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

| | |
|---|---|
| UNITED STATES OF AMERICA *ex rel.* Victoria Starr,<br><br>Plaintiffs,<br><br>v.<br><br>JANSSEN PHARMACEUTICA PRODUCTS, L.P.,<br><br>Defendant. | CIVIL ACTION NO. 04-cv-1529 |
| UNITED STATES OF AMERICA *ex rel.* Lynn Powell,<br><br>Plaintiffs,<br><br>v.<br><br>JANSSEN PHARMACEUTICA PRODUCTS, L.P., and JOHNSON & JOHNSON,<br><br>Defendants. | CIVIL ACTION NO. 04-cv-5184 |
| UNITED STATES OF AMERICA *ex rel.* Camille McGowan and Judy Doetterl,<br><br>Plaintiffs,<br><br>v.<br><br>JANSSEN PHARMACEUTICA, INC., JANSSEN PHARMACEUTICA PRODUCTS, L.P., and JOHNSON & JOHNSON, INC.<br><br>Defendants. | CIVIL ACTION NO. 05-cv-5436 |

| | | |
|---|---|---|
| UNITED STATES OF AMERICA, *et al.*, *ex rel.* Kurtis J. Barry,<br><br>Plaintiffs,<br><br>v.<br><br>ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC. and JOHNSON & JOHNSON, INC.<br><br>Defendants. | : | CIVIL ACTION NO. 10-cv-0098 |

**UNITED STATES' COMPLAINT IN INTERVENTION**

From at least 1999 through 2005, Johnson & Johnson (J&J) and its subsidiary Janssen Pharmaceuticals, Inc. ("Janssen") (collectively, "defendants") promoted Risperdal, an atypical antipsychotic drug, for uses that were not approved as safe and effective by the Food and Drug Administration (FDA) ("off-label uses") and, in some cases, were not covered by Medicaid and other federal healthcare programs. Defendants established a specialized ElderCare sales force to promote Risperdal. This sales force promoted Risperdal in nursing homes to control agitation, aggression, and other behavioral disturbances in elderly dementia patients. Janssen promoted Risperdal to control behavioral disturbances and conduct disorders in children and to treat attention deficit disorder and other off-label conditions. Janssen also promoted Risperdal for use in the general population to control mood and anxiety symptoms unrelated to any psychotic disorder. Clinical trials, including those sponsored by defendants, indicated that taking Risperdal increased the risk of strokes in the elderly and diabetes in all patients. In 2005, FDA requested that Janssen change the Risperdal label to include a "Boxed Warning," commonly known as a "black-box warning" – the agency's strongest warning – about the increased risk of death in the elderly. By knowingly and actively promoting Risperdal as safe and effective for off-label and

non-covered uses, defendants caused Medicaid and other federal healthcare programs to pay hundreds of millions of dollars for uncovered claims.

## I. JURISDICTION AND VENUE

1. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. §§ 1331 and 1345 and supplemental jurisdiction over the common law causes of action pursuant to 28 U.S.C. § 1367(a).

2. This Court may exercise personal jurisdiction over defendants pursuant to 31 U.S.C. § 3732(a), because they transact business in this District.

3. Venue is proper in this District under 31 U.S.C. § 3732 and 28 U.S.C. § 1391(b) and (c) because defendants have transacted business in this District and have committed acts proscribed by 31 U.S.C. § 3729 in this District.

## II. PARTIES

4. The United States brings this action on behalf of the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) (formerly known as the Health Care Financing Administration), which administers the Medicaid program in conjunction with the states; the TRICARE Management Activity (TMA); the United States Office of Personnel Management (OPM); the United States Department of Veterans Affairs (VA); and the Office of Workers' Compensation Programs of the United States Department of Labor (DOL-OWCP).

5. Relator Victoria Starr resides in Oregon. In April 2004, Ms. Starr filed an action alleging violations of the False Claims Act (FCA), 31 U.S.C. §§ 3729-33, on behalf of herself and the United States Government pursuant to the *qui tam* provisions of the FCA, 31 U.S.C. § 3730(b)(1) (2008).

6. Relator Lynn Powell resides in North Carolina. In November 2004, Ms. Powell filed an action alleging violations of the FCA on behalf of herself and the United States Government pursuant to *qui tam* provisions of the FCA.

7. Relators Camille McGowan and Judy Doetterl reside in New York. In December 2004, these relators filed an action alleging violations of the FCA on behalf of themselves and the United States Government pursuant to *qui tam* provisions of the FCA.

8. Relator Kurtis Barry resides in Colorado. In January 2010, Mr. Barry filed an action alleging violations of the FCA on behalf of himself and the United States Government pursuant to *qui tam* provisions of the FCA.

9. Defendant J&J is a New Jersey corporation with its principal place of business in New Jersey. J&J manufactures, markets, and sells a wide range of pharmaceutical, medical, and related products. J&J is qualified to do business in Pennsylvania and does business in Pennsylvania.

10. Defendant Janssen is a Pennsylvania corporation with its principal place of business in New Jersey. Janssen is a wholly owned subsidiary of J&J and the successor in interest to Janssen Pharmaceutical Products, L.P., Janssen Pharmaceutica, Inc., and Ortho-McNeil-Janssen Pharmaceutical Products, Inc. From 1999 through 2005, and at all times relevant to the complaint, Janssen marketed and sold Risperdal. Janssen is qualified to do business in Pennsylvania and does business in Pennsylvania.

11. During the relevant time period, J&J was Janssen's sole owner. Janssen's President and Chief Executive Officer (CEO) reported directly to a J&J Company Group Chairman, who in turn reported to J&J's Executive Committee and Board of Directors. J&J and Janssen executives were also members of a Pharmaceutical Global Operating Committee and a Pharmaceutical Global Strategic Marketing Committee, through which J&J set overall corporate

goals that guided Janssen's strategic and tactical plans for Risperdal. J&J established Janssen's business objectives and sales goals and regularly reviewed and approved Janssen's sales numbers and projections. During the relevant time period, J&J supervised and controlled corporate sales goals; drug research, development, and manufacturing; medical affairs; regulatory affairs and compliance; legal affairs; and public relations. Defendants worked together to achieve the common business purpose of selling Risperdal.

## III. STATUTORY AND REGULATORY FRAMEWORK

### A. The False Claims Act

12. The False Claims Act (FCA), 31 U.S.C. §§ 3729–3733, provides for the award of treble damages and civil penalties for, *inter alia*, knowingly causing the submission of false or fraudulent claims for payment to the United States, knowingly using a false record or statement material to a false claim, or conspiring to get a false claim paid. Specifically, the FCA provided, in part, that any person who:

> (a)(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government . . . a false or fraudulent claim for payment or approval;
>
> (a)(1)(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; [or][1]
>
> (a)(3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid . . .
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000 plus 3 times the amount of damages which the Government sustains because of the act of that person. . . .
>
> * * *

[1] The FCA was amended pursuant to Public Law 111-21, the Fraud Enforcement and Recovery Act of 2009 (FERA), enacted May 20, 2009. Section 3729(a)(1)(B) was formerly Section 3729(a)(2), and is applicable to this case by virtue of Section 4(f) of FERA, while Section 3279(a)(1) of the statute prior to FERA, and as amended in 1986, remains applicable here.

> For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information, (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729(a)(1) (2008), (a)(1)(B) (2009), and (a)(3) (2008).

13. Pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended by the Debt Collection Improvement Act of 1996, 28 U.S.C. § 2461 (notes), and 64 Fed. Reg. 47099 47103 (1999), the FCA civil penalties were adjusted to $5,500 to $11,000 per false claim for violations occurring on or after September 29, 1999.

## B. The Anti-Kickback Statute

14. The federal anti-kickback statute, 42 U.S.C. § 1320a7b(b), arose out of Congressional concern that remuneration given to those who can influence healthcare decisions would result in goods and services being provided that are medically unnecessary, of poor quality, or even harmful to a vulnerable patient population. To protect the integrity of the Medicare and Medicaid programs from these harms, Congress enacted a prohibition against the payment of kickbacks in any form.

15. The anti-kickback statute prohibits drug companies from knowingly and willfully offering, paying, soliciting, or receiving remuneration, in cash or in kind, directly or indirectly to induce physicians or others to prescribe drugs for which payment may be made by federal health care programs.

## C. The Federal Healthcare Programs

### 1. Medicaid Federal-State Health Care Program

16. Medicaid is a joint federal-state program that provides health care benefits for certain groups, primarily the poor and disabled. The federal portion of each state's Medicaid

payments varies by state and is generally between 50 and 83 percent, depending on the state's per capita income. 42 U.S.C. § 1396d(b).

17. Although prescription drug coverage is an optional benefit for states under Medicaid, all states and the District of Columbia have opted to cover prescription drugs under their Medicaid state plan. Before the beginning of each calendar quarter, each state submits to CMS an estimate of its Medicaid federal funding needs for the quarter. CMS reviews and adjusts the quarterly estimate as necessary, determines the amount of federal funding needs for the quarter, and determines the amount of federal funding each state will be permitted to draw down as it actually incurs expenditures during the quarter. The state then draws down federal funding as actual provider claims are presented for payment. At the end of each quarter, the state submits to CMS a final expenditure report, which provides the basis for adjustment to the quarterly federal funding amount (to reconcile the estimated expenditures to actual expenditures). 42 C.F.R. § 430.30.

18. The Medicaid Drug Rebate Program ("Rebate Program") is a partnership between CMS, State Medicaid Agencies, and participating drug manufacturers that helps to offset the Federal and State costs of most outpatient prescription drugs dispensed to Medicaid patients. The Rebate Program requires, among other things, that a drug manufacturer enter into, and have in effect, a national rebate agreement ("Rebate Agreement") with the Secretary of HHS in exchange for State Medicaid coverage of most of the manufacturer's outpatient prescription drugs. Manufacturers are then responsible for paying rebates to states for those drugs based in part on the part on utilization by Medicaid patients. These rebates are paid by drug manufacturers on a quarterly basis and are generally shared between the States and the Federal government to offset the overall cost of the prescription drugs under the Medicaid program.

19. Under the Rebate Program, all states are generally required to provide coverage for drugs that meet the definition of a covered outpatient drug, as defined in the federal Medicaid Drug Rebate Statute, 42 U.S.C. § 1396r-8(k)(2). Once the manufacturer enters into a Rebate Agreement, a state is generally required to cover that manufacturer's covered outpatient drugs under the state plan (with certain limited exceptions) unless "the prescribed use is not for a medically accepted indication." 42 U.S.C. § 1396r-8(d)(1)(B)(I).

20. The Medicaid Rebate Statute defines "medically accepted indication" as any FDA approved use or a use that is "supported by one or more citations included or approved for inclusion in any of the compendia" set forth in the statute. 42 U.S.C. § 1396r-8(k)(6).

21. A drug does not generally meet the definition of a "covered outpatient drug" if it is prescribed for a use that is neither FDA-approved nor supported by a citation included or approved for inclusion in the compendia. 42 U.S.C. § 1396r-8 (k)(3). CMS has stated that the statutory definition of medically accepted indication "requires coverage of off-label uses of FDA-approved drugs for indications that are **supported** (as opposed to listed) in the compendia." Medicaid State Rebate Release No. 141 (May 4, 2006) (emphasis added). Thus, even if a drug is FDA-approved for one indication, Medicaid ordinarily does not cover other uses that do not qualify as medically accepted indications.

**2. The TRICARE Program**

22. TRICARE is a managed health care program established by the Department of Defense. 10 U.S.C. §§ 1071-1110. TRICARE provides health care benefits to eligible beneficiaries, which include, among others, active duty service members, retired service members, and their dependents.

23. The regulatory authority establishing the TRICARE program does not cover drugs not approved by the FDA. *See* 32 C.F.R. § 199.4(g)(15)(i)(A).

24. TRICARE does not cover drugs used for off-label indications unless such off-label use is proven medically necessary and safe and effective by medical literature, national organizations, or technology assessment bodies. *See* 32 C.F.R. § 199.4(g)(15)(i)(A)(Note).

**3. The Federal Employee Health Benefits Program**

25. The Federal Employee Health Benefits Program ("FEHBP") is a federally-funded health care program established by Congress in 1959, pursuant to the Federal Employees Health Benefits Act. 5 U.S.C. §§ 8901 *et seq.*

26. OPM administers this program and contracts with various health insurance carriers to provide services to FEHBP members. *Id.* at §§ 8902, 8909(a).

27. Monies for the FEHBP are maintained in the Employees Benefits Fund ("Treasury Fund"), which OPM administers. *Id.* at § 8909(a). The Treasury Fund — which the United States Treasury holds and invests — is the source of all relevant payments to the insurance carriers for services rendered to members. *Id.* at § 8909.

**4. The Veterans Administration**

28. The VA maintains a system of medical facilities from which all pharmaceutical supplies, including prescription drugs, are purchased directly or indirectly by the VA and dispensed to beneficiaries. It also supports a mail service prescription program as part of the outpatient drug benefit. The system serves approximately four million veterans.

**5. The Labor Department**

29. DOL-OWCP administers the following programs: the Federal Employees' Compensation Act, 5 U.S.C. § 8101 *et seq.*, which provides medical benefits to federal employees injured in the performance of duty; the Energy Employees Occupational Illness Compensation Program Act, 42 U.S.C. § 7384 *et seq.*, which provides medical benefits to eligible Department of Energy nuclear weapons workers; and the Black Lung Benefits Act,

30 U.S.C. § 901 *et seq.*, which provides medical benefits to coal miners who are totally disabled by pneumoconiosis arising out of coal mine employment.

## IV. THE RISPERDAL LABEL

30. Risperdal is an atypical antipsychotic drug. On December 29, 1993, FDA approved Risperdal for "management of the manifestations of psychotic disorders" in adults. The approved label explained that "[t]he antipsychotic efficacy of RISPERDAL was established in short-term (6 to 8-weeks) controlled trials of schizophrenic inpatients."

31. The approved Risperdal label included a statement in the Precautions section that "[c]linical studies of Risperdal did not include sufficient numbers of patients aged 65 and over to determine whether they respond differently from younger patients." The label also provided special dosing instructions for the elderly, stating that "[i]n general, a lower starting dose is recommended for an elderly patient, reflecting a decreased pharmacokinetic clearance in the elderly, as well as a greater frequency of decreased hepatic, renal or cardiac function, and therapy greater tendency to postural hypotension." Janssen later sought FDA approval for 0.5 mg and 0.25 mg Risperdal tablets to address special dosing requirements of certain patient populations, including the elderly. In 1999, FDA approved the lower-dose Risperdal tablets.

32. On March 3, 2002, FDA approved revised labeling for Risperdal to state that Risperdal is indicated for "the treatment of schizophrenia."

