mental Health — Ohio

Stephen Mayberg, Ph.D., Director, Department of Mental Health — California

Joseph Parks, M.D., Medical Director, Department of Mental Health — Missouri

Celeste Putnam, Director of Mental Health, Department of Children and Families — Florida

Mental Health Issues Today is prepared for Janssen Pharmaceutica L.P. by PAREXEL, Centreville, Virginia, (703) 310-2041.

Editors: Tula Michaelides, M.P.H.
Coy Stout, M.S.W.

Letters and comments can be sent to tula.michaelides@parexel.com

Why is Polypharmacy Controversial?

The storm surrounding the practice of polypharmacy can be traced back to the mid-to-late 1970's, when new research that showed there was no advantage to same-class polypharmacy

TABLE 1.

CATEGORIES DESCRIBING THE USE OF POLYPHARMACY[1]

Same-Class Polypharmacy: The use of more than one medication from the same medication class.

Example:
- Using two selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine plus paroxetine.

Multi-Class Polypharmacy: The use of full therapeutic doses of more than one medication from different medication classes for the same symptom cluster.

Example:
- Using lithium along with an atypical antipsychotic.

Adjunctive Polypharmacy: The use of one medication to treat the side effects or secondary symptoms of another medication from a different medication class.

Example:
- Using trazadone along with buproprion for insomnia.

Augmentation: The use of one medication at a lower than normal dose along with another medication from a different medication class at its full therapeutic dose, for the same symptom cluster.

Or, the addition of a medication that would not be used alone for the same symptom cluster.

Example:
- The addition of lithium in a person with major depression who is currently taking an antidepressant.

Total Polypharmacy: The total count of medication used in patient, or total drug load. Consideration of total pharmacy should include prescription medications, over-the-counter medications, alternative medical therapies, and illicit pharmacological agents.

Source: NASMHPD Medical Directors' Technical Report on Psychiatric Polypharmacy, September 2001.

with typical antipsychotics, and that it could cause additional problems.[2] As a result, physician education and drug utilization review (DUR) procedures began to focus on discouraging this practice.

In the 1990s, further developments in the practice of clinical psychopharmacology, coupled with the introduction of new atypical antipsychotic medications, changed circumstances once again. Once more, polypharmacy became a concern as prescribers experimented with combining the new agents, albeit without the support of hard clinical evidence.

Joseph Parks, M.D., Director of the **Missouri** Department of Mental Health explained, "Older therapies had so many more side effects that it usually was not possible to give a patient more than two or three medications simultaneously without them being too sedated or falling down. The new therapies have such lower rates of side effects that patients can tolerate taking seven or eight at once. Since psychiatrists want to help their patients and believe that medications will be effective in combination even though there is not yet research on combinations of more than two medications, we tend to keep adding more until the patient says 'enough.'"

Thomas A.M. Kramer, M.D., Director of the Student Counseling and Resource Service at the University of Chicago agreed. "The good news is that the number of therapeutic agents that are available to us has increased exponentially, so we have a lot more to offer our patients. It was not that long ago that there were only two kinds of antidepres-

[1] NASMHPD Medical Directors' Technical Report on Psychiatric Polypharmacy, September 2001.

[2] NASMHPD, " Medical Directors' Technical Report on Psychiatric Polypharmacy." (September 2001).

sants and there was not a whole lot of evidence that if you failed to improve on one, you would get better on another one within the same class."

"Now, we have all kinds of different medications and polypharmacy has become a bigger deal in psychiatry because of the increased number of possibilities we have to make a cocktail that may actually make somebody better," Dr. Kramer continued.

However, polypharmacy is still somewhat of a "fighting word" in psychiatry because it implies an "inappropriate or irrational use of multiple medications."[3] "Polypharmacy literally means multiple drugs. It does not have anything more to it than that," Sheldon H. Preskorn, M.D., Professor and Chair for the Department of Psychiatry and Behavioral Sciences at the University of Kansas School of Medicine said, adding,

"Unfortunately, polypharmacy in the literature has frequently been used as a synonym for 'bad' polypharmacy. Rarely do people talk about 'good' polypharmacy. It has a negative connotation to it. Physicians often become defensive when they hear the word."

Current Prevalence of Polypharmacy

According to the National Association of State Mental Health Program Directors (NASMHPD), polypharmacy is common practice and has been increasing steadily over the last decade. For example, in **Missouri**, 25 percent of acute care patients and 33 percent of hospitalized patients are using more than one antipsychotic agent.[4] A study by the DUR Committee of California Medi-Cal found that polypharmacy of any two antipsychotics (either atypicals or conventionals) was 11 percent. In **Massachusetts**, Medicaid officials were recently surprised to find that nearly 5,000 patients were on two or more antidepressants and more than 1,100 patients were on five, six or seven different psychiatric medications.

Other reasons for the increasing prevalence of polypharmacy that are often cited in discussions is adding a second drug too quickly and the complexity of switching a patient from one drug to another. The time constraints associated with treating acutely ill patients are often to blame. Dr. Parks explains, "Not adding drugs slowly enough and failed cross-tapers are major reasons for escalating polypharmacy."

Psychiatry may be even more vulnerable to a high prevalence of polypharmacy than other areas of medicine. For one, patients often take the medications for a long time. In addition, patients frequently have multiple symptoms, and some individuals may require more than one medication to achieve the desired therapeutic effect.

"There are many patients who only will get better with multiple medications. The newer therapies are very good, but often patients require more than one of them to get the complete effect," Dr. Kramer observed, also noting that, "Sometimes, polypharmacy can ease side effects instead of cause them. For example, if you give somebody an activating drug and a sedating drug, they may cancel each other out."

Another problematic situation is that while a psychiatrist may be mindful of the interactions between the medications he or she is prescribing, things can get complicated or dangerous when there are multiple practitioners prescribing for one patient.[6] These factors, combined with the reality that

[3] NASMHPD, " Medical Directors' Technical Report on Psychiatric Polypharmacy." (September 2001).

[4] NASMHPD, "Medical Directors' Technical Report on Psychiatric Polypharmacy." (September 2001).

[5] Stephen Stahl et al. "Frequency of High Cost Utilization of Atypical Antipscyhotics within Medi-Cal, the California Medicaid Program: Polypharmacy, High Dosing and Augmentation." (July 2002).

[6] Thomas AM Kramer, "Polypharmacy," Medscape Psychiatry & Mental Health eJournal, 5(3) (March 2000).

outpatient medication management is usually far less expensive than other forms of psychiatric treatment, such as in-patient or partial hospitalization, add up to the increasing prevalence of polypharmacy.

When is Polypharmacy "Bad?"

The concern related to inappropriate polypharmacy is the increased potential for unintended results including drug-drug interactions and side effects. According to Dr. Kramer, the most frightening examples of "bad" polypharmacy are combinations of medications that have drug interactions that might have catastrophic consequences. "There are combinations of medications that can cause cardiac toxicity, arrhythmia, and death," Kramer explained.

Another example would be prescribing combinations of medications that produce intolerable side effects, are too complicated, or that lead to a worsening of symptoms "If the medicine makes you feel so awful you don't take it, or if the regime is so complicated that you cannot keep track of it, there is little hope of it working. In addition, a particular combination of medications might also exacerbate the very problems that you are trying to treat. All of those things are possibilities," Kramer said.

Fortunately, most examples of inappropriate polypharmacy do not lead to catastrophic outcomes; they just have little or no benefit. Dr. Kramer observed that most cases are just "stupid" polypharmacology. "For example, if a patient has severe depression, you do not want to concurrently prescribe two SSRIs."

Apart from issues of safety, combination therapies that are complicated or produce intolerable side effects will often result in the patient not complying with treatment. Moreover, both public and private payers are concerned about the potential to ramp up costs unnecessarily due to inappropriate polypharmacy.

Rational Polypharmacy

The debate over polypharmacy inevitably leads one to question whether it ever makes sense to consider using more than one medication to treat a single condition. Many psychiatrists see polypharmacy as part of the art of treating patients with serious and complicated mental illnesses. In addition, it is difficult to predict which drugs, or which combination of drugs, will help which patients.

Because there is little research on polypharmacy, there are often conflicting opinions. Many experts say that there is no indication that using two drugs within the same class increases effectiveness. However, others assert that even similar drugs in the same class work on different neurotransmitters in the brain, and a combination therapy may be most effective.

Annette Hanson, M.D., Medical Director for **Massachusetts** Medicaid provided an example of some of the mixed information providers and policymakers have to confront.

"Our research indicates that there is absolutely no indication for using more than one SSRI. However, there may be some rationale for using more than one antipsychotic.

In particular, if you pushed one drug as far as the patient can tolerate the side effects, but the patient still seems to be having difficulties, a physician may want to add another drug that has a different side effect profile. The problem with polypharmacy is that prescribers switch to or add another antipsychotic before an adequate trial of the initial drug is completed."

Dr. Parks agreed, adding that, "Polypharmacy within in a drug class with the same mechanisms -- using one or more of fluoxetine, paroxetine,

or sertraline -- or using more than one benzodiazepine is not rational. However, using more than one drug within a class, if each has a difference mechanism of action, may be rational: for example, a tricyicic and a SSRI."

This latter point is espoused by Dr. Alen J. Salerian, the medical director of the Psychiatric Institute of Washington's outpatient facility, the Washington Psychiatric Center. Salerian refers to the three key mood-regulating neurotransmitters in the brain (serotonin, dopamine and norepinephrine) as "the three tenors" – when they "sing" in harmony and balance, depressed patients feel best. Thus, it sometimes makes sense to provide different drugs that target each of these "three tenors" for optimal treatment effect of depression – particularly if a string of single-medication therapies has already failed. For example, this approach might prescribe Wellbutrin (for dopamine levels), Paxil (for serotonin levels) and Effexor (for norepinephrine and serotonin levels). Alternately, augmentation therapy might entail the use of Wellbutrin and Paxil, with Adderall (a stimulant often used for attention deficit hyperactivity disorder) added to further boost dopamine levels. In an article published in the Washington Post, Dr. Salerian notes that he has "treated hundreds of patients who have responded well to combination strategies," adding that, "Just as the three tenors sing best when they work together, the three neurotransmitters make the best mood music for the brain when they're balanced harmoniously."[7] Salerian also points out that often, experimentation with different drugs or dosages of the medications is needed before finding a perfect harmony.

Dr. Kramer agreed that changes in course are part of the territory, underscoring that it is the nature of mental illness to change over time. "Patients experience symptoms that wax and wane," Dr. Kramer said. "As symptoms change, medication needs to change. Monotherapy is sometimes not adequate and the use of polypharmacy may be better for a given patient because it is more easily adapted to subtle but important changes in effectiveness and side effects that the patient may experience over time."

"We have to be careful not to throw the baby out with the bath water here. I understand that people have to cut costs and that everyone is in a budget crisis. But that fact of the matter is, you want to get rid of 'bad' polypharmacy and encourage rational polypharmacy. On the whole, newer generation medications and rational polypharmacy saves the system huge amounts of money because it keeps folks out of the hospital," Dr. Kramer continued.

State Efforts to Reduce Inappropriate Polypharmacy

With budgets stretched thin due to the staggering economy, States are looking at ways to reduce spending. In the last few years, pharmaceuticals have been a major cost driver for states and State Medicaid and mental health officials have focused their attention on controlling spending in this area of the budget. To control pharmaceutical spending, a number of states have adopted or are considering restrictions on access to certain types of more expensive medications, including psychotropic medications, in their Medicaid programs. One way that states are accomplishing this goal is to monitor and manage inappropriate polypharmacy.

For example, Illinois established a DUR system to minimize polypharmacy of antipsychotics. Under the program, prescribers must receive approval for greater than ten days of concurrent antipsychotic use. After the program was implemented, long-term use of concurrent, multiple antipsychotics seemed to be lower in Illinois than observed in other states.[8]

[7] Salerian, Alen J. "Making the Three Tenors Sing." The Washington Post, June 20, 2000, Health Section.

[8] NASMHPD, "Medical Directors' Technical Report on Psychiatric Polypharmacy." (September 2001).

According to Dr. Parks, polypharmacy is very prevalent, but the profession has not yet thought it through rationally. "The first question a provider needs to ask is: does it make sense clinically, and second: does it make sense fiscally? Therapy for a patient on new antipsychotic costs $3,000 to $6,000 a year. If a patient is on two of the new antipsychotics, that increases to $10,000 to $12,000 per annually," Dr. Parks observed.

Allison Jorgenson, Pharm.D., R.Ph., a former Medicaid DUR Director in Nebraska, recognized that currently, there is heightened interest in polypharmacy on the public payer side because states are under enormous budget pressure. "It isn't that we want to cut mental health prescription spending, but that we want to save money rationally. State Medicaid programs are focusing on polypharmacy because they want to ensure that if they reduce instances where patients are receiving multiple medications, that everyone will still be okay," Jorgenson explains.

"In mental health care, this is critical. If a 21-year-old man with schizophrenia or a new mother with postpartum depression is suddenly not allowed to have the combination therapy that was keeping him or her stable, the consequences could be devastating," Jorgensen continued.

States Explore Ways to Optimize Utilization of Antipsychotics

Faced with budget pressures and accelerating spending on mental health drugs, states are under increasing pressure to develop formulary restrictions to cut costs. However, much of the increased use in this area is due to the therapeutic advantages of the newer atypical antipsyhcotics and a restrictive formulary would limit this clinical opportunity.

While restricting access to newer, expensive medications may seem to be the logical choice at first glance, strict controls could harm patients by creating time consuming and onerous processes for prescribers.

In addition, psychiatric drugs keep people who suffer from mental illness stable and, hopefully, out of hospitals and jails, in turn, saving state dollars.

In order to avoid this action, some states are first studying how these medications are currently being used, and then developing educational programs to reduce inappropriate and costly uses. Through voluntary awareness and education programs, these states are attempting to encourage prescribers to optimize the use of certain mental heath drugs to assure unrestricted access to these resources. **California** and **Massachusetts** provide examples of educational initiatives.

California: "Fiscal Pharmacology of Atypical Antipsychotic Drugs"

In California, the DUR Board has been studying the use and costs of atypical antipscyhotics in Medi-Cal, its Medicaid program. Led by Stephen M. Stahl, M.D., Ph.D., and supported by unrestricted educational grants from four manufacturers of atypical antipsychotics, the Medi-Cal DUR Educational Committee on atypical antipsychotics developed evidence-based continuing medical education (CME) programs throughout the state to inform prescribers, providers and mental health professionals about how these drugs are utilized in the fee-for-service Medicaid program. The program's goal was to create a therapeutic resource that would enhance best practices with these agents and be more effective than formulary restrictions in changing clinical practices.[9]

Before the educational programs were developed, a baseline analysis of the Medi-Cal database was con-

[9] Glen L. Stimmel, "Fiscal Pharmacology of Atypical Antipsychotics: Strategies to Limit Costs Yet Maintain Full Formulary Options." Psychiatric Times (June 2002).

ducted to identify possible high-cost, low evidence-based uses of atypical antipsychotics drugs that would become the focus of the educational effort. From the analysis, the state found that polypharmacy and high dosing were frequent practices within the Medi-Cal program and that these practices have "well documented costs and poorly documented benefits."

