

IN RE : COURT OF COMMON PLEAS  
: PHILADELPHIA COUNTY  
REGLAN<sup>®</sup>/METOCLOPRAMIDE :  
LITIGATION : JANUARY TERM, 2010  
: NO. 1997  
*This Document Relates to All Cases* :

DOCKETED  
COMPLEX LIT CENTER

APR 16 2010

J. STEWART

**CASE MANAGEMENT ORDER NO. 3**

**DISCOVERY ORDER GOVERNING ALL REGLAN<sup>®</sup>/METOCLOPRAMIDE CASES**

**I. SCOPE OF THIS ORDER**

This Case Management Order, intended to address discovery issues, shall govern all cases that are presently pending or hereafter filed in the Philadelphia Court of Common Pleas, except for *Hassett v. Dafoe, et al*, August Term, 2008, No. 01551, which become part of the program of coordinated pretrial proceedings relating to the prescription drug Reglan<sup>®</sup> (“Reglan”) and/or metoclopramide, (the “Reglan<sup>®</sup>/metoclopramide Litigation”). Other methods of discovery will be addressed in subsequent case management orders.

**II. DISCOVERY PROVIDED BY PLAINTIFFS**

**A. PLAINTIFF’S FACT SHEET**

1. In every case currently part of the Reglan<sup>®</sup>/metoclopramide Litigation and in all other cases that become part of the Reglan<sup>®</sup>/metoclopramide Litigation by virtue of being filed in or transferred to this Court, each Plaintiff shall complete and submit a Plaintiff Fact Sheet (“PFS”) to Defendants’ Liaison Counsel and Defendants’ counsel in Individual Plaintiff’s case by the method discussed at Section II(A)(2)(a) below. A copy of the agreed to PFS is attached hereto as Exhibit “A.”

In Re: Reglan Litigation-ORDER



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2. Within sixty (60) days of Plaintiff filing a *Short Form Complaint*, each Plaintiff shall serve all named Defendants in that individual Plaintiff's case with:

a. A completed PFS. Accordingly, each Plaintiff shall sign the completed PFS and provide an executed Declaration attesting under penalty of perjury that the information contained therein is true and correct to the best of the Plaintiff's knowledge, information, and belief, formed after due diligence and reasonable inquiry.

A completed PFS shall be treated the same as interrogatory answers and responses to requests for production under the Pennsylvania Rules of Civil Procedure, and will be governed by the standards applicable to written discovery under the Pennsylvania Rules of Civil Procedure. The interrogatories and requests for production in the PFS are non-objectionable and shall be answered by each Plaintiff without objection. Each Plaintiff shall comply with their obligation to supplement their document production by making regular additional productions within reasonable timeframes in accordance with the Pennsylvania Rules of Civil Procedure.

Service of the PFS shall be via email, addressed to Defendants' Liaison Counsel at Mayer Brown LLP ([hbullock@mayerbrown.com](mailto:hbullock@mayerbrown.com)), DLA Piper LLP ([raymond.williams@dlapiper.com](mailto:raymond.williams@dlapiper.com)), Segal McCambridge Singer & Mahoney, Ltd. ([pswayze@smsm.com](mailto:pswayze@smsm.com)) and Nelson Levine de Luca & Horst, LLC ([jmullen@nldhlaw.com](mailto:jmullen@nldhlaw.com)), as well as to Defendants' counsel named in each individual Plaintiff's case.

This Section does not prohibit a Plaintiff from withholding or redacting information based upon a recognized privilege. If information is withheld or redacted on the basis of privilege, Plaintiff shall provide Defendants with a privilege log in accordance with a subsequent Case Management Order. In the event that a dispute arises concerning the completeness or adequacy of a Plaintiff's response to any request contained in the PFS, this Section shall not prohibit Plaintiff from asserting that his/her response is adequate.

b. Authorizations for the release of records. Each Plaintiff shall provide addressed authorizations for the release of records in those categories of records set forth in Section VI(A) of the PFS, together with copies of such records to the extent that those records or copies thereof are in the possession of Plaintiff or Plaintiff's counsel. Defendants will use only the one official record copy service to obtain any of Plaintiff's medical or pharmacy records, and shall notify Plaintiff at the time Plaintiff's authorizations are forwarded by the requesting Defendant to the record copy service. Defendants shall provide via email to Plaintiff's Individual Representative Counsel all completed authorizations for records, and Plaintiff's Individual Representative Counsel shall have five (5) business days to object to the authorizations in writing. Counsel for Plaintiffs and Defendants (the "Parties") shall confer regarding the selection and utilization of a uniform record copy service to be used for obtaining Plaintiffs' official medical and pharmacy records. The Parties will agree that notice to the Plaintiff may be effectuated by the chosen record copy service. The designation of an official

record copy service vendor will be the subject of a subsequent Case Management Order.

i. At the time of production of the PFS, each Plaintiff shall provide authorizations as identified in Section VI(A) of the PFS.

ii. Each Plaintiff's service of undated, blank authorizations constitutes permission for Defendants to date (and where applicable, re-date) and otherwise complete authorizations before sending to records custodians as identified in Section VI(A) of the PFS.

iii. The Court encourages counsel for Plaintiffs to have their clients execute a sufficient number of undated, blank authorizations in order to assure the ability to obtain records promptly as discussed in Section VI(A) of the PFS.

c. Records in Plaintiff's or Plaintiff's individual representative counsel's possession. Plaintiff or each Plaintiff's individual representative counsel "Plaintiff's Individual Representative Counsel," shall provide copies of all documents subject to the Requests for Production at Section VI(B) of the PFS at the same time as the production of the PFS.

3. Each Plaintiff is required to provide Defendants with a PFS that is "substantially complete in all respects." "Substantially complete in all respects" requires that a Plaintiff:

a. Answer every question in the PFS and leave no blanks, even if a Plaintiff can only answer the question in good faith by indicating "not applicable" or "I don't know";

- b. Provide the requested records authorizations; and
- c. Produce the documents subject to the Requests for Production at Section VI(B) of the PFS or a statement certifying that there are no such responsive documents.

4. Remedies to address a deficient PFS will be addressed in a subsequent Case Management Order.

5. In the event that an institution or medical provider to whom any authorization is presented refuses to provide records in response to that authorization, Defendants shall notify Plaintiffs' Liaison Counsel, and the individual Plaintiff shall execute and return within thirty (30) days whatever form is required by that institution or provider, such as a form with an original signature, a notarized form, or the institution's own form in order to secure the release of the relevant records. Should a particular form be required, Defendants will provide it to Plaintiffs' Liaison Counsel.

**B. DISMISSAL OF DEFENDANTS FOR FAILURE TO IDENTIFY PRODUCT**

1. A uniform procedure to govern dismissal of a Defendant from an individual case in the event the Defendant's Reglan<sup>®</sup>/metoclopramide product is not identified in Plaintiff's PFS will be addressed in a subsequent Case Management Order ("Product ID Dismissal").