33. On December 4, 2003, FDA approved Risperdal for the short-term treatment of acute manic or mixed episodes associated with Bipolar I disorder in adults.

34. Between 1999 and 2005, Risperdal was not approved by FDA for any other conditions in adults or for use in children for any purpose.

35. In 2006 and 2007, FDA approved Risperdal for the treatment of irritability associated with autistic disorder in children and adolescents, schizophrenia in adolescents, and Bipolar I disorder in children and adolescents.

## V. PROMOTION OF RISPERDAL

### A. Janssen Promoted Risperdal for Elderly Nursing Home Residents

36. From the time Risperdal was first approved in 1993, FDA repeatedly advised Janssen not to market the drug as safe and effective for the elderly. In addition, clinical studies, including those sponsored by defendants, indicated health risks in elderly dementia patients taking Risperdal, including the risk of strokes. In 2005, FDA requested that Janssen add a black-box warning to the Risperdal label about the risk of death in elderly patients taking the drug. Janssen promoted Risperdal to control behavioral disturbances in the elderly until at least 2005.

#### 1. FDA Warned Janssen Against Promoting Risperdal as Safe and Effective in the Elderly.

37. When Janssen asked FDA to review certain marketing materials in August 1994, FDA advised Janssen "it would be misleading to suggest that the safety and efficacy of Risperdal has been established in the elderly." (Exhibit 1).

38. Janssen subsequently informed FDA that it was conducting a clinical trial (RIS-USA-63) aimed at determining the effectiveness of Risperdal in treating "behavioral disturbances in demented patients." In a letter dated April 28, 1995, FDA responded that the proposed label expansion would improperly suggest that Risperdal was effective for "all the various signs and symptoms that fall under such an umbrella, e.g., anxiety, depression, phobic fears, panic attacks, diurnal rhythm disturbances, etc. We would consider such a claim misleading in that sense. . . ." FDA also cautioned that behavioral disturbances in dementia patients were not necessarily psychotic manifestations and "might even be construed by some as

appropriate responses to the deplorable conditions under which some demented patients are housed, thus raising an ethical question regarding the use of an antipsychotic medication for inappropriate behavioral control." (Exhibit 2).

39. In a 1997 meeting with FDA, Janssen suggested that it might seek an indication for "aggression in dementia." FDA raised concerns about an indication for "aggression":

> [I]f a patient screams (one of the measured behaviors in the aggressive subscale of the BEHAVE-AD), is it because he/she is demented, or because he/she is trying to communicate displeasure or even pain? Many demented patients, particularly those included in our trials, have limited verbal skills. Therefore, an indication for 'aggression' could allow a patient's limited capacity for self-expression to be reduced.

(Exhibit 3).

40. In January 1999, FDA reviewed selected Janssen sales aids for Risperdal and issued an Untitled Letter informing Janssen that "presentations that focus on this [elderly] population are misleading in that they imply that the drug has been found to be specifically effective in the elderly." In its letter, FDA stated that "Janssen is disseminating materials that imply, without adequate substantiation, that Risperdal is safe and effective in specifically treating hostility in the elderly." (Exhibit 4). When Janssen asked FDA to reconsider its position that the promotional materials in question made claims of specific efficacy in the elderly population, FDA explained that "the safety and efficacy in the elderly was not particularly examined in 'fragile' individuals" and that "the campaign 'Hostile Outside, Fragile Inside' implies without adequate substantiation, that Risperdal has been specifically shown to be effective in treating psychotic elderly patients with hostility." (Exhibit 5).

**2. Defendants' Clinical Studies Showed That Risperdal Increased Health Risks in the Elderly.**

41. In 1998, Janssen began pursuing an indication for dementia. In support of a potential indication, defendants funded a series of clinical studies involving the use of Risperdal

to treat behavioral disturbances in the elderly and psychosis in Alzheimer's patients. One study (RIS-USA-63), published in 1999, failed to show a statistically significant improvement in dementia patients taking Risperdal versus a placebo, but appeared to show some efficacy in treating psychosis and aggression in elderly patients. A second study (RIS-INT-24), also published in 1999, failed to show a statistically significant difference in effectiveness between Risperdal and placebo on any scale.

42. In March 2001, defendants received the top-line results of a third study (RIS-AUS-5) that suggested efficacy in some symptoms, but also revealed more cerebrovascular adverse events (CVAEs), including strokes, in elderly dementia patients taking Risperdal than in the placebo group.

43. After receiving the top-line results, one senior Janssen executive objected to immediate submission of an abstract summarizing the study's results for a medical symposium. In an internal e-mail dated March 22, 2001, the executive stated:

> I am very reluctant to have these data in the public domain that soon.
>
> You may have noticed in the topline results that there are substantially more CVD A.E.s [cerebrovascular disease adverse events] in the Risperdal group. They are of substantial concern to us and we are reviewing all the narratives of these cases as well as CVD A.E. in our other dementia studies. It is crucial we have a better understanding of these data before we make the data public. I propose to keep this discussion and concern in house, though, until we have better understanding.
>
> So, I cannot endorse a rapid submission of an abstract end March [sic].

(Exhibit 6).

44. On May 11, 2001, a senior Janssen statistician and co-author of the RIS-AUS-5 study circulated an internal memorandum reporting that the CVAE disparity in the raw statistics was similar in RIS-AUS-5 and RIS-INT-24 and that "this risk was statistically significant in these two trials individually and when they were combined with USA-63." On May 15, 2001,

Janssen made a non-public submission to FDA under applicable regulations of the CVAE data from RIS-AUS-5. On August 22, 2001, Janssen submitted to FDA a separate analysis of records from more than 10,000 patients who had taken Risperdal.

45. In September 2001, three senior Janssen executives assessed whether, in light of RIS-AUS-5 and relevant business considerations, the pursuit of a dementia indication should be terminated. Among other issues, the executives discussed the financial implications of discontinuing the pursuit of a dementia indication, noting that "Risperdal is the foundation of the J&J LTC [long-term care] portfolio." The executives ultimately recommended to the J&J Development Commitment Committee continuing the pursuit of a dementia indication at least through the completion of another ongoing trial (RIS-USA-232). (Exhibit 7). Defendants continued pursuing a dementia indication.

46. Starting in 2002, when presenting the results of RIS-AUS-5 to physicians, Janssen pooled the adverse event data from that study with the adverse event data from two other studies (RIS-USA-63 and RIS-INT-24). Janssen advised paid speakers and sales representatives that the pooled data showed "a significantly higher incidence of cerebrovascular adverse events in patients treated with [Risperdal] compared to patients treated with placebo." However, pooling the data resulted in a lower overall rate of cerebrovascular adverse events than RIS-AUS-5 standing alone.

47. On February 22, 2002, Janssen submitted a manuscript documenting the results of RIS-AUS-5 for publication. The manuscript was published in February 2003.

48. On September 19, 2002, FDA notified Janssen that it was requesting additional warnings on the labels for all antipsychotics, including Risperdal, because of the increased incidence of strokes and other cerebrovascular adverse events reported in elderly dementia patients treated with antipsychotics.

49. On April 3, 2003, at FDA's request, Janssen modified the Risperdal label to include a new warning regarding adverse events in elderly patients with dementia, which stated:

> **Cerebrovascular Adverse Events, Including Stroke, in Elderly Patients with Dementia:** Cerebrovascular adverse events (e.g. stroke, transient ischemic attack), including fatalities, were reported in patients (mean age 85 years; range 73-97) in trials of risperidone in elderly patients with dementia-related psychosis. In placebo-controlled trials, there was significantly higher incidence of cerebrovascular adverse events in patients treated with risperidone compared to patients with placebo. RISPERDAL has not been shown to be safe or effective in the treatment of patients with dementia-related psychosis.

