

368. The Manufacturer Defendants had access to and possession of the information necessary to monitor, report, and prevent suspicious orders and to prevent diversion, but instead they utilized the data to understand which regions and which doctors to target through their sales force.

369. With the knowledge of improper diversion, the Manufacturer Defendants could have but failed to report each instance of diversion to the DEA, as they were required to do, instead rolling out marketing campaigns to churn its prescription opioid sales.

370. Indeed, upon information and belief, the Manufacturer Defendants withheld from the DEA information about suspicious orders – and induced others to do the same – to obfuscate the extent of the opioid epidemic. Upon information and belief, the Manufacturer Defendants knew that if they or the other defendants disclosed suspicious orders, the DEA would become aware that many opioids were being diverted to illegal channels, and would refuse to increase the production quotas for opioids.

371. The Department of Justice has confirmed the suspicious order obligations clearly imposed by law, fining Mallinckrodt \$35 million in 2017 for failure to report suspicious orders of controlled substances, including opioids, and for violating recordkeeping requirements.¹⁰³ Among the allegations resolved by the settlement, the government alleged “Mallinckrodt failed to design and implement an effective system to detect and report suspicious orders for controlled substances – orders that are unusual in their frequency, size, or other patterns. . . [and] Mallinckrodt supplied distributors, and the distributors then supplied various U.S. pharmacies and pain clinics, an

¹⁰³ See U.S. Dep’t of Justice, *Mallinckrodt Agrees to Pay Record \$35 Million Settlement for Failure to Report Suspicious Orders of Pharmaceutical Drugs and for Recordkeeping Violations*, Jul. 11, 2017, <https://www.justice.gov/opa/pr/mallinckrodt-agrees-pay-record-35-million-settlement-failure-report-suspicious-orders>

increasingly excessive quantity of oxycodone pills without notifying DEA of these suspicious orders.”¹⁰⁴ Mallinckrodt agreed that its “system to monitor and detect suspicious orders did not meet the standards outlined in letters from the DEA Deputy Administrator, Office of Diversion Control, to registrants dated September 27, 2006 and December 27, 2007.”¹⁰⁵

372. Indeed, the DEA ARCOS database shows that between 2003 and 2011 Mallinckrodt sold 53 million orders of opioids. Yet, only 33 were halted and reported as suspicious.

373. Purdue also unlawfully and unfairly failed to report or address illicit and unlawful prescribing of its drugs, despite knowing about it for years. Through its extensive network of sales representatives, Purdue had and continues to have knowledge of the prescribing practices of thousands of doctors and could identify doctors who displayed red flags for diversion, such as those whose waiting rooms were overcrowded, whose parking lots had numerous out-of-state vehicles, and whose patients seemed young and healthy or homeless. Using this information, Purdue has maintained a database since 2002 of doctors suspected of inappropriately prescribing its drugs.¹⁰⁶ 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

¹⁰⁴ *Id.* (internal quotation omitted).

¹⁰⁵ 2017 Settlement Agreement between the United States of America and Mallinckrodt, plc, at p. 2-3, <https://www.justice.gov/usao-edmi/press-release/file/986021/download>.

¹⁰⁶ See Scott Glover and Lisa Girion, *OxyContin maker closely guards its list of suspect doctors*, LOS ANGELES TIMES, Aug. 11, 2013, <http://articles.latimes.com/2013/aug/11/local/la-me-rx-purdue-20130811>

Los Angeles Times,¹⁰⁷ 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 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” until years after law enforcement shut it down. In doing so, Purdue protected its own profits at the expense of public health and safety.

374. In 2016, the New York Attorney General found that, between January 1, 2008 and March 7, 2015, Purdue's sales representatives, at various times, failed to timely report suspicious prescribing and continued to detail those prescribers even after they were placed on a “no-call” list.¹⁰⁸

375. As Dr. Mitchell Katz, director of the Los Angeles County Department of Health Services, said in a *Los Angeles Times* article, “Any drug company that has information about physicians potentially engaged in illegal prescribing or prescribing that is endangering people's lives has a responsibility to report it.”¹⁰⁹ The New York Attorney General's settlement with Purdue specifically cited the company for failing to adequately address suspicious prescribing. Yet, on information and belief, Purdue continues to profit from the prescriptions of such prolific prescribers.

376. 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 New York Attorney General found that Endo failed to require sales representatives to report signs of

¹⁰⁷ See Harriet Ryan et al., *More than 1 million OxyContin pills ended up in the hands of criminal and addicts. What the drugmaker knew*, LOS ANGELES TIMES, Jul. 10, 2016, <http://www.latimes.com/projects/la-me-oxycontin-part2/>

¹⁰⁸ See NY Purdue Settlement, at 6-7, available at <https://ag.ny.gov/pdfs/Purdue-AOD-Executed.pdf>

¹⁰⁹ Glover and Girion, *supra* note 109.

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.

377. The New York Attorney General also found that, in certain cases where Endo's sales representatives detailed prescribers who were convicted of illegal prescribing of opioids, those representatives could have recognized potential signs of diversion and reported those prescribers but failed to do so.

378. On information and belief, the other Manufacturer Defendants have engaged in similar conduct in violation of their responsibilities to prevent diversion. They used faulty algorithms to flag questionable orders and frequently handed oversight to customer service employees and account managers, whose pay was tied to drug sales. For example, Teva's suspicious order program was called "DefOps", short for "Defensible Operations". A Teva representative has testified that the program was designed to keep Teva out of trouble and because it "sounded good." Mallinckrodt's suspicious orders were investigated by national account managers whose compensation was linked to sales. Defendant manufacturer emails reveal that the companies were aware that assigning sales staff to monitor suspicious orders created a conflict of interest. The practice nevertheless continued.

379. The Manufacturer Defendants' actions and omissions in failing to effectively prevent diversion and failing to monitor, report, and prevent suspicious orders caused excess shipments of the Manufacturer Defendants' opioids into The Town of Bennington and have enabled the excess opioids to be unlawfully diverted. As a result, The Town of Bennington suffered substantial harm and damages.

b. DISTRIBUTOR DEFENDANTS

380. The Manufacturer Defendants realized early on that the cooperation of the Distributor Defendants was necessary to ensure the success of efforts to flood the market with addictive opioids – specifically, to move opioids from the manufacturers to pharmacies (retail and mail order) and patients, the Manufacturer Defendants needed the Distributor Defendants, a necessary link in the chain of supply.

381. As early as 1996, Purdue recognized that over 80 percent of the distribution drug market was controlled by four players (McKesson, Bergen, Cardinal and Amerisource), and that Purdue would need to build relationships with these “wholesaler trading partners” to ensure that OxyContin was available across the country.

382. The Distributor Defendants were willing participants in the scheme to flood the country with opioids, and the relationship was an instant success. The Manufacturer and Distributor Defendants’ supply chain partnership enabled a meteoric rise in the number of opioid prescriptions – for example, total prescriptions for OxyContin increased from about 316,000 in 1996 to approximately 14 million in 2001-02. Translated into dollars, OxyContin sales rose from \$44 million in 1996 to combined sales of nearly \$3 billion in 2001-02.

383. The Distributor Defendants partnered with the Manufacturer Defendants both directly and through industry associations. Each of the Distributor Defendants was a member of the Healthcare Distribution Alliance, or HDA, and most were also members of the National Association of Chain Drug Stores, or NACDS. These industry associations were valuable tools in efforts to accomplish the Manufacturer and Distributor Defendants’ shared objectives.

384. For example, the HDA was a member of the Pain Care Forum, or PCF, which as discussed above was one of the Manufacturer Defendants’ primary vehicles to grow the opioid market.

385. The industry associations also played a key role by enabling the Distributor Defendants to efficiently coordinate their efforts to fight back against regulation of the supply of opioids.

386. Indeed, while the Manufacturer and Distributor Defendants' objective to flood the country with opioids was extremely successful, by 2005 the supply chain faced an endemic threat, a braking mechanism that threatened to slow or potentially halt the widespread distribution of prescription opioids – namely, the legal duties to prevent diversion and to monitor, report, and prevent suspicious orders of prescription opioids under Vermont and federal law, and the accompanying oversight and regulatory authority of the DEA.

387. All opioid distributors are required to maintain effective controls against opioid diversion, generally referred to as Suspicious Order Monitoring, or SOM. The SOM requirements obligate distributors to create and use a system to identify and report to law enforcement downstream suspicious orders of controlled substances, such as orders of unusually large size, orders that are disproportionate, orders that deviate from a normal pattern, and/or orders of unusual frequency. To comply with these requirements, distributors must know their customers, must conduct due diligence, must report suspicious orders, and must terminate orders if there are indications of diversion.

388. Under Vermont law and the CSA, anyone authorized to handle controlled substances must track their shipments. The DEA's ARCOS is an automated drug reporting system that records and monitors the flow of Schedule II controlled substances from the point of manufacture through distribution to the point of sale. ARCOS accumulates data on distributors' controlled substances and transactions, which are then used to identify diversion. Each person or entity that is registered to distribute controlled substances such as opioids must report each acquisition and distribution transaction to the DEA. See 21 U.S.C. § 827; 21 C.F.R. § 1304.33.

Each registrant must also maintain a complete, accurate and current record of each substance manufactured, imported, received, sold, delivered, exported, or otherwise disposed of.

389. Each registrant must also comply with the security requirements to prevent diversion set forth in 21 C.F.R. § 1301.71 and in Vermont law.

390. In 2005, concerned that these obligations were not being met, the DEA launched “the Distributor Initiative,” an effort to warn distributors (and other partners in the supply chain) about SOM requirements. In 2006 and 2007, these warnings were communicated to distributors and others in a series of letters from the DEA.

391. The DEA then began cracking down in 2007, suspending AmerisourceBergen’s registration to distribute from its Lakeland, Florida distribution center, and following up with suspensions of the registrations of McKesson and Cardinal Health in 2008.

392. The Manufacturer and Distributor Defendants orchestrated a joint response to this existential threat to the supply chain and opioid profits, both directly and through their trade association fronts.

393. While not intended to be a complete recitation of every negligent, unlawful or conspiratorial act of each Distributor Defendant, the conduct at issue includes at least the following.

394. Manufacturer Defendants, including Purdue, Teva and Mallinckrodt, took affirmative steps to support their distributor partners directly. Communications during this time period show that the Manufacturer Defendants were committed to keeping the supply chain open, regardless of the consequences.

395. Purdue explained that its “primary focus” was helping a distributor facing suspension “protect its registration and its business in general and especially in distributing our products.” Purdue explained that the “responsibility for making the decision to ship rests with the

supplier ... that is why we must collaborate. “Purdue observed that, “[w]e need to convince [distributors that] they should talk to us when our product is involved and make it a joint decision, etc. just as we need to consult with them from our end.” Purdue made clear that it wanted “no interruption in the supply chain.”

396. In 2008, Purdue met with AmerisourceBergen to discuss communication and cooperation in relation to Suspicious Order Monitoring. Purdue met with Cardinal Health “to collaborate and support [Cardinal] on any accounts that we feel might require further assessment, etc.” Purdue met with McKesson in 2009 and proposed a “collaborative effort” regarding Suspicious Order Monitoring.

397. In August of 2009 a Purdue employee communicated with Cardinal Health and another drug distributor and said “[w]e should gang up on DEA in Portland, OR,” a reference to a pharmaceutical industry conference on DEA diversion.

398. In 2012, Cardinal Health’s registration was suspended and more discussions were held with Purdue and others in furtherance of their “mutual support” objectives – in their own words, “...we are all in this together – manufacturers and wholesalers/distributors – as well as retail customers, of course.”

399. As noted, these efforts were not limited to Purdue. Teva released held orders because “we need to supply our customer with product” because they would not be able to fill their customer’s demand without it.

400. Mallinckrodt received an email from a distributor who had received an overnight shipment of 1200 bottles of oxycodone and wrote, “Keep ‘em comin’! Flyin’ out of here. It’s like people are addicted to these things or something. Oh, wait, people are ...” A Mallinckrodt employee responded, “Just like Doritos keep eating. We’ll make more.”

401. Endo and Teva communicated with Distributor Defendants about suspicious order

monitoring programs, both in person and through questionnaires about their programs.

402. The net goal of these communications and efforts was to protect the supply chain at all costs. McKesson even advised Purdue that it did not use the word “suspicious” because that term of art could trigger legal obligations on the part of a distributor. Instead, McKesson used terms like “questionable” or “noteworthy.” McKesson had even directly advised its employees to “refrain from using the word ‘suspicious’ in communications. Once we deem an order and/or customer suspicious, McKesson is required to act.”

403. At one point, Mallinckrodt noted that half of the orders identified as “peculiar” in its system were from McKesson, AmerisourceBergen and Cardinal, and that many were from CVS, Walgreens and Walmart. But Mallinckrodt did not elevate the orders from “peculiar” to “suspicious.”

404. And these were just the efforts that were (incorrectly) cast as efforts to comply with SOM requirements. The fact was that many distributors had no compliance program at all, or programs that for all practical purposes were ineffective, notwithstanding the clear requirements of Vermont and federal law.

405. Purdue documents showed that any review was well after shipment because the only data received by their program was a month old. In April of 2019, Purdue’s vice president and chief security officer was questioned under oath and could only recall one instance in which an order was cut or blocked due to size, frequency or pattern. A 2016 audit of Purdue’s monitoring program identified critical deficiencies, including that it used arbitrary thresholds and put review of pending orders in the hands of entities that had sales and marketing as their core mission.

406. Mallinckrodt had no suspicious order program in place in 2008-09 (aside from verifying that the customer had DEA 222 forms), and no mechanism in place to halt suspicious orders.

407. As of September 2012, Teva had never had a written monitoring program in place and had never reported a suspicious order to the DEA.

408. An outside audit determined that in 2010 Endo Defendant Par had no SOM program at all.

409. Janssen's SOM algorithm only compared orders to previous orders of the same product at the same strength, a critical deficiency.

410. McKesson acknowledged to the DEA that from 2009-17 it did not "identify or report to DEA certain orders placed by certain pharmacies which should have been detected by McKesson as suspicious"

411. Cardinal faced numerous DEA enforcement actions and did not have any policy to stop shipment of suspicious orders at all before 2008.

412. Cardinal Health, Amerisource Bergen and McKesson all had early warning systems in place to alert their pharmacy customers when thresholds were being reached so that orders could be adjusted and manipulated to avoid triggering SOM obligations and the attendant "supply chain disruption." In certain instances, a pharmacy could request threshold increases or delays to the next cycle, which were granted.

413. This was critical to the Distributor Defendants, since at various relevant times the national pharmacies provided a huge percentage of the Distributor Defendants' revenue. Currently, CVS provides 25 percent of Cardinal's revenue, over \$34 billion. From 2006-12, Walgreens accounted for approximately 21 percent of Cardinal's revenue. From 2008-18, CVS was McKesson's largest customer, accounting for almost 20 percent of McKesson's revenues, over \$41 billion, in 2018 alone.

414. The failure to implement appropriate SOM procedures was not limited to Cardinal, McKesson and AmerisourceBergen.

415. From 2006 through August 2010, CVS had no written DEA Standard Operating Procedures to identify suspicious orders. Even after that period its procedures were critically deficient. During a DEA investigation commenced in 2013, CVS admitted that it had reported only seven suspicious orders in the entire country. Also during 2013, a CVS employee highlighted the under-staffing on the monitoring program, advising fellow employees that “I do NOT have any backup ... If something happens to me via act of nature or illness, the current daily SOM process would come to a complete halt.”

416. Even though Walmart operated licensed distribution centers supplying its pharmacies with controlled substances from 2000 until 2018, before 2011 Walmart had no formal system in place to identify suspicious orders. Walmart and its representatives have stated that, prior to 2011, hourly associates responsible for filling orders at distribution centers would monitor orders, which consisted of letting a supervisor know if an order looked like “it was kind of high,” based on the associates’ memories. Upon information and belief, there is no evidence of Walmart reporting any suspicious order prior to 2011.

417. After allegedly introducing an SOM system in 2011, in 2014 Walmart acknowledged that it had no “process in place” to comply with government obligations and that this deficiency represented a “severe” risk to the company. During this time, and until approximately 2015, Walmart simply flagged orders of 5000 dosage units or more, or more than 2000 dosage units per week if those orders were 30 percent higher than a rolling 4-week average. But orders were not held; instead there were simply cut to the thresholds and shipped. These cut orders were not reported to the DEA. After 2015, the same system remained in place, but Walmart simply added store-specific thresholds – the limits remained high, and pharmacies could still order up to 2000 dosage units per week (or nearly 8000 per month) without triggering the system.

418. Until 2012, Walgreens took the approach of shipping suspicious orders and then

sending an after-shipment report to the DEA, even though it was advised that this approach was not in compliance with the law. The failures did not end after 2012. In 2013, a Walgreens employee observed that most suspicious orders identified under the new program had already shipped. In 2014, Walgreens ended its own direct distribution efforts and instead entered into a new arrangement with Amerisource Bergen whereby Walgreens acquired enough of AmerisourceBergen's stock to be deemed a "related party" by the SEC and AmerisourceBergen became Walgreens' exclusive distributor. The question of whether this new arrangement solved Walgreens' SOM deficiencies is answered by an AmerisourceBergen employee's comment during the transition: "I'm trying to think of everything we can do to prevent having a bunch of orders reported to the DEA and held."

419. Rite-Aid reported zero suspicious orders, nationwide, from 1995-2014.

420. Manufacturer and Distributor Defendants Purdue, Mallinckrodt, Cardinal, McKesson, CVS, and Walgreens have each admitted to breaking the law and violating their CSA duties.

421. In fact, the DEA initiated 178 registrant actions between 2008 and 2012, 76 orders to show cause were issued by the Office of Administrative Law Judges, and 41 actions involved immediate suspension orders.

422. The specifics of the Distributor Defendants' wrongful conduct and inaction include, but are not limited to, at least the following:

423. In May 2008, McKesson entered into a settlement with the DEA on claims that McKesson failed to maintain effective controls against diversion of controlled substances. McKesson allegedly failed to report suspicious orders from rogue Internet pharmacies around the Country, resulting in millions of doses of controlled substances being diverted. McKesson's system for detecting "suspicious orders" from pharmacies was so ineffective and dysfunctional

that at one of its facilities in Colorado between 2008 and 2013, it filled more than 1.6 million orders, for tens of millions of controlled substances, but it reported just 16 orders as suspicious, all from a single consumer.

424. In a 2017 Administrative Memorandum of Agreement between McKesson and the DEA, McKesson admitted that it “did not identify or report to [the] DEA certain orders placed by certain pharmacies which should have been detected by McKesson as suspicious based on the guidance contained in the DEA Letters.” McKesson was fined \$150,000,000.