In developing the CME program content, the California Medi-Cal DUR Review Committee chose to target three issues: high dose use, polypharmacy of multiple antipsychotic drugs and augmentation of an antipsychotic with other psychotropic drugs. Both evidence-based and cost efficient uses were highlighted and contrasted from unproven and cost inefficient uses. Educational objectives included:

- To review the current uses of atypical antipsychotics within the fee-for-service Medi-Cal sector, including cost trends, dosing, polypharmacy and concomitant therapies.
- To compare these uses with national patterns and with various treatment algorithms including best practices.
- To highlight three areas of high-cost use for atypical antipsychotics, including polypharmacy, high doses, and concomitant administration of augmenting agents.
- To review the evidence for the utility of these high dose uses and how to optimize clinical and economic outcomes by recognizing the uniqueness of the atypical medications and individualizing patient therapy in a cost-effective, evidence-based best practices algorithm.[10]

The Medi-Cal educational program focuses on optimizing monotherapy with one atypical antipsychotic drug.

According to the program, monotherapy has the best literature support for efficacy and is also the least costly treatment.

Additionally, a key message of the Medi-Cal educational program is that monotherapy is optimized when enough time is allowed for clinical response before moving on to other treatment strategies such as high doses, polypharmacy, or augmentation.

In the Medi-Cal educational program, many reasons are given for using polypharmacy on a short-term basis. For example, cross-titration between two antipsychotic drugs results in temporary polypharmacy and short-term conventional-atypical polypharmacy may often occur in emergency department settings or when patients are being switched from one drug to another. This type of short-term use is unlikely to interfere with the long-term benefits of atypicals. However, patients may become caught in cross-titration, resulting in continuation of atypical-atypical polypharmacy for extended periods of time. In the Medi-Cal analysis, 4.4 percent of patients had received long-term atypical-atypical polypharmacy. This practice is not supported by evidence in the literature and the cost of such therapy is excessively high.[11]

In addition, the education program discusses that the addition of a conventional antipsychotic to an atypical may be useful for the purpose of increasing positive symptom efficacy. However, this type of polypharmacy may eliminate the positive side-effect profile of the atypical and there is no evidence that it increases effectiveness.[12]

The Medi-Cal educational program also targets the practices of high-dose use and augmentation of an antipsychotic with other psychotropic drugs. The Medi-Cal data analysis suggested that treating patients with high doses costs an estimated $64 million per year and that $8 to $15 million could be saved if half of those patients were

[10] Medi-Cal DUR Educational Program on Atypical Antipsychotics.

[11] Glen L. Stimmel, "Fiscal Pharmacology of Atypical Antipsychotics: Strategies to Limit Costs Yet Maintain Full Formulary Options." Psychiatric Times (June 2002).

[12] Glen L. Stimmel, "Fiscal Pharmacology of Atypical Antipsychotics: Strategies to Limit Costs Yet Maintain Full Formulary Options." Psychiatric Times (June 2002).

switched to alternative treatments. In addition, according to the educational program, augmentation is described as more expensive than atypical monotherapy. However, augmentation is less expensive than high doses or atypical-atypical polypharmacy and has more evidence to support its use.

Massachusetts Polypharmacy Program: Focusing on Awareness

Like most other states, **Massachusetts** is facing a major budget crisis and budget-makers have focused on one of the fastest-growing line items in the budget, Medicaid. In particular, state budget officers have zeroed in on psychiatric drugs, which consume 47 cents of every dollar spent on the prescriptions Massachusetts Medicaid fills each month.

To reduce spending on psychiatric medicines, the Massachusetts Division of Medical Assistance (DMA), which administers Medicaid, has asked providers to reconsider using the common practice of polypharmacy. While state officials recognize that the treatment of some psychiatric patients requires a sort of "drug cocktail," for various reasons, they contend that polypharmacy has gotten out of hand.

According to Annette Hanson, M.D., Massachusetts' Medicaid Medical Director, a review of Medicaid claims data for psychiatric drugs revealed that about 1,000 Massachusetts physicians had at least one patient on six or more medications. Of those 1,000 physicians, about fifty percent of those had just one such patient.

Dr. Hanson, herself a psychiatrist, explained that a multidisciplinary task force was assembled to determine how best to reduce the level of inappropriate polypharmacy.

"First, we put together a work group of psychopharmacologists, internists, pediatricians, practicing psychiatrists, child psychiatrics and pharmacists. Next, we started thinking about how we could make changes as evidence-based as possible. Right away, we knew we would have to begin by educating the "docs."

The voluntary program, which started in August 2002, advised physicians of potential adverse drug interactions (ADIs) and provided evidence that multiple medications in the same class does not increase successful outcomes. The DMA sent out a letter asking the 500 to 600 physicians with two or more patients on multiple psychiatric medications to review and possibly change patterns of prescribing multiple and duplicative drugs within the same class. The Agency will then track the prescribing habit of these providers to see if improvements are made.

"What we did was send a series of letters telling providers how much the pharmacy budget was, how much was devoted to psychiatric drugs, what were some of the problems that we found (using the criteria of the concomitant treatment with two SSRIs or two atypicals), and then how much the drugs cost. We also sent them a list of their patients that fit this category and asked them to respond or think about the care they were giving these patients," Dr. Hanson explained.

If the most frequent "polypharmacy offenders" do not voluntarily cut back on unnecessary prescribing within three months, they will receive a visit from state-employed pharmacists to discuss their prescribing habits. This type of effort is generally referred to as "counter-detailing."

Dr. Hanson has been pleased with the responses she has gotten from physicians thus far and she feels most have embraced the effort. "You know, I never heard from the physician with 41 patients on seven or more psychiatric drugs. But, some of the physicians with

patients on five or more drugs responded and were upset because they thought they had been labeled as a 'bad doc.' I explained that we just wanted to make them aware of the polypharmacy issue, and encourage them to examine whether their patients needed to be on so many medications."

The state hopes to save $10 million a year from this effort, approximately two percent of current spending on psychiatric drugs. However, this effort is not likely to stop the growth of pharmacy spending. Rather, Massachusetts hopes that it will help to contain the rate of growth in costs of providing drugs to MassHealth members. When asked if there is a next step planned after the education campaign, Dr. Hanson commented: "The next step depends on the results of this effort and the seriousness of our budget problems. We may decide to look at an evidence-based algorithm or take a more aggressive approach with some of these drugs."

The Texas Medication Algorithm Project (TMAP)

Several states have implemented, or are considering using, evidence-based algorithms to assist providers in prescribing medications for individuals with certain mental illness diagnoses. While these algorithms were conceived as a way to provide a very detailed protocol that physicians could use in prescribing medications to patients with certain disorders, they may also reduce polypharmacy.

Beginning in 1995, the Texas Medication Algorithm Project (TMAP) was developed by the Texas Department of Mental Health and Mental Retardation (TDMHMR) in collaboration with academic pharmacists and physicians to assess the value of algorithms in the pharmacological management of mentally ill patients with diagnoses of schizophrenia, major depression, and bipolar disorder.

The mandatory algorithms are evidence-based, relying on thorough literature studies and input from stakeholders such as practitioners, patients, families, and administrators to ensure both efficacy and practicality.

TMAP's specific treatment sequences, tactical recommendations and patient education materials are designed to facilitate clinical decision-making and meet the objectives of long-term safety, tolerability, and full symptom remission – not just response.[13] The state hopes to see a decrease in the use of crisis/hospital services and an increase in the efficiency of patient care.

A by-product of the TMAP project may be a reduction in polypharmacy. According to Steven Shon, M.D., Medical Director of TDMHR, the algorithms give a step-by-step approach to using medication starting with monotherapy. "Only after one has had a long enough trial on a particular medication will you move to another medication. What the algorithm process recommends is going through at least two monotherapies before one considers using a combination like polypharmacy," Dr. Shon said.

Another key feature of the algorithm process is that physicians should only move on to another medication if there is a clear-cut failure after appropriate dosing duration. "What I mean by dosing duration is that if a medication takes ten to fourteen days to see full effect, then you keep the person on it ten to fourteen days at that initial dose and then you raise the dose after that. Sometimes, what you'll find is people will start switching medications way too early, after four days, and the medication really has not had time to achieve full effect. So the issue with going with an initial trial of monotherapy on a single

[13] Texas Implementation of Medication Algorithms (January 2000).

medication is that you have appropriate dose and appropriate duration, Dr. Shon explained.

This protocol is expected to lead to a natural reduction in polypharmacy. "A physician must go through three, or even four trials of monotherapy before he or she considers going to a combination of medications. This tends to reduce polypharmacy because the physician is sure the patient failed on medication A, medication B, and medication C. In this structured mechanism, combination therapy or polypharmacy is not considered until later in the treatment cycle versus jumping to it very quickly, which is a tendency that many psychiatrists have," Dr. Shon said.

According to Pablo Hernandez, M.D., Administrator at the **Wyoming** State Hospital, the Texas Medication Algorithm project is a best practice guideline that other states are watching carefully. "As more and more issues about cost containment arise in all of the states, developing a scientific-based response from the clinical perspective, as well as the cost containment perspective, will be of great interest to clinicians and administrators," Dr. Hernandez said. Several states have implemented one or more of the Texas algorithms including: **Pennsylvania, Illinois, Ohio, Georgia, New Mexico, Nevada,** and **South Carolina.**

In **South Carolina**, state officials are trying to initiate a Medication Algorithm Project for individuals with severe mental illness that is based on the Texas model. According to Stephen McLeod-Bryant, M.D., Medical Director for the South Carolina Department of Mental Health, one of the program's potential benefits will be a reduction in the use of unnecessary polypharmacy.

Dr. McLeod-Bryant explained some of the details of the upcoming clinician training for the initial pilot of the program. "We will discuss some of the components of the algorithm and the fact that it is more than just guiding physicians as to what the most appropriate choice of medication should be. We want clinicians to know that it also involves a change in the way the system works and how it involves consumer and family education."

The pilot will start off with the algorithm for schizophrenia and consider others gradually. "We plan to establish proficiency in that algorithm, then, in six months or so, we can add one of the other algorithms," Dr. Mcleod-Bryant said.

The new program stems from collaboration between the Medial University of South Carolina's Department of Psychiatry and community mental health center sites. "We will be focused on the Department of Mental Health consumers who are being treated in those mental health centers, but the medical university will use the algorithms with all patients with schizophrenia who are admitted to the hospital," Dr. McLeod-Bryant explained.

Conclusions

In the last few years, much attention has been focused on the unproven but well-established practice of polypharmacy in psychiatry. The influx of new medications over the last decade has refuelled the fires of this old debate and the recent state budget crises have kept it going.

Although it is common practice, the word "polypharmacy" has a negative connotation in psychiatry because it often implies wasteful and potentially dangerous over-prescribing. However, many psychiatrists increasingly believe that combinations of drugs, even drugs in the same class, may be more effective when combined. Others disagree, asserting that polypharmacy is not clinically beneficial and inflates health care costs.

Public payers in particular have been focusing on how they can reduce inappropriate polypharmacy. State Medicaid agencies and Mental

Heath Departments are intervening with education campaigns and evidence-based best practice guidelines like TMAP to improve patients' health by avoiding unnecessary medications, as well as reduce costs associated with polypharmacy. These initiatives have avoided the fierce criticism from advocates that has befallen states like Michigan that have adopted restrictive prior authorization policies. In fact, the National Alliance for the Mentally Ill (NAMI) lists development of explicit protocols such as TMAP as one of the strategies states should include.

However, experts like Dr. Preskorn caution that the downside of algorithms is that they are based on responses for the "usual" person. "You want a roadmap, but on the other hand, if the roadmap doesn't show you that a road up ahead is barricaded, you'll just keep mindlessly trying to go down that one road and getting nowhere. You have to be able to back up and allow for individual differences."

Dr. Kramer brings up another interesting argument. "The fact of the matter is that there are not enough psychiatrists out there to treat everybody in need. As the result, a lot of primary care doctors are treating the simplest of mental disorders. Whether we meant to or not, we have essentially abdicated the role of uncomplicated treatment of depression to the primary care doctor. As a result, patients that are visiting psychiatric practices tend to be relatively complicated. What we have to offer as psychopharmacologists is the ability to say that 'I know how to put together a rational, effective combination of medications for you,'" Dr. Kramer observed.

Currently, data on the safety and efficacy of using psychotropic drugs in combination is very limited. While there is anecdotal evidence that polypharmacy can result in successful treatment for patients who were previously unresponsive to monotherapy, there is no hard research available and there are risks and concerns related to cost. Leaders in the field of psychiatry agree that rigorous scientific evidence is necessary to further explore the use of multiple psychiatric medications and that practitioners would benefit from guidelines that clarify when it is appropriate to use multiple psychiatric medications concurrently.

Ultimately, more definitive clinical trials should be conducted to substantiate the clinical benefits of polypharmacy and build best practices for its use using a rational application of our understanding of psychopharmacology.

Resources:

To view the National Association of State Mental Health Program Directors Technical Report on Psychiatric Polypharmacy, please visit: http://www.nasmhpd.org/Polypharmacy.pdf.

For more information on the TMAP research project, please visit: http://www.mhmr.state.tx.us/centraloffice/medicaldirector/TMAPtoc.html. For updated algorithms and other materials to be implemented in daily practice, go to the TIMA website: http://www.mhmr.state.tx.us/centraloffice/medicaldirector/TIMA.html.

If you would like to learn about the potential complexity of polypharmacy, please visit Dr. Sheldon Preskorn's applied clinical psychopharmacology web-site: http://www.preskorn.com/column1.html.