**III. DISCOVERY PROVIDED BY DEFENDANTS**

**A. PREVIOUSLY PRODUCED DOCUMENTS**

1. Notwithstanding any other provision of this Order, but subject to the entry of a Protective Order governing confidentiality of discovery materials effective in these Reglan<sup>®</sup>/metoclopramide Litigation, within thirty (30) days of the date of this Order,

Defendants shall produce to Plaintiffs' Liaison Counsel copies of previously produced company documents by a Defendant in any prior or pending Reglan<sup>®</sup>/metoclopramide litigation ("Previously Produced Documents"). Defendants shall produce the Previously Produced Documents one time, in the same manner and format produced in those prior cases. Plaintiffs reserve the right to request additional metadata to the extent available. Defendants shall comply with all reasonable requests for available metadata from documents produced pursuant to this Section.

**B. MASTER DISCOVERY REQUESTS**

1. Plaintiffs' Liaison Counsel hereby serve upon Defendants their *Master First Set of Interrogatories to All Defendants* (the "Plaintiffs' Interrogatories"). The Plaintiffs' Interrogatories are attached hereto as Exhibit "B." Plaintiffs' Interrogatories shall be deemed to have been served upon all properly-served Defendants in the Reglan<sup>®</sup>/metoclopramide Litigation upon execution of this Case Management Order.

2. Within seventy-five (75) days of Plaintiffs filing the *Amended Master Long Form Complaint*, Defendants' Responses to Plaintiffs' Interrogatories shall be served on Plaintiffs' Liaison Counsel.

3. Plaintiffs' Interrogatories are non-objectionable and shall be answered by each Defendant without objection. Each Defendant shall comply with their obligation to supplement their Responses within reasonable timeframes in accordance with the Pennsylvania Rules of Civil Procedure.

This Section does not prohibit a Defendant from withholding or redacting information based upon a recognized privilege. If information is withheld or redacted on the basis of privilege, Defendant shall provide Plaintiffs' Liaison Counsel with a

privilege log in accordance with a subsequent Case Management Order. In the event that a dispute arises concerning the completeness or adequacy of a Defendant's Response to any Interrogatory, this Section shall not prohibit Defendant from asserting that its Response is adequate.

4. To the extent that Plaintiff disputes any Response, they shall meet and confer with answering Defendant's counsel in an attempt to resolve that dispute. If no agreement is reached, the Parties shall submit their dispute to Harris T. Bock whom the Court has appointed to serve as a Discovery Master in this proceeding.

5. Plaintiffs plan to serve additional Master Discovery Directed to Defendants (*i.e.* (1) *Master First Set of Requests for the Production of Documents to Brand Name Defendants Regarding Forum Non Conveniens Issue*, (2) *Master First Set of Requests for the Production of Documents to Generic Defendants Regarding Forum Non Conveniens Issue*, (3) *Master Second Set of Requests for the Production of Document to Brand Name Defendants*, (4) *Master Second Set of Requests for the Production of Documents to Generic Defendants*, (5) *Master First Set of Interrogatories to Brand Name Defendants Regarding Forum Non Conveniens Issue*, (6) *Master First Set of Interrogatories to Generic Defendants Regarding Forum Non Conveniens Issue*). The Parties are currently conferring on the aforementioned Discovery Requests and addressing any issues regarding same with Discovery Master Harris Bock. As such, service of the Discovery Requests and responses thereto shall be addressed in a subsequent Case Management Order.

6. Plaintiffs plan to serve a Defendants' Fact Sheet that Defendants will be required to respond to in each individual case in which they have been named. The

Parties are currently conferring on the Defendants' Fact Sheet and addressing any issues regarding same with Discovery Master Harris Bock. As such, service of the Defendants' Fact Sheet and responses thereto shall be addressed in a subsequent Case Management Order.

**SO ORDERED**



**HONORABLE SANDRA MAZER MOSS**

Date: 4/16, 2010

# **EXHIBIT A**

IN RE

REGLAN®/METOCLOPRAMIDE  
LITIGATION

COURT OF COMMON PLEAS

PHILADELPHIA COUNTY

JANUARY TERM, 2010

NO. 01997

**PLAINTIFF FACT SHEET**

**PLAINTIFF'S NAME:** \_\_\_\_\_

Plaintiff's Attorney (include email address): \_\_\_\_\_

By Order of the Court and agreement of the Parties, you are required to answer each and every question set forth in this document to the best of your knowledge; no question is to be left blank. To the extent that you do not know or cannot remember the answer to a given question, you must state that in your response to the question. Similarly, to the extent a question does not apply to your claim, you must state that in your response to the question. If the space provided does not allow for a complete answer, please attach additional sheets so that your answer to each question is complete.

Please note that your answers to each question set out in this Fact Sheet constitute answers to written interrogatories pursuant to Rule 4006 of the Pennsylvania Rules of Civil Procedure. In that respect, when completing this Fact Sheet you will be under an oath to tell the truth, and the information you provide must be true and accurate to the best of your knowledge. Further, pursuant to Rule 4007.4 of the Pennsylvania Rules of Civil Procedure, you must supplement your responses to the questions set forth in this Fact Sheet if you, at any time, learn that any of your responses are incomplete or inaccurate in any respect.

**I. CASE INFORMATION**

**A. Please state the following for the lawsuit that you filed:**

Case caption and number: \_\_\_\_\_

Court in which action is pending: \_\_\_\_\_

Your name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Current street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How long have you lived at this address? \_\_\_\_\_

Have you ever lived in the Commonwealth of Pennsylvania? Yes: \_\_\_\_ No: \_\_\_\_

**B. If you are completing this questionnaire in a representative capacity (e.g., on behalf of a minor or the estate of a deceased person), please complete the following:**

The name of the person you are representing: \_\_\_\_\_

If you were appointed by a court, state the:

State, Court Term, and Case Number: \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

Your relationship to the represented person: \_\_\_\_\_

If you represent a decedent's estate, state the date of death of the decedent and the address of the place where the decedent died: \_\_\_\_\_

**NOTE:** If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who ingested Reglan<sup>®</sup> and/or metoclopramide. Those questions using the term "You" refer to the person who ingested Reglan<sup>®</sup> and/or metoclopramide. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.

**II. CLAIM INFORMATION**

**A. Reglan<sup>®</sup> and/or Metoclopramide Ingestion – Identify by name, specialty, and address the physician(s) who prescribed Reglan<sup>®</sup> and/or metoclopramide for you.**

**1. Prescribing Physician(s):**

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Conditions treated by this Physician: \_\_\_\_\_

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Conditions treated by this Physician: \_\_\_\_\_

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Conditions treated by this Physician: \_\_\_\_\_

2. For what condition(s) were you prescribed Reglan<sup>®</sup> and/or metoclopramide (e.g., acid reflux, G.E.R.D., diabetic gastroparesis, nausea, etc.)? \_\_\_\_\_

B. Product Identification - Identify by complete brand name and/or trade name the metoclopramide product(s) you claim caused your injuries, including the formulation of each product, manufacturer of the medication(s), the NDC code(s) for each product, a description of each product, date(s) of ingestion of each product, and the pharmacy at which each product was filled.

