Exhibit 106

BDC meeting – Project Tango

Presentation

September 12th

PURDUE

Page(s) Omitted

Exhibit 107

From: Haddox, Dr. J. David
To: Damas, Raul
Sent: 9/18/2014 9:12:00 PM
Subject: Fwd: Purdue Daily News-Buprenorphine-related hospitalizations of children

FYI

No response as of yet.

Dave

Sent from my iPhone

Begin forwarded message:

From: "Haddox, Dr. J. David" <Dr.J.David.Haddox@pharma.com>
To: "Sackler, Dr Kathe" <Dr.K.A.Sackler@pharma.com>
Cc: "Damas, Raul" <Raul.Damas@pharma.com>, "Timney, Mark (Mark.Timney@pharma.com)" <Mark.Timney@pharma.com>
Subject: RE: Purdue Daily News-Buprenorphine-related hospitalizations of children

Kathe,

The article provides information on emergency hospitalizations (inpatient, transfers, and observations of up to 48 hours) following unsupervised ingestion of prescription medications by children aged <6 years from 2007-2011. OTC medicines and medicines available both by prescription and OTC (eg, ibuprofen) were excluded. If documentation was limited to a class description, only those comprising prescription medicines were included in the analysis (eg, opioid analgesics), whereas those comprising mixtures of medicines available both by prescription and OTC were excluded (eg, unspecified NSAIDs).

Key Findings include:

1) During 2007-2011, an estimated 34,503 Emergency Department visits for unsupervised ingestion of oral prescription medicines by children younger than 6 years of age occurred.

2) 9,490 of those encounters resulted in emergency hospitalizations.

3) 75% of the emergency hospitalizations occurred in children 1-2 years old.

4) Only one drug product was implicated in 78% of the hospitalizations.

5) Opioid analgesics were implicated in 17.6% of the hospitalizations.

6) Benzodiazepines were implicated in 10.1%.

7) Buprenorphine was implicated in 7.7% (n = 734 hospitalizations, or 6 for every 100,000 prescriptions or 200.1 per 100,000 unique patients)

a. 97.2% of buprenorphine-related hospitalizations involved a combination buprenorphine/naloxone product (ie, minimal, if any, Butrans®)

b. None of the buprenorphine-related hospitalizations in this study resulted in a fatal outcome.

c. A previous study of poison center calls involving buprenorphine exposure in children (10/2009 – 03/2012; n = 2,380 cases) showed:

i. Exposure to buprenorphine/naloxone film (n = 26) was significantly-less frequent than to tablets (n = 509); rate ratio = 3.5 [95% CI, 2.7-4.5])

ii. No exposure to film had a maximum adverse-event severity of Grade 4 (life-threatening), while 7.6% of those to buprenorphine/naloxone tablets and 15.8% of those to buprenorphine tablets did.

iii. That study reported four deaths, none of which involved the film dosage form.

While any unintended ingestion of any medication by a child is cause for concern, I offer a few more facts and some observations relevant to these data:

1) The vast majority of exposures were in toddlers, regardless of the drug. This is, unfortunately, not unusual.

2) The buprenorphine/naloxone film has been available only in individual, child-resistant packaging since its introduction. It was approved 08/30/2010, during the time of data collection for this study, so the impact of child-resistant packaging on overall hospitalization rates cannot be assessed by this study. This study did not report buprenorphine exposures by dosage form, either.

3) In 2013, all branded buprenorphine/naloxone products were transitioned to unit-dose packaging.

4) Some generic buprenorphine/naloxone tablets are currently dispensed in bottles.

5) One must consider to whom buprenorphine/naloxone is typically prescribed – patients with a diagnosis of opioid use disorder. It is likely that some of these are not as fastidious about medication security in the home as they should be. Thus, the importance of child-resistant, unit-dose packaging for this population.

In sum, I think this study generally supports the assertions made by the film manufacturer in their Citizen Petition and doesn't harm the product.

As always, I am happy to discuss in more detail or answer specific questions.

Dave

J. David Haddox, DDS, MD
VP, Health Policy
Purdue Pharma L.P.
One Stamford Forum
Stamford, CT 06901-3431
203.588.7667 W
203.588.6242 F

Ms. Beatriz Arredondo
Administrative Associate
203.588.8017 W

From: Timney, Mark
Sent: Wednesday, September 17, 2014 7:51 AM

To: Sackler, Dr Kathe
Cc: Haddox, Dr. J. David; Damas, Raul
Subject: RE: Purdue Daily News

Kathe, we are well aware.

David will provide you a brief note. In essence this is a generic tablet issue, and not a film issue, which is positive for Tango.

Mark.

From: Sackler, Dr Kathe
Sent: Tuesday, September 16, 2014 6:59 PM
To: Timney, Mark
Subject: Fwd: Purdue Daily News

Dear Mark,
In case you have not seen it yet - the article below Susie's welcome (below) requires immediate attention, verification and assessment.
Best,
Kathe

K. A. Sackler, MD
203 588-7300
203 912-4676 direct
ksackler@pharma.com<mailto:ksackler@pharma.com>

Begin forwarded message:
From: Purdue Daily News <Purdue.DailyNews@pharma.com<mailto:Purdue.DailyNews@pharma.com>>
Date: September 15, 2014 at 12:05:33 PM EDT
To: Purdue Daily News <Purdue.DailyNews@pharma.com<mailto:Purdue.DailyNews@pharma.com>>
Subject: Purdue Daily News
[cid:image003.jpg@01CFD0CA.AB122CE0]

Purdue Pharma L.P. Names Susie Robinson Vice President of Human Resources<http://www.marketwatch.com/story/purdue-pharma-lp-names-susie-robinson-vice-president-of-human-resources-2014-09-15>

PR Newswire (Press Release), September 15, 2014

Purdue Pharma L.P. today announced that Susie Robinson, former head of human resources at Lumeris, has joined the company as Vice President of Human Resources. "With her proven record of transforming organizations and building talented workforces, Susie will further strengthen Purdue's high performance culture," said Mark Timney, President and CEO of Purdue Pharma. "I'm confident that the skills and experience she brings to Purdue will have an immediate positive impact on our company." Robinson has more than 17 years of global leadership experience in human capital management, talent development, and organizational and cultural transformation. She has a proven record of building company capabilities and executing strategic change initiatives…

Kids' Poisonings Linked to Anti-Addiction Medicine<http://abcnews.go.com/Health/wireStory/kids-poisonings-linked-anti-addiction-medicine-25502178>

The Associated Press (Chicago, IL), September 15, 2014

An anti-addiction drug used to fight the nation's heroin and painkiller abuse epidemics poses a threat to young children who accidentally swallow relatives' prescriptions, a federal study says. Some children have died. The study found that the drug, buprenorphine, was the adult prescription medication most commonly implicated in emergency hospitalizations of children aged 6 and younger. For every 100,000 patients prescribed buprenorphine, 200 young children were hospitalized for taking it, the study found. That rate is more than four times higher than the statistic for next most commonly implicated drug, a blood pressure medicine. Almost 800 youngsters a year were hospitalized after swallowing buprenorphine, the study found. The research, published Monday in the journal Pediatrics, covered data from 2007 to 2011. It did not include deaths, but other medical journal reports have cited deaths from such incidents…

