

The sales force is currently performing only 67% of the budgeted primary calls on OxyContin

Average monthly OxyContin calls Jan – June 2013			
	P1	P2	Primary Detail Equivalents (PDEs)¹
Per Rep			
▪ Target ²	55	59	84
▪ Actual ³	37	58	66
Field force total			
▪ Target	28,875	30,713	44,231
▪ Actual	19,600	30,400	34,800
▪ % actual v. target	67%	99%	79%

1 P1s plus 50% of P2s

2 Target based on published call plan (e.g. 2 call/mo on Oxy Supercores and 1 call/mo on Cores)

3 Assuming 525 active sales reps

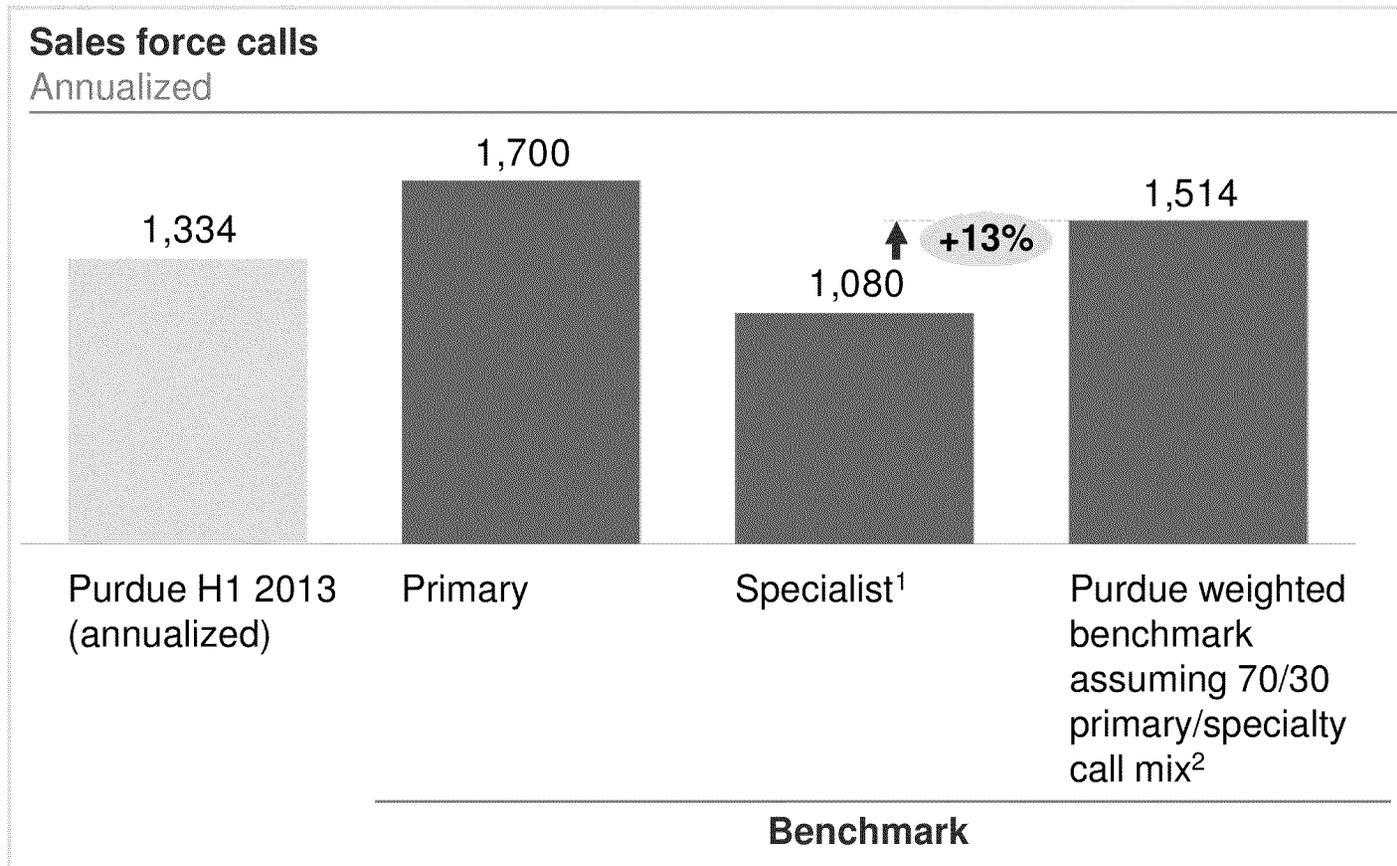
SOURCE: Purdue sales reports; Purdue internal interviews; team analysis

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Purdue call volume is lower than benchmark