<b>Product</b>	<b>Manufacturer</b>	<b>NDC No.</b> (Unknown and See attached Pharmacy Records are acceptable responses)	<b>Description</b> (e.g. tablet, syrup, IV)	<b>Date(s) of Ingestion</b>	<b>Pharmacy</b> (include address)

C. Did you ever ingest Reglan®/metoclopramide in the Commonwealth of Pennsylvania?  
Yes: \_\_\_\_ No: \_\_\_\_ Cannot Recall/Unknown: \_\_\_\_\_

D. Do you claim that you suffer or suffered any physical, mental, emotional, or psychiatric illnesses or disabilities that you believe were caused by Reglan® and/or metoclopramide?  
Yes: \_\_\_\_ No: \_\_\_\_

**If yes**, for each injury, please provide the following information:

1. Describe the nature of your injury, illness or disability: \_\_\_\_\_  
\_\_\_\_\_

2. When, and in what city and state, did you first experience any symptoms you believe are related to the injury/ies alleged in your lawsuit? \_\_\_\_\_  
\_\_\_\_\_

3. Were there any witnesses to the symptoms you identified above in question 2?  
Yes: \_\_\_\_ No: \_\_\_\_ Cannot Recall/Unknown: \_\_\_\_\_

**If yes**, state their name(s), address(es), phone number(s), and the person's relationship to you. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Date(s) of diagnosis of the injury: \_\_\_\_\_

5. Physician by whom first diagnosed: \_\_\_\_\_

a. Address: \_\_\_\_\_

6. Treating Physician: \_\_\_\_\_

a. Address: \_\_\_\_\_

7. Does the injury, illness, or disability persist today? Yes: \_\_\_\_ No: \_\_\_\_

**If yes**, identify the current symptoms, the treatment you continue to receive, and the physician(s) providing treatment:

a. Current symptoms: \_\_\_\_\_

b. Treating physician(s): \_\_\_\_\_

c. Address (if not otherwise provided): \_\_\_\_\_

(Please copy and complete and attach additional pages if necessary to provide a complete response.)

*If no*, state how and when the injury subsided: \_\_\_\_\_

E. Have you had any discussions with any medical provider(s) about whether your condition is related to your ingestion of Reglan® and/or metoclopramide?

Yes: \_\_\_\_\_ No: \_\_\_\_\_ Cannot Recall/Unknown: \_\_\_\_\_

*If yes*, please identify:

Name of physician: \_\_\_\_\_

Address: \_\_\_\_\_

Specialty: \_\_\_\_\_

Date of discussion: \_\_\_\_\_

*and*, check one of the following (only have to answer 6 if 1-5 are not applicable):

1. \_\_\_\_\_ I was told my condition is related to my ingestion of Reglan® and/or metoclopramide.

2. \_\_\_\_\_ I was told my condition is not related to my ingestion of Reglan® and/or metoclopramide.

3. \_\_\_\_\_ I was told my condition may be related to the ingestion of Reglan® and/or metoclopramide.

4. \_\_\_\_\_ I was told by the physician that he/she does not know whether my condition is related to my ingestion of Reglan®/metoclopramide.

5. \_\_\_\_\_ I don't recall what I was told.

6. \_\_\_\_\_ Other (describe discussion regarding your injury and Reglan® and/or metoclopramide): \_\_\_\_\_

(if discussed with more than one medical professional, please copy and complete this section for each)

F. Medical Expenses - Have you paid or incurred any medical expenses, including amounts billed or paid by insurers and other third-party payors, which are related to any condition which you claim was caused by Reglan<sup>®</sup> and/or metoclopramide for which you seek recovery in the action which you have filed?

Yes: \_\_\_\_ No: \_\_\_\_ Cannot Recall/Unknown: \_\_\_\_\_

*If yes*, please provide the best estimate of the total amount of such expenses at this time:

\$ \_\_\_\_\_

To the extent any medical expenses have been paid by an insurance company(ies), please provide the following:

Physician (include address)	Amount Paid (and Amount Billed)

G. Fact Witnesses - Please identify the following for each individual likely to have discoverable information that you may use to support your claims (exclusive of experts and health care professional identified in this Fact Sheet).

1. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Information they possess: \_\_\_\_\_

\_\_\_\_\_

2. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Information they possess: \_\_\_\_\_

\_\_\_\_\_

3. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Information they possess: \_\_\_\_\_

\_\_\_\_\_

(Please copy and complete and attach additional pages if necessary to provide a complete response.)

**III. PERSONAL INFORMATION OF REGLAN<sup>®</sup> AND/OR METOCLOPRAMIDE USER**

**A. Background Information:**

1. Name: \_\_\_\_\_

2. Maiden or other names used or by which you have been known: \_\_\_\_\_

\_\_\_\_\_

3. Identify each address at which you have resided 3 years prior to first ingestion (first date disclosed in Section II.B.) to present, and list when you started and stopped living at each one:

ADDRESS	DATES OF RESIDENCE

Please Initial: \_\_\_\_\_


4. Date of Birth: \_\_\_\_\_
5. Place of Birth: \_\_\_\_\_
6. Sex: Male \_\_\_\_ Female \_\_\_\_
7. Have you ever had a driver's license? Yes: \_\_\_\_ No: \_\_\_\_
8. Has your driver's license ever been revoked or limited because of your health or physical condition? Yes: \_\_\_\_ No: \_\_\_\_  
 If so, when, and for what reason(s): \_\_\_\_\_
9. Have you ever served in any branch of the military? Yes: \_\_\_\_ No: \_\_\_\_
- a. Branch and dates of service: \_\_\_\_\_
- b. Were you discharged for any reason relating to your health or physical condition? Yes: \_\_\_\_ No: \_\_\_\_  
*If yes, state what that condition was:* \_\_\_\_\_
10. Have you ever been rejected from military service for any reason relating to your health or physical condition? Yes: \_\_\_\_ No: \_\_\_\_
11. Have you ever filed a worker's compensation claim? Yes: \_\_\_\_ No: \_\_\_\_  
*If yes, please state:*
- a. Year claim was filed: \_\_\_\_\_
- b. Where claim was filed: \_\_\_\_\_
- c. Claim/docket number, if applicable: \_\_\_\_\_
- d. Nature of claimed injury: \_\_\_\_\_
- e. Period of disability: \_\_\_\_\_

(attach additional sheets as necessary to describe more than one claim)

12. Have you ever made a social security disability claim? Yes: \_\_\_\_ No: \_\_\_\_

*If yes*, please state:

a. Year claim was filed: \_\_\_\_\_

b. Where claim was filed: \_\_\_\_\_

c. Nature of disability: \_\_\_\_\_

d. Period of disability: \_\_\_\_\_

(attach additional sheets as necessary to describe more than one claim)

13. Have you ever made any other type of disability claim? Yes: \_\_\_\_ No: \_\_\_\_

*If yes*, please state:

a. Year claim was filed: \_\_\_\_\_

b. Where claim was filed: \_\_\_\_\_

c. Nature of disability: \_\_\_\_\_

d. Period of disability: \_\_\_\_\_

(attach additional sheets as necessary to describe more than one claim)

14. Has Medicare ever paid for any of your medical treatment?

Yes: \_\_\_\_ No: \_\_\_\_ Cannot Recall/Unknown: \_\_\_\_\_

*If yes*, please state:

a. List any liens placed upon you by Medicare for this treatment: \_\_\_\_\_

\_\_\_\_\_

15. Are you aware of any other liens, besides Medicare, placed upon you?

Yes: \_\_\_\_ No: \_\_\_\_

If so, when, and for what reason(s): \_\_\_\_\_

\_\_\_\_\_

16. Have you ever been denied life insurance for reasons relating to your health?  
Yes: \_\_\_\_ No: \_\_\_\_

*If yes*, please state when, the name of the company and the company's stated reason for denial. \_\_\_\_\_  
\_\_\_\_\_

17. Have you ever filed a lawsuit or made a claim, other than in the present suit, seeking damages for personal injury or medical malpractice?  
Yes: \_\_\_\_ No: \_\_\_\_

*If yes*, state the state and county in which the claim was filed, the caption, case name, and/or names of adverse parties, the civil action or docket number assigned to each such claim, action, or suit, and the outcome of each such claim, action, or suit. \_\_\_\_\_  
\_\_\_\_\_

18. Have you or your spouse ever filed for bankruptcy? Yes: \_\_\_\_ No: \_\_\_\_

If so, please state date filed, jurisdiction, and case identification number:  
\_\_\_\_\_

19. Have you been convicted of, or pled guilty to, a crime in the last 10 years, or a felony or crime of moral turpitude ever?

