IN THE CIRCUIT COURT OF CRITTENDEN COUNTY, ARKANSAS

STATE OF ARKANSAS, *ex rel.* SCOTT ELLINGTON, Second Judicial Circuit Prosecuting Attorney; COUNTY OF ARKANSAS, ARKANSAS; COUNTY OF ASHLEY, ARKANSAS; COUNTY OF BAXTER, ARKANSAS; COUNTY OF BENTON, ARKANSAS; COUNTY OF BOONE, ARKANSAS; COUNTY OF BRADLEY, ARKANSAS; COUNTY OF CALHOUN, ARKANSAS; COUNTY OF CHICOT, ARKANSAS; COUNTY OF CLARK, ARKANSAS; COUNTY OF CLAY, ARKANSAS; COUNTY OF CLEBURNE, ARKANSAS; COUNTY OF COLUMBIA, ARKANSAS; COUNTY OF CONWAY, ARKANSAS; COUNTY OF CRAIGHEAD, ARKANSAS; COUNTY OF CRAWFORD, ARKANSAS; COUNTY OF CROSS, ARKANSAS; COUNTY OF DALLAS, ARKANSAS; COUNTY OF DESHA, ARKANSAS; COUNTY OF FAULKNER, ARKANSAS; COUNTY OF FRANKLIN, ARKANSAS; COUNTY OF FULTON, ARKANSAS; COUNTY OF GARLAND, ARKANSAS; COUNTY OF GRANT, ARKANSAS; COUNTY OF GREENE, ARKANSAS; COUNTY OF HEMPSTEAD, ARKANSAS; COUNTY OF HOT SPRING, ARKANSAS; COUNTY OF HOWARD, ARKANSAS; COUNTY OF INDEPENDENCE, ARKANSAS; COUNTY OF IZARD, ARKANSAS; COUNTY OF JACKSON, ARKANSAS; COUNTY OF JOHNSON, ARKANSAS; COUNTY OF LAFAYETTE, ARKANSAS; COUNTY OF LAWRENCE, ARKANSAS; COUNTY OF LEE, ARKANSAS; COUNTY OF LINCOLN, ARKANSAS; COUNTY OF LITTLE RIVER, ARKANSAS; COUNTY OF LOGAN, ARKANSAS; COUNTY OF LONOKE, ARKANSAS; COUNTY OF MADISON, ARKANSAS; COUNTY OF MARION, ARKANSAS; COUNTY OF MILLER, ARKANSAS; COUNTY OF MISSISSIPPI, ARKANSAS; COUNTY OF MONROE, ARKANSAS; COUNTY OF MONTGOMERY, ARKANSAS; COUNTY OF OUACHITA,

Case No.: CV-2018-268

JURY TRIAL DEMANDED

ARKANSAS; COUNTY OF PERRY,)
ARKANSAS; COUNTY OF PHILLIPS,)
ARKANSAS; COUNTY OF PIKE, ARKANSAS;)
COUNTY OF POINSETT, ARKANSAS;)
COUNTY OF POLK, ARKANSAS; COUNTY OF)
POPE, ARKANSAS; COUNTY OF PRAIRIE,)
ARKANSAS; COUNTY OF RANDOLPH,)
ARKANSAS; COUNTY OF ST. FRANCIS,)
ARKANSAS; COUNTY OF SALINE,)
ARKANSAS; COUNTY OF SCOTT,)
ARKANSAS; COUNTY OF SEARCY,)
ARKANSAS; COUNTY OF SEBASTIAN,)
ARKANSAS; COUNTY OF SEVIER,)
ARKANSAS; COUNTY OF SHARP,)
ARKANSAS; COUNTY OF STONE,)
ARKANSAS; COUNTY OF UNION,)
ARKANSAS; COUNTY OF VAN BUREN,)
ARKANSAS; COUNTY OF WASHINGTON,)
ARKANSAS; COUNTY OF WHITE,)
ARKANSAS; COUNTY OF WOODRUFF,)
ARKANSAS; COUNTY OF YELL, ARKANSAS;)
COUNTY OF CARROLL, ARKANSAS;)
COUNTY OF NEWTON, ARKANSAS; COUNTY)
OF NEVADA, ARKANSAS; COUNTY OF)
CLEVELAND, ARKANSAS; COUNTY OF)
CRITTENDEN, ARKANSAS; CITY OF LITTLE)
ROCK, ARKANSAS; CITY OF FORT SMITH,)
ARKANSAS; CITY OF SPRINGDALE;)
ARKANSAS; CITY OF JONESBORO,)
ARKANSAS; CITY OF NORTH LITTLE ROCK;)
ARKANSAS; CITY OF CONWAY, ARKANSAS;)
CITY OF ROGERS, ARKANSAS; CITY OF PINE)
BLUFF, ARKANSAS; CITY OF BENTONVILLE,)
ARKANSAS; CITY OF HOT SPRINGS,)
ARKANSAS; CITY OF BENTON, ARKANSAS;)
CITY OF TEXARKANA, ARKANSAS; CITY OF)
SHERWOOD, ARKANSAS; CITY OF)
JACKSONVILLE, ARKANSAS; and CITY OF)
MONTICELLO, ARKANSAS;)
)
Plaintiffs,)
)
v.)
)
PURDUE PHARMA, L.P.; PURDUE PHARMA,)
INC.; THE PURDUE FREDERICK COMPANY;)

CEPHALON, INC.; TEVA PHARMACEUTICAL)
INDUSTRIES, LTD; TEVA)
PHARMACEUTICALS USA, INC.; JANSSEN)
PHARMACEUTICALS, INC.; ORTHO-MCNEIL-)
JANSSEN PHARMACEUTICALS, INC.;)
JOHNSON & JOHNSON; WATSON)
LABORATORIES, INC.; ACTAVIS PHARMA,)
INC.; WATSON PHARMA, INC.; ACTAVIS,)
LLC; ENDO HEALTH SOLUTIONS, INC.;)
ENDO PHARMACEUTICALS, INC.; VINTAGE)
PHARMACEUTICALS, LLC; INSYS)
THERAPEUTICS, INC.; MALLINCKRODT, PLC;)
MALLINCKRODT PHARMACEUTICALS;)
MYLAN PHARMACEUTICALS, INC.; SUN)
PHARMACEUTICALS INDUSTRIES, INC.;)
AUROBINDO PHARMA USA, INC.; AUROLIFE)
PHARMA, LLC; LUPIN PHARMACEUTICALS,)
INC.; COLLEGIUM PHARMACEUTICAL, INC.;)
BIODELIVERY SCIENCES INTERNATIONAL,)
INC.; SHIONOGI, INC.; ABBVIE, INC.;)
ABBOTT LABORATORIES, INC.; PERNIX)
THERAPEUTICS HOLDINGS, INC.; DAIICHI)
SANKYO, INC.; FOREST LABORATORIES,)
INC.; FOREST PHARMACEUTICALS, INC.;)
MAYNE PHARMA, INC.; APOTEX, INC.;)
WEST-WARD PHARMACEUTICALS CORP.;)
GEMINI LABORATORIES, LLC;)
POLY-PHARMACEUTICALS, INC.; AKORN,)
INC.; VALEANT PHARMACEUTICALS)
NORTH AMERICA, LLC; ECR)
PHARMACEUTICALS, INC.; DEPOMED, INC.;)
VALIDUS PHARMACEUTICALS, LLC;)
EGALET CORPORATION; VERNALIS)
THERAPEUTICS, INC.; UCB PHARMA, INC.;)
XANODYNE PHARMACEUTICALS, INC.;)
VERTICAL PHARMACEUTICALS, INC.;)
SENTYNL THERAPEUTICS, INC.; RHODES)
TECHNOLOGIES, INC.; RHODES)
TECHNOLOGIES, L.P.; SANDOZ, INC.;)
AMERISOURCEBERGEN DRUG)
CORPORATION; CARDINAL HEALTH, INC.;)
McKESSON CORPORATION; LINDEN CARE,)
LLC; KJ MEDICAL MANAGEMENT, LLC;)
CJN PHARMACY SERVICES, LLC; PERRY)
COUNTY FOOD & DRUG, INC.; MAHMOOD)
AHMAD, M.D.; UNITED PAIN CARE, LTD;)

SHAWN MICHAEL BROOKS, M.D.; KRISTEN HOLLAND; RICHARD DUANE JOHNS; and CHRISTOPHER WATSON;	))))
Defendants.	)

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FIRST AMENDED COMPLAINT

Plaintiffs, the State of Arkansas, Counties of the State of Arkansas (hereinafter "the Counties" or by their respective county names), and Cities of the State of Arkansas (hereinafter "the Cities" or by their respective city names) (hereinafter "Plaintiffs" or identified by their respective names), allege as follows:

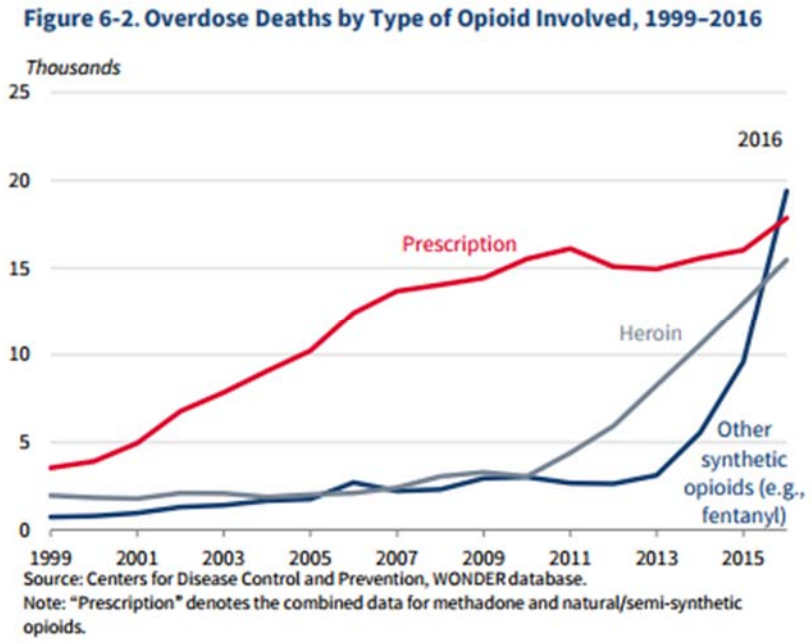
I. INTRODUCTION

A. Opioids devastate Arkansas public health and welfare.

1. Drug poisoning is the leading cause of injury and death in the United States, outnumbering those caused by firearms, car crashes, suicide, and homicide.[1] Controlled prescription drugs, specifically opioid analgesics (painkillers), have been linked to the largest number of overdose deaths of any illicit drug class, outnumbering cocaine and heroin combined.[2] Since 1999, the number of overdose deaths involving opioids has quadrupled.[3] By 2015, opioids were responsible for 63% of all drug-overdose deaths,[4] and that number climbed to 66% in 2016.[5] The Centers for Disease Control and Prevention ("CDC") has stated that "[w]e now know that overdoses from prescription opioids are a driving factor in the 15-year increase in opioid overdose deaths,"[6] and that opioids are, in fact, the main driver of drug overdose deaths.[7]

[1] Drug Enforcement Administration, *2017 National Drug Threat Assessment*, at v (Oct. 2017), *available at* https://www.dea.gov/docs/DIR-040-17_2017-NDTA.pdf (last visited Feb. 9, 2018).
[2] Id. at 25.
[3]Centers for Disease Control, *Understanding the Epidemic* (updated Aug. 30, 2017), *available at* https://www.cdc.gov/drugoverdose/epidemic/index.html (last visited Feb. 9, 2018).
[4] Drug Enforcement Administration, *supra* note 1, at 25.
[5] Centers for Disease Control, *Opioid Basics*, (updated Aug. 30, 2017), *available at* https://www.cdc.gov/drugoverdose/epidemic/index.html (last visited Feb. 9, 2018).
[6] Centers for Disease Control, *Understanding the Epidemic*, *supra* note 3.
[7] Centers for Disease Control, *Drug Overdose Death Data* (updated Dec. 19, 2017), *available at* https://www.cdc.gov/drugoverdose/data/statedeaths.html (last visited Feb. 9, 2018).

2. The national opioid crisis has "reached epidemic levels."[8] The recent Economic Report of the President warns of chilling realities. The 350,000 American deaths from opioid overdose since 1999 amounts to 87% of the 405,399 American lives lost during World War II.[9] Staggeringly, drug overdose is now the *leading cause of death* for Americans under 50 years old and has removed 2.5 months from the average American's life expectancy.[10] Since 1999, overdose deaths caused by prescription opioids have skyrocketed, also inducing a massive rise in heroin and other opioid overdose deaths—even as deaths caused by prescription opioids continues to rise.[11]



3. Arkansas has been at the forefront of this trend. Overdose deaths in Arkansas have ballooned 262% from 5.1 per 100,000 citizens in the year 2000 to 13.4 per 100,000 in 2016.[12] One

[8] Chuck Rosenberg, Acting Administrator, Drug Enforcement Administration, *2015 National Drug Threat Assessment Summary*, at iii, *available at* https://www.dea.gov/docs/2015%20NDTA%20Report.pdf (last visited Feb. 23, 2018).
[9] *Economic Report of the President, February 2018*, at 292.
[10] Id.
[11] Id. at 294.
[12] Nate Smith, M.D., M.P.H., Arkansas Department of Health, *Opioid Prescribing in Arkansas* (July 10, 2017), *available at* http://www.arkleg.state.ar.us/assembly/2017/Meeting%20Attachments/430/I15851/Opioid%20Handout-Nate%20Smith.pdf (last visited Feb. 9, 2018).

thousand, sixty-seven people died from drug overdose deaths in Arkansas from 2013-2015, and at least half of those deaths were opioid-related.[13] In 2016 alone, Arkansas saw the number of drug overdose deaths rise to 401—at least 335 of which are opioid-related.[14]

4. Increased availability of these drugs corresponds with increased use and overdose.[15] As researchers have noted, "[t]he correlation between opioid sales, [opioid pain reliever]-related overdose deaths, and treatment seeking for opioid addiction is striking."[16] It is no surprise, then, that Arkansas's near-tripling in overdose deaths between 2000 and 2015 coincides with a span in which opioid sales have quadrupled. [17] The overwhelming growth in the supply of these drugs has ravaged the State of Arkansas, destroyed the lives of many of her citizens, and strained the capacity of State and local government to cope with the public-health crisis caused by the drugs' rapid influx.

5. Arkansas has been particularly susceptible to the rapid expansion of opioid availability. There are now more opioid prescriptions in Arkansas than people. In fact, it has the second highest opioid prescription rate in the country, with doctors writing 114.6 opioid prescriptions for every 100 persons.[18] In less than five years, Arkansas' opioid prescriptions rates

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[13]Wesley Brown, *Arkansas prescription drug crisis worsens, President Trump addresses national opioid epidemic*, TALK BUSINESS & POLITICS (Aug. 8, 2017), *available at* https://talkbusiness.net/2017/08/arkansas-prescription-drug-crisis-worsens-president-trump-addresses-national-opioid-epidemic/ (last visited Feb. 12, 2018).

[14] Arkansas Prescription Monitoring Program, *Drug Overdose Deaths in Arkansas 2000-2016, available at* http://www.healthy.arkansas.gov/images/uploads/pdf/Mortality_Report_-_2017_v3.pdf (last visited March 2, 2018); Wesley Brown, *Gov. Hutchison, Arkansas health officials announce naloxone standards to curb opioid-related overdose*, TALK BUSINESS & POLITICS (Sept. 6, 2017), *available at* https://talkbusiness.net/2017/09/gov-hutchinson-arkansas-health-officials-announce-naloxone-standards-to-curb-opioid-related-overdose/ (last visited Feb. 9, 2018).

[15] National Institute on Drug Abuse (NIDA), *Prescription Opioids and Heroin* (updated Jan. 2017), *available at* https://www.drugabuse.gov/publications/research-reports/relationship-between-prescription-drug-abuse-heroin-use/increased-drug-availability-associated-increased-use-overdose (last visited Feb. 9, 2018).

[16] Andrew Kolodny, David T. Courtwright, Catherine S. Hwang, Peter Kreiner, John L. Eadie, Thomas W. Clark, & Caleb Alexander, *The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction*, 36 ANNUAL REV. OF PUB. HEALTH 559, 560-561 (2015).

[17]Arkansas Prescription Monitoring Program, *Drug Overdose Deaths in Arkansas 2000-2015*, *available at* http://www.arkansaspmp.com/files/2017/Mortality_Report_Final_v3.pdf (last visited Feb. 12, 2018).

[18] Centers for Disease Control and Prevention, *U.S. State Prescribing Rates* (updated July 31, 2017), *available at* https://www.cdc.gov/drugoverdose/maps/rxstate2016.html (last visited Feb. 9, 2018).

have surged from eighth-most in the nation to second.[19] Drug companies sold 235,934,613 opioid pills across the state in 2016, making opioids both the top-selling class of prescription drug in Arkansas and more than twice as prevalent as the next highest-selling prescription drug class.[20] Drug companies sell enough opioids in Arkansas for every man, woman, and child to each take 80 pills per year.[21]

6. The National Bureau of Economic Research has concluded that economic conditions do not explain the current opioid epidemic and "that efforts to improve economic conditions in distressed locations, while desirable for other reasons, are not likely to yield significant reductions in drug mortality.[22] In fact, the current epidemic is "related to the availability and cost of the drugs."[23] In other words, the epidemic was directly caused, and is perpetuated, by the companies that manufacture and distribute opioids.

7. Drug manufacturers and wholesale distributors have ensured that opioid supplies abound in Arkansas and have made it one of the well-stocked states in the country. According to Retail Summary Reports from the DEA's Automation of Reports and Consolidated Orders System ("ARCOS") database, manufacturers and distributors supplied nearly two billion milligrams of opioids to Arkansas pharmacies in 2015, despite the State's relatively small population.[24] The same year, Arkansas ranked number one in meperidine distribution per 100,000 people, number three in

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[19] *Compare* Centers for Disease Control, *supra* note 14 *with* Centers for Disease Control and Prevention, *Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines, United States, 2012*, 63 Morbidity and Mortality Weekly Report 563 (July 4, 2014), *available at* https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a2.htm (last visited Feb. 13. 2018).

[20] Arkansas Department of Health, *Prescription Monitoring Program Annual Report January-December 2016, available at* http://www.arkansaspmp.com/files/2017/2016_Annual_Report_FINAL.pdf (last visited Feb. 9, 2018).

[21] Wesley Brown, *Arkansas at front line of U.S. opioid epidemic*, TALK BUSINESS & POLITICS (Sept. 13, 2017), *available at* https://talkbusiness.net/2017/09/arkansas-at-front-line-of-u-s-opioid-epidemic (last visited Feb. 9, 2018).

[22] Christopher J. Ruhm, The National Bureau of Economic Research, *Deaths of Despair or Drug Problems?* (Jan. 2018), *available at* http://www.nber.org/papers/w24188 (last visited Feb. 9, 2018).

[23] Id.

[24] Department of Justice, Drug Enforcement Administration, Office of Diversion Control, *ARCOS 3 – Report 5, Statistical Summary for Retail Drug Purchases by Grams WT, Reporting Period: 01/01/2015 to 12/31/2015, available at* https://www.deadiversion.usdoj.gov/arcos/retail_drug_summary/2015/2015_rpt5.pdf (last visited Feb. 9, 2018).

codeine and tapentadol distribution, and number four in hydrocodone distribution.[25] Overall, Arkansas pharmacies received more milligrams of opioids per citizen than those of all but three other states.[26]

8. Abuse and addiction are the natural by-products of the over-supply of opioids saturating Arkansas. Opioids are highly addictive, and repeated exposure has been noted to cause structural changes in the brain that lead to addiction.[27] Research conducted at the University of Arkansas for Medical Sciences has shown just how dangerous even minimal exposure to opioids can be, finding that "[t]he probability of long-term opioid use increases most sharply in the first days of therapy," and "the chances of chronic use begin to increase after the third day [of opioid] supplied and rise rapidly thereafter."[28]

9. The overwhelming availability of these drugs has taken its toll on Arkansas in a variety of ways. In addition to the direct problems of adult addiction, abuse, and overdose, the opioid epidemic has created a ripple effect, touching lives across all age groups and straining public resources. Increased opioid use has been linked with increased emergency room visits for opioid-related problems and an increase in neonatal abstinence syndrome ("NAS").[29] NAS is a constellation of symptoms resulting from drug use during pregnancy.[30] Opioid use by pregnant women increases the risk of NAS,[31] which increases the risk of pregnancy complications, including

[25] Department of Justice, Drug Enforcement Administration, Office of Diversion Control, *ARCOS 3 – Report 4, Cumulative Distribution by State in Grams per 100,000 Population, Reporting Period: 01/01/2015 to 12/31/2015*, *available at* https://www.deadiversion.usdoj.gov/arcos/retail_drug_summary/2015/2015_rpt4.pdf (last visited Feb. 9, 2018).
[26] Department of Justice, *supra* note 20.
[27] Kolodny, et al., *supra* note 12, at 560-561.
[28] Anuj Shah, Corey J. Hayes & Bradley C. Martin, *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use*, 66 CDC Morbidity and Mortality Weekly Report 265 (March 17, 2017), *available at* https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm (last visited Feb. 9, 2018).
[29] Kolodny, et al., *supra* note 12, at 560-561.
[30] Arkansas Department of Health, *Neonatal Abstinence Syndrome in Arkansas 2000–2014*, *available at* http://www.arkansaspmp.com/files/2017/NAS_Report_Final.pdf (last visited Feb. 9, 2018).
[31] Arkansas Department of Health, *supra* note 16.

maternal death and stillbirth.[32] The rate of NAS diagnosis in Arkansas increased more than ten-fold between 2000 and 2014.[33] Babies diagnosed with NAS spend five times more days in the hospital, and medical care costs increase ten-fold as compared to babies born without NAS.[34]

10. Older children have also been affected. According to Arkansas Attorney General Leslie Rutledge, presently "Arkansas ranks first in the nation for ages 12 to 17 in misuse of painkillers."[35] In 2012, former Attorney General Dustin McDaniel noted that prescription drug abuse was plaguing Arkansas's children, stating that "by the time Arkansas high school students have reached their senior year, roughly one in five has abused prescription drugs."[36] For each age group, Arkansas ranks in the top 20 states for opioid abuse.[37]

11. In addition, the opioid epidemic is driving a dramatic increase in the number of children entering foster care.[38] The number of children in Arkansas's foster care system has spiked more than 73%, growing from 3,806 in 2015 to 5,209 as of September 28, 2016.[39] Drug-endangered children are at increased risk of injury, death, physical and sexual assault, neglect, and perpetuation of the cycles of drug and child abuse.[40] In the 4th quarter of the State's 2017 fiscal year, over half of children placed into the foster care system were placed because of substance

[32] Ayumi Maeda, Brian T. Bateman, Caitlin Clancy, Andreea Creanga, Lisa Leffert, *Opioid Abuse and Dependence during Pregnancy: Temporal Trends and Obstetrical Outcomes,* 121 ANESTHESIOLOGY 1158 (Dec. 2014).
[33] Arkansas Department of Health, *supra* note 26.
[34] Id.
[35] Wesley Brown, *supra* note 17.
[36] Dustin McDaniel, Attorney General, *Arkansas Prescription Drug Summit,* Conference Agenda (Apr. 26, 2012).
[37] Arkansas Department of Human Services, *State Targeted Response to Opioid Crisis*.
[38] Teresa Wiltz, *Drug Addiction Epidemic Creates Crisis in Foster Care.* STATELINE (Oct. 7, 2016), *available at* http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/10/07/drug-addiction-epidemic-creates-crisis-in-foster-care (last visited Feb. 13, 2018).
[39] State Targeted Response (STR) to Opioid Crisis citing Brawner S. *Director: Foster spike's cause hard to pinpoint; some caseworkers erring on side of removal*, TALK BUSINESS & POLITICS (Nov. 29, 2016), *available at* https://talkbusiness.net/2016/11/director-foster-spikes-cause-hard-to-pinpoint-some-caseworkers-erring-on-side-of-removal/ (last visited Feb. 13, 2018).
[40] Department of Justice, Office of Public Affairs, *Keeping Them Safe: The Task Force on Drug Endangered Children* (Aug. 17, 2010).

abuse by parents—and the vast majority of which involve drug abuse.[41] The same was true each quarter before that—55% of entries into the foster care system in the 3rd quarter were due to parental substance abuse,[42] 57% in the 2nd quarter,[43] and 53% in the 1st quarter.[44]

12. The fallout from the prescription opioid epidemic has also spawned a public health and criminal justice crisis stemming from increased use of the illegal drug heroin. Heroin use has been increasing every year.[45] Arkansas has seen the number of heroin-related hospitalizations increase more than eight-fold, from 42 in 2011 to 364 in 2015.[46] Opioid users graduate from prescription pills to heroin because it is cheaper, available, and it affects the same brain receptors to provide feelings of euphoria similar to prescription opioids.[47] Three in four heroin users also report use of prescription opioids,[48] and 80% of current heroin users report that their opioid use began with prescription opioids.[49] The CDC reports that overdose deaths involving heroin have more than tripled in the last four years, and the opioid epidemic is largely to blame.[50]

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[41] Hornby Zeller Associates, Inc., *Quarterly Performance Report, 4th Quarter SFY 2017*, at 11 (produced for Arkansas Department of Health, Division of Children and Family Services), *available at* http://humanservices.arkansas.gov/images/uploads/dcfs/4th_Qtr_QPR_SFY_2017_FINAL.pdf (last visited Feb. 9, 2018).
[42] Hornby Zeller Associates, Inc., *Quarterly Performance Report, 3rd Quarter SFY 2017*, at 11 (produced for Arkansas Department of Human Services, Division of Children and Family Services http://humanservices.arkansas.gov/images/uploads/dcfs/3rd_Qtr_QPR_SFY_2017_FINAL.pdf (last visited Feb. 9, 2018).
[43] Hornby Zeller Associates, Inc., *Quarterly Performance Report, 2nd Quarter SFY 2017*, at 11 (produced for Arkansas Department of Human Services, Division of Children and Family Services http://humanservices.arkansas.gov/images/uploads/dcfs/2nd_Qtr_SFY_2017_FINAL.pdf (last visited Feb. 9, 2018).
[44] Hornby Zeller Associates, Inc., *Quarterly Performance Report, 1st Quarter SFY 2017*, at 11 (produced for Arkansas Department of Human Services, Division of Children and Family Services http://humanservices.arkansas.gov/images/uploads/dcfs/1st%20Qtr%20SFY%202017%20FINAL.pdf (last visited Feb. 9, 2018).
[45] Arkansas Department of Human Services, *supra* note 33.
[46] Id.
[47] Id.
[48] Id.
[49] Kolodny, et al., *supra* note 12, at 560-561.
[50] Theodore Cicero, Matthew Ellis, Hilary Surratt, *The Changing Face of Heroin Use in the United States*, 71 J. AM. MED. ASSOC. 821 (July 2014).

13. Arkansas authorities have been active in attempting to ameliorate the epidemic. Over the past decade, the Arkansas Medical Board has disciplined over 80 physicians throughout the State for overprescribing, diverting, and abusing opioids. Medical Board files include the complaints of numerous Arkansas parents that have lost their children to prescription opioid overdose.

