Exhibit 14

To: Damas, Raul[Raul.Damas@pharma.com]; Alessandro_Radici@mckinsey.com[Alessandro_Radici@mckinsey.com]
From: Mallin, William
Sent: Fri 5/23/2014 9:35:27 AM
Subject: RE: EC Meeting Content
20140519_Presentation deck.pptx

Raul:

Here it is. Our friend Alessandro has moved on to greener pastures.

I will find Lundie deck and get it to you.

Bill

From: Damas, Raul
Sent: Friday, May 23, 2014 10:33 AM
To: Mallin, William; Alessandro_Radici@mckinsey.com
Subject: EC Meeting Content

Can I please get the slides we used on Tuesday?

I'm building the board memo and would like to use some of the information, especially regarding E2E results.

Raul Damas
Vice President, Corporate Affairs
Purdue Pharma L.P.
203-588-7600
646-915-4062 - m

Operational planning – full day meeting

May 20, 2014

CONFIDENTIAL

Contents

Overview of key externally focused activities enabling ADF strategy

Key activities enabling ADF strategy	Activities - detail	Progress to date
Build Partnerships	▪ [redacted]	▪ Dinner with Rajiv scheduled for next week
	▪ Definition of partnership structure	▪ Performed analysis of preferred partnership structure
	▪ [redacted]	▪ N/A
	Alternative partnership options: ▪ e.g., Teva	Goal: sign partnership agreement by August or seek different partner
Develop acquisition strategies for each molecule	▪ Evaluate standalone market value for target products for purchase	▪ Analyses under way for Kadian, Avinza, Vicodin
	▪ Evaluate value for Purdue of NDA ownership through: – Increased probability of market conversion to AD – Share of market affected by conversion	
	▪ Develop optimal acquisition strategy	▪ N/A

Progress on developing acquisition strategies for each molecule

Not started
Complete

Molecule	Status overview	Status description
▪ Hydrocodone/APAP (e.g. Vicodin)		▪ Completed legal/regulatory evaluation of NDA/reference drugs and potential paths to market conversion ▪ Understood market size and dynamics at individual dosage level ▪ Evaluated financial value of Vicodin brand
▪ ER morphine		▪ Evaluated generic market for MS Contin, Kadian, Avinza ▪ Built initial valuation of individual brands ▪ Analyzed pricing, market size ▪ Developed initial pros/cons and financial upside of acquisition of NDAs for Avinza and Kadian
▪ IR Oxycodone		▪ Begun evaluation of potential Oxecta acquisition/license
▪ Opana ER		▪ [redacted]
▪ IR Oxycodone/APAP (e.g Percocet)		▪ [redacted]
▪ IR hydromorphone (Dilaudid)		▪ Pending

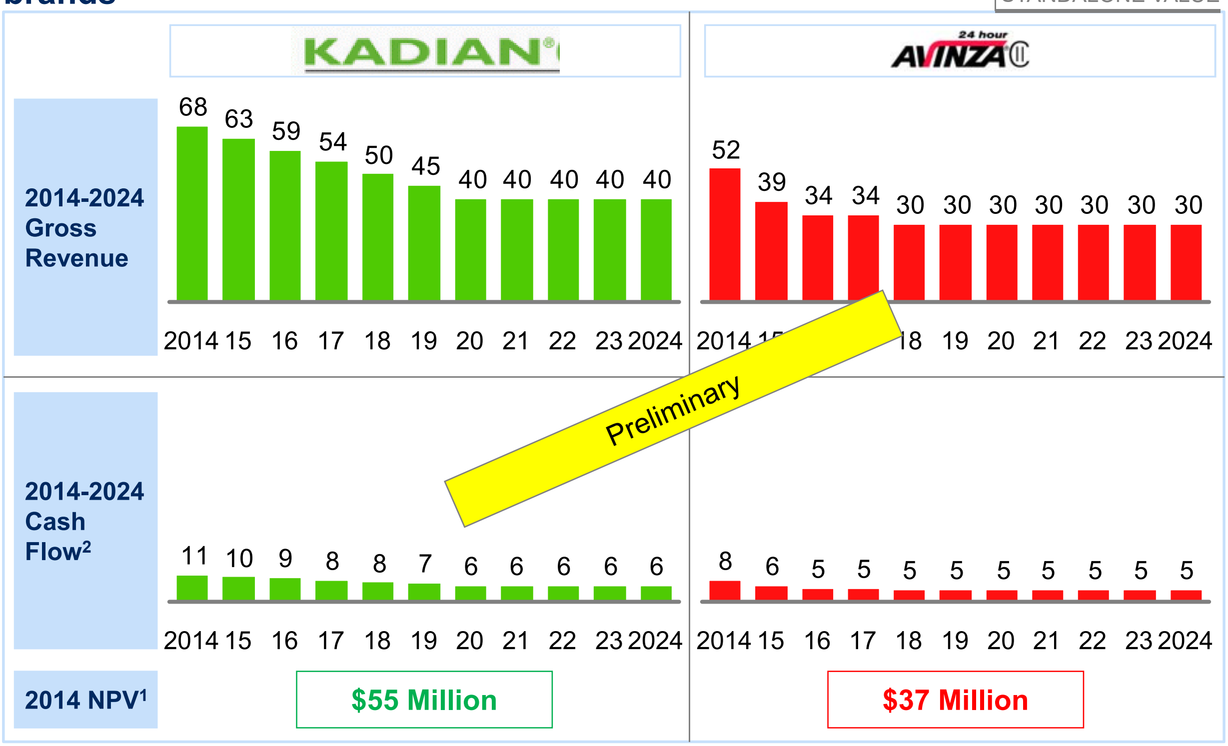
Example analysis: There are 4 options to consider in pursuing the NDA in the morphine sulfate market

VALUE OF NDA

	Potential implications
Acquire neither	▪ Still control MS Contin NDA ▪ Can trigger FDA proceedings on MS Contin only; convert 90% of market ▪ Potential for managed care to require step edits through generics of other 2 MS products; however, unlikely due to current pricing differential
Acquire Avinza	▪ Can trigger FDA proceedings on MS Contin and Avinza generics – 95% of market ▪ Potential for managed care to require step edits through generic Kadian products ▪ Concern with ‘dose dumping’
Acquire Kadian	▪ Can trigger FDA proceedings on MS Contin and Kadian generics – 95% of market ▪ Potential for managed care to require step edits through generics Avinza generic products (2017)
Acquire both	▪ Potentially can trigger FDA proceedings on entire generic market ▪ Remove possibility of substitution by managed care

Example analysis: standalone NPV estimates for Kadian and Avinza brands

STANDALONE VALUE



1 NPV calculated using a 40% cut from gross to net sales, a 40% operating margin, and a 35% tax rate, and a 9% discount rate
2 Cash flow is defined as operating margin minus taxes

SOURCE: IMS data, Analyst projections, EvaluatePharma, team analysis

Detailed activity plan – Advocating for AD conversion

Activities	2014	2015	2016	Owner(s)
– **4.1.14 Advocate for AD conversion of opioid market**				Raul Damas
▫ 4.1.14.1 Continue "Value of ADF" communication capaign, employing both paid and earned media [ongoing]				Raul Damas
▫ 4.1.14.2 Issue releases on each product's milestones (phase 3, filing, approval, launch) [timing TBD]				Raul Damas
▫ 4.1.14.3 Prepare product-specific messages prior to each launch, paired with media exclusives [timing TBD]				Raul Damas
▫ 4.1.14.4 Participate in 24 patient organization-led forums for the purpose of educating about ADFs [Timing TBD]		TBD		Raul Damas
▫ 4.1.14.5 Facilitate media encounters for advocacy community leaders supportive of ADFs [Timing TBD]				Raul Damas
▫ 4.1.14.6 Develop commercial and government plan ADF access assessment for stakeholder use [Timing TBD]				Raul Damas
– 4.1.14.7 Aggregate pro-market conversion arguments for use with media, advocates, and policymakers [Timing TBD]				Raul Damas
– 4.1.14.8 Directly lobby federal and state-level officials on the value of ADFs / risks of abuse [Timing TBD]				Raul Damas
– 4.1.14.9 Promote regulatory incentives for the development and adoption of ADFs (Medical Line Extension, FDA Generic Guidance) [Timing TBD]				Raul Damas

Contents

Overview of commercial implementation activities

Supporting team members	▪ David Rosen, Brianne Weingarten, Garry Hughes, Tim Richards, Others
High level Owned tasks	**2. Achieve Commercial Excellence** 2.1 Design and Execute Corporatized Provider Strategy 2.2 Build Capabilities (managed markets, marketing, analytics, FAMR) 2.3 E2E – Achieve Excellence in Salesforce Execution Levers 2.4 E2E - Complete Outstanding Initiatives (e.g. patient access, no-see alternative promotion, salesforce re-deployment) **4. Optimize the Pain Portfolio** 4.2 Optimize Butrans Performance 4.3 Design Launch Strategy for HYD **3.1 Achieve $100M+ in 2015 Savings (excl. R&D portion)** 3.1.3 Reduce S&P Spend by $5M **5. Demonstrate Our Value To Customers** 5.2 Refine Medical Messaging for Key Products
Tasks Supported/ co-owned	**3.2 Restructure and Upgrade R&D for Future Operating Model** 3.2.2.3.4 Define R&D/BD/ Commercial interface

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We refined the critical objectives of the core E2E workstreams post NSM

Complete initiatives

- Improved method of valuing high potential prescribers ("impact targeting"), improved target list
- New call tier structure
- Tailored OxyContin/ Butrans call mix by territory
- Improved metrics monitoring tools
- Improved Rep productivity:
  - Refocus on higher decile physicians
  - Higher calls/day targets
  - Improved IC/ FCR
  - New Call Routing/ Planning tools
- Map no-see physicians and quantify missed opportuntity

Ongoing initiatives (key priorities only)

- Design IDN Strategy-messaging
- Find ways to complement rep promotion, in particular towards no-see physicians:
  - Implement call center proposal
  - Evaluate further opportunities for personal and non-personal promotion
  - Find ways to communicate to HCPs in corporatized customers
- Identify, assess and implement options to improve patient access
- Continue monitoring and work towards improving call metrics

Field has been receptive to many of the changes we have implemented over the last few months

Strengths	**Roll out**	We agree with the premise of E2E – we focus more calls on the best customers	The call activity section of the FCR is helpful because we can monitor our call activity in a straight-forward way	
	Call List	[We] appreciate having additional lower call tiers	The call list is much more accurate than in the past	It's about time that Purdue developed individualized call mix bands
	Communi-cation	Communication has been fantastic	The improved Phoenix homepage is great because the metric badges clearly define where we are at compared to expectations	
Opportunities	**Access consider-ations**	In high institutional areas, maybe carve those docs into a 'new region'	In territories with difficult access, reps have to select large numbers of prescribers (e.g. up to 180+) to reach the required calls/year, leading to dilution of reps' efforts – especially with reach	
	Workload	In many territories, its difficult to select enough targets to reach 1536 planned calls/year	We're worried that recent performance with Butrans is not accounted for enough in workload algorithm	

SOURCE: Confidential feedback, DM survey

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Productivity metrics are Improving Over Time

	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014
1 Productivity Metrics					
▪ Active Territories	497.9	508.7	511.5	513.1	508.3
▪ Vacancy Rate	5.2%	3.1%	2.6%	2.3%	3.2%
▪ Average Prescriber Calls per day[1]	6.6	7.0	6.8	7.1	7.4
▪ Days on Territory	46.5	50.8	51.6	48.2	48.0
▪ Total Calls Prescriber	153,314	177,773	179,448	176,227	180,071
2 Product Mix[2]					
▪ Actual:					
– OxyContin	30.4%	40.1%	44.7%	47.1%	60.1%
– Butrans	69.6%	59.9%	55.3%	52.9%	39.9%
▪ Targets:					
– OxyContin	50.0%	50.0%	45.8%	45.8%	60.0%
– Butrans	50.0%	50.0%	54.2%	54.2%	40.0%

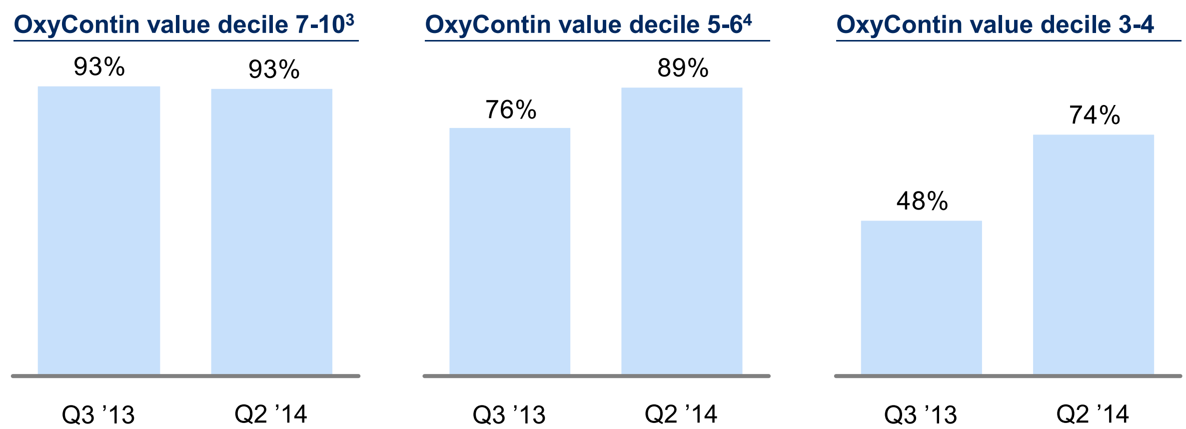
1 Source: iGallery
2 Product % Mix based on Split between OxyContin and Butrans.