Yes: \_\_\_\_ No: \_\_\_\_

*If yes*, describe the crime or offense, the state and county in which convicted/pled guilty, and the outcome of the charge. \_\_\_\_\_  
\_\_\_\_\_

20. Have you had internet access at any time during the last 10 years?

*If yes*, then answer the following:

- a. Did you ever visit any website containing information regarding Reglan<sup>®</sup> and/or metoclopramide and/or any of your claimed injuries?

Yes: \_\_\_\_ No: \_\_\_\_ Cannot Recall/Unknown: \_\_\_\_\_

b. Did you ever visit any social networking sites (such as Facebook) and communicate about Reglan<sup>®</sup> and/or metoclopramide and/or any of your claimed injuries?

Yes: \_\_\_\_ No: \_\_\_\_ Cannot Recall/Unknown: \_\_\_\_\_

*If yes*, identify the account or accounts you used to make such communications. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

c. Did you ever communicate have email or chat room regarding Reglan<sup>®</sup> and/or metoclopramide and/or any of your claimed injuries?

Yes: \_\_\_\_ No: \_\_\_\_ Cannot Recall/Unknown: \_\_\_\_\_

*If yes*, identify the email address or addresses you used to make such communications. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

B. Family Information:

1. Have you ever been married? Yes: \_\_\_\_ No: \_\_\_\_

2. If you have been married, for each spouse, state:

a. Spouse's name: \_\_\_\_\_

b. Dates of marriage(s): \_\_\_\_\_

c. Date of end of marriage: \_\_\_\_\_

d. Reason for end of marriage: \_\_\_\_\_

e. Spouse's date of birth: \_\_\_\_\_

f. Spouse's occupation: \_\_\_\_\_

3. Has your spouse filed a loss of consortium or other claim in this lawsuit?  
Yes: \_\_\_\_ No: \_\_\_\_



Acid Reflux	Yes: _____	No: _____	Unknown _____
GERD (gastroesophageal reflux disease)	Yes: _____	No: _____	Unknown _____
Barrett's Esophagus	Yes: _____	No: _____	Unknown _____
Gastroparesis/diabetic gastroparesis	Yes: _____	No: _____	Unknown _____
Esophageal Cancer	Yes: _____	No: _____	Unknown _____
Dementia	Yes: _____	No: _____	Unknown _____
Alzheimer's	Yes: _____	No: _____	Unknown _____
Tic	Yes: _____	No: _____	Unknown _____
Heartburn	Yes: _____	No: _____	Unknown _____
Any type of unusual or uncontrolled movements	Yes: _____	No: _____	Unknown _____
Any type of upper gastrointestinal problem	Yes: _____	No: _____	Unknown _____
Seizures	Yes: _____	No: _____	Unknown _____

C. Educational History:

- Identify each high school, vocational school, college, university or other post-secondary educational institution you have attended, the dates of attendance, and diplomas or degrees awarded:

School or Educational Institution (provide address)	Dates of Attendance	Diploma/Degree Awarded

D. Employment History:

- Occupation: \_\_\_\_\_
- Current or last employer: \_\_\_\_\_
- Employer's Address: \_\_\_\_\_  
\_\_\_\_\_
- Dates of Employment: \_\_\_\_\_

5. Complete the following information with respect to your employment the 5 years prior to first ingestion (first date disclosed in Section II.B.) to the present. Identify each employer, including the dates of each such employment and positions held:

Employer	Address	Type of Business/Position	Dates of Employment	Salary	Employee health benefits? (Yes or No)

6. Have you ever been out of work for more than thirty (30) days for reasons related to your health? Yes: \_\_\_\_ No: \_\_\_\_

*If yes*, please state the dates, employer, and health condition. \_\_\_\_\_

\_\_\_\_\_

E. Lost Earnings:

- Do you claim or expect to claim that you will lose future earnings as a result of any condition that you believe was caused by Reglan<sup>®</sup> and/or metoclopramide? Yes: \_\_\_\_ No: \_\_\_\_
- Do you claim or expect to claim that you lost earnings or suffered impairment of earning capacity as a result of any condition that you believe was caused by Reglan<sup>®</sup> and/or metoclopramide? Yes: \_\_\_\_ No: \_\_\_\_

*If no*, please proceed to Section IV.

- Give your best estimate of time or wage you have lost from work as a result of any condition you claim was caused by Reglan<sup>®</sup> and/or metoclopramide and the amount of income which you lost: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IV. LIST OF HEALTHCARE PROVIDERS**

A. Please give the following information for each of your physicians (including, but not limited to, primary care physicians, neurologists, gastroenterologists, dentists/dental professionals, etc.) for the 5 years prior to your first ingestion (first date disclosed in Section II.B.) to the present:

Name: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

Specialty (if known): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason for Treatment: \_\_\_\_\_

Name: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

Specialty (if known): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason for Treatment: \_\_\_\_\_

Name: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

Specialty (if known): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason for Treatment: \_\_\_\_\_

Name: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

Specialty (if known): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason for Treatment: \_\_\_\_\_

\_\_\_\_\_

(Please attach additional pages to provide a complete response.)

- B. Health Insurance Providers - Identify each company or carrier that has provided your health insurance coverage for the 5 years prior to your first ingestion (first date disclosed in Section II.B.) to the present:

Name: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

Specialty (if known): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

Specialty (if known): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

(Please copy and complete and attach additional pages, if necessary to provide a complete response.)

C. Hospitalizations - Identify each hospital, clinic, or healthcare facility where you have received treatment for the 5 years prior to your first ingestion (first date disclosed in Section II.B.) to the present:

1. Name: \_\_\_\_\_ Approximate dates: \_\_\_\_\_

Reason for treatment: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

2. Name: \_\_\_\_\_ Approximate dates: \_\_\_\_\_

Reason for treatment: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

(Please copy and complete and attach additional pages, if necessary to provide a complete response.)

D. Pharmacy - Identify each pharmacy, drugstore and/or other supplier (including mail order) where you have had prescriptions filled or from which you have ever received any prescription medication for the 5 years prior to your first ingestion (first date disclosed in Section II.B.) to the present:

1. Name: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

2. Name: \_\_\_\_\_  
 Street address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

(Please copy and complete and attach additional pages, if necessary to provide a complete response.)