425. On November 28, 2007, the DEA issued an Order to Show Cause and Immediate Suspension Order against a Cardinal Health facility in Auburn, Washington, for failure to maintain effective controls against diversion.

426. On December 5, 2007, the DEA issued an Order to Show Cause and Immediate Suspension Order against a Cardinal Health facility in Lakeland, Florida, for failure to maintain effective controls against diversion.

427. On December 7, 2007, the DEA issued an Order to Show Cause and Immediate Suspension Order against a Cardinal Health facility in Swedesboro, New Jersey, for failure to maintain effective controls against diversion.

428. On January 30, 2008, the DEA issued an Order to Show Cause and Immediate Suspension Order against a Cardinal Health facility in Stafford, Texas, for failure to maintain effective controls against diversion.

429. In 2008, Cardinal paid a \$34 million penalty to settle allegations about opioid diversion taking place at seven of its warehouses in the United States.

430. On February 2, 2012, the DEA issued another Order to Show Cause and Immediate Suspension Order against a Cardinal Health facility in Lakeland, Florida, for failure to maintain effective controls against diversion.

431. In 2012, Cardinal reached an administrative settlement with the DEA relating to opioid diversion between 2009 and 2012 in multiple states.

432. In December 2016, the Department of Justice announced a multi-million dollar settlement with Cardinal for violations of the Controlled Substances Act. On information and belief, 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 Wisconsin that was suspected of opioid diversion. Cardinal did nothing to notify the DEA or cut off the supply of drugs to the suspect pharmacy. Cardinal did just the opposite, pumping up opioid shipments to the pharmacy to almost 2,000,000 doses of oxycodone in one year, while other comparable pharmacies were receiving approximately 69,000 doses/year.

433. In 2007, AmerisourceBergen lost its license to send controlled substances from a distribution center in Florida amid allegations that it was not controlling shipments of prescription opioids to Internet pharmacies.

434. In 2012, AmerisourceBergen was implicated for failing to protect against diversion of controlled substances into non-medically necessary channels.

435. Rather than comply with the law, the Distributor Defendants and their manufacturing partners have focused on diverting the attention and focus of the DEA or, in one key instance, simply working to change the law to remove the regulatory burden.

436. When the DEA's crackdown began, the Distributor Defendants worked with their trade association, the HDA, to publish Industry Compliance Guidelines titled "Reporting Suspicious Orders and Preventing Diversion of Controlled Substances." These ICGs emphasized the critical role of each member of the supply chain in distributing controlled substances, stating "[a]t 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.”

437. But the ICGs were not binding on the industry or HDA members. The evidence supports a conclusion that they actually were drafted primarily with the purpose of convincing the DEA that the Distributor Defendants were trying to address the problem and distracting the DEA from its crackdown on violations of the CSA and failure to adopt compliant SOM programs. Indeed, HDA knew that large member entities such as AmerisourceBergen and Cardinal Health would not implement the Guidelines and yet did not reveal that to the DEA during the many discussions it held with the enforcement agency.

438. The HDA ultimately admitted that the ICGs were never intended to constitute an industry standard and even removed them from the trade association’s website.

439. The ICGs were just the first step, however. The Distributor Defendants decided that the best option to remove the threat of penalties for failure to comply with SOM requirements was simply to change the law.

440. On February 19, 2014, acting at the behest of industry lobbyists, U.S. Representative Tom Marino introduced the “Ensuring Patient Access and Effective Drug Enforcement Act” as a supposed effort to define “imminent danger” in the 1970 act. A DEA memo noted that this bill would essentially destroy the agency’s power to file an immediate suspension order of any suspicious drug shipments.

441. This bill required that the DEA show the company’s actions had demonstrated a “substantial likelihood of an immediate threat,” whether in death, serious bodily harm or drug abuse before a suspension order could be sought. It also gave drug companies the ability to submit “corrective action” plans before any penalties could be issued. The law essentially makes it impossible for the DEA to halt any suspicious narcotic shipments before opioids are diverted to the illegal black market.

442. Whereas prior to passage of the Marino Act the DEA had the power to issue an immediate suspension order against a manufacturer or distributor whose unlawful conduct posed an imminent danger to the community, the Marino Act effectively stripped the DEA of this power.

443. At the same time, via the HDA, the Distributor Defendants retained public relations consultants to help polish the public image of the companies responsible for flooding the country with addictive opioids.

444. The HDA exercised strict supervision over consultants to ensure the messaging matched the objectives of the Distributor Defendants. When a consultant refused to give HDA editorial control over a study related to drug diversion and regulation, the project was terminated.

445. The HDA, along with the NACDS, was also instrumental in pushing back against stricter controls and enforcement on a number of additional fronts, including challenging the reclassification of hydrocodone combination products, or HCPs, from Schedule III to the more strictly-controlled Schedule II. In sum, the HDA worked hard at its goal of “help[ing] ease DEA pressure on our members for SO monitoring.”

446. Ironically, these events occurred even as opioid distributors have admitted to the magnitude of the problem and, at least superficially, their legal responsibilities to prevent diversion.

447. McKesson has admitted that the opioid epidemic is a significant interference with public health. In a corporate presentation, McKesson described the opioid epidemic as the “deadliest drug epidemic on record in our nation’s history.” McKesson stated, “[t]he drug problems of the past decades pale when compared to the current opioid epidemic which has killed 165,000 Americans from 2000 to 2014.”

448. In that same presentation, McKesson described how on an average day more than 650,000 opioid prescriptions are dispensed; 3,900 people initiate non-medical use of prescription

opioids and—at that time—78 people died from an opioid-related overdose.

449. McKesson has acknowledged to its own employees that abuse of prescription drugs has risen 66% since 2000.

450. McKesson witnesses have testified as to their awareness that opioid abuse and addiction are gateways to heroin use and addiction.

451. A McKesson representative has testified that it “gives you pause” to be selling opioids in the midst of an opioid epidemic.

452. ABC similarly has acknowledged “some 7.4 million people- almost 3% of the U.S. Population-aged 12 or over had an illicit drug use disorder” and that “the most commonly misused products were hydrocodone products.” ABC has also acknowledged that “Oxycodone was misused by almost 4 million Americans.”

453. Cardinal likewise has admitted that prescription drug abuse is “an unparalleled epidemic and public health crisis.” It has told its employees that “[i]t’s an epidemic that affects all of us, professional and personally” and “a public health crisis”.

454. Cardinal’s website calls the opioid epidemic a “national public health crisis” and recognizes the “devastation opioid misuse has caused American families and communities”.

455. Henry Schein’s website acknowledges that “the statistics for opioid addiction are alarming” and acknowledges that “between 21-29% of patients prescribed opioids for chronic pain misuse them”. It recounts that “more than 2 million Americans have become dependent on or abused prescription pills and street drugs.”

456. Distributor defendants have made statements assuring the public they are supposedly undertaking a duty to curb the opioid epidemic.

457. Cardinal Health has expressly stated the epidemic is “one that our company is deeply committed to help solve.” It has told its employees, “[a]s front line employees, you are an

integral part of our ability to deliver on this commitment.” It has described its “responsibility and [its] obligations to society around this national challenge.”

458. Cardinal has acknowledged, “[w]e are part of a complex healthcare system and everyone in that chain, including us, must help stem the crisis.

459. In these same PR materials, Cardinal has boasted, “[w]e are a leader in implementing anti-diversion controls and prevention programs.”

460. On their face, these assurances – of identifying and eliminating criminal activity and curbing the opioid epidemic – create a duty for the Distributor Defendants to take reasonable measures to do just that.

461. Yet the Distributor Defendants failed to take necessary steps to prevent the damage caused by addictive opioids and instead took affirmative steps to increase and maintain the flow of opioids to the end users.

462. Given the addictive powers of opioids and the corresponding risks of misuse, addiction and death, the Distributor Defendants’ actions in the distribution and sale of opioids as part of the closed supply chain breached their duties to the Plaintiff, created and maintained an ongoing public nuisance, and were at the very least negligent and unlawful, as further alleged below in Counts I - XII. These actions damaged Plaintiff.

463. The additional failure to maintain appropriate SOM programs, to comply with Vermont and federal law regarding the regulation of addictive opioids, is a further basis for liability.

464. Moreover, the Distributor Defendants’ failure to prevent the foreseeable injuries from opioid diversion and misuse created an enormous black market for prescription opioids, which extended to The Town of Bennington. Each Distributor Defendant knew or should have known that the opioids reaching The Town of Bennington were not being consumed for medical

purposes alone and that the amount of opioids flowing to The Town of Bennington was far in excess of what could be consumed for medical purposes.

465. 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 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 the Town of Bennington; providing information to pharmacies and retailers about opioid diversion; and in general, simply following applicable statutes, regulations, professional standards, and guidance from government agencies, and using a little bit of common sense.

466. It was reasonably foreseeable that the Distributor Defendants' conduct in flooding the market in and around the Town of Bennington with highly addictive opioids would allow opioids to fall into the hands of children, addicts, and other unintended users.

467. It is reasonably foreseeable that when unintended users gain access to opioids, tragic preventable injuries will result, including addiction, overdoses, and death.

468. The Distributor Defendants knew or should have known that the opioids being diverted from their supply chains would contribute to the opioid epidemic faced by the Town of Bennington, and would create access to opioids for inappropriate uses, which, in turn, perpetuates the cycle of addiction, demand, illegal transactions, economic ruin, and human tragedy.

469. The Distributor Defendants were aware of widespread prescription opioid abuse in and around the Town of Bennington, but, on information and belief, 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 being consumed in gross excess.

470. The use of opioids by the Town of Bennington's citizens who were addicted could not occur without the knowing cooperation and assistance of the Distributor Defendants. If the Distributor Defendants adhered to effective controls to guard against diversion, the Town of Bennington would have avoided significant injury.

471. The Distributor Defendants made enormous profits over the years based on the diversion of opioids into The Town of Bennington.

472. The Distributor Defendants' intentional distribution of excessive amounts of prescription opioids to the Town of Bennington showed an intentional or reckless disregard for the safety of the Town of Bennington and its citizens. Their conduct poses a continuing threat to the health, safety, and welfare of the Town of Bennington.

3. The Retail and PBM Mail-Order Pharmacy Defendants

473. Pharmacy Defendants (retail and mail order) earned profits by flooding the country with prescription opioids. They were keenly aware of the oversupply of prescription opioids through the extensive data and information they developed and maintained as both distributors and dispensaries. Yet, instead of taking any meaningful action to stem the flow of opioids into the communities, they continued to participate in the oversupply and profit from it.

474. Each of the Pharmacy Defendants does substantial business throughout the U.S., including in Vermont. This business includes the distribution and dispensing of prescription opioids.

475. The Pharmacy Defendants developed and maintained extensive data on the opioids

they distributed and dispensed. Though this data, Pharmacy Defendants had direct knowledge of patterns and instances of improper distribution, prescribing, and use of prescription opioids in communities throughout the country, and in Bennington. They used the data to evaluate their own sales activities and workforce. On information and belief, the Pharmacy Defendants also provided Manufacturer Defendants with data regarding, *inter alia*, individual doctors in exchange for rebates or other forms of consideration. The Pharmacy Defendants' data is a valuable resource that they could have used to help stop diversion, but failed to do so.

a. The Pharmacy Defendants Have a Duty to Prevent Diversion

476. Each participant in the supply chain of opioid distribution, including the Pharmacy Defendants, is responsible for preventing diversion of prescription opioids into the illegal market by, among other things, monitoring and reporting suspicious activity.

477. The Pharmacy Defendants, including PBM mail-order pharmacies and retail pharmacies, like manufacturers and other distributors, are registrants under the CSA. 21 C.F.R. § 1301.11. Under the CSA, pharmacy registrants are required to “provide effective controls and procedures to guard against theft and diversion of controlled substances.”¹¹⁰ In addition, 21 C.F.R. § 1306.04(a) states, “[t]he responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription.” Because pharmacies themselves are registrants under the CSA, the duty to prevent diversion lies with the pharmacy entity, not the individual pharmacist alone.

478. The Pharmacy Defendants owe a duty under both federal law¹¹¹ and Vermont Law,

¹¹⁰ See 21 C.F.R. § 1301.71(a).

¹¹¹ 21 U.S.C. § 823; 21 CFR 1301.74

to monitor, detect, investigate, refuse to fill, and report suspicious orders which the Pharmacy Defendants knew or should have known were likely to be diverted in and around the Town of Bennington.

479. Specifically, pharmacy retailers are required to ensure that controlled substances are dispensed only pursuant to valid prescriptions and for legitimate medicinal or therapeutic purposes.¹¹² Before dispensing an opioid prescription, a pharmacist or healthcare practitioner is required to confirm that the prescription is bona fide and that it was issued pursuant to a bona fide prescriber-patient relationship.¹¹³

480. Further, in order to prevent the abuse of invalid or illegitimate prescriptions, and to generally prevent diversion of opioids, pharmacy retailers are required to keep and maintain thorough records of their receipt and dispensation of all opioids, and of the persons to whom they dispense opioids and certain other drugs.¹¹⁴

481. The DEA, among others, has provided extensive guidance to pharmacies concerning their duties to the public. The guidance advises pharmacies how to identify suspicious orders and other evidence of diversion.

482. Pharmacies have a legal obligation under state and federal law to determine whether a controlled substance was issued for a legitimate purpose and to decline to fill prescriptions they have reason to believe were issued for a non-legitimate purpose.

483. Suspicious pharmacy orders include orders that are disproportionately large in comparison to the population of a community served by the pharmacy, orders that deviate from a normal pattern and/or orders of unusual frequency and duration, among others.

¹¹² 20-4 Vt. Code R. § 1400:10.2

¹¹³ *Id.*

¹¹⁴ 20-4 Vt. Code R. §§ 1400:10.8; 1400:10.25

484. Additional types of suspicious orders include: (1) prescriptions written by a doctor who writes significantly more prescriptions (or in larger quantities or higher doses) for controlled substances compared to other practitioners in the area; (2) prescriptions which should last for a month in legitimate use, but are being refilled on a shorter basis; (3) prescriptions for antagonistic drugs, such as depressants and stimulants, at the same time; (4) prescriptions that look “too good” or where the prescriber’s handwriting is too legible; (5) prescriptions with quantities or doses that differ from usual medical usage; (6) prescriptions that do not comply with standard abbreviations and/or contain no abbreviations; (7) photocopied prescriptions; and (8) prescriptions containing different handwriting. Typically, these attributes are easy to detect and easily recognizable by pharmacies.

485. The industry guidance tells pharmacists how to recognize: (a) stolen prescription pads; (b) prescription pads printed using a legitimate doctor’s name, but with a different call back number that is answered by an accomplice of the drug-seeker; (c) prescriptions written using fictitious patient names and addresses; and (d) other similar red flags.

486. Suspicious pharmacy orders are red flags for if not direct evidence of diversion.

487. Other signs of diversion can be observed through data gathered, consolidated, and analyzed by the Pharmacy Defendants themselves. That data allows them to observe patterns or instances of dispensing that are potentially suspicious, or oversupply in particular stores or geographic areas, or of prescribers or facilities that seem to engage in improper prescribing.

488. According to industry standards, federal and state law, if a pharmacy finds evidence of prescription diversion, the local Board of Pharmacy and DEA must be contacted.

489. Pharmacy Defendants, through their words or actions set forth in news reports and other public documents, have acknowledged these risks and assured the public that issues affecting public health and safety are their highest priority.

490. In 2015, CVS publicly stated that, that abuse of controlled substance pain medication is a nationwide epidemic that is exacting a devastating toll upon individuals, families and communities.

491. Similarly, in 2016, Walgreens issued a press release captioned “Walgreens Leads Fights against Prescription Drug Abuse with New Programs to Help Curb Misuse of Medications and the Rise in Overdose Death.”

492. Despite knowing and even warning of these risks, Pharmacy Defendants recklessly or negligently permitted diversion to occur. In failing to take adequate measures to prevent substantial opioid-related injuries to the nation, Pharmacy Defendants have breached their duties under federal [confirm for VT] and state statute and regulations, under the reasonable care standard of Vermont common law (including violating a voluntarily-undertaken duty to the public which they have assumed by their own words and actions), and professional duties under the relevant standards of professional practice.

493. For example, one official at Walgreens tasked with monitoring suspicious orders said his department was “not equipped” for that work. Walgreens created lists of suspicious orders that ran thousands of pages but, startlingly and against all statutory obligations, then merely shipped the suspicious orders without further review.

494. An official at CVS who was listed as the company’s DEA compliance coordinator admitted that it was not her real job. CVS compliance was relegated to “pickers and packers”, i.e. the warehouse workers at distribution centers who appeared to have no formal training in monitoring and rarely held up orders. In the CVS distribution center, approximately two orders per year were flagged as suspicious between 2006-2014.

495. Upon information and belief, Walmart had no real system to monitor suspicious orders before 2011. Walmart explains that it relied on its hourly employees for this work but there

is no evidence of training or a suspicious order policy. Walmart installed a suspicious order monitoring system in 2015 but it was so forgiving that a store could order 10 dosages of 10 milligrams of oxycodone in one month and 7,999 dosages the next without raising red flags.

496. Pharmacy Defendants were on notice of their ongoing negligence or reckless misconduct towards the nation in part because of their history of being penalized for violating their duties in other jurisdictions.

497. Despite their legal obligations in common law, and as registrants under the CSA, the Pharmacy Defendants failed to meet their obligations and allowed widespread diversion to occur – and they did so knowingly. They knew they made money by filling prescriptions. They knew they made money by making it easy for doctors to refer patients to them to fill drug prescriptions, not by making it difficult for doctors to refer patients to them to fill prescriptions.

498. Upon information and belief, performance metrics and prescription quotas adopted by the Pharmacy Defendants for their retail stores contributed to their failure. For instance, under CVS's Metrics System, pharmacists are directed to meet high goals that make it difficult, if not impossible, to comply with applicable laws and regulations. There is no measurement for pharmacy accuracy or customer safety. Moreover, the bonuses for pharmacists are calculated, in part, on how many prescriptions that pharmacist fills within a year. The result is predictable: opioids flowed out of Pharmacy Defendants and into communities throughout the country. The Pharmacy Defendants had no incentive to stop the outflow, and every financial incentive to further it. Their policies and practices remained in place even as the epidemic raged.

499. Upon information and belief, Plaintiff alleges that the Pharmacy Defendants also failed to adequately use data available to them to identify doctors who were writing suspicious numbers of prescriptions and/or prescriptions of suspicious amounts of opioids, or to adequately use data available to them to do statistical analysis to prevent the filling of prescriptions that were

illegally diverted or otherwise contributed to the opioid crisis.