SOURCE: Purdue Sales Analytics

TARGET SELECTION

The sales force is selecting an increasing percentage of high-value OxyContin prescribers as targets

% HCPs selected as targets, excluding no-sees[1,2]



- E2E has increased the emphasis on reps selecting the highest value targets
- The impact is clear from the increasing trend of mid to high value OxyContin targets being selected; much of this increase comes from re-allocating targets from low value prescribers
- This measures targets selected for either brand – so not simply a result of shifting mix to OxyContin

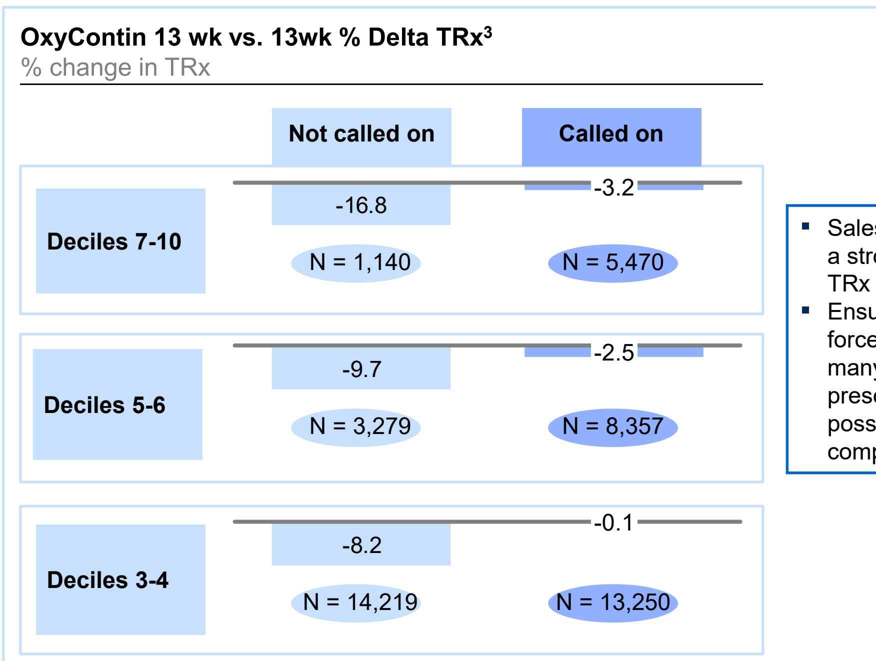
1 As OxyContin or Butrans primary targets
2 No-sees as identified by the field
3 Comparable numbers for Butrans: 100% in Q3 to 94% in Q2 (not excluding no-sees)
4 Comparable numbers for Butrans: 96% in Q3 to 90% in Q2 (not excluding no-sees)

We are drilling down on the OxyContin Core targets that were not reached in Q1

- **8,389 Selected Core HCPs were not reached with a P1** (7,870 with a P1 or P2)
  - 2,249 (27%) HCPs were in value deciles 5-10
  - 6,140 (78%) were in value deciles 0 – 4
- **There are multiple explanations for why the sales force did not reach these prescribers**
  - **Vacant territories and disability/illness:** 1,304 (15%) of these unreached Cores were impacted by partial or full territory vacancies or disability/illness status of rep
  - **Days on Territory:** 1,040 (12%) of these unreached Cores can be attributed to lower than expected days on territory[1]
  - **Calls per day:** 1,986 (23%) of these unreached Cores can be attributed to lower than expected calls/day[2]
- **Other:** 4,158 (49%) of HCPs were not seen are not attributed to territory vacancy, rep disability, lower than expected days on territory, or lower than expected calls per day

1 Assumes expected days on territory is the median, or 50 days
2 Assumes expected 7.5 calls per day

TRx performance among called-on prescribers is better than those not called on



- Sales force calls have a strong impact on TRx performance
- Ensuring the sales force calls on as many high value prescribers as possible is a core component of E2E

1 Selected either as Butrans or OxyContin target in Q1 2014
2 No see HCPs do not include limited access HCPs
3 Comparison of week ending 1/3/14 – 3/28/14 to 10/4/13 – 12/27/13
NOTE: excludes physicians not deciled by ZS and reg 0. Source IMS Earlyview

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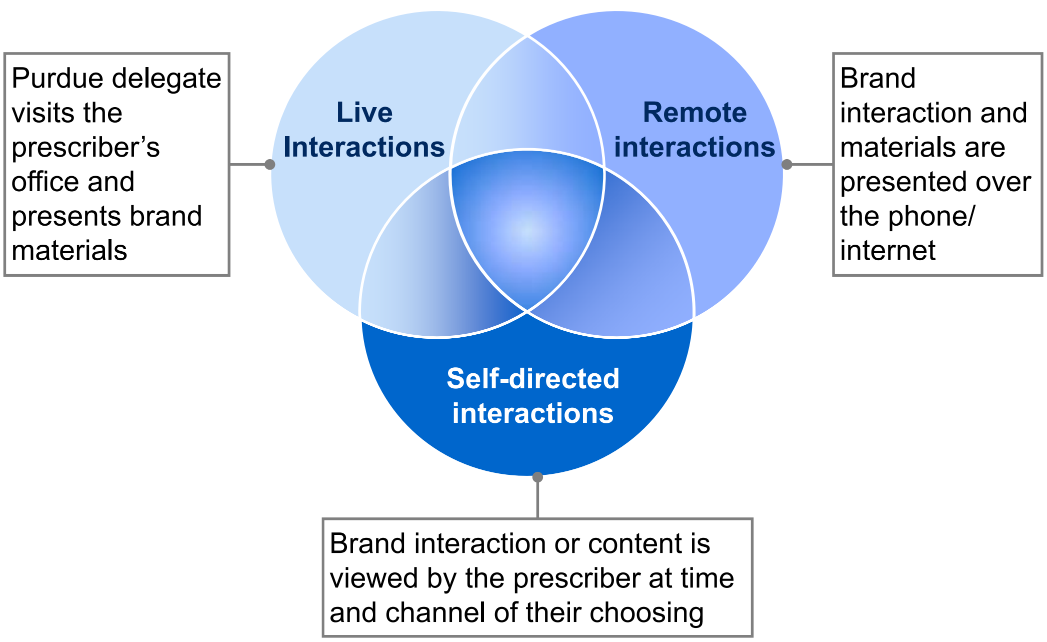
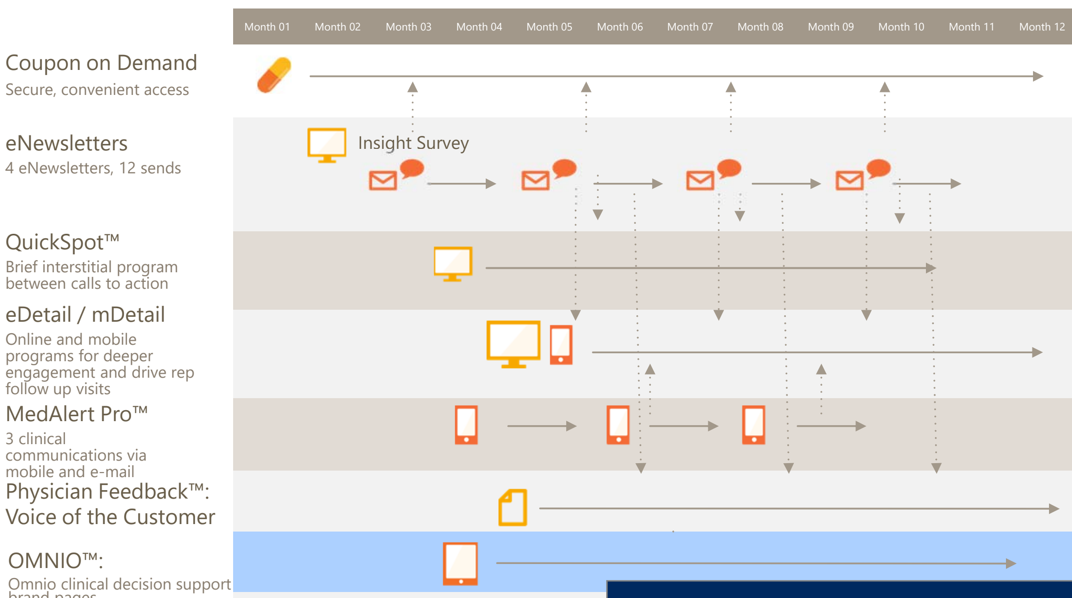
We will utilize a 3-pronged multi-channel strategy to increase Purdue interactions with "No-see" physicians

Multi-channel approach



Physicians Interactive: Integrated Campaign Calendar

Campaign Plan Illustration for Each Brand



Expected to generate additional revenues of $91.1M

Call Center Initiative Objectives

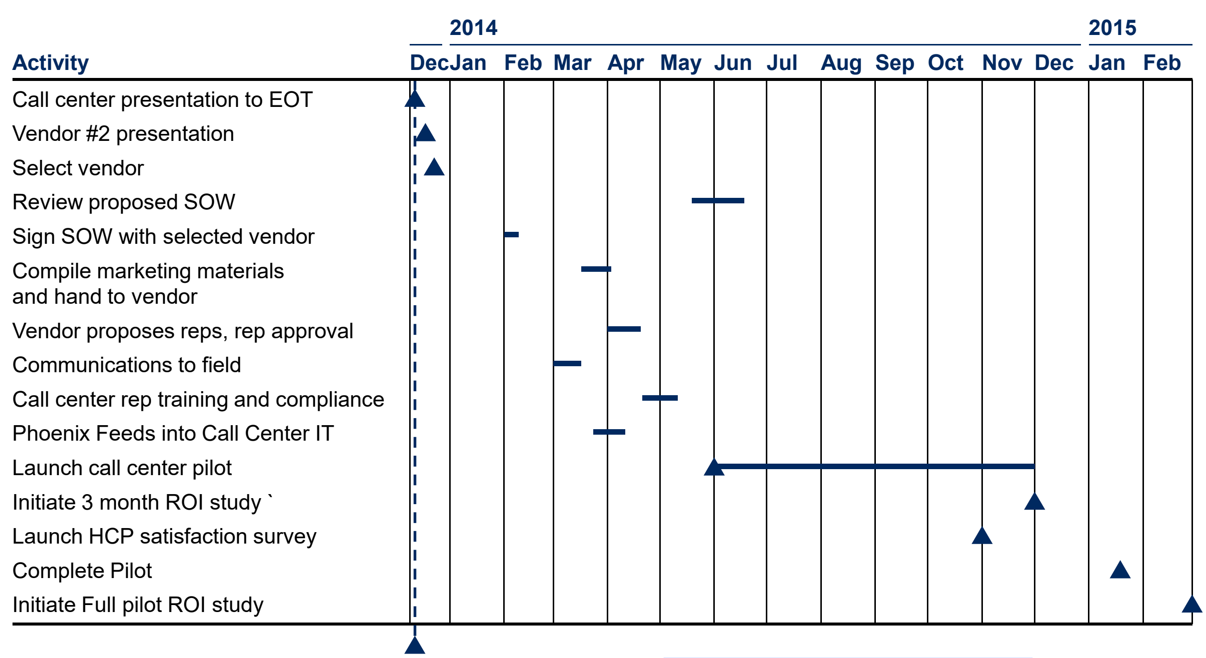
1. Provide **live representative coverage** of targeted HCPs within "vacant" territories, "no see" prescribers[1] in currently staffed territories and "no see" IDN targets in 9 regional IDNs[2]
2. **Maintain script levels** of Butrans and OxyContin in "vacant" territories
3. **Increase scripts for Butrans and OxyContin** with the "no see" HCPs
4. Provide called-on HCPs a **"satisfactory" or better service level**
5. **Be transparent** to existing Purdue Sales Force
6. **Be 100% compliant** to the Purdue Sales SOPs

1 As identified in November 2013 call list cleanup
2 IDNs include Partner's Healthcare, Johns Hopkins, Cleveland Clinic, UAB Medical School, Henry Ford Clinic, Health Partners, Baylor Scott & White Health, Scripps, Swedish Medical Group

Day to Day Operations: Who are the reps and what do they do?