14. Recently, the Drug Enforcement Administration ("DEA")'s Little Rock office and various Arkansas law enforcement agencies took part in the "Operation Pilluted" campaign targeting abuse of prescription opioids in Arkansas, which former U.S. Attorney Christopher Thyer branded as "perhaps the greatest drug problem Arkansas currently faces."[51] As a result of Operation Pilluted, the DEA and Arkansas law enforcement exposed eminent examples of opioid diversion throughout the State, including:

a. Dr. Mahmood Ahmad, who from his Sherwood clinic colluded with Insys and internet pharmacy Linden Care to illegally prescribe Subsys fentanyl spray—one of the deadliest opioids and 100 times more powerful than morphine—in exchange for kickbacks, committing at least 121 violations of the Controlled Substances Act in the process;

b. KJ Medical Clinic of Little Rock, from which federal prosecutors indicted 16 individuals in connection with the clinic's long term hydrocodone diversion, including illegitimate prescriptions for approximately 287,500 10mg hydrocodone pills in a 10-month period, most of which were filled at local Bowman Curve Pharmacy.[52] Between just December 15, 2014 and March 6, 2015, Bowman Curve Pharmacy filled 1,484 prescriptions—only six of which were *not* from KJ Medical Clinic[53];

c. Dr. Richard Johns of Little Rock and at least 38 others' oxycodone diversion enterprise in Lonoke, Pulaski, and White Counties, in which the doctor and his

[51] Department of Justice, U.S. Attorney's Office, Eastern District of Arkansas, *140 Charged In Arkansas As Part of National Prescription Drug Initiative* (May 20, 2015), *available at* https://www.justice.gov/usao-edar/pr/140-charged-arkansas-part-national-prescription-drug-initiative (last visited Feb. 4, 2018).

[52] Linda Satter, *Former Little Rock doctor gets probation in pill mill case,* NORTHWEST ARKANSAS DEMOCRAT-GAZETTE (Apr. 1, 2017); Linda Satter, *Conway doctor pleads guilty in drug case,* NORTHWEST ARKANSAS DEMOCRAT GAZETTE (Apr. 21, 2016).

[53] Linda Satter, *Conway doctor pleads guilty in drug case,* NORTHWEST ARKANSAS DEMOCRAT-GAZETTE (Apr. 21, 2016).

accomplices distributed at least 39,000 oxycodone and OxyContin pills with a street value of $30 a piece[54];

d. Perry County Food and Drug Store, from which a pharmacist diverted "tens of thousands of Schedule II, III, IV pills," likely including more than 49,000 oxycodone and 72,000 hydrocodone pills[55]; and

e. a hydromorphone diversion network in Little Rock that illegally distributed roughly 2,500 Dilaudid pills a month between the fall of 2013 and August 2014.[56]

15. Despite law enforcement efforts, prescription opioids continue to flood into the State of Arkansas and Plaintiff Counties and Cities, and the epidemic of addiction continues to plague their citizens.

16. All of the foregoing factors have dramatically increased demand for state, county, city, and medical services needed to respond to the additional problems created by the opioid epidemic. The epidemic has strained public funding and required public services that so far exceed the normal, expected costs that they are distinct from and unrelated to their normal provision and have resulted in a need for services above what the State, Counties, and Cities are able to currently provide. The relief requested in this case is necessary for the State, Counties, and Cities to adequately respond to the opioid epidemic.

17. Defendants' conduct has foreseeably exacted a financial burden on Arkansas citizens, including Plaintiffs. Plaintiffs have unnecessarily and jointly spent, and will continue to spend, considerable funds on costs directly attributable to the flood of opioids that Defendants unleashed upon the State, the Counties, the Cities and their citizens.

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[54] Linda Satter, *Internist admits selling opioid prescriptions,* NORTHWEST ARKANSAS DEMOCRAT-GAZETTE (Mar. 3, 2017).

[55] Department of Justice, U.S. Attorney's Office, Eastern District of Arkansas, *Perryville Pharmacist Sent to Prison for 10 Years, to Pay $850,000 for Role in Pill Scheme* (Sept. 27, 2017), *available at* https://www.justice.gov/usao-edar/pr/perryville-pharmacist-sent-prison-10-years-pay-850000-role-pill-scheme (last visited Feb. 4, 2018); Linda Satter, *Ex-pharmacist draws 10 years for pill scheme,* NORTHWEST ARKANSAS DEMOCRAT-GAZETTE (Sept. 28, 2017).

[56] Department of Justice, *supra* note 47.

18. To redress and punish these violations of law, Plaintiffs seek damages for the amounts they have paid in the past and will pay in the future, among other damages, compensation, and penalties.

B. The Opioid Epidemic emerges from a conspiracy of greed.

19. Defendants manufacture, market, distribute, dispense, and prescribe opioids, including brand-name drugs like Oxycontin and Percocet, and generics like oxycodone and hydrocodone, which are powerful narcotic painkillers. Historically, because they were considered too addictive and debilitating for the treatment of common chronic pain (e.g., back pain, migraines, and arthritis), opioids were used only to treat short-term acute pain or for palliative (end-of-life) care.

20. However, by the late 1990s, and continuing today, opioid manufacturers began a marketing scheme designed to persuade doctors and patients that opioids can and should be used for chronic pain, a far broader group of patients much more likely to become addicted and suffer other adverse effects from the long-term use of opioids. The White House itself blames Manufacturer Defendants for inciting the opioid epidemic: "[I]n response to claims that pain was under-treated and assurances from manufacturers that new opioid formulations were safe, the number of opioid prescriptions skyrocketed. What followed was an increase in the misuse of and deaths related to these prescriptions."[57]

21. In connection with this scheme, each Manufacturer Defendant spent, and continues to spend, millions of dollars on promotional activities and materials that falsely deny or trivialize the risks of opioids while overstating the benefits of using them for chronic pain. As to the risks, Manufacturer Defendants falsely and misleadingly, and contrary to the language of their drugs'

[57] *Economic Report of the President, supra* note 9, at 293.

labels: (1) downplayed the serious risk of addiction; (2) promoted the concept of "pseudoaddiction" and thus advocated that the signs of addiction should be treated with more opioids; (3) exaggerated the effectiveness of screening tools in preventing addiction; (4) claimed that opioid dependence and withdrawal are easily managed; (5) denied the risks of higher opioid dosages; and (6) exaggerated the effectiveness of "abuse-deterrent" opioid formulations to prevent abuse and addiction. Conversely, Manufacturer Defendants also falsely touted the benefits of long-term opioid use, including the supposed ability of opioids to improve function and quality of life, even though there was no "good evidence" to support their claims.

22. Manufacturer Defendants disseminated these common messages to reverse the prevalent popular and medical understanding that opioids were not suitable for such use. They disseminated these messages directly, through their sales representatives, and in speaker groups led by physicians who were recruited for their support of the marketing messages. Borrowing a page from Big Tobacco's playbook, Manufacturer Defendants also worked through third parties they controlled by: (a) funding, assisting, encouraging, and directing doctors, known as "key opinion leaders" ("KOLs") and (b) funding, assisting, directing, and encouraging seemingly neutral and credible professional societies and patient advocacy groups (referred to hereinafter as "Front Groups"). Manufacturer Defendants then worked together with those KOLs and Front Groups to taint the sources that doctors and patients relied on for ostensibly "neutral" guidance, such as treatment guidelines, Continuing Medical Education ("CME") programs, medical conferences and seminars, and scientific articles. Thus, working individually and collectively, and through these Front Groups and KOLs, Manufacturer Defendants persuaded doctors and patients that what they had long known—that opioids are addictive drugs, unsafe in most circumstances

for long-term use—was untrue, and that the compassionate treatment of pain, in fact, *required* opioids.

23. Each Manufacturer Defendant knew that its misrepresentations of the risks and benefits of opioids were not supported by or were directly contrary to the scientific evidence. Opioid manufacturers, including Defendants Endo Pharmaceuticals, Inc. and Purdue Pharma L.P., have also entered into settlement agreements with public entities that prohibit them from making many of the misrepresentations identified in this Complaint in other jurisdictions. Yet even now, each Defendant continues to misrepresent the risks and benefits of long-term opioid use in Arkansas and continues to fail to correct its past misrepresentations.

24. Manufacturer Defendants also formed an opioid marketing enterprise in violation of Arkansas law for the purpose of illegally promoting the widespread use of opioids for chronic pain.

25. Manufacturer Defendants' efforts were wildly successful. Opioids are now the most prescribed class of drugs; they generated $11 billion in revenue for drug companies in 2014 alone. In an open letter to the nation's physicians in August 2016, the then-U.S. Surgeon General expressly connected this "urgent health crisis" to "heavy marketing of opioids to doctors . . . [m]any of [whom] were even taught – incorrectly – that opioids are not addictive when prescribed for legitimate pain." This epidemic, fueled by opioids lawfully prescribed by doctors, has resulted in a flood of prescription opioids available for illicit use or sale (the supply), and a population of patients physically and psychologically dependent on them (the demand). And when those patients can no longer afford or legitimately obtain opioids, they often turn to the street to buy prescription opioids or even heroin. Arkansas is now awash in opioids and engulfed in a public health crisis the likes of which has not been seen before.

26. While Manufacturer Defendants ignited the fires of the opioid epidemic, the Distributor Defendants fanned the flames. Controlling 85 to 90% of prescription opioid wholesale distribution, Distributor Defendants could and should have curbed the excess opioid supply in Arkansas, but they did not. Despite being required by Arkansas law to prevent unlawful opioid diversion, Distributor Defendants purposefully shunned their responsibilities to line their pockets at Arkansas' expense. The result of Arkansas's opioid crisis has been catastrophic. Opioids have become the main source of unintentional drug overdose in the state and, due to the vast supply of opioids, the number of annual deaths attributable to unintentional drug overdoses has rapidly increased in recent years. The dramatic increase in opioid prescriptions to treat chronic pain has resulted in a population of addicts who seek drugs from doctors. Efforts by physicians to reverse course for a chronic pain patient with long term dependence on opioids are often thwarted by a secondary criminal market well-stocked by a pipeline of drugs that are diverted to supply these patients.

27. Prescription opioid abuse has not displaced heroin, but rather triggered a resurgence in its use, imposing additional burdens on Arkansas' local governments that address heroin use addiction. Individuals who are addicted to prescription opioids often transition to heroin because it is a less expensive, readily available alternative that provides a similar high.

28. Many Arkansas citizens suffer from chronic pain, which takes an enormous toll on their health, lives and families. These patients deserve both appropriate care and the ability to make informed decisions based on accurate and complete information about treatment risks and benefits. But Defendants' deceptive marketing campaign deprived Arkansas patients and their doctors of the ability to make informed medical decisions and, instead, caused important, sometimes life-or-death decisions to be made based not on science, but on hype. Defendants deprived patients, their

doctors, and health-care payors of the chance to exercise informed judgment and subjected them to enormous costs and suffering.

29. Defendants' conduct has also foreseeably exacted a financial burden on Arkansas citizens, including Plaintiffs. Plaintiffs have unnecessarily and jointly spent, and will continue to spend, considerable funds on costs directly attributable to the flood of opioids that Defendants unleashed upon the State and its citizens.

30. To redress and punish these violations of law, Plaintiffs seek damages for the amounts they have paid in the past and will pay in the future, among other damages, compensation, and penalties.

II. PARTIES

A. Plaintiffs

31. Plaintiff, the STATE OF ARKANSAS, *ex rel*. Scott Ellington, the duly elected Second Judicial Circuit Prosecuting Attorney, the venue in which this action is brought, (hereinafter "the State") brings this suit "in favor of the State and in which the State is interested," "in the name of the State," and in the State's sovereign capacity pursuant to ARK. CODE ANN. § 16-106-101.

32. Plaintiff, ARKANSAS COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

33. Plaintiff, ASHLEY COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

34. Plaintiff, BAXTER COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

35. Plaintiff, BENTON COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

36. Plaintiff, BOONE COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

37. Plaintiff, BRADLEY COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

38. Plaintiff, CALHOUN COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

39. Plaintiff, CARROLL COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

40. Plaintiff, CHICOT COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

41. Plaintiff, CLARK COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

42. Plaintiff, CLAY COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

43. Plaintiff, CLEBURNE COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

44. Plaintiff, COLUMBIA COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

45. Plaintiff, CONWAY COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

46. Plaintiff, CRAIGHEAD COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

47. Plaintiff, CRAWFORD COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

48. Plaintiff, CROSS COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

49. Plaintiff, DALLAS COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

50. Plaintiff, DESHA COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

51. Plaintiff, FAULKNER COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

52. Plaintiff, FRANKLIN COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

53. Plaintiff, FULTON COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

54. Plaintiff, GARLAND COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

55. Plaintiff, GRANT COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

56. Plaintiff, GREENE COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

57. Plaintiff, HEMPSTEAD COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

58. Plaintiff, HOT SPRING COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

59. Plaintiff, HOWARD COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

60. Plaintiff, INDEPENDENCE COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

61. Plaintiff, IZARD COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

62. Plaintiff, JACKSON COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

63. Plaintiff, JOHNSON COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

64. Plaintiff, LAFAYETTE COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

65. Plaintiff, LAWRENCE COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

66. Plaintiff, LEE COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

67. Plaintiff, LINCOLN COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

68. Plaintiff, LITTLE RIVER COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

69. Plaintiff, LOGAN COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

70. Plaintiff, LONOKE COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

71. Plaintiff, MADISON COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

72. Plaintiff, MARION COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

73. Plaintiff, MILLER COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

74. Plaintiff, MISSISSIPPI COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

75. Plaintiff, MONROE COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

76. Plaintiff, MONTGOMERY COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

77. Plaintiff, NEVADA COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant ARK. CODE ANN. § 14-14-102.

78. Plaintiff, NEWTON COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

79. Plaintiff, OUACHITA COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

80. Plaintiff, PERRY COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

81. Plaintiff, PHILLIPS COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

82. Plaintiff, PIKE COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

83. Plaintiff, POINSETT COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

84. Plaintiff, POLK COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

85. Plaintiff, POPE COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

86. Plaintiff, PRAIRIE COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

87. Plaintiff, RANDOLPH COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

88. Plaintiff, ST. FRANCIS COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

89. Plaintiff, SALINE COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

90. Plaintiff, SCOTT COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

91. Plaintiff, SEARCY COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

92. Plaintiff, SEBASTIAN COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

93. Plaintiff, SEVIER COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

94. Plaintiff, SHARP COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

95. Plaintiff, STONE COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

96. Plaintiff, UNION COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

97. Plaintiff, VAN BUREN COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

98. Plaintiff, WASHINGTON COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

99. Plaintiff, WHITE COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

100. Plaintiff, WOODRUFF COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

101. Plaintiff, YELL COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

102. Plaintiff, CARROLL COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

103. Plaintiff, NEWTON COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

104. Plaintiff, NEVADA COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

105. Plaintiff, CLEVELAND COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

106. Plaintiff, CRITTENDEN COUNTY, ARKANSAS is a political subdivision of the State of Arkansas pursuant to ARK. CODE ANN. § 14-14-102.

107. Plaintiff, CITY OF LITTLE ROCK, ARKANSAS, is a municipal corporation of the State of Arkansas pursuant to ARK. CONST. art. 12, § 3 and ARK. CODE ANN. § 14-37-102, and is located in Pulaski County.

108. Plaintiff, CITY OF FORT SMITH, ARKANSAS, is a municipal corporation of the State of Arkansas pursuant to ARK. CONST. art. 12, § 3 and ARK. CODE ANN. § 14-37-102, and is located in Sebastian County.

109. Plaintiff, CITY OF SPRINGDALE, ARKANSAS, is a municipal corporation of the State of Arkansas pursuant to ARK. CONST. art. 12, § 3 and ARK. CODE ANN. § 14-37-102, and is located in Washington and Benton County.

110. Plaintiff, CITY OF JONESBORO, ARKANSAS, is a municipal corporation of the State of Arkansas pursuant to ARK. CONST. art. 12, § 3 and ARK. CODE ANN. § 14-37-102, and is located in Craighead County.

111. Plaintiff, CITY OF NORTH LITTLE ROCK, ARKANSAS, is a municipal corporation of the State of Arkansas pursuant to ARK. CONST. art. 12, § 3 and ARK. CODE ANN. § 14-37-102, and is located in Pulaski County.

112. Plaintiff, CITY OF CONWAY, ARKANSAS, is a municipal corporation of the State of Arkansas pursuant to ARK. CONST. art. 12, § 3 and ARK. CODE ANN. § 14-37-102, and is located in Faulkner County.

113. Plaintiff, CITY OF ROGERS, ARKANSAS, is a municipal corporation of the State of Arkansas pursuant to ARK. CONST. art. 12, § 3 and ARK. CODE ANN. § 14-37-102, and is located in Benton County.

114. Plaintiff, CITY OF PINE BLUFF, ARKANSAS, is a municipal corporation of the State of Arkansas pursuant to ARK. CONST. art. 12, § 3 and ARK. CODE ANN. § 14-37-102, and is located in Jefferson County.

115. Plaintiff, CITY OF BENTONVILLE, ARKANSAS, is a municipal corporation of the State of Arkansas pursuant to ARK. CONST. art. 12, § 3 and ARK. CODE ANN. § 14-37-102, and is located in Benton County.

116. Plaintiff, CITY OF HOT SPRINGS, ARKANSAS, is a municipal corporation of the State of Arkansas pursuant to ARK. CONST. art. 12, § 3 and ARK. CODE ANN. § 14-37-102, and is located in Garland County.

117. Plaintiff, CITY OF BENTON, ARKANSAS, is a municipal corporation of the State of Arkansas pursuant to ARK. CONST. art. 12, § 3 and ARK. CODE ANN. § 14-37-102, and is located in Saline County.

118. Plaintiff, CITY OF TEXARKANA, ARKANSAS, is a municipal corporation of the State of Arkansas pursuant to ARK. CONST. art. 12, § 3 and ARK. CODE ANN. § 14-37-102, and is located in Miller County.

119. Plaintiff, CITY OF SHERWOOD, ARKANSAS, is a municipal corporation of the State of Arkansas pursuant to ARK. CONST. art. 12, § 3 and ARK. CODE ANN. § 14-37-102, and is located in Pulaski County.

120. Plaintiff, CITY OF JACKSONVILLE, ARKANSAS, is a municipal corporation of the State of Arkansas pursuant to ARK. CONST. art. 12, § 3 and ARK. CODE ANN. § 14-37-102, and is located in Pulaski County.

121. Plaintiff, CITY OF MONTICELLO, ARKANSAS, is a municipal corporation of the State of Arkansas pursuant to ARK. CONST. art. 12, § 3 and ARK. CODE ANN. § 14-37-102, and is located in Drew County.

122. Each County is a "political subdivision of the state for the more convenient administration of justice and the exercise of local legislative authority" and "a body politic and corporate operating within specified geographic limitations established by law." ARK. CODE ANN. § 14-14-102. Thus the Counties serve as "the state's auxiliaries and instrumentalities in the administration of its government." *Beaumont v. Adkisson*, 593 S.W.2d 11, 17 (Ark. 1980). "The word 'county' signifies a portion of a state resulting from a division of the state into such areas for the better government thereof and the easier administration of justice." *Id.*

123. The State maintains a "County Aid Fund," recorded on the books of the Treasurer of the State, the Auditor of the State, and the Chief Fiscal Officer, from which it funds, in part, county services. ARK. CODE ANN. § 19-5-602. Moreover, the State requires and empowers the

counties to provide numerous services that are severely strained because of the opioid epidemic.

For example:

a. All counties have a sheriff who is required to be a conservator of the peace in his or her county. ARK. CODE ANN. § 14-15-501. The Counties all maintain sheriff departments, which employ deputies to aid sheriffs in their statutory duties. Should the Counties lack sufficient resources to meet sheriff law enforcement obligations, those obligations fall to the State. Arkansas law enforcement has been greatly impacted at the state, county, and city level by the opioid epidemic. The Counties have expended and will continue to expend enormous additional resources to fulfill their law enforcement obligations necessitated by Defendants' conduct in causing the opioid epidemic.

b. Pursuant to ARK. CODE ANN. § 14-14-802(a), the Counties are required to provide the following necessary services to their citizens: (1) the administration of justice through the several courts of record of the county, (2) law enforcement protection services and the custody of persons accused or convicted of crimes, and (3) court and public records management, including registration, recording, and custody of public records. These services will hereinafter be referred to as "mandatory services." Due solely to the opioid epidemic caused by Defendants' actions, the Counties have been forced to expend monies and will continue to expend monies for mandatory services they otherwise would not have had to expend and in an amount far greater than they can afford. The State's delegation of state duties to the Counties as enumerated in § 14-14-802(a) does not eliminate the State's continuing obligations to its citizens. Because the Counties' revenues have been insufficient to underwrite the expanded cost of mandatory services caused by Defendants, the State of Arkansas has made and will continue to make the remaining payments.

c. Pursuant to ARK. CODE ANN. § 14-14-802(b), the Counties are empowered to provide the following necessary services to their citizens: (1) emergency services, including ambulance, civil defense, fire prevention and protection, and juvenile detention; and (2) human services, including air and water pollution control, child care/youth and senior citizen services, public health and hospital care, public nursing and extended care, and social and rehabilitative care. Due solely to the opioid epidemic caused by Defendants' actions, the Counties have been forced and will continue to be forced to expend monies for these much-needed services they otherwise would not have had to expend and in an amount far greater than they can afford. The State's delegation of state duties to the Counties as enumerated in § 14-14-802(b) does not eliminate the State's continuing obligations to its citizens. Because the Counties' revenues have been and will continue to be insufficient to underwrite the expanded cost of these services caused by Defendants, the State of Arkansas has made and will continue to make the remaining payments.

d. In administering the courts, counties supply a significant amount of the funding. In 2015, the counties reported $64.1 million in costs while only generating $18.1

million in revenues through county fees and costs, so the counties paid $46 million into the courts.[58]

e. Counties employ Drug Court Juvenile Intake and Probation Officers, who assist the courts with cases involving delinquent juveniles, dependent-neglected juveniles, or families in need of services. The State of Arkansas shares in the cost of one-half of the juvenile probation and intake officers' salaries up to $15,000 per position, as provided under ARK. CODE ANN. §§ 16-13-327 through 328.

f. The District Courts of the State of Arkansas bear the extraordinary cost of judicial proceedings in relation to Arkansas' opioid epidemic. Pursuant to ARK. CODE ANN. § 16-17-115 and 16-17-1106, the Counties are required to reimburse the State for one-half of the State's obligation to pay the salaries of the district judge and the chief district court clerk. These statutorily prescribed district court services will hereinafter be referred to as "mandatory services." Due solely to the opioid epidemic caused by Defendants' actions, the Counties have been and will continue to be forced to expend monies for mandatory services the additional cost of which they otherwise would not have had to expend and in an amount far greater than they can afford. The State's delegation of state duties to the Counties as enumerated in § 16-17-115 does not eliminate the State's continuing obligations to its citizens. Because the Counties' revenues have been and will continue to be insufficient to underwrite the expanded cost of mandatory services caused by Defendants, the State of Arkansas has made and will continue to make the remaining payments through the County Aid Fund.

g. Pursuant to ARK. CODE ANN. § 16-10-201, *et seq.*, the State has statutory authority over and audits the municipal and county accounts pertaining to Arkansas' District Courts, and the State has statutory authority over and mandates the activities of cities and counties in relation to their required duties regarding Arkansas' District Courts. The State's authority extends to and directs the activities of all police departments, city or town marshals, sheriffs' offices, court clerks, court administrators, the city treasurers, the county treasurers, and the governing bodies of the cities and counties.

h. Arkansas' opioid epidemic has caused a dramatic increase in the number of involuntary commitments throughout the State. While the jurisdiction for these commitments lies in the circuit courts, the Counties and Cities bear the increased costs of transporting those committed through their respective sheriffs' and police departments. While the Arkansas Department of Human Services promulgates the rules setting costs for individuals committed or those responsible for them, many cannot reimburse the State for the costs. Further, the State assigns the Counties the cost of appointed counsel for persons sought to be committed.

[58] Arkansas Legislative Audit, Special Report, *Information Regarding the Arkansas Supreme Court, Court of Appeals, and Circuit Courts*, *available at* http://www.arklegaudit.gov/pdf.aspx?id=SPSA01315 (last visited Feb. 9, 2018).

124. The State also maintains a "Municipal Aid Fund," recorded on the books of the Treasurer of the State, the Auditor of the State, and the Chief Fiscal Officer, from which the State funds, in part, city services. ARK. CODE ANN. § 19-5-601. Those city services are and will continue to be severely strained because of the opioid epidemic. For example:

a. Pursuant to ARK. CODE ANN. §§ 14-52-101, the Cities have established police departments. The law enforcement performed by the City Police Departments would fall to the State and/or the Counties should the Cities not possess sufficient resources to meet their law enforcement obligations. Arkansas law enforcement has been and will continue to be greatly impacted at the state, county, and city level by the opioid epidemic. The Cities have expended and will continue to expend enormous additional resources to fulfill their law enforcement obligations that were necessitated by the Defendants' conduct in causing the opioid epidemic. Cities have likewise expended and will continue to expend enormous additional resources responding to first responder calls, through their fire departments, that were necessitated by the Defendants' conduct in causing the opioid epidemic.

b. The district courts bear extraordinary costs of judicial proceedings in relation to Arkansas' epidemic. Pursuant to ARK. CODE ANN. §§ 16-17-115 and 16-17-1106, the Cities are required to: (1) pay the operational expenses of the district court in that town or city, and (2) reimburse the State for one-half of the State's obligation to pay the salaries of the district judge and the chief district court clerk. Pursuant to ARK. CODE ANN. § 16-17-119, in those counties having a population of 250,000 or more inhabitants, the State requires the city or town in which the district courts are located to bear their applicable salaries and operation expenses. These statutorily prescribed district court services will hereinafter be referred to as "mandatory services." Due solely to the opioid epidemic caused by Defendants' actions, the Cities have been and will continue to be forced to expend monies for mandatory services the additional cost of which they otherwise would not have had to expend and in an amount far greater than they can afford. The State's delegation of state duties to the Cities as enumerated in § 16-17-115 does not eliminate the State's continuing obligations to its citizens. Because the Cities' revenues have been and will continue to be insufficient to underwrite the expanded cost of mandatory services caused by Defendants, the State of Arkansas has made and will continue to make the remaining payments through the Municipal Aid Fund.

c. Pursuant to ARK. CODE ANN. §§ 16-10-201 *et seq.*, the State has statutory authority over and audits the municipal and county accounts pertaining to Arkansas' District Courts, and the State has statutory authority over and mandates the activities of cities and counties in relation to their required duties regarding Arkansas' District Courts. The State's authority extends to and directs the activities of all police departments, city or town marshals, sheriff's offices, court clerks, court administrators, the city treasurers, the county treasurers, and the governing bodies of the cities and counties.

d. Pursuant to ARK. CODE ANN. §§ 16-21-115, a prosecuting attorney may designate a city attorney within the prosecutor's district to prosecute in the name of the State in the district courts violations of state misdemeanor laws occurring within the municipal limits and upon agreement by the city attorney.

e. Arkansas' opioid epidemic has caused a dramatic increase in the number of involuntary commitments throughout the State. While the jurisdiction for these commitments lies in the circuit courts, the increased cost of transportation of those committed is born by the Counties and Cities through their sheriff's departments and police departments. While, the Division of Aging, Adult, and Behavior Health Services of the Arkansas Department of Human Services promulgates the rules specifying the amounts to be fixed as costs as against the individuals committed or those responsible for same, many cannot reimburse the State for such costs.