500. Upon information and belief, Plaintiff alleges that the Pharmacy Defendants failed to analyze: (a) the number of opioid prescriptions filled by individual pharmacies relative to the population of the pharmacy's community; (b) the increase in opioid sales relative to past years; (c) the number of opioid prescriptions filled relative to other drugs; and (d) the increase in annual opioid sales relative to the increase in annual sales of other drugs.

501. Upon information and belief, Plaintiff alleges that the Pharmacy Defendants also failed to conduct adequate internal or external audits of their opioid sales to identify patterns regarding prescriptions that should not have been filled and to create policies accordingly, or if they conducted such audits, they failed to take any meaningful action as a result.

502. Upon information and belief, Plaintiff alleges that the Pharmacy Defendants also failed to effectively respond to concerns raised by their own employees regarding inadequate policies and procedures regarding the filling of opioid prescriptions.

503. The Pharmacy Defendants were, or should have been, fully aware that the quantity of opioids being distributed and dispensed by them was untenable, and in many areas patently absurd; yet, they did not take meaningful action to investigate or to ensure that they were complying with their duties and obligations under the law with regard to controlled substances.

504. In failing to take adequate measures to prevent substantial opioid-related injuries that have affected Bennington, Pharmacy Defendants have breached their duties under the "reasonable care" standard and their professional duties under the relevant standards of professional practice.

505. It was reasonably foreseeable to Pharmacy Defendants that filling invalid or suspicious prescriptions for opioids would cause harm to the Town of Bennington.

506. It was reasonably foreseeable to Pharmacy Defendants that, when unintended users

gain access to opioids, tragic yet preventable harm will result, including the type of harm for which Bennington seeks redress.

507. At all relevant times, Pharmacy Defendants have engaged in improper dispensing practices, and continue to do so, despite knowing full well they could take measures to substantially eliminate their complicity in opioid diversion

508. At all relevant times, Pharmacy Defendants engaged in these activities, and continue to do so, knowing full well that Bennington would be harmed thereby and would be constrained to provide essential County services in response, including paying for additional law enforcement services, social services, and emergency services.

509. It was foreseeable to Pharmacy Defendants that the Town of Bennington would be forced to bear substantial expenses and suffer serious socio-economic harm as a result of Pharmacy Defendants' acts.

510. Pharmacy Defendants were on notice of their ongoing negligence or intentional misconduct, in part because of their history of being penalized for violating their duties and legal requirements in other jurisdictions.

511. The Pharmacy Defendants each have one or more pharmacies that fill prescriptions for opioids which are operating within or in close proximity to the Town of Bennington, or are sending prescriptions to the Town of Bennington via their mail service.

b. Multiple Enforcement Actions against the Retail Pharmacy Defendants Confirms Their Compliance Failures.

512. The Pharmacy Defendants have long been on notice of their failures to abide by state and federal law and regulations governing the distribution and dispensing of prescription opioids. Several of the Pharmacy Defendants have been repeatedly penalized for their illegal prescription opioid practices. In consideration of a reasonable opportunity for further investigation

and discovery, Plaintiff alleges that based upon the widespread nature of these violations, these enforcement actions are the product of, and confirm, national policies and inadequate control practices of the Pharmacy Defendants.

i. CVS

513. CVS is one of the largest companies in the world, with annual revenue of more than \$150 billion. CVS manages medications for more than 92 million lives at over 9,900 retail locations. CVS could be a force for good in connection with the opioid crisis, but like other Defendants and contrary to its public pronouncements, CVS sought profits over patient safety.

514. CVS is a repeat offender; the company has paid fines totaling over \$40 million as the result of a series of investigations by the DEA and the DOJ. It nonetheless appears to have treated these fines as the cost of doing business and has allowed its pharmacies to continue dispensing opioids in quantities significantly higher than any plausible medical need would require, and to continue violating its recordkeeping and dispensing obligations under the CSA.

515. As recently as July 2017, CVS entered into a \$5 million settlement with the U.S. Attorney's Office for the Eastern District of California regarding allegations that its pharmacies failed to keep and maintain accurate records of Schedule II, III, IV, and V controlled substances.¹¹⁵

516. This fine was preceded by numerous others throughout the country.

517. In February 2016, CVS paid \$8 million to settle allegations made by the DEA and the DOJ that from 2008-2012, CVS stores and pharmacists in Maryland violated their duties under the CSA by filling prescriptions with no legitimate medical purpose.¹¹⁶

¹¹⁵ Press Release, U.S. Attorney's Office E. Dist. of Cal., *CVS Pharmacy Inc. Pays \$5M to Settle Alleged Violations of the Controlled Substance Act*, U.S. DEP'T OF JUST. (July 11, 2017), <https://justice.gov/usao-edca/pr/cvs-pharmacy-inc-pays-5m-settle-alleged-violationscontrolled-substance-act>.

¹¹⁶ Press Release, U.S. Attorney's Office Dist. of Md., *United States Reaches \$8 Million Settlement Agreement with CVS for Unlawful Distribution of Controlled Substances*, U.S. DEP'T OF JUST. (Feb. 12, 2016),

518. In October 2016, CVS paid \$600,000 to settle allegations by the DOJ that stores in Connecticut failed to maintain proper records in accordance with the CSA.¹¹⁷

519. In September 2016, CVS entered into a \$795,000 settlement with the Massachusetts Attorney General wherein CVS agreed to require pharmacy staff to access the state's prescription monitoring program website and review a patient's prescription history before dispensing certain opioid drugs.¹¹⁸

520. In June 2016, CVS agreed to pay the DOJ \$3.5 million to resolve allegations that 50 of its stores violated the CSA by filling forged prescriptions for controlled substances – mostly addictive painkillers – more than 500 times between 2011 and 2014.¹¹⁹

521. In August 2015, CVS entered into a \$450,000 settlement with the U.S. Attorney's Office for the District of Rhode Island to resolve allegations that several of its Rhode Island stores violated the CSA by filling invalid prescriptions and maintaining deficient records. The U.S. alleged that CVS retail pharmacies in Rhode Island filled a number of forged prescriptions with invalid DEA numbers, and filled multiple prescriptions written by psychiatric nurse practitioners for hydrocodone, despite the fact that these practitioners were not legally permitted to prescribe

<https://www.justice.gov/usao-md/pr/united-states-reaches-8-millionsettlement-agreement-cvs-unlawful-distribution-controlled>.

¹¹⁷ Press Release, U.S. Attorney's Office Dist. of Conn., *CVS Pharmacy Pays \$600,000 to Settle Controlled Substances Act Allegations*, U.S. DEP'T OF JUST. (Oct. 20, 2016), <https://www.justice.gov/usao-ct/pr/cvs-pharmacy-pays-600000-settle-controlled-substances-actallegations>.

¹¹⁸ Dialynn Dwyer, *CVS will pay \$795,000, strengthen policies around dispensing opioids in agreement with state*, BOSTON.COM (Sept. 1, 2016), <https://www.boston.com/news/localnews/2016/09/01/cvs-will-pay-795000-strengthen-policies-around-dispensing-opioids-inagreement-with-state>.

¹¹⁹ Press Release, U.S. Attorney's Office Dist. of Mass., *CVS to Pay \$3.5 Million to Resolve Allegations that Pharmacies Filled Fake Prescriptions*, U.S. DEP'T OF JUST. (June 30, 2016), <https://www.justice.gov/usao-ma/pr/cvs-pay-35-million-resolve-allegations-pharmacists-filledfake-prescriptions>.

that drug. Additionally, the government alleged that CVS had recordkeeping deficiencies.¹²⁰

522. In May 2015, CVS agreed to pay a \$22 million penalty following a DEA investigation that found that employees at two pharmacies in Sanford, Florida, had dispensed prescription opioids, “based on prescriptions that had not been issued for legitimate medical purpose by a health care provider acting in the usual course of professional practice.” CVS also acknowledged that its retail pharmacies had a responsibility to dispense only those prescriptions that were issued based on legitimate medical need.¹²¹

523. In September 2014, CVS agreed to pay \$1.9 million in civil penalties to resolve allegations that in the State of Texas it had filled 153 prescriptions written by a doctor whose controlled-substances registration within the Texas Department of Public Safety had expired.¹²² The alleged violations of the Comprehensive Drug Abuse Prevention and Control Act occurred in the spring and summer of 2012.

524. In August 2013, CVS was fined \$350,000 by the Oklahoma Pharmacy Board for improperly selling prescription narcotics in at least five locations in the Oklahoma City metropolitan area.¹²³

525. Dating back to 2006, CVS retail pharmacies in Oklahoma and elsewhere intentionally violated the CSA by filling prescriptions signed by prescribers with invalid DEA

¹²⁰ Press Release, U.S. Attorney’s Office Dist. of R.I., *Drug Diversion Claims Against CVS Health Corp. Resolved with \$450,000 Civil Settlement*, U.S. DEP’T OF JUST. (Aug. 10, 2015), <https://www.justice.gov/usao-ri/pr/drug-diversion-claims-against-cvs-health-corp-resolved-450000-civil-settlement>.

¹²¹ Press Release, U.S. Attorney’s Office M. Dist. of Fla., *United States Reaches \$22 Million Settlement Agreement with CVS for Unlawful Distribution of Controlled Substances*, U.S. DEP’T OF JUST. (May 13, 2015), <https://www.justice.gov/usao-mdfl/pr/united-states-reaches-22-million-settlement-agreement-cvs-unlawful-distribution>.

¹²² Patrick Danner, *H-E-B, CVS Fined Over Prescriptions*, SAN ANTONIO EXPRESS-NEWS (Sept. 5, 2014), <http://www.expressnews.com/business/local/article/H-E-BCVSfined-over-prescriptions-5736554.php>.

¹²³ Andrew Knittle, *Oklahoma pharmacy board stays busy, hands out massive fines at time*, NEWSOK (May 3, 2015), <http://newsok.com/article/5415840>.

registration numbers.¹²⁴

ii. **Walgreens**

526. Walgreens is the second-largest retail pharmacy store chain in the U.S. behind CVS, with annual revenue of more than \$118 billion. According to its website, Walgreens operates more than 8,000 retail locations and filled 990 million prescriptions on a 30-day adjusted basis in fiscal 2017.

527. Walgreens also has been penalized for serious and flagrant violations of the CSA. Indeed, Walgreens agreed to the largest settlement in DEA history -- \$80 million -- to resolve allegations that it committed an unprecedented number of recordkeeping and dispensing violations of the CSA, including negligently allowing controlled substances such as oxycodone and other prescription painkillers to be diverted for abuse and illegal black market sales.¹²⁵

528. As part of the settlement, Walgreens admitted that it failed to uphold its obligations as a DEA registrant regarding the above-described conduct.¹²⁶

529. The settlement resolved investigations into and allegations of CSA violations in Florida, New York, Michigan, and Colorado that resulted in the diversion of millions of opioids into illicit channels.

530. Walgreens' Florida operations highlight its egregious conduct regarding diversion of prescription opioids. Walgreens' Florida pharmacies each allegedly ordered more than one

¹²⁴ Press Release, U.S. Attorney's Office W. Dist. of Okla., *CVS to Pay \$11 Million to Settle Civil Penalty Claims Involving Violations of Controlled Substances Act*, U.S. DEP'T OF JUST. (Apr. 3, 2013), <https://www.justice.gov/usao-wdok/pr/cvs-pay-11-million-settle-civil-penaltyclaims-involving-violations-controlled>.

¹²⁵ Press Release, U.S. Attorney's Office S. Dist. of Fla., *Walgreens Agrees to Pay a Record Settlement of \$80 Million for Civil Penalties Under the Controlled Substances Act*, U.S. DEP'T OF JUST. (June 11, 2013), <https://www.justice.gov/usao-sdfl/pr/walgreens-agrees-pay-recordsettlement-80-million-civil-penalties-under-controlled>.

¹²⁶ *Id.*

million dosage units of oxycodone in 2011 – more than ten times the average amount.¹²⁷

531. The subject pharmacies increased their orders over time, in some cases as much as 60% in the space of just two years, including, for example, supplying a town of 3,000 with 285,800 orders of oxycodone in a one-month period. Yet, Walgreens corporate officers not only turned a blind eye, but provided pharmacists with incentives through a bonus program that compensated them based on the number of prescriptions filled at the pharmacy. In fact, corporate attorneys at Walgreens suggested, in reviewing the legitimacy of prescriptions coming from pain clinics, that “if these are legitimate indicators of inappropriate prescriptions perhaps we should consider not document our own potential noncompliance,” underscoring Walgreen’s attitude that profit outweighed compliance with the CSA or the health of communities.¹²⁸

532. Defendant Walgreens’ settlement with the DEA stemmed from the DEA’s investigation into Walgreens’ distribution center in Jupiter, Florida, which was responsible for significant opioid diversion in Florida. According to the Order to Show Cause, Defendant Walgreens’ corporate headquarters pushed to increase the number of oxycodone sales to Walgreens’ Florida pharmacies, and provided bonuses for pharmacy employees based on the number of prescriptions filled at the pharmacy in an effort to increase oxycodone sales. In July 2010, Defendant Walgreens ranked all of its Florida stores by number of oxycodone prescriptions dispensed in June of that year, and found that the highest-ranking store in oxycodone sales sold almost 18 oxycodone prescriptions per day. All of these prescriptions were filled by the Jupiter Center.¹²⁹

¹²⁷ Order to Show Cause and Immediate Suspension of Registration, *In the Matter of Walgreens Co.* (Drug Enf’d Admin. Sept. 13, 2012).

¹²⁸ *Id.*

¹²⁹ *Id.*

533. The six retail pharmacies in Florida that received the suspicious drug shipments from the Jupiter Distribution Center, in turn, filled customer prescriptions that they knew or should have known were not for legitimate use.¹³⁰

534. Walgreens has also settled with a number of state attorneys general, including West Virginia (\$575,000) and Massachusetts (\$200,000).¹³¹

535. The Massachusetts Attorney General's Medicaid Fraud Division found that, from 2010 through most of 2015, multiple Walgreens stores across the state failed to monitor the opioid use of some Medicaid patients who were considered high-risk. As a result, Walgreens agreed to pay \$200,000 and follow certain procedures for dispensing opioids.¹³²

iii. Rite Aid

536. On January 11, 2009 Rite Aid entered into an agreement to pay \$5 Million in civil penalties for CSA violations and to enter into a Compliance Plan to ensure compliance with all requirements of the CSA and applicable DEA regulations and to prevent diversion of controlled substances. This action was based on systemic violations of Rite Aid's obligation to prevent diversion across 53 Rite Aid locations.

537. On March 9, 2017 Rite Aid entered into an agreement to pay \$834, 200 in civil fines for CSA violations.

¹³⁰ *Id.*

¹³¹ *Walgreens to pay \$200,000 settlement for lapses with opioids*, APHA (Jan. 25, 2017), <https://www.pharmacist.com/article/walgreens-pay-200000-settlement-lapses-opioids>.

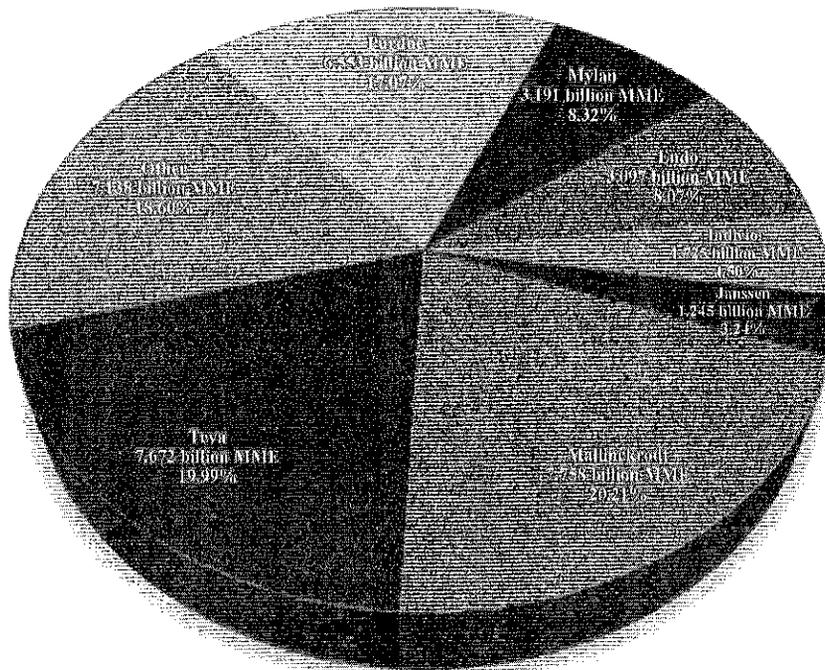
¹³² *Id.*

c. PBM Mail Order Pharmacies

538. Each of the PBM Defendants operate lucrative mail order pharmacies that have purchased, dispensed and profited from the movement of the brand and generic opioids at issue in this litigation.

539. During the 2006-2012 time period, PBM mail order pharmacies purchased more than 38 billion MMEs, spread over more than 2.1 billion dosage units.

National Mail Order MME by Defendant Manufacturer
ARCOS Data 20106-2012

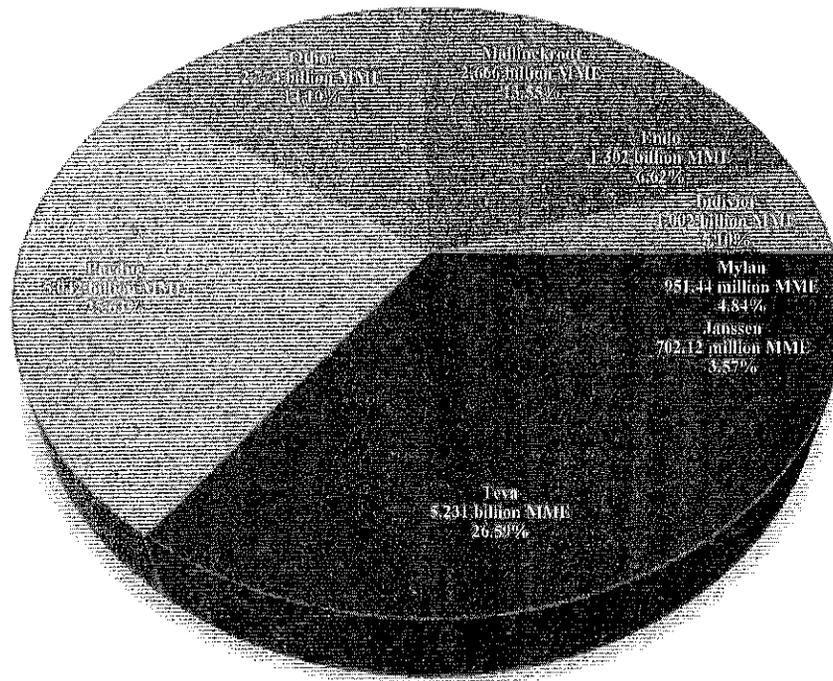


540. The DEA Arcos Database reveals that over 51% of the 45+ billion MMEs moved through the mail order channel were purchased by Express Scripts Mail Order pharmacies. Specifically, during the 2006-2012 time period, Express Scripts mail order pharmacies bought 19,674,412 MMEs spread over 993 million opioid dosage units.