- **There will be two types of rep, fully dedicated to Purdue**
  - **Customer Service Rep (CRS; $5.14 per call)**
  - **Full Service Rep (FSR; $16 per call)**
- **Managed by Vendor Engagement Manager**
- Vendor employs the Reps
- Purdue has Quality Assurance methods in place to insure appropriate quantity and quality of calls
  - Approval of proposed CRS scripts, call transcripts, live call monitoring, call center visits, weekly call note review, weekly activities reports

Call Center Implementation Plan



- **Timeline assumes**
  - SOW to Purdue May 16
  - SOW signed by June 6
  - First Outbound Call - July 21

Contents

Over the course of the next 2 years, Purdue will build its IDN strategy by incorporating more groups into this new commercial model

PRELIMINARY

Proposed "go live" timing	"Wave 1" – October 1, 2014	"Wave 2" – Q2 2015	"Wave 3" – Q1 2016
Proposed Regions/ Accounts	▪ California[1] – Sutter – Adventist – University of California – St. Josephs ▪ Pacific Northwest – Legacy Health – Peace Health – Providence Health and Services ▪ Massachusetts – Partners HealthCare System – Steward Health Care System – UMass (within Top 100 IDNs by ERO volume) – Atrius Physicians[2] ▪ Pennsylvania – Allegheny Health Network – Geisinger Health System – UPMC	▪ Michigan – Beaumont Health System – Franciscan Alliance, Inc – McLaren Health Care Corporation – Spectrum Health ▪ Missouri – BJC HealthCare – Mercy Health – SSM Health Care ▪ North Carolina – Carolinas HealthCare System – Duke University Medical Center and Health System – Novant Health, Inc – Sentara Healthcare ▪ Minnesota – Allina Health System – Mayo Clinic – Sanford Health Network	▪ Select remaining groups based on pre-defined criteria (e.g., market share, potential upside, managed care coverage, etc.)
Incremental FTEs	▪ 4 Account Managers ▪ 2 MSL	▪ 4 Account Managers ▪ 2 MSL	

1 May consider adding high value multi-specialty medical groups (currently not captured in HCOS) such as Hill Physicans and Brown and Toland in CA in future waves
2 Atrius Physicians in greater Boston should also be added (although not-captured through HCOS) because of the high level of centralized control

A focus on the Top IDNs by ERO volume could generate $47M in incremental annual gross revenue annually

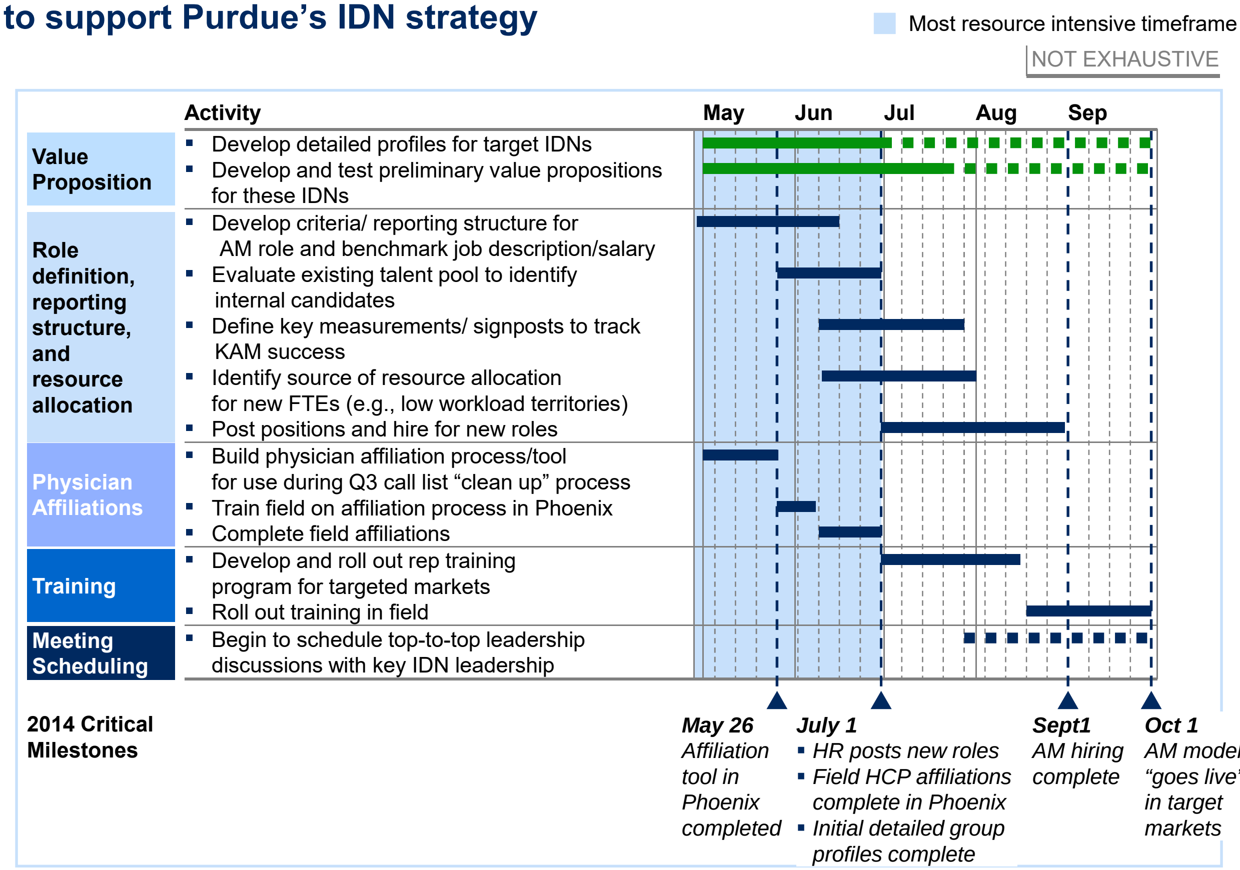
	Top IDNs[1] by ERO volume	6 month ERO TRx, (%)	OxyContin market share, (%)	6 month Potential upside, TRx[2]
Top 10 under-perform-ing	Providence Health and Services	134,190	22	1585
	Sutter Health	102,317	22	1461
	PeaceHealth	72,726	20	2488
	UPMC	56,453	23	187
	BayCare Health System	52,388	15	4063
	Intermountain Healthcare	49,635	18	2430
	McLaren Health Care Corporation	47,721	15	3701
	Adventist Health	45,414	18	2269
	IASIS Healthcare Corporation	43,175	19	1627
	Baptist Memorial Health Care Corporation	43,131	19	1846
Top 10 over-perform-ing	Catholic Healthcare Partners	68,834	27	1377
	Carolinas HealthCare System	58,604	24	1172
	SSM Health Care	52,729	27	1055
	Mercy Health	52,035	26	1041
	The Cleveland Clinic Health System	39,231	29	785
	Baptist Healthcare System, Inc	36,645	24	733
	Steward Health Care System, LLC	36,428	31	729
	Novant Health, Inc	36,354	25	727
	Banner Health	35,977	28	720
	UC Health	35,053	27	701

- The Top 50 IDNs (based on ERO TRx volume) represent ~30% of OxyContin volume in IDNs
- 25 of the Top 50 IDNs[2] by ERO volume are underperforming compared to the national OxyContin market share of 23%, and 25 are over-performing
- Total upside associated with "right-sizing" underperformers is: 71K TRx annually ($31M gross revenue)
- Total upside associated with growing over-performers is: 36K TRx annually ($16M gross revenue)

1 Excludes multi-specialty medical groups and IPA, as well as large hospital systems like Tenet, HCA, etc
2 Assumes all IDNs reach OxyContin market share of 23%
3,4 Full List of Top 50 IDNs (both over-performing and over-performing) provided in appendix

SOURCE: HCOS data (note, HCOS data is ~60% accurate), IMS

Proposed timing for key upcoming activities to develop the infrastructure to support Purdue's IDN strategy



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Purdue has employed multiple tactics to address these issues, but could consider additional activities to more fully address stakeholders

✓ Primary stakeholder impacted

(✓) Secondary stakeholder impacted

Stakeholder impacted

	Purdue activity	Wholesalers	Large Retail Chain Pharmacy	Small chains/ independent pharmacies	HCP	Patient
Current activity	1 Collaborate with NABP to develop industry standards for dispensing guidelines	✓	✓	✓	✓	
Current activity	2 Encourage wholesaler/retailers to establish thresholds by NDC (vs. API), segregate problematic products, or give protective benefit to ADFs	✓	✓	(✓)		
Current activity	3 Work with retailers to modify dispensing guidelines to recognize value of ADF products		✓			
Current activity	4 Encourage patients to raise concerns with wholesalers / retailers to create broader awareness of patient access issues	(✓)	(✓)			✓
Current activity	5 Develop medical services playbook to address patient concerns				✓	✓
Current activity	6 Organize event with the former DEA agent and discuss potential solutions and partnerships to address the patient access issue.	(✓)	(✓)			
Current activity	7 Engage former/ current wholesalers in collaborative discussions to identify what it would take to address independent retailer challenges	(✓)		(✓)		
Current activity	8 Work with NCPA to support independent pharmacy OMS programs	(✓)		✓		
Additional activities for consideration	9 Create national "playbook " for reps to standardize key messages and tactics used to address patient access at the field level		(✓)	(✓)	✓	✓
Additional activities for consideration	10 Refine Medical Services playbook to be more proactive in generating solutions (e.g., form letters sent to legislators)				✓	✓
Additional activities for consideration	11 Facilitate a patient or provider verification system to streamline pharmacist identification of "trusted" HCPs and ERO patients	(✓)	✓	✓	✓	(✓)
Additional activities for consideration	12 Create alternate distribution model (e.g, direct to patient) , independently or through partnerships through which Purdue assumes some risk (e.g., indemnifies other stakeholders)	✓		(✓)	✓	✓

SOURCE: Patient Access team analysis

Exhibit 15

Doc ID

PURDUE

Update on E2E – Evolve to Excellence implementation

April 24, 2014

Doc ID

Agenda

In today's meeting we will cover six main topics:

- Re-cap of core E2E initiatives
- Metrics
- IDN Strategy
- Multi-channel approach to No-sees
- Patient Access
- Next steps