B. Manufacturer Defendants

125. PURDUE PHARMA L.P. is a limited partnership organized under the laws of Delaware. PURDUE PHARMA INC. is a New York corporation with its principal place of business in Stamford, Connecticut, and THE PURDUE FREDERICK COMPANY is a Delaware corporation with its principal place of business in Stamford, Connecticut (collectively, "Purdue"). Purdue manufactures, promotes, sells, and distributes opioids such as OxyContin, MS Contin, Dilaudid/Dilaudid HP, Butrans, Hysingla ER, and Targiniq ER in the U.S. and Arkansas. OxyContin is Purdue's best-selling opioid. Since 2009, Purdue's annual sales of OxyContin have fluctuated between $2.47 billion and $2.99 billion, up four-fold from its 2006 sales of $800 million. OxyContin constitutes roughly 30% of the entire market for analgesic drugs (painkillers).

126. CEPHALON, INC. is a Delaware corporation with its principal place of business in Frazer, Pennsylvania. TEVA PHARMACEUTICAL INDUSTRIES, LTD. ("Teva Ltd.") is an Israeli corporation with its principal place of business in Petah Tikva, Israel. In 2011, Teva Ltd. acquired Cephalon, Inc. TEVA PHARMACEUTICALS USA, INC. ("Teva USA") is a wholly-owned subsidiary of Teva Ltd. and is a Delaware corporation with its principal place of business in Pennsylvania. Teva USA acquired Cephalon in October 2011. Cephalon, Inc. manufactures, promotes, sells, and distributes opioids such as Actiq and Fentora in the U.S. and Arkansas. Teva

Ltd., Teva USA, and Cephalon, Inc. work together closely to market and sell Cephalon products in the United States. Teva Ltd. conducts all sales and marketing activities for Cephalon in the United States through Teva USA and has done so since its October 2011 acquisition of Cephalon. Teva Ltd. and Teva USA hold out Actiq and Fentora as Teva products to the public. Teva USA sells all former Cephalon branded products through its "specialty medicines" division. Teva Ltd. has directed Cephalon, Inc. to disclose that it is a wholly-owned subsidiary of Teva Ltd. on prescription savings cards distributed in Arkansas, indicating Teva Ltd. would be responsible for covering certain co-pay costs. All of Cephalon's promotional websites, including those for Breakthrough pain is a short-term flare of moderate-to-severe pain in patients with otherwise stable persistent pain, Actiq and Fentora, prominently display Teva Ltd.'s logo. Teva Ltd.'s financial reports list Cephalon's and Teva USA's sales as its own, and its year-end report for 2012 – the year immediately following the Cephalon acquisition – attributed a 22% increase in its specialty medicine sales to "the inclusion of a full year of Cephalon's specialty sales." Through interrelated operations like these, Teva Ltd. operates in Arkansas and the rest of the United States through its subsidiaries Cephalon and Teva USA. The United States is the largest of Teva Ltd.'s global markets, representing 53% of its global revenue in 2015, and, were it not for the existence of Teva USA and Cephalon, Inc., Teva Ltd. would conduct those companies' business in the United States itself. Teva Ltd. directs the business practices of Cephalon and Teva USA, and their profits inure to the benefit of Teva Ltd. as controlling shareholder. (Teva Pharmaceutical Industries, Ltd., Teva Pharmaceuticals USA, Inc., and Cephalon, Inc. are referred to as "Cephalon.")

127. JANSSEN PHARMACEUTICALS, INC. is a Pennsylvania corporation with its principal place of business in Titusville, New Jersey, and is a wholly owned subsidiary of JOHNSON & JOHNSON (J&J), a New Jersey corporation with its principal place of business in

New Brunswick, New Jersey. ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC., now known as JANSSEN PHARMACEUTICALS, INC., is a Pennsylvania corporation with its principal place of business in Titusville, New Jersey. JANSSEN PHARMACEUTICA INC., now known as JANSSEN PHARMACEUTICALS, INC., is a Pennsylvania corporation with its principal place of business in Titusville, New Jersey. J&J is the only company that owns more than 10% of Janssen Pharmaceuticals' stock. J&J controls the sale and development of Janssen Pharmaceuticals' drugs and Janssen's profits inure to J&J's benefit. (Janssen Pharmaceuticals, Inc., Ortho-McNeil-Janssen Pharmaceuticals, Inc., Janssen Pharmaceutica, Inc., and J&J are referred to as "Janssen.") Janssen manufactures, promotes, sells, and distributes drugs in the U.S. and Arkansas, including the opioid Duragesic. Before 2009, Duragesic accounted for at least $1 billion in annual sales. Until January 2015, Janssen developed, marketed, and sold the opioids Nucynta and Nucynta ER. Together, Nucynta and Nucynta ER accounted for $172 million in sales in 2014.

128. WATSON LABORATORIES, INC. is a Nevada corporation with its principal place of business in Corona, California, and is a wholly-owned subsidiary of Allergan plc (f/k/a Actavis, Inc., f/k/a Watson Pharmaceuticals, Inc.). ACTAVIS PHARMA, INC. (f/k/a Actavis, Inc.) is a Delaware corporation with its principal place of business in New Jersey and was formerly known as WATSON PHARMA, INC. ACTAVIS LLC is a Delaware limited liability company with its principal place of business in Parsippany, New Jersey, and no members of ACTAVIS LLC are citizens of Arkansas. Each of these Defendants is owned by Allergan plc, which uses them to market and sell its drugs in the United States. Allergan Plc is a public limited company incorporated in Ireland with its principal place of business in Dublin, Ireland. Actavis Plc acquired Allergan Plc in March 2015, and the combined company changed its name to Allergan plc in

January 2013. Before that, WATSON PHARMACEUTICALS, INC. acquired ACTAVIS, INC. in October 2012, and the combined company changed its name to Actavis, Inc. as of January 2013 and then Actavis plc in October 2013. Allergan Plc exercises control over these marketing and sales efforts and profits from the sale of Allergan/Actavis products ultimately inure to its benefit. (Allergan plc, Actavis plc, Actavis, Inc., Actavis LLC, Actavis Pharma, Inc., Watson Pharmaceuticals, Inc., Watson Pharma, Inc., and Watson Laboratories, Inc. are referred to as "Actavis.") Actavis manufactures, promotes, sells, and distributes opioids, including the branded drugs Kadian and Norco, a generic version of Kadian, and generic versions of Duragesic and Opana, in the U.S. and Arkansas. Actavis acquired the rights to Kadian from King Pharmaceuticals, Inc. on December 30, 2008, and began marketing Kadian in 2009.

129. ENDO HEALTH SOLUTIONS INC. is a Delaware corporation with its principal place of business in Malvern, Pennsylvania. ENDO PHARMACEUTICALS INC. is a wholly-owned subsidiary of Endo Health Solutions Inc. and is a Delaware corporation with its principal place of business in Malvern, Pennsylvania. (Endo Health Solutions Inc. and Endo Pharmaceuticals Inc. are referred to as "Endo.") Endo develops, markets, and sells prescription drugs, including the opioids Opana/Opana ER, Percodan, Percocet, and Zydone, in the U.S. and Arkansas. Opioids made up roughly $403 million of Endo's overall revenues of $3 billion in 2012. Opana ER yielded $1.15 billion in revenue from 2010 and 2013, and it accounted for 10% of Endo's total revenue in 2012. Endo also manufactures and sells generic opioids such as oxycodone, oxymorphone, hydromorphone, and hydrocodone products in the U.S. and Arkansas, by itself and through its subsidiary, Qualitest Pharmaceuticals, Inc.

130. VINTAGE PHARMACEUTICALS, LLC ("Vintage") is a limited liability company organized under the laws of the State of Delaware, with its principal place of business in

Huntsville, Alabama. Vintage is a wholly-owned subsidiary of Endo International Plc and manufactures, promotes, sells, and distributes generic opioid products in the United States and Arkansas.

131. INSYS THERAPEUTICS, INC. ("Insys") is a Delaware corporation with its principal place of business in Chandler, Arizona. Insys manufactures, promotes, sells, and distributes a sublingual fentanyl spray under the brand name Subsys in the U.S. and Arkansas.

132. MALLINCKRODT PLC is a public limited liability company organized and existing under the laws of the State of Ireland, with its principal place of business in Staines-Upon-Thames, Surrey, United Kingdom. Mallinckrodt PLC manufactures, promotes, sells, and distributes branded opioids Exalgo, Roxicodone, Xartemis XR, and Methadose; and morphine sulfate extended release, fentanyl extended release, fentanyl citrate, oxycodone, hydrocodone, and other generic opioid products in the U.S. and Arkansas. MALLINCKRODT PHARMACEUTICALS ("Mallinckrodt Pharma") (Mallinckrodt PLC and Mallinckrodt Pharma are collectively referred to as "Mallinckrodt") is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in Hazelwood, Missouri. Mallinckrodt Pharma manufactures, promotes, sells, and distributes branded opioids such as Exalgo, Roxicodone, Xartemis XR, and Methadose; and morphine sulfate extended release, fentanyl extended release, fentanyl citrate, oxycodone, hydrocodone, and other generic opioid products in the U.S. and Arkansas.

133. MYLAN PHARMACEUTICALS INC. ("Mylan") is a company organized and existing under the laws of the State of West Virginia, with its principal place of business in Morgantown, West Virginia. Mylan manufactures, promotes, sells, and distributes—or at times

relevant to this Complaint, manufactured, promoted, sold, and distributed—generic opioid pharmaceutical products in the United States and Arkansas.

134. SUN PHARMACEUTICALS INDUSTRIES, INC. ("Sun") is a corporation organized under the laws of the State of Michigan, with its principal place of business in Cranbury, New Jersey. Sun manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—generic opioid pharmaceutical products in the United States and Arkansas.

135. AUROBINDO PHARMA USA, INC. ("Aurobindo USA") is a corporation organized under the laws of the State of Delaware, with its principal place of business in Dayton, New Jersey. Aurobindo USA is a wholly-owned subsidiary of Aurobindo Pharma Ltd. and manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

136. AUROLIFE PHARMA LLC ("Aurolife") is a limited liability company organized under the laws of the State of Delaware, with its principal place of business in Dayton, New Jersey. Aurolife is a wholly-owned subsidiary of Aurobindo USA and manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

137. LUPIN PHARMACEUTICALS, INC. ("Lupin") is a corporation organized under the laws of the State of Delaware, with its principal place of business in Baltimore, Maryland. Lupin is a wholly-owned subsidiary of Lupin Ltd. and manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and

distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

138. COLLEGIUM PHARMACEUTICAL, INC. ("Collegium") is a corporation organized under the laws of the State of Delaware, with its principal place of business in Canton, Massachusetts. Collegium manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

139. BIODELIVERY SCIENCES INTERNATIONAL, INC. ("BSI") is a corporation organized under the laws of the State of Delaware, with its principal place of business in Raleigh, North Carolina. BSI manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas. BSI licenses its branded fentanyl buccal soluble film Onsolis to Collegium.

140. SHIONOGI, INC. ("Shionogi") is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in Florham Park, New Jersey. Shionogi manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

141. ABBVIE, INC. ("AbbVie"), is a corporation organized under the laws of Delaware, with its principal place of business in North Chicago, Illinois. AbbVie manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas. ABBOTT LABORATORIES, INC. ("Abbott") is a corporation organized under the

laws of the State of Delaware, with its principal place of business in Chicago, Illinois. Before splitting from AbbVie in 2013, Abbott manufactured, promoted, sold, and distributed branded and generic opioid pharmaceutical products in the United States and Arkansas.

142. PERNIX THERAPEUTICS HOLDINGS, INC. ("Pernix") is a corporation organized under the laws of the State of Maryland, with its principal place of business in Morristown, New Jersey. Pernix manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

143. DAIICHI SANKYO, INC. ("Daiichi Sankyo") is a corporation organized under the laws of the State of Delaware, with its principal place of business in Parsippany, New Jersey. Daiichi Sankyo manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

144. FOREST LABORATORIES, INC. ("Forest Laboratories") is a wholly-owned subsidiary of Allergan and is a corporation organized under the laws of Delaware, with its principal place of business in New York, New York. FOREST PHARMACEUTICALS, INC. ("Forest Pharmaceuticals") is a wholly-owned subsidiary of Forest Laboratories and is a corporation organized under the laws of the State of Delaware, with its principal place of business in St. Louis, Missouri. (Forest Laboratories and Forest Pharmaceuticals are collectively referred to as "Forest"). Forest manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

145. MAYNE PHARMA INC. ("Mayne") is a corporation organized under the laws of the State of North Carolina, with its principal place of business in Paramus, New Jersey. Mayne manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

146. APOTEX INC. ("Apotex") is a corporation organized and existing under the laws of Canada, with its principal place of business in Ontario, Canada. Apotex manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

147. WEST-WARD PHARMACEUTICALS CORP. ("West-Ward") is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in Eatontown, New Jersey. West-Ward merged with Roxane Laboratories, Inc. after the latter's acquisition by Hikma Pharmaceuticals Plc, and West-Ward manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas. Before its acquisition, Roxane Laboratories manufactured, promoted, sold, and distributed branded and generic opioid products in the United States and Arkansas.

148. GEMINI LABORATORIES, LLC ("Gemini") is a limited liability company organized and existing under the laws of the State of Delaware, with its principal place of business in Bridgewater, New Jersey. Gemini manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

149. POLY-PHARMACEUTICALS, INC. ("Poly") is a corporation organized under the laws of the State of Alabama, with its principal place of business in Owens Cross Roads, Alabama. Forest Pharmaceuticals is in the business of manufacturing and selling branded and generic opioid pharmaceutical products for the United States and Arkansas markets. Poly manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

150. AKORN, INC. ("Akorn") is a corporation organized under the laws of the State of Louisiana, with its principal place of business in Lake Forest, Illinois. Akorn manufactures, promotes, sells, and distributes—or at all times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

151. VALEANT PHARMACEUTICALS NORTH AMERICA, LLC ("Valeant") is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in Bridgewater, New Jersey. Valeant manufactures, promotes, sells, and distributes—or at all times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

152. ECR PHARMACEUTICALS, INC. ("ECR") is a wholly-owned subsidiary of Valeant and a corporation organized under the laws of the State of Delaware, with its principal place of business in Richmond, Virginia. ECR manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas markets.

153. DEPOMED, INC. ("Depomed") is a corporation organized and existing under the laws of the State of California, with its principal place of business in Newark, California. Depomed manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

154. VALIDUS PHARMACEUTICALS, LLC ("Validus") is a limited liability company organized and existing under the laws of the State of Delaware, with its principal place of business in Parsippany, New Jersey. Validus manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

155. EGALET CORPORATION ("Egalet") is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in Wayne, Pennsylvania. Egalet manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

156. VERNALIS THERAPEUTICS, INC. ("Vernalis") is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in Berwyn, Pennsylvania. Vernalis manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

157. UCB PHARMA, INC. ("UCB") is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in Smyrna, Georgia. UCB manufactures, promotes, sells, and distributes—or at times relevant to this Complaint,

manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

158. XANODYNE PHARMACEUTICALS, INC. ("Xanodyne") is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in Newport, Kentucky. Xanodyne manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

159. VERTICAL PHARMACEUTICALS, INC. ("Vertical") is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in Bridgewater, New Jersey. Vertical manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

160. SENTYNL THERAPEUTICS, INC. ("Sentynl") is a corporation organized and existing under the laws of the State of Virginia, with its principal place of business in Solana Beach, California. Sentynl manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

161. RHODES TECHNOLOGIES, INC. is a corporation organized under the laws of the State of Delaware, with its principal place of business at Coventry, Rhode Island. RHODES TECHNOLOGIES L.P. is a general partnership organized under the laws of the State of Delaware, with its principal place of business in Coventry, Rhode Island (Rhodes Technologies, Inc. and Rhodes Technologies L.P. are collectively referred to as "Rhodes"). Rhodes are wholly-owned subsidiaries of Purdue Pharma, L.P. and manufacture, promote, sell, and distribute—or at times

relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

162. SANDOZ, INC. is a corporation organized under the laws of the State of Colorado, with its principal place of business at Princeton, New Jersey. Sandoz manufactures, promotes, sells, and distributes—or at times relevant to this Complaint, manufactured, promoted, sold, and distributed—branded and generic opioid pharmaceutical products in the United States and Arkansas.

C. Distributor Defendants

163. AMERISOURCEBERGEN DRUG CORPORATION, is a Delaware corporation with a principal place of business in Chesterbrook, Pennsylvania, and distributes opioids within Arkansas.

164. CARDINAL HEALTH, INC. is an Ohio corporation with its principal office located in Dublin, Ohio, and distributes opioids within Arkansas.

165. McKESSON CORPORATION, is a Delaware corporation that has its principal place of business located in San Francisco, California, and distributes opioids within Arkansas.

166. Plaintiffs have named three (3) wholesale distributors which dominate 85% of the Market share for the distribution of prescription opioids. The "Big 3" are Fortune 500 corporations listed on the New York Stock Exchange whose principal business is the nationwide wholesale distribution of prescription drugs. Each has been investigated and/or fined by the DEA for the failure to maintain effective controls against opioid diversion. Plaintiffs allege that each has engaged in unlawful conduct which resulted in the diversion of prescription opioids into our community and that discovery will reveal others who likewise engaged in unlawful conduct.

D. Retail Defendants

167. LINDEN CARE, LLC ("Linden Care") is a foreign limited liability company licensed in Arkansas as an out-of-state pharmacy. Linden Care's principal place of business and corporate headquarters is located in Woodbury, New York. At all relevant times, Linden Care served as a concierge pharmacy service specializing in filling, dispensing, and shipping pain medications throughout the United States, including Arkansas, using commercial shipping services. During the relevant time period, Linden was reportedly the leading pharmacy dispenser of fentanyl spray. Linden does not have physical retail pharmacies in Arkansas. Instead, it dispensed and shipped fentanyl spray to patients throughout the United States, and in Arkansas, by Federal Express. Between April 2014 and November 2015, Linden solicited and received from Arkansas prescriptions for fentanyl spray.

168. KJ MEDICAL MANAGEMENT, LLC ("KJ Medical Management") is a domestic limited liability company with its principal place of business in Little Rock, Arkansas. KJ Medical management owns and operates—or at times relevant to this Complaint owned and operated—KJ Medical Clinic in Little Rock, Arkansas. During the relevant time period, KJ Medical Clinic participated in an opioid diversion scheme with Dr. Jerry Reifeiss, Dr. Shawn Michael Brooks, Bowman Curve Pharmacy, and Kristen Holland.

169. CJN PHARMACY SERVICES, LLC ("CJN") is a domestic limited liability company with its principal place of business in Little Rock, Arkansas. CJN owns and operates—or at times relevant to this Complaint owned and operated—Bowman Curve Pharmacy in Little Rock, Arkansas. During the relevant time period, Bowman Curve Pharmacy participated in an opioid diversion scheme with KJ Medical Clinic, Dr. Jerry Reifeiss, Dr. Shawn Michael Brooks, and Kristen Holland.

170. PERRY COUNTY FOOD & DRUG, INC. is a domestic corporation with its principal place of business in Perryville, Arkansas. Perry County Food & Drug, Inc. owns and operates—or at times relevant to this Complaint owned and operated—the Perry County Food & Drug retail pharmacy in Perryville, Arkansas. During the relevant time period, Perry County Food & Drug participated in an opioid diversion scheme with pharmacist Christopher Watson.

171. KRISTEN HOLLAND is a pharmacist who was licensed in Arkansas and practiced pharmacology at Bowman Curve Pharmacy in Little Rock, Arkansas. In connection with the Operation Pilluted campaign, Holland was charged with conspiracy to distribute controlled substances. Holland pleaded guilty to misprision of a felony and was sentenced to three years' probation.

E. Physician Defendants

172. MAHMOOD AHMAD, M.D. is a physician who was licensed in Arkansas and Alaska and practicing in the field of pain management at his medical practice in Sherwood, Arkansas. In October 2016, the Arkansas State Medical Board revoked Ahmad's medical license for gross negligence and professional incompetence arising from his practice of overprescribing high dose opioids. A few weeks earlier, Ahmad lost his license to practice in Alaska after that state's medical board ruled that his practices in prescribing opioids and treating patients posed "a clear and immediate danger to the public health and safety."

173. UNITED PAIN CARE, LTD ("UPC") is an Arkansas corporation that at all relevant times was providing health care services for profit in the State of Arkansas in Sherwood, Arkansas. UPC, through its employees and physicians, including Ahmad, was in the business of providing medical services through its agents, principles, and employees. At all material times, Ahmad was the president, owner, and medical director of UPC. While an entity, UPC is included in "Physician Defendants" for sake of efficiency.

174. SHAWN MICHAEL BROOKS, M.D. is a physician who was licensed in Arkansas and Utah and practiced in the field of pain management at his medical practice, KJ Medical Clinic in Little Rock, Arkansas. In connection with the Operation Pilluted campaign, Dr. Brooks was charged with conspiracy to distribute controlled substances; the Arkansas State Medical Board entered an emergency suspension order suspending Dr. Brooks' license for overprescribing controlled substances and endangering Arkansas public health, safety, and welfare; and Dr. Brooks stipulated to his license's revocation from the Utah Division of Occupational and Professional Licensing. Dr. Brooks pleaded guilty to misprision of a felony and was sentenced to five years' probation.

175. RICHARD DUANE JOHNS is a physician who was licensed in Arkansas and practiced in the field of internal medicine. In connection with Operation Pilluted, Dr. Johns was charged with conspiracy to distribute controlled substances without an effective prescription, and the Arkansas State Medical Board entered an emergency suspension order suspending Dr. Johns' license for endangering Arkansas public health, safety, and welfare.

176. CHRISTOPHER WATSON is a pharmacist who was licensed in Arkansas and practiced pharmacy at Perry County Food & Drug in Perryville, Arkansas. In connection with the Operated Pilluted campaign, Watson was charged with, *inter alia*, conspiracy to distribute controlled substances without an effective prescription, healthcare fraud, and structuring. Watson pleaded guilty to these counts and was sentenced to 120 months imprisonment. Though a pharmacist, Watson is included in "Physician Defendants" for sake of efficiency.

III. JURISDICTION

177. This Court has jurisdiction over this matter pursuant to ARK. CODE ANN. § 16-13-201. The instant Complaint does not confer diversity jurisdiction upon the federal courts pursuant to 28 U.S.C. § 1332 because the State of Arkansas is not a citizen for purposes of diversity

jurisdiction. Likewise, federal question subject matter jurisdiction pursuant to 28 U.S.C. § 1331 is not invoked because the allegations are wholly state law claims. Nowhere do the parties plead, expressly or implicitly, any cause of action or request any remedy that arises under or is founded upon federal law, nor do they bring this action or seek any relief on behalf of any person, a class, or any group of persons that can be construed as a class. The relief sought by the Counties is in their respective capacities as political subdivisions of the State, and they seek no relief on behalf of any other person(s). The relief sought by the Cities is in their respective capacities as municipal corporations of the State, and they seek no relief on behalf of any other person(s). The parties specifically disclaim any such claims that would support removal of this action to a United States District Court on the basis of diversity or jurisdictional mandates under the Class Action Fairness Act of 2005 (28 U.S.C. §§ 1332(d), 1453, 1711-1715). The issues presented in the allegations of the instant, well-pleaded Complaint do not implicate significant or substantial federal issues and do not turn on the necessary interpretation of any federal law. The parties expressly aver that the only causes of action claimed, and the only remedies sought herein, are founded upon the statutory, common, and decisional laws of the State of Arkansas. The assertion of federal diversity jurisdiction over these claims would improperly disturb the constitutionally mandated and congressionally approved balance of federal and state responsibilities because federal jurisdiction does not exist over this case under 28 U.S.C. § 1332. "There is no question that a State is not a 'citizen' for purposes of the diversity jurisdiction." *Moor v. Alameda County*, 411 U.S. 693, 717, 93 S. Ct. 1785, 36 L. Ed. 2d 596 (1973). And, it is well settled that "a State's presence as a party will destroy complete diversity." *Mississippi ex rel. Hood v. AU Optronics Corp.*, 134 S. Ct. 736, 745 (2014)(citing *Missouri, K. & T. R. Co. v. Missouri Railroad and Warehouse Comm'rs,* 183 U.S. 53, 58–59, 22 S. Ct. 18 (1901). Moreover, because this suit involves less than 100 plaintiffs

and "[a]ccording to CAFA's plain text, a 'mass action' must involve monetary claims brought by 100 or more persons who propose to try those claims jointly as named plaintiffs," no federal jurisdiction exists. *Mississippi ex rel. Hood v. AU Optronics Corp.*, 134 S. Ct. 736, 739 (2014). Accordingly, any attempt by Defendants to remove this case to federal court would be without a reasonable legal basis in fact or law. *See State of New Hampshire v. Perdue Pharma,* et al., 17-cv-427-PB, USDC D. N.H., Remanding opioid complaint to state court on similar grounds ("A state's action on behalf of its citizens does not become a class action merely because it seeks injunctive relief that benefits individual class members.").

178. This Court has personal jurisdiction over Defendants as they conduct business in Arkansas, purposefully direct or directed their actions toward Arkansas, and/or have the requisite minimum contacts with Arkansas necessary to constitutionally permit the Court to exercise jurisdiction.

IV. VENUE

179. Venue is proper in this Court pursuant to ARK. CODE ANN. § 16-60-101(a) and (c) because Crittenden County is the county in which a substantial part of the events or omissions giving rise to these claims occurred; and Plaintiffs assert rights to relief against Defendants jointly, severally, and arising out the same transaction or occurrence, and common questions of law or fact will predominate over individual questions of law or material fact to each Plaintiff, this action can be maintained more efficiently and economically for all parties than if prosecuted separately, and the interests of justice support joinder of Plaintiffs in one action.

V. FACTUAL ALLEGATIONS

180. Before the 1990s, generally accepted standards of medical practice dictated that opioids should only be used short-term for acute pain, pain relating to recovery from surgery, or for cancer or palliative (end-of-life) care. Due to the lack of evidence that opioids improved

patients' abilities to overcome pain and function, coupled with evidence of greater pain complaints as patients developed tolerance to opioids over time and the serious risk of addiction and other side effects, the use of opioids for chronic pain was discouraged or prohibited. As a result, doctors generally did not prescribe opioids for chronic pain.

181. To take advantage of the lucrative market for chronic pain patients, each Manufacturer Defendant developed a well-funded marketing scheme based on deception. Each Manufacturer Defendant used both direct marketing and unbranded advertising disseminated by seemingly independent third parties to spread false and deceptive statements about the risks and benefits of long-term opioid use – statements that benefited not only themselves and the third-parties who gained legitimacy when Manufacturer Defendants repeated those statements, but also other opioid manufacturers. These statements were contrary to the scientific evidence and targeted susceptible prescribers and vulnerable patient populations.

A. Manufacturer Defendants used multiple avenues to disseminate their false and deceptive statements about opioids.

182. Manufacturer Defendants spread their false and deceptive statements by marketing their branded opioids directly to doctors and patients in Arkansas. Manufacturer Defendants also deployed seemingly unbiased and independent third parties that they controlled to spread their false and deceptive statements about the risks and benefits of opioids for the treatment of chronic pain throughout the State.