541. Not surprising given their lengthy collaboration with regard to OxyContin, nearly 26% of Express Scripts Mail Order MME purchases were for Purdue opioids.

542. 26.59% of Express Scripts' mail order opioid purchases were for Teva generics; 13.55% were for Mallinckrodt generics; 6.62% were for Endo generics; 5.1% were for Indivior generics; and 4.84% were for Mylan generics. Express Scripts dispensed these opioid products by mail to patients nationwide, including in Bennington.

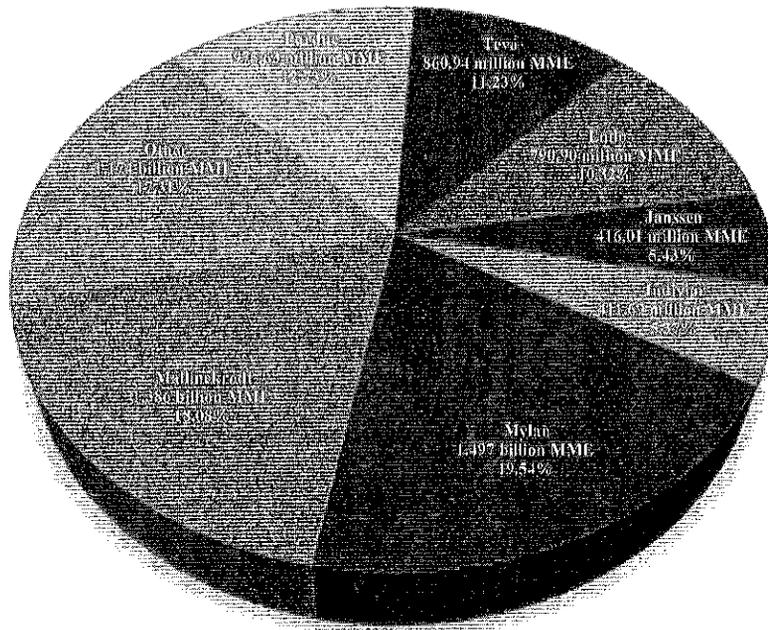
Express Scripts National Mail Order MME by Defendant Manufacturer
ARCOS Data 2006-2012



543. The publicly available ARCOS data also reveals that nearly 20% of the 38+ billion mail order MMEs were purchased by Caremark's mail order pharmacy. Specifically, during the 2006-2012 time period, Caremark mail order pharmacies bought 7,666,788,043 MMEs spread over 447,097,994 opioid dosage units.

544. 19.54% of Caremark’s Mail Order opioid purchases were for Mylan generics; 18.08% were for Mallinckrodt generics; 16.67% were for Mylan generics; 12.73% were for Purdue products; 11.23% were for Teva generics; 10.32% were for Endo generics; and 5.37% were for Indivior products. Caremark dispensed these opioid products by mail to patients nationwide, including in Bennington.

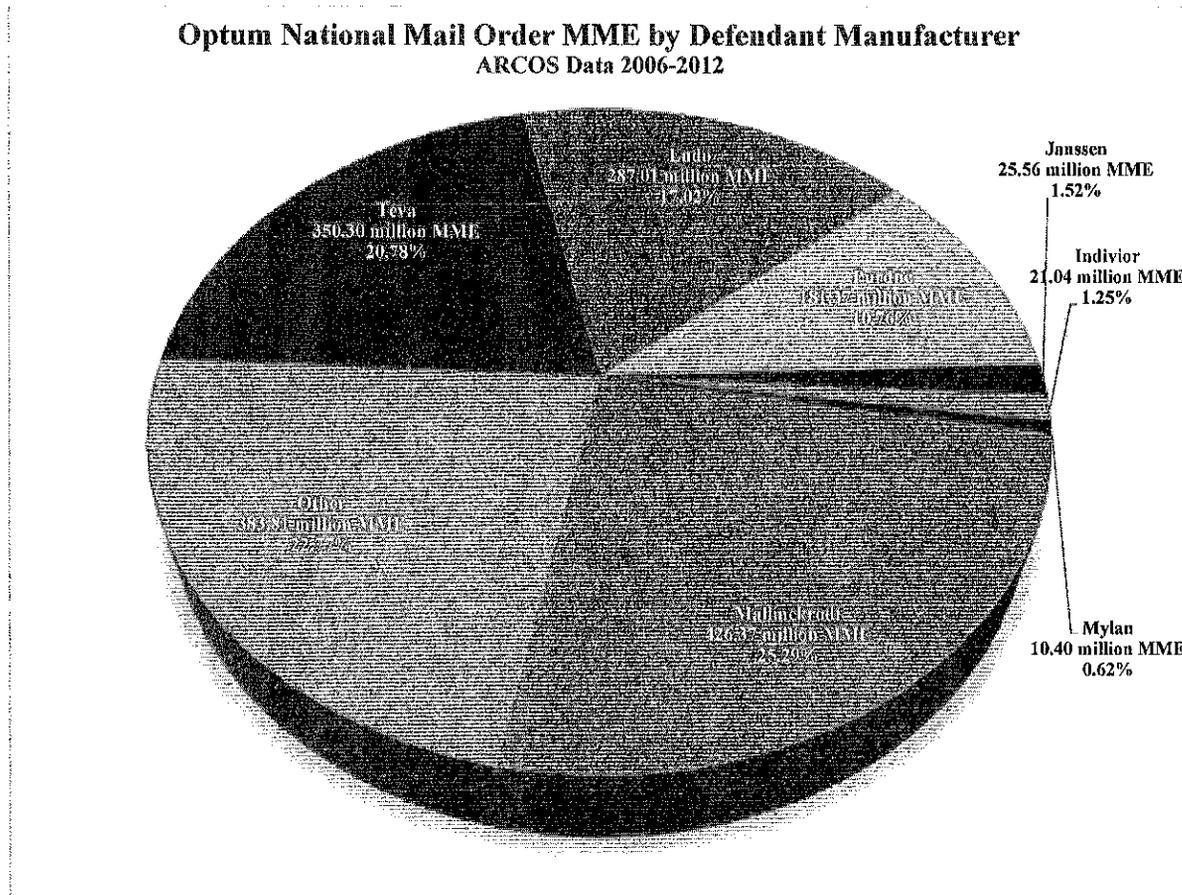
Caremark National Mail Order MME by Defendant Manufacturer
ARCOS Data 2006-2012



545. The publicly available ARCOS data also reveals that 4.39% of the 45+ billion mail order MMEs were purchased by Optum’s mail order pharmacy. Specifically, during the 2006-2012 time period, Optum mail order pharmacies bought and sold 1,685,881,413 MMEs spread over 142,490,200 opioid dosage units.

546. 25.29% of Optum’s Mail Order opioid purchases were for Mallinckrodt generics; 20.78% were for Teva generics; 17.02% were for Endo generics; 10.76% were for Purdue

products; and 1.25% were Indivior products. Optum dispensed these opioid products by mail to patients nationwide, including in Bennington.



547. PBM Mail Order pharmacies earn particularly large profits from their purchase and dispensing of generic drugs, including the generic opioids at issue in this litigation.

548. They earn these profits in assorted ways including but not limited to manipulation of maximum allowable cost (MAC) pricing lists; spread pricing practices; repackaging; and negotiating discounts for generic purchases that are not shared with their customers.

549. As a general proposition, drugs dispensed from mail order pharmacies account for a minority of PBM's prescriptions but more than half of their per-prescription profits.

4. The PBM Defendants Ensured that Opioids Were Regularly Prescribed and Flooded the Market.

550. PBMs are the middlemen between the defendant drug manufacturers and the availability of opioids. The PBM plan designs determine what drugs (a) will be available (or not available) to patients; (b) for what diagnosis, efficacious or otherwise; (c) in what quantities; (d) at what co-pay; (e) what level of authorization will be required; and (f) what beneficial drugs or treatments will not be available.

551. PBMs not only control the majority of this country's prescriptions through their benefit plan design and formulary management, they generate massive profits from that work. PBMs are paid by drug companies to move product. "[N]early one third of all expenditures on branded drugs in 2015 were eventually rebated back. And, most of these rebates directly benefited the PBM."

552. In addition to rebates, PBMs negotiate the payment of administrative fees, volume bonuses and other forms of consideration from manufacturers. The PBMs' ability to negotiate these incentives from drug manufacturers derives from their control of the factors driving utilization, including formulary development and plan design.

553. PBMs have incentives to move both brand and generic opioids. On the brand side, as stated above, PBMs collude with manufacturers who pay fees in the form of rebates, administrative fees and other incentives in exchange for favorable formulary placement. The more favorable the formulary placement, the greater the utilization. Utilization inures to the financial benefit of the PBMs and manufacturers. It also leads to more prescriptions and more pills available to the general public, many of which find their way to the black market. PBMs make additional profits through imprecise definitions of what constitutes a brand drug, particularly one facing generic competition, as in this case. PBMs treat such brand drugs as "true brands" for purpose of

pricing through their mail order facilities (thereby earning additional profit at the higher AWP benchmark reimbursement); they treat such brands as generics when called upon to make a reimbursement payment themselves to an unaffiliated retailer.

554. On the generic side, PBMs make substantial profits through their interactions with, and operation of, mail order and retail pharmacies. At all times relevant hereto, the PBM Defendants were operating both and dispensing or reimbursing generic opioids through both. PBMs routinely pocket the spreads between the reimbursement it receives for generics from its clients as compared with the price the PBM pays the pharmacy for that same drug (including when that pharmacy is the PBM's own captive mail order pharmacy). In this way the PBM profits from every generic it sells or reimburses.

555. PBMs also pay retail pharmacies based upon maximum allowable costs (MACs) but pay their own captive mail order pharmacies based on AWP- for the very same NDC. AWP's are higher than MACs; through this disparate reimbursement the PBM enhances what it earns on any opioid subject to this pernicious practice. The gamesmanship creates an incentive for the PBM to drive customers towards its own mail order delivery system.

556. The ARCOS data confirms that the PBMs were moving opioids through their national mail order pharmacies.

557. PBMs also escape the pricing constraints imposed by MAC lists by repackaging certain drugs.

558. At all times relevant hereto, PBMs have had the ability to limit the number of opioid pills, refills and daily MME made available. PBMs were well aware of their influence over utilization as a result of benefit plan design, formulary placement, and drug utilization management. They knew and understood that through their self-dealing, more addictive opioids- brand and generic- would enter the marketplace and more addicts would be created. Indeed, PBMS

have now expressly acknowledged that they are “uniquely positioned to help address the opioid epidemic”. Yet, for over a decade they elected to construct national offerings designed to maximize access to the most dangerous, addictive, overused and oversupplied drugs at issue in this national epidemic.

559. The power of the PBMs has evolved over time. Originally mere claims processors, PBMs now play a major role in managing pharmaceutical spending and enhancing health benefits for end-users. Drug manufacturers recognize the power of the PBMs to drive utilization.

560. PBMs quietly became an integral part of the pharmaceutical supply chain – that is, the path a drug takes from the manufacturing facility to a bathroom medicine cabinet – following the passage of the Medicare Modernization Act in 2003.

561. Today, the big three PBMs manage the drug benefits for nearly 95% of the population.¹³³ They drive what drugs are covered by virtually all health insurance providers for over 260 million people. PBMs made almost \$260 billion last year.¹³⁴ In 2015 they covered most of the 4 billion retail prescriptions that were covered in the United States.¹³⁵ They are key participants and play a crucial role in the administration and reimbursement of prescription drugs.¹³⁶

562. PBM influence results from the lack of competition in the PBM space. Market concentration is an important indicator of a company’s ability to earn extraordinary returns, and

¹³³ Hoffman-Eubanks, *supra* note 16.

¹³⁴ John Breslin, *Health care experts call for more transparency into PBMs*, PATIENTDAILY, Dec. 20, 2017, <https://patientdaily.com/stories/511298841-health-care-experts-call-for-more-transparency-into-pbms>

¹³⁵ Lydia Ramsey and Skye Gould, *A huge pharma middleman just lost its biggest customer — and it shows how drug pricing really works*, BUSINESS INSIDER, Apr. 25, 2017, <http://www.businessinsider.com/express-scripts-esrx-anthem-not-renewing-pbm-2017-4>

¹³⁶ Health Policy Brief, *supra* note 29.

several segments in the United States pharmaceutical distribution system are highly concentrated.¹³⁷

563. In this environment, the top three PBMs have substantial if not exclusive control over the dissemination of opioids. In concert with drug manufacturers who provide them with assorted complicated payments as incentives,¹³⁸ PBMs design benefit plans determining which drugs will be paid for, reimbursed, or covered by public and private pharmacy benefit plans, allowing the drugs to enter the marketplace to be abused.

564. For example, notwithstanding its express assurance to its customers that it “agrees to act as a fiduciary in good faith, with candor and due diligence in connection with the performance of [its PBM contract] and any negotiations related thereto,”¹³⁹ OptumRx proceeds to define its formulary as follows:

“A list of prescription drugs administered by PBM that has been evaluated by the PBM for inclusion on its formulary (‘Formulary’)... [T]he drugs included on the PBM's Formulary may be modified by PBM . . . from time-to-time as a result of factors including, but not limited to, medical appropriateness, *manufacturer rebate arrangements* and patent expirations.¹⁴⁰[emphasis added]

565. Notably, OptumRx does not explain how “manufacturer rebate arrangements” impact its formulary design.

566. Express Scripts likewise is paid by drug manufacturers based on formulary design:

Express Scripts contracts for its own account with pharmaceutical manufacturers to obtain rebates attributable to the utilization of certain prescription products by individuals who receive benefits from clients for

¹³⁷ Neeraj Sood, Tiffany Shih, Karen Van Nuys, Dana Goldman, *Follow the Money: The Flow of Funds In the Pharmaceutical Distribution System*, HEALTH AFFAIRS, Jun. 13, 2017, <https://www.healthaffairs.org/doi/10.1377/hblog20170613.060557/full/>

¹³⁸ Health Policy Brief, *supra* note 37.

¹³⁹ United Healthcare Services, Inc. and Employees Retirement System of Texas, *Pharmacy Benefit Management Services Executed Contract*, Section 2.3 (2016), <https://ers.texas.gov/Doing-Business-with-ERS/PDFs/Contract-for-Pharmacy-Benefit-Management-Services-for-the-HealthSelect-Prescription-Drug-Program.pdf>

¹⁴⁰ *Id.* at Section 4.1(h)(i).f

whom we provide PBM services. *Rebate amounts vary based on the volume of utilization as well as the benefit design and formulary position applicable to utilization of a product.* Express Scripts often pays all or a portion of the rebates it receives to a client based on the client's PBM services agreement. Express Scripts retains the financial benefit of the use of any funds held until payment is made to a client. In connection with our maintenance and operation of the systems and other infrastructure necessary for managing and administering the rebate process, *Express Scripts also receives administrative fees* from pharmaceutical manufacturers participating in the rebate program discussed above. *The services provided to participating manufacturers include making certain drug utilization data available, as allowed by law, for purposes of verifying and evaluating the rebate payments.* The administrative fees paid to Express Scripts by manufacturers for participation in the rebate program do not exceed 3.5% of the AWP of the rebated products.¹⁴¹

567. It is notable that Express Scripts does not commit to share all of the rebates it receives from drug manufacturers with its clients, nor does it commit to share any of the administrative fees. Nor does it explain all of the services for which it receives the administrative fees. Nor does it explain how any of these payments actually influence its formulary design. Also noteworthy is that Express Scripts pegs its administrative fees to Average Wholesale Price (AWP), which is a reported price higher than any Express Scripts customer pays for any drug.

568. Express Scripts' standard contract language contemplates that it will derive even further revenue from drug manufacturers in other vaguely described arrangements, none of which are shared with its customers:

[I]f any, ESI and ESI's wholly-owned subsidiaries derive margin from fees and revenue in one or more of the ways as further described [herein] ESI and ESI's wholly-owned subsidiaries act on their own behalf, and not for the benefit of or as agents for [its customers]. *ESI and ESI's wholly-owned subsidiaries retain all proprietary rights and beneficial interest in such fees*

¹⁴¹ Express Scripts, Inc. and Oklahoma City Municipal Facility Authority, Pharmacy Benefit Management Agreement, pg. 30, Exhibit E (2008), <http://nationalprescriptioncoveragecoalition.com/wp-content/uploads/2017/07/WebPage-2.pdf>

*and revenues described in the Financial Disclosure and, accordingly, [customer] acknowledges that neither it, any Member, nor the Plan, has a right to receive, or possesses any beneficial interest in, any such fees or revenues*¹⁴²

569. A standard Caremark PBM Contract reflects similar perverse incentives. It explains that “‘Manufacturer’ means a pharmaceutical company that has contracted with Caremark (or its affiliate or agent) *to offer discounts for pharmaceutical products in connection with Caremark's Formulary Services.*”¹⁴³[emphasis added]

570. And, “‘Manufacturer Payments’ include revenues received by Caremark, [F]rom each of the following sources: 1) payments received in accordance with agreements with pharmaceutical manufacturers for formulary placement and, if applicable, drug utilization; 2) rebates, regardless of how categorized; 3) market share incentives; 4) commissions; 5) any fees received for the sale of utilization data to a pharmaceutical manufacturer; 6) educational grants; 7) administrative management fees; and 8) all compensation from manufacturers including rebates paid by a manufacturer as a result of product inflation caps and/or guarantees negotiated by the Service Provider.”¹⁴⁴

571. Caremark’s standard PBM contract further explains:

[T]hat, in lieu of billing Member County a ‘per Claim’ fee for Services, Caremark shall retain 100% of the Rebates as reasonable compensation for the Services. Customer and Member County understand and agree that neither they nor any Participant will share in the Rebate monies collected from Manufacturers by Caremark.¹⁴⁵

572. Caremark also explains that it will encourage the use of its “Preferred Drugs” (those where it has the most lucrative arrangement with a drug manufacturer) over “non-Preferred” drugs.