Prescription Opioid Drug-Use Soars in Canada<http://www.scienceworldreport.com/articles/17148/20140912/prescription-opioid-drug-use-soars-in-canada.htm>

Science World Report, September 12, 2014

Prescription drug abuse throughout North America is continuing to become a problem throughout the continent. In the United States in particular, statistics show that many southern states are dealing with increasingly high amounts of overdose. Now, new findings also show that neighbors to the north are dealing with issues. Recent findings published in the journal Canadian Family Physician show that Canada is dealing with significant prescription drug abuse. Researchers at St. Michael's Hospital and the Institute for Clinical Evaluative Sciences examined available data and discovered that from 2006 to 2011 that the percentage of prescriptions written for high-dose opioids increased by 23 percent. Furthermore, the incidence rate went from 781 units per 1,000 patients to 961 units per 1,000 patients…

FOR INTERNAL PURPOSES ONLY. NOT TO BE USED IN PROMOTION.
<Buprenorphine Poison Calls re Children-Root Causes-JPeds 2013-EJLavonas RCDart.pdf>
<Ingestion of Drugs by Children Resulting in Hospitalizations-Pediatrics-2014-buprenorphine.pdf>

Exhibit 108

BOD Science & Technology Committee

Project Tango

J. David Haddox, DDS, MD

Vice President, Health Policy

Submitted February 24th, 2015

PURDUE

Purpose and Agenda

- Purdue has been approached by [redacted] to form a joint venture – [redacted]
  - This JV would acquire [redacted]
  - Through this JV, we would be acquiring the market leader in the addiction medicine space, SUBOXONE® (buprenorphine and naloxone) sublingual film
  - [redacted]

- This presentation will re-introduce
  - SUBOXONE®
  - Medication-Assisted Treatment (MAT)
  - Buprenorphine
  - [redacted]

SUBOXONE® film is Indivior's lead product and market leader in MAT

	Description	Sample quotes
Suboxone film has a leading position in the opioid addiction treatment space	▪ Buprenorphine + naloxone ▪ Gold standard for opioid addiction over the last decade ▪ Limited differentiation by new market entrants	*"The film is my first choice, I know what I get and I continue to have confidence using it"* **Prescriber**
Numerous product attributes encourage continued adoption	▪ Convenient, discreet, fast-dissolving formula ▪ Child-resistant packaging ▪ Lower rates of abuse than tablets ▪ Safer than methadone in accidental ingestion	*"My film is discreet, quick, easy to use [not accidently swallow] and doesn't make me feel drugged. It give me more stability"* **Patient**
Favorable pricing situation promotes market penetration	▪ Market leader on cost (priced similar to generics) ▪ Generous co-pay support program	*"Suboxone film gives me the ability to have a normal life"* **Patient**
Extensive patient support services	▪ Here to Help® Program: provides patients personalized information regarding addiction and treatment	

Medication-Assisted Treatment (MAT)

- The use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders
- Medication-Assisted Treatment
  - Is safe
  - Is cost-effective
  - Reduces:
    - Relapse
    - HIV/AIDS (rates drop significantly after one year of MAT)
    - Urine drug test positives
    - Hepatitis
    - Cutaneous infections and spesis
    - Embolic complications from impurities
    - Overdose events and fatalities
    - Criminal justice costs

Buprenorphine is the preferred molecule in Medication-Assisted Treatment (MAT)

	Buprenorphine	Methadone	Naltrexone
MOA	■ Partial MOR agonist	■ Full MOR agonist	■ MOR antagonist
Route	■ Sublingual	■ Oral	■ Oral or IM depot
Administration	■ Prescribe	■ Dispense (OTP)	■ Prescribe/Inject
Advantages	■ Decreased craving; decreased reward if opiate abused	■ Decreased craving; long track record of success	■ Doesn't cause physical dependence
Disadvantages	■ Has some nonmedical use;	■ OTP; physical dependence; drug-drug interactions; QTc interval effects;	■ Poor compliance with po; early drop-out with IM; pain control?;

Modified from: **Volkow ND, Frieden TR, Hyde PS, Cha SS. Medication-Assisted Therapies — Tackling the Opioid-Overdose Epidemic. N Engl J Med 370:(2063-2066). May 29, 2014**

History of Buprenorphine Clinical Development

- 1968 – Reckitt & Colman begin Phase 1 analgesia studies
- 1978 – landmark paper postulating use in treating addiction
- 1978 – injectable formulation launched as analgesic in UK
- 1982 – sublingual formulation launched as analgesic in UK
- 1985 – injectable available in 29 countries; sublingual in 16
- **1989 – NIDA begins Medication Development Division (MDD)**
- 1989 – UN CND: buprenorphine listed in Psychotropic Convention
- **1993 – MDD approaches R&C about buprenorphine for addiction**
- 1995 – France approves Subutex for treatment of addiction
- **2000 – US Drug Addiction Treatment Act signed into law**
- **2002 – DEA reschedules buprenorphine from CV to CIII**
- **2002 – FDA approves SL buprenorphine (+/- naloxone) for use in addiction**
- 2010 – FDA approves transdermal buprenorphine for analgesia

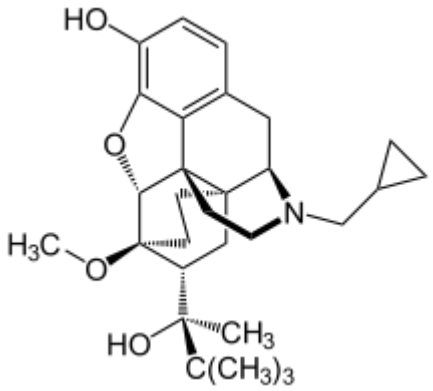
Buprenorphine Clinical Pharmacology

- Partial agonist at mu-opioid receptor (MOR)
  - 25-50x analgesic potency of morphine
  - Highly lipophilic
  - Comparatively-long MOR occupancy time
  - Duration of morphine-like effects longer than morphine
  - Ceiling effect of morphine-like effects (debated)
- Antagonist at kappa-opioid receptor
- Agonist at delta-opioid receptor
- Partial agonist at ORL-1 (nociceptin) receptor

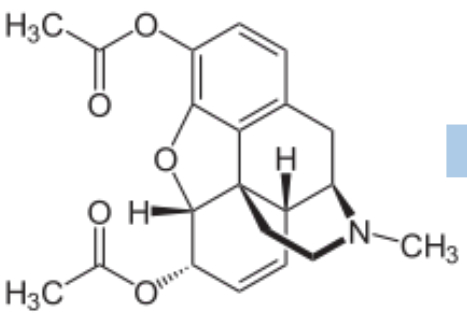
- **Buprenorphine is capable of suppressing craving and preventing withdrawal syndrome without inducing euphoria**

- **The prime motivator for its nonmedical use is withdrawal avoidance, not euphoria**