183. Manufacturer Defendants spread and continue to spread their false and deceptive statements through direct marketing of their branded opioids.

184. Manufacturer Defendants' direct marketing of opioids generally proceeded on two tracks. First, each Defendant conducted and continues to conduct advertising campaigns touting the purported benefits of their branded drugs. For example, Manufacturer Defendants spent more

than $14 million on medical journal advertising of opioids in 2011, nearly triple what they spent in 2001. This amount included $8.3 million by Purdue, $4.9 million by Janssen, and $1.1 million by Endo.

185. A number of Manufacturer Defendants' branded ads deceptively portrayed the benefits of opioids for chronic pain. For example, Endo distributed and made available on its website opana.com a pamphlet promoting Opana ER with photographs depicting patients with physically demanding jobs like construction worker and chef, misleadingly implying that the drug would provide long-term pain-relief and functional improvement. Purdue also ran a series of ads, called "Pain vignettes," for OxyContin in 2012 in medical journals. These ads featured chronic pain patients and recommended OxyContin for each. One ad described a "54-year-old writer with osteoarthritis of the hands" and implied that OxyContin would help the writer work more effectively. Endo and Purdue agreed in late 2015 and 2016 to halt these misleading representations in New York, but they may continue to disseminate them in Arkansas.

186. Second, each Defendant promoted the use of opioids for chronic pain through "detailers"—sales representatives who visited individual doctors and medical staff in their offices—and small-group speaker programs. Manufacturer Defendants have not corrected this misinformation. Instead, each Defendant devoted and continues to devote massive resources to direct sales contacts with doctors. In 2014 alone, Manufacturer Defendants spent $168 million on detailing branded opioids to doctors. This amount is twice as much as Manufacturer Defendants spent on detailing in 2000. The amount includes $108 million spent by Purdue, $34 million by Janssen, $13 million by Cephalon, $10 million by Endo, and $2 million by Actavis.

187. Manufacturer Defendants also identified doctors to serve, for payment, on their speakers' bureaus and to attend programs with speakers and meals paid for by Manufacturer

Defendants. These speaker programs provided: (1) an incentive for doctors to prescribe a particular opioid (so they might be selected to promote the drug); (2) recognition and compensation for the doctors selected as speakers; and (3) an opportunity to promote the drug through the speaker to his or her peers. These speakers give the false impression that they are providing unbiased and medically accurate presentations when they are, in fact, presenting a script prepared by Manufacturer Defendants. On information and belief, these presentations conveyed misleading information, omitted material information, and failed to correct Manufacturer Defendants' prior misrepresentations about the risks and benefits of opioids.

188. Manufacturer Defendants' detailing to doctors is effective. Numerous studies indicate that marketing impacts prescribing habits, with face-to-face detailing having the greatest influence. Even without such studies, Manufacturer Defendants purchase, manipulate and analyze some of the most sophisticated data available in any industry, data available from IMS Health Holdings, Inc., to track, precisely, the rates of initial prescribing and renewal by individual doctor, which in turn allows them to target, tailor, and monitor the impact of their core messages. Thus, Manufacturer Defendants know their detailing to doctors is effective.

189. Manufacturer Defendants employed the same marketing plans and strategies and deployed the same messages in Arkansas as they did nationwide. Across the pharmaceutical industry, "core message" development is funded and overseen on a national basis by corporate headquarters. This comprehensive approach ensures that Manufacturer Defendants' messages are accurately and consistently delivered across marketing channels—including detailing visits, speaker events, and advertising—and in each sales territory. Manufacturer Defendants consider this high level of coordination and uniformity crucial to successfully marketing their drugs.

190. Manufacturer Defendants ensure marketing consistency nationwide through national and regional sales representative training; national training of local medical liaisons, the company employees who respond to physician inquiries; centralized speaker training; single sets of visual aids, speaker slide decks, and sales training materials; and nationally coordinated advertising. Manufacturer Defendants' sales representatives and physician speakers were required to stick to prescribed talking points, sales messages, and slide decks, and supervisors rode along with them periodically to both check on their performance and compliance.

191. Manufacturer Defendants used a diverse group of seemingly independent third parties to spread false and deceptive statements about the risks and benefits of opioids.

192. Manufacturer Defendants also deceptively marketed opioids in Arkansas through unbranded advertising – i.e., advertising that promotes opioid use generally but does not name a specific opioid. This advertising was ostensibly created and disseminated by independent third parties. But by funding, directing, reviewing, editing, and distributing this unbranded advertising, Manufacturer Defendants controlled the deceptive messages disseminated by these third parties and acted in concert with them to falsely and misleadingly promote opioids for the treatment of chronic pain. Much as Manufacturer Defendants controlled the distribution of their "core messages" via their own detailers and speaker programs, Manufacturer Defendants similarly controlled the distribution of these messages in scientific publications, treatment guidelines, CMEs, and medical conferences and seminars. To this end, Manufacturer Defendants used third-party public relations firms to help control those messages when they originated from third-parties.

193. Manufacturer Defendants also used third-party, unbranded advertising to give the false appearance that the deceptive messages came from an independent and objective source. Like the tobacco companies, Manufacturer Defendants used third parties that they funded, directed, and

controlled to carry out and conceal their scheme to deceive doctors and patients about the risks and benefits of long-term opioid use for chronic pain.

194. Manufacturer Defendants' deceptive unbranded marketing often contradicted what they said in their branded materials.

1. Key Opinion Leaders ("KOLs")

195. Manufacturer Defendants also spoke through a small circle of doctors who, were selected, funded, and elevated by Manufacturer Defendants because their public positions supported the use of opioids to treat chronic pain. These doctors became known as "key opinion leaders" or "KOLs."

196. Manufacturer Defendants paid KOLs to serve as consultants or on their advisory boards and to give talks or present CMEs, and their support helped these KOLs become respected industry experts. As they rose to prominence, these KOLs touted the benefits of opioids to treat chronic pain, repaying Manufacturer Defendants by advancing their marketing goals. KOLs' professional reputations became dependent on continuing to promote a pro-opioid message, even in activities that were not directly funded by Manufacturer Defendants.

197. KOLs have written, consulted on, edited, and lent their names to books and articles, and given speeches and CMEs supportive of chronic opioid therapy. Manufacturer Defendants created opportunities for KOLs to participate in research studies Manufacturer Defendants suggested or chose and then cited and promoted favorable studies or articles by their KOLs. By contrast, Manufacturer Defendants did not support, acknowledge, or disseminate publications of doctors unsupportive or critical of chronic opioid therapy.

198. Manufacturer Defendants' KOLs also served on committees that developed treatment guidelines that strongly encourage the use of opioids to treat chronic pain, and on the boards of pro-opioid advocacy groups and professional societies that develop, select, and present

CMEs. Manufacturer Defendants were able to direct and exert control over each of these activities through their KOLs.

199. Pro-opioid doctors are one of the most important avenues that Manufacturer Defendants use to spread their false and deceptive statements about the risks and benefits of long-term opioid use. Manufacturer Defendants know that doctors rely heavily and less critically on their peers for guidance, and KOLs provide the false appearance of unbiased and reliable support for chronic opioid therapy. For example, the State of New York found in its settlement with Purdue that the Purdue website In the Face of Pain failed to disclose that doctors who provided testimonials on the site were paid by Purdue and concluded that Purdue's failure to disclose these financial connections potentially misled consumers regarding the objectivity of the testimonials.

200. Thus, even though some of Manufacturer Defendants' KOLs have recently moderated or conceded the lack of evidence for many of the claims they made, those admissions did not reverse the effect of the false and deceptive statements that continue to appear nationwide and throughout the State of Arkansas in Manufacturer Defendants' own marketing as well as treatment guidelines, CMEs and other seminars, scientific articles and research, and other publications available in paper or online.

201. Manufacturer Defendants utilized many KOLs, including many of the same ones. Two of the most prominent are described below.

202. Dr. Russell Portenoy, former Chairman of the Department of Pain Medicine and Palliative Care at Beth Israel Medical Center in New York, is one example of a KOL whom Manufacturer Defendants identified and promoted to further their marketing campaign. Dr. Portenoy received research support, consulting fees, and honoraria from Cephalon, Endo, Janssen, and Purdue (among others), and was a paid consultant to Cephalon and Purdue.

203. Dr. Portenoy was instrumental in opening the door for the regular use of opioids to treat chronic pain. He served on the American Pain Society ("APS") / American Academy of Pain Medicine ("AAPM") Guidelines Committees, which endorsed the use of opioids to treat chronic pain, first in 1997 and again in 2009. He was also a member of the board of the American Pain Foundation ("APF"), an advocacy organization almost entirely funded by Manufacturer Defendants.

204. Dr. Portenoy also made frequent media appearances promoting opioids and spreading misrepresentations. He appeared on Good Morning America in 2010 to discuss the use of opioids for long-term treatment of chronic pain. On this widely-watched program, broadcast in Arkansas and across the country, Dr. Portenoy claimed: "Addiction, when treating pain, is distinctly uncommon. If a person does not have a history, a personal history, of substance abuse, and does not have a history in the family of substance abuse, and does not have a very major psychiatric disorder, most doctors can feel very assured that that person is not going to become addicted."

205. To his credit, Dr. Portenoy later admitted that he "gave innumerable lectures in the late 1980s and '90s about addiction that weren't true." These lectures falsely claimed that fewer than 1% of patients would become addicted to opioids. According to Dr. Portenoy, because the primary goal was to "destigmatize" opioids, he and other doctors promoting them overstated their benefits and glossed over their risks. Dr. Portenoy also conceded that "[d]ata about the effectiveness of opioids does not exist." Portenoy candidly stated: "Did I teach about pain management, specifically about opioid therapy, in a way that reflects misinformation? Well, . . . I guess I did."

206. Another KOL, Dr. Lynn Webster, was the co-founder and Chief Medical Director of Lifetree Clinical Research, an otherwise unknown pain clinic in Salt Lake City, Utah. Dr. Webster was President in 2013 and is a current board member of AAPM, a front group that ardently supports chronic opioid therapy. He is a Senior Editor of Pain Medicine, the same journal that published Endo special advertising supplements touting Opana ER. Dr. Webster was the author of numerous CMEs sponsored by Cephalon, Endo, and Purdue. At the same time, Dr. Webster was receiving significant funding from Manufacturer Defendants (including nearly $2 million from Cephalon).

207. During a portion of his time as a KOL, Dr. Webster was under investigation for overprescribing by the U.S. Department of Justice's Drug Enforcement Agency, which raided his clinic in 2010. Although the investigation was closed without charges in 2014, more than 20 of Dr. Webster's former patients at the Lifetree Clinic have died of opioid overdoses.

208. Ironically, Dr. Webster created and promoted the Opioid Risk Tool, a five question, one-minute screening tool relying on patient self-reports that purportedly allows doctors to manage the risk that their patients will become addicted to or abuse opioids. The claimed ability to pre-sort patients likely to become addicted is an important tool in giving doctors confidence to prescribe opioids long-term, and for this reason, references to screening appear in various industry-supported guidelines. Versions of Dr. Webster's Opioid Risk Tool appear on, or are linked to, websites run by Endo, Janssen, and Purdue.

209. In 2011, Dr. Webster presented, via webinar, a program sponsored by Purdue titled, Managing Patient's Opioid Use: Balancing the Need and the Risk. Dr. Webster recommended use of risk screening tools, urine testing, and patient agreements as a way to prevent "overuse of

prescriptions" and "overdose deaths." This webinar was available to and was intended to reach Arkansas doctors.

210. Dr. Webster also was a leading proponent of the concept of "pseudoaddiction," the notion that addictive behaviors should be seen not as warnings, but as indications of undertreated pain. In Dr. Webster's description, the only way to differentiate the two was to increase a patient's dose of opioids. As he and his co-author wrote in a book entitled Avoiding Opioid Abuse While Managing Pain (2007), a book that is still available online, when faced with signs of aberrant behavior, increasing the dose "in most cases . . . should be the clinician's first response." Endo distributed this book to doctors. Years later, Dr. Webster reversed himself, acknowledging that "[pseudoaddiction] obviously became too much of an excuse to give patients more medication."

211. These KOLs are non-party co-conspirators in this case.

2. Front Groups

212. Manufacturer Defendants also entered into arrangements with seemingly unbiased and independent patient and professional organizations to promote opioids for the treatment of chronic pain. Under the direction and control of Manufacturer Defendants, these "Front Groups" generated treatment guidelines, unbranded materials, and programs that favored chronic opioid therapy. They also assisted Manufacturer Defendants by responding to negative articles, by advocating against regulatory changes that would limit opioid prescribing in accordance with the scientific evidence, and by conducting outreach to vulnerable patient populations targeted by Manufacturer Defendants.

213. These Front Groups depended on Manufacturer Defendants for funding and, in some cases, for survival. Manufacturer Defendants also exercised control over programs and materials created by these groups by collaborating on, editing, and approving their content, and by funding their dissemination. In doing so, Manufacturer Defendants made sure that the Groups

would generate only the messages Manufacturer Defendants wanted to distribute. Despite this, the Front Groups held themselves out as independent and serving the needs of their members—whether patients suffering from pain or doctors treating those patients.

214. Manufacturer Defendants Cephalon, Endo, Janssen, and Purdue utilized many Front Groups, including many of the same ones. Several of the most prominent are described below, but there are many others, including the American Pain Society ("APS"), American Geriatrics Society ("AGS"), the Federation of State Medical Boards ("FSMB"), American Chronic Pain Association ("ACPA"), American Society of Pain Educators ("ASPE"), National Pain Foundation ("NPF") and Pain & Policy Studies Group ("PPSG").

215. The most prominent of Manufacturer Defendants' Front Groups was APF, which received more than $10 million in funding from opioid manufacturers from 2007 until it closed its doors in May 2012. Endo alone provided more than half that funding; Purdue was next, at $1.7 million.

216. APF issued education guides for patients, reporters, and policymakers that touted the benefits of opioids for chronic pain and trivialized their risks, particularly the risk of addiction. APF also launched a campaign to promote opioids for returning veterans, which has contributed to high rates of addiction and other adverse outcomes—including death—among returning soldiers. APF also engaged in a significant multimedia campaign—through radio, television and the internet—to educate patients about their "right" to pain treatment, namely opioids. All of the programs and materials were available nationally and were intended to reach Arkansas' citizens.

217. In addition to Perry Fine (a KOL from the University of Utah who received funding from Janssen, Cephalon, Endo, and Purdue) Russell Portenoy, and Scott Fishman (a KOL from the University of California, Davis who authored Responsible Opioid Prescribing, a publication

sponsored by Cephalon and Purdue), all of whom served on APF's Board and reviewed its publications, another board member, Lisa Weiss, was an employee of a public relations firm that worked for both Purdue and APF.

218. In 2009 and 2010, more than 80% of APF's operating budget came from pharmaceutical industry sources. Including industry grants for specific projects, APF received about $2.3 million from industry sources out of total income of about $2.85 million in 2009; its budget for 2010 projected receipts of roughly $2.9 million from drug companies, out of total income of about $3.5 million. By 2011, APF was entirely dependent on incoming grants from Manufacturer Defendants Purdue, Cephalon, Endo, and others to avoid using its line of credit. As one of its board members, Russell Portenoy, explained, the lack of funding diversity was one of the biggest problems at APF.

219. APF held itself out as an independent patient advocacy organization. It often engaged in grassroots lobbying against various legislative initiatives that might limit opioid prescribing, and thus the profitability of its sponsors. It was often called upon to provide "patient representatives" for Manufacturer Defendants' promotional activities, including for Purdue's Partners Against Pain and Janssen's Let's Talk Pain. APF functioned largely as an advocate for the interests of Manufacturer Defendants, not patients. Indeed, as early as 2001, Purdue told APF that the basis of a grant was Purdue's desire to "strategically align its investments in nonprofit organizations that share [its] business interests."

220. In practice, APF operated in close collaboration with opioid makers. On several occasions, representatives of the drug companies, often at informal meetings at Front Group conferences, suggested activities and publications for APF to pursue. APF then submitted grant

proposals seeking to fund these activities and publications, knowing that drug companies would support projects conceived as a result of these communications.

221. APF assisted in other marketing projects for drug companies. One project funded by another drug company—APF Reporter's Guide: Covering Pain and Its Management (2009)—recycled text that was originally created as part of the company's training document.

222. The same drug company made general grants, but even then it directed how APF used them. In response to an APF request for funding to address a potentially damaging state Medicaid decision related to pain medications generally, the company representative responded, "I provided an advocacy grant to APF this year—this would be a very good issue on which to use some of that. How does that work?"

223. The close relationship between APF and the drug company was not unique, but mirrors relationships between APF and Manufacturer Defendants. APF's clear lack of independence—in its finances, management, and mission—and its willingness to allow Manufacturer Defendants to control its activities and messages support an inference that each Defendant that worked with it was able to exercise editorial control over its publications.

224. Indeed, the U.S. Senate Finance Committee began looking into APF in May 2012 to determine the links, financial and otherwise, between the organization and the manufacturers of opioid painkillers. The investigation caused considerable damage to APF's credibility as an objective and neutral third party, and Manufacturer Defendants stopped funding it. Within days of being targeted by Senate investigation, APF's board voted to dissolve the organization "due to irreparable economic circumstances." APF "cease[d] to exist, effective immediately."

225. The American Academy of Pain Medicine, with the assistance, prompting, involvement, and funding of Manufacturer Defendants, issued treatment guidelines and sponsored

and hosted medical education programs essential to Manufacturer Defendants' deceptive marketing of chronic opioid therapy.

226. AAPM received over $2.2 million in funding since 2009 from opioid manufacturers. AAPM maintained a corporate relations council, whose members paid $25,000 per year (on top of other funding) to participate. The benefits included allowing members to present educational programs at off-site dinner symposia in connection with AAPM's marquee event – its annual meeting held in Palm Springs, California, or other resort locations. AAPM describes the annual event as an "exclusive venue" for offering education programs to doctors. Membership in the corporate relations council also allows drug company executives and marketing staff to meet with AAPM executive committee members in small settings. Manufacturer Defendants Endo, Purdue, Cephalon and Actavis were members of the council and presented deceptive programs to doctors who attended this annual event.

227. AAPM is viewed internally by Endo as "industry friendly," with Endo advisors and speakers among its active members. Endo attended AAPM conferences, funded its CMEs, and distributed its publications. The conferences sponsored by AAPM heavily emphasized sessions on opioids – 37 out of roughly 40 at one conference alone. AAPM's presidents have included top industry-supported KOLs Perry Fine, Russell Portenoy, and Lynn Webster. Dr. Webster was even elected president of AAPM while under a DEA investigation. Another past AAPM president, Dr. Scott Fishman, stated that he would place the organization "at the forefront" of teaching that "the risks of addiction are . . . small and can be managed."

228. AAPM's staff understood they and their industry funders were engaged in a common task. Manufacturer Defendants were able to influence AAPM through both their significant and regular funding and the leadership of pro-opioid KOLs within the organization.

229. In addition, treatment guidelines have been particularly important in securing acceptance for chronic opioid therapy. They are relied upon by doctors, especially the general practitioners and family doctors targeted by Manufacturer Defendants, who are neither experts nor trained in the treatment of chronic pain. Treatment guidelines not only directly inform doctors' prescribing practices, but are cited throughout the scientific literature and referenced by third-party payors in determining whether they should cover treatments for specific indications. Pharmaceutical sales representatives employed by Endo, Actavis, and Purdue discussed treatment guidelines with doctors during individual sales visits.

230. In 1997, AAPM and the American Pain Society jointly issued a consensus statement, The Use of Opioids for the Treatment of Chronic Pain, which endorsed opioids to treat chronic pain and claimed that the risk that patients would become addicted to opioids was low. The co-author of the statement, Dr. Haddox, was at the time a paid speaker for Purdue. Dr. Portenoy was the sole consultant. The consensus statement remained on AAPM's website until 2011, and was taken down from AAPM's website only after a doctor complained, though it lingers on the internet elsewhere.

231. AAPM and APS issued their own guidelines in 2009 ("AAPM/APS Guidelines") and continued to recommend the use of opioids to treat chronic pain. Fourteen of the 21 panel members who drafted the AAPM/APS Guidelines, including KOLs Dr. Portenoy and Dr. Perry Fine of the University of Utah, received support from Janssen, Cephalon, Endo, and Purdue.

232. The 2009 Guidelines promote opioids as "safe and effective" for treating chronic pain, despite acknowledging limited evidence, and conclude that the risk of addiction is manageable for patients regardless of past abuse histories. One panel member, Dr. Joel Saper, Clinical Professor of Neurology at Michigan State University and founder of the Michigan

Headache & Neurological Institute, resigned from the panel because of his concerns that the 2009 Guidelines were influenced by contributions that drug companies, including Manufacturer Defendants, made to the sponsoring organizations and committee members. These AAPM/APS Guidelines have been a particularly effective channel of deception and have influenced not only treating physicians, but also the body of scientific evidence on opioids; the Guidelines have been cited 732 times in academic literature, were disseminated in Arkansas during the relevant time period, are still available online, and were reprinted in the Journal of Pain.

233. Manufacturer Defendants widely referenced and promoted the 2009 Guidelines without disclosing the acknowledged lack of evidence to support them.

234. In this way and others, Manufacturer Defendants worked together, through Front Groups, to spread their deceptive messages about the risks and benefits of long-term opioid therapy.

235. These Front Groups are non-party co-conspirators in this case.

B. The U.S. Senate Homeland Security and Governmental Affairs Committee February 2018 Minority Staff Report recognizes collusive opioid promotion between Manufacturer Defendants and Front Groups.

236. On February 12, 2018, U.S. Senator Claire McCaskill of the Senate Homeland Security and Governmental Affairs Committee ("HSGAC") released the second congressional report resulting from her investigation into opioid manufacturers and distributors.[59] Focusing on financial ties between the manufacturers and third party advocacy groups—i.e., the Front Groups—, the report disclosed that Defendants Purdue, Janssen, Mylan, Depomed, and Insys made nearly $9 million in payments to advocacy groups in the field of chronic pain and opioid use

[59] HSGAC Minority Staff Report, *Exposing the Financial Ties Between Opioid Manufacturers and Third Party Advocacy Groups*, Fueling an Epidemic, Report Two (Feb. 12, 2018), *available at* https://www.hsgac.senate.gov/media/minority-media/breaking-millions-in-payments-among-findings-of-mccaskill-opioid-investigation-into-ties-between-manufacturers-and-third-party-advocacy-groups- (last visited Feb. 19, 2018).

between February 2012 and March 2017.[60] The same five manufacturers made over $1.6 million in payments to physicians affiliated with the advocacy groups since 2013, while all opioid manufacturers paid the same physicians over $10 million in the same time period.[61]

237. The HGSAC report recognizes a direct correlation between payments and sales. For instance, Insys's payments to Front Groups rose sharply in 2012—when it began selling Subsys fentanyl spray.[62] The company's revenues and profits skyrocketed between 2013 and 2015, and its stock increased 296% between 2013 and 2016.[63] Similarly, Janssen's payments to Front Groups ceased as soon as it sold its major opioid brand Nucynta to Depomed in 2015; Depomed's Front Group payments promptly tripled.[64]

238. Senator McCaskill's report mirrors widespread recognition of Manufacturer Defendants' glaring collusion with Front Groups to promote opioid use and oppose all efforts to combat abuse:

> Initiatives from the groups in this report often echoed and amplified messages favorable to increased opioid use—and ultimately, the financial interests of opioid manufacturers. These groups have issued guidelines and policies minimizing the risk of opioid addiction and promoting opioids for chronic pain, lobbied to change laws directed at curbing opioid use, and argued against accountability for physicians and industry executives responsible for overprescription and misbranding. Notably, a majority of these groups also strongly criticized 2016 guidelines from the Centers for Disease Control and Prevention (CDC) that recommended limits on opioid prescriptions for chronic pain—the first national standards for prescription opioid and a key response to the ongoing epidemic.

[60] Id. at 1-3.
[61] Id. at 3.
[62] Id. at 5.
[63] Id. (citing Joseph Walker, *Fentanyl Billionaire Comes Under Fire as Death Toll Mounts From Prescription Opioids*, WALL STREET JOURNAL (Nov. 22, 2016), *available at* https://www.wsj.com/articles/fentanyl-billionaire-comes-under-fire-as-death-toll-mounts-from-prescription-opioids-1479830968 (last visited Feb. 19, 2018); Matthew Herper, *An Opioid Spray Showered Billionaire John Kapoor In Riches. Now He's Feeling the Pain*, Forbes (Oct. 25, 2016), *available at* https://www.forbes.com/sites/matthewherper/2016/10/04/death-kickbacks-and-a-billionaire-the-story-of-a-dangerous-opioid/#2cf376a76e3f (last visited Feb. 19, 2018)).
[64] Id.

> The fact that these same manufacturers provided millions of dollars to the groups described below suggests, at the very least, a direct link between corporate donations and the advancement of opioid-friendly messaging.[65]

The report concluded:

> As a 2011 study in the *American Journal of Public Health* noted, a tension exists between the status of advocacy organizations as "among the most influential and trusted stakeholders in U.S. health policy," and the reality that their "positions closely correspond to the marketing aims of pharmaceutical and device companies."[66] The findings in this report indicate that this tension exists in the area of opioids policy—that organizations receiving substantial funding from manufacturers have, in fact, amplified and reinforced messages favoring increased opioid use.[67]

C. Manufacturer Defendants' marketing scheme misrepresented the risks and benefits of opioids.

239. To convince doctors and patients in Arkansas that opioids can and should be used to treat chronic pain, Manufacturer Defendants had to convince them that long-term opioid use is both safe and helpful. Knowing that they could do so only by deceiving those doctors and patients about the risks and benefits of long-term opioid use, Manufacturer Defendants made claims that were not supported by or were contrary to the scientific evidence. Regardless, Manufacturer Defendants have not corrected these claims, or instructed their KOLs or Front Groups to correct them, and continue to spread them today.

1. Manufacturer Defendants falsely trivialized or failed to disclose the known risks of long-term opioid use.

240. To convince doctors and patients that opioids are safe, Manufacturer Defendants deceptively trivialized and failed to disclose the risks of long-term opioid use, particularly the risk of addiction, through a series of misrepresentations that have been conclusively debunked. These misrepresentations – which are described below – reinforced each other and created the

[65] Id. at 1.
[66] Id. at 17 (quoting Sheila M. Rothman et al., *Health Advocacy Organizations and the Pharmaceutical Industry: An Analysis of Disclosure Practices,* 101(4) AM. J. PUB. HEALTH 602 (Apr. 2011)).
[67] Id.

dangerously misleading impression that: (1) starting patients on opioids was low-risk because most patients would not become addicted, and because those who were at greatest risk of addiction could be readily identified and managed; (2) patients who displayed signs of addiction probably were not addicted and, in any event, could easily be weaned from the drugs; (3) the use of higher opioid doses, which many patients need to sustain pain relief as they develop tolerance to the drugs, do not pose special risks; and (4) abuse-deterrent opioids both prevent abuse and overdose and are inherently less addictive. Manufacturer Defendants have not only failed to correct these misrepresentations, they continue to make them today.