G

DEPARTMENT OF HEALTH & HUMAN SERVICES

Food and Drug Administration
Rockville MD 20857

FOI

JAN 5 1999

TRANSMITTED VIA FACSIMILE

Todd McIntyre, Ph.D.
Director, Regulatory Affairs
Janssen Research Foundation
1125 Trenton-Harbourton Rd.
Titusville, NJ 08560-0200

RE: NDA #20-272, 20-588
Risperdal (risperidone) Tablets
Risperdal (risperidone) Oral Solution
MACMIS #6908

Dear Dr. McIntyre:

This letter concerns Janssen Research Foundation's (Janssen) promotional materials and activities for the marketing of Risperdal (risperidone) Tablets that have been reviewed by the Division of Drug Marketing, Advertising and Communications (DDMAC) as part of its monitoring and surveillance program. In particular, DDMAC is concerned with a campaign that markets Risperdal for geriatric patients. These materials include, but are not limited to sales aids (ID# RS-420, RS-422, RS-473, RS-494), journal ads (ID# RS-470-1, RS-470-1-C, RS-470-1RB, RS-470-2, RS-470-2RB), a display panel (ID# RS-468), brochures (ID# RS-459, RS-469), and a letter (ID #RS-308). Other recent materials include journal ads (ID # RS-450-2, RS-451-2, RS-451-2A, RS-451-C, RS-470-1R, RS-470-2R), letters (ID # RS-462S, RS-477-1, RS-477-1R), a flashcard (ID # RS-518), a calendar (ID #RS-474), and a computer program (ID #RS-463). DDMAC has concluded that these materials are false, misleading, and/or lacking in fair balance, and in violation of the Federal Food, Drug, and Cosmetic Act and the regulations promulgated thereunder.

Specifically, DDMAC has the following objections:

Geriatric Campaign

1. Janssen is disseminating materials that state or imply that Risperdal has been determined to be safe and effective for the elderly population in particular. There is limited data on the use of Risperdal in the elderly, and the elderly population was not specifically studied in the clinical trials for Risperdal. Thus, presentations that focus on this population are

misleading in that they imply that the drug has been found to be specifically effective in the elderly population.

Also, according to the approved product labeling (PI), there are safety considerations for Risperdal in the elderly population. In healthy elderly subjects, the clearance of both risperidone and its active metabolite was decreased, and the elimination half-lives were prolonged. Hepatic impairment would further increase the mean free fraction of plasma risperidone. Risperdal should be used cautiously in healthy elderly individuals because of the potential for decreased clearance of drug, potential drug interactions, hepatic and renal dysfunction, and cardiovascular sensitivity. The safety of Risperdal in "fragile" individuals or individuals with concomitant illnesses has not been evaluated in adequate and well-controlled studies.

2. Risperdal is indicated for the management of the manifestations of psychotic disorders. However, Janssen is disseminating materials that imply, without adequate substantiation, that Risperdal is safe and effective in specifically treating hostility in the elderly.

Efficacy

Materials that claim that Risperdal is indicated "for psychotic symptoms associated with a broad range of disorders," including schizophrenia, schizophreniform disorder, schizoaffective disorder, bipolar disorder, and elderly psychosis, are false or misleading because the adequate and well-controlled clinical studies for Risperdal were not designed to examine the efficacy of Risperdal in this broad range of disorders.

Fair Balance

1. Janssen is disseminating materials that are lacking in fair balance because the risk information appears in pale and tiny font at the bottom or back of a journal ad or other presentation, or after the closing of a letter. Thus, the risk information is not presented with a prominence and readability that is reasonably comparable to the presentation of efficacy information.

2. Janssen is disseminating materials that are lacking in fair balance because they emphasize that Risperdal has a low incidence of certain side effects while minimizing or ignoring important risk information for Risperdal. For example, the sales aid ID# RS-420 has bolded headlines that state that Risperdal has a "low incidence of excessive sedation" and "low incidence of anticholinergic side effects," but the precaution concerning orthostatic hypertension is located in plain text in the "Dosing/Formulations" section, the ninth page of the ten-page piece. Further, the warning regarding tardive dyskinesia is minimized and the common adverse events, which occurred up to 34% of the time, have been reduced to a small paragraph with no quantification beneath a half-page table of common events associated with discontinuation (showing discontinuations were infrequent). Treatment-emergent extrapyramidal symptoms occurred 17-34% of patients on Risperdal (16% placebo). The dose-relationship of extrapyramidal symptoms is important risk information that is not included in many of the materials including this sales aid.

3. Materials that state or imply that Risperdal has a low incidence of movement disorders are false or misleading. According to the PI for Risperdal, adverse events that would cause movement disorders were common in the clinical studies for Risperdal and were often dose-related, as in the treatment-emergent extrapyramidal symptoms.

4. Materials that state or imply Risperdal has a low incidence of excessive sedation are false or misleading. According to the PI, the incidence of somnolence was 3% for 10 mg/day and 8% for 16 mg/day Risperdal (placebo = 1%). Sleepiness, increased duration of sleep, accommodation disturbances, asthenia, lassitude, and increased fatigability were all dose-related adverse events.

5. Materials that state or imply that Risperdal has a low incidence of anticholinergic effects are false or misleading. According to the PI, the incidence of constipation was 7% for the 10 mg/day and 13% for the 16 mg/day dose of Risperdal (placebo = 3%), and cognitive impairment (Precautions section of the PI) and reduced salivation are frequent adverse events. Furthermore, this claim is lacking in fair balance because there is no similar emphasis on adverse events that do occur with Risperdal.

6. Claims of low incidence of adverse events coupled with presentations of adverse events associated with discontinuation are false or misleading

because it implies that the events associated with discontinuation were the extent of the adverse events experienced with Risperdal.

Comparative Claims

1. Materials that state or imply that Risperdal has superior safety or efficacy to other antipsychotics due to its receptor antagonist profile are false or misleading because the mechanism of action of Risperdal is unknown, as is the correlation of the specific receptor antagonism to the clinical effectiveness and safety of the drug.

2. Presentations that compare the efficacy or safety of Risperdal to an active control make false and misleading superiority claims in the absence of substantiation from adequate and well-controlled comparative data (see for example, sales aid #RS-422).

Quality of Life Claims

1. Materials that claim that Risperdal can "enhance daily living" or that it offers "quality control of symptoms for daily living" are considered to be false or misleading in the absence of adequate and well-controlled studies using validated instruments to determine benefit to health-related quality of life.

2. The tagline "Quality control" is false or misleading because it is used out of context and can be interpreted to mean, without adequate substantiation, that Risperdal can control health-related quality of life.

The materials and promotional messages Janssen has disseminated contain false and/or misleading information about the safety and effectiveness of Risperdal. The violations discussed above do not necessarily constitute an exhaustive list. Accordingly, Janssen should immediately discontinue the use of all materials that state, suggest, or imply false, misleading, or unbalanced claims of the type discussed in this letter. Janssen should provide a written response to DDMAC stating its intent to comply with this request. The letter should also include a complete listing of the materials that Janssen will discontinue as a result of this letter, including the dates that the materials were discontinued, as well as a list of those materials that will remain in use.

Janssen's response should be received no later than January 19, 1999. If Janssen has any questions or comments, please contact the undersigned by facsimile at (301) 594-6771, or at the Food and Drug Administration, Division of Drug Marketing, Advertising and Communications, HFD-40, rm.17B-20, 5600 Fishers Lane, Rockville, MD 20857. DDMAC reminds you that only written communications are considered official.

In all future correspondence regarding this particular matter, please refer to MACMIS 6908 in addition to the NDA number.

Sincerely,

Lisa L. Stockbridge, Ph.D.
Regulatory Reviewer
Division of Drug Marketing,
Advertising and Communications

DISCLOSURE OF SUBSTANTIALLY ALL MATERIAL EVIDENCE SUPPORTING FALSE CLAIMS ACT COMPLAINT AGAINST JANSSEN PHARMACEUTICA PRODUCTS L.P., JANSSEN PHARMACEUTICA, INC., AND JOHNSON & JOHNSON, INC., PURSUANT TO 31 U.S.C.§3730(E)(4)(B)

Submission of this document to the United States Government is not and shall not be construed to be a waiver of any privilege or a waiver of any exemption from discovery of this document that otherwise applies. This document is voluntarily provided to the government in conjunctions with the filing of an action under the False Claims Act, 31 U.S.C. §§3729 et seq. Submission of this memorandum does not constitute an admission that any of the information upon which relator's claim is based was publicly disclosed.

The anticipated suit involves violations of the False Claims Act by Janssen Pharmaceutica Products, L.P., Janssen Pharmaceutica, Inc., and Johnson & Johnson, Inc. and potentially other defendants.

I. Introduction

A. An OIG Investigator is shut down when he uncovers drug company payments to state employees.

Allen Jones is employed as an Investigator in the Commonwealth of Pennsylvania Office of Inspector General ("OIG"), Bureau of Special Investigations.

As an OIG Investigator, he attempted to expose evidence of major pharmaceutical company wrongdoing. The industry was influencing state officials with trips, perks, lavish meals, transportation to and first-class accommodations in major cities. He uncovered payments made by drug companies, laundered through state accounts, to state employees of Pennsylvania and Texas. Some state employees were personally paid honorariums of up to $2,000 for speaking *in their official capacities* at drug-company sponsored events, promoting the use of the companies' drugs.

As he attempted to explore these facts he met stiff resistance by OIG officials. He was told that pharmaceutical companies are major political contributors and that he should not continue his probe. The more he attempted to delve, the more he was oppressed by his supervisors. He was effectively threatened with loss of job, career, and reputation if he continued to investigate the pharmaceutical companies.

The day after his initial visit to Janssen to question its representatives about payments made in the form of "grants" to state employees of Pennsylvania and Texas in order to promote Janssen products, his supervisors told him to limit the investigation to one relatively low-level Pennsylvania employee, and to leave the drug companies out of it.

In the words of the OIG manager who curtailed his investigation and participated in overt threats against him: **"Drug companies write checks to politicians — they write checks to politicians on both sides of the aisle".**

In short order, he was removed from the drug investigation, forbidden to inquire further, and assigned to menial duties. However, he continued the investigation on his own as a private citizen. This report contains his findings from that ongoing private investigation.

In November of 2002, Jones entered a civil rights lawsuit against OIG officials to preserve his right to speak out on issues of vital public interest involving pharmaceutical industry influence on the treatment of mental health patients in state institutions.

B. Using a "Model Program" to promote drugs and bypass FDA procedures.

Jones' investigation uncovered an intricate marketing program by drug companies such as Janssen. Working with certain drug-company subsidized state officials and health care professionals, the companies pushed the adoption of a "Model Program" to all-but-require the prescription of their drugs to schizophrenics and others suffering from mental illness through Medicaid-funded state programs. The companies' initial foothold was in Texas, and has since spread to other states.

The "Model Program" being implemented in Pennsylvania with drug industry hard-sell, misinformation and inducements has just been recommended by President Bush's New Freedom Commission as a model program for the entire country.

Beginning in 1995, the initial Model Program was started in Texas, and is known as the Texas Medication Algorithm Project" (TMAP-pronounced T-Map).

TMAP is a program involving the pharmaceutical industry's newest and most expensive mental health drugs. Through TMAP, the drug industry methodically compromised the decision making of elected and appointed public officials to gain access to captive populations of mentally ill individuals in prisons and state mental health hospitals.

The pharmaceutical industry bypassed governmental safeguards and medical review by creating and marketing TMAP as a "treatment model" that was instituted in various states as an *administrative* decision by a few select and often politically-appointed officials, rather than a clinical decision approved by the Food and Drug Administration ("FDA").

The treatment model accepted by these state officials had a fundamental requirement rooted deep within it: Doctors must first treat their patients with the newest, most expensive drugs patented by the pharmaceutical companies. The state doctors treating mental illness could choose which patented drug to use, but effectively could not choose to use less expensive generic drugs unless and until the patented drugs failed.

Drug companies marketed their newer, patented medications as safer and more effective than the older, generic brands. These drugs, they said, not only better-treated the symptoms of mental

illness, they did so without the troublesome side-effects often seen with conventional medications.

However, these new "miracle" drugs did not live up to their hype. They have proven to be no better than generics. Most importantly, most of the new drugs have been found to cause serious, even fatal side-effects, particularly in children. It is a statistical certainty that many lives have been lost and many others irreparably damaged.

The drug companies involved in financing and/or directly creating and marketing TMAP include: Janssen Pharmaceutica, Johnson & Johnson, Eli Lilly, and AustraZeneca, Pfizer, Novartis, Janssen-Ortho-McNeil, GlaxoSmithKline, Abbott, Bristol Myers Squibb, Wyeth-Ayerst, Forrest Laboratories, and U.S. Pharmacopeia.

Janssen Pharmaceutica operates a specialty sales division devoted to public sector marketing. Janssen was the most aggressive of the companies in developing this model and in directly compromising and influencing public officials. All of the other companies mentioned contributed funding to the effort.

The patented mental health drugs embedded within this model program include anti-psychotics and anti-depressants: Risperdal, Zyprexa, Seroqual, Geodone, Depakote, Paxil, Zoloft, Celexa, Wellbutron, Zyban, Remeron, Serzone, Effexor, Buspar, Adderall, and Prozac, all manufactured by the above companies.

Drug industry money guided TMAP from conception through development and expansion to other states. The growth of TMAP began with misleading science. It grew and expanded with the aid of compromised public officials at all levels of our government.

II. Drug Company Marketing Tactics Cross the Line Into Propagating Faux Science.

TMAP arose during a period of decreased FDA oversight and vastly increased sophistication in pharmaceutical industry marketing practices. These practices aggressively pursued favorable public and professional "opinion" through media promotion, "advisory boards," "speakers bureaus," using healthcare professionals to front ghost-written articles, and biased reporting of drug trial results.

The industry flooded the psychiatric profession, and psychiatric professionals, with money and salted medical journals with reports by "researchers" who were the direct beneficiaries of drug industry funding.

Award winning science journalist Robert Whitaker, in his book *Mad in America,* outlines the pharmaceutical industry influence on the science and promotion of the Atypical Antipsychotics (new schizophrenia medications). In Whitaker's words:

> *"By the late 1980s the pharmaceutical Industry's storytelling apparatus had evolved into a well oiled machine. The creation of a tale of a breakthrough medication could be carefully plotted. Such was the case with the Atypicals, and behind the public façade of medical achievement is a story of science marred by greed, deaths and the deliberate deception of the American public"*

Whitaker cites Marcia Angell in a 2000 *New England Journal of Medicine* article:

> *"The ties between clinical researchers and industry include not only grant supports, but also a host of other financial arrangements. Researchers also serve as consultants to companies whose products they are studying, join advisory boards and speakers bureaus, enter into patent and royalty arrangements, agree to be the listed authors of articles ghostwritten by interested companies, promote drugs and devices at company-sponsored symposiums, and allow themselves to be plied with expensive gifts and trips to luxurious settings"*

Whitaker found the factors of biased review and deceptive reporting to be particularly relevant to the advancement of Atypical antipsychotics. Via the Freedom of Information Act he gained access to FDA raw data on the Atypical drug trials. Whitaker learned that the trials, and the FDA's review of the trials, did **not** support industry claims that the Atypicals were safer or more effective than existing generic drugs. In fact, in the approval letter to Janssen regarding their drug Risperdal, the FDA specifically stated:

> *"We would consider any advertisement or promotion labeling for RISPERDAL false, misleading or lacking fair balance under section 502 (a) and 502 (n) of the ACT if there is a presentation of data that conveys the impression that Risperidone is superior to haloperidol* [a generic antipsychotic] *or any other marketed antipsychotic drug product with regard to safety or effectiveness."*

Whitaker noted "while the FDA had the authority to stop Janssen from making false claims in its ads, it had no control over what academic physicians, who had been paid by Janssen to conduct the trials, reported in their medical journals or told the press."