Last Modified 4/23/2014 11:02 PM Eastern Standard Time

Printed 4/17/2014 12:56 PM Eastern Standard Time

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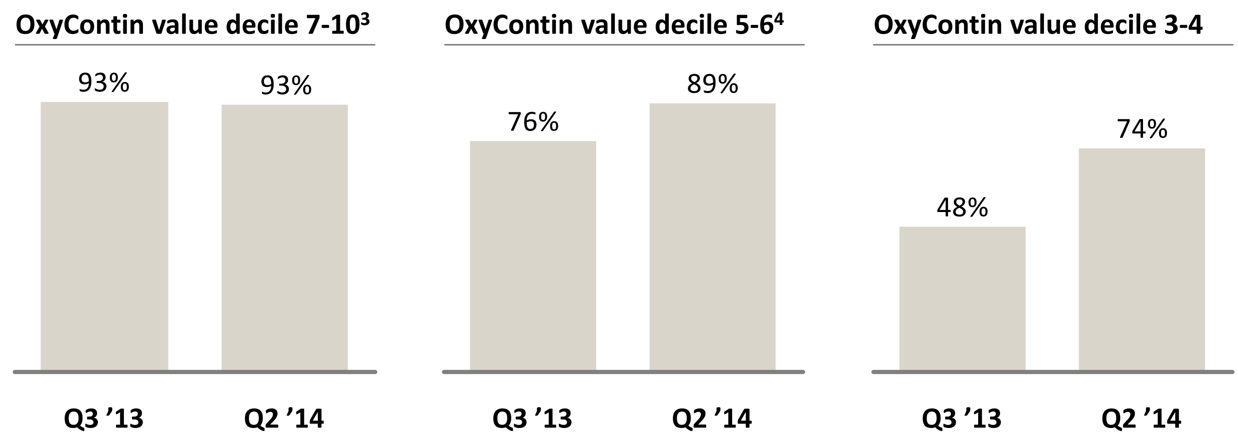
% HCPs selected as targets, excluding no-sees[1,2]

TARGET SELECTION



- E2E has increased the emphasis on reps selecting the highest value targets
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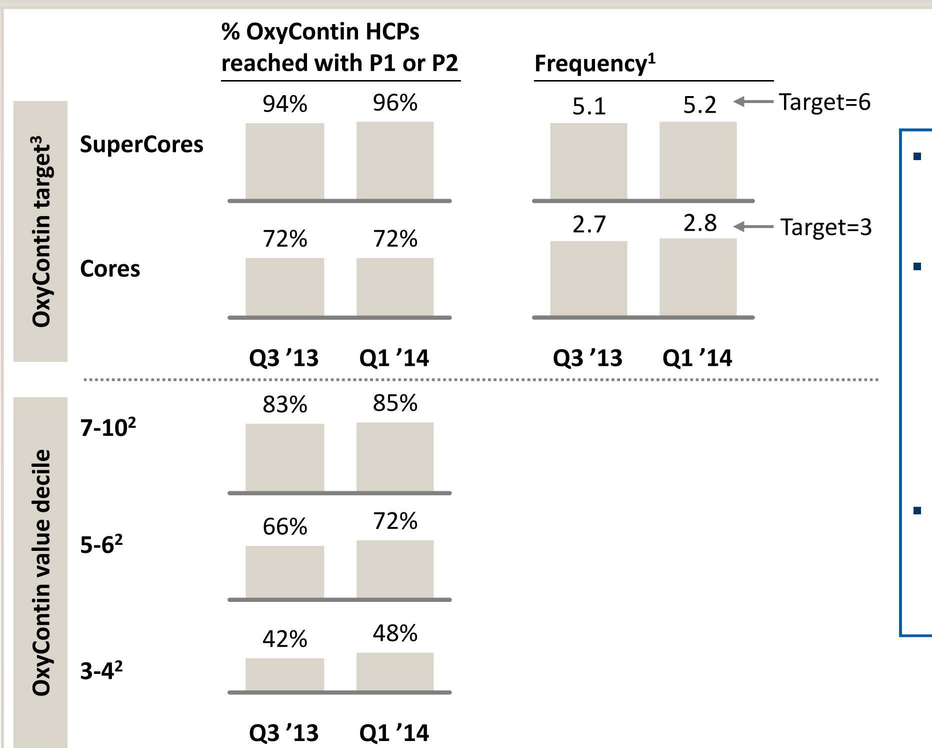
- This measures targets selected for either brand – so not simply a result of shifting mix to OxyContin

1 As OxyContin or Butrans primary targets
2 No-sees as identified by the field
3 Comparable numbers for Butrans: 100% in Q3 to 94% in Q2 (not excluding no-sees)
4 Comparable numbers for Butrans: 96% in Q3 to 90% in Q2 (not excluding no-sees)

While reach and frequency are trending upward, there is still room for improvement - particularly in reach

ACTUAL REACH/FREQUENCY



- Reach on targets has improved slightly from Q3 '13 to Q1 '14
- A process is in place to increase the Core reach of 72% currently
  - In Q2, there will be Phoenix tools and management focus to help improve reach
- Frequency is impacted by limited-see HCPs and should improve in Q2 with additional call tiers

1 P1 frequency only
2 Excluding no-sees as identified by field
3 Comparable numbers for Butrans in Appendix p. 4. Reach has changed from 95% to 96% for SuperCores and 79% to 78% for Butrans. Frequency has changed from 4.9 to 4.7 for SuperCores and 2.8 to 2.8 for Cores

Doc ID

We are drilling down on the OxyContin Core targets that were not reached in Q1

- **8,389 Selected Core HCPs were not reached with a P1** (7,870 with a P1 or P2)
  - 2,249 (27%) HCPs were in value deciles 5-10
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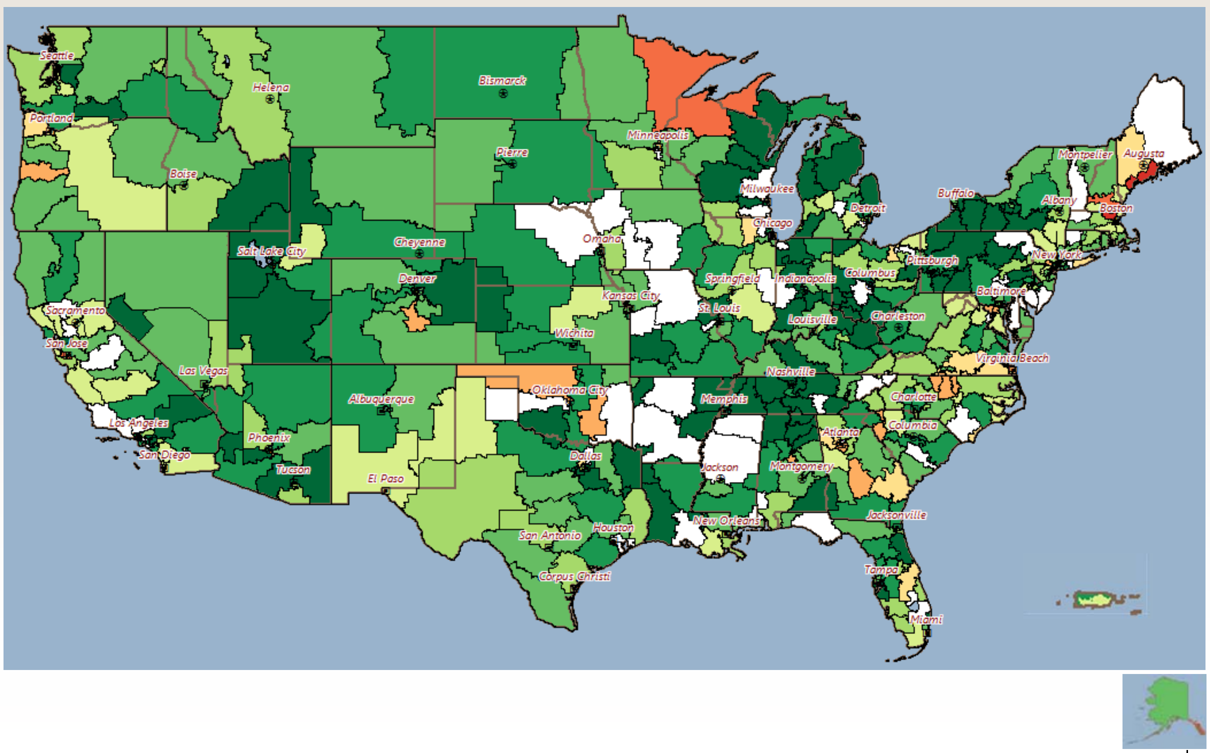
1 Assumes expected days on territory is the median, or 50 days
2. Assumes expected 7.5 calls per day

We are evaluating territory level data to better understand and address territory-specific variability in reach

Thematic Map Legend - % Called On

Vacant | 0%+ to 10% | 10%+ to 20% | 20%+ to 30% | 30%+ to 40% | 40%+ to 50% | 50%+ to 60% | 60%+ to 70% | 70%+ to 80% | 80%+ to 90% | 90%+ to 100%



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TRx performance among called-on prescribers is better than those not called on

OxyContin 13 wk vs. 13wk % Delta TRx[3]
% change in TRx

	Not called on	Called on
Deciles 7-10	-16.8 N = 1,140	-3.2 N = 5,470
Deciles 5-6	-9.7 N = 3,279	-2.5 N = 8,357
Deciles 3-4	-8.2 N = 14,219	-0.1 N = 13,250

- Sales force calls have a strong impact on TRx performance
- Ensuring the sales force calls on as many high value prescribers as possible is a core component of E2E

1 Selected either as Butrans or OxyContin target in Q1 2014
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NOTE: excludes physicians not deciled by ZS and reg 0. Source IMS Earlyview

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OxyContin HCPs with increased calls consistently outperform HCPs with decreasing or no change in call frequency

OxyContin Primary Call Change

Q3 2013 to Q4 2013	HCP Count	TRx % change
Increase	14,594	3.40%
Decrease	13,240	-2.90%
No change	4,283	0.40%
No Call in Q3 or Q4	120,931	1.50%
Grand Total	153,048	0.90%

Q4 2013 to Q1 2014	HCP Count	TRx % change
Increase	20,267	1.40%
Decrease	10,830	-6.00%
No change	5,060	-2.70%
No Call in Q4 or Q1	115,635	-1.40%
Grand Total	151,792	-1.50%

Key Takeaways

- Better target selection and increased frequency have a positive impact:
  - In Q1, there were more prescribers with increasing calls and fewer prescribers with decreasing calls
  - Approximately 50% of HCPs increasing from Q4 to Q1 were new to the call list
- HCPs for whom # of calls increased significantly outperformed those HCPs whose calls decreased or remained unchanged

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SOURCE: Early view weekly data for both TRx and call. Region 0 HCPs are excluded from analysis

Contents

Executive summary: IDN strategy

- **The provider landscape is undergoing considerable change**
  - Physicians are increasingly professionalizing and consolidating into larger provider systems
  - Decision making is becoming more 'corporatized'
  - A targeted approach to these corporatized accounts is increasingly becoming "table stakes" for Pharmaceutical companies across a broad spectrum of Therapeutic areas
- **The top 50 IDN's by OxyContin ER TRx volume represent ~30% of Purdue's IDN business**
- **Evolution of healthcare environment is impacting patient access to our offerings**
  - ~30% of OxyContin volume flows through limited and no see physicians within these the top 50 IDNs
  - We have not yet responded to address most complex accounts and/or markets
  - A concerted approach to these IDNs could result in 107k incremental OxyContin TRx annually, with an annual incremental gross revenue value of ~$47M
- **We have evaluated these IDNs and propose a phased approach to addressing this business**
  - Focus near term efforts on ~14 IDNs in 4 high value geographies
  - Incorporate additional ~10-15 IDNs every 4-6 months beginning in Q2 2015
- **Detail around Purdue's value proposition for addressing unmet needs**
  - Purdue has many commercial and non-commercial tools/ resources that can be built out or better leveraged to address the needs of these various stakeholders
- **A targeted IDN strategy will require "top-to-top" interactions between Purdue and IDN leadership**, but will also require a supporting infrastructure to manage the implementation and refinement of ongoing collaboration

Doc ID

Scope of Purdue's initial IDN strategy: "Corporatized Providers" with centralized control over ambulatory prescribing