241. First, Manufacturer Defendants falsely claimed that the risk of addiction is low and that addiction is unlikely to develop when opioids are prescribed, as opposed to obtained illicitly; and failed to disclose the greater risk of addiction with prolonged use of opioids. Some illustrative examples of these false and deceptive claims are described below:

a. Actavis's predecessor caused a patient education brochure to be distributed in 2007 that claimed opioid addiction is possible, but "less likely if you have never had an addiction problem." Upon information and belief, based on Actavis's acquisition of its predecessor's marketing materials along with the rights to Kadian, Actavis continued to use this brochure in 2009 and beyond.

b. Cephalon and Purdue sponsored APF's Treatment Options: A Guide for People Living with Pain (2007), which instructed that addiction is rare and limited to extreme cases of unauthorized dose escalations, obtaining duplicative opioid prescriptions from multiple sources, or theft. This publication is still available online.

c. Endo sponsored a website, Painknowledge.com, which claimed in 2009 that "[p]eople who take opioids as prescribed usually do not become addicted." Another Endo website,

PainAction.com, stated "Did you know? Most chronic pain patients do not become addicted to the opioid medications that are prescribed for them."

d. Endo distributed a pamphlet with the Endo logo entitled Living with Someone with Chronic Pain, which stated that: "Most health care providers who treat people with pain agree that most people do not develop an addiction problem." A similar statement appeared on the Endo website www.opana.com.

e. Janssen reviewed, edited, approved, and distributed a patient education guide entitled Finding Relief: Pain Management for Older Adults (2009), which described as "myth" the claim that opioids are addictive, and asserted as fact that "[m]any studies show that opioids are rarely addictive when used properly for the management of chronic pain."

f. Janssen currently runs a website, Prescriberesponsibly.com (last updated July 2, 2015), which claims that concerns about opioid addiction are "overestimated."

g. Purdue sponsored APF's A Policymaker's Guide to Understanding Pain & Its Management – which claims that less than 1% of children prescribed opioids will become addicted and that pain is undertreated due to "misconceptions about opioid addiction[]." This publication is still available online.

h. Detailers for Purdue, Endo, Janssen, and Cephalon in Arkansas minimized or omitted any discussion with doctors of the risk of addiction; misrepresented the potential for abuse of opioids with purportedly abuse-deterrent formulations; and routinely did not correct the misrepresentations noted above.

242. These claims are contrary to longstanding scientific evidence.

243. The State of New York, in a 2016 settlement agreement with Endo, found that opioid "use disorders appear to be highly prevalent in chronic pain patients treated with opioids,

with up to 40% of chronic pain patients treated in specialty and primary care outpatient centers meeting the clinical criteria for an opioid use disorder." Endo had claimed on its www.opana.com website that "[m]ost healthcare providers who treat patients with pain agree that patients treated with prolonged opioid medicines usually do not become addicted," but the State found that Endo had no evidence for that statement. Consistent with this, Endo agreed not to "make statements that . . . opioids generally are non-addictive" or "that most patients who take opioids do not become addicted" in New York. Endo remains free, however, to make those statements in Arkansas.

244. Second, Manufacturer Defendants falsely instructed doctors and patients that the signs of addiction are actually signs of undertreated pain and should be treated by prescribing more opioids. Manufacturer Defendants called this phenomenon "pseudoaddiction" – a term coined by Dr. David Haddox, who went to work for Purdue, and popularized by Dr. Russell Portenoy, a KOL for Cephalon, Endo, Janssen, and Purdue – and falsely claimed that pseudoaddiction is substantiated by scientific evidence. Some illustrative examples of these deceptive claims are described below:

a. Cephalon and Purdue sponsored Responsible Opioid Prescribing (2007), which taught that behaviors such as "requesting drugs by name," "demanding or manipulative behavior," seeing more than one doctor to obtain opioids, and hoarding, are all signs of pseudoaddiction, rather than true addiction. Responsible Opioid Prescribing remains for sale online. The 2012 edition, which also remains available online, continues to teach that pseudoaddiction is real.

b. Janssen sponsored, funded, and edited the Let's Talk Pain website, which in 2009 stated: "pseudoaddiction . . . refers to patient behaviors that may occur when pain is under-treated . . . . Pseudoaddiction is different from true addiction because such behaviors can be resolved with effective pain management."

c. Endo sponsored a National Initiative on Pain Control (NIPC) CME program in 2009 titled Chronic Opioid Therapy: Understanding Risk While Maximizing Analgesia, which promoted pseudoaddiction by teaching that a patient's aberrant behavior was the result of untreated pain. Endo substantially controlled NIPC by funding NIPC projects; developing, specifying, and reviewing content; and distributing NIPC materials.

d. Purdue published a pamphlet in 2011 entitled Providing Relief, Preventing Abuse, which described pseudoaddiction as a concept that "emerged in the literature" to describe the inaccurate interpretation of [drug-seeking behaviors] in patients who have pain that has not been effectively treated."

e. Purdue sponsored a CME program entitled Path of the Patient, Managing Chronic Pain in Younger Adults at Risk for Abuse. In a role play, a chronic pain patient with a history of drug abuse tells his doctor that he is taking twice as many hydrocodone pills as directed. The narrator notes that because of pseudoaddiction, the doctor should not assume the patient is addicted even if he persistently asks for a specific drug, seems desperate, hoards medicine, or "overindulges in unapproved escalating doses." The doctor treats this patient by prescribing a high-dose, long-acting opioid.

245. The 2016 CDC Guideline rejects the concept of pseudoaddiction. The Guideline nowhere recommends that opioid dosages be increased if a patient is not experiencing pain relief. To the contrary, the Guideline explains that "[p]atients who do not experience clinically meaningful pain relief early in treatment . . . are unlikely to experience pain relief with longer-term use," and that physicians should "reassess[] pain and function within 1 month" in order to decide whether to "minimize risks of long-term opioid use by discontinuing opioids" because the patient is "not receiving a clear benefit."

246. Even one of the Manufacturer Defendants has effectively repudiated the concept of pseudoaddiction. In finding that "[t]he pseudoaddiction concept has never been empirically validated and in fact has been abandoned by some of its proponents," the State of New York, in its 2016 settlement with Endo, reported that "Endo's Vice President for Pharmacovigilance and Risk Management testified that he was not aware of any research validating the 'pseudoaddiction' concept" and acknowledged the difficulty in distinguishing "between addiction and 'pseudoaddiction.'" Consistent with this, Endo agreed not to "use the term 'pseudoaddiction' in any training or marketing" in New York. Endo, however, remains free to do so in Arkansas.

247. Third, Manufacturer Defendants falsely instructed doctors and patients that addiction risk screening tools, patient contracts, urine drug screens, and similar strategies allow them to reliably identify and safely prescribe opioids to patients predisposed to addiction. These misrepresentations were especially insidious because Manufacturer Defendants aimed them at general practitioners and family doctors who lack the time and expertise to closely manage higher-risk patients on opioids. Manufacturer Defendants' misrepresentations made these doctors feel more comfortable prescribing opioids to their patients, and patients more comfortable starting on opioid therapy for chronic pain. Some illustrative examples of these deceptive claims are described below:

a. Endo paid for a 2007 supplement in the Journal of Family Practice written by a doctor who became a member of Endo's speakers' bureau in 2010. The supplement, entitled Pain Management Dilemmas in Primary Care: Use of Opioids, emphasized the effectiveness of screening tools, claiming that patients at high risk of addiction could safely receive chronic opioid therapy using a "maximally structured approach" involving toxicology screens and pill counts.

b. Purdue sponsored a 2011 webinar, Managing Patient's Opioid Use: Balancing the Need and Risk, which claimed that screening tools, urine tests, and patient agreements prevent "overuse of prescriptions" and "overdose deaths."

c. As recently as 2015, Purdue has represented in scientific conferences that "bad apple" patients—and not opioids—are the source of the addiction crisis and that once those "bad apples" are identified, doctors can safely prescribe opioids without causing addiction.

248. The CDC confirms the falsity of these misrepresentations. Its 2016 Guideline notes that there are no studies assessing the effectiveness of risk mitigation strategies—such as screening tools, patient contracts, urine drug testing, or pill counts widely believed by doctors to detect and deter abuse—"for improving outcomes related to overdose, addiction, abuse, or misuse." As a result, the Guideline recognizes that available risk screening tools "show insufficient accuracy for classification of patients as at low or high risk for [opioid] abuse or misuse" and counsels that doctors "should not overestimate the ability of these tools to rule out risks from long-term opioid therapy."

249. Fourth, to underplay the risk and impact of addiction and make doctors feel more comfortable starting patients on opioids, Manufacturer Defendants falsely claimed that opioid dependence can easily be addressed by tapering and that opioid withdrawal is not a problem, and failed to disclose the increased difficulty of stopping opioids after long-term use.

250. For example, a CME sponsored by Endo, entitled Persistent Pain in the Older Adult, claimed that withdrawal symptoms can be avoided by tapering a patient's opioid dose by 10%-20% for 10 days. And Purdue sponsored APF's A Policymaker's Guide to Understanding Pain & Its Management, which claimed that "[s]ymptoms of physical dependence can often be

ameliorated by gradually decreasing the dose of medication during discontinuation" without mentioning any hardships that might occur.

251. Manufacturer Defendants deceptively minimized the significant symptoms of opioid withdrawal—which, as explained in the 2016 CDC Guideline, include drug cravings, anxiety, insomnia, abdominal pain, vomiting, diarrhea, sweating, tremor, tachycardia (rapid heartbeat), spontaneous abortion and premature labor in pregnant women, and the unmasking of anxiety, depression, and addiction—and grossly understated the difficulty of tapering, particularly after long-term opioid use. Yet the 2016 CDC Guideline recognizes that the duration of opioid use and the dosage of opioids prescribed should be "limit[ed]" to "minimize the need to taper opioids to prevent distressing or unpleasant withdrawal symptoms," because "physical dependence on opioids is an expected physiologic response in patients exposed to opioids for more than a few days." The Guideline further states that "tapering opioids can be especially challenging after years on high dosages because of physical and psychological dependence" and highlights the difficulties, including the need to carefully identify "a taper slow enough to minimize symptoms and signs of opioid withdrawal" and to "pause[] and restart[]" tapers depending on the patient's response. The CDC also acknowledges the lack of any "high-quality studies comparing the effectiveness of different tapering protocols for use when opioid dosage is reduced or opioids are discontinued."

252. Fifth, Manufacturer Defendants falsely claimed that doctors and patients could increase opioid dosages indefinitely without added risk and failed to disclose the greater risks to patients at higher dosages. The ability to escalate dosages was critical to Manufacturer Defendants' efforts to market opioids for long-term use to treat chronic pain because, absent this misrepresentation, doctors would have abandoned treatment when patients built up tolerance and lower dosages did not provide pain relief. Some illustrative examples are described below:

a. Actavis's predecessor created a patient brochure for Kadian in 2007 that stated, "Over time, your body may become tolerant of your current dose. You may require a dose adjustment to get the right amount of pain relief. This is not addiction." Based on Actavis's acquisition of its predecessor's marketing materials along with the rights to Kadian, Actavis continued to use these materials in 2009 and beyond.

b. Cephalon and Purdue sponsored APF's Treatment Options: A Guide for People Living with Pain (2007), which claims that some patients "need" a larger dose of an opioid, regardless of the dose currently prescribed. The guide stated that opioids have "no ceiling dose" and are therefore the most appropriate treatment for severe pain. This guide is still available for sale online.

c. Endo sponsored a website, painknowledge.com, which claimed in 2009 that opioid dosages may be increased until "you are on the right dose of medication for your pain."

d. Endo distributed a pamphlet edited by a KOL entitled Understanding Your Pain: Taking Oral Opioid Analgesics, which was available during the time period of this Complaint on Endo's website. In Q&A format, it asked "If I take the opioid now, will it work later when I really need it?" The response is, "The dose can be increased. . . . You won't 'run out' of pain relief."

e. Janssen sponsored a patient education guide entitled Finding Relief: Pain Management for Older Adults (2009), which was distributed by its sales force. This guide listed dosage limitations as "disadvantages" of other pain medicines but omitted any discussion of risks of increased opioid dosages.

f. Purdue's In the Face of Pain website promotes the notion that if a patient's doctor does not prescribe what, in the patient's view, is a sufficient dosage of opioids, he or she should find another doctor who will.

g. Purdue sponsored APF's A Policymaker's Guide to Understanding Pain & Its Management, which taught that dosage escalations are "sometimes necessary," even unlimited ones, but did not disclose the risks from high opioid dosages. This publication is still available online.

h. Purdue sponsored a CME entitled Overview of Management Options that is still available for CME credit. The CME was edited by a KOL and taught that NSAIDs and other drugs, but not opioids, are unsafe at high dosages.

i. Purdue presented a 2015 paper at the College on the Problems of Drug Dependence, the "the oldest and largest organization in the US dedicated to advancing a scientific approach to substance use and addictive disorders," challenging the correlation between opioid dosage and overdose.

253. These claims conflict with the scientific evidence.

254. Finally, Manufacturer Defendants' deceptive marketing of the so-called abuse-deterrent properties of some of their opioids has created false impressions that these opioids can curb addiction and abuse. Indeed, in a 2014 survey of 1,000 primary care physicians, nearly half reported that they believed abuse-deterrent formulations are inherently less addictive.

255. More specifically, Manufacturer Defendants have made misleading claims about the ability of their so-called abuse-deterrent opioid formulations to deter abuse. For example, Endo's advertisements for the 2012 reformulation of Opana ER claimed that it was designed to be crush resistant, in a way that suggested it was more difficult to abuse. This claim was false. Endo's own studies, which it failed to disclose, showed that Opana ER could still be ground and chewed.

256. In a 2016 settlement with the State of New York, Endo agreed not to make statements in New York that Opana ER was "designed to be, or is crush resistant." The State found

those statements false and deceptive because there was no difference in the ability to extract the narcotic from Opana ER. Similarly, the 2016 CDC Guideline states that "[n]o studies" support the notion that "abuse-deterrent technologies [are] a risk mitigation strategy for deterring or preventing abuse," noting that the technologies—even when they work—"do not prevent opioid abuse through oral intake, the most common route of opioid abuse, and can still be abused by nonoral routes."

257. These numerous, longstanding misrepresentations of the risks of long-term opioid use spread by Manufacturer Defendants successfully convinced doctors and patients to discount those risks.

2. Manufacturer Defendants grossly overstated the benefits of chronic opioid therapy.

258. To convince doctors and patients that opioids should be used to treat chronic pain, Manufacturer Defendants also had to persuade them that there was a significant upside to long-term opioid use. Again, this claim is not supported by scientific evidence. Despite this, Manufacturer Defendants falsely and misleadingly touted the benefits of long-term opioid use and falsely and misleadingly suggested that these benefits were supported by scientific evidence. Not only have Manufacturer Defendants failed to correct these false and deceptive claims, they continue to make them today.

259. For example, Manufacturer Defendants falsely claimed that long-term opioid use improved patients' function and quality of life. Some illustrative examples are described below:

a. Actavis distributed an advertisement that claimed that the use of Kadian to treat chronic pain would allow patients to return to work, relieve "stress on your body and your mental health," and help patients enjoy their lives.

b. Endo distributed advertisements that claimed that the use of Opana ER for chronic pain would allow patients to perform demanding tasks like construction work or work as a chef and portrayed seemingly healthy, unimpaired subjects.

c. Janssen sponsored and edited a patient education guide entitled Finding Relief: Pain Management for Older Adults (2009) – which states as "a fact" that "opioids may make it easier for people to live normally." The guide lists expected functional improvements from opioid use, including sleeping through the night, returning to work, recreation, sex, walking, and climbing stairs.

d. Purdue ran a series of advertisements for OxyContin in 2012 in medical journals entitled "Pain vignettes," which were case studies featuring patients with pain conditions persisting over several months and recommending OxyContin for them. The ads implied that OxyContin improves patients' function.

e. Responsible Opioid Prescribing (2007), sponsored and distributed by Cephalon, Endo and Purdue, taught that relief of pain by opioids, by itself, improved patients' function. The book remains for sale online.

f. Cephalon and Purdue sponsored APF's Treatment Options: A Guide for People Living with Pain (2007), which counseled patients that opioids "give [pain patients] a quality of life we deserve." The guide was available online until APF shut its doors in 2012.

g. Endo's NIPC website painknowledge.com claimed in 2009 that with opioids, "your level of function should improve; you may find you are now able to participate in activities of daily living, such as work and hobbies, that you were not able to enjoy when your pain was worse." Elsewhere, the website touted improved quality of life (as well as "improved function") as benefits of opioid therapy. The grant request that Endo approved for this project specifically indicated

NIPC's intent to make misleading claims about function, and Endo closely tracked visits to the site.

h. Endo was the sole sponsor, through NIPC, of a series of CMEs titled Persistent Pain in the Older Patient, which claimed that chronic opioid therapy has been "shown to reduce pain and improve depressive symptoms and cognitive functioning." The CME was disseminated via webcast.

i. Janssen sponsored, funded, and edited a website, Let's Talk Pain, in 2009, which featured an interview edited by Janssen claiming that opioids allowed a patient to "continue to function." This video is still available today on YouTube.

j. Purdue sponsored the development and distribution of APF's A Policymaker's Guide to Understanding Pain & Its Management, which claimed that "multiple clinical studies" have shown that opioids are effective in improving daily function, psychological health, and health-related quality of life for chronic pain patients." The Policymaker's Guide was originally published in 2011 and is still available online today.

k. Purdue's, Cephalon's, Endo's, and Janssen's sales representatives have conveyed and continue to convey the message that opioids will improve patient function.

260. These claims find no support in the scientific literature.

261. In addition, Purdue misleadingly promoted OxyContin as being unique among opioids in providing 12 continuous hours of pain relief with one dose. In fact, OxyContin does not last for 12 hours—a fact that Purdue has known at all times relevant to this action. According to Purdue's own research, OxyContin wears off in under six hours in one quarter of patients and in under 10 hours in more than half. This is because OxyContin tablets release approximately 40% of their active medicine immediately, after which release tapers. This triggers a powerful initial

response, but provides little or no pain relief at the end of the dosing period, when less medicine is released. This phenomenon is known as "end of dose" failure, and a "substantial number" of chronic pain patients taking OxyContin experience it. This not only renders Purdue's promise of 12 hours of relief false and deceptive, it also makes OxyContin more dangerous because the declining pain relief patients experience toward the end of each dosing period drives them to take more OxyContin before the next dosing period begins, quickly increasing the amount of drug they are taking and spurring growing dependence.

262. Purdue's competitors were aware of this problem. For example, Endo ran advertisements for Opana ER referring to "real" 12-hour dosing. Nevertheless, Purdue falsely promoted OxyContin as if it were effective for a full 12 hours. Indeed, Purdue's sales representatives continue to tell Arkansas doctors that OxyContin lasts a full 12 hours.

263. Front Groups supported by Purdue likewise echoed these representations. For example, in an amicus brief submitted to the Supreme Court of Arkansas by the American Pain Foundation, the National Foundation for the Treatment of Pain and the Arkansas Pain Initiative in support of Purdue, those amici represented:

> Oxycontin is particularly useful for sustained long-term pain because it comes in higher, compact pills with a slow release coating. OxyContin pills can work for 12 hours. This makes it easier for patients to comply with dosing requirements without experiencing a roller-coaster of pain relief followed quickly by pain renewal that can occur with shorter acting medications. It also helps the patient sleeps through the night, which is often impossible with short-acting medications. For many of those serviced by Pain Care Amici, Oxycontin has been a miracle medication.

3. Manufacturer Defendants also engaged in other unlawful, unfair, and fraudulent misconduct.

264. Purdue unlawfully and unfairly failed to report or address illicit and unlawful prescribing of its drugs, despite knowing about it for years. Purdue's sales representatives have maintained a database since 2002 of doctors suspected of inappropriately prescribing its drugs.

Rather than report these doctors to state medical boards or law enforcement authorities (as Purdue is legally obligated to do) or cease marketing to them, Purdue used the list to demonstrate the high rate of diversion of OxyContin—the same OxyContin that Purdue had promoted as less addictive—in order to persuade the FDA to bar the manufacture and sale of generic copies of the drug because the drug was too likely to be abused. In an interview with the Los Angeles Times, Purdue's senior compliance officer acknowledged that in five years of investigating suspicious pharmacies, Purdue failed to take action—even where Purdue employees personally witnessed the diversion of its drugs. The same was true of prescribers; despite its knowledge of illegal prescribing, Purdue did not report until years after law enforcement shut down a Los Angeles clinic that prescribed more than 1.1 million OxyContin tablets and that Purdue's district manager described internally as "an organized drug ring." In doing so, Purdue protected its own profits at the expense of public health and safety.

265. The State of New York's settlement with Purdue specifically cited the company for failing to adequately address suspicious prescribing. Yet, Purdue continues to profit from the prescriptions of such prolific prescribers.

266. Like Purdue, Endo has been cited for its failure to set up an effective system for identifying and reporting suspicious prescribing. In its settlement agreement with Endo, the State of New York found that Endo failed to require sales representatives to report signs of abuse, diversion, and inappropriate prescribing; paid bonuses to sales representatives for detailing prescribers who were subsequently arrested or convicted for illegal prescribing; and failed to prevent sales representatives from visiting prescribers whose suspicious conduct had caused them to be placed on a no-call list.

D. Manufacturer Defendants targeted susceptible prescribers and vulnerable patient populations.

267. As a part of their deceptive marketing scheme, Manufacturer Defendants identified and targeted susceptible prescribers and vulnerable patient populations in the U.S., including Arkansas. For example, Manufacturer Defendants focused their deceptive marketing on primary care doctors, who were more likely to treat chronic pain patients and prescribe them drugs, but were less likely to be educated about treating pain and the risks and benefits of opioids and therefore more likely to accept Manufacturer Defendants' misrepresentations.

268. Manufacturer Defendants also targeted vulnerable patient populations like the elderly and veterans, who tend to suffer from chronic pain. Manufacturer Defendants targeted these vulnerable patients even though the risks of long-term opioid use were significantly greater for them. For example, the 2016 CDC Guideline observes that existing evidence shows that elderly patients taking opioids suffer from elevated fall and fracture risks, greater risk of hospitalization, and increased vulnerability to adverse drug effects and interactions. The Guideline therefore concludes that there are "special risks of long-term opioid use for elderly patients" and recommends that doctors use "additional caution and increased monitoring" to minimize the risks of opioid use in elderly patients. The same is true for veterans, who are more likely to use anti-anxiety drugs (benzodiazepines) for post-traumatic stress disorder, which interact dangerously with opioids.

E. Although Manufacturer Defendants knew that their marketing of opioids was false and deceptive, they fraudulently concealed their misconduct.

269. Manufacturer Defendants, both individually and collectively, made, promoted, and profited from their misrepresentations about the risks and benefits of opioids for chronic pain even though they knew that their misrepresentations were false and deceptive. The history of opioids, as well as research and clinical experience over the last 20 years, established that opioids were

highly addictive and responsible for a long list of very serious adverse outcomes. Manufacturer Defendants had access to scientific studies, detailed prescription data, and reports of adverse events, including reports of addiction, hospitalization, and deaths—all of which made clear the harms from long-term opioid use and that patients are suffering from addiction, overdoses, and death in alarming numbers.

270. Moreover, at all times relevant to this Complaint, Manufacturer Defendants took steps to avoid detection of and to fraudulently conceal their deceptive marketing and unlawful, unfair, and fraudulent conduct. For example, Manufacturer Defendants disguised their own role in the deceptive marketing of chronic opioid therapy by funding and working through third parties like Front Groups and KOLs. Manufacturer Defendants purposefully hid behind the assumed credibility of these individuals and organizations and relied on them to vouch for the accuracy and integrity of Manufacturer Defendants' false and deceptive statements about the risks and benefits of long-term opioid use for chronic pain.

271. Manufacturer Defendants also never disclosed their role in shaping, editing, and approving the content of information and materials disseminated by these third parties. Manufacturer Defendants exerted considerable influence on these promotional and "educational" materials in emails, correspondence, and meetings with KOLs, Front Groups, and public relations companies that were not, and have not yet become, public. For example, painknowledge.org, which is run by the NIPC, did not disclose Endo's involvement. Other Manufacturer Defendants, such as Purdue and Janssen, ran similar websites that masked their own direct role.

272. Finally, Manufacturer Defendants manipulated their promotional materials and the scientific literature to make it appear that these items were accurate, truthful, and supported by objective evidence when they were not. Manufacturer Defendants distorted the meaning or import

of studies they cited and offered them as evidence for propositions the studies did not support. The lack of support for Manufacturer Defendants' deceptive messages was not apparent to medical professionals who relied upon them in making treatment decisions, nor could it have been detected by Plaintiffs.

273. Thus, Manufacturer Defendants successfully concealed from the medical community, patients, and health care payers facts sufficient to arouse suspicion of the claims that Plaintiffs now assert. Plaintiffs did not know of the existence or scope of Manufacturer Defendants' industry-wide fraud and could not have acquired such knowledge earlier through the exercise of reasonable diligence.

F. By increasing opioid prescriptions and use, Manufacturer Defendants' deceptive marketing scheme has fueled the Opioid Epidemic and devastated Arkansas communities.

274. Manufacturer Defendants' misrepresentations deceived doctors and patients about the risks and benefits of long-term opioid use. Studies also reveal that many doctors and patients are not aware of or do not understand these risks and benefits. Indeed, patients often report that they were not warned they might become addicted to opioids prescribed to them. As reported in January 2016, a 2015 survey of more than 1,000 opioid patients found that 4 out of 10 were not told opioids were potentially addictive.

275. Manufacturer Defendants' deceptive marketing scheme caused and continues to cause doctors in Arkansas to prescribe opioids for chronic pain conditions such as back pain, headaches, arthritis, and fibromyalgia. Absent Manufacturer Defendants' deceptive marketing scheme, these doctors would not have prescribed as many opioids. Manufacturer Defendants' deceptive marketing scheme also caused and continues to cause patients to purchase and use opioids for their chronic pain believing they are safe and effective. Absent Manufacturer

Defendants' deceptive marketing scheme, fewer patients would be using opioids long-term to treat chronic pain, and those patients using opioids would be using less of them.

276. Manufacturer Defendants' deceptive marketing has caused and continues to cause the prescribing and use of opioids to explode. Indeed, this dramatic increase in opioid prescriptions and use corresponds with the dramatic increase in Manufacturer Defendants' spending on their deceptive marketing scheme. Manufacturer Defendants' spending on opioid marketing totaled approximately $91 million in 2000. By 2011, that spending had tripled to $288 million.

277. The escalating number of opioid prescriptions written by doctors who were deceived by Manufacturer Defendants' deceptive marketing scheme is the cause of a correspondingly dramatic increase in opioid addiction, overdose, and death throughout the U.S. and Arkansas. In August 2016, then-U.S. Surgeon General Vivek Murthy published an open letter to be sent to physicians nationwide, enlisting their help in combating this "urgent health crisis" and linking that crisis to deceptive marketing. He wrote that the push to aggressively treat pain, and the "devastating" results that followed, had "coincided with heavy marketing to doctors . . . [m]any of [whom] were even taught – incorrectly – that opioids are not addictive when prescribed for legitimate pain."