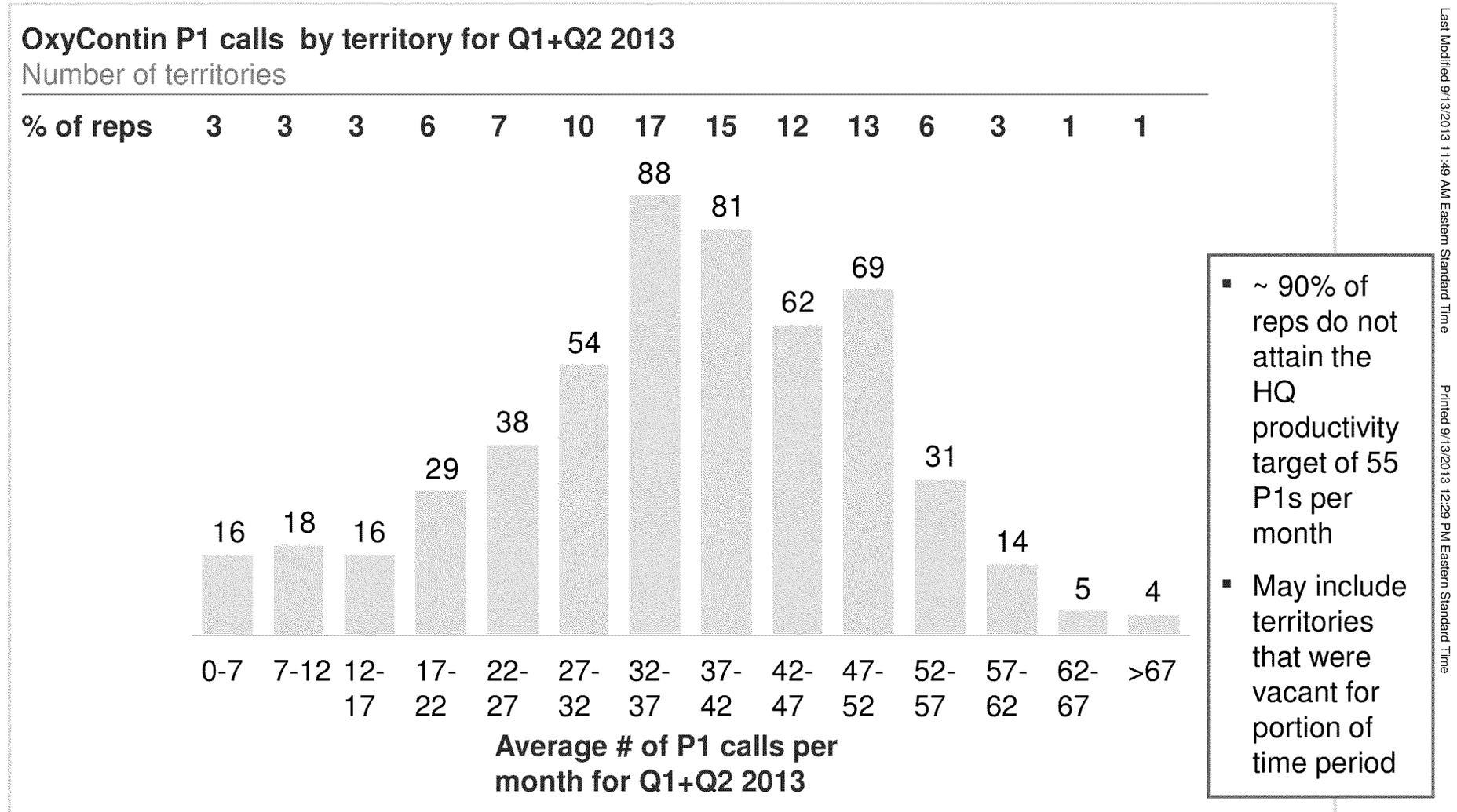


Making the incremental 180 calls per rep per year could result in incremental net revenue of ~\$100 mn³

1 This is the lowest sales force call benchmark among specialties; this benchmark is for niche oncology drugs.
 2 70% of Purdue OxyContin details are for GPs, which include GPs (52% of OxyContin details) and NRP (18% of OxyContin details). Specialty details include Phys Med & Rehab (7% of OxyContin details), Anesthesiology (7%), Rheum (2%), Orthopedic (2%), Neurology (2%), and other specialties that each make up 1% or less of OxyContin details.
 3 Assuming 12 calls/ year/ prescriber, 39 incremental scripts per prescriber that is newly called upon (assuming Decile 5-7 sales responsiveness calculated by ZS Associates), 71 pills/ script, \$6.2 average price per pill, with 25% rebate and other fees.