Janssen also sent out a letter to doctors on April 16, 2003, as FDA requested, warning them of the CVAE risk in elderly dementia patients.

50. After the label change and letter to doctors, Janssen instructed ElderCare sales personnel to affirmatively communicate the CVAE warning to doctors and to inform doctors that the risk of CVAEs increases with age and that patients who experienced CVAEs in Risperdal trials had a mean age of 85.

51. On March 21, 2003, Janssen received the top-line results of the fourth study involving the use of Risperdal in elderly dementia patients (RIS-USA-232). The study failed to demonstrate efficacy in treating dementia and confirmed the increased risk of CVAE in elderly patients treated with Risperdal. The RIS-USA-232 results showed that four patients treated with Risperdal experienced CVAEs compared to one patient in the placebo group. Internally, Janssen concluded that the results of RIS-USA-232 "confirmed the imbalance" of the risk of cerebrovascular events in patients taking Risperdal.

52. Janssen filed a non-public safety report with FDA under applicable regulations in June 2003 that included the CVAE data from RIS-USA-232.

53. On September 1, 2003, one of the physicians who designed the protocol for the RIS-USA-232 trials sent an e-mail to a senior Janssen executive encouraging Janssen to publish the RIS-USA-232 results. The physician stated:

> Janssen has been sitting on the [RIS-USA-232] trial results for a long time. Yet it has a moral and ethical responsibility to publish results quickly and in a way that they can be understood and makes clinical sense. It has an obligation to publish not just the clinical efficacy data which could very well be informative and supportive of the use of risperidone if considered properly, but also the safety data, including events that have been labeled in the past as "cerebrovascular adverse events" and deaths.

(Exhibit 8).

54. Janssen finalized its internal analysis of the results of RIS-USA-232 and completed its internal Clinical Study Report for RIS-USA-232 on February 26, 2004. The same month, at the meeting of the American Association of Geriatric Psychiatry, an FDA representative presented a paper regarding CVAE that included data from RIS-USA-232. In March 2004, Janssen began including data from RIS-USA-232 in medical information packets the company provided in response to requests for information submitted by physicians.

55. Through 2004, Janssen continued to disseminate the "pooled data" from the three earlier studies to doctors and sales representatives, not updating the "pooled data" to include the results of RIS-USA-232. Janssen retained physicians identified as Key Opinion Leaders ("KOLs") to present the "pooled" data that omitted the results of RIS-USA-232.

56. On March 25, 2004, another physician – a Janssen KOL – urged Janssen to include the RIS-USA-232 results in the pooled data with the three earlier dementia studies:

> At this point, so long after RIS 232 has been completed, I think it is wrong to continue to submit abstracts of the three pooled studies. At this point, we must be concerned that this gives the strong appearance that Janssen is purposely withholding the findings from RIS 232.
>
> Adverse effect findings from 232 are available on the web through the British government's regulatory site. It was also mentioned by someone

> from FDA at the AAGP annual meeting. It is not a secret that a fourth study has been conducted. As an investigator who is loyal to this program, I really do have to speak out and urge that Janssen avoids embarrassment and accusations about suppressing information that is relevant to providers and consumers.

(Exhibit 9). In response, a Janssen executive agreed: "[A]t this point it is my opinion that all pooled analysis should include -232."

57. Janssen presented some of the RIS-USA-232 data, including safety data, at a medical symposium in June 2004. Janssen submitted a poster documenting the results of RIS-USA-232, including safety data, at another medical symposium in October 2004. The full study results, including safety data, were submitted for publication on February 1, 2005 and published in March 2006.

58. Separately, FDA conducted a meta-analysis of data from seventeen clinical trials involving four atypical antipsychotic drugs, including clinical trial data unavailable to Janssen. On April 11, 2005, FDA issued a safety alert referencing risk of death in elderly dementia patients taking Risperdal and other atypical antipsychotics. FDA's safety alert also announced the agency's intention to ask manufacturers of all atypical antipsychotics to add a black-box warning to their label. In subsequent correspondence with the company, FDA noted that "[a]lthough the signal for increased mortality is somewhat weaker and somewhat less consistent for risperidone than for several other drugs in this class, it is strong enough, in our view, for us to conclude this is likely a class effect." The Risperdal package label was subsequently modified to state:

> **Increased Mortality in Elderly Patients with Dementia-Related Psychosis**
>
> Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo controlled trials (modal duration of 10 weeks) in these patients revealed a risk of death in the drug-treated

> patients of between 1.6 to 1.7 times that seen in placebo treated-patients. Over the course of a typical 10 week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. RISPERDAL (risperidone) is not approved for the treatment of patients with Dementia-Related Psychosis.

### 3. Janssen Promoted Risperdal as Safe and Effective for Elderly Patients

59. From 1999 through 2005, Janssen aggressively marketed Risperdal as having an "unparalleled safety profile" and being effective in controlling behavioral disturbances in the elderly. In its 1999 business plan for the ElderCare market, one of Janssen's express objectives was to "[e]xpand [the] geriatric market and enhance leadership position for the treatment of late life mental disorders." (Exhibit 10). That year, Janssen increased the size of its ElderCare sales force to 136 sales representatives. This specialized sales force focused on nursing homes, long term care facilities, and doctors who treated the elderly. It marketed Risperdal as effective to treat symptoms such as hostility, aggression, agitation, wandering, and depression, regardless of whether the patients exhibited any evidence of psychosis or schizophrenia. In 2000, one of Janssen's business plan objectives was to "[m]aximize and grow RISPERDAL's market leadership in geriatrics and long term care. Dementia share goal is 57% with sales of $302 MM." The core sales messages for 2000 included: "RISPERDAL has proven efficacy in treating geriatric patients" and "RISPERDAL has an excellent safety and tolerability profile in geriatric patients." (Exhibit 11).

60. In a 2001 ElderCare Sales Force update, Janssen congratulated its ElderCare sales force for helping to increase Risperdal's market share in the elderly population, noting that:

> [A]s a result of your focused efforts and dedication, RISPERDAL continues to be the market leader in the LTC/geriatric market. . . . RISPERDAL continues to dominate the dementia market, with a share of 52.5% for the 12 months ending February 2001.

61. In 2001, Janssen created a Business Plan titled "Risperdal LTC/Geriatrics Business Plan" reflecting its continued focus on marketing Risperdal for behavioral disturbances in the elderly. (Exhibit 12). That year, Janssen produced a series of 2,100 continuing medical education ("CME") presentations called "Senior Care Seminars" attended by thousands of healthcare providers nationwide. Sales representatives tracked prescriptions written by doctors who attended the programs.

62. In 2002, Janssen indicated in its Business Plan that it would continue to focus its marketing message on the elderly. Its position statement was that "RISPERDAL is 1st choice for psychotic & behavioral disorders," including behaviors associated with dementia. In one study completed in early 2002, Janssen tracked physicians' recall of sales messages, including "Effective for Geriatrics," "Effective for Dementia," and "Effective for Agitation," to confirm that the sales representatives were delivering these sales messages and to identify opportunities for better market penetration.