**V. MEDICAL BACKGROUND**

A. Do you currently suffer from any physical injuries, illnesses, or disabilities other than those that you believe were caused by Reglan® and/or metoclopramide?  
 Yes: \_\_\_\_ No: \_\_\_\_

*If yes*, identify the injury, illness, or disability, symptoms, date(s) of onset and date(s) of diagnosis, by whom the condition was first diagnosed, any treatment received for the condition, and treating physician: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

B. Height and weight on the date of your alleged injury: \_\_\_\_\_

C. Current height and weight: \_\_\_\_\_

D. Height and weight when first prescribed Reglan® or metoclopramide (as disclosed in Section II.B): \_\_\_\_\_

E. Please indicate whether, to the best of your knowledge, you have ever experienced, been diagnosed with, or treated for the following conditions PRIOR to your use of Reglan®/metoclopramide:

1. Health conditions, including but not limited to:

Tardive Dyskinesia	Yes: ____	No: ____	Unknown ____
Dystonia	Yes: ____	No: ____	Unknown ____
Chorea	Yes: ____	No: ____	Unknown ____
Myoclonus	Yes: ____	No: ____	Unknown ____
Akathisia	Yes: ____	No: ____	Unknown ____
Tremors	Yes: ____	No: ____	Unknown ____
Movement Disorders	Yes: ____	No: ____	Unknown ____
Tourette's Syndrome	Yes: ____	No: ____	Unknown ____

Neuroleptic Malignant Syndrome	Yes: _____	No: _____	Unknown _____
Stroke	Yes: _____	No: _____	Unknown _____
Parkinson's Disease	Yes: _____	No: _____	Unknown _____
Huntington's Disease	Yes: _____	No: _____	Unknown _____
Diabetes	Yes: _____	No: _____	Unknown _____
Alcoholism	Yes: _____	No: _____	Unknown _____
Head trauma	Yes: _____	No: _____	Unknown _____
Schizophrenia	Yes: _____	No: _____	Unknown _____
Psychosis	Yes: _____	No: _____	Unknown _____
Mental Illness	Yes: _____	No: _____	Unknown _____
Bipolar Disorder	Yes: _____	No: _____	Unknown _____
Depression	Yes: _____	No: _____	Unknown _____
Anxiety Disorder	Yes: _____	No: _____	Unknown _____
Mood Disorder	Yes: _____	No: _____	Unknown _____
Hallucinations	Yes: _____	No: _____	Unknown _____
Suicidal Ideation	Yes: _____	No: _____	Unknown _____
Restless Leg Syndrome	Yes: _____	No: _____	Unknown _____
Wilson's Disease	Yes: _____	No: _____	Unknown _____
Stiff Persons Syndrome	Yes: _____	No: _____	Unknown _____
Acute Dystonic Reaction	Yes: _____	No: _____	Unknown _____
Blepharospasm	Yes: _____	No: _____	Unknown _____
Acid Reflux	Yes: _____	No: _____	Unknown _____
GERD (gastroesophageal reflux disease)	Yes: _____	No: _____	Unknown _____
Barrett's Esophagus	Yes: _____	No: _____	Unknown _____
Gastroparesis/diabetic gastroparesis	Yes: _____	No: _____	Unknown _____
Esophageal Cancer	Yes: _____	No: _____	Unknown _____
Cerebrovascular disease	Yes: _____	No: _____	Unknown _____
Dementia	Yes: _____	No: _____	Unknown _____
Alzheimer's	Yes: _____	No: _____	Unknown _____
Tic	Yes: _____	No: _____	Unknown _____
Heartburn	Yes: _____	No: _____	Unknown _____
Any type of unusual or uncontrolled movements	Yes: _____	No: _____	Unknown _____
Any type of upper gastrointestinal problem	Yes: _____	No: _____	Unknown _____
Head injury	Yes: _____	No: _____	Unknown _____
Seizures	Yes: _____	No: _____	Unknown _____

***If you answered "Yes" to any of the above, for each condition, identify the specific condition(s)/disorder(s), symptoms, date(s) of onset, and date(s) of diagnosis:***

Specific condition/disorder: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Date(s) of onset: \_\_\_\_\_

Date(s) of diagnosis: \_\_\_\_\_

Diagnosis Physician: \_\_\_\_\_

Address (if not otherwise provided): \_\_\_\_\_

Treating Physician: \_\_\_\_\_

Address (if not otherwise provided): \_\_\_\_\_

Medication and/or Treatment: \_\_\_\_\_

Current Status of Condition: \_\_\_\_\_

(Please copy and complete and attach additional pages, if necessary to provide a complete response.)

F. Drinking History:

1. Have you ever consumed alcohol (beer/wine/whiskey/etc.)?  
Yes: \_\_\_\_ No: \_\_\_\_

*If yes*, check which represents your typical alcohol consumption during adulthood:

\_\_\_\_ Daily

\_\_\_\_ Weekly

\_\_\_\_ Monthly

\_\_\_\_ Other (explain: \_\_\_\_\_)

G. Smoking History:

1. Have you ever smoked cigarettes? Yes: \_\_\_\_ No: \_\_\_\_

*If yes*, state the amount smoked: \_\_\_\_\_ packs per day for \_\_\_\_\_ years during the years \_\_\_\_\_.

2. Have you ever smoked cigars or pipe tobacco? Yes: \_\_\_\_ No: \_\_\_\_

*If yes*, state the product smoked: \_\_\_\_\_ and amount smoked: \_\_\_\_\_ for \_\_\_\_\_ years during the years \_\_\_\_\_.

H. Drug Use History:

1. Please indicate whether you have ever used the following:

Stimulants	Yes: _____	No: _____	Unknown _____
Attention deficit medications	Yes: _____	No: _____	Unknown _____
Antipsychotic medications	Yes: _____	No: _____	Unknown _____
Tranquilizers	Yes: _____	No: _____	Unknown _____
Amisulpride (Solian <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Amitriptyline (Elavil <sup>®</sup> , Endep <sup>®</sup> , Limbitrol <sup>®</sup> , Chlordiazepoxide)	Yes: _____	No: _____	Unknown _____
Amoxapine (Asendin <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Anticholinergics	Yes: _____	No: _____	Unknown _____
Aripiprazole (Abilify <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Asenapine (Saphris <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Bupropion (Wellbutrin <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Bupropion Hydrobromide (Aplenzin <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Buspirone (Buspar <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Chlorpromazine (Thorazine <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Chlorprothixene (Taractan <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Cimetidine (Tagamet <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Cisapride (Propulsid <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Citalopram (Celexa <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Clozapine (Clozaril <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Cocaine	Yes: _____	No: _____	Unknown _____
Crack cocaine	Yes: _____	No: _____	Unknown _____
Desipramine (Norpramin <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Desvenlafaxin (Pristiq <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Diphenhydramine (e.g., Benadryl <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Droperidol (Inapsine <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Duloxetine (Cymbalta <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Escitalopram (Lexapro <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Fluphenazine (Prolixin <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Fluoroquinolones (e.g., ofloxacin)	Yes: _____	No: _____	Unknown _____
Haloperidol (Haldol)	Yes: _____	No: _____	Unknown _____
Heroin	Yes: _____	No: _____	Unknown _____
Iloperidone (Fanapt <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Isocarboxazid (Marplan <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
LSD	Yes: _____	No: _____	Unknown _____
Lithium (Cibalith-S Syrup, Eskalith <sup>®</sup> , Lithane <sup>®</sup> , Lithobid <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Lorazepam (Ativan <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Loxapine (Loxitane <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Maprotiline (Ludiomil <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Mesoridazine (Serentil <sup>®</sup> )	Yes: _____	No: _____	Unknown _____