The same applied to doctors, academics, and practitioners within the range of influence of Janssen money. Janssen needed a mouthpiece.

A. Enter TMAP

TMAP began in 1995 as an alliance of individuals from within the pharmaceutical industry and the Texas state university, mental health and corrections systems. Start-up funds included a 1.7 million dollar grant from the Robert Wood Johnson Foundation; a Johnson & Johnson related foundation. Johnson & Johnson owns the pharmaceutical companies Janssen Pharmaceutica Products, L.P., Janssen Pharmaceutica, Inc., and Janssen/Ortho McNeil.

The group's goal was to develop a model mental health treatment program for incorporation into public mental health and prison systems. This model program would ensure that newer, expensive medications would be heavily used.

But the drug industry had a problem: Clinical trials simply did not favor their new products. Alternative justification for favoring these drugs would have to be developed.

B. "Expert Consensus Guidelines"

This consortium sought to "legitimize" the medications recommended in the model program's "drug menus". The group elected to utilize "Expert Consensus Guidelines", rather than clinical studies or drug trials to form these recommendations.

Essentially, TMAP opted to "establish" new drugs as the best drugs for various illnesses by surveying the opinions of doctors and psychiatrists of TMAP's own choosing. **No hard science, no patients, no study review, and no clinical trials** — just the "Expert Opinions" of persons TMAP elected to survey.

The "Expert Consensus" process became TMAP's standard mechanism for creating the *appearance* of superiority for certain drugs and it was employed repeatedly from 1996 to 2003.

The doctors who were surveyed included persons who had already published articles favoring the new drugs. The survey included doctors with strong ties to the drug industry.

They included **Dr. Jack Gorman**. According to a March 13, 1999, *New York Post* article by Greg Birnbaum, Gorman resigned his position as the number two official of New York's Psychiatric Institute after it was disclosed that he received over $140,000 from drug companies in a single year between April 1, 1997, and March 31, 1998.

During that time Gorman received speaking fees, travel, board memberships, and consulting deals from Janssen, Johnson & Johnson, Eli Lilly, and Pfizer, among others. Gorman received $12,000 from Pfizer while he was heading research into Pfizer drugs.

Twelve other Institute researchers were found to be profiting from similar drug company payments including the head of the Psychiatric Institute's *Patient Protection Panel*, which was charged with ensuring patient safety in drug trials.

The Institute was found to have conducted Prozac experiments on children without advising parents of risks. It also conducted non-therapeutic research on children with the dangerous drug fenfuranine, which was subsequently been removed from the market due to deadly side effects.

From a pool of such candidates, TMAP drew their "Expert Consensus" panels.

TMAP formulated the questions to be posed to these physicians and formulated the structure of the responses permitted. No input aside from the survey questions was solicited. A total of only fifty-seven doctors and psychiatrists responded to the medication survey.

TMAP analyzed the resultant responses without input from non-TMAP health care professionals.

TMAP concluded that the Atypical antipsychotic medications **Risperdal**, produced by Janssen Pharmaceutica, **Zyprexa** produced by Eli Lilly, and **Seroqual**, produced by AustraZeneca, are the drugs of choice for all first, second, and third-line treatments of Schizophrenia.

TMAP concluded that all newer, patented anti-depressants were superior to generics.

TMAP concluded that the patented bi-polar drugs were superior to generic drugs.

TMAP concluded that "Expert Consensus" established these drugs to be safer, more effective, better tolerated and relatively free of side effects when compared to the older, generic, medications.

TMAP then formulated separate "algorithms" (flow charts) and drug menus for the treatment of schizophrenia, depression and bi-polar disorder. (See sample algorithm attached to the Complaint.) All of the new, patented drugs were incorporated into the TMAP algorithms.

State doctors following the algorithms were and are ***required*** to use these drugs. The ***administrative*** decision of a State Mental Health Program to adopt TMAP brought with it the ***clinical*** decision to use the recommended drugs on all patients in the state system. A state doctor may choose which patented drug to use, but he may not choose to use a generic drug until at least two, often three, patented drugs have failed.

In order for a state doctor to use a generic drug as first or second line treatment, that doctor must set down his or her rational in writing, effectively assuming liability for deviating from the state-sponsored requirements.

Janssen Pharmaceutica funded the "**Expert Consensus Guidelines**" survey and analysis.

Eli Lilly and AustraZeneca were also funding the project by the time the initial results were published in 1996. Pfizer, Novartis, Ortho-McNeil, GlaxoSmithKline, Abbott, Bristol Myers Squibb, Wyeth-Ayerst Forrest Laboratories and U.S. Pharmacopeia have since joined them.

All of these drug companies have patented drugs in one or more of the TMAP "menus".

The larger mental health treatment community did not share TMAP's bold and aggressive endorsement of Risperdal, Zyprexa, and Seroqual for the first three stages of the treatment of schizophrenia.

At the time TMAP was developed, there were other guideline and algorithm projects in existence or in contemporaneous development, namely the Patient Outcome Research Team ("PORT") recommendations, the American Psychiatric Association ("APA") Guidelines, and the Harvard Medication Algorithm Project ("HMAP"). These projects employed actual science and a comprehensive analysis of state-of-the art methodology and practice in the treatment of Schizophrenia. Their outcomes, and recommendations, did not echo or support TMAP's "Expert Consensus Guidelines." (Attachment 1 – Other Schizophrenia Algorithms and Guidelines)

C. Challenges to the "Consensus"

In January 1999, in the *Journal of Practice in Psychiatry and Behavioral Health*, Peter J. Weidman M.D. published an article entitled "Guidelines for Schizophrenia: Consensus or Confusion?" that compared the PORT guidelines, the APA guidelines and the Expert Consensus guidelines.

Dr. Weidman, who himself participated in the TMAP "Expert Consensus" process had this to say about the Guidelines three years later:

> "Weaknesses of the Expert Consensus Schizophrenia Guidelines:"
>
> *"The most important weakness of the EC Guidelines is that the recommendations are based on opinions, not data. History shows that expert's opinions about "best" treatments have frequently been disproved, and there is no assurance that what the experts recommend is actually the best treatment. One danger here is that clinicians or administrators may misinterpret "current consensus" as truth.*
>
> *Another limitation involves the development of the survey itself. Treatment options are limited to those items appearing on the questions, and it was not possible to cover all situations. Another problem is potential bias from funding sources. The 1996 Guidelines were funded by Janssen (makers of Risperidone [Risperdal]) and most of the guideline's authors have received support from the pharmaceutical industry. This potential conflict of interest may create credibility problems, especially concerning any recommendations supporting the use of atypical antipsychotics."*

The National Institute of Mental Health ("NIMH") launched a multi-year study in 1999 to address the issue of Atypical vs. generic antipsychotic drug usage. The *Clinical Antipsychotic Trials of Intervention Effectiveness* ("CATIE") project is a carefully controlled and monitored project involving over 10,000 schizophrenic patients.

CATIE has independent investigators, co-investigators and collaborators involved in a multi year clinical trial designed to determine precisely the kind of information that TMAP claims to have determined with their "expert consensus" process. The CATIE study is genuine science as opposed to selective opinions.

Independent clinical trials and studies in Europe have been far less supportive of the Atypicals and far more scientific in examining the true benefits and dangers of the drugs. In 2000, the *British Medical Journal* published the results of a multi-year study by Dr. John Geddes, who examined the results of independent clinical trials involving over 12,000 patients and examined the effectiveness and dangers of the Atypical and Typical antipsychotics in clinical, scientific head-to-head trials. The results:

> *A. There is no clear evidence that atypical antipsychotics are more effective or are better tolerated than conventional antipsychotics. Conventional anti-psychotics should usually be used in the initial treatment of an episode of schizophrenia unless the patient has previously not responded to these drugs or has unacceptable extrapyramidal side effects.*
>
> *B. Conventional drugs should remain the first treatment, although atypical antipsychotics are a valuable addition to treatment options, especially when extrapyramidal side effects are a problem.*

The British study was funded by the British Department of Health, and included no drug company funding.

In a *New York Times* article entitled *Leading Drugs for Psychosis Come Under New Scrutiny*, Erica Goode reports on the results of a study by Dr. Robert Rosenheck, Director of the Department of Veterans Affairs Northeast Program Evaluation Center. Rosenheck found that Zyprexa cost the V.A. $3,000 to $9,000 more per patient, with no benefit to symptoms, side effects or overall quality of life.

D. TMAP "Science" and "Retroactive Analysis"

With the support of Governor George W. Bush and members of the Texas Legislature, the "Expert Consensus Guidelines" and resultant algorithms were adopted, and sixteen Texas prisons, juvenile facilities, and mental hospitals were made available for pilot projects for the TMAP algorithms.

With the doors of the Texas prisons and mental hospitals open to TMAP, TMAP personnel were free to "mine" patient records in a process called "Retrospective Analysis." Essentially they could research files of those patients who had previously been treated with the newer medications and report on those cases that offered favorable results Additionally, TMAP personnel were responsible for monitoring the usage of the drugs, gathering raw data, analyzing data and formulating reports. (In Pennsylvania this included experimentation with dosage levels and new symptoms.)

Not surprisingly, TMAP "research" confirmed the "Expert Consensus". TMAP, funded by the drug companies, found **Risperdal, Zyprexa,** and **Seroqual** to be safer and more effective than generic drugs for the treatment of schizophrenia.

TMAP "research" found **Paxil, Zoloft, Celexa, Wellbutron, Zyban, Remeron, Serzone, Effexor, Buspar, Adderall,** and **Prozac,** to be safer and more effective than generic drugs for the treatment of depression.

TMAP "research" found **Depakote** to be more efficient than generic drugs for the treatment of bi-polar disorder.

Undaunted by a rising independent body of contrary findings, and with their own retrospective and clinical analysis in hand, TMAP began referring to their algorithms as being "Evidence Based" and "Evidence Based Best Practices."

Members of TMAP began publishing widely. Co-directors and staff of TMAP traveled widely, at the expense of pharmaceutical companies, to tout the wonders of the new drugs and to expand their guidelines and algorithms to other states — and to other nations. As early as 1997, TMAP members were traveling to China, Japan, and other nations to sell the TMAP agenda.

The principal TMAP spokesman is **Dr. Steven Shon**, who has lauded TMAP and pursued TMAP development under several titles at both state and national levels.

By 1999, the TMAP program was officially adapted by the Texas Legislature, which has passed several bills endorsing the project and funding the project's ever-increasing drug costs. These funding measures included expanding Medicaid eligibility to families whose income would not otherwise meet guidelines, in order that they could continue on the expensive medications upon discharge from institutions.

In 1997-98, TMAP, with pharmaceutical industry funding, began working on the Texas Children's Medication Algorithm Project. ("TCMAP"). An "Expert Consensus" panel was assembled to determine which drugs would be best for the treatment of mental and emotional problems in children and adolescents.

The panel consisted almost exclusively of persons already involved in TMAP or associated with TMAP officials and who had ample ties to the drug industry. (See Attachment 2 – Texas Children's Medication Algorithm Project: Drug Industry Connections to Members and Directors) A survey was not necessary for TCMAP. These persons simply met and decided that the identical drugs being used on adults should also be used on children. There were no studies or clinical trial results whatsoever to support this consensus.

One of the members of the children's "expert consensus panel" was **Graham J. Emslie, M.D.**, Professor and Chair, Division of Child and Adolescent Psychiatry, University of Texas Southwestern Medical Center, (a TMAP site) and Director, Bob Smith Center for Research in Pediatric Psychiatry, Dallas, Texas.

The website http://www.cspinet.org/integrity/index.html which links drug company money to researchers, lists the following drug company involvement by Emslie: "Consultant to GlaxoSmithKline, Forest, and Pfizer. Receives research support from Eli Lilly, Organon, Religion, and Wyeth-Ayerst. Member of the speaker's bureau for McNeil. ("Experience in the use of SSRIs and other antidepressants in children and teens.")."

These drug makers all manufacture TMAP depression medications, including Paxil, Prozac, Remeron, Wellbutron, and Effexor. These new generation depression medications are known as Selective Serotonin Reuptake Inhibitors or SSRIs.

The panel also included **Dr. Karen Dineen Wagner**. In the Aug. *27 Journal of the American Medical Association*, Wagner reported on a **Pfizer-funded** study conducted by Wagner and colleagues at the University of Texas Medical Branch in Galveston. Wagner reported that the **Pfizer** SSRI Zoloft was safe, effective and well tolerated in children.

Incredibly, this claim was made in the wake of UK bans on the use of Paxil and Effexor (both SSRI's) in children, when both the FDA and the British Committee on Safety in Medicines announced that they were re-examining *all* SSRI clinical trial data.

An article by Fred Gardner in *Drugnews,* published on September 3, 2003 critiques the report and offers the following information about Dr. Wagner:

> *"Dr Wagner has received research support from Abbott, Bristol-Myers Squibb, Eli Lilly, Forest Laboratories, GlaxoSmithKline, Organon, Pfizer, and Wyeth-*

Ayerst; has served as a National Institute of Mental Health consultant to Abbott, Bristol-MyersSquibb, Cyberonics, Eli Lilly, Forest Laboratories, GlaxoSmithKline, Novartis, Otsuka, Janssen, Pfizer, and UCB Pharma; and has participated in speaker's bureaus for Abbott, Eli Lilly, GlaxoSmithKline, Forest Laboratories, Pfizer, and Novartis."