63. In 2003, Janssen indicated in its Business Plan that dementia "remains an important strategic area of focus for RISPERDAL and the company." At the 2003 ElderCare National Meeting in Atlanta, Janssen encouraged sales representatives to deliver the following core message:

> Risperdal is the #1 prescribed product in its class BECAUSE it offers *superior efficacy* in the treatment of behavioral, psychotic, mood and anxiety related symptoms of schizophrenia in patients 65+ with a low risk for diabetes/DKA, movement disorders and falls.

64. In April 2003, FDA approved quick dissolving Risperdal tablets, commonly referred to as "M-Tabs." In an April 2, 2003 memorandum to the J&J Global Pharmaceutical Pricing Committee, Janssen stated that their marketing strategy was to promote M-Tabs in the long-term care market, given the high prevalence of swallowing difficulties in the elderly.

65. Janssen's 2004 Business Plan indicated that one of its main themes for the year would be to "Re-establish growth in the LTC market."

66. Janssen did not disband the ElderCare sales force and exit the nursing home market until 2005.

67. From at least 1998 through 2004, thousands of records of sales calls by Janssen sales representatives (known as "call notes") and individualized instruction provided by district managers following sales calls (known as "field conference reports") reflect promotion of Risperdal as safe and effective in controlling behavioral disturbances in the elderly. For example:

**Examples from 1998 Call Notes**

**New York**: "DISCUSSED HOW RIS[PERDAL] IS EFFECTIVE AND SAFE IN THE TX [TREATMENT]: OF BEHAVIORAL DISTURBANCES IN THE ELDERLY, ESPECIALLY THOSE WITH DEMENTIA."

**California**: "Left a note introducing myself and ElderCare with Ref[erence] to Risp[erdal] for Geriatric hostility/behavioral problems . . . ."

**Examples from 1999 Call Notes**

**Ohio**: "detailed her on ris[perdal] - she said she would think about pts [patients] who display behavior symp[tom]s we talked about, ensured her ris[perdal] safe in elderly. . . ."

**Florida**: "risp[erdal] - core message - safe and effective in elderly pt [patient] with behavior problems. . ."

**Examples from 2000 Field Conference Reports**

**Minnesota:** "We had the opportunity to meet with five of your targeted psychiatrists. . . .All five psychiatrists confirmed their support of Risperdal in the treatment of behavioral problems due to Dementia."

**Examples from 2001 Call Notes**

**Washington**: "spoke to dr [doctor] about using RIS[perdal] for pts [patients] w/behavioral disturbances assoc [associated] w/dementia, described positive and negative symptoms, agitation"

**Maryland**: "She [the doctor] attended an inservice program today that was held at Menno Village addressing behavioral problems with or w/o dementia."

**Examples from 2002 Call Notes**

**Michigan**: "Detailed on Risperdal efficacy, dosing and side-effect profile vs. competitors for dementia patients w/behavioral problems"

**New Jersey**: "Risp[erdal] works not only for agitation in the elderly but at low doses acts like an SSRI [antidepressant]. People live longer . . . ."

**Examples from 2003 Call Notes**

**Connecticut**: "Risp[erdal]: Admits to not using as much as he could, not comfortable with APS [antipsychotic] meds. So, I went over dosing .25mg for his elderly patients, 1 mg maintenance dose. Stressed use for agitation and anxiety, esp when current SSRI [anti-depressant] therapy is not responding. . . ."

**Delaware**: "[F]ocused on mixed dementia w/ Dr this trip & Ris[perdal] as adjunct therapy for the mood & behavioral problems assoc. w/ dementia"

**Michigan:** "Dr . . . [s]aid he has very little experience with Risperdal and the elderly. Explained how it could help with sundowning syndrome. Told me that he would try it on Gloria's mother."

**Examples from 2004 Call Notes**

**Tennessee**: "ris[perdal]: efficacy on behavioral problems in dementia patients"

**Texas**: "Risp[erdal]: . . . Said he writes in nursing home. Asked for nxt [next] pt [patient] w/ anxiety/depression. Said he will consider as adjunct w/ ssri [antidepressant]."

**4. Janssen Recruited Consultant Pharmacists to Assist In Off-Label Promotion.**

68. A J&J subsidiary entered into agreements with long-term care pharmacy providers that provided financial incentives for increasing the use of Risperdal in the facilities they serviced. Defendants recognized that consultant pharmacists could influence doctors to write Risperdal prescriptions for off-label uses. As part of the off-label marketing campaign, Janssen recruited consultant pharmacists to attend advisory boards and worked with those pharmacists to identify patients to be placed on or switched to Risperdal.

69. In addition to nursing homes, the long-term care pharmacy providers also serviced mental health facilities. In its 2002 business plan, Janssen identified mental retardation and developmental disability (MRDD) as a target market and encouraged sales representatives to market Risperdal as "the first choice for psychotic and behavioral disorder, including MRDD." Janssen trained speakers and consultant pharmacists and sponsored advisory boards or round table discussions to promote Risperdal for behavioral and conduct symptoms in MRDD patients.

**B. Janssen Promoted Risperdal for Use in Children**

70. Until late 2006, Risperdal was not approved for use in children for any purpose. The Risperdal label stated that "[t]he safety and effectiveness in children have not been established." Nonetheless, from at least 1999 through 2005, Janssen promoted Risperdal to treat children for a variety of unapproved uses, including conduct disorders, attention-deficit-hyperactivity disorder (ADHD), and bipolar disorder.

71. On August 15, 1996, Janssen asked FDA to approve an addition of language to the Risperdal label regarding pediatric use. FDA rejected Janssen's request, stating:

> [Y]ou have not identified any pediatric indications for which you believe Risperdal could be approved and you have provided no data from adequate and well controlled trials to support any such approvals. . . To permit the inclusion of the proposed vague references to the safety and effectiveness of Risperdal in pediatric patients and the nonspecific cautionary advice about how to prescribe Risperdal for the unspecified target indication would only serve to promote the use of this drug in pediatric patients without any justification.

(Exhibit 13).

72. On March 3, 2000, Janssen met with FDA to discuss a clinical development plan for an indication for "conduct disorder" in children. Although FDA recognized that "conduct disorder" is a diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders, the agency questioned whether it could approve Risperdal for "conduct disorder," explaining that its

"main concern is that RISPERDAL or any other product would be used as a chemical straight jacket." In addition, FDA expressed concern that conduct disorder was "synonymous with aggression" and that Janssen was "trying to get approval of aggression under the guise of CD [conduct disorder]." (Exhibit 14).

73. Defendants knew that Risperdal could cause elevated levels of prolactin, a hormone released by the pituitary gland that stimulates breast development and milk production. Since launch, the FDA-approved label stated that Risperdal, like other antipsychotics, "elevates prolactin levels." The Risperdal label further stated that "the clinical significance of elevated serum prolactin levels is unknown for most patients."

74. One of Janssen's Key Base Business Goals was to grow and protect share in the child/adolescent market, which Janssen defined to include patients 19 years and under. Janssen's 2001 Base Business Plan stated that the fastest-growing market for Risperdal was pediatrics, with the use of Risperdal "exploding" at a growth rate of 17 percent, for a total market share of $340 million per year. Janssen recognized that Risperdal was used in children primarily for non-psychotic diagnoses: bipolar disorder (21%), autism (18%), ADHD (15%). Janssen also noted that Risperdal was typically prescribed in children "to control aggressive/impulsive behavior."

75. Janssen instructed its sales representatives to call on child psychiatrists as well as on mental health facilities that primarily treated children and to market Risperdal as effective to treat symptoms associated with various childhood disorders such as ADHD, OCD, and autism. The company sponsored numerous advisory boards with child psychiatrists and speakers programs concerning "Risperdal in Children and Adolescents with Severe and Disruptive Behaviors and Below-Average IQ."