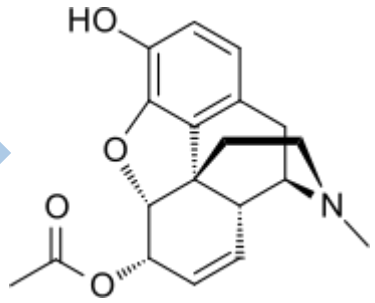
Buprenorphine Chemical Structure



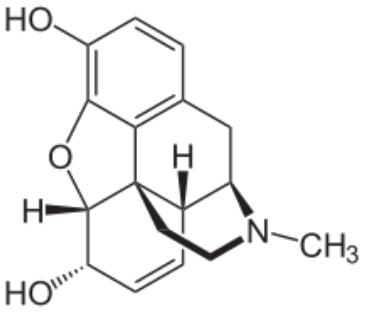
Buprenorphine



Heroin



6-monoacetyl morphine



Morphine

SUBOXONE® revolutionized MAT

- Methadone maintenance was the standard MAT from 1974
- Buprenorphine has lower abuse potential than alternatives (CIII vs CII)
- Favorable safety profile
  - Fewer drug-drug interactions
  - Less inter-patient variability in PK and PD
  - Ceiling Effect
- Similar maternal and fetal outcome, compared to methadone
  - Less severe and less prolonged NAS
- Drug Addiction Treatment Act of 2000
  - Allowed prescribing by qualified physicians
  - Destigmatized addiction and its treatment
- Federal government educational resources facilitate its use
  - TIPs – Treatment Improvement Protocols
  - PCCS-MAT – Providers' Clinical Support System for MAT

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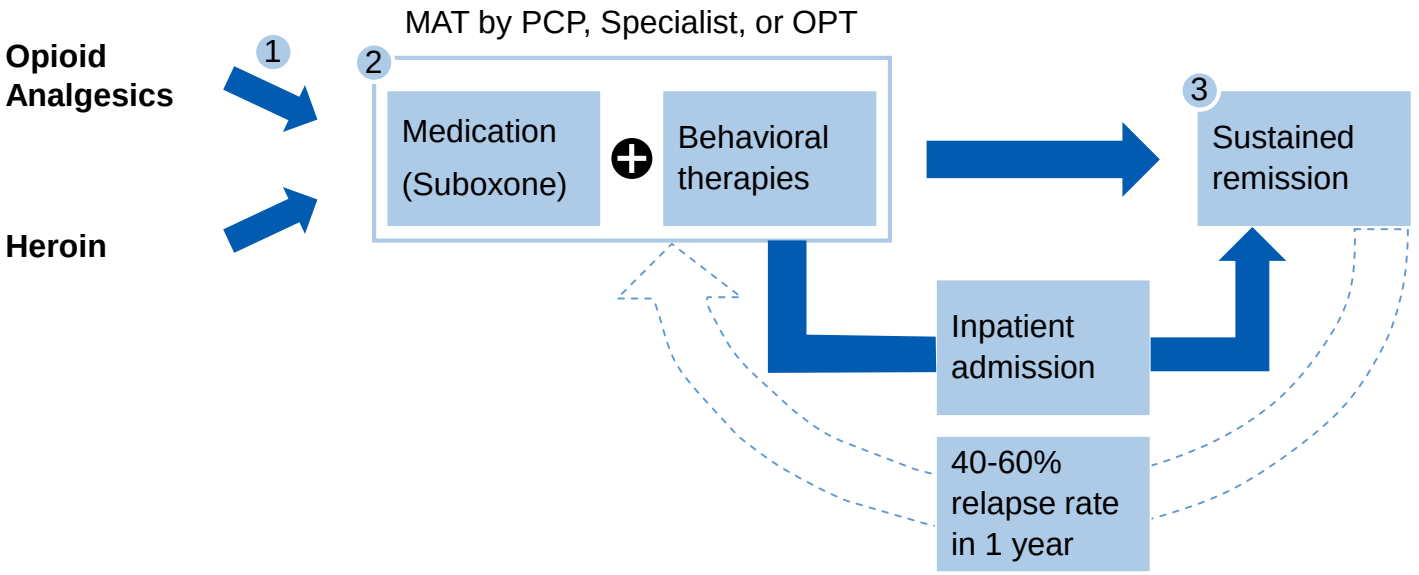
Appendix

Minimal differentiation between agonist products keeps SUBOXONE Film as the Gold Standard

	Effectiveness	Safety / tolerability	Formulation	Other
SUBOXONE sublingual Film	Bioequivalence to SUBOXONE tablets	Fewer accidental deaths than SUBOXONE tablets	Film that is discrete and easy to use	▪ Film is safer for non-patients
Buprenorphine SL tablets (mple generics)	Retention in treatment 20%-68% for 1 mg to 8 mg	AEs consistent with those in a population in opiate treatment	Tablet with potential risk of swallowing	▪ Not all packaging is child-resistant
Zubsolv (Orexo)	BE to SUBOXONE tablets but at lower dosage (5.7/1.4 mg – 8/2 mg)	AEs consistent with those in a population in opiate treatment	Tablet with potential risk of swallowing	
Bunavail (BDSI)	BE to SUBOXONE tablets but at lower dosage (4.2/0.7 mg - 8/2mg)	Lower drug load	Buccal mucoadhesive film that is discrete and easy to use	
Methadone	Retention in treatment 20%-82% for 30 mg to 80 mg	Variable PK/PD profile; Drug-drug interaction; QT risks	Inconvenient liquid formulation or diskette	▪ Dispensed, not prescribed; Inconvenient

NB: ER Naltrexone, injectable is also approved by FDA for use in MAT

Illustrative Patient Flow



Areas in need of improvement

1. Improve diagnosis rate through provider education, outreach to treatment settings likely to see a large population of substance abusing patients (e.g. ED, pain clinics)
2. Improve integrated approach to therapy through fostering collaboration with psychological care, local mental health and social service agencies - drawing on KOLs
3. Improve follow-up rate to reduce relapse rates. Requires a data-driven approach to understand current scope of problem and where changes may make an impact.

What is good MAT with SUBOXONE?

1. Timely identification of an opioid-use disorder (SBIRT)
2. Individualized treatment of addiction and related comorbidities
3. Induction, Titration, and Maintenance (ie, Medication-Assisted Treatment)
4. Psychological counseling (eg, Cognitive Behavioral Therapy)
5. Mutual-support groups (eg, Narcotics Anonymous)
6. Management of co-occurring pain, mental illness, and other comorbidities
7. Social and community support (eg, vocational rehabilitation)
8. Treatment retention and management of relapse

Current status of MAT

	Medication-Assisted Treatment (buprenorphine or methadone + psychotherapy)
Objective	▪ **Improved control over substance abuse** – Abstinence or increased time between relapses ▪ **Improved individual and public health outcomes** – Decrease in cases of HIV, hepatitis, septic complications, etc. – Better management of other health conditions (eg, mental health) – Better social function (Fewer arrests, improved employment, etc.)
Current outcomes	▪ Currently, there is a very high drop-out rate from treatment programs – Only 34% complete full course or transfer to a different treatment program ▪ High proportion (60-80%) have comorbid mental health problems – Currently, majority are un-diagnosed, un-treated, or under-treated ▪ High public health impact of untreated or poorly treated patients – 5% of those entering treatment incarcerated within last 30 days – Risk of HIV, hepatitis 2-10X that of non-abusers (rates drop to near-normal following 1 year of successful treatment) – 80% of those entering treatment unemployed

Exhibit 109

Executive Committee

December 10, 2015

PURDUE

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Budget action items (1/5)

Immediate followup

Not intended for detailed live walkthrough – please review and note any open items or questions