The article states:

> *"What we have here is a case study in how pharmaceutical companies respond to warnings that their products cause harm. Earlier this summer British health authorities advised against treating children and teenagers with Paxil because it triggers suicidal thinking and actual suicide attempts. Zoloft (which is Pfizer's name for a chemical called "sertraline") affects the same receptor system, and is evidently just as dangerous."*

http://mail.psychedelic-library.org/show.cfm?postid=4258&row=29

In an article in *The Guardian* on Wednesday October 1, 2003 entitled *Scientist in rethink over drug link to suicide*, Sarah Boseley, health editor reported:

> *"The scientist who led the latest trial of an antidepressant drug given to children, which claimed that it was effective and safe, has conceded to the Guardian that the drug's potential to cause suicidal thinking needs to be investigated.*
>
> *Last month the Journal of the American Medical Association published results from two trials of children treated with Pfizer's antidepressant drug Lustral, known in the US as Zoloft.*
>
> *Seventeen children who were given the drug were pulled out of the trial because of side effects, compared with five who were given a placebo. Only 10% more children improved on the drug than improved on a placebo.*
>
> *The researchers nonetheless concluded "the results of this pooled analysis demonstrate that sertraline (Lustral) is an effective and well-tolerated short-term treatment for children and adolescents with major depressive disorder."*
>
> *The lead author of the study was Karen Wagner of the department of psychiatry at the University of Texas. She was also one of the authors of studies of a similar antidepressant, Seroxat, which was banned for use in children in June by the UK licensing body, the medicines and healthcare products regulatory agency.*
>
> *The MHRA said a re-analysis of the data from the Seroxat trials showed an increase in the numbers of children who became suicidal on the drug. The*

studies that Dr. Wagner and colleagues carried out on Seroxat in children had also concluded that Seroxat was effective and well tolerated.

Asked whether she still believed both drugs were safe, after the MHRA ban on Seroxat and the inquiry that has now been launched by the US regulator, she replied: "I think it requires further investigation and looking at the entire database of these medications. With regards to paroxetine [Seroxat], it is being investigated."

In 1998, without any published trial data and based on the "consensus opinion" of Emslie, Wagner and others, TCMAP began widespread usage of these SSRI's and other drugs on children within the Texas state Juvenile Justice system and state Foster Care System.

By some accounts, antidepressant drug prescriptions for children in the United States has increased over 500% from 1999 to 2003, with tragic results. Example:

Paxil was one of the wonder drugs recommended by the TCMAP "expert consensus" panel and prescribed in treatment of children when the drug was brand-new and relatively untested.

Since then, Paxil has been linked to a myriad of violent and deadly side effects in adolescents. Lawsuits have named Paxil as factors in murder, suicide, debilitating disease and school shootings. Additional cerebral and cardiac problems have been linked to the drug. In June of 2003, the FDA issued a warning that Paxil should not be prescribed to persons under 18 due to the alarming number of suicides by children on this drug.

The FDA "Talk Paper, report # T03-43, June 9, 2003 says, in part:

The Food and Drug Administration (FDA) said today it is reviewing reports of a possible increased risk of suicidal thinking and suicide attempts in children and adolescents under the age of 18 treated with the drug Paxil for major depressive disorder (MDD).

FDA is recommending that Paxil not be used in children and adolescents for the treatment of MDD. There is currently no evidence that Paxil is effective in children or adolescents with MDD, and Paxil is not currently approved for use in children and adolescents.

Three well-controlled trials in pediatric patients with MDD failed to show that the drug was more effective than placebo. The new safety information that is currently under review was derived from trials of Paxil in pediatric patients.

Following its review of the same data, the UK Department of Health issued a Press Release on June 10 stating that paroxetine (Paxil)(brand name Seroxat in the UK) must not be used to treat children and teenagers under the age of 18 years for depressive illness because UK authorities have concluded that there is an increase in the rate of self harm and potentially suicidal behavior in this age group, when paroxetine is used for depressive illness.

More information about this statement is available at http://www.fda.gov/cder/drug/infopage/paxil/default.htm

The TCMAP-recommended drugs **Effexor, Prozac,** and **Serzone**, and others, likewise accumulated a deadly side-effects profile. These drugs have also been linked to violence and mayhem in young persons. Serzone was withdrawn from European markets and received "black box" warnings in the United States when it was conclusively linked to a high incidence of deaths from liver failure. The use of Effexor in children was banned in the UK in August of 2003.

On December 10, 2003, the British Medicines and Healthcare Products Regulatory Agency, the British equivalent of the FDA, issued stern warnings against the use of six antidepressant drugs in persons under 18 years of age. A December 11, 2003 *New York Times* article by Erica Goode reports in part:

> *"British drug regulators yesterday recommended against the use of all but one of a new generation of antidepressants in the treatment of depressed children under 18.*
>
> *In a letter sent to doctors and other health professionals, the government regulators said a review of data on the safety and effectiveness of the drugs, known as S.S.R.I.'s, indicated that their benefits did not outweigh their potential risks.*
>
> *Their effectiveness in treating depression in children, they said, has not been sufficiently demonstrated, and some drugs have been linked with suicidal thoughts and self-harm in children and adolescents. A summary of the findings was published on the Web site of the British Medicines and Healthcare Products Regulatory Agency* www.mhra.gov.uk

The agency recommended against the use of six drugs: Paxil, Zoloft, Effexor, Celexa, Lexapro, and Luvox.

Between 1998 and 2003, state doctors following the TCMAP guidelines routinely and regularly prescribed these antidepressant drugs to children in accordance with the TCMAP algorithm requirements.

They continue to prescribe these drugs.

On March 22, 2004, the FDA released a warning statement about SSRIs and the apparent increased incidence of suicide by their users, particularly adolescents. For more information about the FDA's actions see http://www.fda.gov/cder/drug/antidepressants/default.htm.

E. TMAP Expansion via TIMAP

With TMAP and TCMAP in place, a Johnson & Johnson foundation provided a $300,000 grant to fund the implementation of the Texas Implementation of Medication Algorithms Project (TIMAP) for the sole purpose of exporting TMAP and TCMAP to other states. Janssen and

those drug companies previously mentioned also funded the expansion. As of 2002, ten states, including Pennsylvania, had implemented TMAP or were in the process of doing so.

The pharmaceutical industry influence on the development of TMAP was not limited to political contributions and TMAP, TCMAP and TIMAP funding. Janssen funded efforts of the newly created Research Committee of the National Association of State Mental Health Program Directors ("NASMHPD").

One Director of TMAP, himself a State Medical Director, took a prominent role in the organization. **Dr. Steven Shon**, a co-director of TMAP authored reports and articles under the NASMHPD banner in which he lauded TMAP, the TMAP algorithms and the TMAP medications.

Through NASMHPD, Janssen and other companies had the means of fostering the growth of TMAP in a very concise and effective way. By influencing only fifty key people, the pharmaceutical industry could pave the way for acceptance of TMAP in all fifty of the United States.

Janssen's influence of state Mental Health Directors was not limited to NASMHPD funded events. Janssen also formed "Advisory Boards" comprised entirely of State Mental Health Directors and regularly treated these "Advisory Board" members to trips and conferences, with all expenses paid by Janssen.

The Pennsylvania Director who oversaw the implementation of TMAP in Pennsylvania attended multi-day "Advisory Board Meetings" in Tampa, Seattle and Chicago, all during the time when PENNMAP, the Pennsylvania version of TMAP, was being developed.

The Ohio state director, Michael Hogan, and the California State Director, Stephen W. Mayberg, who are now New Freedom Commission members, also participated on this Janssen advisory board.

In Washington state, Janssen funneled money to promote its product through an advocacy organization, the National Alliance for the Mentally Ill ("NAMI"). Janssen gave NAMI a $15,000 "grant" to fly Dr. Shon and others to speak to Washington legislators about TMAP. Each speaker was paid a $1,500 honorarium, apparently personally. In addition to Dr. Shon, Joe Lovelace, a NAMI-Texas official, Dr. Stuart Krane, Dr. John Chiles, and Clifford Gay received funds for the trip either as expenses or as honorariums.

Janssen's influence of State Mental Health systems was not limited to deluxe treatment of state Directors. Janssen also funded trips and, through intermediaries, paid money, to other key state employees who were in a position to implement TMAP.

Janssen and Pfizer's influence on individual Pennsylvania Employees is described later.

F. TMAP's cost breaks the budget in Texas

By 1998, the Texas MHMR network was in severe financial trouble. An article by Jerry Daniel Reed in the *Abilene Reporter News* on June 18, 1998, entitled "*Medications' costs forces MHMR*

into rationing" described the Texas MHMR system as "choking on the costs" of "new-generation medications that treat schizophrenia, depression and bi-polar disorder."

The article described the need for emergency funding to pay for these drugs and described rationing of MHMR services to the general public. One official noted, "I believe that our (Mental Health) centers are in crisis right now because they're trying to squeeze money out for these new medications". He added, "And they've diverted money from other programs that are also helpful to people with mental illness".

By early 2001, TMAP and TCMAP had bankrupted the Texas Medicaid program and the budgets of the state's mental health and prison systems.

A February 9, 2001, article by Nancy San Martin, in the *Dallas Morning News*, entitled *State Spending More on Mental Illness Drugs* reported, in part:

> *"Texas now spends more money on medication to treat mental illness for low-income residents than on any other type of prescription drug."*
>
> *"Prescription drugs are the fastest growing expense within the health care system. And the cost for mental disorder treatments is rising faster than any type of prescription drug."*
>
> *"The costs of treating schizophrenia, bipolar conditions and depression have surpassed expenditures for medications to treat physical ailments, such as bacterial infections, high blood pressure, respiratory problems and even chronic disorders, notably diabetes."*
>
> *"In addition to covering nearly 40 percent of the costs of prescription drugs for Medicaid recipients, the state also spends about another $60 million annually. Most of that money goes to purchase hundreds of thousands of prescription drugs for other state-funded programs at the Texas Department of Mental Health and Mental Retardation and the Texas Department of Criminal Justice."*
>
> *'This week, health officials asked for at least $657 million more to help cover Medicaid costs."*
>
> *"According to a report on the state's Medicaid Vendor Drug Program, mental health drugs made up the largest category of expenditures among the top 200 drugs in 1999. They accounted for nearly $148 million. Those costs have more than doubled since 1996."*
>
> *"For the proposed 2002-2003 budget, lawmakers have increased by $1 billion the amount of money allocated to health and human services. A significant portion of that will go for medications, officials said."*
>
> *"While the growing and aging population is a contributing factor to the rise in cost in Texas, there also has been a dramatic increase in the use of "new*

generation" drugs such as Zyprexa, an anti-psychotic, and Prozac, an anti-depressant."

"Those who make decisions on where money is going have to consider: 'Are we going to give Texans access to newer and more effective medication, or are we going to hold the money and limit access and not provide up-to-date treatment that Texans will benefit from?'" said Dr. Shon of the Department of Mental Health and Mental Retardation. "My advice is to think of these types of medication like you would treatment for diabetes or hypertension".

"It's an investment in the future," he said. "The issue really is to try to get people the best medication as soon as possible. It becomes one of those, 'pay me now or pay me later' situations."

Dr. Steven Shon is a Director of TMAP. He did not mention this in his comments.

Prior to leaving for the White House, Texas Governor Bush recommended an additional increase of $67 million in the Texas state budget for FY 2000-01 to pay for additional medications for the Texas Prison and Mental Health Systems. Bush referenced his support of TMAP during his presidential campaign and in campaign literature.

III. The Drug Companies' Influence Continues Through a Network of "Associations"

The political/pharmaceutical alliance that generated TMAP is poised, via the New Freedom Commission recommendations, to consolidate the TMAP effort into a comprehensive national policy to treat mental illness with expensive, patented medications of questionable benefit and deadly side effects, and to force private insurers to pick up more of the tab.

TMAP proponents occupy positions in federal organizations that can directly promote and smooth the way for TMAP expansion. The list includes:

Substance Abuse and Mental Health Services Agency ("SAMHSA")

Charles Currie, a key official in Pennsylvania when TMAP was adapted there, heads the national Substance Abuse and Mental Health Services Agency. In Pennsylvania Currie endorsed the TMAP agenda and permitted employees to solicit "educational grants" from drug companies who had a vital interest in TMAP. Currie has lauded TMAP in SAMHSA speeches and SAMHSA documents. He had a $500,000 budget in FY 2002-2003 for the express purpose of expanding TMAP.

National Association of Mental Health Program Directors ("NASMHPD")

The National Association of Mental Health Program Directors continues to provide a forum for Janssen, and other drug makers, to recruit state mental health program directors. TMAP has become institutionalized in the NASMHPD agenda. TMAP officials regularly praise TMAP under the guise of NASMHPD.

The New Freedom Commission ("NFC")

This commission was purportedly formed to examine issues and provide guidance to the president relative to mental health treatment. The NFC is likely another "Expert Consensus" panel with a pre-set mission to create an aura of legitimacy for TMAP and to advance administration plans to implement Mental Health Parity legislation requiring private insurers, in addition to Medicaid and Medicare, to pay for expensive mental health drugs.

The NFC currently has 22 members. Simple link analysis ties 14 of these members to TMAP, directly or by close association. They are:

Charles Currie – Pennsylvania

As previously mentioned, Currie was the Deputy Secretary for OMHSAS in Pennsylvania when PENNMAP was adopted. He seemed comfortable with a great deal of pharmaceutical company influence in the state mental health system. He is reported to have approved a "slush fund" account into which OMHSAS employees solicited "educational grants" from drug companies.

Internal Janssen documents list Janssen's purpose and goal in providing these "educational grants. These grants were drawn from a promotional account for the Janssen drug Risperdal. The stated purpose of one grant was to support "TMAP initiative to expand atypical usage and drive **Steve Shon's** expenses". Another grant lists the purpose of the grant as being "Pennsylvania OMH to meet with TMAP group" (In New Orleans). The expected "deliverable" result was "Successful implementation of PENNMAP".

Currie currently heads the federal SAMHSA agency. SAMHSA literature favors TMAP and Currie has a budget for the express purpose of fostering the growth of TMAP.

Michael F. Hogan – Ohio

Hogan is the president of the NASMHPD Research Institute, an entity heavily supported by Janssen and other pharmaceutical company grants. Hogan was the Mental Health Program Director in Ohio when TMAP was implemented there.

Hogan participated on a Janssen advisory Board along with Steven Karp, the Pennsylvania Director who implemented TMAP. He serves with Steve Shon in NASMHPD.

Rodolfo Arredondo – Texas

Arredondo served on the board of the Texas Department of Mental Health and Mental Retardation during TMAP's development. He was a member of the TMAP steering committee and is currently working with TMAP to develop algorithms for disorders co-occurring with schizophrenia and depression.

Stephen W. Mayberg – California

Mayberg was the California State Mental Health Program Director when California implemented TMAP. Mayberg is a past president of NAMHPD and the NASMHPD research institute.

Mayberg participated on a Janssen advisory Board along with Michael Hogan and Steven Karp. He serves with Steve Shon in NASMHPD.

Henry Harbin – Maryland

Harbin is a past Director of Mental Health Services in Maryland, another state listed in TMAP literature as having adopted TMAP. Harbin is now the CEO of Magellan Health Systems, the world's largest Managed Care Agency. As early as 2001, Pennsylvania officials met with Magellan to pitch TMAP as a model program. Magellan's interest in the administrative structure of TMAP is manifest.