'In-patient/ aggregation level': High → Low

'In-patient/ aggregation level'		Examples
High	Hospital systems/ single hospitals	HCA; TENET; Catholic Health
	IDN/ PHO[1] (including ACOs)[2]	Providence; Sutter; Intermountain
	Multi-specialty Medical Groups	HealthCare Partners; Facey; Brown & Toland
	Independent Physician Association (IPA)	Hill Physicians; Primecare; Greater Newport IPA
	Single-specialty Group Practices	Inland Rheum & Osteo; San Diego Cardiology Clinic; Ctrl Coast GI Group
Low	Solo physicians	Dr. Jim Kim; Dr. Gary R Feldman

- Groups in this category have some degree of centralized decision-making that impacts the prescriber writing
- Initial assessment for Purdue based on HCOS[3] affiliation data, but more rigorous opportunity analysis will require field-driven physician affiliations in target markets

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1 PHO – Physician Hospital Organization
2 Focus on retail volume for initial round of analysis
3 IMS Healthcare Organization Services Data
SOURCE: Team analysis

Doc ID

Initial interviews with select corporatized provider administrators highlight opportunities for Purdue to more effectively meet their needs

Group	Role	Relevant quote
Advocate Medical Group	▪ Director of Pharmacy ▪ Previously Director of Pharmacy and Chronic Disease Management	*[Pharma] really needs to have a champion or sponsor at medical or pharmacy management level. The executive level is too in the weeds to be the only one to engage*
Beth Israel / Boston Medical	▪ SVP at Beth Israel New York ▪ Previously VP at BMC	*There is uniform agreement that fee for service will go away. If pharma wants to be at the table, they have to participate in risk sharing*
Aurora Health Care	▪ Senior Director of Pharmacy Services	*We need to find out who is at risk: many IDNs are starting to take on more risk, and as they do, will look for partners to help them and share that risk.*
Fairview	▪ Former CEO of regional hospital within Fairview	*We have a tough time identifying the 5% of patients who are responsible for 50% of costs*
Intermountain Healthcare	▪ CFO at regional hospital within Intermountain Healthcare	*We want to track that the right patient is getting the right drug at the right time. Hopefully we can identify and treat symptoms before getting to crisis situation*

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SOURCE: Expert interviews

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A focus on the Top IDNs by ERO volume could generate $47M in incremental annual gross revenue annually

	Top IDNs[1] by ERO volume	6 month ERO TRx, (%)	OxyContin market share, (%)	6 month Potential upside, TRx[2]
Top 10 under-performing	Providence Health and Services	134,190	22	1585
	Sutter Health	102,317	22	1461
	PeaceHealth	72,726	20	2488
	UPMC	56,453	23	187
	BayCare Health System	52,388	15	4063
	Intermountain Healthcare	49,635	18	2430
	McLaren Health Care Corporation	47,721	15	3701
	Adventist Health	45,414	18	2269
	IASIS Healthcare Corporation	43,175	19	1627
	Baptist Memorial Health Care Corporation	43,131	19	1846
Top 10 over-performing	Catholic Healthcare Partners	68,834	27	1377
	Carolinas HealthCare System	58,604	24	1172
	SSM Health Care	52,729	27	1055
	Mercy Health	52,035	26	1041
	The Cleveland Clinic Health System	39,231	29	785
	Baptist Healthcare System, Inc	36,645	24	733
	Steward Health Care System, LLC	36,428	31	729
	Novant Health, Inc	36,354	25	727
	Banner Health	35,977	28	720
	UC Health	35,053	27	701

- The Top 50 IDNs (based on ERO TRx volume) represent ~30% of OxyContin volume in IDNs
- 25 of the Top 50 IDNs[2] by ERO volume are underperforming compared to the national OxyContin market share of 23%, and 25 are over-performing
- Total upside associated with "right-sizing" underperformers is: 71K TRx annually ($31M gross revenue)
- Total upside associated with growing over-performers is: 36K TRx annually ($16M gross revenue)

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1 Excludes multi-specialty medical groups and IPA, as well as large hospital systems like Tenet, HCA, etc
2 Assumes all IDNs reach OxyContin market share of 23%
3,4 Full List of Top 50 IDNs (both over-performing and over-performing) provided in appendix
SOURCE: HCOS data (note, HCOS data is ~60% accurate), IMS

The Top 50 IDNs by ERO volume are concentrated in 24 states

Top 50 IDNs by ERO volume
(Estimated incremental TRx generated)[1]

Red text = IDN performing below market share average

Iowa (192 TRx)
- UnityPoint Health

Minnesota (1,444 TRx)
- Allina Health System
- Mayo Clinic
- Sanford Health Network

Illinois (1,997TRx)
- Advocate Health Care
- Presence Health

Massachusetts (1,344 TRx)
- Partners HealthCare System, Inc
- Steward Health Care System, LLC

New York (532 TRx)
- North Shore Long Island Jewish Health System

New Hampshire (485 TRx)
- Dartmouth-Hitchcock

Pennsylvania (1,297) TRx)
- Allegheny Health Network
- Geisinger Health System
- UPMC

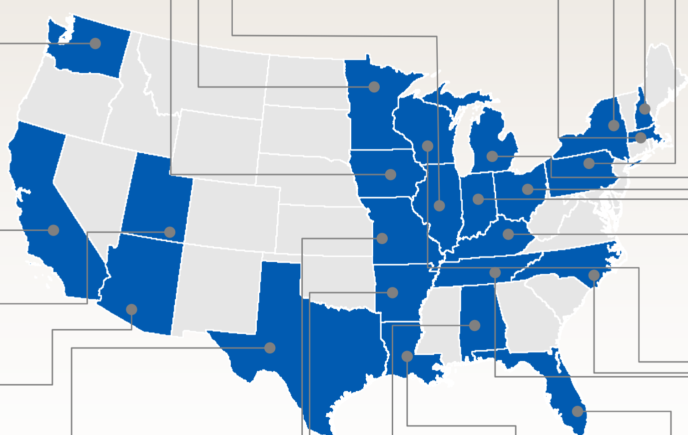
Washington (4,591 TRx)
- Legacy Health
- Peace Health
- Providence Health and Services

California (5,380 TRx)
- Adventist Health
- Saint Joseph Health System
- Sutter Health
- University of California Office of the President Health Sciences and Services

Utah (2,429 TRx)
- Intermountain Healthcare

Arizona (719 TRx)
- Banner Health

Texas (2,569 TRx)
- Baylor Health Care System
- Texas Health Resources
- United Surgical Partners International, Inc



Michigan (8,471 TRx)
- Beaumont Health System
- Franciscan Alliance, Inc
- McLaren Health Care Corporation
- Spectrum Health

Ohio (3,555 TRx)
- Catholic Healthcare Partners
- OhioHealth
- The Cleveland Clinic Health System
- UC Health

Indiana (992 TRx)
- Indiana University Health

Kentucky (1,032 TRx)
- Baptist Healthcare System, Inc
- Norton Healthcare, Inc

Wisconsin (1,201TRx)
- Aurora Health Care, Inc
- Wheaton Franciscan Healthcare

North Carolina (2,7480TRx)
- Carolinas HealthCare System
- Duke University Medical Center and Health System
- Novant Health, Inc
- Sentara Healthcare

Tennessee (1,627 TRx)
- IASIS Healthcare Corporation

Missouri (2,685 TRx)
- BJC HealthCare
- Mercy Health
- SSM Health Care

Arkansas (1,846 TRx)
- Baptist Memorial Health Care Corporation

Alabama (507 TRx)
- UAB Health System

Louisiana (1,221 TRx)
- Franciscan Missionaries of Our Lady Health System, Inc

Florida (4,062 TRx)
- BayCare Health System

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1 Assumes 2% lift for all IDNs currently performing above national average of 23%, and assumes that all IDNs under-performing compared to national average are brought up to national average

We considered a number of quantitative and qualitative criteria when evaluating Purdue's opportunity to drive impact within these IDNs

Detail included on following pages

	Prioritization criteria	Key considerations	Rationale for inclusion
Quantitative	**Share and opportunity size**	▪ OxyContin TRx volume ▪ ERO TRx volume ▪ OxyContin market share compared to National Average	▪ Define top groups that represent 30% of OxyContin TRx volume ▪ Estimate the potential upside associated with each of these IDNs
Quantitative	**No-see/limited see impact**	▪ Volume of ERO flowing through no-see and limited see HCPs	▪ High no-see markets require non-traditional model to drive change
Quantitative	**Managed Care Coverage**	▪ Favorability of coverage for primary plans associated with IDN	▪ Coverage must be sufficiently positive to ensure field pull-through of initiatives
Quantitative	**Geographic concentration**	▪ High value IDNs located within moderate geographic proximity (e.g., metro areas, state)	▪ Difficult for organization to implement IDN strategy effectively without geographic concentration
Qualitative	**Group control over HCP prescribing**	▪ Physician employment ▪ Existence of out-patient PDL ▪ Degree of risk sharing	▪ More "controlling" groups are better equipped to affect broad-scale change among their HCPs
Qualitative	**Existing relation-ships/contacts**	▪ Known Relationships/ organizational familiarity	▪ Existing relationships can be leveraged to initiate initial executive-level conversations
Qualitative	**External/ regional factors**	▪ Key legislation impacting opioids (e.g., ADF support, "triplicate" states) ▪ Regional advocacy efforts (e.g., PROP)	▪ External factors may make improve (e.g., recent MA legislation) or reduce (e.g., TX is a triplicate state) likelihood of success
Qualitative	**PharmaCo benchmarks**	▪ Key geographies targeted with IDN-specific strategy by other mid and large cap PharmaCos	▪ Identifies geographies that are increasingly shifting to this new commercial model

Doc ID

Limited
Moderate
Strong

Quantitative analysis of Top 50 IDNs (1/2)

Red text = IDN performing below market share average

State	IDN	6 month ERO volume (TRx)	OxyContin Market share	6 month TRx upside potential	6 month No-see[1] ERO TRx	6 month Limited-see ERO TRx	OxyContin Managed Care Coverage[2]
Michigan	McLaren Health Care Corporation	47,721	15%	3,701	6,916	9,876	
	Spectrum Health	32,501	12%	3,514	10,762	9,523	
	Beaumont Health System	22,601	19%	919	7,129	4,286	
	Franciscan Alliance, Inc	28,169	22%	337	1,372	5,274	
California	Adventist Health	45,414	18%	2,269	8,644	7,208	
	Sutter Health	102,317	22%	1,461	24,506	18,730	
	Saint Joseph Health System	37,399	20%	1,074	5,755	5,403	
	University of California Office of the President Health Sciences and Services	28,794	26%	576	10,315	1,397	
Pacific NW	PeaceHealth	72,726	20%	2,488	32,628	13,293	
	Providence Health and Services	134,190	22%	1,585	49,246	21,403	
	Legacy Health	25,914	23%	518	11,966	2,395	
Florida	BayCare Health System	52,388	15%	4,062	708	3,514	
Ohio	Catholic Healthcare Partners	68,834	27%	1,377	7,202	15,073	
	The Cleveland Clinic Health System	39,231	29%	785	6,580	7,687	
	UC Health	35,053	27%	701	1,260	5,241	
	OhioHealth	34,635	23%	693	3,180	4,968	
North Carolina	Carolinas HealthCare System	58,604	24%	1,172	3,866	11,172	
	Novant Health, Inc	36,354	25%	727	1,016	4,292	
	Duke University Medical Center and Health System	24,815	29%	496	879	4,576	
Missouri	Sentara Healthcare	26,045	22%	352	1,628	5,539	
	SSM Health Care	52,729	27%	1,055	8,185	8,980	
	Mercy Health	52,035	26%	1,041	4,904	8,113	
	BJC HealthCare	29,510	29%	590	3,654	8,652	
Texas	Baylor Health Care System	24,267	18%	1,143	1,511	1,990	
	Texas Health Resources	27,843	19%	1,022	1,535	2,748	
	United Surgical Partners International, Inc	24,829	21%	404	2,436	2,949	

1 No-see/ limited see HCPs identified through field-level targeting 2 Tier Coverage for Top 2-3 plans associated with each IDN

SOURCE: IMS, HCOS data, Managed Care Team

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Quantitative analysis of Top 50 IDNs (2/2)