Request	Who requested	Owner	Urgency
Offline briefing on performance management aspect of SF realignment	P. Costa	Saeed	Nov 30
Update on Region Zero	P. Boerr	Phil	[redacted]
[redacted]	J. Sackler	Phil	
	K. Sackler	Phil	
	P. Costa	Phil	
Discuss R&D capabilities upgrade	J. Sackler	Gail / Alan D / Susie	Dec 1 [TBC – may be better as Q1 board update]
Share updated 10 year plan	K. Sackler	JJ	ASAP [pending JJ/Mark review]

Budget action items (2/5)

December followup

Not intended for detailed live walkthrough – please review and note any open items or questions

Request	Who requested	Owner	Urgency
For each drug, productivity data broken out by indication vs HCP specialty	R. Snyderman / K. Sackler / M. Sackler	Saeed	December
Share details on analytics used to calculate 2016 mg/tablet trends	R. Sackler	Saeed	December
EC-level review of Compliance implications of NP/PA and LTC targeting	EC-level	Bert / Saeed	December
Followup briefing on OxyContin market impact of CDC guidelines	J. Sackler	Saeed	December
Share global plant productivity benchmarking plan	K. Sackler	David	December
Share slides connecting Core Competencies to Purdue strategy	K. Sackler	Susie	December
Share analysis of long-term impact of competitive launches	K. Sackler	Saeed	December
Explain X's in "Other investments" on BD slide 10, especially for Ophthalmology	D. Sackler	Alan B / Saeed	December

Budget action items (3/5)

Q1 followup - offline

Not intended for detailed live walkthrough – please review and note any open items or questions

Request	Who requested	Owner	Urgency [proposed response timing]
Share methodology for confirming SF impact – Hysingla and Total Portfolio	R. Snyderman	Saeed	Q1 [offline briefing]
EC-level review on potential of OAG for Conscious Sedation	EC-level	Gail / Alan D	Q1 [February EC]

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Exhibit 110

APRIL BOARD MEETING

Q1 2016 Commercial Update

April 13, 2016

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Maximum state impact of CDC guidelines on OxyContin

State	Est. Patients at Risk	Annual Rx at Risk	Est. Annual $ Impact
CA	[redacted]	[redacted]	[redacted]
TX	[redacted]	[redacted]	[redacted]
FL	[redacted]	[redacted]	[redacted]
NY	[redacted]	[redacted]	[redacted]
IL	[redacted]	[redacted]	[redacted]
PA	[redacted]	[redacted]	[redacted]
OH	[redacted]	[redacted]	[redacted]
GA	[redacted]	[redacted]	[redacted]
NC	[redacted]	[redacted]	[redacted]
MI	[redacted]	[redacted]	[redacted]
NJ	[redacted]	[redacted]	[redacted]
VA	[redacted]	[redacted]	[redacted]
WA	[redacted]	[redacted]	[redacted]
MA	7,848	47,928	$23,964,122
AZ	[redacted]	[redacted]	[redacted]
IN	[redacted]	[redacted]	[redacted]
TN	[redacted]	[redacted]	[redacted]
MO	[redacted]	[redacted]	[redacted]
MD	[redacted]	[redacted]	[redacted]
WI	[redacted]	[redacted]	[redacted]
MN	[redacted]	[redacted]	[redacted]

Estimate of MAXIMUM impact of CDC guidelines 90 MME/day limit of opioids

All states. Assumes no Rx's above 90 MME/Day. No exceptions.

Assumes state distribution of 90MME/Day is the same as national.

state distribution of Rx based on IMS NPA state level data

Assumes consistent $/Rx of $500

No consideration of concomitant use of other opioids included

State	Est. Patients at Risk	Annual Rx at Risk	Est. Annual $ Impact
CO	[redacted]	[redacted]	[redacted]
AL	[redacted]	[redacted]	[redacted]
SC	[redacted]	[redacted]	[redacted]
LA	[redacted]	[redacted]	[redacted]
KY	[redacted]	[redacted]	[redacted]
OR	[redacted]	[redacted]	[redacted]
OK	[redacted]	[redacted]	[redacted]
PR	[redacted]	[redacted]	[redacted]
CT	[redacted]	[redacted]	[redacted]
IA	[redacted]	[redacted]	[redacted]
MS	[redacted]	[redacted]	[redacted]
AR	[redacted]	[redacted]	[redacted]
UT	[redacted]	[redacted]	[redacted]
KS	[redacted]	[redacted]	[redacted]
NV	[redacted]	[redacted]	[redacted]
NM	[redacted]	[redacted]	[redacted]
NE	[redacted]	[redacted]	[redacted]
WV	[redacted]	[redacted]	[redacted]
ID	[redacted]	[redacted]	[redacted]
HI	[redacted]	[redacted]	[redacted]
ME	[redacted]	[redacted]	[redacted]
NH	[redacted]	[redacted]	[redacted]
RI	[redacted]	[redacted]	[redacted]
MT	[redacted]	[redacted]	[redacted]
DE	[redacted]	[redacted]	[redacted]
SD	[redacted]	[redacted]	[redacted]
ND	[redacted]	[redacted]	[redacted]
AK	[redacted]	[redacted]	[redacted]
DC	[redacted]	[redacted]	[redacted]
VT	[redacted]	[redacted]	[redacted]
WY	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]

Estimates:

Est. $/Rx $500

Est. 12 mos OxyContin patients (IMS NPA MD) 863,213

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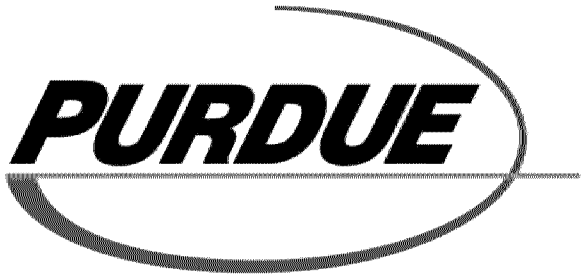
Exhibit 111

Board of Directors:
Business Development Strategy

CONFIDENTIAL

PRE-READ

Submitted May 27, 2016
June 2016



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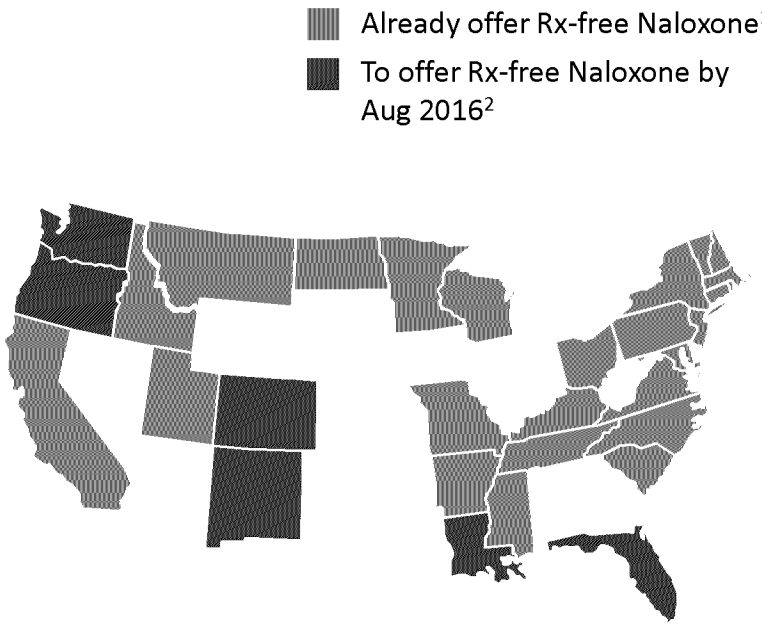
National and local governments have mobilized resources to increase patient access to Naloxone