¹⁴² *Id.* at pp. 8-9, Section 6.4.

¹⁴³ CaremarkPCS Health, L.P. and the National Association of Counties, Managed Pharmacy Benefit Service Agreement, pg. 10, Section 10(f) (2006), <http://www.nassauclerk.com/agendaindex/Ordinances/other/CS-08-125.pdf>

¹⁴⁴ CaremarkPCS Health, L.L.C. and Florida Department of Management Services, *Pharmacy Benefit Management Services contract*, pg. 7, Section 1.1 (2015), https://www.dms.myflorida.com/content/download/107930/607791/2015_PBM_Contract_REDACTED_FINAL.pdf

¹⁴⁵ CaremarkPCS Health, L.P. and the National Association of Counties, Managed Pharmacy Benefit Service Agreement, pg. 4, Section 2.1 (2006), <http://www.nassauclerk.com/agendaindex/Ordinances/other/CS-08-125.pdf>

Its standard contract language states that Caremark will encourage the use of “Preferred Drugs” by:

(i) identifying appropriate opportunities for converting a prescription from a non-Preferred Drug to a Preferred Drug, and (ii) contacting the Participant and the prescriber to request that the prescription be changed to the Preferred Drug. A Preferred Drug is one on the Performance Drug List, which has been developed by Caremark as a clinically appropriate *and economically advantageous subset of the Caremark Formulary*, as revised by Caremark from time to time.¹⁴⁶ [emphasis added]

573. The harm caused by the PBMs is not just monetary: “The PBMs and insurers are harming the health of patients with chronic and rare diseases by limiting access and charging them retail for drugs they buy at deep discounts.”¹⁴⁷ PBMs also fail to control quantities, or numbers of refills for highly addictive drugs and ignore or neglect their duties to ensure patient wellness.

574. PBMs also provide discount drug cards so individuals can directly purchase medications without going through insurance companies. This allows individuals to fill multiple prescriptions while avoiding the oversight that insurance coverage brings, thus fueling the epidemic. PBMs allow this loophole because they are paid for every prescription filled in this manner.

575. MedPageToday, a source for clinical and policy coverage that directly affects the lives and practices of health care professionals, describes the PBMs’ complicity in the opioid crisis this way:

We live in a world where payers -- not physicians -- determine what drugs and treatments patients receive. If patients have a life-threatening condition, it is not unusual for a payer to demand that a physician first prescribe a cheaper and less effective alternative. Physicians know that the drugs they are allowed to use may not work very well, but frequently, payers demand that they be tried first anyway.

¹⁴⁶ CaremarkPCS Health, L.P. and the National Association of Counties, *Managed Pharmacy Benefit Service Agreement*, pg. 3, Section 1.11 (2006), <http://www.nassauclerk.com/agenda/index/Ordinances/other/CS-08-125.pdf>

¹⁴⁷ Jonathan Wilcox, *PBMs Must Put Patients First*, HUFFINGTON POST, Feb. 28, 2017, https://www.huffingtonpost.com/entry/pbms-must-put-patients-first_us_58b60bd8e4b02f3f81e44dcc

What happens if the patient doesn't respond to the cheap drug? Often, the physician continues to prescribe it, because -- to gain access to the more effective drug -- physicians need to go through a painful process of preauthorization. For many practitioners, it isn't worth it.

So we spend more for healthcare than any other country in the world, but Americans do not get the care they need. There is a simple reason. Treatment decisions are not being driven based on a physician's knowledge or judgment. They are being driven by what payers are willing to pay for.¹⁴⁸

576. Thus, people with chronic pain are at the mercy of PBMs, yet PBMs make it easier to get opioids than to get other pain medication that is less addictive, because opioids are generally cheaper than non-opioid alternatives and opioid manufacturers have provided rich incentives, as described above. According to a study by the New York Times and ProPublica, of 35.7 million people on Medicare prescription drug plans, in the second quarter of 2017 only one-third of them had access to pain medication less addictive than opioids.¹⁴⁹

577. Even when they were asked to limit accessibility to opioids, PBMs refused. The seeds of the opioid epidemic were sown with early over prescription of OxyContin. In 2001, when officials in the West Virginia state employee health plan tried to get Purdue, which manufactured OxyContin, to require pre-authorization, Purdue refused.¹⁵⁰ Using the financial quid pro quo it had with the West Virginia PBM, it paid Merck Medco (now Express Scripts) to prevent insurers from limiting access to the drug. This practice was consistent nationwide.

The strategy to pay Merck Medco extended to other big pharmacy benefit managers and to many other states, according to a former Purdue official responsible for ensuring favorable treatment for OxyContin. The payments were in the form of "rebates" paid by Purdue to the companies. In return,

¹⁴⁸ Milton Packer MD, *Are Payers the Leading Cause of Death in the United States?*, MEDPAGETODAY, Nov. 1, 2017, <https://www.medpagetoday.com/blogs/revolutionand revelation/68935>

¹⁴⁹ Thomas and Ornstein, *supra* note 49.

¹⁵⁰ David Armstrong, *Drug maker thwarted plan to limit OxyContin prescriptions at dawn of opioid epidemic*, STAT, Oct. 26, 2016, <https://www.statnews.com/2016/10/26/oxycontin-maker-thwarted-limits/>

the pharmacy benefit managers agreed to make the drug available without prior authorization and with low copayments.

“That was a national contract,” Bernadette Katsur, the former Purdue official, who negotiated contracts with pharmacy benefit managers, said in an interview. “We would negotiate a certain rebate percentage for keeping it on a certain tier related to copay or whether it has prior authorization. We like to keep prior authorization off of any drug.”¹⁵¹

578. PBMs are “driving patients to opioids, away from abuse-deterrent form (ADF) and less addictive forms of opiates through formulary and pricing strategies.”¹⁵²

579. Not only do PBMs place roadblocks in the way of limiting excessive opioid prescriptions, they also make it more difficult to obtain ADF opioids. These pills are more difficult to physically alter (crushing to snort or dissolving to inject) and therefore are less prone to abuse.¹⁵³ The three major PBMs carry at most 3 of the 10 FDA approved ADF opioids, while CVS Caremark, which has nearly 90 million members, carries none.¹⁵⁴ A study by Tufts CSSD found that ninety-six percent (96%) of all prescription opioids were non-ADF in 2015.¹⁵⁵

580. Making matters worse, in addition to making it easy to obtain generic highly addictive opioids, PBMs make it *harder* to obtain *treatment*. The NY Times/ProPublica study found that insurers have erected more hurdles to approving addiction treatments than for the addictive substances themselves.¹⁵⁶ Only after being subject to much public pressure and congressional investigations did some insurers remove the barriers to addiction treatment.

¹⁵¹ *Id.*

¹⁵² Charles L. Bennett MD PhD MPP, *Do you have pain, cancer, or diabetes? Your PBM may now be your doctor for these illnesses*, COLLABRX, Dec. 27, 2017, <http://www.collabrx.com/pain-cancer-diabetes-pbm-may-now-doctor-illnesses/>

¹⁵³ Pitts, *supra* note 17.

¹⁵⁴ Bennett, *supra* note 104.

¹⁵⁵ Pitts, *supra* note 17.

¹⁵⁶ Thomas and Ornstein, *supra* note 16.

581. A 2008 study by the Mayo Clinic¹⁵⁷ found that patients who were weaned off opioids and followed a non-drug treatment experienced less pain than when they were on opioids and had improved functioning. Some plans cover these costs but other do not.¹⁵⁸

582. In addition to their role designing prescription drug benefit programs, one responsibility of all PBMs and their employed pharmacists is to properly monitor and control the distribution of prescription opioids. PBMs market their abilities to ensure that the medications they dispense are appropriately dosed, and monitored for drug interactions, therapeutic duplications, and possible misuse or abuse.

583. PBMs also market their ability to manage and oversee the quality of the retail pharmacies that are contracted to be in their network. At critical times, PBMs were – at best – asleep at the switch when it came to auditing pharmacies that were dispensing huge quantities of opioids. The fact that very few if any “pill-mill” pharmacies or over-prescribing physicians were reported by PBMs to the State Boards of Pharmacies or State Medical Boards is testament to the PBMs’ lack of oversight of opioids.

584. In fact, OptumRx has recently been transparent with its knowledge that 45% of ‘first fill’ opioid prescriptions nationwide are not in compliance with CDC guidelines.¹⁵⁹

585. There are steps the PBMs could take. They could make it easier to access other non-addictive forms of pain relief. They could require doctors to start treating pain first with non-opioid pain medications as recommended by the CDC and turn to opioids as a last resort. They could cover alternative, non-medication treatments for pain. They could make addiction treatment more

¹⁵⁷ Available at <https://www.ncbi.nlm.nih.gov/pubmed/18804915>

¹⁵⁸ Barry Meier and Abby Goodnough, *New Ways To Treat Pain Meet Resistance*, THE NEW YORK TIMES, Jun. 22, 2016, <https://www.nytimes.com/2016/06/23/business/new-ways-to-treat-pain-without-opioids-meet-resistance.html?mcubz=1>,

¹⁵⁹ OptumRx, *OptumRx Opioid Risk Management*, 2018, <https://www.optum.com/resources/library/opioid-risk-management0.html>, at 3.

accessible. They could monitor prescriptions. They could forbid 90-day supplies of opioids. They could audit pharmacies. They could require doctors and pharmacies in their networks to use PDMPs. They could make their pricing more transparent so everyone could see if they were being improperly influenced by manufacturers to make choices for financial, not medical reasons.

586. The PBM defendants expressly recognize that they have the ability to abate the opioid epidemic. OptumRx admits that PBMs are “uniquely positioned to help address the opioid epidemic.”¹⁶⁰ Express Scripts admits that “we have the ability to make a significant impact.”¹⁶¹

587. Yet PBMs are still not doing all they (easily) can to halt the improper dispensing of opioids and expand access to treatments for opioid overdose and addiction.

588. Each of the PBM Defendants recently have begun offering opioid management programs for certain customers that they claim (falsely) are consistent with the March 2016 U.S. Centers for Disease Control and Prevention, CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016, 65 Morbidity and Mortality Weekly Report 1 (2016) (“CDC Guideline”).

589. In truth, even these new opioid management programs do not apply across the board to all customers and still fall woefully short of the CDC Guideline and all current medical literature regarding the highly dangerous properties of opioids.

590. None of the big three PBMs’ new opioid management programs are consistent with the CDC Guideline – they still permit the largely unchecked prescribing of opioids for chronic pain (the CDC says opioids are not proven effective for chronic pain); still provide seven-day

¹⁶⁰ OptumRx, *Confronting the Opioid Epidemic*, 2018, <https://www.optum.com/resources/library/opioid-e-book.html?s3=rxopioid>, at 9.

¹⁶¹ Express Scripts, *Express Scripts Significantly Reduces Inappropriate Selection and Excessive Dispensing of Opioids for New Patients*, Jan. 11, 2018, <http://lab.express-scripts.com/lab/insights/drug-safety-and-abuse/reducing-inappropriate-selection-and-excessive-dispensing-of-opioids>, at 2.

quantity limits for acute pain (when the CDC says “three days or less will often be sufficient” and the PBMs themselves acknowledge that “a few days” can make a difference in whether one becomes addicted); still permit opioid prescriptions to be delivered through mail-order pharmacies for conditions outside of active cancer, end-of-life or palliative care (which typically supply maintenance drugs for chronic conditions; it is well-established that except for active cancer, end-of-life or palliative care, opioids should not be dispensed for chronic pain); do not adhere to CDC MME/day recommendations; do not cover high dosage nonopioid alternatives; do not require step therapies; and do not require prior authorizations for the most commonly prescribed immediate-release opioids.

591. At the same time, the PBMs also continue to impose unnecessary restrictions on access to treatments for opioid overdose and addiction.

592. These failures have contributed mightily to the roots of the opioid epidemic and its ongoing impact today.

593. The PBMs own documents confirm the important role PBMs play in implementing the CDC Guideline.

594. Nearly one year after the CDC Guideline was issued, Caremark publicly acknowledged that, “[p]harmacy benefit managers (PBMs) play an important role in implementing the CDC [G]uideline, and helping ensure access and patient safety” and assured its customers that it had “taken a thoughtful, evidence-based approach to implementing the CDC guideline into our utilization management (UM) criteria with consideration of the needs of those with chronic pain, as well as the potential for harm from these powerful medications.”¹⁶²

¹⁶² CVS Health, *The Balancing Act, Helping Ensure Appropriate Access to Opioids While Minimizing Risk*, INSIGHTS FEATURE, Feb. 28, 2017, <https://payorsolutions.cvshealth.com/insights/balancing-act>, at 1 (emphasis added).

595. Caremark also assured the public that its “UM criteria reinforce [the CDC] principles and encourage appropriate use of opioids by patients and prescribers. They provide coverage that fosters safe use of opioids, consistent with the ... CDC [G]uideline, to support plans helping members on their path to better health.”¹⁶³

596. Express Scripts similarly boasts that its Advanced Opioid Management program “is based on CDC prescribing guidelines” and “promot[es] greater compliance with CDC guidelines.”¹⁶⁴

597. OptumRx likewise claims that its “utilization management edits are tightly aligned with Centers for Disease Control (CDC) prescribing guidelines.”¹⁶⁵

598. The foregoing assurances of fostering “safe use of opioids” consistent with the CDC Guideline are false. The PBM Defendants’ utilization management criteria – to this day and despite all their talk – fall far short of meeting the CDC Guideline. As one news outlet described it, “[o]ne overlooked culprit worsening the epidemic, however, comes straight from our health care system: pharmacy benefit managers, or PBMs. To improve their bottom line, they’re blocking access to prescriptions that can help prevent overdoses.”¹⁶⁶

599. In sum, because PBMs are the intermediary between drug manufacturers, pharmacies, and ultimately patients, these companies influence everything from pharmacy reimbursements, to what drugs are covered under formularies. In these ways, the PBMs drive which drugs enter the marketplace. Their fingerprints are on nearly every opioid prescription filled and they profit in myriad ways on every pill.

¹⁶³ *Id.* at 5 (emphasis added).

¹⁶⁴ Express Scripts, *Express Scripts Significantly Reduces Inappropriate Selection and Excessive Dispensing of Opioids for New Patients*, *supra* note 161 at 1.

¹⁶⁵ *OptumRx Opioid Risk Management*, *supra* note **Error! Bookmark not defined.**

¹⁶⁶ Pitts, *supra* note 153.

600. PBMs' complicity in the overall fraudulent scheme is knowing and purposeful. Drug manufacturers compete for PBM formulary placement (preferred placement results in greater utilization and greater profits) and pay PBMs incentives to avoid pre-authorization requirements and other hurdles that would slow down flow. A review of the defendant PBM formularies confirms that they include all of the opioids at issue in this case, often in preferred tiers, without quantity limits or prior authorization requirements.

601. Caremark has three basic formularies: Standard Control, Advanced Control, and Value.¹⁶⁷

602. A wholly owned Caremark subsidiary (SilverScript) also manages two basic formularies for Medicare Prescription Drug Plans ("PDPs"), Choice and Plus.¹⁶⁸ Each of Caremark's basic formularies include opioids.

603. Caremark's Standard Control formulary contains no step therapies, prior authorization requirements or quantity limits for opioids on its face.¹⁶⁹

604. It imposes no three-day limitations for acute pain.¹⁷⁰

605. It does not limit the use of opioids for chronic pain outside active cancer, end-of-life and palliative care.¹⁷¹

¹⁶⁷ CVS Health, *Formulary Management*, <https://payorsolutions.cvshealth.com/programs-and-services/cost-management/formulary-management> (last visited Sept. 10, 2018)

¹⁶⁸ SilverScript, *Compare 2018 Plans – SilverScript*, <https://www.silverscript.com/plan/compare-module.aspx> (last visited Sept. 10, 2018)

¹⁶⁹ See CVS Caremark, *Performance Drug List – Standard Control*, July 2018, https://www.caremark.com/portal/asset/caremark_recaprclaimsdruglist.pdf (last visited Sept. 10, 2018) at 1;

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

606. The prescribing guide for the Standard Control formulary refers clinicians to 2017 prescribing guidelines, but even those do not require nonopioid step therapies for treatment of chronic pain or three-day limits for acute pain.¹⁷²

607. As late as 2018, although Caremark's Standard Control formulary covers methadone, and multiple buprenorphine and naloxone treatments, it did not cover any naltrexone treatments and it is unclear what utilization management or cost-sharing requirements may apply.¹⁷³

608. Caremark's Standard Control formulary does not cover the higher strength prescription dosages of the following nonopioid pharmacological options, useful in many step therapies: ibuprofen, topical lidocaine, amitriptyline, doxepin, desipramine, diflunisal, choline magnesium trisalicylate, salsalate, etodolac, sulindac, indomethacin, celecoxib, meclofenamate, and nabumetone.¹⁷⁴

609. Caremark's Advanced Control formulary contains no step therapies, prior authorization requirements or quantity limits for opioids on its face.¹⁷⁵

610. The Advanced Control formulary does not include many of the following prescription nonopioid pain treatment alternatives: capsaicin, diflunisal, choline magnesium trisalicylate, salsalate, etodolac, sulindac, indomethacin, meclofenamate, and nabumetone.¹⁷⁶

¹⁷² See CVS Caremark, *Prescribing Guide – Standard Control 2018*, https://www.caremark.com/portal/asset/Prescribing_Guide_Un-Authenticated.pdf (last visited Sept. 10, 2018) at 11.

¹⁷³ See CVS Caremark, *Performance Drug List – Standard Control*, *supra* note 169 at 1, 3.

¹⁷⁴ *Id.*

¹⁷⁵ See CVS Caremark, *Advanced Control Formulary*, July 2018, https://www.caremark.com/portal/asset/Advanced_Control_Formulary.pdf, at 1.

¹⁷⁶ *Id.*

611. Caremark's Value Formulary contains no step therapies for any immediate release opioids.¹⁷⁷

612. It has prior authorization requirements for some opioids, but not the most widely abused: hydrocodone-acetaminophen, oxycodone-acetaminophen and codeine-acetaminophen.¹⁷⁸

613. The Value Formulary points to the same lax 2017 opioid prescribing guidelines.¹⁷⁹

614. Caremark's Value Formulary imposes both prior authorization and/or quantity limits on the majority of pharmacologic treatments for opioid addiction and overdose.¹⁸⁰

615. This Value formulary (like Caremark's other commercial offerings) excludes an array of nonopioid pain relief options including: topical lidocaine, choline magnesium trisalicylate, salsalate, indomethacin, celecoxib, and meclufenamate.¹⁸¹

616. Even with its new Opioid Utilization Management Program, Caremark does not require step therapy as a pre-condition for coverage of immediate-release opioids.¹⁸²

617. Caremark does not impose three-day limits on opioids prescribed for acute pain.¹⁸³

618. Caremark does not require prior authorization when opioids are prescribed for chronic pain.¹⁸⁴

¹⁷⁷ See CVS Caremark, *CVS Caremark® Value Formulary Effective as of 07/01/2018*, https://www.caremark.com/portal/asset/Value_Formulary.pdf, at 9-10.