Red text = IDN performing below market share average

Limited
Moderate
Strong

State	IDN	6 month ERO volume (TRx)	OxyContin Market share	6 month TRx upside potential	6 month No-see ERO TRx[1]	6 month Limited-see ERO TRx	OxyContin Managed Care Coverage[2]
Utah	Intermountain Healthcare	49,635	18%	2,430	3,174	4,310	
Illinois	Advocate Health Care	27,629	19%	1,087	3,705	3,717	
	Presence Health	26,048	20%	910	2,070	3,295	
Arkansas	Baptist Memorial Health Care Corporation	43,131	19%	1,846	2,309	7,515	
Tennessee	IASIS Healthcare Corporation	43,175	19%	1,627	1,981	5,052	
Minnesota	Sanford Health Network	23,041	21%	499	1,078	6,100	
	Allina Health System	24,857	42%	497	9,031	4,091	
	Mayo Clinic	22,431	32%	449	4,291	2,895	
Mass-achusetts	Steward Health Care System, LLC	36,428	31%	729	4,204	10,106	
	Partners HealthCare System, Inc	30,787	32%	616	11,428	3,103	
Penn-sylvania	Allegheny Health Network	28,466	26%	569	3,373	5,052	
	Geisinger Health System	27,016	26%	540	5,329	5,357	
	UPMC	56,453	23%	187	9,993	9,378	
Louisiana	Franciscan Missionaries of Our Lady Health System, Inc	22,209	18%	1,221	598	6,321	
Wisconsin	Aurora Health Care, Inc	34,779	31%	696	2,309	6,608	
	Wheaton Franciscan Healthcare	25,302	30%	506	1,609	3,056	
Kentucky	Baptist Healthcare System, Inc	36,645	24%	733	3,586	8,153	
	Norton Healthcare, Inc	32,683	22%	300	4,052	8,925	
Indiana	Indiana University Health	36,616	20%	992	3,655	10,028	
Arizona	Banner Health	35,977	28%	720	4,681	7,203	
New York	North Shore Long Island Jewish Health System	26,637	33%	533	3,852	5,119	
Alabama	UAB Health System	25,349	28%	507	1,059	948	
New Hampshire	Dartmouth-Hitchcock	24,274	32%	485	3,836	6,842	
	UnityPoint Health	34,479	22%	192	4,293	11,284	

1 No-see/ limited see HCPs identified through field-level targeting 2 Tier Coverage for Top 2-3 plans associated with each IDN

SOURCE: IMS, HCOS data, Managed Care Team

Doc ID

Based on the quantitative and qualitative assessments of these accounts, we propose that the initial phase of this strategy is focused on 14 IDNs

Red text = IDN performing below market share average

Market	IDN	Quantitative Rationale for inclusion	Qualitative Rationale for inclusion
1 California	▪ Sutter ▪ Adventist ▪ University of California? ▪ St. Josephs	▪ ~160K ERO TRx flowing through No-Sees/ Limited Sees annually ▪ Moderate to good Managed Care Coverage ▪ ~$4.4M potential upside	▪ Moderate system-level control over out-patient Rx ▪ Increasing amount risk-bearing ▪ Key geography targeted with IDN-specific strategy by other mid/ large cap PharmaCos
2 Pacific Northwest	▪ Legacy Health ▪ Peace Health ▪ Providence Health and Services	▪ ~260K ERO TRx flowing through No-Sees/ Limited Sees annually ▪ Moderate Managed Care Coverage ▪ ~$4.3M potential upside	▪ Several Key relationships already in place (e.g., Providence Health) ▪ Potential to counter PROP influence with relevant value propositions ▪ Moderate risk-sharing ▪ Key geography targeted with IDN-specific strategy by other mid/ large cap PharmaCos
3 Massachusetts	▪ Partners Health-Care System ▪ Steward Health Care System ▪ UMass[1] ▪ Atrius Physicians[2]	▪ ~52K ERO TRx flowing through No-Sees/ Limited Sees annually ▪ Good Managed Care Coverage ▪ ~$1.2M potential upside[3]	▪ Moderate to high system-level control over outpatient Rx ▪ Increasing amount of risk sharing ▪ Key geography targeted with IDN-specific strategy by other mid/ large cap PharmaCos
4 Pennsylvania	▪ Allegheny Health Network ▪ Geisinger Health System ▪ UPMC	▪ ~74K ERO TRx flowing through No-Sees/ Limited Sees annually ▪ Moderate Managed Care Coverage ▪ ~$1.2M potential upside	▪ Several Key relationships already in place (e.g., Geisinger) ▪ Moderate-high system level control over outpatient Rx ▪ Increasing amount of risk sharing

1 Should consider adding UMass to this KAM region. It is within the Top 100 IDNs by ERO volume – and adding an additional account in this market may ensure that the Account Manager has sufficient worklo
2 Atrius Physicians in greater Boston should also be added (although not-captured through HCOS) because of the high level of centralized control
3 Upside excludes potential lift from Atrius, which has not yet been calculated because of HCOS data limitations

SOURCE: Team Analysis

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IDN administrators identify several unmet needs and potential Pharma value propositions based on the evolving healthcare landscape

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Green text = initial focus of value prop development

NOT EXHAUSTIVE

Unmet Needs	Potential Value Props
Care quality and clinical outcomes	▪ **Coordinating health of patient through continuum of care (e.g. transitions, home care, etc.)** ▪ Reducing adverse events (e.g. hospital acquired conditions) ▪ **Improving patient satisfaction (e.g. pain in HCAHPS surveys)** ▪ Monitoring opioid use in ambulatory setting (variation in prescribing patterns/protocols, identify red flags) ▪ Reducing redundancy among providers by increasing communication
Provider education	▪ **Disseminating best practices for pain (prescribing, preventing abuse, appropriate urine screening tests)** ▪ **Analyzing data to flag high-risk behavior**
Improved practice economics	▪ **Reducing overall cost of care (reduce ER visits, readmission, LOS; increase pre-noon discharges, preventing back surgery due to back pain)** ▪ Value based purchasing (eliminating wholesaler, buying meds in bulk and distributing to hospitals)
Patient adherence and support	▪ Providing tools to access state Rx monitoring in EMR, so not an additional step ▪ Helping patients buy into lifestyle changes, exercise ▪ Tracking medication adherence ▪ Creating a pain discharge plan

Administrators often identified pain management as a specific IDN pain point, which suggests a unique opportunity for Purdue to generate near term value to form long term relationships with IDNs

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SOURCE: Expert interviews

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We are currently taking inventory of current Purdue resources that are well-positioned to address these unmet needs

ILLUSTRATIVE

Analyzing Data to Flag High-Risk Behavior

Palliative Care: Improving Quality of Care Across the Healthcare Continuum
Tele Assessment of Pain Flyer (Print and PDF)
Introduction to Clinical Pharmacology
FACETS Flyer (Print and PDF)
Complexities of Caring for People in Pain
Pain Pathophysiology: An Illustrated Resource
3rd Party Resources via Consultation
Handbook for People with Pain
A Hands-On Approach for Pain Management Communication Guide
Medication Therapy Management: Opportunities for Improving Pain Care
PDMP Consultation
Current epidemiology data on abuse, misuse, diversion and addiction
Prescription Opioid Abuse: Strategies to Minimize Risks
Pearls and Pitfalls of Urine Drug Testing During Opioid Therapy Flyer
Providing Relief, Preventing Abuse Brochure
How to Protect Your Practice
How to Protect Your Pharmacy
How to Protect Your Institution Brochure
How to Protect Your Medicines at Home (English)
Diversion Prevention in Pharmacies and Healthcare Institutions
Internal Pharmacy Theft: Tips and Practices to Protect Your Pharmacy From Diversion
State Rx Drug Monitoring Program and prescribing guidelines

Patient Satisfaction

Overview of Federation of State Medical Boards Model Policy on Use of Opioids… *
Palliative Care: Improving Quality of Care Across the Healthcare Continuum
Home Care of the Hospice Patient (English) (BOOKLET)
Opioid-Related Adverse Effects: Mechanisms, Etiology, and Considerations for Care
Patient Comfort Assessment Guide (pad of tear-off)

Disseminating Best Practices for Pain

Overview of Federation of State Medical Boards Model Policy on Use of Opioids… *
Opioid Analgesics Utilization Data Review Flyer (Print and PDF)
Palliative Care: Improving Quality of Care Across the Healthcare Continuum
Introduction to Clinical Pharmacology
Medication Routes and Delivery Systems: Administration & Safety Considerations
Complexities of Caring for People in Pain
How to Protect Your Medicines at Home (English)

Reducing Redundancy Among Providers by Increasing Communication

FACETS (Print and PDF)
Tips for Overcoming the Challenges of Communicating About Pain with Your Patients

Monitoring Opioid Use in an Ambulatory Setting

Community Action Toolkit
Community Anti-Drug Coalitions of America (CADCA)
National Council on Patinet Information and Education (NCPIE)
National Education Association (NEA)
Partnership@Drugfree.org
AMA Community grants
Diversion Prevention in Pharmacies and Healthcare Institutions (PPT-CD ROM)
Internal Pharmacy Theft: Tips and Practices to Protect Your Pharmacy From Diversion
RxSafetyMatters Community Action Kit (1 kit = 5 c

Reducing Adverse Events

Pain PACT Information Flyer / Order Form (Print and PDF)
Introduction to Clinical Pharmacology
Opioid-Related Adverse Effects: Mechanisms, Etiology, and Considerations for Care
FACETS Flyer (Print and PDF)
Senokot Laxatives Protocol Pad

Coordinating Health of Patient Through the Care Continuum

Overview of Federation of State Medical Boards Model Policy on Use of Opioids… *
Opioid Analgesics Utilization Data Review Flyer (Print and PDF)

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SOURCE: Value Proposition sub-team analysis of current Purdue resources

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Over the course of the next 2 years, Purdue will continue to build its IDN strategy by incorporating more groups into this new commercial model

Doc ID

PRELIMINARY

Proposed "go live" timing	"Wave 1" – October 1, 2014	"Wave 2" – Q2 2015	"Wave 3" – Q1 2016
Proposed Regions/ Accounts	▪ California[1] – Sutter – Adventist – University of California – St. Josephs ▪ Pacific Northwest – Legacy Health – Peace Health – Providence Health and Services ▪ Massachusetts – Partners HealthCare System – Steward Health Care System – UMass (within Top 100 IDNs by ERO volume) – Atrius Physicians[2] ▪ Pennsylvania – Allegheny Health Network – Geisinger Health System – UPMC	▪ Michigan – Beaumont Health System – Franciscan Alliance, Inc – McLaren Health Care Corporation – Spectrum Health ▪ Missouri – BJC HealthCare – Mercy Health – SSM Health Care ▪ North Carolina – Carolinas HealthCare System – Duke University Medical Center and Health System – Novant Health, Inc – Sentara Healthcare ▪ Minnesota – Allina Health System – Mayo Clinic – Sanford Health Network	▪ Select remaining groups based on pre-defined criteria (e.g., market share, potential upside, managed care coverage, etc.) **Wave 2 and Wave 3 IDNs must be defined using refreshed data (both qualitative and quantitative) at the time of decision-making – this current list is very preliminary**
Incremental FTEs	▪ 4 Account Managers ▪ 2 MSL	▪ 4 Account Managers ▪ 2 MSL	

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1 May consider adding high value multi-specialty medical groups (currently not captured in HCOS) such as Hill Physicans and Brown and Toland in CA in future waves
2 Atrius Physicians in greater Boston should also be added (although not-captured through HCOS) because of the high level of centralized control

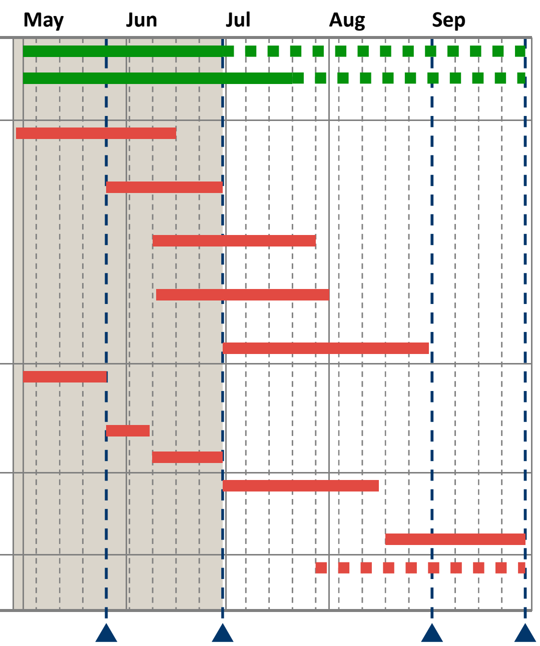
Doc ID

Proposed timing for key upcoming activities to develop the infrastructure to support Purdue's IDN strategy