[redacted]

Large support base among the medical community

- Naloxone is on the World Health Organization's List of Essential Medicines, the most important medications needed in a basic health system
- Experts in health and overdose treatment acknowledge Naloxone's importance
- There are many patient support programs that offer Naloxone free of charge (e.g., Purdue's collaboration with the NSA[3] on law enforcement training of use of Naloxone)

Over 20 states offer Rx-free Naloxone today, growing to over 30 by end of year



1 Through standing order or collaborative practice agreement: Arkansas, California, Indiana, Massachusetts, Minnesota, Mississippi, Montana, New Jersey, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Utah and Wisconsin, Connecticut, Kentucky, Maryland, North Carolina, New Hampshire, Ohio, Virginia and Vermont

2 Through standing order or collaborative practice agreement: New Mexico, Louisiana, Florida, Colorado, Idaho, Oregon and Washington

3 National Sheriff's Association

Source: Web search, WHO, CDC

Exhibit 112

Mid-year update

June 8, 2016

PURDUE

Page(s) Omitted

Lawmakers Are Curbing Opioid Prescriptions, But Also Supporting Access to Opioids with Abuse-Deterrent Technology

- CARA Passed in Senate
- 18 Bills Passed in House
- $1.1B White House Request

- CMS Line Extension Ruling
- White House ADF Statement
- Rep. Rogers Scolds Insurers

- MA, CT, VT, ME Limit Opioids
- CT Considered Tax on CIIs
- Takeback Bills Proliferating

- 7 States Passed OADP Law
- Passed 3 State Chambers
- 21 States Considering Law

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Exhibit 113

Braeburn Pharmaceuticals: Structuring Analysis

CONFIDENTIAL

DRAFT

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Braeburn Pharmaceuticals Company Profile

Asset/opportunity overview

Braeburn Pharmaceuticals, a commercial stage pharmaceutical company, focuses on long-acting implantable and injectable therapies for serious neurological and psychiatric disorders, including addiction, pain, and schizophrenia. The FDA approved Probuphine in May 2016 as the first buprenorphine implant for the treatment of opioid dependence.

[redacted]

Page(s) Omitted

Exhibit 114

To: Sackler, Mortimer D.A.[msackler@pharma.com]; Sackler, Dr Richard[DrRichard.Sackler@pharma.com]; Sackler, Jonathan[Jonathan.Sackler@pharma.com]; Timney, Mark[Mark.Timney@pharma.com]; Charhon, JJ[JJ.Charhon@pharma.com]; Butcher, Alan[Alan.Butcher@pharma.com]; Motahari, Saeed[Saeed.Motahari@pharma.com]; Dunton, Alan[Alan.Dunton@pharma.com]; Ronning, Michael[Michael.Ronning@pharma.com]; Adams, Corey[Corey.Adams@pharma.com]; Khanarian, Nora[Nora.Khanarian@pharma.com]
Cc: Ruiz, Elliott[Elliott.Ruiz@pharma.com]; Laing, Alicia[Alicia.Laing@pharma.com]; Condon, Donna[Donna.Condon@pharma.com]
Bcc: Patel, Niyoshi[patelni3@purdue.mail.onmicrosoft.com]
From: Ruiz, Elliott
Sent: Thur 12/22/2016 4:44:24 PM
Subject: Braeburn Presentation
Braeburn Structuring Proposal_vF3.pdf

All,

In advance of tomorrow morning's call, please see the attached presentation on Braeburn.

Let us know if there are any questions.

Thanks,
Elliott

Elliott Ruiz
Purdue Pharma L.P.
Business Development Finance & Treasury
Tel: 203-588-7220

Exhibit 115

To: Cawkwell, Gail[Gail.Cawkwell@pharma.com]
Cc: Baker, Stuart[sbaker@chadbourne.com]; Pickett, Cecil[Cecil.Pickett@pharma.com]; Sackler, Dr Richard[DrRichard.Sackler@pharma.com]; Sackler, Mortimer D.A.[msackler@pharma.com]; Snyderman, Ralph[Ralph.Snyderman@pharma.com]; Sackler, Dr Raymond R[DrRaymondR.Sackler@pharma.com]; Sackler, Beverly[Beverly.Sackler@pharma.com]; Sackler Lefcourt, Ilene[Ilene.SacklerLefcourt@pharma.com]; Sackler, Dr Kathe[Dr.K.A.Sackler@pharma.com]; Sackler, Jonathan[Jonathan.Sackler@pharma.com]; Sackler Hunt, Samantha[Samantha.SacklerHunt@napp.co.uk]; Sackler, David A.[ds@srllc.com]; Boer, Peter[Peter.Boer@pharma.com]; Costa, Paulo[Paulo.Costa@pharma.com]; Theurillat, Jacques[Jacques.Theurillat@pharma.com]; Singh, Raman[Raman.Singh@mundipharma.com.sg]; Mattessich, Antony[Antony.Mattessich@mundipharma.com]; Landau, Dr. Craig[Craig.Landau@purdue.ca]; McGowan, Peter[Peter.McGowan@mundipharma.com]; Wikström, Åke[Ake.Wikstrom@mundipharma.com]; Martin, Josephine[Josephine.Martin@pharma.com]; Mayne, Tracy[Tracy.Mayne@pharma.com]; Weiss, Elizabeth[Elizabeth.Weiss@pharma.com]; Timney, Mark[Mark.Timney@pharma.com]
From: Sackler, Dame Theresa
Sent: Sat 5/6/2017 3:04:54 AM
Subject: Re: ICER update - report released

Many thanks...
What was Purdue,s involvement in 1-4 of the remedial action plan ?

Sent from my iPad

On 6 May 2017, at 01:21, Cawkwell, Gail <Gail.Cawkwell@pharma.com> wrote:

Dear Board Members and others,

As expected, today, May 5th, the Institute for Clinical and Economic Review (ICER), a non-profit organization that analyzes the cost effectiveness of medicines, released a draft report on the clinical and cost effectiveness of abuse deterrent opioids. The report is available at this link: https://icer-review.org/wp-content/uploads/2016/08/NECEPAC_ADF_Draft_Report_05.05.17.pdf. As a reminder, ICER's funding and Board are dominated by commercial insurers. While there has been no media coverage yet today, we expect that this will receive attention and a robust action plan is in place and some of the on-line responses (see links, below) are worth reading.

There are three sections to the ICER report.

1. Systematic review. ICER reviewed 15 pre-marketing studies, all showing that ADF reduced drug liking and desire to take drug again versus non-ADFs. ICER also reviewed 26 post-marketing epidemiologic studies, all were OxyContin-specific and all showed reductions in abuse, overdose, death, diversion and doctor shopping after reformulation. Despite this, ICER inappropriately interpreted several studies on switching and route of administration to conclude

that the net benefit of ADFs is inconclusive.