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* at 9.

¹⁸⁰ *Id.* at 10, 22-23.

¹⁸¹ *Id.*

¹⁸² See CVS Caremark, *CVS Caremark Opioid Quantity Limits Pharmacy Reference Guide*, Jan. 2018, https://www.caremark.com/portal/asset/Opioid_Reference_Guide.pdf.

¹⁸³ *Id.*

¹⁸⁴ *Id.*

619. Caremark limits the quantity of opioids prescribed per day, but only to 90 MME/day,¹⁸⁵ a quantity the CDC says should be avoided.¹⁸⁶

620. Caremark does not require prior authorization prior to dispensing immediate-release opioids, *i.e.*, hydrocodone-acetaminophen, oxycodone-acetaminophen, codeine-acetaminophen.¹⁸⁷

621. Caremark merely allows for an “emergency supply” of buprenorphine-naloxone products while it processes prior authorization, rather than broadly waiving such requirements.¹⁸⁸

622. The standard commercial Express Scripts formulary contains no restrictions whatsoever on the majority of opioids covered – no quantity limits, no step therapies, no prior authorization requirements.

623. Express Scripts recently updated its National Preferred Formulary to exclude coverage for two long-acting opioid oral analgesics (Opana ER and Oxycodone ER) and two narcotic analgesics (Buprenorphine Patches and Butrans) but, even there, Express Scripts presents no fewer than six “preferred alternatives,” each of which are highly addictive opioids available in extended-release forms.¹⁸⁹

¹⁸⁵ *Id.*

¹⁸⁶ *CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016*, 65 MORBIDITY AND MORTALITY WEEKLY REPORT 1 (2016) at 16, 22, 23.

¹⁸⁷ See *Performance Drug List – Standard Control*, *supra* note 169; *Prescribing Guide – Standard Control 2018*, *supra* note 172; *Advanced Control Formulary*, *supra* note 175; *CVS Caremark® Value Formulary Effective as of 07/01/2018*, *supra* note 177; *SilverScript Choice Formulary*, *supra* note **Error! Bookmark not defined.**; *SilverScript Choice Formulary*, *supra* note **Error! Bookmark not defined.**

¹⁸⁸ See CVS Health, *The Balancing Act, Helping Ensure Appropriate Access to Opioids While Minimizing Risk*, INSIGHTS FEATURE, Feb. 28, 2017, <https://payorsolutions.cvshealth.com/insights/balancing-act>, at 6.

¹⁸⁹ See Express Scripts, *2018 National Preferred Formulary Exclusions*, https://www.express-scripts.com/art/pdf/Preferred_Drug_List_Exclusions2018.pdf (last viewed Sept. 10, 2018) at 1.

624. The National Preferred Formulary indicates that certain naloxone (Narcan nasal spray) and buprenorphine Suboxone Sublingual Film and Zubsolv sublingual tablets) treatments are available, but does not list any methadone or naltrexone treatments.¹⁹⁰

625. The Express Scripts National Preferred formulary does not cover numerous highly effective prescription nonopioids including: doxepin, desipramine, diflunisal, choline magnesium trisalicylate, etodolac, sulindac, indomethacin, and meclofenamate.¹⁹¹

626. For an additional fee, Express Scripts now offers customers its Advanced Opioid Management Program.

627. Even in this program, Express Scripts does not impose a three-day limit for first-time users dealing with acute pain; does not require step therapy prior to dispensing immediate-release opioids; and does not require prior authorization for immediate-release opioids.¹⁹²

628. Express Scripts limits the dosage of opioids prescribed per day, but only to 200 MME/day, more than double the dosage which the CDC Guideline says should be avoided.¹⁹³

629. Nowhere does any Express Scripts formulary advise that opioids are inappropriate for chronic pain treatment outside active cancer, end-of-life or palliative care.¹⁹⁴ To the contrary,

¹⁹⁰ See Express Scripts, *2018 Express Scripts National Preferred Formulary*, https://www.express-scripts.com/art/open_enrollment/INTEL_NPFList.pdf (last viewed Sept. 10, 2018).

¹⁹¹ *Id.*

¹⁹² See Express Scripts, *Putting the brakes on the opioid epidemic*, <https://my.express-scripts.com/opioids.html>; Express Scripts, *A Comprehensive Solution to Reduce Opioid Abuse*, June 7, 2017, <http://lab.express-scripts.com/lab/insights/industry-updates/a-comprehensive-solution-to-reduce-opioid-abuse>; Nicholas Hamm, *Express Scripts Limits Opioid Prescriptions*, DRUG TOPICS, Aug. 17, 2017, <http://www.drugtopics.com/clinical-news/express-scripts-limits-opioid-prescriptions>; and Express Scripts, *Express Scripts Significantly Reduces Inappropriate Selection and Excessive Dispensing of Opioids for New Patients*, *supra* note 161.

¹⁹³ Nicholas Hamm, *Express Scripts Limits Opioid Prescriptions*, DRUG TOPICS, Aug. 17, 2017, <http://www.drugtopics.com/clinical-news/express-scripts-limits-opioid-prescriptions>, at 1.

¹⁹⁴ See *2018 National Preferred Formulary Exclusions*, *supra* note 189; *2018 Express Scripts National Preferred Formulary*, *supra* note 190; Saver Plan Formulary, Value Plan Formulary and Choice Plan Formulary, *supra* note **Error! Bookmark not defined.**

virtually every opioid analgesic on every Express Scripts formulary (commercial or Medicare) is available through its mail order pharmacy.¹⁹⁵

630. OptumRx offers five basic formularies, each of which includes opioids.¹⁹⁶

631. OptumRx's 2018 Generic Centric Formulary appears to have no limits whatsoever surrounding the dispensing of opioids.¹⁹⁷

632. OptumRx's other commercial formularies require prior authorization only on some opioids, not including the most popular immediate-release drugs.¹⁹⁸

633. They do not appear to require step therapy for immediate-release opioids or a three-day limit for acute pain treatment.¹⁹⁹

634. They do not advise against the dispensing of opioids for chronic pain.²⁰⁰

635. OptumRx currently limits immediate-release opioids for patients new to opioid therapy to 49 MME a day. However, patients not new to opioid therapy may receive 90 MME per day, a limit the CDC Guideline recommends should avoided.

636. These formularies have very few quantity limits, as well, including no apparent limits on the popular opioids identified above.²⁰¹

637. OptumRx offers its OptumRx Opioid Risk Management program for an additional fee. Only through enrollment in that program, for extra money, will its commercial customers

¹⁹⁵ *Id.*

¹⁹⁶ See OptumRx, *Formulary and drug lists*, <https://professionals.optumrx.com/resources/formulary-drug-lists.html> (last visited Sept. 10, 2018)

¹⁹⁷ OptumRx, *2018 Generic Centric Formulary*, July 1, 2018, <https://professionals.optumrx.com/content/dam/optum3/professional-optumrx/resources/forms/Generic-Centric%20Formulary.pdf>, at 7-9.

¹⁹⁸ See OptumRx, *Formulary and drug lists*, *supra* note 196.

¹⁹⁹ *Id.*

²⁰⁰ *Id.*

²⁰¹ *Id.*

receive services that OptumRx's falsely claims are compliant with the CDC Guideline. Even in its Opioid Risk Management Program, OptumRx does not appear to limit acute treatment to three-days and does not require step therapy for opioid treatment of chronic pain.²⁰²

638. As with the manufacturer, distributor, and pharmacy defendants, PBMs must contribute to rectify the damage their intentional and purposeful conduct in the context of pharmacy benefit management has foreseeably caused plaintiff.

V. CAUSES OF ACTION

COUNT I PUBLIC NUISANCE VIOLATION OF 24 V.S.A. § 2121 (AGAINST ALL DEFENDANTS)

639. Plaintiff incorporates all preceding and subsequent paragraphs by reference.

640. This action is brought by Plaintiff pursuant to 24 V.S.A. § 2121 to abate the public nuisance created by Defendants, and to recover costs Plaintiff has already incurred and future costs the Plaintiff expects to incur in its provision of emergency services that are reasonably required to abate the public nuisance created by Defendants.

641. Each Defendant, acting alone or with one or more co-defendants, created a condition that was and continues to be dangerous to the public and has injured those inhabitants of the Town of Bennington who have come within its influence. By causing dangerously addictive drugs to flood the community, and to be diverted for illicit purposes, in contravention of federal and state law, each Defendant has injuriously affected rights common to the general public, specifically including Plaintiffs Community, to public health, public safety, public peace, public

²⁰² *OptumRx Opioid Risk Management*, *supra* note **Error! Bookmark not defined.**

comfort, and public convenience. The public nuisance caused by Defendants' diversion of dangerous drugs has caused substantial annoyance, inconvenience, and injury to the public. Each Defendant, acting alone or in concert, injured the property of the Town of Bennington.

642. The Manufacturer Defendants knew or should have known that their promotion of opioid use would create a public nuisance:

(a) The Manufacturer Defendants have engaged in massive production, promotion, and distribution of opioids for use by the residents of the Town of Bennington;

(b) The Manufacturer Defendants' actions created and expanded the market for opioids, promoting their wide use for pain management;

(c) The Manufacturer Defendants misrepresented the benefits of opioids for chronic pain and fraudulently concealed, misrepresented, and omitted the serious adverse effects of opioids, including the addictive nature of the drugs; and

(d) The Manufacturer Defendants knew or should have known that their promotion would lead to addiction and other adverse consequences and that the larger community would suffer as a result.

643. The Manufacturer Defendants' actions were a substantial factor in making opioids widely available and widely used. The Manufacturer Defendants' actions were a substantial factor in doctors and patients not accurately assessing and weighing the risks and benefits of opioids for chronic pain. The Manufacturer Defendants' actions caused excess opioids to be shipped to the Town of Bennington, and these excess opioids were diverted into the black market. Without the Manufacturer Defendants' actions, opioid use would not have become so widespread, and the enormous public health hazard of opioid overuse, abuse, and addiction that now exists would have been averted.

644. The Manufacturer Defendants also knowingly, intentionally, recklessly, and/or negligently funneled massive quantities of prescription opioids to physicians and other prescribers who they knew or should have known wrote suspicious prescriptions and/or wrote prescriptions for known abusers of prescription opioids.

645. The Manufacturer Defendants knowingly, intentionally, recklessly, and/or negligently disseminated prescription opioids to distributors who they knew or should have known failed to implement effective controls and procedures to guard against theft, diversion, and abuse of prescription opioids.

646. The Manufacturer Defendants also knowingly enabled and/or failed to prevent the illegal diversion of prescription opioids into the black market, including “pill mills” known for providing opioids to known drug abusers, and known drug dealers, knowing that such opioids would be illegally trafficked and abused.

647. The Manufacturer Defendants knowingly and intentionally financially incentivized the PBM Defendants to place their opioids on the PBMs formularies irrespective of medical necessity, resulting in widespread and unnecessary overuse.

648. The Distributor and Pharmacy Defendants’ nuisance-causing activities include failing to implement effective controls and procedures in their supply chains to guard against theft, diversion and misuse of prescription opioids, and failing to adequately design and operate a system to detect, halt, and report suspicious orders of prescription opioids.

649. The Distributor and Pharmacy Defendants also knowingly and intentionally enabled and/or failed to prevent the illegal diversion of prescription opioids into the black market, including “pill mills” known for providing opioids to known drug abusers, and known drug dealers, knowing that such opioids would be illegally trafficked and abused.

650. The PBM Defendants knowingly and intentionally designed benefit plans that would maximize the number of opioids in the marketplace.

651. The PBM Defendants knowingly, intentionally, recklessly and/or negligently failed to manage and/or monitor these plans to minimize the use and abuse of opioids.

652. The PBM Defendants knowingly and intentionally chose to include opioids on their formularies that were more addictive to users. This led directly to the increased likelihood of addiction.

653. The PBM Defendants knowingly and intentionally chose to include opioids that were easier to misuse (for example, by crushing them into powder and mixing them with liquid in order to inject them) instead of ADFs which tended to be more expensive. This choice directly led to the ease with which the pills could be misused.

654. The PBM Defendants knowingly and intentionally made it more expensive or more difficult to obtain knowingly efficacious non-opioid medications for pain. This led directly to the increased sale and use of opioids.

655. The PBM Defendants knowingly and intentionally chose not to include certain medications that would prevent overdoses or made them more difficult or expensive to obtain.

656. The PBM Defendants chose not to cover or provide less coverage for drug treatment.

657. The PBM Defendants knowingly and intentionally created their formularies to ensure that an excessive number of pills were made available to users for use and abuse.

658. The Purdue Individual Defendants, who are officers, directors and/or equity holders of Purdue and affiliates, directed and participated in the tortious conduct of Purdue and are individually liable.

659. The public nuisance created by the Defendants endangers the life, health and safety of the town of Bennington's residents.

660. The public nuisance created by Defendants interferes with the reasonable and comfortable use of The Town of Bennington's property and resources.

661. The public nuisance created by Defendants' actions has caused and continues to cause significant harm to the community that includes but is not limited to:

- (a) Opioid-related drug overdose deaths;
- (b) The disease of opioid addiction and other diseases related to long-term opioid use;
- (c) Infants born addicted to opioids due to prenatal exposure, causing severe withdrawal symptoms and lasting developmental impacts;
- (d) Other child abuse and neglect resulting from opioid abuse;
- (e) Crime associated with illegal drug use and opioid sales;
- (f) Unemployment resulting from an inability to work while addicted to opioids;
- (g) Blight, vagrancy, property damage, and property crime.

662. Defendants controlled the creation and supply of a new secondary market for opioids—providing both the supply of narcotics to sell and the demand of addicts to buy them. The result of Defendants' actions is not only an explosion of prescription opioids on the black market, but also a marked increase in the availability of heroin and synthetic opioids.

663. The diversion of opioids into the secondary, criminal market by Defendants and the increase in the number of individuals who abuse or are addicted to opioids has placed unnecessary and excessive demands on the medical, public health, law enforcement, and financial resources of the Town of Bennington Adults and children in the Town of Bennington who have never taken opioids have also suffered the costs of the Defendants' public nuisance. Many have endured both the emotional and financial costs of caring for loved ones addicted to or injured by opioids, and the loss of companionship, wages, or other support from family members who have used, abused, become addicted to, overdosed on, or been killed by opioids.

664. Public resources are being unreasonably consumed in efforts to address the opioid epidemic, thereby eliminating available resources which could be used to benefit the public at large in The Town of Bennington.

665. The public nuisance created, perpetuated, and maintained by Defendants can be abated and further recurrence of such harm and inconvenience can be abated.

666. the Town of Bennington has incurred significant costs to date in its efforts to provide services that were reasonably necessary to abate the public nuisance created, perpetuated, and maintained by Defendants. the Town of Bennington expects to incur significant costs going forward to ameliorate the harm caused by Defendants.

667. As a direct and proximate result of the public nuisance, The Town of Bennington has sustained (and continues to sustain) harm by spending a substantial amount of money trying to fix the societal harms caused by the Defendants' nuisance-causing activity, including, but not limited to, the costs of healthcare, emergency medical services, social services, prevention, treatment, intervention, law enforcement, lost tax revenues, direct spending on opioids and opioid antagonists, and lost communal benefits of the Town of Bennington's limited and diverted resources as set forth more fully above.

COUNT II
COMMON LAW PUBLIC NUISANCE
(AGAINST ALL DEFENDANTS)

668. Plaintiff incorporates all preceding and subsequent paragraphs by reference.

669. This action is brought by Plaintiff to abate the public nuisance created by Defendants, and to recover costs Plaintiff has already incurred and future costs the Plaintiff expects to incur in its provision of emergency services that are reasonably required to abate the public nuisance created by Defendants.

670. Under common law, a public nuisance is a condition that is dangerous to the public.

A public nuisance adversely impacts an entire community or significant portion of the public. Therefore, a cause of action for public nuisance exists where a defendant's conduct negatively affects the community at large. The public nuisance complained of herein includes the oversaturation, unlawful availability, and abuse of opioids in The Town of Bennington as well as the adverse social and environmental outcomes associated with widespread and/or illegal opioid use.

671. Each Defendant, acting alone or with one or more co-defendants, knowingly, intentionally, recklessly, and/or negligently created a condition of a grossly excessive amount of opioids in circulation that was and continues to be dangerous to the public and has injured those inhabitants of the Town of Bennington who have come within its influence. By causing dangerously addictive drugs to flood into the community, and to be diverted for illicit purposes, in contravention of federal and state law, each Defendant has injuriously affected rights common to the general public, including the Town of Bennington public health, public safety, public peace, public comfort, and public convenience. The public nuisance caused by Defendants' diversion of dangerous drugs has caused substantial annoyance, inconvenience, and injury to the public. The Manufacturer Defendants knew or should have known that their promotion of opioid use would create a public nuisance:

(a) The Manufacturer Defendants have engaged in massive production, promotion, and distribution of opioids for use by the residents of Bennington;

(b) The Manufacturer Defendants' actions created and expanded the market for opioids, promoting their wide use for pain management;

(c) The Manufacturer Defendants misrepresented the benefits of opioids for chronic pain and fraudulently concealed, misrepresented, and omitted the serious adverse effects of opioids, including the addictive nature of the drugs; and

(d) The Manufacturer Defendants knew or should have known that their promotion would lead to addiction and other adverse consequences and that the larger community would suffer as a result.

672. The Manufacturer Defendants' actions were a substantial factor in making opioids widely available and widely used. The Manufacturer Defendants' actions were a substantial factor in doctors and patients not accurately assessing and weighing the risks and benefits of opioids for chronic pain. The Manufacturer Defendants' actions caused excess opioids to be shipped to the Town of Bennington, and these excess opioids were diverted into the black market. Without the Manufacturer Defendants' actions, opioid use would not have become so widespread, and the enormous public health hazard of opioid overuse, abuse, and addiction that now exists would have been averted.

673. The Manufacturer Defendants also knowingly, intentionally, recklessly, and/or negligently funneled massive quantities of prescription opioids to physicians and other prescribers who they knew or should have known wrote suspicious prescriptions and/or wrote prescriptions for known abusers of prescription opioids.