Mirtazapine (Remeron <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Molindone (Moban <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Marijuana or hashish	Yes: _____	No: _____	Unknown _____
Ecstasy or MDMA	Yes: _____	No: _____	Unknown _____
Methodone	Yes: _____	No: _____	Unknown _____
Methamphetamine or "Ice"	Yes: _____	No: _____	Unknown _____
Nortriptyline (Pamelor <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Olanzapine (Zyprexa, Symbax <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Paliperidone (Invega <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Paroxetine (Paxil <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
PCP	Yes: _____	No: _____	Unknown _____
Perphenazine	Yes: _____	No: _____	Unknown _____
(Etrafon <sup>®</sup> , Trilafon <sup>®</sup> , Amitriptylin, Triavil <sup>®</sup> )			
Phenelzine (Nardil <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Phenytoin (Dilantin <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Pimozide (Orap <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Prochlorperazine (Compazine <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Promethazine (Phenergan <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Protriptyline (Vicatil <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Quetiapine (Serzone <sup>®</sup> , Seroquel <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Risperidone (Risperdal <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Selegiline Transdermal System (Emsam <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Sertraline (Zoloft <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Thioridazine (Mellaril <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Thiothixene (Navane <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Tranlycypromine (Parnate <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Trazodone (Desyrel <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Trifluoperazine (Stelazine <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Triflupromazine (Vesprin <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Trimipramine (Surmontil <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Venlafaxine (Effexor <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Ziprasidone (Geodon <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Amphetamines	Yes: _____	No: _____	Unknown _____
Inhaled non-prescription substances (e.g., glue, paint, or solvents)	Yes: _____	No: _____	Unknown _____
Caffeine-containing stimulants (e.g., No-Doz, Vivarin)	Yes: _____	No: _____	Unknown _____
Sleep medications	Yes: _____	No: _____	Unknown _____
Antidepressants, Cyclic (e.g., doxepin, imipramine, Adapin, Sinequan <sup>®</sup> , Tofranil <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Antidepressants, SSRI (e.g., fluoxetine, Prozac <sup>®</sup> , Symbax <sup>®</sup> )	Yes: _____	No: _____	Unknown _____
Tricyclic antidepressants	Yes: _____	No: _____	Unknown _____
Over the counter appetite suppressants	Yes: _____	No: _____	Unknown _____

Prescription appetite suppressants	Yes: _____	No: _____	Unknown _____
Dietary supplements	Yes: _____	No: _____	Unknown _____
Herbal products	Yes: _____	No: _____	Unknown _____
Steroids	Yes: _____	No: _____	Unknown _____

*If you answered "Yes" to any of the above, to the extent a response is applicable, specify:*

The product(s): \_\_\_\_\_

Dates of ingestion(s): \_\_\_\_\_

Dosage of each ingestion: \_\_\_\_\_

Prescriber: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

The product(s): \_\_\_\_\_

Dates of ingestion(s): \_\_\_\_\_

Dosage of each ingestion: \_\_\_\_\_

Prescriber: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

(Please copy and complete and attach additional pages, if necessary to provide a complete response.)

**VI. DOCUMENTS**

- A. Authorizations - ORIGINAL SIGNED authorizations for the release of records in the forms appended hereto. You shall provide addressed authorizations for each health care provider, including hospitals, clinics and outpatient treatment centers, and any other custodian of records, including employers and educational institutions, you have identified above in your Answers to Sections III.C-D. and IV.A-H.

B. Documents in your possession - If you or your counsel have any of the following materials in your custody or possession, or in the possession, custody or control of your lawyers, please attach a copy to this Fact Sheet. This does not include privileged materials.

1. If you have been the claimant or subject of any personal injury lawsuit, worker's compensation, Social Security or other disability proceeding in the 5 years prior to ingestion of Reglan<sup>®</sup> and/or metoclopramide to present, all documents relating to such proceeding.
2. Copies of all medical records, bills, and any other documents from physicians, healthcare providers, hospitals, pharmacies, or others who have provided treatment to you in the 5 years prior to ingestion of Reglan<sup>®</sup> and/or metoclopramide to present, or that you otherwise identified in this Fact Sheet.
3. If you have ever had any radiological studies of the head, neck, or spine done in the 5 years prior to ingestion of Reglan<sup>®</sup> and/or metoclopramide to present, and you are in possession of such studies. If you are not in possession of such radiological studies, provide where these studies were done.
4. All insurance records, bills, letters, or other documents constituting, concerning, or relating to product use instructions, product warnings, package inserts, pharmacy handouts, or other materials distributed with or provided to you in connection with your use of Reglan<sup>®</sup> and/or metoclopramide.
5. Copies of advertisements, brochures, pamphlets, web pages, or other promotional material for Reglan<sup>®</sup> and/or metoclopramide.
6. Copies of the entire packaging, including the pills, bottle, box, and label for the Reglan<sup>®</sup> and/or metoclopramide you allege caused you injury and any remaining medication. (Plaintiff must maintain the originals of the items requested in this subpart.)
7. All statements obtained from or given by any person having knowledge of facts relevant to the subject of this litigation.
8. All documents relating to your purchase of Reglan<sup>®</sup> and/or metoclopramide, including, but not limited to, receipts, prescriptions, or records of purchase.
9. Any documents on which you relied in deciding to take Reglan<sup>®</sup> and/or metoclopramide.
10. All documents in your possession which you believe were provided to you (not to your lawyer) by defendant.
11. Representative photographs, drawings, slides or videos depicting the injuries you alleged Reglan<sup>®</sup> and/or metoclopramide caused.

12. All entries in journals, diaries, notes, letters, emails, or other documents written by you or received by you relating to your injuries, your use of Reglan<sup>®</sup> and/or metoclopramide, or the injuries you alleged Reglan<sup>®</sup> and/or metoclopramide caused (excluding privileged materials).
13. All documents relating to any communication by you to or from the Food & Drug Administration (“FDA”), including but not limited to on-line, telephoned, mailed, or faxed communications to the FDA’s MedWatch program, regarding Reglan<sup>®</sup> and/or metoclopramide, including the dates of such communications.
14. If you claim you have suffered a loss of earnings or earning capacity, your federal W-2s for each of the last five (5) years.
15. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other healthcare provider.
16. Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable).
17. Decedent’s death certificate and autopsy report (if applicable).