2. Economic model. The economic model reports that among 100,000 patients treated over 5 years, reformulated OxyContin was not cost effective:

   - Averted 3,082 cases of abuse; and 8,852 years of abuse
   - Increased overall medical costs by $511 million
   - The cost per abuser averted is $165,868
   - The cost per overdose death averted is $977 million
   - To be cost neutral, ADFs would need to reduce their price by 39%

3. State-level analysis: A state-level economic analysis reported that converting 100% of the extended release opioid market to ADF would:

   - In Massachusetts, prevent 1100 cases of abuse, but cost an incremental $490 million per year
   - In Vermont, prevent 160 cases of abuse, but cost an incremental $27 million per year

It is disappointing, but not unexpected, that ICER has missed the opportunity to fairly assess a technology that has the potential to play an important role in the current opioid crisis. A robust action plan has been instituted, including the following actions:

1. Stories highlighting ICERs subversion of its own scientific process, creating a model to conform with its preconceived conclusions, are expected to be published over the next 5 days in: Bloomberg, Forbes, Politico, Pink Sheet, and Fierce Pharma

2. Numerous organizations and individuals (PhRMA, BIO, National Pharmaceutical Council, Abuse Deterrent Coalition (http://abusedeterrent.org/news/Abuse-Deterrent-Coalition-Comment-on-Institute-for-Clinical-and-Economic-ICER-Review-Draft-Scoping-Document-on-Abuse-Deterrent-Formulation-of-Opioids-Effectiveness-and-Value.aspx#.WQ0UV1UrKCg), Edward Pezalla, Peter Pitts (http://www.drugwonks.com/), Richard Dart, Noam Kirson, and potentially individuals at NIDA and former FDA officials) have agreed to make supportive public statements

3. A letter highlighting ICER report errors and violations, and co-signed by many ADF manufacturers, has been made public by the Abuse Deterrent Coalition

4. A scientific article, co-authored by the former National Medical Director of Aetna and T. Mayne (Purdue Pharma), showing the $200 million cost savings found by ICER's original model, is expected to be published in the Journal of Managed Care Pharmacy in the next 2 weeks with an accompanying press release.

5. Internal Purdue statements; FAQs; talking points; reactive statements and slide decks; and Medical Science Liaison, Medical information and Managed Markets trainings have been developed and will be executed next week.

Best wishes,

Gail Cawkwell, MD, PhD

Chief Medical Officer and
Vice President, Medical Affairs
Purdue Pharma , L.P.
1 Stamford Forum
Stamford, CT 06901

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Mobile Phone: 203-968-3339
Gail.cawkwell@pharma.com
Assistant: Naya Mohammed (203) 588-7051

Purdue Medical Affairs: Transforming Science into Value

Click here<http://www.purduepharma.com/healthcare-professionals/products> for Full Prescribing information for all Purdue products

Exhibit 116

Board of Directors: Purdue Mid Year Pre-Read

June 2017

Page(s) Omitted

Sales & Promotion Expenses – Sales Force Cost

PDEs:	2017 LE	2018	2019	2020	2021	CAGR
OxyContin	202,397	200,000	166,221	150,167	149,335	**(7%)**
Butrans	204,928	0	0	0	0	**(100%)**
Hysingla	476,034	370,000	307,508	277,809	276,297	**(13%)**
[redacted]						
Total	**1,123,359**	**1,050,000**	**872,659**	**788,378**	**763,796**	**(9%)**
Sales Territory Business Managers (HC)	534	534	433	385	371	**(9%)**
Cumulative Reduction vs. '17		*0%*	*(19%)*	*(28%)*	*(31%)*	
Cost of Sales Force ($M)	**195**	**148**	**125**	**118**	**118**	**(12%)**
Cumulative Reduction vs. '17		*(24%)*	*(36%)*	*(40%)*	*(39%)*	

PDE assumptions:

- Call to PDE conversion rate went down from average 1.45 (assumed in last year June Strat Plan) to 1.30 due to additional time to detail Symproic (new product).
- 2017LE TBMs HC of 534 includes 100 Account Service Education Reps (ASERs) that work 65% of the time (translates into 499 FTEs).
- PDE calculation based on 7.5 retail calls per day, 216 days per year.

Re-deploying Sales Force Capacity to reflect new portfolio dynamics

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Exhibit 117

Butrans Total Prescriptions by HCP, Product and Strength
source: QuintilesIMS xponent. Aug 2017 data deliverable.
retail pharmacies and mail order

Product	Strength	First	Middle	Last	Address	City	State	Zip	Specialty	1998-01	1998-02	1998-03	1998-04
Butrans	[redacted]					BIRMINGHA	AL	[redacted]					
Butrans						BIRMINGHA	AL						
Butrans						BIRMINGHA	AL						
Butrans						BIRMINGHA	AL						
Butrans						BIRMINGHA	AL						
Butrans						MOBILE	AL						
Butrans						AUBURN	AL						
Butrans						AUBURN	AL						
Butrans						AUBURN	AL						
Butrans						AUBURN	AL						
Butrans						MONTGOMI	AL						
Butrans						HUNTSVILLE	AL						
Butrans						OPELIKA	AL						
Butrans						MONTGOMI	AL						
Butrans						OPELIKA	AL						
Butrans						OPELIKA	AL						
Butrans						BIRMINGHA	AL						
Butrans						MONTGOMI	AL						
Butrans						OPELIKA	AL						
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Butrans						BIRMINGHA	AL						
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Butrans						HUNTSVILLE	AL						
Butrans						HUNTSVILLE	AL						
Butrans						BIRMINGHA	AL						
Butrans						HELENA	AL						
Butrans						GEORGIANA	AL						
Butrans						BIRMINGHA	AL						
Butrans						BIRMINGHA	AL						
Butrans						BIRMINGHA	AL						
Butrans						BIRMINGHA	AL						
Butrans						DOTHAN	AL						

Butrans	[redacted]	DOTHAN	AL	[redacted]
Butrans		DOTHAN	AL	
Butrans		MONTGOMI	AL	
Butrans		MONTGOMI	AL	
Butrans		FAIRHOPE	AL	
Butrans		BIRMINGHA	AL	
Butrans		BIRMINGHA	AL	
Butrans		BIRMINGHA	AL	
Butrans		DOTHAN	AL	
Butrans		FULTONDAL	AL	
Butrans		FULTONDAL	AL	
Butrans		FULTONDAL	AL	
Butrans		BIRMINGHA	AL	
Butrans		BIRMINGHA	AL	
Butrans		TUSCALOOS	AL	
Butrans		TUSCALOOS	AL	
Butrans		TUSCALOOS	AL	
Butrans		TUSCALOOS	AL	
Butrans		MOBILE	AL	
Butrans		ANNISTON	AL	
Butrans		TRUSSVILLE	AL	
Butrans		DECATUR	AL	
Butrans		MILLBROOK	AL	
Butrans		MONTGOMI	AL	
Butrans		MOBILE	AL	
Butrans		ANNISTON	AL	
Butrans		TRUSSVILLE	AL	
Butrans		FOLEY	AL	
Butrans		MOBILE	AL	
Butrans		ANNISTON	AL	
Butrans		FOLEY	AL	
Butrans		ANNISTON	AL	
Butrans		TRUSSVILLE	AL	
Butrans		DECATUR	AL	
Butrans		ANNISTON	AL	
Butrans		BIRMINGHA	AL	
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Butrans		TUSCALOOS	AL	
Butrans		JASPER	AL	
Butrans		FLORENCE	AL	
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Butrans		FOLEY	AL	
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Butrans		DAPHNE	AL	
Butrans		ALABASTER	AL	
Butrans		IRONDALE	AL	
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Butrans		HOMEWOOI	AL	
Butrans		BIRMINGHA	AL	
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Butrans		DAPHNE	AL	
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Butrans		FOLEY	AL	
Butrans		FLORENCE	AL	
Butrans		FLORENCE	AL	
Butrans		FLORENCE	AL	
Butrans		UNIONTOW	AL	
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Butrans		NORTHPORT	AL	
Butrans		NORTHPORT	AL	
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Butrans		ALEXANDER	AL	
Butrans		ALEXANDER	AL	
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Butrans		ALEXANDER	AL	
Butrans		HUEYTOWN	AL	