Larke Nahme Huang

Huang was involved in the planning and formation of the National Asian American Pacific Islander Mental Health Association ("NAAPIMHA"). Steven Shon who is a TMAP Director and major TMAP proponent heads this recently-formed group. Haung currently serves under **Shon** in NAAPIMHA.

Randolf Townsend – Nevada

Townsend was a Nevada state Senator when Nevada adopted TMAP. In Nevada, he worked to provide extended state and insurance company funds for mental health services and mental health medications.

Anil Godbole – Illinois

Godbole had a strong partnership with the Illinois State office of Mental Health when Illinois adopted TMAP.

Robert Pasternak – New Mexico

Pasternak served as the Assistant Secretary for Special Education and Rehabilitative Services when New Mexico adopted TMAP.

Nancy Carter Speck – Texas

Speck was a coordinator at the University of Texas Medical Branch at Galveston while TMAP was being developed at that facility. Speck was also associated with the Texas Department of Mental Health during TMAP's development.

Deanna Yates – Texas

Yates was associated with universities and psychological services in both Texas and California during the time in which TMAP was adopted in those states. Yates is an outspoken proponent for legislation allowing Psychologists to prescribe medication for mental illness.

Patricia Carlile – Texas

Carlisle is a Texas native who served in HUD under the first President Bush.

Norwood Knight– Richardson, Texas

Norwood is an associate professor at facilities where TMAP was implemented. Knight-Richardson was a college friend of George W. Bush and was appointed by then-Governor Bush to the Texas drug and alcohol council during TMAP development.

Knight-Richardson is a director and shareholder in Eagle Global Logistics, a transportation company with a specialty pharmaceutical delivery division. Eagle's profits soared in 2003 with multiple contracts to ship goods in conjunction with the war and reconstruction in Iraq. Knight Richardson/Eagle have a manifest interest in pleasing Pharma and the administration.

Robert Postlehwait – Eli Lilly

Postlehwait was the head of the Neuroscience unit at Eli Lilly during the development and implementation of TMAP. It is unknown if he had any direct contact with TMAP, but Lilly's interest in TMAP is manifest.

TMAP appears prominently in NFC publications as an example of a program that really works.

On July 22, 2003, the NFC issued its recommendations for redesigning the mental health network in each of our fifty states. Not surprisingly, TMAP is recommended as the model program for all states to follow.

IV. TMAP comes to Pennsylvania:

TMAP was "sold" to Pennsylvania by Janssen Pharmaceutica. Janssen compromised public officials who would have been in a position to raise an alarm about the legitimacy of TMAP.

A. Pennsylvania Medication Algorithm Project ("PENNMAP")

The Pennsylvania Medication Algorithm Project is a treatment model and regimen for the treatment of schizophrenia. It was adopted by the Pennsylvania Department of Public Welfare ("DPW"), Office of Mental Health and Substance Abuse Services ("OMHSAS") in 2002 and fully implemented in January of 2003.

This model was incorporated into OMHSAS as an ***administrative*** decision to accept and implement a self-contained approach to the ***medical*** treatment of schizophrenia and related conditions.

The centerpiece of this model is a set of algorithms that, together with text guidelines, guide a clinician in prescribing medications to schizophrenic patients and in changing or adjusting medications. Algorithms are basically flow charts, or graphs, that illustrate step-by-step movements in a process. (See sample algorithm attached to Complaint.)

The centerpiece of the algorithms is a formulary of approved and required medications. A formulary is like a menu in a restaurant, but it lists medications instead of food. It is a list of what medications a doctor may choose from. If a drug is not on the menu, it cannot be used.

The menu also stipulates the order in which classifications of drugs can be used. To carry the restaurant analogy further, the "appetizer menu" must be used first. In the drug formularies, "the appetizer menu" is that list of drugs that must be used first, second and often third, before moving on.

The PENNMAP schizophrenia formulary has a restrictive, proprietary, "appetizer menu" consisting exclusively of new, patented and very expensive drugs. These drugs are referred to in literature and throughout this report as "Atypical Antipsychotics," or "Atypicals." This refers to a new classification of schizophrenia drugs developed from the early 1990s through the present day. These drugs will occasionally be referred to as "SGAs," or Second Generation Antipsychotics. This report focuses on the Atypicals, **Risperdal, Zyprexa, and Seroqual**.

The older drugs, first appearing in the 1960's are referred to as "Typical Antipsychotics," or "Typicals." All of these drugs are available in generic form today. These drugs will occasionally be referred to, in the bibliography section of this report, as "FGAs," or First Generation Antipsychotics.

The designation of PENNMAP by OMHSAS as the required treatment methodology for all schizophrenic patients required that *all schizophrenic patients* coming in contact with the state hospital system be treated with Atypicals, *regardless* of patient history and regardless of past or current success with Typical medications.

During the phase-in of PENNMAP hundreds of mental patients had their medications switched ***in the absence of medical need or indication*** to comply with an administrative decision. This was an unethical practice instituted without regard for the rights of patients and in the absence of meaningful consent.

Contrast this with what happened in Massachusetts when state doctors were found to have switched the medication of only four patients for non-medical reasons: A *Boston Globe* article by Ellen Barry published on November 10, 2003, addresses the issue.

Barry found that four patients were switched, without informed consent or medical need, to the Janssen drug Risperdal to make them eligible for a Janssen drug trial. One of the patients nearly died from the experience. When other staff complained about the ethics of the move, a state agency investigated and confirmed the switch. As a result, (1) the drug trial was halted; (2) the doctor's conduct is being reviewed by the Massachusetts Board of Registration in Medicine; (3) All Massachusetts state hospital doctors are required to undergo re-certification in the ethics of medical research; (4) Dr. Douglas Hughes, the facility medical director, resigned on September 29, 2003, and disclosed having received $30,000 in speaker's fees from Janssen in 2003.

In Pennsylvania, a wholesale change in medications, which is a ***clinical*** matter, was implemented as a result of an ***administrative*** decision made by a relatively few administrators within OMHSAS.

All of these OMHSAS administrators were subjected to, and willingly accepted, concerted and pervasive influence on their decision-making by the drug manufacturers, including Janssen, who have Atypical medications represented in the algorithms.

The Atypicals were adopted because of drug manufacturers' claims that they were safer, more effective and produced fewer side effects than the Typical Drugs. Claims of greater effectiveness and safety were not supported by the clinical trials leading to FDA approval of the Atypicals.

In reality, the Atypicals entered the market with significant warnings and are evolving a side effect profile that includes serious and life threatening conditions in an alarming number of patients. In fact, the FDA data established that one of every 145 persons enrolled in clinical trials for these drugs *died* as a result of adverse reactions to the drugs.

These side effects include, but are not limited to: Suicide, Diabetes Type 1 and Type 2, Diabetes Mellitus, Hyperlipidemia, Convulsions, Neuroplectic Malignant Syndrome, Pancreatitis, Necrotic pancreas, Hyperglycemia, Tardive Dyskinesia, Stroke, Hypertension, Cardio Arrhythmia, Cardiomyopathy, Hyperlprolactinaemia, Obesity Somnolence and Amenorrhoea.

People are dying of these side effects at alarming rates. The FDA is far behind its European counterparts in issuing strong warnings for Atypicals, but has recently issued warnings regarding suicide, stroke and diabetes.

Persons on Atypicals have been found to commit suicide at rates two to five times more frequently than the schizophrenic population in general. Older persons in particular are victims of stroke when taking Risperdal. Adult onset diabetes has been found to occur ten years earlier and in far greater frequency in patients treated with Atypicals than in the general population.

There is evidence that drug manufacturers were aware of the emergence of these side effects when PENNMAP was "sold" to Pennsylvania. In fact, drug companies had been sued successfully as a result of some of these effects years prior to PENNMAP. Many of the side effects had in fact been identified in clinical trials prior to the drugs receipt of FDA approval.

An independent researcher, Dr. David Healy, studied FDA raw data on the Atypical schizophrenia drug Zyprexa and concluded that it was among "the deadliest drugs ever to gain FDA approval."

The *Journal of the American Medical Association*, Nov 26, 2003 edition pages 290:2693-2702 reports on a study by Yale researchers who followed 309 schizophrenic patients at 17 Veterans Affairs hospitals nationwide. Of those, 159 received Zyprexa and 150 took Haldol, a generic antipsychotic.

This 12-month double-blind study found no statistically or clinically significant advantages of Zyprexa for schizophrenia on measures of compliance, symptoms, or overall quality of life, nor did it find evidence of reduced inpatient use or total cost.

This study is meaningful in that, unlike drug company controlled clinical trials, this study examined the drugs' effects on patients' lives and functioning: it monitored symptom reduction, adverse effects, and also patient quality of life, patient satisfaction, and maintenance costs.

The study revealed that neither Zyprexa nor Haldol were superior to the other. Zyprexa did NOT reduce hospitalizations as has been claimed. No cost benefit was found to offset the high cost of Zyprexa. Acute weight gain in patients taking Zyprexa puts them at increased risk of diabetes and other health problems. The major difference between the older and newer antipsychotic drug is the cost. Zyprexa costs $3,000 to $9,000 more per patient per year than Haldol.

More than 80 percent of schizophrenics in the VA system now take atypical antipsychotics, with 38 percent on Zyprexa. In fiscal year 2003, the VA spent $208.5 million on Psychotropic drugs, including $106.6 million on Zyprexa.

The study results were reported in the Wall Street Journal on November 26, 2003. http://online.wsj.com/article/0,,SB10697854598899400,00.html

Journalist Robert Whitaker, via the Freedom of Information Act gained access to FDA data on the drug trials for the Atypicals Risperdal, Seroqual, and Zyprexa. Whitaker found that:

1. One in every 145 patients who entered the trials *died*, and yet those deaths were never mentioned in the scientific literature.

2. The trials were structured to favor the Atypicals and most of the study reports were discounted by the FDA as being biased.

3. One in every thirty-five patients in Risperdal trials experienced a serious adverse event, defined by the FDA as a life threatening event or one that required hospitalization.

4. Twenty-two percent of patients in Zyprexa trials suffered serious adverse events

5. The Atypicals did not demonstrate superior effectiveness or safety over Typical antipsychotics.

It is important to note that a drug company does not have to prove that a new drug is safer or more effective than an old drug to gain FDA approval. Essentially, the manufacturer has to demonstrate that the drug is proved to yield better results than placebo in a statistically significant number of patients in short-term trials (6-8 weeks).

With these results at their disposal, and in the presence of other independent studies questioning the drug company claims regarding the safety and effectiveness of the Atypicals, Pennsylvania's OMHSAS Administration went resolutely forward with the implementation of PENNMAP.

Why?

The answer leads to the same pattern of drug industry influence and political intervention that created the Texas Medication Algorithm Project. The following is an account of the ***known*** drug industry influence on ***known*** members of the Pennsylvania OMHSAS administration, leading to the adoption of PENNMAP.

B. Key Pennsylvania OMHSAS Administrative Employees And Their Association With Drug Manufacturers

Charles Currie, Deputy Secretary, Office of Mental Health and Substance Abuse Services

Currie was appointed by Governor Ridge to a key position within the Pennsylvania Mental Health system even though Currie lacked medical credentials. His highest degree is a MSW. Currie did have administrative experience and political connections.

Currie approved a slush fund and an off-the-books account that formed the basis of the initial OIG investigation. Currie approved the receipt of pharmaceutical company "educational grants" intended to promote the TMAP agenda. The OIG received reports that drug company sales representatives frequently and openly made gifts of meals and sporting event tickets to officials and state hospitals during Currie's tenure.

Currie seems to have been very tolerant of drug company influence in Pennsylvania. The decision to implement PENNMAP was made during his tenure.

Currie's involvement was discovered at the same time Jones was being removed from the OIG investigation. Thus, he did not have an opportunity to interview Currie. Given the OIG's attitude toward the investigation, it is doubtful that Currie was interviewed concerning his contacts/affiliations with drug companies.

It seems, however, that Currie was intimately involved with the importation of TMAP into Pennsylvania as PENNMAP.

Following the start of the PENNMAP implementation process in Pennsylvania, Currie was appointed by President Bush to head the national SAMHSA.

In that capacity, Currie has worked to further the expansion of TMAP, which is listed as one of his prime initiatives. SAMHSA had a $500,000 budget in FY 2002-03 for the express purpose of aiding TMAP development.

Currie also serves on President Bush's New Freedom Commission, which seeks to expand the role of the insurance industry in more fully funding mental health services, including mental health medications.

Steven J. Fiorello, Director of Pharmacy Services, Office of Mental Health and Substance Abuse Services

An April 2002 "Faculty Bio" in a Janssen publication describes Fiorello as being "responsible for the formulation of policies and procedures for drug use for ten state hospitals and facilities including the development and implementation of the PENNMAP project."

Fiorello describes himself as the "Point Man" in Pennsylvania for any drug company wishing to have their product placed on the state drug formulary, a step that is necessary for Medicaid coverage. He is the Chairman of the Pennsylvania Formulary Committee that approves or disapproves drugs for the state "menu."

Known Fiorello interactions with drug companies:

Fiorello solicited "educational grants" from pharmaceutical companies totaling at least $13,765.

Part of this amount was spent to bring **Steven Shon** to Pennsylvania to "sell" the TMAP agenda.

Part of this amount was spent on trips to New Orleans for Fiorello and OMHSAS Psychiatric Services Manager; Dr. Robert Davis's to meet with TMAP representatives and marketing representatives of Janssen Pharmaceutica.

While in New Orleans, Fiorello was treated to lavish dinners by the Janssen Sales representatives and attended Janssen entertainment venues.

Along with Dr. Fredrick Maue, Chief, Clinical Services Division, Pennsylvania Department of Corrections, Fiorello did a presentation on PENNMAP at a Janssen sponsored event in Hershey, Pennsylvania on April 17, 2002. He was paid a $2,000 honorarium for the presentation, which he delivered in his official state capacity. Fiorello noted that Maue was implementing a similar program in the state prison system.

A Janssen sub-contractor, Comprehensive NeuroSciences, ("CNS") arranged the Hershey event for Janssen. A Janssen sales representative attended the event. Documents indicate that CNS, as Janssen's sub-contractor and Janssen personnel themselves, prepared and reviewed Fiorello's presentation materials. CNS sent Fiorello Janssen slides from the previous year to use as a model. This Janssen involvement was in direct violation of American Medical Association regulations and FDA *Guidelines for Industry.*

Comprehensive NerouSciences is a high-sounding name for an events-management company that facilitates educational seminars for pharmaceutical companies. The two CNS employees involved in Janssen Pharmaceutica events in Pennsylvania worked out of their homes and their cars. They work on contract with the companies to do for the pharmaceutical companies what the companies cannot legally do for themselves.