278. Scientific evidence demonstrates a strong correlation between opioid prescriptions and opioid abuse. In a 2016 report, the CDC explained that "[o]pioid pain reliever prescribing has quadrupled since 1999 and has increased in parallel with [opioid] overdoses." Patients receiving prescription opioids for chronic pain account for the majority of overdoses. For these reasons, the CDC concluded that efforts to rein in the prescribing of opioids for chronic pain are critical "to reverse the epidemic of opioid drug overdose deaths and prevent opioid-related morbidity."

279. Contrary to Manufacturer Defendants' misrepresentations, most opioid addiction begins with legitimately prescribed opioids, and therefore could have been prevented had Manufacturer Defendants' representations to prescribers been truthful. Numerous doctors and substance abuse counselors note that many of their patients who misuse or abuse opioids started with legitimate prescriptions, confirming the important role that doctors' prescribing habits have played in the opioid epidemic.

280. As the FDA observed in 2016, the opioid epidemic is getting worse, not better. Opioids are by far the most commonly prescribed class of substances in Arkansas. When compared to previous drug overdose epidemics in Arkansas, the current prescription drug epidemic is responsible for considerably more deaths, and the epidemic will continue unabated absent relief from the Court.

281. Manufacturer Defendants' deceptive marketing scheme has also had a significant detrimental impact on children in Arkansas in a number of ways. The overprescribing of opioids for chronic pain has made the drugs more accessible to school-aged children, who come into contact with opioids after they have been prescribed to friends or relatives in the same household. Furthermore, children with parents addicted to drugs tend to stay in foster care longer, and they often enter the system having experienced significant trauma, which makes these cases more difficult and expensive to handle. Although the foster care system in Arkansas is managed by the State, all Plaintiffs bear many of the additional costs caused by Defendants' actions.

282. The overprescribing of opioids for chronic pain caused by Manufacturer Defendants' deceptive marketing scheme has also resulted in a dramatic rise in the number of infants in Arkansas who are born addicted to opioids due to prenatal exposure and suffer from neonatal abstinence syndrome. These infants face painful withdrawal and may suffer long-term

neurologic and cognitive impacts. Babies with NAS typically require extensive hospital stays as they withdraw.

283. Opioid addiction is now the primary reason that Arkansas' citizens seek substance abuse treatment. The number of emergency medical services ("EMS") runs for suspected opioid-related overdose has also increased. The costs associated with the increase in medical treatments are borne in part by Plaintiffs.

284. Manufacturer Defendants' creation, through false and deceptive advertising and other unlawful and unfair conduct, of a virtually limitless opioid market has significantly harmed communities throughout Arkansas. Manufacturer Defendants' success in extending the market for opioids to new patients and chronic pain conditions has created an abundance of drugs available for non-medical and criminal use and fueled a new wave of addiction and injury. It has been estimated that 60% of the opioids that are abused come, directly or indirectly, through doctors' prescriptions.

285. Law enforcement agencies have increasingly associated prescription drug abuse with violent and property crimes. Despite efforts to curtail it, local law enforcement agencies are faced with increasing diversion from legitimate sources for illicit purposes, including: doctor shopping, forged prescriptions, falsified pharmacy records, and employees who steal from their place of employment. The opioid epidemic has prompted a growing trend of crimes against pharmacies including robbery and burglary. In fact, a 2005 study by The Center on Addiction and Substance Abuse at Columbia University revealed that, by that time, 20.9% of pharmacies nationwide had stopped stocking certain medications such as OxyContin and Percocet, in order to protect themselves from robbery. This ongoing diversion of prescription narcotics creates a lucrative marketplace.

286. The costs and consequences of opioid addiction are staggering. Prescription opioid misuse, abuse and overdose have an enormous impact on the health and safety of individuals as well as communities at large, as the consequences of this epidemic reach far beyond the individual who is addicted. Some of the repercussions for individuals include job loss, loss of custody of children, physical and mental health problems, homelessness and incarceration. This results in instability in communities often already in economic crisis and contributes to increased demand on community services such as hospitals, courts, child services, treatment centers and law enforcement.

287. Manufacturer Defendants knew and should have known about these harms that their deceptive marketing has caused. Manufacturer Defendants closely monitored their sales and the habits of prescribing doctors. Their sales representatives, who visited doctors and attended CMEs, knew which doctors were receiving their messages and how they were responding. Manufacturer Defendants also had access to and watched carefully government and other data that tracked the explosive rise in opioid use, addiction, injury, and death. They knew—and, indeed, intended—that their misrepresentations would persuade doctors to prescribe and patients to use their opioids for chronic pain.

288. Manufacturer Defendants' causal role is not broken by the involvement of doctors. Manufacturer Defendants' marketing efforts were ubiquitous and highly persuasive. Their deceptive messages tainted virtually every source doctors could rely on for information and prevented them from making informed treatment decisions. Manufacturer Defendants also were able to harness and hijack what doctors wanted to believe—namely, that opioids represented a means of relieving their patients' suffering and of practicing medicine more compassionately.

G. Distributor Defendants likewise breached their duties to Plaintiffs.

289. The supply chain for prescription opioids begins with the manufacture and packaging of the pills. The manufacturers then transfer the pills to distribution companies, including the Defendants Cardinal, McKesson, and AmerisourceBergen, which together account for 85 to 90 percent of all revenues from drug distribution in the United States, estimated to be at $378.4 billion in 2015. The distributors then supply opioids to hospitals, pharmacies, doctors, and other healthcare providers, which then dispense the drugs to patients.

290. Each participant in the supply chain shares the responsibility for controlling the availability of prescriptions opioids. Opioid "diversion" occurs whenever the supply chain of prescription opioids is broken, and the drugs are transferred from a legitimate channel of distribution or use, to an illegitimate channel of distribution or use.

291. Opioid diversion occurs in the United States at an alarming rate. In recent years, the number of people who take prescription opioids for non-medical purposes is greater than the number of people who use cocaine, heroin, hallucinogens, and inhalants combined.

292. Like all people, Distributors Defendants have a duty to exercise reasonable care under the circumstances. This involves a duty not to create a foreseeable risk of harm to others. Additionally, one who engages in affirmative conduct—and thereafter realizes or should realize that such conduct has created an unreasonable risk of harm to another—is under a duty to exercise reasonable care to prevent the threatened harm.

293. In addition to having common law duties, the Distributor Defendants are governed by the statutory requirements of the Arkansas Controlled Substances Act, ARK. CODE ANN. §§ 5-64-101, *et seq.*; the Arkansas Uniform Narcotic Drug Act, *id*. §§ 20-64-201, *et seq.*; and Arkansas Department of Health regulations promulgated thereunder, ARK. ADMIN. CODE §§ 007.07.1-I, *et seq.* These requirements were enacted to protect society from the harms of drug diversion. The

Distributor Defendants' violation of these requirements shows that they failed to meet the relevant standard of conduct that society expects from them.

294. The Arkansas CSA acts as a system of checks and balances from the manufacturing level through delivery of the pharmaceutical drug to the patient or ultimate user. Every person or entity who manufactures, distributes, or dispenses opioids must obtain a registration with the Arkansas Department of Health and the DEA. Registrants at every level of the supply chain must fulfill their obligations under the CSA, otherwise controlled substances move from the licit to the illicit marketplace, and there is great potential for harm to the general public.

295. All opioid distributors are required to maintain effective controls against opioid diversion.

296. To prevent unauthorized users from obtaining opioids, Arkansas law creates a distribution monitoring system for controlled substances. At the heart of this system are registration and tracking requirements imposed upon anyone authorized to handle controlled substances. The DEA's Automation of Reports and Consolidation Orders System ("ARCOS") is an automated drug reporting system which monitors the flow of Schedule II controlled substances from their point of manufacture through commercial distribution channels to point of sale. ARCOS accumulates data on distributors' controlled substances acquisition/distribution transactions, which are then summarized into reports used by the DEA to identify any diversion of controlled substances into illicit channels of distribution. Each person or entity that is registered to distribute ARCOS Reportable controlled substances must report acquisition and distribution transactions to the DEA.

297. In addition to filing acquisition/distribution transaction reports, Arkansas law requires each registrant to maintain on a current basis a complete and accurate record of each

substance manufactured, imported, received, sold, delivered, exported, or otherwise disposed of. *See* ARK. CODE ANN. § 20-64-209. It is a violation of Arkansas law for any person to negligently fail to abide by the recordkeeping and reporting requirements.

298. In order to maintain registration, Arkansas law requires distributors to maintain effective controls against diversion of controlled substances into other than legitimate medical, scientific and industrial channels. ARK. ADMIN. CODE § 007.07.2-II-III.

H. Distributor Defendants knew or should have known they were facilitating widespread opioid diversion.

299. The problem of opioid diversion in the supply chain has been widely publicized for years. Numerous publications, studies, federal agencies, and professional organizations have highlighted the epidemic rate of opioid abuse and overdose rates in communities in Arkansas, as well as throughout the United States.

300. The Distributor Defendants were on notice that their own industry group, the Healthcare Distribution Management Association, published Industry Compliance Guidelines titled "Reporting Suspicious Orders and Preventing Diversion of Controlled Substances" that stressed the critical role of each member of the supply chain in distributing controlled substances.

301. These industry guidelines further provided: "At the center of a sophisticated supply chain, distributors are uniquely situated to perform due diligence in order to help support the security of controlled substances they deliver to their customers."

302. Opioid distributors have themselves recognized the magnitude of the problem and, at least rhetorically, their legal responsibilities to prevent diversion. They have made statements assuring the public they are supposedly undertaking a duty to curb the opioid epidemic.

303. For example, a Cardinal executive recently claimed that it uses "advanced analytics" to monitor its supply chain; Cardinal assured the public it was being "as effective and

efficient as possible in constantly monitoring, identifying, and eliminating any outside criminal activity."

304. At the very least, these assurances about constantly eliminating criminal activity and curbing the opioid epidemic create a duty for the Distributor Defendants to reasonably follow through.

305. Thus, in addition to the obligations imposed by Arkansas law, through their own words and actions, the Distributor Defendants have voluntarily undertaken a duty to protect the public at large against diversion from their supply chains, and to curb the opioid epidemic.

306. Despite these kinds of statements, the Distributor Defendants have knowingly or negligently allowed diversion. Their misconduct has resulted in numerous civil fines and other penalties.

307. In 2008, Cardinal paid a $34 million penalty to settle allegations about opioid diversion taking place at seven warehouses around the United States. Again in 2012, Cardinal reached an administrative settlement with the DEA relating to opioid diversion between 2009 and 2012 in multiple states. Just several months ago, in December 2016, a Department of Justice press released announced that, in connection with the CSA violations, the United States "Reaches $34 Million Settlement With Cardinal Health For Civil Penalties Under The Controlled Substances Act." In connection with the investigations of Cardinal, the DEA uncovered evidence that Cardinal's own investigator warned Cardinal against selling opioids to a particular pharmacy in Florida that was suspected of opioid diversion. Cardinal did nothing to notify the DEA or cut off the supply of drugs to the suspect pharmacy. Instead, Cardinal's opioid shipments to the pharmacy increased—to almost two million doses of oxycodone in one year—while other comparable pharmacies were receiving approximately 69,000 doses/year.

308. In May 2008, McKesson entered into a settlement agreement with the DEA to settle claims that McKesson failed to maintain effective controls against diversion of controlled substances. McKesson agreed to pay a $13.25 million civil fine. After the 2008 settlement, McKesson was supposed to change its ways and act tougher towards opioid diversion. But it did not do so. Again in 2015, McKesson found itself in the middle of allegations concerning its failure to provide effective controls against opioid diversion. In early 2017 it was reported that McKesson agreed to pay $150 million to the government to settle certain opioid diversion claims that it allowed drug diversion at 12 distribution centers in 11 states.

309. In 2007, AmerisourceBergen lost its license to send controlled substances from a distribution center amid allegations that it was not controlling shipments of prescription opioids to Internet pharmacies. Again in 2012, AmerisourceBergen was implicated for failing to protect against diversion of particular controlled substances into non-medically necessary channels. It has been reported that the U.S. Department of Justice has subpoenaed AmerisourceBergen for documents in connection with a grand jury proceeding seeking information on the company's program for controlling and monitoring diversion of controlled substances into channels other than for legitimate medical, scientific and industrial purposes.

310. Although distributors have been penalized by law enforcement authorities, they remain obstinate. Instead of changing their behavior, they pay millions of dollars in fines as a cost of doing business in an industry which generates billions of dollars in revenue. In an October 2017 interview on “60 Minutes,” former head of the DEA Office of Diversion Control Joe Rannazissi, who spent over a decade combating the national opioid epidemic, put it bluntly:

> This is an industry that’s out of control. What they want to do is what they want to do and not worry about what the law is. If they don’t follow the law in drug supply, people die. That’s just it, people die.

. . .

> This is an industry that allowed millions and millions of drugs to go into bad pharmacies and doctors' offices that distribute them out to people who had no need for those drugs.
>
> Interviewer: Who are these distributors?
>
> Rannazissi: The three largest distributors are Cardinal Health, McKesson, and AmerisourceBergen. They control probably 85 or 90% of the drugs going downstream.
>
> Interviewer: You know the implication of what you're saying . . . that these big companies knew that people were pumping drugs into American communities that were killing people.
>
> Rannazissi: That's not an implication; that's a fact. That's exactly what they did.[68]

I. Distributor Defendants' misconduct has injured and continues to injure Plaintiffs.

311. The Distributor Defendants had the ability and duty to prevent opioid diversion, which presented a known or foreseeable danger of serious injury to Arkansas and Plaintiffs. But they failed to do so.

312. The Distributor Defendants have supplied quantities of prescription opioids in and around Arkansas with the actual or constructive knowledge that the opioids were ultimately being consumed by Arkansas' citizens for non-medical purposes. Many of these shipments should have been stopped or investigated, but the Distributor Defendants negligently or intentionally failed to do so.

313. Each Distributor Defendant knew or should have known that the amount of opioids that it allowed to flow into Arkansas was far in excess of what could be consumed for medically-necessary purposes in the relevant communities (especially given that each Distributor Defendant knew it was not the only opioid distributor servicing those communities).

[68] Bill Whitaker and Joe Rannazissi, *The Whistleblower*, CBS 60 MINUTES (Oct. 15, 2017).

314. The Distributor Defendants negligently or intentionally failed to adequately control their supply lines to prevent diversion. A reasonably-prudent distributor of Schedule II controlled substances would have anticipated the danger of opioid diversion and protected against it by, for example, taking greater care in hiring, training, and supervising employees; providing greater oversight, security, and control of supply channels; looking more closely at the pharmacists and doctors who were purchasing and prescribing large quantities of commonly-abused opioids in amounts greater than the populations in those areas would warrant; investigating demographic or epidemiological facts concerning the increasing demand for narcotic painkillers in and around Arkansas; providing information to pharmacies and retailers about opioid diversion; and in general, simply following applicable statutes, regulations, professional standards, and guidance from government agencies.

315. The Distributor Defendants made little to no effort to visit the pharmacies servicing Arkansas to perform due diligence inspections to ensure that the controlled substances the Distributors Defendants had furnished were not being diverted to illegal uses.

316. The compensation the Distributor Defendants provided to certain of their employees was affected, in part, by the volume of their sales of opioids to pharmacies and other facilities servicing Arkansas, thus improperly creating incentives that contributed to and exacerbated opioid diversion and the resulting epidemic of opioid abuse.

317. It was reasonably foreseeable to the Distributor Defendants that their conduct in flooding the market in and around Arkansas with highly-addictive opioids would allow opioids to fall into the hands of children, addicts, criminals, and other unintended users.

318. It is reasonably foreseeable to the Distributor Defendants that, when unintended users gain access to opioids, tragic preventable injuries will result, including addiction, overdoses,

and death. It is also reasonably foreseeable that many of these injuries will be suffered by Arkansas citizens, and that the costs of these injuries will be shouldered by Plaintiffs.

319. The Distributor Defendants knew or should have known that the opioids being diverted from their supply chains would contribute to the opioid epidemic of Arkansas, and would create access to opioids by unauthorized users, which, in turn, perpetuates the cycle of addiction, demand, and illegal transactions.

320. The Distributor Defendants knew or should have known that a substantial amount of the opioids dispensed in and around Arkansas were being dispensed based on invalid or suspicious prescriptions.

321. The Distributor Defendants were aware of widespread prescription opioid abuse in and around Arkansas, but they nevertheless persisted in a pattern of distributing commonly abused and diverted opioids in geographic areas—and in such quantities, and with such frequency—that they knew or should have known these commonly abused controlled substances were not being prescribed and consumed for legitimate medical purposes.

322. The use of opioids by Arkansas citizens who were addicted or who did not have a medically-necessary purpose could not occur without the knowing cooperation and assistance of the Distributor Defendants. If any of the Distributor Defendants adhered to effective controls to guard against diversion, Arkansas, its citizens, and Plaintiffs would have avoided significant injury.

323. The Distributor Defendants made substantial profits over the years based on the diversion of opioids into Arkansas. Their participation and cooperation in a common enterprise has foreseeably caused injuries to the citizens of Arkansas and financial damages to Plaintiffs. The

Distributor Defendants knew full well that Arkansas and its citizens, including Plaintiffs, would be unjustly forced to bear the costs of these injuries and damages.

324. The Distributor Defendants' intentional distribution of excessive amounts of prescription opioids to relatively small communities primarily serving Arkansas citizens showed an intentional or reckless disregard for the safety of Arkansas and its citizens. Their conduct poses a continuing threat to the health, safety, and welfare of Arkansas and its citizens.

325. There have been monumental costs associated with the treatment of patients addicted to prescription opioids as well.

326. Nationally, claims involving workers who take opioids are almost four times more likely to reach costs of over $100,000 than claims involving workers without opioids because opioid patients suffer greater side effects and are slower to return to work. Even adjusting for injury severity and self-reported pain score, receiving an opioid for more than seven days and receiving more than one opioid prescription increased the risk that a patient will be on work disability one year later. A prescription for opioids as the first treatment for a workplace injury doubles the average length of the claim.

327. While the use of opioids has taken an enormous toll on the State of Arkansas, its residents, and Plaintiffs, Defendants have realized blockbuster profits. In 2014 alone, opioids generated $11 billion in revenue for drug companies like Defendants. Indeed, financial information indicates that each Defendant experienced a material increase in sales, revenue, and profits from the false and deceptive advertising and other unlawful and unfair conduct described above.

J. Insys, Linden Care, UPC, and Ahmad's Arkansas Scheme.

1. The Fraudulent Scheme to Illegally Promote Fentanyl Spray

328. Insys directed and engaged in a conspiracy with certain health care providers, including Dr. Ahmad and UPC, to write Subsys fentanyl spray prescriptions for patients using

bribes and kickbacks. The conspirators also made material misrepresentations regarding the patients' conditions, their needs for the drug, and their prior or current uses of other drugs during the prior authorization process in order to get payment for the fentanyl spray. As a result, patients across the country, including Plaintiffs' citizens, received fentanyl spray and suffered its side effects even though they were unqualified to use it.

a. Insys's Illegal Kickbacks

329. One of the necessary components to Insys's plan to expand the market for fentanyl spray was to co-opt health care professionals to prescribe the drug to non-cancer patients for common pain. Insys accomplished this by paying illegal kickbacks to clinicians, including Ahmad, who had the legal permission to write prescriptions for potent narcotics. Insys provided some, but not all, of the kickbacks through a sham front organization called the "Insys Speaker Program."

330. Through the speaker program, Insys paid health care professionals speaking fees, also referred to as an "honoraria," so long as they prescribed Subsys in high volumes. Using pharmacy data from third parties, Insys tracked and targeted the top prescribers. Because Insys focused on obtaining one or two doctors to write at least 30 Subsys prescriptions per month, it targeted prescribers running pain clinics with high-volume practice.

331. To disguise the real purpose of the money exchange, Insys described the fees as compensation for giving an educational talk on Subsys to colleagues and other potential prescribers at a "meeting." But many, if not all, of the "meetings" consisted only of the speaker and the sales representative in attendance; in some cases, they never took place. This did not matter to Insys. As then Vice President of Sales Alec Burlakoff stated to one sales representative while telling her not

to worry about speaker doctors' communications skills: "They do not need to be good speakers, they need to write a lot of [Fentanyl Spray prescriptions]."[69]

332. Insys specifically designed its program to direct payments only to those physicians who were dedicated to prescribing Subsys in high volumes. For instance, in September 2012, then Vice President of Sales Alec Burlakoff emphasized to the sales force the critical connection between speaker program fees and volume prescriptions:

> If your speaker does not have at least 20 patients on Subsys (QTD), he or should not be booked to speak at this juncture. You should cancel or suspend your programs until you and your manager have had ample chance to think this investment entirely through.

333. Burlakoff re-emphasized the purpose of the speaker programs to his sales force, telling them that they "must hold off on the conduction of these valuable speaker programs," until they knew "for absolute sure" that "if you use a specific speaker that the program will yield positive results." At the company's national sales meeting days later, Burlakoff again emphasized that a "critical success factor" in selling Subsys was to schedule a "consistent number of [Insys Speaking Programs] with top 20 targets." By the spring of 2013, the company's speaker payment plan was in full force. Burlakoff emphasized the critical nature of the program to the success of the company when admonishing the sales force:

> I said it a thousand times. [Insys Speaking Programs] are the most important thing you will do to increase your business. ISP's are basically the ONLY thing you should be focusing on to increase your sales.

334. Burlakoff explained to his sales force what he meant by praising his top five sales representatives:

> The below 5 names mentioned at the top of the company rankings—literally have their entire business being driven by basically 1 customer . . . [These top five sales

[69] U.S. v. Burlakoff, No. 1:16-cr-10343-ADB, Doc. 1 (D. Mass. Dec. 6 2016) (alteration in original).

> representatives] found a customer to own and they packed the proverbial suitcase and moved in . . . Every winning team, must have their "MVP player."
>
> . . .
>
> It is and has always been your assignment to find this key player. If you have not found this doctor, throw the decile list, call list, routing, ROO list, etc. out the window. You have to start prospecting and develop a key doctor.

335. In another e-mail to his sales force, Burlakoff encouraged them to develop one or two prescribers from whom they could generate prescriptions on demand:

> The goal is 1 rx per day . . . Are you still calling on multiple doctors a day giving a 'stand up message' in the hallway. If so, you don't stand a chance of lasting in this market. Do you have 1 or 2 customers whom [sic] have now become your best friend, that you rely on at least 1 rx per day and are you visiting this office every single day. If the answer is no, you are truly in a very bad situation.

336. For at least the three years between 2012 and 2015, the Insys speaker program allowed Insys to pay kickbacks to clinicians who prescribed fentanyl spray in high volumes and dramatically increased profits of the company. The brazen kickback conspiracy between Insys and prescribers of large amounts of fentanyl spray, including Ahmad and UPC, eventually got the attention of federal authorities.

337. On December 6, 2016, a federal grand jury indicted six former Insys executives, including the founder and owner John Kapoor, former CEO Michael Babich and Burlakoff, on charges of conspiracy to violate the federal anti-kickback statute for their role in the speaker fee scheme. Without identifying him by name, the indictment described Dr. Ahmad as one of ten clinician co-conspirators.

b. Ahmad's Kickbacks

338. After serving as Resident Medical Officer at University Hospital in Malaysia, Dr. Ahmad trained at Yale University in both Anesthesia and Pain Management between 1993 and 1998. In 2004, Dr. Ahmad became Director of Anesthesia and Pain Medicine at St. Vincent

Medical Center in Sherwood, Arkansas. During that same time period, and up until his license was suspended, he also served as Medical Director of the United Pain Care Clinic in Sherwood.

339. While serving as Medical Director at UPC, Ahmad owned and managed the pain clinic in Sherwood, where he saw as many as 75-100 patients per day. Ahmad treated few, if any, cancer patients. In or about the fall of 2012, Insys identified Ahmad as a target doctor. In September 2012, the company's Arkansas sales representative advised Insys senior management that the pharmacy next to Ahmad's office (a Pharmacy which Ahmad owned), had been forced to close because it was selling too many opioids. Insys further suspected that Ahmad and the pharmacy might be under investigation for over-prescribing opioids. Internal communications stated:

> 9/7 — . . . I have been unable to reach ... Dr. Ahmad or his office manager for at least a month. The pharmacy which is located in the same stand-alone building was shut down due to the high percentage of opioids being dispensed. It has recently been opened but is unable to stock opioids. I spoke to ... [my sales manager] and we are both under the opinion that they may be under investigation. I will follow up in 3-4 weeks to let things settle down.

340. The Arkansas sales representative also told senior management that Ahmad was "[v]ery pleased with . . . [the fentanyl spray]", but that he has "had difficulty with insurance coverage lately." He noted that the Pharmacy located within same building "cannot order CII Rx from distributors due to the ratio of opioids to other Rx. See once every week."

341. Armed with knowledge that Ahmad's pharmacy had been closed for dispensing too many opioids, was forbidden from selling more, and that Dr. Ahmad may be under investigation, Insys ignored the facts and continued to recruit Ahmad to become a fentanyl spray prescriber.

342. On or about October 8, 2012, the Arkansas sales representative for Insys sent corporate headquarters another update, this one to advise corporate that over dinner, Ahmad

guaranteed that he would write more fentanyl spray prescriptions than the company could imagine, once he was able to fill them at his pharmacy and start receiving his speaker fees.

> 10/5-RSM Rich Simon and I took . . . Dr Ahmad and his office manager to dinner and turned things around 180 degrees. We set out a plan to conduct dinner programs for . . . Dr. Ahmad to speak at his request.
>
> . . .
>
> Dr. Ahmad was not able to receive schedule two drugs in his buildings pharmacy which prevented his writing our drug. Rich Simon and I have been speaking to [the] pharmacist, ... [the Director of Trade and Distribution for the Company] & ... Dr. Ahmad to resolve the issue but have a guarantee from ... Dr. Ahmad to have "more scripts than we can handle" once the pharmacy issue is resolved and he begins to speak.

343. The investigation of Ahmad and his pharmacy continued into 2013. In or about April 2013, the Insys sales manager for Arkansas notified headquarters that she had cancelled scheduled Speaker Programs for Ahmad because he was not giving Insys enough business. In or about July 2013, the Arkansas sales manager sent another email to the assigned sales representative and senior management noting:

> "Dr. Ahmad never wrote in Q2 and so far he has not written in Q3. I truly don't believe he is worth any more of your time especially since he is in AR. I am perplexed by his prescribing habits."

344. By the fall of 2013, Ahmad was writing one fentanyl spray prescription per week. But everything soon changed when Insys hired a new sales representative who had a history with Ahmad and was soon assigned directly to him. When the sales manager complained about the assignment, the company's Vice-President of Sales responded, stating:

> [t]he current rep did not eat what he killed. He did not KILL anything, he merely braised the doctor! ... I need and want the business TODAY. I need to see if ... [the new sales representative] can bring me what the other rep could not. I need ... [the new sales representative] to make his living off this doctor. This is my job.

345. The sales manager received the message loud and clear, and Ahmad was soon in the fold. During the first quarter of 2014, Ahmad was paid for eight (8) Speaker Program events,

which generated big returns. By the end of March 2014, Ahmad had gone from writing one fentanyl spray prescription per week to as many as 30. Ahmad also went from having Speaker Program events cancelled for lack of prescriptions to receiving more speaking fees at higher rates. Many of the events Ahmad attended were mere social gatherings also attended by friends and office staff, and involved no presentation regarding fentanyl spray.