Butrans	[redacted]	HUEYTOWN	AL	[redacted]
Butrans		FOLEY	AL	
Butrans		FOLEY	AL	
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Butrans		FOLEY	AL	
Butrans		ROGERSVILL	AL	
Butrans		TALLASSEE	AL	
Butrans		TALLASSEE	AL	
Butrans		TALLASSEE	AL	
Butrans		BIRMINGHA	AL	
Butrans		COLUMBIAN	AL	
Butrans		HOOVER	AL	
Butrans		HOOVER	AL	
Butrans		HOOVER	AL	
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Butrans		TUSCALOOS	AL	
Butrans		TUSCALOOS	AL	
Butrans		BESSEMER	AL	
Butrans		MOBILE	AL	
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Butrans		TUSCALOOS	AL	
Butrans		MOBILE	AL	
Butrans		MOBILE	AL	
Butrans		HUNTSVILLE	AL	
Butrans		MOBILE	AL	
Butrans		MOBILE	AL	
Butrans		MOBILE	AL	
Butrans		MOBILE	AL	
Butrans		CENTRE	AL	
Butrans		CENTRE	AL	
Butrans		NORTHPORT	AL	
Butrans		DOTHAN	AL	
Butrans		MOUNTAIN	AL	
Butrans		MONTGOMI	AL	
Butrans		PRATTVILLE	AL	
Butrans		MONTGOMI	AL	
Butrans		OPELIKA	AL	
Butrans		OZARK	AL	
Butrans		OZARK	AL	
Butrans		HUNTSVILLE	AL	
Butrans		ALBERTVILLE	AL	

Butrans	[redacted]	STEVENSON	AL	[redacted]
Butrans		DOTHAN	AL	
Butrans		STEVENSON	AL	
Butrans		MOBILE	AL	
Butrans		MOBILE	AL	
Butrans		MOBILE	AL	
Butrans		HUNTSVILLE	AL	
Butrans		HUNTSVILLE	AL	
Butrans		HUNTSVILLE	AL	
Butrans		FAIRHOPE	AL	
Butrans		GUNTERSVIL	AL	
Butrans		MOBILE	AL	
Butrans		MOBILE	AL	
Butrans		MOBILE	AL	
Butrans		MOBILE	AL	
Butrans		DAPHNE	AL	
Butrans		DAPHNE	AL	
Butrans		DAPHNE	AL	
Butrans		DAPHNE	AL	
Butrans		DAPHNE	AL	
Butrans		OZARK	AL	
Butrans		BIRMINGHA	AL	
Butrans		PHENIX CITY	AL	
Butrans		MOBILE	AL	
Butrans		MOBILE	AL	
Butrans		MOBILE	AL	
Butrans		MOBILE	AL	
Butrans		BIRMINGHA	AL	
Butrans		BIRMINGHA	AL	
Butrans		BIRMINGHA	AL	
Butrans		PRATTVILLE	AL	
Butrans		BIRMINGHA	AL	
Butrans		BIRMINGHA	AL	
Butrans		BIRMINGHA	AL	
Butrans		AUTAUGAVI	AL	
Butrans		HUNTSVILLE	AL	
Butrans		AUTAUGAVI	AL	
Butrans		AUTAUGAVI	AL	
Butrans		TUSCALOOS	AL	
Butrans		MONTGOMI	AL	
Butrans		MONTGOMI	AL	

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Exhibit 118

Commercial Budget Meeting

DRAFT

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Sales Force Alignment

DRAFT

- 254 geographies designed around population areas with population of at least 10K
  - CBSA (core based statistical area)
- Flexibility and Scalability

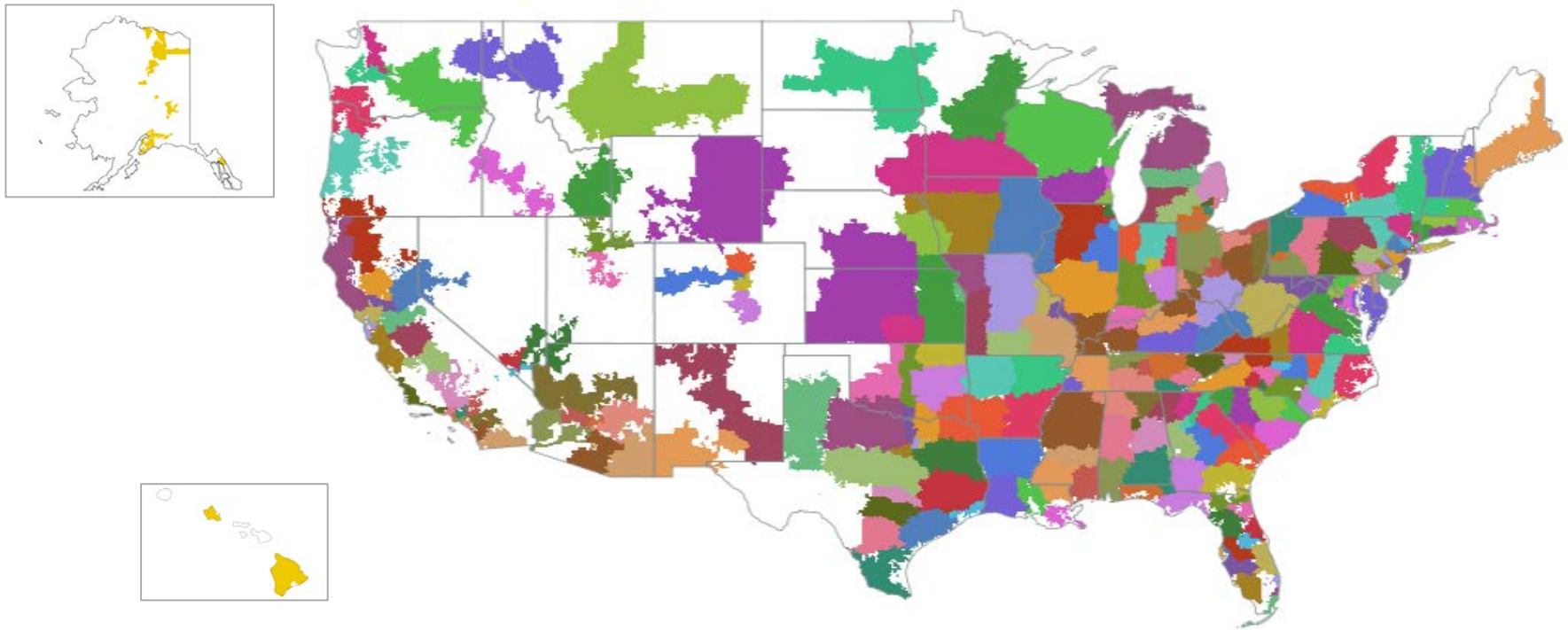

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Exhibit 119

From: Landau, Dr. Craig (US)
Sent: 2017年11月21日 20:04
To: Medeiros, Paul; Strassburger, Philip; Shah, Tejash; Kelly, Marv; Lowne, Jon
Subject: Fwd: Press Announcements > Statement from FDA Commissioner Scott Gottlieb, M.D., on steps to promote development of generic versions of opioids formulated to deter abuse

FYI.