At the request of Pfizer, Fiorello traveled to Maryland with Pfizer Representatives as a consulting pharmacist. There he met with his counterpart in the Maryland Department of Mental Health. The purpose of the meeting was to discuss TMAP and PENNMAP.

Fiorello traveled three times to Pfizer headquarters in Manhattan, at Pfizer's invitation, to participate on an "advisory counsel" with "an elite group of pharmacists." Pfizer paid all of Fiorello's expenses including lodging at the Millennium Hotel in Manhattan. Fiorello was paid an honorarium of $1,000 in addition to expenses for each "advisory council" appearance.

Fiorello traveled to Philadelphia in late 2001, at the request of Janssen to do a PENNMAP presentation to community based managed care service providers to promote PENNMAP outside of the Pennsylvania State Hospital system. Fiorello went to Philadelphia as a pharmacy consultant to Janssen.

At the request of Janssen Pharmaceutica, Fiorello conducted "retrospective analysis" of patient records within the Pennsylvania State Hospital system. He essentially "mined" the patient

records for information favorable to Janssen and compiled a "study report". Fiorello was then treated to a trip to New Orleans to present his "report" to pharmacists from across the nation. All expenses were paid by Janssen.

During the implementation phase of TMAP, Fiorello gathered data regarding off-label experimentation with dosages of Atypical medications that were higher and/or lower than the FDA approved dosages listed in the Physician's Desk Reference ("PDR"), which is the authoritative prescribing guide for doctors. He also gathered data on usages of the medications for symptoms for which the drugs were not approved for usage.

Fiorello gathered this information into a computerized data collection system that was provided, at least in part, by pharmaceutical companies. Fiorello relayed, to the drug companies, the medication data and results drawn from the affected patient's records.

The Pennsylvania OIG limited its investigation to Fiorello's honorariums. The matter was treated as an issue of possible employee misconduct related to non-reporting of outside employment income on code of conduct forms.

Steven J. Karp, DO, Medical Director, Office of Mental Health and Substance Abuse Services DPW

Karp was recruited from private industry by Charles Currie to fill the position of Medical Director in OMHSAS.

Karp is a supervisory level above Fiorello and, according to Fiorello, authorized the slush fund account and approved expenditures. Karp was aware of Fiorello's association with Janssen.

Karp was aware of the gathering of patient information and the dissemination of that information to the drug companies.

Known Karp affiliations with drug companies:

Prior to state service, Karp frequently gave presentations for drug companies for which he received honorariums and expenses.

In December of 2000, Karp was appointed to the advisory board of *Mental Health Issues Today*, ("MHIT") a Janssen publication. Janssen contracts with Parexel International Corporation to produce MHIT. Janssen funds the project, but Parexel writes the checks.

New Freedom Commissioner Michael Hogan served on this same "advisory board"

As a result, Karp was invited, at Parexel's expense to attend periodic " advisory board meetings". In 2001, Karp attended a meeting at the Mayflower Park Hotel in Seattle Washington on June 23-25. Janssen, via Parexel, provided airfare, lodging and sustenance in Seattle and reimbursed Karp for his expenses in getting to the BWI airport.

Karp also attended a meeting at the Hyatt Regency Westshore in Tampa, Florida on November 17-19, 2001. Again, Janssen, via Parexel, covered his expenses.

In June or July of 2002 Karp again attended an Advisory Board Meeting in Chicago with all expenses paid by Janssen, via Parexel.

As a result of Karp's participation in these meetings, he was quoted in *Mental Health Issues Today* articles and achieved a degree of notice in his profession. Janssen, via Parexel, funded the publication and distribution of the articles.

A list of attendees at these functions indicates the membership is exclusively comprised of state mental health directors.

Karp also belongs to the National Association of State Mental Health Program Directors ("NASMHPD") along with **Steven Shon** and NFC commissioner Michael Hogan. The growth of this organization paralleled the development of TMAP and was likewise heavily subsidized by Janssen. The group has actively sought, and accepted grants from other drug companies to fund their conferences and publications.

Members of this organization are directors of all of the states that have implemented TMAP.

The OIG management tightly restricted the scope and depth of questions Jones was permitted to ask Karp. Jones was forbidden to interview Karp regarding his knowledge of the treatment of schizophrenia in the Pennsylvania corrections system or his knowledge of drug company involvement of commonwealth employees other than Fiorello.

Robert H. Davis, MD, Psychiatric Physician Manager, Medical Services Division, OMHSAS

Davis works under Karp in the Medical Services Division.

Known Davis affiliations with Drug Companies

Davis attended two functions in New Orleans with Fiorello. Expenses were paid with Janssen funds. Davis attended the dinner meetings with Fiorello and the Janssen Representative.

Davis participated in Fiorello's above-described retrospective analysis of patient data, the formulation of a "study report" and the dissemination of information to drug companies.

Davis was not interviewed by the OIG, as the focus of the inquiry was strictly limited to Fiorello. Jones was not permitted to question Davis concerning any other drug company affiliations or his role in data gathering and data transmission to drug companies.

Fredrick Maue, Chief, Clinical Services Division, Pennsylvania Department of Corrections

Maue is Karp's counterpart in the Department of Corrections.

Known Maue affiliations with Drug Companies

In April of 2002, Maue did three presentations at Janssen-funded events sponsored by Janssen's contractor Comprehensive NeuroSciences. They included the one with Fiorello described above.

The other two were held in Sacramento California and Orlando Florida. According to CNS, Maue received a $2,000 honorarium plus all expenses for each of the presentations.

There is abundant anecdotal evidence that Maue and the Department of Corrections were involved with the receipt of drug company funds and the implementation of a medication algorithm long before the OMHSAS. Maue in fact introduced some of the state employees and pharmaceutical company representatives.

Jones was expressly forbidden from pursuing this lead and was not permitted to request documentation on Maue that would have been easily obtainable from existing sources. Jones was not even permitted to determine if PENNMAP or a similar project was in use within the Department of Corrections.

V. The Pennsylvania Office of Inspector General Turns Its Back

The vast majority of the information in this report is the product of Jones' individual investigative efforts as a private citizen.

However, the entirety of the information contained in the "Key Employee" section was part of the OIG record when Jones was removed from the case. If not destroyed, the evidence remains in the OIG file.

In the face of pervasive evidence of corruption and improper influence, the OIG limited its investigation to a single employee who was the lowest ranking employee identified as being involved in the matter.

Jones was removed from the investigation when he refused to hide or ignore clear fact and compelling evidence that would impact on the pharmaceutical industry and that industry's political contributions. In the words of the OIG manager who curtailed his investigation and participated in overt threats against me: **"Drug companies write checks to politicians — they write checks to politicians on both sides of the aisle".**

Jones was forbidden to contribute to the final OIG report on and was forbidden to review a copy. The report was silent on the issue of drug company misconduct. The drug companies were not cited for wrongdoing and no further investigation into the drug companies or the legitimacy of PENNMAP was done.

Here are some of the issues the OIG chose to overlook:

Janssen may have violated AMA Guidelines, FDA Guidelines, Federal Health and Human Services OIG guidelines, and federal anti-kickback laws in that:

1. Janssen made direct payments of money to state officials for representing Janssen products. The remuneration was far in excess of "reasonable value" ($2,000 for ½ day presentations) and was made to officials who were in a position to influence the state drug formulary.

2. Janssen provided trips, entertainment and meals directly to the persons who were in key positions to accept or reject Janssen's product in the state formulary.

3. Janssen influenced, to the point of control, the content and materials in which Janssen had provided "educational grant" funding.

4. Janssen selected speakers for "educational grant" funded symposiums and paid travel expenses and honorariums to these speakers.

5. Janssen, through these symposiums and through direct contact with Pennsylvania officials, encouraged doctors to prescribe drugs in dosages that were not FDA approved.

6. Janssen, through these symposiums and through direct contact with Pennsylvania officials, encouraged doctors to prescribe medications for non-FDA approved indications.

7. Janssen conspired with commonwealth employees to obtain data generated from the non-FDA approved activities.

8. Janssen funded travel and expenses for commonwealth employees to represent Janssen in the employee's official state capacities.

9. Janssen's cooperation with other drug manufacturers in the advancement of TMAP has clear anti-trust and racketeering implications.

In addition to the drug company impropriety, the OIG had solid evidence that employees in addition to Fiorello had engaged in the same conduct. Yet Fiorello was the only one investigated and recommended for prosecution.

Information provided to the OIG clearly established that state employees were experimenting on mental health patients and reporting the results to drug companies, yet this was not even mentioned in their report.

A. Additional Costs

Jones was not permitted to obtain census data from the state mental hospitals or the Department of Corrections regarding the numbers of schizophrenics being served in Pennsylvania. His best estimate based on tangential data is that there are approximately 9,000 schizophrenics in the state's prisons and mental hospitals at any given time.

Based on average length of stays, it is believed that at minimum, an additional 4,000 persons will cycle through the systems in any given year, taking their prescriptions for Atypicals with them, resulting in an estimated 13,000 persons affected.

At an average cost of $6,000 per patient, Pennsylvania could spend **$78 million,** for the medication of institutionalized schizophrenics alone in 2003.

It is important to note that state mental hospitals and prisons have a flow-through population. Patients treated at these facilities will leave the facilities with prescriptions for the medications they were treated with while institutionalized. Most will rely on Medicaid or Medicare to pay for the drugs. This is "patient recruitment and retention" in pharmaceutical industry terms.

The costs to Pennsylvania government will grow annually, and exponentially, as patients are "recruited" through the prisons and state hospitals.

Ohio, with a population of 11.5 million, one million fewer residents than Pennsylvania, implemented TMAP in 1999. In 2002, Ohio spent $145 million in Medicaid funds on the TMAP atypical schizophrenia medications alone.

Jones has not been able to determine how much in non-Medicaid dollars was spent on these medications.

Missouri, which embraced an algorithm program even earlier, has less than half of the population of Pennsylvania, approximately 5.5 million. In 2002, Missouri spent $104 million in Medicaid funds for three of the TMAP schizophrenia drugs alone. The three drugs topped the list of all drugs covered by the state Medicaid program, including cancer, HIV, and heart medications.

In short, two small to medium sized states alone generated an annual Medicaid expenditure of a **quarter of a billion** dollars on three new schizophrenia drugs within three years of adopting the TMAP program.

California, now in the process of implementing TMAP spent over $500 million in Medicaid funds on the Atypicals Risperdal, Zyprexa, and Seroqual alone in 2003.

TMAP literature, at various times between 1996 and the present, lists TMAP programs in the following states: Texas, California, Colorado, Nevada, Illinois, Kentucky, New Mexico, New York, Ohio, Pennsylvania, South Carolina, Maryland, Missouri, and Washington D.C. The discussion of TMAP in the New Freedom Commission report presents a smaller list.

Several states have adopted the depression and bi-polar algorithms as well as algorithms for ***children.*** The Texas Medication Algorithm Project has already generated many billions of dollars in sales in the United States.

If we extrapolate the Ohio and Missouri costs for a 17 million population, based on a national population of 250 million Americans, the annual costs to the Medicaid programs would be approximately **$3.7 billion per year** to treat schizophrenia alone. That is over **$10 million per day** just in ***Medicaid*** expenditures for schizophrenia drugs.

The costs of TMAP algorithm drugs for depression and bipolar disorder are likely to be at least double that figure, possibly far more.

B. Human Toll

Jones' best effort at correlating dollars spent with deaths from drug side effects suggests that people may be dying from side effects from the schizophrenia drugs alone at the rate of at least

one death for each $1 million spent on these drugs. The actual numbers may reflect a much higher death rate.

FDA data indicates that one of every 145 patients enrolled in clinical trials of the schizophrenia drugs ***died*** of side effects. In some trials, 22% of participants were hospitalized with severe adverse reactions. At that rate alone, Pennsylvania can expect a minimum of 90 unnecessary deaths in 2003. This figure will grow steadily.

It is statistically possible that thousands of persons in the United States will die from side effects of Atypical antipsychotics in 2003.

Attorney Generals in thirty-five states are looking at pharmaceutical marketing practices and the states of New York, California and Texas have also filed suits alleging improprieties in Medicaid pricing practices.

The state of Pennsylvania has been silent on the issue.

Two Investigators in the Pennsylvania Office of Inspector General are involved in Jones' federal suit alleging cover-up of investigations into matters that are "politically sensitive," including the matters outlined in this report. The suit names the former Inspector General, his Chief Deputy and former Governor Ridge's Chief Counsel as defendants, among other high-ranking officials. See *Dwight McKee and Allen Jones v Henry Hart, Sydni Guido, Wesly Rish, Albert Masland, James Sheehan and Daniel P. Sattele*, CIVIL ACTION No: 4:CV-02-1910, in the United States District Court for the Middle District of Pennsylvania.

The Pennsylvania OMHSAS employees listed earlier in this report are still in their jobs.

Absent external pressure, it is likely that Pennsylvania elected and appointed officials will remain silent on the issue of pharmaceutical industry fraud.

VI. Conclusions

Pennsylvania citizens and taxpayers are saddled with an expensive treatment model for the treatment of schizophrenics and other mentally ill persons who are in the care of the Commonwealth. This model is part of a large pharmaceutical marketing scheme designed to infiltrate public institutions and influence treatment practices. Pennsylvania is paying tens of millions of dollars for patented drugs that have no proven advantage over cheaper generic drugs.

The Pennsylvania administrators who approved the model were all receiving improper and/or illegal gratuities and perks from the pharmaceutical companies involved. The officials acted in an administrative and political atmosphere that openly allowed improper drug company influence.

Pennsylvania taxpayers may pay nearly $100 million in the unnecessary purchases of patented medications in 2003 alone. This figure will grow dramatically with each passing year.

It is a statistical certainty that some of Pennsylvania's most vulnerable citizens have died as a result of this program. Deaths can be expected to continue.

ATTACHMENT 1

OTHER SCHIZOPHRENIA ALGORITHMS AND GUIDELINES

The Schizophrenia Patient Outcomes Research Team ("PORT") Treatment Recommendations (published 1997)

In 1992, the Agency for Health Care Policy and Research ("AHCPR") and the National Institute of Mental Health established a Patient Outcomes Research Team ("PORT") for Schizophrenia at the University of Maryland School of Medicine and the Johns Hopkins University School of Public Health.

This PORT combined the expertise of three major research centers at two universities: the Center for Research on Services for Severe Mental Illness (Johns Hopkins University and the University of Maryland), the University of Maryland Center for Mental Health Services Research, and the Maryland Psychiatric Research Center (at the University of Maryland).

The prime objective of the PORT was to develop recommendations for the treatment of persons with schizophrenia based on a synthesis of the best scientific evidence, with the ultimate goal of improving the quality and cost-effectiveness of care for persons with this diagnosis.