346. During 2014 and 2015, as a direct part of executing the scheme, Insys paid Dr. Ahmad approximately $150,000.00 in kickbacks under the speaker program. In exchange, Ahmad wrote more than 1,450 fentanyl spray prescriptions while actively engaged in the scheme to defraud. During that same time, Ahmad is believed to have been the largest fentanyl spray prescriber in Arkansas, and one of the largest in the country.

c. Insys misled insurers for reimbursement.

347. Paying kickbacks to prescribing health care providers to incentivize writing fentanyl spray prescriptions for non-cancer patients was an important step in the Insys scheme. But unless someone agreed to pay for the fentanyl spray, Insys and Defendants knew the plan would fail.

348. Fentanyl spray is expensive and the only practical way that most patients could pay for the medication was through insurance—either private insurance, Medicare, or Medicaid. But insurers typically require prior authorization before they approve payment to the pharmacy. If the insurer or its agent denies authorization, most patients will request a more affordable alternative covered by insurance, and Insys loses profits. As a consequence, the pre-authorization screening process posed a significant hurdle to the Insys scheme to promote and sell fentanyl spray.

349. During 2012, insurers were regularly denying pre-authorization requests for fentanyl spray. In November 2012, for example, an internal Insys analysis showed that insurers were approving only about 30% of fentanyl spray pre-authorization requests. To address the

problem, Insys devised a plan to deceive insurers into granting pre-authorizations and thereby increase sales of fentanyl spray.

350. In January 2013, Insys launched what it described as the Insys Reimbursement Center (IRC). The IRC was a call-center at Insys corporate headquarters used to fraudulently obtain pre-authorizations for fentanyl spray prescriptions from insurers. The leader of the IRC was Elizabeth Gurrieri, an Insys employee, who was given the title of Manager of Reimbursement Services. In that role, she supervised and instructed the IRC employees until July 2016.

351. The employees working in the IRC were designated to receive significant financial incentives in the form of group and individual bonuses to boost the rate of pre-authorizations. They also received pressure from management, including Gurrieri, who according to one former company employee, told IRC employees to improve their rate of approvals because "Dr. Kapoor's (the company chairman) not happy, we have to get these approvals up."

352. The IRC employees used a number of nefarious, deceptive, and illegal techniques to meet the demands. For example, Insys directed members of its reimbursement unit to falsely represent that patients for whom they were seeking pre-authorization had cancer despite knowledge to the contrary. In fact, Insys employees were trained to answer questions from the insurers or their agents using a deceptive script, sometimes called "the spiel". When insurers asked, as part of the pre-authorization process, whether the patient suffered from breakthrough cancer pain, the Insys employee was told to say "[t]he physician is aware that the medication is intended for the management of breakthrough cancer patients. The physician is treating the patient for their pain (or breakthrough pain, whichever is applicable)."

353. The script deliberately omitted the word "cancer" in order to mislead the insurers and their agents. IRC employees were also taught to falsify the medical histories of patients,

fraudulently asserting that a patient had a cancer diagnosis when that was untrue and that fentanyl spray was being prescribed for a different diagnosis.

354. In addition, Insys concealed that the pre-authorization calls were coming from the company and not the prescriber's office. Ordinarily, insurers wanted to talk directly to their insured or the prescriber's office to collect necessary information. Knowing that fact, Insys employees hid outgoing phone numbers on caller ID and, if required to leave a phone number for a return call, provided an Insys 1-800 number rather than the prescribing physician's phone number. IRC employees were told to represent to insurers that they were calling from the doctor's office or "on behalf" of a doctor or with a doctor's office.

355. The IRC scheme for deceiving insurance companies to approve payment for fentanyl spray was extraordinarily successful. Within a few months, the approval for pre-authorization went from about 30% in November 2012, to 75% (according to a Board of Directors presentation in July 2013), to 100% (according to a Board of Directors presentation in November 2013).

356. The Insys Board of Directors knew that the company lacked the policies and monitoring procedures to prevent the IRC employees from manipulating the pre-authorization process. They were advised by outside consultants to prepare specific policies and operating procedures to prevent fraudulent and misleading communications by the IRC employees. But, the Board never did so. In June 2017, Elizabeth Gurrieri, the Insys employee who managed the IRC, pled guilty in federal court to conspiracy to commit wire fraud for her role in directing the deceptive and fraudulent conduct described above.

d. Linden Care aided and assisted in the scheme.

357. The Insys scheme to profit by marketing and promoting fentanyl spray included one other player: a pharmacy willing to dispense such large amounts of the medication and look

the other way. Linden Care, a New York pharmacy specializing in supplying opioids and pain medicine, was just the pharmacy. It turned a blind eye to what Insys was doing and shipped fentanyl spray to patients throughout the United States. Linden Care filled approximately 50% of the sales of fentanyl spray in the United States and most of the prescriptions written by Ahmad.

358. Linden Care was formed in New York in 2006 to provide concierge pharmacy services. It specialized in filling, dispensing, and shipping pain medications throughout the country via mail/commercial shipping services, most of which related to treatment of chronic disease and pain management. In essence, Linden Care was engaged in the practice of mail-order pharmacology, by and through its agents and employees, who were obligated to use professional skill, knowledge and care from their education, training and standards.

359. At all times relevant to the Complaint, Linden Care ignored and subverted its legal duties in dispensing fentanyl spray and was willfully blind and reckless in the manner in which it operated.

360. Defendants Insys, Linden Care, UPC, and Ahmad conducted a nationwide illegal scheme to market and sell one of the most potent and addicting opioids in the world, fentanyl spray under the brand name Subsys, which also directly targeted Arkansas citizens. Through kickbacks and bribes of doctors and other health care professionals, and other fraudulent means, Insys, Linden Care, UPC, and Ahmad collectively made hundreds of millions of dollars while exposing Plaintiffs' citizens to the drug's extraordinary risks, including addiction, abuse, and, in many cases, death.

K. Additional Arkansas Diversion Schemes Exposed by Operation Pilluted

1. The KJ Medical Clinic, Dr. Shawn Michael Brooks, Dr. Jerry Reifeiss, Bowman Curve, and Kristen Holland Opioid Diversion Scheme.

361. In May of 2015, federal authorities arrested Dr. Shawn Michael Brooks, Kristen Holland, and five others at KJ Medical Clinic, formerly Artex Medical Clinic, and Bowman Curve Pharmacy—both in Little Rock.[70]

362. A "'pill mill' where individuals obtained prescriptions for narcotic drugs without having legitimate need," KJ Medical Clinic had been the target of a coordinated investigation by the DEA and Arkansas law enforcement since July of 2014.[71] After his arrest, Dr. Brooks admitted to writing "illegitimate prescriptions" for at least 156,630 10mg hydrocodone pills during his tenure at KJ Medical Clinic.[72] Likewise, Dr. Jerry Reifeiss, now deceased, admitted to writing illegitimate prescriptions for 110,044 10mg hydrocodone pills at KJ Medical Clinic during just over a 3-month period.[73]

363. Beginning in November of 2014, KJ Medical Clinic staff directed recipients to fill their illegitimate prescriptions at Bowman Curve Pharmacy.[74] Of the 1,484 prescriptions filled at Bowman Curve between December 15, 2014 and March 6, 2015, only six did not originate from KJ Medical Clinic.[75]

[70] Department of Justice, *supra* note 47.
[71] Department of Justice, U.S. Attorney's Office, Eastern District of Arkansas, *140 Charged In Arkansas As Part of National Prescription Drug Initiative, available at* https://www.justice.gov/usao-edar/pr/140-charged-arkansas-part-national-prescription-drug-initiative (last visited Feb. 9, 2018).
[72] Linda Satter, Arkansas Democrat-Gazette, *Pill mill's doctor gets probation* (Apr. 1, 2017).
[73] Linda Satter, Northwest Arkansas Democrat-Gazette, *Conway doctor pleads guilty in prescription drug case* (Apr. 21, 2016).
[74] Department of Justice, *supra* note 55.
[75] Linda Satter, *supra* note 57.

364. Dr. Reifeiss pleaded guilty to one count of conspiracy to distribute hydrocodone without an effective prescription,[76] and Dr. Brooks and Holland pleaded guilty to misprision of a felony.[77] Dr. Brooks and Holland were sentenced to five and three years' probation, respectively.[78]

2. The Perry County Food & Drug and Christopher Watson Opioid Diversion Scheme.

365. Federal DEA authorities took Christopher Watson into custody in January of 2015 following a roughly six-month investigation into the opioid diversion scheme at Perry County Food & Drug pharmacy in Perryville.[79]

366. In November of 2014, DEA agents fabricated a hydrocodone and alprazolam prescription, and an undercover agent went to fill it at Perry County Food & Drug.[80] Watson acknowledged that the prescription was forged, gave the agent specific instructions on how to make it look legitimate, and filled it.[81] Further DEA investigation revealed that Watson "sold tens of thousands of Schedule II, III, and IV pills and other pharmaceuticals from the pharmacy shelves after hours and forged prescriptions to account for the missing pills, and filled fraudulent prescriptions presented by pharmacy customers."[82] Indeed, a pharmacy audit revealed that more than 49,000 oxycodone and more than 72,000 hydrocodone pills were missing after Watson's arrest.[83]

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[76] U.S. v. Reifeiss, No. 4:15-cr-00101-JM, Doc. 371 (E.D. Ark. Apr. 20, 2016).
[77] U.S. v. Brooks, No. 4:15-cr-00101-JM, Doc. 382 (E.D. Ark. May 10, 2016); U.S. v. Holland, No. 4:15-cr-00101-JM, Doc. 294 (E.D. Ark. Feb. 10, 2016).
[78] U.S. v. Brooks, No. 4:15-cr-00101-JM, Doc. 655 (E.D. Ark. Mar. 31, 2017); U.S. v. Holland, No. 4:15-cr-00101-JM, Doc. 474 (E.D. Ark. July 15, 2016).
[79] Department of Justice, U.S. Attorney's Office, Eastern District of Arkansas, *Perry County Pharmacist Arrested On Federal Drug Charge* (Jan. 28, 2015), *available at* https://www.justice.gov/usao-edar/pr/perry-county-pharmacist-arrested-federal-drug-charge (last visited Feb. 9, 2018).
[80] *Id.*
[81] *Id.*
[82] Department of Justice, U.S. Attorney's Office, Eastern District of Arkansas, *Perryville Pharmacist Sent to Prison for 10 Years, to Pay $850,000 for Role in Pill Scheme* (Sept. 27, 2017), *available at* https://www.justice.gov/usao-edar/pr/perryville-pharmacist-sent-prison-10-years-pay-850000-role-pill-scheme (last visited Feb. 9, 2018).
[83] *Id.*

367. McKesson was Perry County Food & Drug's wholesale supplier.[84] A pharmacist that had worked at Perry County Food & Drug for 26 years testified that McKesson was able to adequately supply opioids until Watson became involved at the pharmacy.[85] A pharmacy technician that worked at Perry County Food & Drug for roughly one year testified that, after Watson became involved, the pharmacy usually reached its controlled substances limit with McKesson on the ninth day of each month.[86] Unsurprisingly, she believed that "orders placed by [Perry County Food & Drug were] excessive in light of the number of prescriptions that [were] actually filled there."[87]

368. Watson pleaded guilty to conspiracy to distribute hydrocodone without an effective prescription, healthcare fraud, and structuring[88] and was sentenced to 120 months imprisonment.[89]

3. The Dr. Richard Duane Johns Opioid Diversion Scheme

369. In May of 2015, the Lonoke County Sheriff's Office took Dr. Johns into custody in connection with a long-standing oxycodone diversion enterprise, for which federal authorities indicted Dr. Johns and 18 others.[90]

370. The investigation into Dr. Johns originated under tragic circumstances: the overdose death of a 25-year-old man from oxycodone fraudulently prescribed by Dr. Johns.[91] The investigation revealed that Dr. Johns wrote at least 187 fraudulent oxycodone prescriptions, which

[84] Department of Justice, Drug Enforcement Administration, Perry County Food & Drug; Decision and Order, 80 Fed. Reg. 70083, at 70099.
[85] *Id.*
[86] *Id.*
[87] *Id.*
[88] U.S. v. Watson, No. 4:15-cr-00038-JM, Doc. 581 (E.D. Ark. Oct. 5, 2016).
[89] U.S. v. Watson, No. 4:15-cr-00038-JM, Doc. 809 (E.D. Ark. Sept. 28, 2017).
[90] Department of Justice, Drug Enforcement Administration, Eastern District of Arkansas, *Local Physician And 18 Others Charged in Federal Prescription Drug Distribution Indictment* (Sept. 2, 2015), *available at* https://www.justice.gov/usao-edar/pr/local-physician-and-18-others-charged-federal-prescription-drug-distribution-indictment (Feb. 9, 2018).
[91] *Id.*; Gwen Moritz, Arkansas Business, *One Bad Doctor: Richard Johns Pill Mill Scheme Leads to Death of One, Ensnares Dozens* (Mar. 13, 2017).

his co-conspirators filled and distributed on the street in Lonoke County alone during just a twelve-month period.[92] This amounted to approximately 16,830 oxycodone pills with a street value of $505,000.[93]

371. Dr. Johns' diversion enterprise extended also into Pulaski and White Counties, where Dr. Johns would write oxycodone prescriptions in individual's names—in many cases, having never examined or even met them—and selling them for $500 apiece.[94] Prescriptions were filled at local pharmacies, and oxycodone pills were sold on the street for $30 each.[95] All told, "Dr. Johns was responsible for illegally distributing at least 39,000 pills, with a street value of more than $1,000,000."[96]

372. Dr. Johns pleaded guilty to conspiracy to distribute and dispense Schedule II controlled substances without an effective prescription[97] and was sentenced to 108 months imprisonment.[98]

L. The Arkansas opioid diversion exposed by federal and state investigation is only the tip of the iceberg.

373. The specific examples discussed above represent only a sample of opioid diversion taking place throughout the State of Arkansas and Plaintiff Counties and Cities. Operation Pilluted, which exposed several Arkansas schemes, was the product of an "aggressive campaign" coordinated as a "national effort" between the DEA and law enforcement of four states.[99] Likewise,

[92] Department of Justice, *supra* note 74.
[93] *Id.*
[94] *Id.*
[95] *Id.*
[96] Department of Justice, Drug Enforcement Administration, Eastern District of Arkansas, *Physician Admits to Illegally Distributing 39,000 Pills, Pleads Guilty to Federal Conspiracy* (March 2, 2017), *available at* https://www.justice.gov/usao-edar/pr/physician-admits-illegally-distributing-39000-pills-pleads-guilty-federal-conspiracy (last visited Feb. 9, 2018).
[97] U.S. v. Johns, No. 4:15-cr-00224-BSM, Doc. 333 (E.D. Ark. Mar. 2, 2017).
[98] U.S. v. Johns, No. 4:15-cr-00224-BSM, Doc. 504 (E.D. Ark. Aug. 8, 2017).
[99] *See* Department of Justice, *supra* note 55.

Insys, Linden Care, UPC, and Ahmad were exposed by FBI investigation into their illegal fentanyl distribution and kickback scheme.[100] The sheer volume of opioid prescriptions per capita, supply per capita, overdoses, and criminal activity in Arkansas demonstrate that the exposed operations are only the tip of the iceberg. Discovery will reveal the massive scope of opioid diversion throughout this State.

VI. CAUSES OF ACTION

COUNT I
Negligence/Gross Negligence
(Against All Defendants)

374. The Plaintiffs re-allege and incorporate by reference all preceding paragraphs as if fully stated herein.

375. Defendants are all in the chain of manufacturing, distributing, and dispensing dangerous controlled substances.

376. Based upon the Defendants' (a) knowledge and foreseeability of the effects of their actions or inactions and (b) control over the chain of manufacturing and supply as detailed throughout this Complaint and identified further herein, Defendants owe a duty of reasonable care in the manufacture, distribution, dispensing, and prescribing of opioids.

377. Likewise, based upon the Defendants' (a) knowledge and foreseeability of the effects of their actions or inactions and (b) control over the chain of manufacturing and supply as detailed throughout this Complaint and identified further herein, Defendants owe a duty of care not to endanger public health, welfare, or safety.

[100] Department of Justice, U.S. Attorney's Office, District of Massachusetts, *Founder and Owner of Pharmaceutical Company Insys Arrested and Charged with Racketeering* (Oct. 26, 2017), *available at* https://www.justice.gov/usao-ma/pr/founder-and-owner-pharmaceutical-company-insys-arrested-and-charged-racketeering (last visited Feb. 9, 2018).

378. Knowledge, control, and reasonable care by these Defendants are evidenced by the Arkansas Controlled Substances Act ("CSA"), the Arkansas Uniform Narcotic Drug Act ("UNDA"), and their accompanying regulations promulgated by the Arkansas Department of Health.

379. Schedule II controlled substances have "high potential for abuse," which "may lead to severe psychic or physical dependence," despite having a currently accepted medical use. ARK. CODE ANN. § 5-64-205; ARK. ADMIN. CODE § 060.00.1-7.

380. Arkansas law restricts manufacturers' and distributors' ability to manufacture and distribute Schedule II controlled substances like opioids by, among other things, requiring them to register to manufacture or distribute opioids and maintain effective controls against diversion of the controlled substances that they manufacture or distribute.

381. Arkansas Department of Health regulations require practitioners—which include manufacturers, wholesalers, and retailers of controlled substances—to maintain effective controls against opioid diversion. ARK. ADMIN. CODE § 007.07.2-II-III.

382. Department of Health regulations also require physicians and retail pharmacies to ensure that opioid prescriptions are issued for legitimate medical purposes. ARK. ADMIN. CODE § 007.07.2-II-VIII. Prescriptions "issued to an addict or habitual user of controlled substances, not in the course of professional treatment but for the purpose of providing the user with controlled substances sufficient to keep him/her comfortable by maintaining his/her use, is not a prescription" under the regulations. *Id.* at § 007.07.2-II-VIIIB(2).

383. The Arkansas CSA, UNDA, and their accompanying regulations, exist to prevent public harm threatened by narcotic drugs, which by definition are "dangerous to the public health" and "promotive of addiction-forming or addiction-sustaining results upon the user that threaten

harm to the public health, safety, or morals[.]" ARK. CODE ANN. § 5-64-101(16)(A)(i). In failing to maintain effective controls against their diversion and illegitimate use, it is foreseeable that controlled substances will be prescribed for illegitimate purposes, diverted by corrupt retailers, and abused by the public that have fallen victim to their "high potential for abuse." ARK. CODE ANN. § 5-64-205. Likewise, it is foreseeable that states and counties, and cities, including Plaintiffs, will face extraordinary costs in responding to the ensuing epidemic in, *inter alia*, law enforcement, incarceration, court costs, medical treatment, blight, lost tax revenue, lost productivity, and other areas. Further, Defendants had actual knowledge of these types of activities and their effects.

384. In addition, the Arkansas UNDA imposes specific record-keeping requirements on manufacturers and wholesalers who are required to maintain detailed records of all inventory of narcotic drugs received by and disposed of by them. ARK. CODE ANN. § 20-64-209. The information required to be collected and maintained includes dates of production and distribution and contact information of the persons to whom or for whose use the drugs were sold, administered or dispensed. These requirements serve to prevent diversion and non-medical use of the Manufacturer and Distributor Defendants' products, as well as other controlled substances.

385. The Manufacturer Defendants and Distributor Defendants further owed Plaintiffs duties to be forthright and honest with Arkansas enforcement authorities regarding their products and to disclose the true risk of addiction associated with the use of opioids. The Manufacturer Defendants and Distributor Defendants had control over their own actions to ensure these requirements were performed by them. It is foreseeable that Plaintiffs would be injured by the failure of the Defendants to perform these duties, and these Defendants had actual knowledge that the failure of these duties was causing harm to states, counties, and municipalities like Plaintiffs.

The Retail Defendants further owed Plaintiffs a duty to refrain from, and enact policies to prevent, filling opioid prescriptions that would be deemed questionable or suspicious by a reasonably prudent pharmacist; a duty to train and supervise their employees at the point of sale to investigate or report suspicious or invalid prescriptions; a duty to check the state prescription monitoring program before dispensing prescriptions; and a duty to protect against corruption or theft by their employees or agents. The Retail Defendants had control over their own actions to ensure these requirements were performed by them. It is foreseeable that Plaintiffs would be injured by the failure of the Defendants to perform these duties, and these Defendants had actual knowledge that the failure of these duties was causing harm to states, counties, and municipalities like Plaintiffs.

386. The Physician Defendants further owed Plaintiffs a duty to, at the very least, refrain from prescribing or dispensing opioids for the purpose of maintaining patients' addiction or diversion to the illicit market.

387. Defendants' conduct fell below the reasonable standard of care. Their negligent acts include:

a. consciously oversupplying the market throughout the State with highly-addictive prescription opioids;

b. using unsafe distribution and dispensing practices;

c. disregarding the Arkansas statutes and regulations for safe dispensing;

d. affirmatively enhancing the risk of harm from prescription opioids by failing to act as a last line of defense against diversion;

e. inviting and enabling criminal activity in the State, counties, and cities by disregarding precautionary measures built into Arkansas law;

f. failing to properly train or investigate their employees;

g. failing to properly review controlled substance orders for red flags;

h. failing to establish effective controls to combat diversion of opioids;

i. failing to police the integrity of their supply chains;

j. knowingly writing illegitimate opioid prescriptions to feed addiction; and

k. knowingly writing illegitimate opioid prescriptions for diversion to the illicit market.

388. Each Defendant had an ability to control the opioids at a time when it knew or should have known it was passing control of the opioids to an actor further down in the supply chain that was incompetent or acting illegally and should not be entrusted with the opioids.

389. Each Defendant sold opioids in the supply chain knowing both that (1) there was a substantial likelihood many of the sales were for non-medical purposes, and (2) opioids are an inherently dangerous product when used for non-medical purposes.

390. Defendants were negligent or reckless in not acquiring and utilizing special knowledge and special skills that relate to the dangerous activity in order to prevent or ameliorate such distinctive and significant dangers.

391. Controlled substances are dangerous commodities. Defendants breached their duty to exercise the degree of care, prudence, watchfulness, and vigilance commensurate to the dangers involved in the transaction of their business.

392. Defendants were also negligent or reckless in failing to guard against foreseeable third-party misconduct, e.g., the foreseeable conduct of: corrupt prescribers, corrupt pharmacists and staff, and/or criminals who buy and sell opioids for non-medical purposes.

393. Defendants are in a limited class of registrants authorized to legally manufacture and distribute controlled substances. Likewise, Defendants are in exclusive control of the management of the opioids they distributed to retail stores throughout Arkansas. This places Defendants in a position of great trust and responsibility vis-à-vis the Plaintiffs. Defendants owe a special duty to the Plaintiffs; the duty owed cannot be delegated to another party.

394. The Plaintiffs are without fault, and their injuries and those of their citizens would not have happened in the ordinary course of events had the Defendants used due care commensurate to the dangers involved in the distribution and dispensing of controlled substances.

395. The aforementioned conduct of Defendants foreseeably and proximately caused damage to the Plaintiffs, which have suffered an unprecedented epidemic of opioid addiction and overdose.

396. As a result of the epidemic, the Plaintiffs have shouldered tremendous costs that are not derivative of third-party injuries. Plaintiffs' damages include, but are not limited to, increased emergency response costs, law enforcement costs, incarceration costs, court administration costs, addiction treatment costs, and medical costs caused by Defendants' conduct in creating and exacerbating the opioid epidemic. High levels of sustained opioid drug abuse, also created or accelerated economic blight in some portion of the State of Arkansas and Plaintiff Counties and Cities, resulting in diminished property values and a loss in tax revenue. The Plaintiffs have also suffered a loss of productivity in their workforces.

397. The opioid epidemic has caused the Plaintiffs to suffer past, present, and future damages in the form of the increased expenses in providing public services that so far exceed the normal, expected costs that they are distinct from and unrelated to the normal provision of public services. Defendants' conduct was extraordinary, unexpected, and rare, and is a repeated course of conduct that did, does, and will continue to result in recurring costs to the Plaintiffs. The magnitude of the acts of the Defendants were neither discrete nor of a sort that a state, county, or municipality, including the Plaintiffs, could reasonably expect to have to respond to at any time during their existence as such. It would be unreasonable, wrong, and inequitable not to allocate these additional governmental expenses, and any other costs associated with the harms

Defendants' wrongful conduct has caused, to the very parties responsible for creating the need for such extraordinary resources to be expended in the manner they were—and will be—in responding to the opioid epidemic.

398. As a direct result of Defendants' grossly negligent, willful, wanton, reckless, malicious, and/or intentional conduct, Plaintiffs have suffered actual injury entitling them to an award of all compensatory damages incurred in the past and likely to occur in the future, and punitive damages.

COUNT II
Common Law Public Nuisance
(Against All Defendants)

399. The Plaintiffs re-allege and incorporate by reference all preceding paragraphs as if fully stated herein.

400. The nuisance is the over-saturation of opioids in the Plaintiffs' cities and counties for non-medical purposes, the adverse social and environmental outcomes associated with widespread illegal opioid use, and the attendant endangerment of public health, welfare, and safety.

401. All Defendants substantially participated in and/or aided and abetted activities that caused the nuisance.

402. Defendants caused the nuisance by selling or facilitating the sale of prescription opioids from premises in and around the Plaintiffs' cities and counties to unintended users—including children, people at risk of overdose or suicide, and criminals.

403. Defendants also caused the nuisance by failing to implement effective controls and procedures in their supply chain to guard against theft, diversion, and misuse of controlled substances.

404. The Defendants had actual knowledge that the conditions created by their actions and inactions as described herein would in fact and did result in harm to the Plaintiffs.

405. The Defendants were driven by profits and had the intent to over-saturate the market with opioids and cause addiction in order to boost sales.

406. The Defendants were further aware and complicit in their knowledge that their failure to follow state law would remove them from any regulated scheme of commerce of opioids.

407. Defendants' activities unreasonably interfere with the following common rights of the public, including the Plaintiffs' citizens:

a. to be free from reasonable apprehension of danger to person and property;

b. to be free from the spread of disease within the community including the disease of addiction and other diseases associated with widespread illegal opioid use;

c. to be free from negative health and safety effects of widespread illegal drug sales on premises in and around the State of Arkansas and Plaintiff Counties and Cities;

d. to be free from blights on the community created by areas of illegal drug use and opioid sales;

e. to live or work in a community in which local businesses do not profit from using their premises to sell products that serve the criminal element and foster a secondary market of illegal transactions; and,

f. to live or work in a community in which community members are not under the influence of narcotics unless they have a legitimate medical need to use them.

408. The Defendants' interference with these public rights is unreasonable because it:

a. has harmed and will continue to harm the public health, safety, and welfare of the Plaintiffs' citizens;

b. has harmed and will continue to harm Plaintiffs' neighborhoods and communities by increasing the levels of vagrancy and property crime, and thereby interfering with the rights of the community at large;

c. is proscribed by Arkansas statutes, including the Arkansas Controlled Substances Act and Uniform Narcotic Drug Act;

d. is proscribed by Arkansas regulations, including those of the Department of Health and the Pharmacy Board; and

e. is of a continuing nature, and will produce long-lasting effects.

409. The nuisance undermines the Plaintiffs' citizens' public health, safety, and welfare. It has resulted in increased crime and property damage within the Plaintiffs' cities and counties. It has resulted in high rates of addiction, overdoses, dysfunction, and despair within the Plaintiffs' families and entire communities, which threatens the fabric of the Plaintiffs' society.