**DECLARATION**

I, \_\_\_\_\_, **declare under penalty of perjury subject to 18 Pa. C.S. §4904** that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry, that I have supplied all the documents requested in Part VI of this Plaintiff Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the authorizations attached to this declaration.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Sworn and subscribed before me  
This \_\_\_\_ day of \_\_\_\_\_

\_\_\_\_\_  
Notary Public

# **EXHIBIT B**

IN RE : COURT OF COMMON PLEAS  
: PHILADELPHIA COUNTY  
REGLAN®/METOCLOPRAMIDE :  
LITIGATION :  
: JANUARY TERM, 2010  
*This Document Relates to All Cases* : NO. 1997

**PLAINTIFFS' MASTER FIRST SET  
OF INTERROGATORIES TO ALL DEFENDANTS**

Pursuant to Pa. R.C.P. 4005 and 4006, Plaintiffs hereby request that all Defendants answer under oath the following Interrogatories in accordance with Case Management Order No. 3, Section III. B. These Interrogatories are deemed to be continuing to the extent provided in Pa. R.C.P. 4007.4.

Respectfully Submitted,

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Ray Peppelman  
GILLIGAN & PEPPELMAN  
606 E. Baltimore Pike  
Media, PA 19063  
Phone: 610-566-7777  
Fax: 610-566-0808  
ray@gandplaw.us

Stewart Eisenberg  
EISENBERG, ROTHWEILER, WINKLER,  
EISENBERG & JECK  
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Phone: 215-546-6636  
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Rosemary Pinto  
Lynn Seithel  
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[rpinto@feldmanpinto.com](mailto:rpinto@feldmanpinto.com)  
[lseithel@feldmanpinto.com](mailto:lseithel@feldmanpinto.com)

## **DEFINITIONS**

The following terms have the following meanings, unless the context requires otherwise:

1. Parties. The term "plaintiff" or "defendant," as well as a party's full or abbreviated name or a pronoun referring to a party, means the party and, when applicable, its agents, representatives, officers, directors, employees, partners, corporate parent, subsidiaries, or affiliates. This definition is not intended to impose a discovery obligation on any person who is not a party to the litigation.
2. Person. The term "person" means any natural person, a business, a legal or governmental entity, or an association.
3. You & your. The terms "you" and "your" mean the Defendant and its agents, representatives, attorneys, experts (not retained for litigation), and other persons acting or purporting to act on Defendant' behalf.
4. Material. The term "material" means all documents, electronically stored information, or tangible things. The term is synonymous with and equal in scope to the terms "documents," "electronically stored information," and "tangible things." A draft or nonidentical copy of a document, electronically stored information, or a tangible thing is a separate item within the meaning of this term.
  - a. Document. The term "document" means information that is fixed in a tangible medium, such as paper. It includes, but is not limited to, writings, drawings, films, charts, photographs, notices, memoranda, diaries, minutes, correspondence, books, journals, ledgers, reports, worksheets, notes, printed e-mails, letters, abstracts, audits, charts, checks, diagrams, drafts, instructions, lists, logs, resumes, summaries, clinical trials, studies, data, etc.
  - b. Electronically stored information. The term "electronically stored information" means electronic information that is stored in a medium from which it can be retrieved and examined. It includes, but is not limited to, all electronic files that are electronically stored.
    - i. "Electronic file" includes, but is not limited to, the following: voicemail messages and files; e-mail messages and files; deleted files; temporary files; system-history files; Internet- or web-browser-generated information stored in textual, graphical, or audio format, including history files, caches, and cookies; computer-activity logs; metadata; etc.
    - ii. "Electronic storage" refers to electronic files contained on magnetic, optical, or other storage media, such as hard drives, flash drives, DVDs, CDs, tapes, cartridges, floppy diskettes, smart cards, integrated-circuit cards (e.g., SIM cards), etc.

- c. Tangible thing. The term "tangible thing" means a physical object that is not a document or electronically stored information.
5. Communication. The term "communication" means the transmittal of information in the form of facts, ideas, inquiries, or otherwise.
6. Relating. The term "relating" means concerning, referring, describing, evidencing, or constituting, either directly or indirectly.
7. Any. The term "any" should be understood in either its most or its least inclusive sense as necessary to bring within the scope of the discovery request all responses that might otherwise be construed to be outside its scope.
8. And & or. The connectives "and" and "or" should be construed either conjunctively or disjunctively as necessary to bring within the scope of the discovery request all responses that might otherwise be construed to be outside its scope.
9. Number. The use of the singular form of any word includes the plural and vice versa.
10. Reglan® and/or metoclopramide. The term "Reglan® and/or metoclopramide" refers to the prescription medication (generic name: metoclopramide) manufactured, designed, marketed, and sold by Defendant to treat gastrointestinal medical problems.
11. FDA. The term "FDA" refers to the United States Food & Drug Administration.
12. Study. "Study" includes any type of research to determine either the efficacy, mechanism of action, safety, or pharmacology of Reglan® and/or metoclopramide, including but not limited to clinical trials, cohort studies, case control studies, and meta-analysis.
13. Brand Name Defendants. The term "Brand name Defendants" means any and all Defendants that manufactured, designed, labeled, marketed, sold, distributed or had any other involvement with Reglan® whether in tablet, syrup, or injection form.
14. Generic Defendants. The term "Generic Defendants" means any and all Defendants that manufactured, designed, labeled, marketed, sold, distributed or had any other involvement with the generic form of Reglan®, otherwise known as *metoclopramide*, whether in tablet, syrup, or injection form.

### **RULES OF CONSTRUCTION**

In construing these Requests:

- (A) The singular shall include the plural and plural shall include the singular.
- (B) A masculine, feminine or neuter pronoun shall not exclude the other genders.

(C) Unless otherwise specified in the Request, each Request shall extend to all information and documents which have been available to you, in your possession or subject to your control up to the date of your response to these Requests. This paragraph does not limit your duty to supplement your responses.

### **INSTRUCTIONS**

1. If there is a claim of privilege with respect to any information requested, Defendant is responsible for following the Privilege Log protocol set forth in Case Management Order No. 6 (Document Production Protocol).
2. When asked to identify a person, or if the response involves a person, for each person please state the full name, business title, and the current and/or last known home and business addresses and telephone numbers.
3. These interrogatories shall be deemed continuing, to the full extent required or permitted under the Pennsylvania Rules of Civil Procedure, so as to require supplementary responses as soon as practical after receipt of information which renders any of your answers to these interrogatories incomplete or inaccurate.

**PLAINTIFFS' MASTER FIRST SET**  
**OF INTERROGATORIES TO ALL DEFENDANTS**

1. Please identify the following officials; if no such person exists within the corporate structure with the outlined responsibilities then state as such;
  - a. Your director of clinical research who was responsible for any chemical research that was done by you at any time prior to the sale or distribution of Reglan® and/or metoclopramide.
  - b. Your director of clinical research who was responsible for evaluating or reviewing any clinical trials done by you or anyone on Reglan® and/or metoclopramide at any time.
  - c. Your director of post-marketing research who was responsible for any post-marketing studies or clinical trials done by you or anyone on Reglan® and/or metoclopramide after it was approved as a prescription drug.
  - d. Your director of regulatory affairs who was responsible for liaison with the FDA regarding any warnings or instructions to be disseminated with Reglan® and/or metoclopramide before, during, or after it was approved as a prescription drug.
  - e. Your regulatory affairs official who was responsible for approving the warnings and/or instructions contained on the package or bottle of Reglan® and/or metoclopramide before, during, or after it was approved as a prescription drug.
  - f. Your director of marketing who was overall responsible for approving all advertising materials regarding Reglan® and/or metoclopramide before, during, or after it was approved as a prescription drug.
  - g. Your director of pharmacology who was overall responsible for evaluating Reglan® and/or metoclopramide's actions on a living organism.
  - h. Your director of pharmacovigilance who was overall responsible for the detection, assessment, understanding and prevention of adverse effects associated with Reglan® and/or metoclopramide.
  - i. Your current corporate records manager regarding Reglan® and/or metoclopramide.
  - j. Your current director of management information systems, or other official responsible for design, implementation, and maintenance of computer systems within the defendants regarding Reglan® and/or metoclopramide.
  - k. Your current director of sales force automation, or other official responsible for policies and procedures for reporting and tracking of sales call activities regarding Reglan® and/or metoclopramide.