In writing the recommendations, the PORT investigators graded the reliability levels of evidence used for development of Guidelines, as follows:

> Level A: Good research-based evidence, with some expert opinion, to support the recommendation
>
> Level B: Fair research-based evidence, with substantial expert opinion, to support the recommendation
>
> Level C: Recommendation **based primarily on expert opinion, with minimal research-based evidence,** but significant clinical experience.

The PORT recommendation regarding the usage of antipsychotic medications, published in 1997, noted:

"Since studies have found no superior efficacy of any antipsychotic medication over another in the treatment of positive symptoms, except for Clozapine in treatment-refractory patients, choice of antipsychotic medication should be made on the basis of patient acceptability, prior individual drug response, individual side-effect profile, and long-term treatment planning."

This research-based conclusion differs dramatically from the TMAP "Expert Consensus Guidelines" recommendations.

PORT did not receive funding from pharmaceutical companies.

The American Psychiatric Association ("APA") Practice Guidelines for the Treatment of Patients With Schizophrenia (Published in 1997)

The APA developed its guidelines in a process of broad and comprehensive review of scientific research into the treatment of Schizophrenia. It was headed by a work group of clinical experts who subjected their findings to widespread peer review prior to publishing their guidelines.

The psychopharmacologic recommendations of the APA Guidelines do not weigh the atypical antipsychotics above the typical antipsychotics. The guidelines recommended cautious usage of the atypicals until clear efficacy and side effect profiles emerged.

The ASA Guidelines were developed without funding from the pharmaceutical industry.

The Harvard Medication Algorithm Project ("HMAP")

The Harvard School of Medicine developed a Psychopharmacology Algorithm program at the Harvard South Shore Department of Psychiatry. This project began in 1997 with the goals of formulating evidence-based treatment guidelines for the treatment of mental disorders and making these guidelines available to clinicians on-line.

HMAP algorithms were created on the basis of high quality empirical studies, field trials, expert opinion, peer review and review of other guidelines. HMAP offers a free web site where any physician or psychiatrist can consult the Harvard algorithms regarding specific patients and clinical situations.

HMAP solicits continuous feed back from clinicians around the world who use the on-line algorithms. This continuous input from actual results is utilized to refine the treatment guidelines.

The current HMAP schizophrenia algorithm allows for the usage of atypical antipsychotics, but, unlike TMAP, does not require their usage. Atypicals are usually recommended for first-episode psychosis where there has been no history of success on typical antipsychotics. Persons with a history of success with typicals are not discouraged from using them.

Unlike TMAP, the HMAP algorithms provide options for usage of typical antipsychotics after the failure of a single atypical.

HMAP was developed without funding from the pharmaceutical industry.

HMAP is available on-line at http://mhc.com/Algorithms/index.html

ATTACHMENT 2

TEXAS CHILDREN'S MEDICATION ALGORITHM PROJECT
DRUG INDUSTRY CONNECTIONS TO MEMBERS AND DIRECTORS

Crismon, M Lynn.

Lynn Crismon, PharmD Research Support: AstraZeneca Pharmaceuticals LP; Bristol-Myers Squibb Company; Eli Lilly and Company; Forest Laboratories, Inc.; Janssen Pharmaceutica, Inc.; Pfizer Inc. Speakers Bureau: AstraZeneca Pharmaceuticals LP; Eli Lilly and Company; Forest Laboratories, Inc.; Janssen Pharmaceutica, Inc.; Pharmacia Corporation; Pfizer Inc. Consultant: Merck-Medco Managed Care, LLC. Janssen Pharmaceutica, Inc.; Pharmacia Corporation; Pfizer Inc.; Eli Lilly and Company; Magellan Behavioral Healthcare, Inc.; Bristol-Myers Squibb Company

http://www.mesinc.com/education/monographs2/panic_disorder/disclosure.html

Emslie, Graham J

Co-Author of Study 309 Report: *Efficacy of paroxetine in the treatment of adolescent major depression: a randomized controlled trial.*
Co-Author of the Preliminary Report of the Task Force on SSRIs and Suicidal Behavior in Youth, American College of Neuropsychopharmacology
Graham J. Emslie, M.D., Professor and Chair, Division of Child and Adolescent Psychiatry, University of Texas Southwestern Medical Center and Director, Bob Smith Center for Research in Pediatric Psychiatry, Dallas, TX. Consultant and member of speaker's bureaus for Bristol-Myers Squibb, Eli Lilly, McNeil, Otsuka, and Wyeth-Ayerst. Receives grant/research support from Novartis. (Preliminary Report of the Task Force on SSRIs and Suicidal Behavior in Youth, American College of Neuropsychopharmacology, January 21, 2004, p.16; On file with CSPI) Consultant to GlaxoSmithKline, Forest, and Pfizer. Receives research support from Eli Lilly, Organon, RepliGen, and Wyeth-Ayerst. Member of the speaker's bureau for McNeil. ("Experience in the use of SSRIs and other antidepressants in children and teens": conference disclosure notes: Child & Adolescent Psychiatry, convened by The College of Physicians and Surgeons of Columbia University, April 2003, Washington, DC. On file at CSPI) Serves on the Corporate Contributions and Research Committee for the American Academy of Child and Adolescent Psychiatry. (http://www3.utsouthwestern.edu/psychiatry/facbios/emslie.htm; accessed 6/16/03) http://www.cspinet.org/cgi-bin/integrity.cgi

Participated in a consensus panel for child and adolescent bipolar disorder funded by:

Abbott, Brystol-Myers Squibb, GlaxoSmithKline, INC Research, Janssen, Johnson & Johnson, Eli Lilly, Novartis, Pfizer, and Solvay.

Participants did not disclose compensation or affiliations.

http://www.liebertpub.com/cap/jcappaper1.pdf

Geller, Barbara

Barbara Geller, M.D., professor of psychiatry, has received a two-year, $855,833 grant from the National Institute of Mental Health for research titled "Family Psychopathology in Child Bipolarity." http://record.wustl.edu/archive/2000/05-04-00/notables.html

Barbara Geller, M.D., professor of psychiatry at the School of Medicine, recently received a one-year $633,876 grant from the National Institute of Mental Health for a project titled "Phenomenology and Course of Pediatric Bipolar Disorders." http://www.imakenews.com/cabf/e_article000015889.cfm

Recent research by Barbara Geller, M.D. Supported by an unrestricted educational grant from Glaxo SmithKline. http://record.wustl.edu/news/page/normal/1304.html

http://www.wpic.pitt.edu/STANLEY/4thbipconf/introduction.htm

Barbara Geller, M.D.Grant/Research Support Layton Bioscience

Speakers' Bureau Solvay Pharmaceuticals

http://www.aacap.org/meeting/Annual/2003/PreliminaryProgram/ss.pdf

Symposi presenter supported by AustraZeneca

Hoagwood, Kimberly

http://www.bpkids.org/learning/reference/articles/coyle.pdf

Participant – Depression and Bipolar Support Alliance – underwritten by Abbot, AustraZeneca, Bristol Myers Squibb, Forest Lab, Glaxo Smith Kline, Janssen, Eli Lilly, Merck and Wyeth Ayerst.

Kowatch, Robert

http://www.liebertpub.com/cap/jcappaper1.pdf

Participant and co-author in Expert Consensus Bipolar panel funded by: Abbott, Bristol Myers Squibb, Glaxo Smith Kline, INC Research, Janssen, Johnson & Johnson, Eli Lilly, Novartis, Pfizer and Solvay.

Rush, A John

http://home.cwru.edu/activism/READ/NEJM051800.html

Dr. Rush has received grants and research support from Abbott, Bristol-Myers Squibb, Cyberonics, Eli Lilly, Forest Laboratories/Parke-Davis, Glaxo Wellcome, Janssen, Novartis, Organon, Pfizer, Pharmacia - Upjohn, SmithKline Beecham, Wyeth - Ayerst, and Zeneca.

He has served as a consultant to Bristol-Myers Squibb, Cyberonics, Eli Lilly, Forest Laboratories/Parke-Davis, Glaxo Wellcome, Janssen, Merck, Organon, Pfizer, Pharmacia - Upjohn, and Wyeth - Ayerst.

He has been a member of speakers' bureaus sponsored by Abbott, Bristol-Myers Squibb, Cyberonics, Eli Lilly, Forest Laboratories/Parke-Davis, Glaxo Wellcome, Organon, Pfizer, Pharmacia - Upjohn, and Wyeth - Ayerst.

Ryan, Neal D

Co-Author of the Preliminary Report of the Task Force on SSRIs and Suicidal Behavior in Youth, American College of Neuropsychopharmacology

Co-Author of Study 309 Report: *Effacy of paroxetine in the treatment of adolescent major depression: a randomized controlled trial.*

Neal Ryan, M.D., Professor of Psychiatry, Western Psychiatric Institute & Clinic, University of Pittsburgh, PA. Member of the FDA's Psychopharmacologic Drugs Advisory Committee (Term: 01/12/04 - 06/30/05).

(http://www.fda.gov/cder/audiences/acspage/psychopharmroster1.htm; accessed 01/28/04)

Consultant to GlaxoSmithKline, designing a study and performance site for the Company's study of paroxetine (Paxil or Seroxat) in adolescents. In addition, Ryan was paid to examine the company's aggregate Paxil suicidality data, while also consulting on the design of design of further studies on adolescent antidepressant use. Consultant to Pfizer (Prozac) and Wyeth (Effexor) on studies on adolescent antidepressant use. Principle investigator of Wyeth-funded research on the company's antidepressant, venlafaxine (Effexor), on adolescent depression. (*Preliminary Report of the Task Force on SSRIs and Suicidal Behavior in Youth*, American College of Neuropsychopharmacology, January 21, 2004, p.16; On file with CSPI)

Strober, Michael

Co-Author of Study 309 Report: *Effacy of paroxetine in the treatment of adolescent major depression: a randomized controlled trial.*
http://www.bpkids.org/learning/reference/articles/coyle.pdf

Participant - Depression and Bipolar Support Alliance – underwritten by Abbot, AustraZeneca, Bristol Myers Squibb, Forest Lab, Glaxo Smith Kline, Janssen, Eli Lilly, Merck and Wyeth Ayers. http://www.liebertpub.com/cap/jcappaper1.pdf

Participated in a consensus panel for child and adolescent bipolar disorder funded by:

Abbott, Brystol-Myers Squibb, GlaxoSmithKline, INC Research, Janssen, Johnson & Johnson, Eli Lilly, Novartis, Pfizer, and Solvay.

Participants did not disclose compensation or affiliations.

http://www.liebertpub.com/cap/jcappaper1.pdf

Toprac, Marcia

http://www.nimh.nih.gov/ncdeu/abstracts2003/ncdeu2018.cfm

Poster Session II - 18Service Utilization Among Patients with Bipolar Disorder in the Texas Medication Algorithm Project Source of Funding: TMAP was funded by: United States Pharmacopoeia Convention, Inc., Abbott Laboratories, AstraZeneca, Bristol-Myers Squibb, Eli Lilly & Company, Forest Laboratories, GlaxoSmithKline, Janssen Pharmaceutica, Novartis, Organon, Pfizer, Inc. and Wyeth-Ayerst Laboratories.

http://www.mhmr.state.tx.us/centraloffice/medicaldirector/timaMDDman.pdf

[PDF] TEXAS IMPLEMENTATION OF MEDICATION ALGORITHMS (TIMA) Guidelines were provided by Abbott Laboratories, Bristol-Myers Squibb Company, Eli Lilly and Company M. Lynn Crismon, PharmD. Tawny Bettinger, PharmD. Marcia Toprac, Ph.D ...

www.mhmr.state.tx.us/centraloffice/medicaldirector/timaMDDman.pdf

Trivedi, Madhukar

Dr. Trivedi has received research grants from Abbott, Akzo (Organon), Bayer, Bristol-Myers Squibb, Eli Lilly, Forest Laboratories, Glaxo Wellcome, Janssen, Johnson & Johnson, MeadJohnson, Parke-Davis, Pfizer, Pharmacia - Upjohn, Solvay, and Wyeth - Ayerst. He has been a member of speakers' bureaus sponsored by Bristol-Myers Squibb, Forest Laboratories, Pharmacia - Upjohn, Solvay, and Wyeth Ayerst.

http://home.cwru.edu/activism/READ/NEJM051800.html

Trivedi has received research grant support from Abbott Laboratories, Bayer Corporation Pharmaceutical Division, Bristol-Myers Squibb Company, Forest Pharmaceuticals, Inc., Glaxo Wellcome Inc., Johnson & Johnson - Merck Consumer Pharmaceuticals Co., Eli Lilly and Company, Mead Johnson, Parke-Davis, Pfizer Inc, Pharmacia Corporation, Wyeth-Ayerst Laboratories, and Organon Inc.; and is a member of the speaker's bureau/advisory boards for Bristol-Myers Squibb Company, Pharmacia Corporation, Solvay Pharmaceuticals, Inc., and Wyeth-Ayerst Laboratories.

http://www.psychiatrist.com/audiograph/indexc.htm

Wagner, Karen D.

Co-Author of Study 309 Report*: Effacy of paroxetine in the treatment of adolescent major depression: a randomized controlled trial.*

Co-Author of the Preliminary Report of the Task Force on SSRIs and Suicidal Behavior in Youth, American College of Neuropsychopharmacology

Karen Dineen Wagner, M.D., Ph.D., Director, Professor, and Vice Chair, Department of Psychiatry and Behavioral Sciences, Division of Child and Adolescent Psychiatry, University of Texas Medical Branch, Galveston, TX. Consultant to Wyeth-Ayerst. Member of the speaker's bureau for Janssen. Member of the scientific advisory board for Abbott Laboratories, Eli Lilly, Forest Laboratories, GlaxoSmithKline, Novartis, Otsuka, Janssen, Pfizer, UCB Pharma, and Wyeth-Ayerst. (Preliminary Report of the Task Force on SSRIs and Suicidal Behavior in Youth, American College of Neuropsychopharmacology, January 21, 2004, p.16; On file with CSPI) Receives research support from Abbott Laboratories, Bristol-Myers Squibb, Eli Lilly, Forest Laboratories, Novartis, Otsuka, Janssen, Pfizer, and UCB Pharma. GlaxoSmithKline, Organon, Pfizer, and Wyeth-Ayerst. Served as a National Institute of Mental Health consultant to Abbott Laboratories, Bristol-Myers Squibb, Cyberonics, Eli Lilly, Forest Laboratories, GlaxoSmithKline, Member of the speaker's bureaus for Abbott Laboratories, Eli Lilly, GlaxoSmithKline, Forest Laboratories, Pfizer, and Novartis. (JAMA 2003; 290:1033-41)

http://www.cspinet.org/cgi-bin/integrity.cgi