Most resource intensive timeframe

NOT EXHAUSTIVE

	Activity
Value Proposition	▪ Develop detailed profiles for target IDNs ▪ Develop and test preliminary value propositions for these IDNs
Role definition, reporting structure, and resource allocation	▪ Develop criteria/ reporting structure for AM role and benchmark job description/salary ▪ Evaluate existing talent pool to identify internal candidates ▪ Define key measurements/ signposts to track KAM success ▪ Identify source of resource allocation for new FTEs (e.g., low workload territories) ▪ Post positions and hire for new roles
Physician Affiliations	▪ Build physician affiliation process/tool for use during Q3 call list "clean up" process ▪ Train field on affiliation process in Phoenix ▪ Complete field affiliations
Training	▪ Develop and roll out rep training program for targeted markets ▪ Roll out training in field
Meeting Scheduling	▪ Begin to schedule top-to-top leadership discussions with key IDN leadership



2014 Critical Milestones

May 26 *Affiliation tool in Phoenix completed*

July 1
- *HR posts new roles*
- *Field HCP affiliations complete in Phoenix*
- *Initial detailed group profiles complete*

Sept1 *AM hiring complete*

Oct 1 *AM model "goes live" in target markets*

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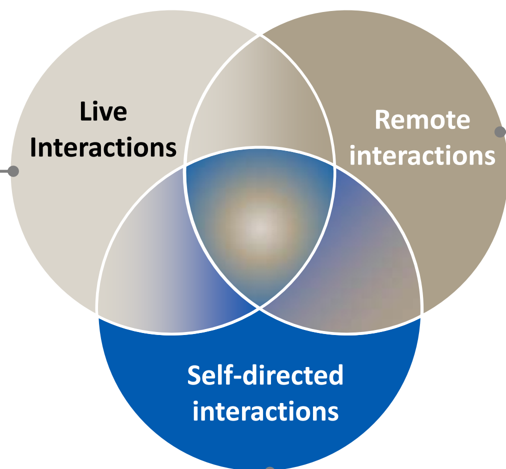
We will utilize a 3-pronged multi-channel strategy to increase Purdue interactions with "No-see" physicians

Multi-channel approach

Purdue delegate visits the prescriber's office and presents brand materials



Brand interaction and materials are presented over the phone/ internet

Brand interaction or content is viewed by the prescriber at time and channel of their choosing

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The multi-channel strategy utilizes numerous modalities to maximize reach, both broadly and specifically for no/ limited see HCPs

Budgeted
Proposed

<1 1-2 >2

		Timing for roll-out		Prospective no-see/ limited see impact			
	Modality	Budgeted/ Proposed	Status	# Prescribers Targeted	Total # of No-Sees targeted[4] (N = 10,896)	Total # of Limited-Sees targeted[4] (N= 14, 470)	ROI[5]
Live Inter-actions	1. Company reps deliver brand folders		Q3 2014	5,250[1]	5,250[1]		N/A
	2. Contract sales organization		N/A	N/A	N/A	N/A	
	3. Concierge reps		TBD	TBD	TBD	TBD	N/A
Remote Inter-actions	4. Outbound call center		Q3 2014	54,000	8,695	387	
	5. Online Webinar		Current	3,079	343	494	
	6. Virtual lunch in learn		Q4 2014		196[2]	312	N/A
Self-directed Inter-actions	7. Content on third party sites (e.g., Medscape)		Q3 2014	N/A	N/A	N/A	N/A
	8. eMR savings cards		Current	TBD	TBD	TBD	
	9. E-mail broadcast		Current	63,000	6,045	7,905	
	10. e-details		Q3 2014	3,573[2]	196[2]	312[2]	
	11. Virtual case studies/vignettes		Q3 2014	230	2	11	
	12. Savings cards		Current	TBD	TBD	TBD	
	13. Third party collaborations (e.g., Peer Review)		Q3 2014	3,574[2]	196[2]	312[2]	
	14. Direct mail		Current	3,574[2]	196[2]	312[2]	
	15. Third party e-mails		TBD	N/A	N/A	N/A	
	16. Patient management program	[3]	Q3 2014	TBD	TBD	TBD	
	17. Mobile apps/website		2015	N/A	N/A	N/A	N/A
	18. Physicians interactive		Q3 2014	47,500	8,211	10,596	N/A

1 10 prescribers/territory
2 Decile 8-10 prescribers
3 In place for Butrans
4 Deciles 2-10
5 ROI is "N/A" for in those instances where we are unable to calculate ROI (e.g., data/measurement limitations)

SOURCE: Purdue proposed multi-channel marketing plan; Physicians Interactive; Team analysis

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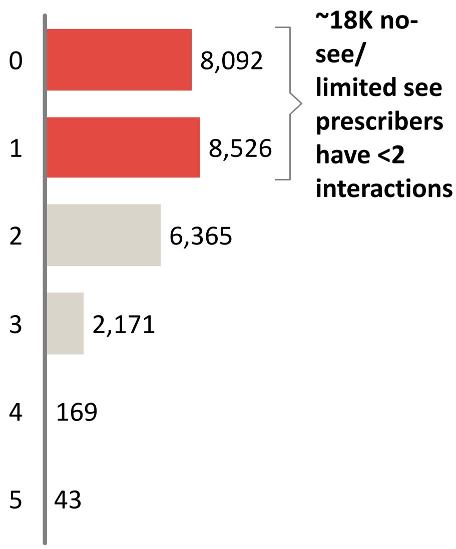
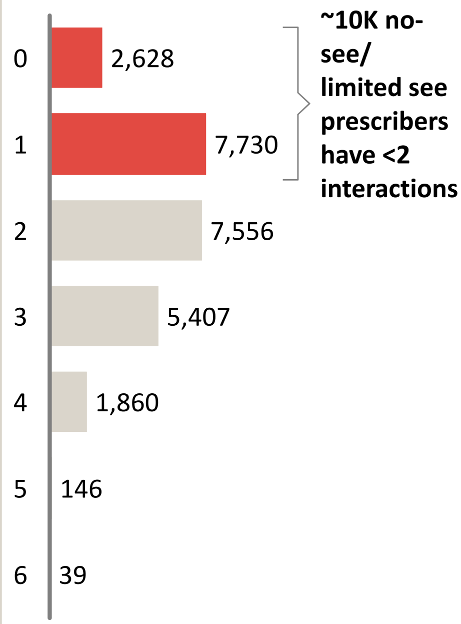
A collaboration with Physicians Interactive could increase coverage against no-see and limited-see prescribers

Current[1] # of digital touches per no/limited see prescriber
Prescribers, n=25,366[2]



# of touches per no/limited see pre-scriber with Physicians Interactive
Prescribers, n=25,366[2]



- If Physicians Interactive agreement is approved, # of no/ limited see HCPs with <2 touches would decrease from ~18,000 to ~10,000
- Other ideas currently be explored to increase reach:
  - Nurse Educators
  - Education on reimburse-ment
  - Additional call center duties

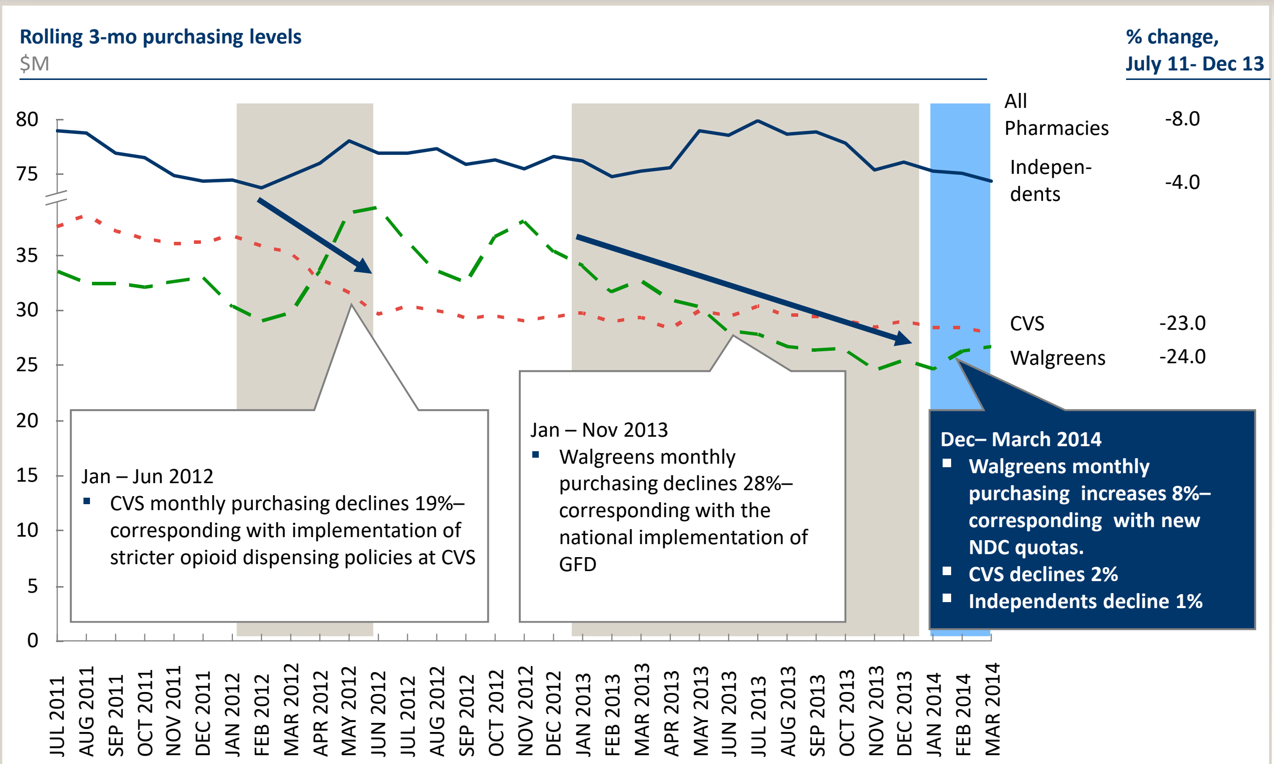
1. Prescribers either targeted in last 12 months or plan to target with budgeted campaign
2 Deciles 2-10

SOURCE: Purdue proposed multi-channel marketing plan; Physicians Interactive; Team analysis

Contents

- Re-cap of core E2E initiatives
- Metrics
- IDN Strategy
- Multi-channel approach to no-sees
- **Improved Patient Access**
- Next Steps

CVS and Walgreens implemented more stringent programs to restrict opioid dispensing between 2011 and 2013



SOURCE: Market Visibility data, updated 4/09/2014

Doc ID

Purdue has employed multiple tactics to address these issues, but could consider additional activities to more fully address stakeholders

✓ Primary stakeholder impacted

(✓) Secondary stakeholder impacted

	Purdue activity	Stakeholder impacted: Wholesalers	Large Retail Chain Pharmacy	Small chains/ independent pharmacies	HCP	Patient
Current activity	1 Collaborate with NABP to develop industry standards for dispensing guidelines	✓	✓	✓	✓	
	2 Encourage wholesaler/retailers to establish thresholds by NDC (vs. API), segregate problematic products, or give protective benefit to ADFs	✓	✓	(✓)		
	3 Work with retailers to modify dispensing guidelines to recognize value of ADF products		✓			
	4 Encourage patients to raise concerns with wholesalers / retailers to create broader awareness of patient access issues	(✓)	(✓)			✓
	5 Develop medical services playbook to address patient concerns				✓	✓
	6 Organize event with the former DEA agent and discuss potential solutions and partnerships to address the patient access issue.	(✓)	(✓)			
	7 Engage former/ current wholesalers in collaborative discussions to identify what it would take to address independent retailer challenges	(✓)		(✓)		
	8 Work with NCPA to support independent pharmacy OMS programs	(✓)		✓		
Additional activities for consideration	9 Create national "playbook " for reps to standardize key messages and tactics used to address patient access at the field level		(✓)	(✓)	✓	✓
	10 Refine Medical Services playbook to be more proactive in generating solutions (e.g., form letters sent to legislators)				✓	✓
	11 Facilitate a patient or provider verification system to streamline pharmacist identification of "trusted" HCPs and ERO patients	(✓)	✓	✓	✓	(✓)
	12 Create alternate distribution model (e.g, direct to patient) , independently or through partnerships through which Purdue assumes some risk (e.g., indemnifies other stakeholders)	✓		(✓)	✓	✓