76. Janssen prepared two plans for addressing the child and adolescent market in 2002: a business plan ("Risperdal Child and Adolescent Market Segment: 2002 Business Plan

Summary") and a tactical plan ("2002 Tactical Plan RISPERDAL Child and Adolescent Segment: Reach New Heights with Risperdal in 2002"). Janssen identified four key business strategies:

- Understand the level of awareness of RISPERDAL in the child and adolescent market segment;
- Educate health care providers on therapeutic options for treating mental illness in children;
- Develop a child and adolescent public relations and media management plan; and
- Clarify FDA requirements and accelerate JRF program to obtain child and adolescent labeling.

77. In 2002, Janssen created a "C&A Educational Initiative" to promote the use of Risperdal in children and adolescents ("C&A"). As part of this Initiative, Janssen developed advisory boards and CME programs and utilized national and regional opinion thought leaders in child psychiatry. For example, in March 2002, Janssen sponsored a meeting attended by 1,000 physicians, which Janssen executives later described as "[a] great way to get the word out to a big part of the child and adolescent prescribing community." Similarly, at an "Advisory Summit" in February 2003, Janssen presented data promoting Risperdal to treat conduct disorders in children with disruptive behavior disorders.

78. When FDA approved M-Tabs in April 2003, Janssen district managers encouraged contests and other incentives to promote this quick-dissolving Risperdal formulation in children:

> In the San Antonio District, district managers encouraged "Risperdal 'Back to School' Bashing" and proposed ice-cream parties, snacks and lunches as an effective way to deliver an efficacy message of fast onset of M-Tabs and use in the pediatric population.
>
> Notes from a District Managers' Conference Call on August 11, 2003 state: "'There is a very large market for the M-TABs* for children/adolescents!"

In an August 20, 2003 Field Conference Report, a district manager praised the sales representative, stating " You have a great idea for M-Tab starter kits by including lollipops or small toys to be included in the kit along with a coupon and a 1 box of sample. These will be great to use on any child & adolescent psychiatrists that you have....Plan to have these made for our next work session." (Exhibit 15).

79. From at least 1997 through 2004, call notes by Janssen sales representatives and field conference reports from their managers reflect promotion of Risperdal as safe and effective in controlling behavioral disturbances in children and adolescents. For example:

**Examples from 1997 & 1998 Call Notes**

**Maryland:** "remind her [doctor] that risperdal is very effective and safe because she sees lots of children and aldolescence [sic]."

**Michigan:** "sold him on efficacy and safety in children."

**Examples from 2000 Field Conference Reports**

**New York**: "I observed that prolactin was a concern with several of your customers. [Y]ou have a good understanding of prolactin and how to handle this objection with your customers. For example, Dr. H[] stated that she sees prolactin related side effects quite often with Risperdal . . . You did a nice job of discussing how rare prolactin related side effects occur, how to manage it i.e. lowering the dose, and brought the discussion back to side effects that are not easily managed, i.e. diabetes."

**Examples from 2001 Call Notes**

**Texas:** "Discussed . . . proper dosing in children. Warned him about competition putting side effects out of centext [sic] regarding R[isperdal] in children. Asked for starts/switches in aggression"

**Virginia:** "INSERVICE FOR THE GROUP, WENT OVER RISPERDAL USE IN ADULTS AND CHILDREN, THE SYMPTOMS IT COVERS . . ."

**Examples from 2002 Call Notes**

**Washington:** "Dr. has not received information on conduct disorder and recent published articles. We reviewed efficacy of risperdone on aggression and hostility in special populations and doses."

**New York:** "[D]oesn't see adhd but will rx [prescribe] when sees."

**Examples from 2002 Field Conference Reports**

**Minnesota**: "[The doctor] then told you a story about a young woman who developed some prolactin related side effects on Risperdal. Based on his comments it was clear prolactin was an issue of his. You handled his objection and issue perfectly by explaining that any drug that blocks D2 [dopamine] can have an effect on prolactin however the incidence of seeing side effects is very low. You then went onto explain that he may be able to decrease the dose and maintain the great efficacy that he is seeing with Risperdal and at the same time hopefully the side effect will subside. He agreed that this was a good idea and would give it a try."

**Examples from 2003 Call Notes**

**North Carolina:** "Sees 30% kids, 40% adolescents, 30% adults . . . With kids – discussed serotonin profile page – lower doses equate to efficacy in treatment of agitation, aggression – symptoms with behavioral problems."

**Indiana:** "Next call remind him of the type of syms [symptoms] he can treat with Ris[perdal]. [P]aint the picture of a younger patient suffering from these sym [symptoms] and what ris can do for them."

**Examples from 2004 Call Notes**

**South Carolina:** "[B]rief follow up on use of Risperdal and moa [mechanism of action] that will treat anxiety and depressive symptoms. [E]mphasized the importance of dosing and how if dosed appropriately will treat odd [Oppositional Defiant Disorder] symptoms that present with adhd."

**Maryland:** "Goal: aggitated [sic]/aggression in children. Response: must rule out ADHD in children before rx [prescribing] atypical – Risperdal effectively treat[s] resistant depression at lower doses."

## C. Off-Label Promotion in the General Population

80. In addition to marketing Risperdal for use in the elderly, children, and the mentally disabled, Janssen used many of the same tactics to promote Risperdal for off-label use in the general population. Janssen's business and tactical plans aimed at expanding the use of Risperdal to any patient who exhibited mood and anxiety symptoms.

81. At a National Meeting in 2001, Janssen directed sales representatives to emphasize that Risperdal was effective in treating a broad range of symptoms. Janssen's Mood and Anxiety Positioning statement for 2001 was:

> Broad spectrum RISPERDAL is 1st choice for psychotic, behavioral, and mood disorders (bipolar disorder with/without psychosis, refractory depression and refractory anxiety disorders) because it is the only therapy to deliver rapid and sustained efficacy across the full range of symptoms (anxious, manic, depressed) and is uncompromised by safety concerns . . . .

82. Janssen's 2002 Business Plan continued to emphasize marketing to behaviors and mood and anxiety symptoms:

> Broad spectrum RISPERDAL is 1st choice for psychotic and behavioral disorders (Schizophrenia, Schizoaffective disorder, Psychotic depression, Dementia, Bipolar Mania, MRDD) because it is the only therapy to deliver rapid, sustained (within 30 min and for at least 1 year) efficacy across the full range of symptoms (PANSS, cognition, anxiety, mood and behavioral disturbances as well as improved patient function) . . . .

83. In 2002, pursuant to FDA's request, Janssen modified the Risperdal label to state that Risperdal was approved only for the treatment of "schizophrenia." Nonetheless, Janssen instructed the sales managers that there was "No need to notify customers of the label change" because "Our strategy remains the same - **SYMPTOM** focus!" One of Janssen's "core message" for 2002 was:

> For patients with mood disorders (anxiety/depression), Risperdal is the #1 prescribed product in its class because it offers superior efficacy in treating mood symptoms versus both Zyprexa and Haldol with less frequency to cause diabetes in your patients.
>
> Turn off-label use into symptom WAR!

84. In 2002, defendants created a new sales force, "the 500 Gold," to market Risperdal to primary care physicians (PCPs), who do not generally treat schizophrenia or psychotic disorders.