674. The Manufacturer Defendants knowingly, intentionally, recklessly, and/or negligently disseminated prescription opioids to distributors who they knew or should have known failed to implement effective controls and procedures to guard against theft, diversion, and abuse of prescription opioids.

675. The Manufacturer Defendants also knowingly enabled and/or failed to prevent the illegal diversion of prescription opioids into the black market, including "pill mills" known for providing opioids to known drug abusers, and known drug dealers, knowing that such opioids would be illegally trafficked and abused.

676. The Manufacturer Defendants knowingly and intentionally incentivized the PBM Defendants to place their opioids on the PBMs' formularies irrespective of medical necessity, resulting in widespread and unnecessary overuse.

677. The Distributor and Pharmacy Defendants' nuisance-causing activities include failing to implement effective controls and procedures in their supply chains to guard against theft, diversion and misuse of prescription opioids, and failing to adequately design and operate a system to detect, halt, and report suspicious orders of prescription opioids.

678. The Distributor and Pharmacy Defendants also knowingly and intentionally enabled and/or failed to prevent the illegal diversion of prescription opioids into the black market, including "pill mills" known for providing opioids to known drug abusers, and known drug dealers, knowing that such opioids would be illegally trafficked and abused.

679. The PBM Defendants knowingly and intentionally designed benefit plans that would maximize the number of opioids in the marketplace.

680. The PBM Defendants knowingly, intentionally, recklessly and/or negligently failed to manage and/or monitor these plans to minimize the use and abuse of opioids.

681. The PBM Defendants knowingly and intentionally chose to include opioids on their formularies that were more addictive to users. This led directly to the increased likelihood of addiction.

682. The PBM Defendants knowingly and intentionally chose to include opioids that were easier to misuse (for example, by crushing them into powder and mixing them with liquid in order to inject them) instead of ADFs which tended to be more expensive. This choice directly led to the ease with which the pills could be misused.

683. The PBM Defendants knowingly and intentionally made it more expensive or more difficult to obtain knowingly efficacious non-opioid medications for pain. This led directly to the increased sale and use of opioids.

684. The PBM Defendants knowingly and intentionally chose not to include certain medications that would prevent overdoses or made them more difficult or expensive to obtain.

685. The PBM Defendants chose not to cover or provide less coverage for drug treatment.

686. The PBM Defendants knowingly and intentionally created their formularies to ensure that an excessive number of pills were made available to users for use and abuse.

687. The public nuisance created by the Defendants endangers the life, health and safety of the Town of Bennington's residents.

688. The public nuisance created by Defendants interferes with the reasonable and comfortable use of The Town of Bennington's property and resources.

689. The public nuisance created by Defendants' actions has caused and continues to cause significant harm to the community that includes but is not limited to:

- (a) Opioid-related drug overdose deaths;
- (b) The disease of opioid addiction and other diseases related to long-term opioid use;
- (c) Infants born addicted to opioids due to prenatal exposure, causing severe withdrawal symptoms and lasting developmental impacts;
- (d) Other child abuse and neglect resulting from opioid abuse;
- (e) Crime associated with illegal drug use and opioid sales;
- (f) Unemployment resulting from an inability to work while addicted to opioids;
- (g) Blight, vagrancy, property damage, and property crime.

690. Defendants' controlled the creation and supply of a new secondary market for opioids—providing both the supply of narcotics to sell and the demand of addicts to buy them.

The result of Defendants' actions is not only an explosion of prescription opioids on the black market, but also a marked increase in the availability of heroin and synthetic opioids.

691. The diversion of opioids into the secondary, criminal market by Defendants and the increase in the number of individuals who abuse or are addicted to opioids has placed unnecessary and excessive demands on the medical, public health, law enforcement, and financial resources of the Town of Bennington.

692. Adults and children in the Town of Bennington who have never taken opioids have also suffered the costs of the Defendants' public nuisance. Many have endured both the emotional and financial costs of caring for loved ones addicted to or injured by opioids, and the loss of companionship, wages, or other support from family members who have used, abused, become addicted to, overdosed on, or been killed by opioids.

693. Public resources are being unreasonably consumed in efforts to address the opioid epidemic, thereby eliminating available resources which could be used to benefit the public at large in Bennington.

694. The public nuisance created, perpetuated, and maintained by Defendants can be abated and further recurrence of such harm and inconvenience can be abated.

695. The Town of Bennington has incurred significant costs to date in its efforts to provide services that were reasonably necessary to abate the public nuisance created, perpetuated, and maintained by Defendants. The Town of Bennington expects to incur significant costs going forward to ameliorate the harm caused by Defendants.

696. As a direct and proximate result of the public nuisance, the Town of Bennington has sustained (and continues to sustain) harm by spending a substantial amount of money trying to fix the societal harms caused by the Defendants' nuisance-causing activity, including, but not

limited to, the costs of healthcare, emergency medical services, social services, prevention, treatment, intervention, law enforcement, lost tax revenues, direct spending on opioids and opioid antagonists, and lost communal benefits of The Town of Bennington's limited and diverted resources as set forth more fully above.

**COUNT III
FRAUD
(AGAINST MANUFACTURER DEFENDANTS)**

697. Plaintiff incorporates all preceding and subsequent paragraphs by reference.

698. Defendants, individually and acting through their employees and agents, and in concert with each other, made misrepresentations and omissions of facts material to Plaintiff and its residents to induce them to purchase, administer, and consume opioids as set forth herein.

699. Defendants' representations and assertions to Plaintiff, healthcare providers, and consumers contained intentional misrepresentations and material omissions as to the risks associated with opioids.

700. Defendants intentionally made inaccurate representations regarding the adverse medical conditions associated with the use of opioids and such false representations were made with the intent to mislead.

701. Defendants knew or reasonably should have known that the representations made to Plaintiff and the public-at large regarding the risks of opioids were false or incomplete and misrepresented material facts regarding the use of opioids for chronic pain.

702. Defendants had a duty to provide accurate information regarding the risks and side effects associated with opioids to consumers, including healthcare providers and the Plaintiff.

703. Defendants willfully, knowingly, and deceptively withheld material facts regarding the risks and side effects associated with opioids from Plaintiff, healthcare providers, and consumers.

704. Plaintiff and its residents reasonably relied on the representations made by Defendants, which caused excess opioids to flood into The Town of Bennington and be diverted into the black market. Plaintiff, through its programs, departments, and agencies, to incurred increased costs attempting to stop the flow of excess opioids into the Town of Bennington and bearing the costs of cleaning them up, including, but not limited to the costs of healthcare, emergency medical services, social services, prevention, treatment, intervention, law enforcement, lost tax revenues, direct spending on opioids and opioid antagonists, and lost communal benefits of the Town of Bennington's limited and diverted resources as set forth more fully above.

705. Plaintiff, healthcare providers, and consumers were justified in their reliance on Defendants to educate them as to the risks and dangerous and potentially life-threatening side effects associated with opioid use.

706. Defendants' conduct was willful, wanton, and malicious and was directed at Plaintiff and their residents.

707. The reprehensible nature of the Defendants' conduct further entitles Plaintiff to an award of punitive damages.

708. As a proximate and legal result of Defendants' fraudulent misrepresentations, Plaintiff has suffered and will continue to suffer damages and is therefore entitled to recover for those damages.

**COUNT IV
NEGLIGENCE PER SE
(AGAINST MANUFACTURER AND DISTRIBUTOR DEFENDANTS)**

709. Plaintiff incorporates all preceding and subsequent paragraphs by reference.

710. The Manufacturer and Distributor Defendants failed to perform their statutory and regulatory obligations under 20-4 Vt. Code R. § 1400:17.1 *et seq.*, 26 V.S.A. § 2068 *et seq.*, and

the CSA, which were enacted to promote safety and to prevent exactly the type of harm that occurred as a result of Defendants' failures.

711. The Manufacturer and Distributor Defendants had a duty under 20-4 Vt. Code R. § 1400:17.1 *et seq* and 26 V.S.A. § 2068 *et seq.*, and the CSA to maintain effective controls against diversion of prescription opioids and to guard against, prevent, and report suspicious orders of opioids.

712. The Manufacturer and Distributor Defendants failed to maintain effective controls against diversion, failed to report suspicious orders to law enforcement and perform due diligence prior to filling orders, and failed to design and operate a system to disclose suspicious orders of controlled substances, as required by Vermont law and the CSA. As a result, excess opioids were shipped into the Town of Bennington and diverted into the black market, causing The Town of Bennington to incur substantial costs.

713. 20-4 Vt. Code R. § 1400:17.1 *et seq* and 26 V.S.A. § 2068 *et seq.*, and the CSA were enacted, at least in part, to prevent the harms that can arise as a result of the Manufacturer and Distributor Defendants' failures to comply with Vermont law and the CSA, as described herein.

714. Plaintiff is among the persons and entities intended to benefit from the protections of 20-4 Vt. Code R. § 1400:17.1 *et seq* and 26 V.S.A. § 2068 *et seq.*, and the CSA, and the harm that has occurred as a result of the Manufacturer and Distributor Defendants' violations are among the types of harm that the statutes and regulations were intended to prevent.

715. Therefore, as a proximate result of their violations of Vermont law and the CSA, the Manufacturer and Distributor Defendants have caused Plaintiff to incur excessive costs related to responding to the opioid crisis. These costs include, but are not limited to, the costs of healthcare, emergency medical services, social services, prevention, treatment, intervention, law enforcement, lost tax revenues, direct spending on opioids and opioid antagonists, and lost

communal benefits of The Town of Bennington's limited and diverted resources as set forth more fully above.

**COUNT V
NEGLIGENCE PER SE
(AGAINST PHARMACY DEFENDANTS)**

716. Plaintiff incorporates all preceding and subsequent paragraphs by reference.

717. The Pharmacy Defendants failed to perform their statutory and regulatory obligations under Vermont law and the CSA, all of which were enacted to promote safety and to prevent exactly the type of harm that occurred as a result of Defendants' failures.

718. Pharmacy Defendants are to dispense prescriptions for controlled substances only for legitimate medicinal or therapeutic purposes. 20-4 Vt. Code R. § 1400:10.2.

719. Furthermore, Pharmacy Defendants are required to keep and maintain thorough records of their receipt and dispensation of all opioids, and of the persons to whom they dispense opioids and certain other drugs. 20-4 Vt. Code R. §§ 1400:10.8; 1400:10.25.

720. These statutes and regulations are designed for Pharmacist Defendants to identify persons who could use the prescriptions for non-legitimate, medical purposes and stop pharmacists from dispensing opioids to patients at risk for abuse.

721. Pharmacy Defendants were negligent in failing to take any action to prevent or reduce the unnecessary, non-medical, or criminal use of opioids. Each Pharmacy Defendant sold opioids with the knowledge that the purchased opioids were likely being used for non-medical purposes, and therefore failed to meet their duties under Vermont Law.

722. The laws and regulations that require Pharmacy Defendants to ensure that they dispense opioids only for legitimate medical and therapeutic purposes, and the laws and regulations that require Pharmacy Defendants to carefully monitor and record their dispensation of opioids were enacted, at least in part, to prevent the harms that can arise as a result of an

overabundance of opioids being made available in communities.

723. Plaintiff is among the persons and entities intended to benefit from the protections of the laws and regulations described above. The harms that have occurred as a result of the Pharmacy Defendants' failure to abide by their legal obligations are among the types of harm that these laws and regulations were intended to prevent.

724. As a proximate result of their failure to exercise their professional judgement and/or their failure to keep records, as required by the statute, in the continual dispensation of opioids, the Pharmacy Defendants have caused Plaintiff to incur excessive costs related to responding to the opioid crisis. These costs include, but are not limited to, increased policing, medical, fire, and court services, lost tax revenues, and lost communal benefits of the County's limited and diverted resources.

**COUNT VI
NEGLIGENCE
(AGAINST ALL DEFENDANTS)**

725. Plaintiff incorporates all preceding and subsequent paragraphs by reference.

726. Defendants have a duty to Plaintiff to employ a reasonable standard of care in the sale, distribution, dispensing, reimbursement and promotion of prescription opioids, as required to protect Bennington's citizens and property. This includes a duty to not create a foreseeable risk of harm to others.

727. Defendants breached this duty by failing to take any action to prevent or reduce the unnecessary, non-medical, or criminal use of opioids. Collectively, and individually, Defendants made prescription opioids available to the marketplace with the knowledge that they were likely being used for unnecessary, non-medical, or criminal purposes and/or posed an inherent danger to patients who were using them for other than short-term acute pain or palliative care.

728. Specifically, the PBMs have a duty to Plaintiff to employ a reasonable standard of

care in their role as the intermediary between the drug manufacturers, pharmacies, and patients, as required to protect Bennington's citizens and property. This duty is independent of the PBMs' contractual obligations.

729. The PBMs breached their duty to employ reasonable care, causing injuries to Bennington beyond any contractual expectancy. In doing so, the PBMs caused foreseeable harm to Bennington's citizens and property.

730. The Purdue Individual Defendants, who are officers, directors and/or equity holders of Purdue and affiliates, directed and participated in the tortious conduct of Purdue and are individually liable.

731. Defendants were negligent in failing to monitor and guard against third-party misconduct and participated and enabled such misconduct. This third-party misconduct, including criminal acts, were the foreseeable consequences of Defendants' negligence.

732. Defendants placed their profit motives above their legal duty and enabled, encouraged and caused the over-prescribing and distribution of opioids.

733. All Defendants knew of the highly addictive nature of prescription opioids and knew of the high likelihood of foreseeable harm to patients and communities from prescription opioid addiction and diversion. Defendants should have anticipated an injury to Bennington as a probable result of flooding the market with opioids. Where there is a flood of highly addictive drugs into a community, it is foreseeable – to the point of being a foregone conclusion – that there will be a secondary, 'black' market created for those drugs. It was further foreseeable that Bennington would be responsible for combatting the creation of that market and mitigating its effects. Defendants breached their duties when they failed to act with reasonable care to prevent the diversion of prescription opioids.

734. A negligent and/or intentional violation of the Defendants' duties poses distinctive

and significant dangers to the Plaintiff and its residents, including epidemic levels of addiction and the grossly excessive prescription and distribution of opioids.

735. As a proximate result of the failure to prevent the over prescription and excessive distribution of opioids, the Defendants have caused the Plaintiff to incur excessive costs related to responding to the opioid crisis. These costs include but are not limited to, the costs of healthcare, emergency medical services, social services, prevention, treatment, intervention, law enforcement, lost tax revenues, direct spending on opioids and opioid antagonists, and lost communal benefits of The Town of Bennington's limited and diverted resources as set forth more fully above.

**COUNT VII
UNJUST ENRICHMENT
(AGAINST ALL DEFENDANTS)**

736. Plaintiff incorporates all preceding and subsequent paragraphs by reference.

737. As an intended result of their intentional wrongful conduct as set forth in this Complaint, Defendants have knowingly profited and benefited from opioid purchases made by Plaintiff and its residents.

738. In exchange for opioid purchases, and at the time Plaintiff and its residents made these payments, Plaintiff and its residents expected that Defendants had not misrepresented any material facts regarding opioids, and had complied with their legal obligations in the manufacture, marketing, distribution, dispensation, and reimbursement of opioids.

739. Defendants have been unjustly enriched in the form of profits because of their wrongful conduct, and as a matter of equity, Defendants should be required to disgorge their unjustly obtained profits from purchases of opioids made by the County.

**COUNT VIII
COMMON LAW CIVIL CONSPIRACY
(AGAINST ALL DEFENDANTS)**

740. Plaintiff incorporates all preceding and subsequent paragraphs by reference.

741. The Defendants acted in concert for the purpose of increasing the use of opioids and fraudulently selling and distributing as many opioids as possible, causing significant harm to the Town of Bennington.

742. The Manufacturer and Distributor Defendants violated Vermont law and the CSA by, *inter alia*:

- (a) fraudulently making false or misleading statements, falsely marketing opioids as safe for treatment of chronic pain; falsely representing that their opioids were less likely to be abused or were safer; suppressing evidence to the contrary, and improperly inducing physicians to prescribe opioids for chronic pain;
- (b) evading controls on opioid diversion, increasing opioid quotas; and
- (c) failing to design and operate a system to disclose suspicious orders of controlled substances, failing to provide and maintain appropriate inventory controls.

743. The conspiracy would not have succeeded absent the PBM's control of the flow of opioids from manufacturer to the end user. The PBM's plan design, including formulary placement, controlled which opioids were paid for, reimbursed, and covered by public and private pharmacy benefit plans. The PBMs exacerbated the opioid crisis by (a) intentionally designing benefit plans that would maximize the number of opioids in the marketplace, (b) failing to manage and/or monitor these plans to minimize the use and abuse of opioids, and (c) choosing drugs to put on their formularies that provided the largest profit to themselves, regardless of the addictive quality of the drug and whether there was an alternative available and limiting access to competing less-addictive alternatives.

744. The PBM and Manufacturer Defendants coordinated to ensure that the maximum number of Manufacturers' opioids were prescribed and sold, and the PBM Defendants got the maximum profit at the expense of patients.

745. The conspiracy also would not have succeeded absent the Pharmacy Defendants, which coordinated with the Distributor Defendants to enable the theft, diversion and misuse of prescription opioids.

746. Each of the participants in the conspiracy received revenue, directly or indirectly, and/or otherwise benefitted from the scheme to promote opioids as safe and non-addictive.

747. At all relevant times, each Defendant was a knowing and willing participant in the conspiracy, and reaped profits from the conspiracy in the form of increased sales, distributions, rebates and kick-backs. Distributor Defendants received kick-backs from Manufacturer Defendants if they reached particular monthly goals. PBM Defendants received rebates, chargebacks, kickbacks, administrative fees, and other financial incentives to promote the Manufacturer Defendants' drugs. Manufacturer and Pharmacy Defendants received profits from increased sales of the Manufacturer Defendants' drugs.

748. All participants of the enterprise described herein were aware of Defendants' control over the activities of the conspiracy in promoting opioids for use in every situation in which a patient is in pain and selling a grossly excessive amount of opioids. Each part of the conspiracy benefited from the existence of the other parts.

749. The persons engaged in the conspiracy are systematically linked through contractual relationships, financial ties, and continuing coordination of activities.

750. The Defendants' concerted actions caused excess opioids to enter The Town of Bennington, which were diverted into the black market.

751. The Town of Bennington has been injured by reason of these violations in that it has incurred increased costs attempting to stop the flow of excess opioids into the Town of Bennington and bearing the costs of clean up, including, but not limited to the costs of healthcare, emergency medical services, social services, prevention, treatment, intervention, law enforcement,

lost tax revenues, direct spending on opioids and opioid antagonists, and lost communal benefits of Town of Bennington's limited and diverted resources as set forth more fully above. The Town of Bennington would not have incurred these costs had Defendants not conspired together. The injuries suffered by the Town of Bennington were directly and proximately caused by Defendants' actions and inactions.