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SOURCE: Patient Access team analysis

Exhibit 16

To: Maldonado, Martha[Martha.Maldonado@pharma.com]
Cc: Kelly, Marv[Marv.Kelly@pharma.com]; Cramer, Phil[Phil.Cramer@pharma.com]
From: Vance, Matthew
Sent: Mon 10/9/2017 8:09:21 AM
Subject: Craig Landau Field Rides
2018 Sales Calendar.pptx

Martha,

Below are the updated dates and TBM/ATBMs that Craig will be working with. A couple notes:

- I deleted the dinner on 10/31 in Hartford as this is Halloween and will be a hard night to get people out to dinner
- Red Team is Symproic Leads and Blue Team is Opioid Leads

Region	City	Date	Activity	Date	Activity	TBM/ATBM	Team	DBM	RBD
Northeast	Hartford			11/1	Field Ride (8-2)	Carly Grobbel TBM I	Red	Tim Fulham	Rich Scatoni
Midwest	Chicago	11/7	Dinner (6-9)	11/8	Field Ride (8-2)	Carol Devries-Witucki TBM II	Red	Dan McAvoy	Neyl Williams
Southeast	Atlanta	11/20	Dinner (6-9)	11/21	Field Ride (8-2)	Sarah Leatherwood TBM II	Red	Mike Moulton	Ron Cadet
Southcentral	Dallas	11/21	Dinner (6-9)	11/22	Field Ride (8-2)	Robert Leffler TBM II	Blue	James Galluccio	David McIntyre
Mid-Atlantic	Baltimore	12/4	Dinner (6-9)	12/5	Field Ride (8-2)	Tim Oakjones TBM I	Blue	Mike Ciaffi	Tony Morello
West	San Francisco	1/10	Dinner (6-9)	1/11	Field Ride (8-2)	Eric Horowitz ATBM	Red	Patrick Nave (acting DBM)	Rich Gilardoni

Please let me know if any of these dates change.

Thanks!

Matthew Vance
Associate Director, Field Force Effectiveness
Purdue Pharma L.P.
Matthew.vance@pharma.com
c. 203.914.6388
o. 203.588.7019

Click here for Full Prescribing information for all Purdue products.

Exhibit 17

To: maria_gordian@mckinsey.com[maria_gordian@mckinsey.com]
From: Landau, Dr. Craig
Sent: Tue 11/25/2008 3:19:06 PM
Subject: Fw: Deliverable Summary for Call
Opioid Training Program PurduePharma.Deliverable Summary.doc

For our discussion with Nat at 4pm.

From: Kevin Flynn
To: Landau, Dr. Craig
Cc: Nathaniel Katz
Sent: Tue Nov 25 14:40:22 2008
Subject: Deliverable Summary for Call

Hi Craig:

Attached is a brief summary of the deliverables AR is proposing. We may not need this for the call, but it may help kick start (or clarify) our discussion about the scope of AR services.

Looking forward to speaking with you and your team at 4.

Best,

Kevin

From: Landau, Dr. Craig [mailto:Dr.Craig.Landau@pharma.com]
Sent: Thursday, November 20, 2008 4:38 PM
To: Nathaniel Katz
Cc: Kevin Flynn
Subject: Re: opioid training registry

I believe we're on the same paragraph, if not the same sentence. I suggest a more detailed discussion with a subset of the most appropriate folks (yours and mine) to determine how to move forward contractually. This is not be area of responsibility, but of course will do everything I can to move the ball forward. I can speak late tonight from Toronto if you wish, or any time from tomorrow night through the weekend if this helps.

-Craig

From: Nathaniel Katz
To: Landau, Dr. Craig
Cc: Kevin Flynn
Sent: Thu Nov 20 16:32:50 2008

Subject: opioid training registry

Hi Craig, Just got your voicemail, glad to hear we are moving forward. We are certainly willing to help with the briefing package as we begin this project, and are comfortable moving forward in parallel with the contracting process. However it would be important for us to define in general terms the scope of the entire contract in general terms before proceeding, even if the minutiae take awhile to work out. We are assuming that Purdue will contract with AR, and our technology partners, to carry out the activities outlined in the Powerpoint presentation, including developing a web-based training program for prescribers, pharmacists, patients/caregivers, and a registration process for pharmacies/health care systems, as well as develop a few different methods for potential registrants to get into the system without direct web access. The issue of how to get the data into pharmacies real-time at point of care will be determined outside the scope of this specific project. Are we on the same page? My Tufts meeting will end early tomorrow afternoon, so if you are available we could talk then. Nat

Please make a note of my new e-mail & contact information below:

Nathaniel Katz, MD, MS
Analgesic Research
109 Highland Avenue
Needham, MA 02494
Main: 781-444-9605
Fax: 781-444-9608
Cell: 617-233-3433
nkatz@analgesicresearch.com
www.analgesicresearch.com

Project Specification Summary

Specific Deliverables for the Opioid Training Registry (OTR)

The OTR will be priced on a fixed-fee basis plus annual subscription. Annual subscription will be waived for a certain number of years for a company or companies that fund a substantial portion of the OTR development costs.

Website Features

Portals
- Pharmacies (for certification)
- Prescribers (for training, certification, and patient enrollment)
- Patients (for education)
- Pharmacists (for education)

The FDA letter does not require pharmacist certification (just pharmacies), and it does not make patients responsible for their own training and enrollment into the registry (these tasks are placed on the prescriber). However, we believe that:
- educational opportunities should also be provided to these audiences Supplementary education for patients (and their caregivers) will enhance public health, and having an educational program for pharmacists may enhance pharmacy buy-in
- patients should have the option of self-registering and self-educating
- pharmacists should have the option of enrolling patients in the registry at the point of dispensing—multiple paths to registration should be included to prevent barriers to access

Education Topics for General Principles Section (CME)
- Proper patient selection
- General principles of opioid therapy
- Risks
- Methods for detecting misuse/abuse/addiction/diversion
- Other critical elements of safe opioid prescribing/dispensing/utilizing

Education Topics for OxyContin Module (non-CME)
- Indication
- Dosing and administration
- Overdose risks
- Abuse/addiction/diversion risks
- Other topics, as needed, to fulfill regulatory requirements

Database Components/Features

- Patient registry (unique identifiers, basic demographics)
- Certification metrics (prescribers, pharmacies)
- Automated notifications for re-training and re-certification
- Certified prescriber and certified pharmacy look-up feature (for patients)
- Reporting

AR recognizes that to optimize this program, communication compatibility between the OTR and point-of-dispensing software in the pharmacy may be essential. AR will liaise with other vendors to determine best methods to optimize compatibility as much as possible.

Separate Deliverables to be Covered under a Time and Materials Agreement

- FDA briefing package support
- Support for FDA meeting (preparation & attendance)
- Design of outcome studies and data mining projects
- Outcomes analysis
- Scientific communications reporting outcomes analysis results
- Relationship building/stakeholder support generation
    - Payers
    - State medical boards
    - Medical societies
    - Hospital systems
    - Regulatory bodies
    - Key vendors (e.g., switch companies)

Deliverables Not Proposed

- Point-of dispensing verification

  AR is proposing the development of a secure database that can *provide* necessary information *to* pharmacies (or their agents, e.g., switch companies) to verify enrollment and certification but *we are not* proposing to develop or manage any system that directly verifies patient enrollment or prescriber certification at the point of dispensing.

Exhibit 18

From:	Landau, Dr. Craig
To:	maria_gordian@mckinsey.com; Tony_Tramontin@mckinsey.com; Laura_Nelson_Carney@mckinsey.com; Sarraf, Pasha; Kenneth_Yoon@mckinsey.com
CC:	Innaurato, Mike; Egan, Larry; Steiner, LaDonna; Haddox, Dr. J. David; Natarajan, Sayee; Pickett, Larry; Weingarten, Brianne; Harris, Stephen; Karen Becker; Udell, Howard; Stewart, John H. (US); Steven Weisman
BCC:	Pasha_Sarraf@mckinsey.com; Mike.Innaurato@pharma.com; Larry.Egan@pharma.com; LaDonna.Steiner@pharma.com; Dr.J.David.Haddox@pharma.com; Sayee.Natarajan@pharma.com; LAP1957@pharma.com; Brianne.Weingarten@pharma.com; Stephen.Harris@pharma.com; Howard.Udell@pharma.com; John.H.Stewart@pharma.com; Stewart, John H. (US)
Sent:	12/2/2008 1:44:02 AM
Subject:	First Draft- OTR Briefing Document for FDA
Attachments:	20081204 FDA Briefing Document EARLY DRAFT v10 nk.doc; APPENDIX TO 9D - REMS description DRAFT v2 nk.doc

Colleagues,

I spoke with Nat this evening. Here are his detailed comments on the REMS draft and FDA Briefing Document. Given the diverse nature of his comments, I've included what I believe to be the proper distribution. I'll look forward to discussing further in a meeting I'll look to schedule either late tomorrow or early Wed morning.

-Craig

Craig Landau, MD
Chief Medical Officer
VP Clinical, Medical and Regulatory Affairs
Purdue Pharma LLP
Stamford, CT 06901-3431
Cell (203) 912-5576
Office (203) 588-7252
Email: dr.craig.landau@pharma.com

From: Nathaniel Katz [mailto:NKatz@analgesicresearch.com]
Sent: Monday, December 01, 2008 6:40 PM
To: Landau, Dr. Craig
Cc: Kevin Flynn
Subject: RE: First Draft- OTR Briefing Document for FDA

Craig,
Attached are marked up documents.
A few overarching comments:

1. The strategy of meeting the FDA's expectations for OxyContin and/or OTR by responding with a "class-wide" REMS could backfire.

a. They might get the idea that Purdue only intends to meet its product-specific obligations if these are implemented for the class (however one might define the class)

b. Not all elements of REMS should be, or can be, class-wide. For example the Med Guide must be product-specific. Only certain elements make more sense for the class than specific products, such as education/training, registration when required, pt treatment agreements, core pt education, surveillance, etc.

2. I made a number of comments in the place they first came up, but did not repeat them in other portions of the document when they would also have applied.

3. There is a good focus on measuring unintended negative consequences, but it seems to have pushed aside measurement of intended consequences, i.e. does the program work.

4. The major comment I had on the REMS Appendix was that it would be better to cleave the PROMISE program into discrete parts. (1) the training program and registry, for prescribers, pharmacists, and patients. Analgesic Research would develop and maintain this. That way you have a respected independent third party doing the training and tracking the outcomes, and nobody is in a Purdue or FDA database. This makes it more convincing and feasible to crank it up to industry standard. We would also take patient-enrollments into the database by a variety of means (fax, phone, web, etc). (2) the inputs into the database (sales reps, phone training, letters, phone calls, etc). Purdue could take responsibility for this. Main goal is to push people to the website. (3) integration with dispensing systems. This will take some thought, planning, and negotiation, as pointed out.

I think the major flaw of the current proposal is that it looks like a Purdue-only program, down to the P in PROMISE, which undermines your strategy of creating a class-wide program ultimately.

5. But you are making amazing progress – not a small job.

I will take a more detailed look and mark up the appendix in more detail tomorrow.

If you have any updated versions please send them along.

Regards,
Nat

Please make a note of my new e-mail & contact information below:
Nathaniel Katz, MD, MS
Analgesic Research
109 Highland Avenue
Needham, MA 02494
Main: 781-444-9605
Fax: 781-444-9608
Cell: 617-233-3433
nkatz@analgesicresearch.com
www.analgesicresearch.com