410. Public resources are being unreasonably consumed in efforts to address the prescription drug abuse epidemic, thereby eliminating available resources which could be used to benefit the Plaintiffs' public at large.

411. Defendants' nuisance-causing activities are not outweighed by the utility of Defendants' behavior. In fact, their behavior is illegal and has no social utility whatsoever. There is no legitimately-recognized societal interest in deceptively marketing opioids, misrepresenting the risks and benefits of opioids, or failing to maintain effective controls against opioid diversion.

412. At all times, all Defendants possessed the right and ability to control the nuisance-causing outflow of opioids from pharmacy locations or other points of sale into the Plaintiffs' cities and counties.

413. As a direct and proximate result of the nuisance, the Plaintiffs' citizens have suffered in their ability to enjoy the rights of the public.

414. As a direct and proximate result of the nuisance, the Plaintiffs have sustained economic harm by spending a substantial amount of money trying to fix the societal harms caused by Defendants' nuisance-causing activity, including, but not limited to, costs of hospital services, healthcare, child services, rehabilitation services, prisons and jails, courts, and law enforcement.

415. The Plaintiffs have also suffered unique harms of a kind that is different from the Plaintiffs' citizens at large, namely, that the Plaintiffs have been harmed in each's proprietary interests.

416. The effects of the nuisance can be abated, and the further occurrence of such harm and inconvenience can be prevented. All Defendants share in the responsibility for doing so.

417. As a direct result of Defendants' grossly negligent, willful, wanton, reckless, malicious, and/or intentional conduct, Plaintiffs have suffered actual injury entitling them to an award of all compensatory damages incurred in the past and likely to occur in the future, and punitive damages.

418. Defendants should be required to pay the expenses the Plaintiffs have incurred or will incur in the future to fully abate the nuisance, as well as punitive damages.

COUNT III
Violations of the Arkansas Uniform Narcotic Drug Act,
ARK. CODE ANN. §§ 20-64-101, *et seq*.:
Civil Action by Crime Victim, ARK. CODE ANN. § 16-118-107
(Against All Defendants)

419. The Plaintiffs re-allege and incorporate by reference all preceding paragraphs as if fully stated herein.

420. ARK. CODE ANN. § 16-118-107 provides that "[a]ny person injured or damaged by reason of conduct of another person that would constitute a felony under Arkansas law may file a civil action to recover damages based on the conduct."

421. The Arkansas Uniform Narcotic Drug Act ("UNDA") states, "It shall be unlawful for any person to manufacture, purchase, possess, have under his control, sell, prescribe, administer, dispense, or compound any narcotic drug, *except as authorized by this subchapter*." ARK. CODE ANN. § 20-64-202 (emphasis added).

422. "Narcotic drug[s]" are those that are "promotive of addiction-forming or addiction-sustaining results upon the user which threaten harm to the public health, safety, or morals . . . whether produced directly or indirectly by extraction from substances of vegetable origin or

independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis." ARK. CODE ANN. § 20-64-201(8).

423. Any violation of the UNDA constitutes a felony. ARK. CODE ANN. § 20-64-220.

424. The UNDA empowers the Arkansas Department of Health to "promulgate regulations for the efficient enforcement of th[e] act. . . ." ARK. CODE ANN. § 20-64-419. The Department has done so in its regulations under Division 7, Rule 2. *See* ARK. ADMIN. CODE §§ 007.07.2-I-I.

425. Under authority of the UNDA, the Department mandates that "[a]ll Practitioners shall provide effective controls and procedures to guard against theft and diversion of controlled substances." ARK. ADMIN. CODE § 007.07.2-II-III. "Practitioners" include physicians, pharmacies, manufacturers, wholesalers, and distributers—i.e., all Defendants. *Id.* § 007.07.2-II-I.

426. Department of Health regulations further mandate that opioid prescriptions issue only for legitimate medical purposes. ARK. ADMIN. CODE § 007.07.2-II-VIIIB(1). Any physician or pharmacist who knowingly prescribes or dispenses a controlled substance for illegitimate purposes—that is, to "an addict or habitual user" to "keep him/her comfortable by maintaining his/her customary use"—commits a felony. *Id.* § 007.07.2-II-VIIIB(2).

427. As described throughout this Complaint, Defendants have violated the UNDA by, *inter alia*:

a. consciously oversupplying the market throughout Arkansas with highly-addictive prescription opioids;

b. using unsafe distribution and dispensing practices;

c. disregarding statutory and regulatory rules for safe distributing and dispensing;

d. affirmatively enhancing the risk of harm from prescription opioids by failing to act as a last line of defense against diversion;

e. inviting and enabling criminal activity in the State, counties, and cities by disregarding precautionary measures built into Arkansas law;

f. failing to properly train or investigate their employees;

g. failing to properly review controlled substance orders for red flags;

h. failing to establish effective controls to combat diversion of opioids;

i. failing to police the integrity of their supply chains;

j. knowingly prescribing opioids for illegitimate purposes; and

k. knowingly dispensing opioids for illegitimate purposes.

428. As a direct result of the Defendants' negligent, grossly negligent, knowing, willful, wanton, reckless, and/or intentional violations of the UNDA, the Plaintiffs have suffered actual injury entitling them to an award of all compensatory damages incurred in the past and likely to occur in the future, and punitive damages.

COUNT IV
Accomplice to Violations of the Arkansas Uniform Narcotic Drug Act,
ARK. CODE ANN. §§ 5-2-403; 20-64-101, *et seq.*:
Civil Action by Crime Victim, ARK. CODE ANN. § 16-118-107
(Against All Defendants)

429. The Plaintiffs re-allege and incorporate by reference all preceding paragraphs as if fully stated herein.

430. ARK. CODE ANN. § 16-118-107 provides that "[a]ny person injured or damaged by reason of conduct of another person that would constitute a felony under Arkansas law may file a civil action to recover damages based on the conduct."

431. ARK. CODE ANN. § 5-2-403(a) provides that "[a] person is an accomplice of another person in the commission of an offense if, with the purpose of promoting or facilitating the commission of an offense, the person: (1) [s]olicits, advises, encourages, or coerces the other person to commit the offense; (2) [a]ids, agrees to aid, or attempts to aid the other person in

planning or committing the offense; or (3) [h]aving a legal duty to prevent the commission of the offense, fails to make a proper effort to prevent the commission of the offense."

432. As set out above, Defendants manufactured, distributed, dispensed, and prescribed opioids in violation of the Arkansas UNDA and accompanying Arkansas Department of Health regulations. Defendants' unauthorized manufacture, distribution, dispensing, and prescribing constitute felonies under the UNDA.

433. To maximize profits, Defendants manufactured, encouraged excessive prescriptions, distributed, and dispensed as many highly-addictive, and often deadly, pills as possible. To that end, Defendants transferred pills through the supply chain, from the manufacturer to the end user, and without regard for state law requiring them to take affirmative steps to prevent the diversion of drugs into the illegal marketplace or for other illegitimate purposes.

434. The Manufacturer Defendants continuously supplied opioids to Distributor Defendants despite knowing that Distributor Defendants were habitually violating state law, despite knowing of widespread opioid diversion and abuse, and despite Manufacturer Defendants' duty to prevent diversion. The Distributor Defendants, in turn, continuously supplied opioids to Retail Defendants, despite Distributor Defendants' knowledge that the Retail Defendants were habitually violating state law in dispensing opioids, despite knowing of widespread opioid diversion and abuse, and despite Distributor Defendants' duty to prevent diversion.

435. The Retail Defendants and other retail stores continuously paid the Distributor Defendants to supply large quantities of prescription opioids and continuously dispensed them in order to satisfy demand for the drugs, despite knowing of their illegitimate or, at best, suspicious nature, despite knowing that Manufacturer Defendants and Distributor Defendants were habitually violating state law, and despite Retail Defendants' duty to prevent diversion.

436. Thus, Defendants actively aided in, agreed to aid in, and failed to prevent each other and other manufacturers, distributors, retail stores, and physicians from habitually violating the Arkansas UNDA and Department of Health regulations, and Defendants failed to prevent each other from engaging in or aiding others' opioid diversion, despite Defendants' duty to do so.

437. As a direct result of the Defendants' knowing, willful, wanton, reckless, and/or intentional conduct, the Plaintiffs have suffered actual injury entitling them to an award of all compensatory damages incurred in the past and likely to occur in the future, and punitive damages.

COUNT V
Civil Conspiracy to Violate the Arkansas Uniform Narcotic Drug Act
(Against All Defendants)

438. The Plaintiffs re-allege and incorporate by reference all preceding paragraphs as if fully stated herein.

439. The Defendants, along with other manufacturers, wholesale distributors, retail stores, and physicians, agreed to continuously oversupply prescription opioids without regard for the drug's end use and without regard for the UNDA requiring them to guard against opioid diversion.

440. Disregarding their statutory and regulatory duties to guard against diversion, Defendants are not concerned with consumers' opioid use after sale. Consumers may ingest the opioids for purportedly legitimate medical purposes, such as to treat severe acute or chronic pain; they may abuse the opioids personally by ingesting them for recreational purposes or to feed a drug addiction; or they may give or sell them to a third party abuser who ingests them recreationally or to feed an addiction.

441. The Defendants' goal was to maximize their profits at all costs—to manufacture, encourage excessive prescriptions, distribute, and sell as many highly addictive, and often deadly, pills as possible. The Defendants accomplished this by transferring pills through the supply chain,

from the manufacturer to the end user, and without regard for the UNDA requiring them to take affirmative steps to prevent the diversion of drugs into the illegal marketplace or other illegitimate purposes.

442. The Manufacturer Defendants continuously supplied opioids to Distributor Defendants and other wholesale distributors despite knowing that the Distributor Defendants and other wholesale distributors were habitually breaching their common law duties and violating state law. The Distributor Defendants, in turn, continuously supplied opioids to Retail Defendants and other retail stores, despite the Manufacturer Defendants' and Distributor Defendants' knowledge that the Retail Defendants and other retail stores were habitually breaching their common law duties and violating state law in dispensing opioids.

443. Without the Defendants' supply of opioids, the Retail Defendants and other retail stores would not be able to fill and dispense the increasing number of prescription opioids throughout the Plaintiffs' cities and counties.

444. The Retail Defendants and other retail stores continuously paid the Distributor Defendants to supply large quantities of prescription opioids and continuously dispensed them in order to satisfy demand for the drugs, regardless of their suspicious nature.

445. To achieve their goal, these Defendants systematically violated their statutory duties to maintain effective controls against opioid diversion for illegitimate purposes.

446. Defendants knew that opioid diversion would endanger public health, welfare, or safety.

447. As a direct result of the Defendants' knowing, willful, wanton, reckless, and/or intentional concerted action, the Plaintiffs have suffered actual injury entitling them to an award

of all compensatory damages incurred in the past and likely to occur in the future, and punitive damages.

COUNT VI
Possessing, Delivering, Manufacturing, and Trafficking Controlled Substances in Violation of the Arkansas Controlled Substances Act, ARK. CODE ANN. §§ 5-64-419, 5-64-424, 5-64-426, 5-64-427, and 5-64-440: Civil Action by Crime Victim, ARK. CODE ANN. § 16-118-107 (Against All Defendants)

448. The Plaintiffs re-allege and incorporate by reference all preceding paragraphs as if fully stated herein.

449. ARK. CODE ANN. § 16-118-107 provides that "[a]ny person injured or damaged by reason of conduct of another person that would constitute a felony under Arkansas law may file a civil action to recover damages based on the conduct."

450. The Arkansas CSA directs the Arkansas Department of Health to classify certain substances that have "high potential for abuse" and "may lead to severe psychic or physical dependence" as Schedule II controlled substances. ARK. CODE ANN. § 5-64-205. Schedule II controlled substances include codeine, hydrocodone, hydromorphone, morphine, oxycodone, oxymorphone, tapentadol, dihydrocodeine, fentanyl, methadone, and pethidine (meperidine). ARK. ADMIN. CODE § 007.02.2.

451. As discussed more fully above, the Arkansas CSA and accompanying Department of Health regulations permit the Manufacturer Defendants, Distributor Defendants, and Retail Defendants to manufacture, distribute, and dispense controlled substances within Arkansas subject to their compliance with the Arkansas CSA and Department of Health regulations. Outside the bounds set by state law, possessing, delivering, manufacturing, and trafficking in controlled substances is unlawful.

452. ARK. CODE ANN. § 5-64-419 provides that, except as authorized by the Arkansas CSA, it is unlawful to possess a Schedule II controlled substance. Such possession is a felony. *Id*.

453. ARK. CODE ANN. § 5-64-424 provides that, except as authorized by the Arkansas CSA, it is unlawful to possess a Schedule II controlled substance with purpose to deliver. Such possession with purpose to deliver is a felony. *Id*.

454. ARK. CODE ANN. § 5-64-426 provides that, except as authorized by the Arkansas CSA, it is unlawful to deliver a Schedule II controlled substance. Such delivery is a felony. *Id*.

455. ARK. CODE ANN. § 5-64-427 provides that, except as authorized by the Arkansas CSA, it is unlawful to manufacture a Schedule II controlled substance. Such manufacture is a felony. *Id*.

456. ARK. CODE ANN. § 5-64-440 provides that, except as authorized by the Arkansas CSA, it is unlawful to traffic a Schedule II controlled substance. Such trafficking is a felony. *Id*.

457. As discussed above, the Manufacturer Defendants, Distributor Defendants, and Retail Defendants unlawfully possessed, delivered, manufactured, and trafficked controlled substances in Arkansas while knowingly ignoring their statutory and regulatory duties to, *inter alia*, maintain effective controls against opioid diversion.

458. As a direct result of the Defendants' negligent, grossly negligent, knowing, willful, wanton, reckless, and/or intentional violations of the CSA, the Plaintiffs have suffered actual injury entitling them to an award of all compensatory damages incurred in the past and likely to occur in the future, and punitive damages.

COUNT VII
Accomplice to Violations of the Arkansas Controlled Substances Act,
ARK. CODE ANN. §§ 5-64-419, 5-64-424, 5-64-426, 5-64-427, and 5-64-440:
Civil Action by Crime Victim, ARK. CODE ANN. § 16-118-107
(Against All Defendants)

459. The Plaintiffs re-allege and incorporate by reference all preceding paragraphs as if fully stated herein.

460. ARK. CODE ANN. § 16-118-107 provides that "[a]ny person injured or damaged by reason of conduct of another person that would constitute a felony under Arkansas law may file a civil action to recover damages based on the conduct."

461. ARK. CODE ANN. § 5-2-403(a) provides that "[a] person is an accomplice of another person in the commission of an offense if, with the purpose of promoting or facilitating the commission of an offense, the person: (1) [s]olicits, advises, encourages, or coerces the other person to commit the offense; (2) [a]ids, agrees to aid, or attempts to aid the other person in planning or committing the offense; or (3) [h]aving a legal duty to prevent the commission of the offense, fails to make a proper effort to prevent the commission of the offense."

462. As set out above, Defendants unlawfully manufactured, possessed, delivered, and trafficked prescription opioids in violation of the Arkansas CSA and accompanying Department of Health regulations. Defendants' manufacture, possession, delivery, and trafficking constitute felonies under Arkansas law.

463. To maximize profits, Defendants manufactured, encouraged excessive prescriptions, distributed, and dispensed as many highly-addictive, and often deadly, pills as possible. To that end, Defendants transferred pills through the supply chain, from the manufacturer to the end user, and without regard for state law requiring them to take affirmative steps to prevent the diversion of drugs into the illegal marketplace or for other illegitimate purposes.

464. The Manufacturer Defendants continuously supplied opioids to Distributor Defendants despite knowing that Distributor Defendants were habitually violating state law, despite knowing of widespread opioid diversion and abuse, and despite Manufacturer Defendants'

duty to prevent diversion. The Distributor Defendants, in turn, continuously supplied opioids to Retail Defendants and other retail stores, despite Distributor Defendants' knowledge that the Retail Defendants and other retail stores were habitually violating state law in dispensing opioids, despite knowing of widespread opioid diversion and abuse, and despite Distributor Defendants' duty to prevent diversion.

465. The Retail Defendants and other retail stores continuously paid the Distributor Defendants to supply large quantities of prescription opioids and continuously dispensed them in order to satisfy demand for the drugs, despite knowing of their illegitimate or, at best, suspicious nature, despite knowing that Manufacturer Defendants and Distributor Defendants were habitually violating state law, and despite Retail Defendants' duty to prevent diversion.

466. Thus, Defendants actively aided in, agreed to aid in, and failed to prevent each other and other manufacturers, distributors, retail stores, and physicians from habitually violating the Arkansas CSA and Department of Health regulations, and Defendants failed to prevent each other from engaging in or aiding others' opioid diversion, despite Defendants' duty to do so.

467. As a direct result of the Defendants' knowing, willful, wanton, reckless, and/or intentional conduct, the Plaintiffs have suffered actual injury entitling them to an award of all compensatory damages incurred in the past and likely to occur in the future, and punitive damages.

COUNT VIII
Civil Conspiracy to Violate the Arkansas Controlled Substances Act
(Against All Defendants)

468. The Plaintiffs re-allege and incorporate by reference all preceding paragraphs as if fully stated herein.

469. The Defendants, along with other wholesale distributors, retail stores, and physicians, agreed to continuously oversupply prescription opioids without regard for the drugs' end use and without regard for state law requiring them to guard against opioid diversion.

470. Disregarding their statutory and regulatory duties to guard against diversion, Defendants are not concerned with consumers' opioid use after sale. Consumers may ingest the opioids for purportedly legitimate medical purposes, such as to treat severe acute or chronic pain; they may abuse the opioids personally by ingesting them for recreational purposes or to feed a drug addiction; or they may give or sell them to a third party abuser who ingests them recreationally or to feed an addiction.

471. The Defendants' goal was to maximize their profits at all costs—to manufacture, encourage excessive prescriptions, distribute, and sell as many highly addictive, and often deadly, pills as possible. The Defendants accomplished this by transferring pills through the supply chain, from the manufacturer to the end user, and without regard for state law requiring them to take affirmative steps to prevent the diversion of drugs into the illegal marketplace or for other illegitimate purposes.

472. The Manufacturer Defendants continuously supplied opioids to Distributor Defendants and other wholesale distributors despite knowing that the Distributor Defendants and other wholesale distributors were habitually breaching their common law duties and violating state law. The Distributor Defendants, in turn, continuously supplied opioids to Retail Defendants and other retail stores, despite the Manufacturer Defendants' and Distributor Defendants' knowledge that the Retail Defendants and other retail stores were habitually breaching their common law duties and violating state law in dispensing opioids.

473. Without the Defendants' supply of opioids, the Retail Defendants and other retail stores would not be able to fill and dispense the increasing number of prescription opioids throughout the Plaintiffs' cities and counties.

474. The Retail Defendants and other retail stores continuously paid the Distributor Defendants to supply large quantities of prescription opioids and continuously dispensed them in order to satisfy demand for the drugs, regardless of their suspicious nature.

475. To achieve their goal, these Defendants systematically violated their statutory and regulatory duties to, *inter alia*, maintain effective controls against opioid diversion.

476. Defendants knew that opioid diversion would endanger public health, welfare, or safety.

477. As a direct result of the knowing, willful, wanton, reckless, and/or intentional concerted action between the Defendants, the Plaintiffs have suffered actual injury entitling them to an award of all compensatory damages incurred in the past and likely to occur in the future, and punitive damages.

COUNT IX
Violations of the Arkansas Drug Dealer Liability Act,
ARK. CODE ANN. §§ 16-124-101, *et seq.*
(Against All Defendants)

478. The Plaintiffs re-allege and incorporate by reference all preceding paragraphs as if fully stated herein.

479. The Arkansas Drug Dealer Liability Act ("DDLA") provides a civil remedy "for damages caused by use of an illegal drug by an individual." ARK. CODE ANN. § 16-124-104(a).

480. An "illegal drug" is any "drug whose distribution is a violation of the Uniform Controlled Substances Act." ARK. CODE ANN. § 16-124-102(1). Thus, opioids that Defendants' manufactured, possessed, delivered, trafficked, dispensed, or prescribed in violation of the Arkansas CSA and accompanying Department of Health regulations constitute "illegal drugs" under the DDLA.

481. The DDLA's remedies extend to "a medical facility, insurer, governmental entity, employer, or other entity that funds a drug treatment program or employee assistance program for the individual drug user, or that otherwise expended money on behalf of the individual drug user." ARK. CODE ANN. § 16-124-104(a)(4).

482. Plaintiffs are governmental entities that fund drug treatment programs or have otherwise expended, and will continue to expend, money on behalf of illegal drug users. Indeed, prescription opioid diversion and the corresponding increase in abuse, addiction, and criminal activity has placed an **insurmountable demand** on County and City resources to meet the medical, public health, jail and prison, court, and law enforcement needs of their communities.

483. Under the DDLA, any "person who knowingly participates in the illegal drug market is liable for civil damages," ARK. CODE ANN. § 16-124-103(b), and the "illegal drug market" extends "from production to retail sales." *Id*. § 16-124-102(2).

484. The DDLA imposes liability on those who directly participate in the distribution of an illegal drug that causes damage. This includes any "person who knowingly distributed, or knowingly participated in the chain of distribution of, an illegal drug that was actually used by the individual drug user." ARK. CODE ANN. § 16-124-104(b)(1).

485. It also imposes market liability on those who participate in the illegal drug distribution in the area where the illegal drug causes damage. This includes any "person who knowingly participated in the illegal drug market if: (A) [t]he place of the illegal drug activity by the individual drug user is within the illegal drug market target community of the defendant; (B) [t]he participation of the defendant in the illegal drug market was connected with the same type of illegal drug used by the individual drug user; and (C) [t]he defendant participated in the illegal

drug market at any time during the illegal drug use of the individual drug user." ARK. CODE ANN. § 16-124-104(b)(2).

486. An individual drug user is "the individual whose illegal drug use is the basis of an action brought under" the DDLA. ARK. CODE ANN. § 16-124-102(4). Plaintiffs' residents who purchased or used Schedule II prescription opioids without valid and/or effective prescriptions are "individual drug users" under the DDLA.

487. Defendants knowingly participated in the manufacture, distribution, and dispensing of prescription opioids that reached the Plaintiffs during all times relevant to this Complaint. Defendants' "illegal drug market target community" is the entire State of Arkansas, because Defendants participated in the illegal drug market by distributing four or more ounces of "specified illegal drug[s]," that is, Schedule II controlled substances. ARK. CODE ANN. §§ 16-124-102(5), (14); 16-124-109(4).

488. The Manufacturer Defendants and Distributor Defendants knowingly failed to implement effective controls and procedures in their supply chains to guard against theft, diversion, and abuse of prescription opioids in violation of the Arkansas CSA and Department of Health regulations.

489. As a result, the Manufacturer Defendants and Distributor Defendants knowingly supplied massive quantities of prescription opioids to suspect physicians and pharmacies and into the illicit market, including diversion enterprises such as KJ Medical Clinic, Dr. Brooks, Dr. Reifeiss, and Bowman Curve Pharmacy; Perry County Food & Drug; Dr. Ahmad, UPC, and Linden Care; Dr. Johns; and other diversion operations.

490. The Manufacturer Defendants and Distributor Defendants knowingly enabled and/or failed to prevent the illegal diversion of prescription opioids into the illicit market, including

diversion enterprises such as KJ Medical Clinic and Bowman Curve Pharmacy; Perry County Food & Drug; Dr. Ahmad, UPC, and Linden Care; Dr. Johns; and other diversion operations, knowing that such opioids would be illegally diverted and abused.

491. As a direct result of Defendants' knowing and/or intentional conduct, the Plaintiffs have suffered actual injury entitling them to an award of all damages available under the DDLA that they have incurred in the past and are likely to incur in the future, including punitive damages.

VII. JOINT AND SEVERAL LIABILITY

492. This case arises from a nationwide effort among opioid manufacturers to first manipulate public and professional perception of opioids—even then (and for a century or more before then) commonly known as dangerous and highly-addictive. Once they achieved this shift in longstanding public and professional disposition, the same manufacturers then acted in concert with wholesale distributors and retail stores to continuously saturate the market with these drugs to make colossal profits, even in the wake of known widespread abuse, addiction, overdose, death, and criminal activity.

493. *At a minimum*, all Defendants knowingly aided and abetted even the worst conduct of the most culpable Defendants and profited from their illegal conduct at the expense of the Plaintiffs and their citizens.

494. Defendants acted in concert, and in doing so, are jointly and severally liable to Plaintiffs for the claims at issue in this Complaint.

PRAYER FOR RELIEF

Despite the best efforts of the State, Counties, and Cities, through an allocation of all available resources, the Arkansas Opioid Epidemic continues to infect Arkansas. Absent the relief sought in this action, the resources of the State, Counties, and Cities will continue to be inadequate to respond to the epidemic.

WHEREFORE, Plaintiffs respectfully pray:

A. That Plaintiffs recover all measures of damages allowable, and that judgment be entered against Defendants in favor of Plaintiffs and for those damages to include, but not be limited to:

1. Past damages and restitution for monies spent by the State, Counties, and Cities for those extraordinary and additional services provided which they would not have otherwise incurred but as a result of the Arkansas Opioid Epidemic and their past efforts to abate it.

2. Prospective damages so that the State, Counties, and Cities can **comprehensively intervene in the Arkansas Opioid Epidemic**:

    a. to **prevent opioid use, injury, and death** through, *inter alia*, the purchase of naloxone kits for drug users, first responders, jailers, hospitals, schools, public buildings, and other appropriate recipients; and requisite training in the identification of overdose and proper naloxone administration;

    b. to **treat, cure, and prevent opioid misuse and addiction** through, *inter alia*, the creation of mental health clinics, opioid abuse treatment clinics, programs to increase public awareness of opioid addiction, programs to remove barriers to treatment and insurance coverage, and programs to increase physician awareness of opioid addiction and to correct misinformation disseminated by Defendants directly or through KOLs, Front Groups, and other third parties; connecting Arkansas citizens to effective treatment, including medication-assisted treatment and telemedicine; and creating and disseminating educational materials for elementary schools, high schools, vocational schools, colleges and universities;

    c. to **reduce the supply of dangerous opioids** through, *inter alia*, testing and information-sharing so that law enforcement can better understand the Arkansas Opioid Epidemic; creating overdose response teams; hiring and training of additional patrol officers and detectives, hiring and training of additional lab personnel, and hiring and training of additional personnel to optimize the Arkansas Prescription Monitoring Program; expanding efforts to provide clear guidance on safe disposal of prescription opioids; expanding take-back programs; creating linked and shared public health, healthcare, and criminal justice data related to the Arkansas Opioid Epidemic; and

    d. To **reduce crime and involuntary commitments associated with opioid addiction** through, *inter alia*, creating and expanding drug and mental health courts in the Arkansas judicial system; crisis stabilization units;

treatment options in jails and prisons; training of law enforcement, first responders, jailers, and other regarding crisis intervention and diversion; and prisoner re-entry programs;

B. That Plaintiffs recover the costs and expenses of suit, pre- and post-judgment interest, and reasonable attorneys' fees as provided by law;

C. That Defendants be ordered to pay punitive and treble damages as provided by law; and;

D. That the Court order such other and further relief as the Court deems just, necessary and appropriate.

JURY TRIAL DEMANDED

Plaintiffs demand a trial by jury on all claims to the maximum number of jurors permitted by law.

Respectfully submitted,

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