Craig Landau, MD

President & CEO
Purdue Pharma
US mobile (203) 912-5576
CDN Mobile (416) 347-6284

Sent from my iPhone
Please excuse typos and auto-dictation errors...

Begin forwarded message:

From: "Landau, Dr. Craig (US)" <Dr.Craig.Landau@pharma.com>
Date: November 21, 2017 at 20:02:26 EST
To: "Sackler, Jonathan" <Jonathan.Sackler@pharma.com>
Cc: "Landau, Dr. Craig (US)" <Dr.Craig.Landau@pharma.com>
Subject: Re: Press Announcements > Statement from FDA Commissioner Scott Gottlieb, M.D., on steps to promote development of generic versions of opioids formulated to deter abuse

Thanks for the message, Jon. [redacted] I spoke with Phil, Paul M, and our new commercial head, Marv Kelly about this just this evening.

[redacted]

[redacted]

We'll be presenting a consolidated ADF strategy to the board on Thursday, Nov 30th. This will certainly be part of it.

Craig Landau, MD

President & CEO
Purdue Pharma
US mobile (203) 912-5576
CDN Mobile (416) 347-6284

Sent from my iPhone
Please excuse typos and auto-dictation errors...

On Nov 21, 2017, at 19:44, Sackler, Jonathan <Jonathan.Sackler@pharma.com> wrote:

Per our prior conversation:

"To date, the U.S. Food and Drug Administration has approved 10 opioid drugs with these properties. But their uptake has been slow among doctors who are treating patients in pain. The reason for their more limited use is likely multifold. We know there can be a learning curve that comes with new technologies. Some prescribers may not be aware of the existence of these drugs, or may be uncertain of when to prescribe the abuse-deterrent versions. But we also know a significant barrier to use can be price. Because these new formulations are currently only available as brand-name products, they're inherently more expensive than the numerous non-abuse deterrent formulations that are also available in generic formulations."

"But to transition this market more quickly to the ADFs, and consider permanently withdrawing the older formulations that lack abuse-deterrent features in the event these products were judged to be less safe ? there are a number of factors we must consider. One of the factors that the FDA would consider relates to generic access. We must have the potential to improve access to the newer formulations, for appropriately selected and monitored patients, through the introduction of generic competitors."

https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm586117.htm

Do you think we should consider an ANDA filing for AD CR morphine?

- Jon

Exhibit 120

Drugs@FDA: FDA Approved Drug Products

Home (index.cfm) | Previous Page

Product Names Beginning with "O"

Other product names: A (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=A) B (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=B) C (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=C) D (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=D) E (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=E) F (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=F) G (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=G) H (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=H) I (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=I) J (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=J) K (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=K) L (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=L) M (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=M) N (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=N) O (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=O) P (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=P) Q (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=Q) R (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=R) S (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=S) T (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=T) U (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=U) V (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=V) W (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=W) X (/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=X) Y (/scripts/cder/daf/index.cfm?

event=browseByLetter.page&productLetter=Y) Z (/scripts/cder/daf/index.cfm?
event=browseByLetter.page&productLetter=Z) 0-9 (/scripts/cder/daf/index.cfm?
event=browseByLetter.page&productLetter=0-9)

Products listed on this page may not be equivalent to one another.

« ‹ 1 2 3 › »

- OTICAIR
- OTIPRIO
- OTOBIONE
- OTOBIOTIC
- OTOCORT
- OTOVEL
- OTREXUP
- OTREXUP PFS
- OVCON-35
- OVCON-50
- OVIDE
- OVIDREL
- OVRAL
- OVRAL-28
- OVULEN
- OVULEN-21
- OVULEN-28
- OXACILLIN SODIUM
- OXALIPLATIN
- OXANDRIN

« ‹ 1 2 3 › »

« ‹ 1 2 3 › »

OXANDROLONE

OXAPROZIN

OXAYDO

OXAZEPAM

OXCARBAZEPINE

OXERVATE

OXICONAZOLE NITRATE

OXILAN-300

OXILAN-350

OXISTAT

OXSORALEN

OXSORALEN-ULTRA

OXTELLAR XR

OXTRIPHYLLINE

OXTRIPHYLLINE PEDIATRIC

OXY-KESSO-TETRA

OXYBUTYNIN

Oxybutynin Chloride

OXYCET

OXYCODONE 2.5/APAP 500

OXYCODONE 5/APAP 500

OXYCODONE AND ACETAMINOPHEN

OXYCODONE AND ASPIRIN

« ‹ 1 2 3 › »

« ‹ 1 2 3 › »

OXYCODONE AND ASPIRIN (HALF-STRENGTH)

OXYCODONE HYDROCHLORIDE

OXYCODONE HYDROCHLORIDE AND ACETAMINOPHEN

OXYCODONE HYDROCHLORIDE AND IBUPROFEN

OXYCONTIN

OXYGEN, USP

OXYLONE

OXYMORPHONE HYDROCHLORIDE

OXYPHENBUTAZONE

OXYTETRACYCLINE HYDROCHLORIDE

OXYTOCIN

OXYTOCIN 10 USP UNITS IN DEXTROSE 5%

OXYTOCIN 20 USP UNITS IN DEXTROSE 5%

OXYTOCIN 5 USP UNITS IN DEXTROSE 5%

OXYTROL

OXYTROL FOR WOMEN

OZEMPIC

OZURDEX

« ‹ 1 2 3 › »

Exhibit 121

To: Hentzsch, Dr. Cornelia[Cornelia.Hentzsch@purdue.ca]
From: Rosen, Burt
Sent: Tue 1/15/2013 4:20:12 PM
Subject: Fw: As Requested Examples of Support for Abuse Deterrent Formulations Policy
Board Presentation Examples of Support for Abuse Deterrent Formulations Policy.docx
Fw: FDA Guidelines on Abuse-deterrent Opioid Formulations

See FDA letter link.

From: Mallin, William
Sent: Tuesday, January 15, 2013 04:08 PM
To: Sackler, Dr Raymond R; Sackler, Beverly; Sackler, Dame Theresa; Sackler, Dr Richard; Sackler Lefcourt, Ilene; Sackler, Dr Kathe; Sackler, Jonathan; Sackler Hunt, Samantha; Sackler, Mortimer D.A.; Sackler, David; Boer, Peter; Boer, Peter; Lewent, Judy; Pickett, Cecil; Costa, Paulo; Snyderman, Ralph
Cc: Rosen, Burt; Must, Alan; Mallin, William; Mahony, Edward; Strassburger, Philip; Mattessich, Antony; Singh, Raman; Stewart, John H. (US); Wikström, Åke; Roncalli, Anthony
Subject: As Requested Examples of Support for Abuse Deterrent Formulations Policy

Attached please find the materials referenced by Burt and Alan during their presentation today.

Regards,

Bill