85. One sales representative summarized the direction she received in a 2002 memorandum she sent to other sales representatives and her district manager:

Summary: Mid-Cycle Meeting

Discussion Regarding Off Label Uses for Risperdal

Risperdal has a large volume of studies with proven efficacy in a wide variety of symptoms. There are studies on file for treatment-resistant depression, bipolar disorder and pediatrics usage. We can and should request information medical services whenever these issues arise.

However, in the meantime . . .BRING IT BACK TO THE SYMPTOMS . . . with ANY disease state we can sell Risperdal instead of any of the competition using the studies we currently have in our hands.

Bipolar Disorder. BRING IT BACK TO THE SYMPTOMS (Excitability, Agitation, Aggression, Depression, Delusions)

Pediatrics: BRING IT BACK TO THE SYMPTOMS (Impulsiveness, Agitation, Aggression, Depression, Anxiety).

86. At the National Sales Meeting in February 2003, Janssen identified mood and anxiety among the fastest growing market segments. Janssen told representatives that "[f]ocusing your discussion around these symptoms (hostility, anxiety, depression and impulsiveness) is important because it will help physicians identify appropriate patients for whom low dose (.25mg and .50mg) is an ideal option."

87. Janssen developed a "Mood Backgrounder" and provided sales representatives with the following direction:

Sell symptoms not disease states.

Use patient profiles to make connection to broader usage.

Sell the geriatric benefits of Risperdal.

Ask for female mood and anxiety patients because of weight gain with Zyprexa

Sales representatives were also taught to use the following technique to "Cement the Sale:"

Ask for a specific outcome. Dr. based on the information we've discussed will you use Risperdal for your female mood and anxiety patients? Dr.

can I ask you to use Risperdal for 5 of your next 10 patients suffering from hostility and aggression?

88. In 2004, defendants set a business goal of establishing Risperdal as "a broad spectrum (mood & anxiety symptom patients, and agitated aggressive patients) psychotropic that helps improve patient functioning through its unique mechanism of action."

89. Sales representative call notes and district manager field conference reports reflect sales representatives' efforts to promote Risperdal for non-psychotic disorders and non-schizophrenic patients exhibiting mood and anxiety symptoms:

**Examples from 2001 Field Conference Reports**

"you then bridged into risperdal and explained to Dr. G. the benefits of risperdal in the adult population over others, specifically mood symptoms, by discussing the symptom he is trying to manage."

"Risperdal has proven superior to Zyprexa on positive symptoms and mood disorders."

**Examples from 2002 Call Notes**

**Pennsylvania**: "We went over treatment-resistant depression concept again with Risperdal use over Zyprexa."

**New Hampshire**: "confirmed Risperdal to be first line choice for PTSD [post-traumatic stress disorder] patient."

**Examples from 2003 Call Notes**

**California**: "[T]old him how risp[erdal] is appropriate for pts [patients] with mood disorders or treatment resistant depression. Went over dosing. He said he will rx [prescribe]."

**Arizona**: "He does not have elderly pts [patients], and prefers to leave Risp. up to psychs. We did discuss use of Risp. by PCPs [primary care physicians] for treatment resistant depression and other mood symptoms."

**Examples from 2004 Call Notes**

**Texas**: "Reminded him of using Risp[erdal] for that stubborn depression and sleep problems."

**Alabama:** "Discussed mood, irritability, depressive symptoms and or aggressive symptoms as they relate to serotonin and norepinephrine. . . ."

## VI. RISPERDAL'S KNOWN DIABETES RISKS

90. In marketing Risperdal, Janssen claimed that there was a low risk of developing diabetes associated with the use of Risperdal and that Risperdal was therefore safer than other atypical antipsychotic drugs.

91. In its 2002 Business Plan, one of Janssen's messages was that Risperdal was "uncompromised by safety concerns (does not cause diabetes)." In an October 13, 2002 letter, a district manager praised a sales representative, stating, "You shared with [the doctor] that the prevalence of diabetes was not a class effect, highlighting that Risperdal has a less than one percent incidence. Good Job!"

92. Janssen sponsored a retrospective study of insurance billing data for 6,641 patients to determine the rate of diabetes in patients taking Risperdal and Zyprexa (the "Fuller Study"). When the initial study results were circulated internally, a Janssen medical affairs employee stated: "These are hot off the presses . . . . The general gist is there is no difference between Risperdal and Zyprexa in diabetes risk."

93. Janssen subsequently hired an outside consultant to review the results of the Fuller Study. The consultant reported that the association between medication group and diabetes was "not reliable" due to switching of medications. The outside consultant subsequently re-analyzed the data to control for switching, removed patients from the study, and changed its primary end-point. In 2003, the Fuller study was published in the journal Pharmacotherapy in an article entitled "*A Comparative Study of the Development of Diabetes in Patients Taking Risperdal and Zyprexa.*" The article described the revised analysis and stated that "Zyprexa was associated with a 37% increased risk of development of diabetes compared to Risperdal in a VA population." Janssen disseminated the Fuller Study to sales representatives and through advisory boards and CMEs.

94. In September 2003, FDA requested that additional language be added to the Warnings section of the label for all atypical antipsychotics, including Risperdal, regarding the risk of hyperglycemia and diabetes. Defendants were concerned that the diabetes warning would lead doctors to conclude that diabetes risk was a "class effect" and that all atypical antipsychotics presented the same risk of diabetes. Janssen instructed its sales representatives to cite the Fuller Study as evidence that Risperdal was safer than other antipsychotics for use in patients with diabetes or who were at high risk of developing diabetes.

95. In September 2003, Janssen obtained summary results of a prospective, double-blind, controlled study comparing the diabetes risk of Risperdal versus Zyprexa (RIS-USA-275), which indicated that Zyprexa had no greater tendency to increase the risk of diabetes than Risperdal. In March 2004, Janssen retained outside consultants to review the results of RIS-USA-275. Janssen ultimately removed 17 of the original 59 patients from the study as "not evaluable" based on an assessment of drug levels, medical history, fasting levels, body composition, and glucoregulatory parameters. Janssen finalized its internal Clinical Study Report in May 2004 and first presented the study results at a medical symposium in May 2005.

96. On September 26, 2003, a Voicemail Message Confirmation distributed by the Director of Sales to inform the sales force that Janssen:

> [c]ontinues to believe the scientific evidence shows a difference in the incidence of diabetes among the different atypical antipsychotics. The data DOES NOT show an association between RISPERDAL and an increased risk of diabetes. However, the data DOES SUGGEST a greater association with some of the other products. We are in the process of submitting this data to the FDA for their review and anticipate that they will respond asap. As always, patient safety is our first priority as we share FDA's interest in ensuring that physicians and patients have accurate safety information about our products. You should also be confident that you will be the first to know if or when the FDA makes any decision regarding this issue. In the meantime, you should follow our company position and sales direction and continue to emphasize that RISPERDAL has a 'low' risk of diabetes and DKA (diabetic ketoacidosis) compared to

other drugs in this class utilizing our diabetes reprint carrier combined with our new sales brochure. So let's ensure that we stay FOCUSED on promoting RISPERDAL based on it's [sic] EFFICACY AND SAFETY."

97. On November 6, 2003, Janssen submitted supplemental new drug applications to FDA that included a diabetes warning in the label, as requested by FDA. As revised, the label stated:

> Hyperglycemia, in some cases extreme and associated with kekoacidosis or hypersmolar coma or death, has been reported in patients treated with atypical antipsychotics including RISPERDAL®. Assessment of the relationship between atypical antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes mellitus in patients with schizophrenia and the increasing incidence of diabetes milletus in the general population. Given these confounders, the relationship between atypical antipsychotic use and hyperglycemia-relates adverse events is not completely understood. However, epidemiologic studies suggest an increased risk of treatment emergent hyperglycemia-related adverse events in patients treated with atypical antipsychotics. Precise risk estimates for hyperglycemia-related adverse events in patients treated with atypical antipsychotics are not available.