1. Your current director of drug safety surveillance, or other official responsible for collection and distribution of data concerning all adverse drug experiences (ADE's) associated with Reglan® and/or metoclopramide.

**ANSWER:**

2. Please describe the participation, if any, that defendant, as described in definition No. 1, had for the design, manufacture, marketing, or distribution of Reglan® and/or metoclopramide. In this connection, please give the full name, address, job title and present employer of each person.

**ANSWER:**

3. Identify specifically all clinical trials on adults or children done by you or anyone on Reglan and/or metoclopramide which you relied upon before you began marketing it, as a prescription drug.
  - a. State in whose custody these clinical trials data may currently be found.
  - b. State whether or not they exist in electronic form. If so, state whether or not they are on CD-ROM, and in whose custody or possession these electronic data currently exist.

**ANSWER:**

4. Identify specifically all post-marketing clinical trials or studies of any kind on adults or children done by you or anyone on your behalf at any time, either before and after you began distributing Reglan and/or metoclopramide as a prescription drug.
  - a. State in whose custody these clinical trials may currently be found.
  - b. State whether or not they exist in electronic form. If so, state whether or not they are on CD-ROM, and in whose custody or possession these electronic data currently exist.

**ANSWER:**

5. Identify any electronic data bases you or anyone on your behalf have created to monitor post-marketing adverse drug experiences (ADE's) with Reglan and/or metoclopramide, and state whether or not this data exists on CD-ROM. Please redact patient information protect by HIPAA.

**ANSWER:**

6. Identify any electronic data bases regarding Reglan® and/or metoclopramide you or anyone on your behalf have created to process and maintain ADE reports and to monitor and report the company's compliance with FDA or foreign ADE reporting requirements, and state whether or not this data exists on CD-ROM.

**ANSWER:**

7. Identify any electronic data bases you or anyone on your behalf have created to process sales information, or that contain total number of bottles of pills, or total number of pills sold over a given period of time, and state whether or not this data exists on CD-ROM, regarding Reglan® and/or metoclopramide.

**ANSWER:**

8. Do you have the New Drug Application (NDA) and/or any Investigational New Drug Applications (INDA's) and/or Abbreviated New Drug Applications (ANDA) on Reglan and/or metoclopramide in electronic form? If so, state whether this data exists on CD-ROM, in whose custody it is, and the location and address of facility where it is stored and maintained.

**ANSWER:**

9. If not already done, please list the name, title, address, and phone number of each person with an M.D. or Ph.D. degree now or ever in the Defendants employ who has had as part of his or her duties the evaluation or review of the evaluations of the safety or efficacy of Reglan and/or metoclopramide, and for each such person outline his or her specific duties and inclusive dates of these duties.

(Retained Expert Disclosures are not requested at this time)

**ANSWER:**

10. Identify all persons (excluding retained experts but including employees and former employees) with knowledge of relevant facts by stating their name, title, current or last known address, and phone number, and state the category of their knowledge, of safety of Reglan and/or metoclopramide. Plaintiffs do not seek case specific answers to this interrogatory.

**ANSWER:**

11. On any occasion has the Defendant ever advertised Reglan and/or metoclopramide to the general public? If so, please state as to each such occasion:
- a. the date;
  - b. the media in which Reglan and/or metoclopramide was advertised;
  - c. state verbatim the information furnished in the advertisement, or attach copies to your answers;
  - d. the name, title, and address of each person who has custody of the transcript of the advertisement or a copy thereof.

**ANSWER:**

12. If the Defendants affixed, attached, or caused to be affixed or attached to Reglan and/or metoclopramide or to the packaging of Reglan and/or metoclopramide any label, tag, warning, directions, or instructions, please state for each such writing:
- a. its date and purpose;
  - b. its complete and verbatim contents, or alternatively, attach copies to your answers;
  - c. the name and address of each person who has custody of any records relating to the formulation and composition of the writing on each such label or tag;

**ANSWER:**

13. On any occasion have the Defendants prepared and distributed a pamphlet or brochure designed to be distributed to users of Reglan and/or metoclopramide either directly or through their distributor, pharmacist, or physician? If so, please state for such pamphlet:
- a. its date and the facts and circumstances that caused the items to be designed and distributed (purpose);
  - b. its complete and verbatim contents, or alternatively, attach copies to your answers; and
  - c. give the name, title, and address of the person responsible for the preparation of each such pamphlet or brochure.

**ANSWER:**

14. Has the Defendant ever employed or contracted with any third party in connection with the promotion of Reglan and/or metoclopramide? If so, please state:
- a. the name and address of each such agency;
  - b. the dates between which each such agency was employed; and
  - c. a complete list of all advertisements prepared by each such agency that were actually used by the Defendants.

**ANSWER:**

15. Please list in chronological order the names and addresses of all persons who have received or claim to have received injuries resulting, or suspected by them or their physicians to have resulted, from the use of Reglan® and/or metoclopramide, and with respect to each such person, please state:
- a. the nature of the injury claimed, i.e., the ADE claimed;
  - b. the date the Defendants first received notice of the injury;
  - c. the name and address of the attending physician involved; and
  - d. the Defendants response to the notice of injury.

(Please redact confidential patient information protected by HIPAA).

**ANSWER:**

16. If any notices of intent to file lawsuits, or actual lawsuits have been filed against the Defendants for injury or death from the use of Reglan® and/or metoclopramide, please provide:
- a. the case caption;
  - b. Jurisdictional Court;
  - c. Status of the litigation, by indicating whether the case is ongoing, settled, dismissed;
  - d. Trial dates.

**ANSWER:**

17. With reference to Plaintiffs' Amended Master Long Form Complaint, in what respect do you claim plaintiffs have failed to sue the Defendants in the proper capacity, and what is the factual basis for this contention?

**ANSWER:**

18. If you are claiming federal preemption, what is the factual basis for your claim?

**ANSWER:**

19. Please state the names, titles, addresses, and phone numbers of all persons who knew about any and all indemnification agreements ever entered into with Defendants regarding the relevant drug Reglan® and/or metoclopramide, including but not limited to those persons who executed the agreements in full or part.

**ANSWER:**

20. Identify any and all Reglan®/metoclopramide studies known to the Defendant that were conducted inside the United States of America and not provided to the FDA by the Answering Defendant.

**ANSWER:**

21. Are there any entities, including individuals, to whom the answering defendant ascribes liability for any Reglan/metoclopramide liability of the answering defendant, independent of the facts specific to any individual plaintiff? If so, identify such entity, and state the alleged factual basis for such liability.

**ANSWER:**