752. Plaintiff was directly and proximately harmed by the Defendants' civil conspiracy.

COUNT IX
VIOLATIONS OF THE RACKETEER INFLUENCED AND CORRUPT
ORGANIZATIONS ACT ("RICO") 18 U.S.C § 1962(C) - RICO
(AGAINST ALL DEFENDANTS)

753. Plaintiff re-alleges and incorporates by reference each of the allegations contained in the preceding Paragraphs of this Complaint as though fully alleged herein.

754. This claim is brought against each Defendant for actual damages, treble damages, and equitable relief under 18 U.S.C. § 1964 for violations of 18 U.S.C. §§ 1961 et seq.

755. Section 1962(c) makes it "unlawful for any person employed by or associated with any enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity . . ." 18 U.S.C. § 1962(c).

756. Defendants conducted and continue to conduct their business through legitimate and illegitimate means in the form of an association-in-fact enterprise and/or a legal entity enterprise. At all relevant times, Defendants were "person[s]" under 18 U.S.C. § 1961(3) because they are entities capable of holding, and do hold, a legal or beneficial interest in property.

757. The Defendants conducted and participated in the conduct of the RICO enterprise described herein through a pattern of racketeering activity as defined in 18 U.S.C. §1961(b), including mail fraud (18 U.S.C. § 1341) and wire fraud (18 U.S.C. § 1343); 18 U.S.C. § 1961(d)

“fraud connected with ... the felonious manufacture, importation, receiving, concealment, buying, selling, or otherwise dealing in a controlled substance ... as defined in section 102 of the Controlled Substances Act”; and 19 U.S.C. § 1952 (entering goods into commerce using a statement or omission that is materially false).

758. The RICO enterprise described herein was created and organized to effectuate a pattern of racketeering activity, and maintained systematic links for a common purpose: to increase the use of opioids and fraudulently sell, distribute and authorize for third-party reimbursement as many opioids as possible by falsely marketing them as safe for treatment of chronic pain outside active cancer, end-of-life or palliative care, suppressing evidence to the contrary, maintaining their placement on formularies to ensure reimbursement, limiting access to competing less-addictive alternatives and improperly inducing physicians to prescribe opioids for chronic pain.

759. The RICO enterprise described herein engaged in and affected interstate commerce because, *inter alia*, it marketed, promoted, sold, provided or reimbursed for opioids to thousands of individuals and entities throughout the U.S.

760. Each of the Defendants either actively participated and/or aided and abetted in the pursuance of this common purpose. Each of the participants in the RICO enterprise described herein received substantial revenue from the scheme, in the form of sales for Manufacturer Defendants, sales and kickbacks for Distributor and Pharmacy Defendants who reached particular monthly goals, and rebates or other financial incentives for PBM Defendants who placed opioids in a preferred place on a formulary or otherwise made opioids readily available for improper use – all in an effort to maximize profits.

761. Under the present facts, each co-conspirator either (a) agreed to operate or manage the enterprise that did and does feloniously deal in controlled substances, an offense punishable under the laws of the United States, or (b) if a co-conspirator did not agree to operate

or manage the enterprise, each co-conspirator knowingly agreed to facilitate others who did and do operate or manage the enterprise of felonious dealing in controlled substances, an offense punishable under the laws of the U.S.

762. The Defendants engaged in a pattern of related and continuous predicate acts for years. The predicate acts constituted a variety of unlawful activities, each conducted with the common purpose of obtaining significant monies and revenues while benefitting from, encouraging, indirectly creating, contributing to, and maintaining an illegal secondary market for highly addictive and dangerous drugs. The predicate acts are not isolated events.

763. While Defendants participated in, and are members of, the enterprise described herein, they have an existence separate from the enterprise, including distinct legal statuses, affairs, offices and roles, officers, directors, employees, individual personhood, reporting requirements, and financial statements.

764. In addition, finding it impossible to achieve their increasing sales ambitions through legal means, the Defendants systematically and fraudulently violated their statutory duties to maintain effective controls against diversion of their drugs, to design and operate a system to identify suspicious orders of their drugs, to halt unlawful sales of suspicious orders, and to notify the DEA of suspicious orders, allowing hundreds of millions of pills to enter the illicit market, which allowed the Defendants to derive and be unjustly enriched by enormous profits.

765. An association-in-fact enterprise existed between the Defendants, the purpose of which was to engage in the sale of opioids while deceiving the public and regulators into believing that the Defendants were faithfully fulfilling their obligations.

766. The Defendants operated as an association-in-fact to unlawfully increase sales and revenues in order to unlawfully increase the quotas set by the DEA, which in turn allowed them to collectively profit from distributing a greater pool of opioids each year. Each member of the RICO

enterprise described herein participated in the conduct of the enterprise, including patterns of racketeering activity, and shared in the astounding profits generated by the scheme.

767. The Defendants also engaged in lobbying efforts against the DEA's authority to investigate and hold responsible those who failed in their duty to prevent diversion. The Ensuring Patient Access and Effective Drug Enforcement Act was the result of an effort by the Defendants to reduce the DEA's ability to issue orders to show cause and to suspend and/or revoke registrations.

768. In order to achieve this goal, Defendants thwarted the ability of federal and state regulators to prevent diversion. As set forth herein, this unified scheme was furthered by (1) habitual noncompliance with federal and state law; (2) intensive lobbying of federal and state official to evade further regulation; and (3) increasing and/or maintaining high production quotas for their prescription opioids from which Defendants could profit for as long as possible.

769. The RICO enterprise described herein functioned by selling prescription opioids in interstate commerce in violation of the Defendants' legal obligations to maintain effective controls against opioid diversion.

770. Each Defendant communicated with other Defendants, shared information on a regular basis, and participated in joint lobbying efforts, trade industry organizations, contractual relationships, and other coordination of activities to effect the RICO Scheme. The contractual relationships included, on information and belief, rebates, chargebacks, kickbacks, administrative fees, and other financial incentives on opioid sales and security arrangements.

771. The Defendants refused to identify, investigate, or report suspicious orders despite their actual knowledge of drug diversion rings.

772. The Defendants worked together to ensure that opioid production quotas continued to increase, allowing them to generate more and more profits from the RICO enterprise described

herein.

773. In addition to violating their statutory requirement to minimize diversion of opioids, as set forth herein, Defendants and their co-conspirators engaged in a coordinated conspiracy to deceive the American public and the medical profession about the efficacy and safety of opioids, including by minimizing the addictive qualities of opioids.

774. To effectuate their goal of maximizing the number of opioid users and their profits at all costs, Defendants engaged in a sophisticated, well-developed, and fraudulent marketing scheme designed to increase the prescription rate for the sale and distribution of the Defendants' opioids and to popularize the misunderstanding that opioids are effective for chronic pain outside active cancer, end-of-life and palliative care and that the risk of addiction is low.

775. The formation, existence, and actions of the enterprise described herein were essential to the success of Defendants' campaign to increase and maintain profits from unlawful sales of opioids. The constituent members of the enterprise were aware that, unless they agreed to act and acted as an enterprise, their sales of prescription opioids would substantially decrease, and accordingly, the profits would substantially diminish.

776. Each of the Defendants, in concert with co-conspirators, created and maintained systematic links for a common purpose, *i.e.*, to aid in marketing opioids as effective and safe for use by patients in moderate pain, while suppressing evidence to the contrary. Each of the participants in the enterprise described herein received revenue, directly or indirectly, and/or otherwise benefitted from the scheme to promote opioids as safe and non-addictive.

777. At all relevant times, each Defendant was aware of the enterprise's conduct, was a knowing and willing participant in that conduct, and reaped profits from that conduct in the form of increased sales, distributions, and reimbursement of opioids. In fact, Distributor and Pharmacy Defendants received kick-backs from Manufacturer Defendants if they reached particular monthly

goals and PBM Defendants received rebates and other financial incentives to promote the Manufacturer Defendants' drugs.

778. Such revenue was exponentially greater than it would have been had opioids been marketed appropriately, had the true efficacy and safety risks of prescription opioids disclosed, had formularies properly provided access to less addictive alternatives or installed appropriate controls on the drugs which created this public health crisis.

779. The Manufacturer and PBM Defendants and their co-conspirators engaged in a conspiracy to increase the use of the least expensive, most addictive opioids by controlling the drugs' availability for utilization through the formulary and the plan design. The enterprise would not have succeeded absent the PBMs controlling the flow of opioids from manufacturer to the end user.

780. The PBM and Manufacturer Defendants coordinated to ensure that the PBM Defendants got the maximum profit at the expense of patient health and communities nationwide who are now forced to address the foreseeable consequences of the scheme.

781. The persons engaged in the enterprise are systematically linked through contractual relationships, financial ties, and continuing coordination of activities.

782. Taken together, the interaction and length of the relationships between and among the Defendants reflects a deep level of interaction, data sharing and cooperation between four groups in a tightly knit industry. The Manufacturer, Distributor, Pharmacy and PBM Defendants were not four separate groups operating in isolation or four groups forced to work together in a closed system. The Defendants operated together as a united entity, working together as an ongoing and continuous organization on multiple fronts to engage in the unlawful sale of prescription opioids.

783. All participants of the enterprise described herein were aware of Defendants'

control over the activities of the enterprise in promoting opioids for use in every situation in which a patient is in pain. Furthermore, each part of the enterprise benefited from the existence of the other parts.

784. The enterprise described herein is engaged in interstate commerce, or its activities affect interstate commerce, because Defendants marketed, promoted, sold, provided or arranged for the reimbursement of opioids to thousands of individuals and entities throughout the U.S., including promotion of opioid sales between or among residents of different states, and/or physically transporting drugs or promotional materials across state lines.

785. The Defendants used, directed the use of, and caused to be used, thousands of interstate mail and wire communications in service of their scheme through virtually uniform misrepresentations, concealments, and material omissions regarding (a) the safety and efficacy of opioids for the treatment of chronic pain and (b) their compliance with their mandatory reporting requirements and the actions necessary to carry out their unlawful goal of selling prescription opioids without reporting suspicious orders or the diversion of opioids into the illicit market.

786. The Defendants' predicate acts of racketeering, 18 U.S.C. § 1961(1) include, but are not limited to:

(a) Mail Fraud: Defendants violated 18 U.S.C. §1341 by sending and receiving, and by causing to be sent and/or received, materials via U.S. Mail or commercial interstate carriers for the purpose of executing the unlawful scheme to deceptively market, sell, promote, distribute and reimburse the opioids by means of false pretenses, misrepresentations, promises, omissions and the operation of the PBM plan design; and

(b) Wire Fraud: Defendants violated 18 U.S.C. §1343 by transmitting and/or receiving, and by causing to be transmitted and/or received, materials by wire for the purpose of executing the unlawful scheme to deceptively market, sell, promote, reimburse, distribute the opioids by means of false pretenses, misrepresentations, promises, omissions and the operation of the PBM plan design.

787. The Defendants' use of the mails and wires include, but are not limited to:

(a) representations that they would comply with their duty to (1) design and operate a system to disclose to the registrant suspicious orders of controlled substances, and (2) disclose the results of such a program to resolve concerns about overprescription and diversion of opioids;

(b) communications with and among the enterprise participants that misrepresented the safety and risks of opioid drugs amongst themselves and others;

(c) communications with Plaintiff, inducing payments for opioids by misrepresenting the safety and risks of opioids;

(d) receiving the proceeds in the course of and resulting from Defendants' improper scheme;

(e) transmittal and receipt of payments in exchange for, directly or indirectly, activities in furtherance of the RICO enterprise;

(f) suppressed and destroyed records of suspicious orders to hide evidence of overprescription and diversion; and

(g) negotiations concerning opioid formulary placement, opioid alternatives, quantity limits, refill limits, prior authorization requirements, rebates and other financial incentives and arrangements between Manufacturer and PBM Defendants.

788. The Defendants, with knowledge and intent, agreed to the overall objective of their fraudulent scheme, and participated in the common course of conduct to commit acts of fraud and indecency in manufacturing, promoting, and distributing prescription opioids.

789. Many of the precise dates of the Defendants' criminal actions are not known and cannot be alleged without access to Defendants' books and records. Indeed, an essential part of the successful operation of the unified scheme alleged herein depended upon secrecy and, towards that end, Defendants took deliberate steps to conceal their wrongdoing. However, given the massive scope of the illegal and scheme, Defendants likely committed thousands, if not millions, of predicate acts of racketeering activity. All of the data necessary to prove these allegations resides on Defendants' databases, and is shared between them routinely and for the purpose inter alia, of perpetuating the epidemic.

790. The multiple acts of racketeering activity that the Defendants committed, or

aided and abetted in the commission of, were related to each other, had a similar purpose, involved the same or similar participants and methods of commission, and have similar results affecting similar victims, including Plaintiff. These acts pose a threat of continued racketeering activity and constitute a “pattern of racketeering activity” within the meaning of 18 U.S.C. § 1961(5).

791. These acts were conducted pursuant to an understanding and agreement, whether explicit or implicit, that each member would participate to facilitate and further the purpose of the Defendants’ enterprise, which was to maximize profits by manufacturing, distributing, and selling as many opioid pills as possible.

792. As a result of Defendants' racketeering activity, the Town of Bennington has been injured in their business and/or property in multiple ways, including but not limited to increased costs of providing necessary county services, increased human services and resource costs, costs related to dealing with opioid-related crimes and emergencies, and other public safety costs. But for the conduct of the enterprise’s affairs, the Town of Bennington would not have sustained damages.

793. The RICO enterprise described herein largely created, encouraged, contributed to, and maintained an illegal secondary market for opioids.

794. The pattern of racketeering activity alleged herein is continuing as of the date of this Complaint and, upon information and belief, will continue into the future unless enjoined by this Court.

795. Defendants' violations of 18 U.S.C. §1962(c) have directly and proximately caused injuries and damages to the Town of Bennington who is entitled to bring this action for three times its actual damages, as well as injunctive/equitable relief, costs, and reasonable attorney's fees pursuant to 18 U.S.C. §1964(c).

COUNT X
VIOLATIONS OF THE RACKETEER INFLUENCED AND CORRUPT
ORGANIZATIONS ACT 18 U.S.C § 1962(D) - RICO CONSPIRACY
(AGAINST ALL DEFENDANTS)

796. Plaintiff incorporates by reference all preceding paragraphs as if fully set forth.

797. Section 1962(d) of RICO provides that it “shall be unlawful for any person to conspire to violate any of the provision of subsection (a), (b), or (c) of this section.”

798. Defendants have violated § 1962(d) by conspiring to violate 18 U.S.C. § 1962(c). The object of this conspiracy has been and is to conduct or participate in, directly or indirectly, the conduct of the affairs of the RICO enterprise described herein through a pattern of racketeering activity.

799. Defendants' co-conspirators have engaged in numerous overt and predicate fraudulent racketeering acts in furtherance of the conspiracy, including material misrepresentations and omissions designed to defraud Plaintiff of money.

800. The nature of the above-described Defendants' acts, material misrepresentations, and omissions in furtherance of the conspiracy gives rise to an inference that they not only agreed to the objective of an 18 U.S.C. § 1962(d) violation of RICO by conspiring to violate 18 U.S.C. § 1962(c), but they were aware that their ongoing fraudulent acts have been and are part of an overall pattern of racketeering activity.

801. As a direct and proximate result of Defendants' overt acts and predicate acts in furtherance of violating 18 U.S.C. § 1962(d) by conspiring to violate 18 U.S.C. § 1962(c), Jefferson County has been and continues to be injured in its business or property as set forth more fully above.

802. Defendants sought to and have engaged in the commission of and continue to commit overt acts, including the following unlawful racketeering predicate acts:

- (a) Multiple instances of mail and wire fraud violations of 18 U.S.C. §§ 1341 and 1342; and
- (b) Multiple instances of unlawful activity in violation of 18 U.S.C. § 1952.

803. Defendants' violations of the above federal laws and the effects thereof detailed above are continuing and, upon information and belief, will continue into the future unless enjoined by this Court.

804. The Town of Bennington has been injured in its property by reason of these violations in that Bennington has been constrained to provide essential county services, and in effect, "clean up" the harm Defendants have recklessly and intentionally caused. Jefferson County must abate the societal harms resulting from Defendants conduct, a significant and ongoing cost Bennington would not have paid, or be paying, had Defendants not conspired to violate 18 U.S.C. § 1962(c).

805. Injuries suffered by Plaintiff were directly and proximately caused by Defendants' racketeering activity as described above.

806. By virtue of these violations of 18 U.S.C. § 1962(d), Defendants are liable to Plaintiff for compensatory damages, equitable and declaratory relief, punitive damages, costs and reasonable attorneys' fees.

PUNITIVE DAMAGES

807. Plaintiff incorporates all preceding and subsequent paragraphs by reference.

808. Defendants' scheme to optimize profits regardless of the effect on The Town of Bennington was undertaken and executed intentionally. Defendants' intentional actions were malicious, wanton, and oppressive.

809. Defendants' failure to take any action to prevent or reduce the unnecessary, non-medical, or criminal use of opioids was willful and wanton, and in conscious disregard of the rights

of The Town of Bennington and its residents and/or with reckless indifference to the consequences of their actions.

810. At all relevant times, Defendants were aware, from their knowledge of existing circumstances and conditions, that their conduct would probably cause injury to The Town of Bennington and its residents. Defendants' intentional and negligent actions described above were wanton, oppressive, and undertaken with such malice as to evince a spirit of malice or criminal indifference to their legal obligations.

811. Defendants should be held liable for punitive damages to the Town of Bennington because their actions were wanton, oppressive, and undertaken with actual malice, such that an award of punitive damages is appropriate as punishment and deterrence.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, the Town of Bennington, prays that the Court enter judgement against the Defendants, jointly and severally, as follows:

- (1) awarding compensatory damages in an amount to be determined at trial;
- (2) awarding punitive damages to the Plaintiff in an amount to be determined at trial;
- (3) awarding treble damages, as well as all costs and expenses of maintaining this action, including reasonable attorneys' fees, pursuant to statute where appropriate;
- (4) awarding pre- and post-judgment interest;
- (5) compelling the defendants to abate and remove the public nuisance they have caused by immediately ceasing the unlawful conduct described throughout this Complaint and by funding an abatement fund on behalf of the Plaintiff for the purpose of abating the ongoing opioid nuisance;
- (6) such other and further relief as the Court deems just and proper.

[signature page follows]

The Town of Bennington, Vermont

/s/ Kevin Sharp

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