98. On November 10, 2003, Janssen sent approximately 753,000 doctors a letter informing them about the addition of the diabetes warning to the Risperdal label. The letter stated that FDA had requested that all manufacturers of atypical antipsychotics include a diabetes warning on their product labels and enclosed a copy of the complete prescribing information for Risperdal that included the diabetes warning. However, the letter also asserted that the evidence indicated that Risperdal was ***not*** associated with an increased risk of diabetes when compared to untreated patients:

> Hyperglycemia-related adverse events have infrequently been reported in patients receiving RISPERDAL. Although confirmatory research is still needed, a body of evidence from published peer-reviewed epidemiology research[1-8] suggests that Risperdal is not associated with an increased risk of diabetes when compared to untreated patients or patients treated with conventional antipsychotics. Evidence also suggests that Risperdal is associated with a lower risk of diabetes than some other studied atypical antipsychotics.

Notes 1 through 8 referred to a list of all eight published, peer-reviewed epidemiological studies addressing atypical antipsychotics and diabetes risk.

99. On April 19, 2004, FDA sent a Warning Letter to Janssen that identified several concerns regarding the way Janssen characterized the diabetes risk of Risperdal in its November 10, 2003 letter (Exhibit 16).

100. Janssen sent a second letter to doctors on July 21, 2004, which reported the concerns that FDA had identified in its Warning Letter.

## VII. PAYMENTS TO HEALTHCARE PROVIDERS

101. Janssen paid doctors who participated in the speakers program and other programs related to Risperdal to influence the doctors to write more prescriptions for Risperdal, and certain of the prescriptions written by these doctors were reimbursed by Medicaid and other public healthcare programs.

102. Sales representatives identified local doctors to be trained as speakers based on their potential for writing Risperdal prescriptions. Sales representatives told doctors that if they wanted to speak, they had to increase their Risperdal prescriptions. For example, in an October 7, 2003, e-mail, one sales representative told her district manager that a doctor in her district wanted to be a speaker for Janssen, but only 16 percent of his antipsychotic prescriptions were for Risperdal. The representative discussed plans to tell the doctor that he could qualify to speak the following year if he wrote 50 percent of his prescriptions for Risperdal. The doctor subsequently increased his Risperdal prescriptions and became a paid speaker in 2004.

103. Like local speakers, attendees at advisory boards were chosen by sales representatives based on their ability to write prescriptions for Risperdal. Attendees were paid an honorarium of approximately $1,500 to $2,000. Janssen intended to induce these attendees to

write prescriptions for Risperdal and tracked their prescriptions before and after their attendance at advisory boards to measure whether they increased their prescriptions.

## VIII. SUBMISSION OF FALSE CLAIMS TO FEDERAL HEALTHCARE PROGRAMS

104. Defendants' fraudulent conduct resulted in the submission of false claims to federal healthcare programs. From 1999 through 2005, domestic sales of Risperdal increased from $892 million to $2 billion per year. Defendants targeted patient populations that they knew included large numbers of Medicaid beneficiaries, such as nursing home residents. As a result, during the same time period, defendants caused the Medicaid reimbursements for Risperdal to more than double from $500 million to over $1 billion annually. Defendants also closely tracked the effect of their sales and marketing on both on-label and off-label utilization. According to defendants' own market research, in 2002 as much as 70 to 75 percent of the prescriptions for Risperdal were for off-label uses, some of which were not medically accepted indications for which the United States and state Medicaid programs provided coverage.

### FIRST CAUSE OF ACTION
### (False Claims Act: Presentation of False Claims)
### (31 U.S.C. § 3729(a)(1) (2008))

105. The United States re-alleges the preceding paragraphs as if fully set forth herein.

106. Defendants knowingly caused to be presented false or fraudulent claims for payment or approval to the United States for Risperdal prescriptions that were not covered by Medicaid and/or were ineligible for payment as a result of illegal kickbacks.

107. By virtue of the false or fraudulent claims that defendants caused to be made, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus civil penalties of not less than $5,500 and up to $11,000 for each violation after September 29, 1999. Prior to September 29, 1999, civil penalties are not less than $5,000 and up to $10,000.

**SECOND CAUSE OF ACTION**
**(False Claims Act: False Statements)**
**(31 U.S.C. § 3729(a)(1)(B) (2009))**

108. The United States re-alleges the preceding paragraphs as if fully set forth herein.

109. Defendants knowingly made, used, or caused to be made or used, false records or statements material to a false or fraudulent claim.

110. By virtue of the false records or statements that defendants made, used, or caused to be made or used, the United States is entitled to treble damages and civil penalties of not less than $5,500 or more than $11,000 for each such false record or statement.

**THIRD CAUSE OF ACTION**
**(False Claims Act: Conspiracy)**
**(31 U.S.C. § 3729(a)(3) (2008))**

111. The United States re-alleges the preceding paragraphs as if fully set forth herein.

112. Defendants and others conspired to defraud the Government by getting false or fraudulent claims allowed.

113. By virtue of the conspiracy, defendants and others got false or fraudulent claims paid and the United States is entitled to treble damages and civil penalties of not less than $5,500 or more than $11,000 for each such false or fraudulent claim.

**FOURTH CAUSE OF ACTION**
**(Unjust Enrichment)**

114. The United States re-alleges the preceding paragraphs as if fully set forth herein.

115. As a consequence of the acts set forth above, defendants were unjustly enriched at the expense of the United States in an amount to be determined which, under the circumstances, in equity and good conscience, should be returned to the United States.

116. The United States claims the recovery of all monies by which defendants have been unjustly enriched.

## PRAYER FOR RELIEF

WHEREFORE, the United States demands and prays that judgment be entered in its favor against defendants as follows:

1. On the First Count under the False Claims Act, for the amount of the United States' damages, trebled as required by law, and such civil penalties as are required by law.

2. On the Second Count under the False Claims Act, for the amount the United States was damaged, trebled as required by law, and such civil penalties as are required by law.

3. On the Third Count under the False Claims Act, for the amount of the United States' damages, trebled as required by law, and such civil penalties as are required by law.

4. On the Fourth Count for unjust enrichment, for the amounts by which defendants were unjustly enriched, plus interest, costs, and expenses.

5. On all Counts, such further relief as the Court deems just and proper.

Respectfully submitted,

STUART F. DELERY
Assistant Attorney General
Civil Division

ZANE DAVID MEMEGER
United States Attorney
Eastern District of Pennsylvania

LOUIS D. LAPPEN
First Assistant United States Attorney

MARGARET L. HUTCHINSON
Chief, Civil Division
Assistant United States Attorney

MARY CATHERINE FRYE
Deputy Chief, Civil Division
Assistant United States Attorney

CHARLENE KELLER FULLMER
Assistant United States Attorney
Eastern District of Pennsylvania
615 Chestnut Street, Suite 1250
Philadelphia, PA 19106
(215) 861-8301

MICHAEL GRANSTON
JAMIE A. YAVELBERG
JENNIFER L. CIHON
EDWARD C. CROOKE
Attorneys, Civil Division
U.S. Department of Justice
Commercial Litigation Branch
601 D Street NW
Washington, D.C. 20044

Dated: November 4, 2013