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There is a wide variance of actual P1 call attainment across territories



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One possible way to attain benchmark ~1500 calls per year is to decrease training days by ~6 days and increase calls per day by 5%

■ One possible route to benchmark

Current call activity	
Number of "on territory" days per year	
Item	Days ¹
Number of working days	260
Holidays	-11.3
Vacation and other time off	-27.2
Trainings and meetings	-17.5
Other company-related time off of field	-4.3
Total days	199.7
Avg calls per day	x 7
Total calls per year	1398

Potential new allocation	
Number of "on territory" days per year	
Item	Days ¹
Number of working days	260
Holidays	-11.3
Vacation and other time off	-27.2
Trainings and meetings	-11.5
Other company-related time off of field	-4.3
Total days	205.7
Avg calls per day	x 7.35
Total calls per year	1512

1 Purdue 2012 Actual data was used for this analysis

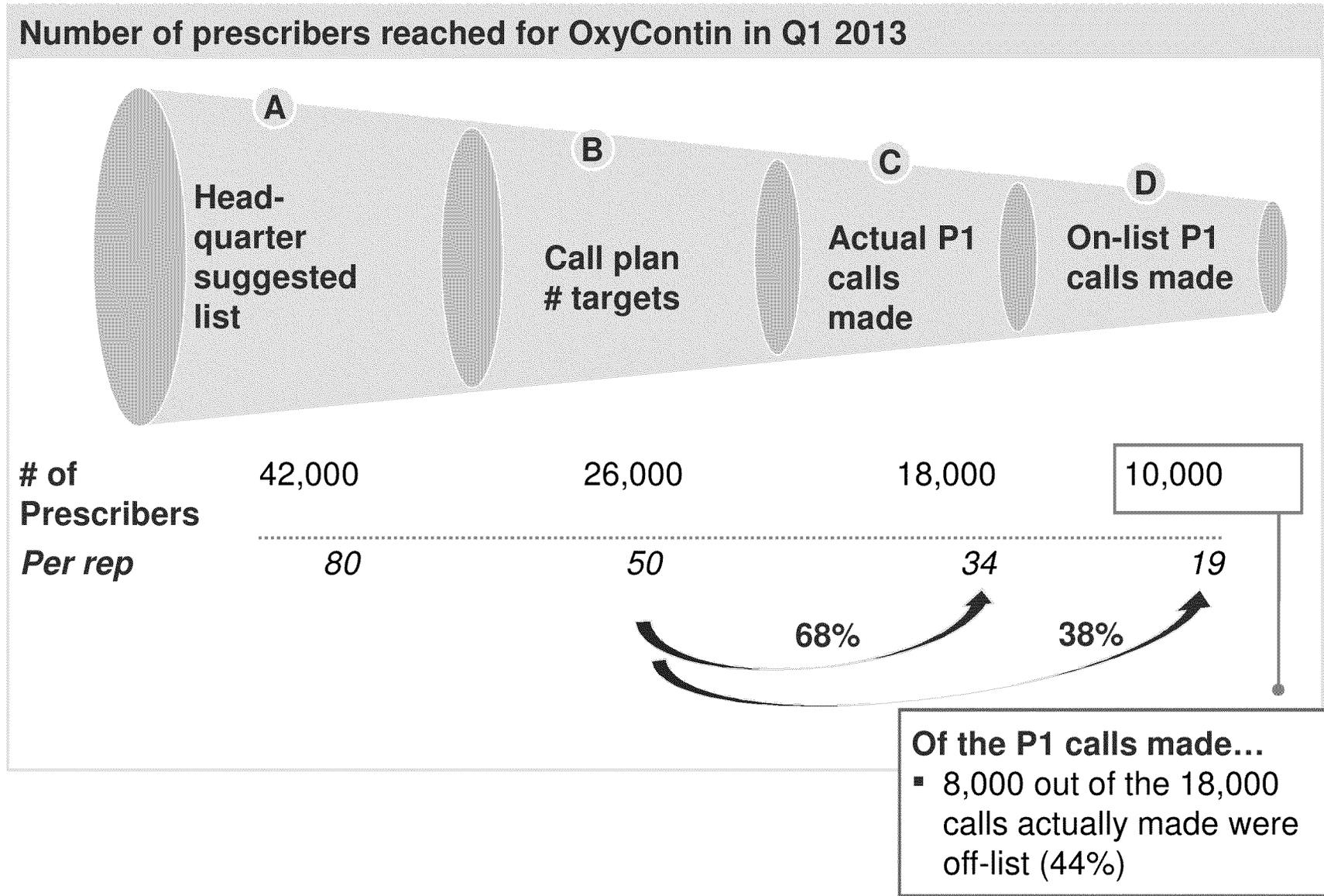
SOURCE: Purdue; team analysis

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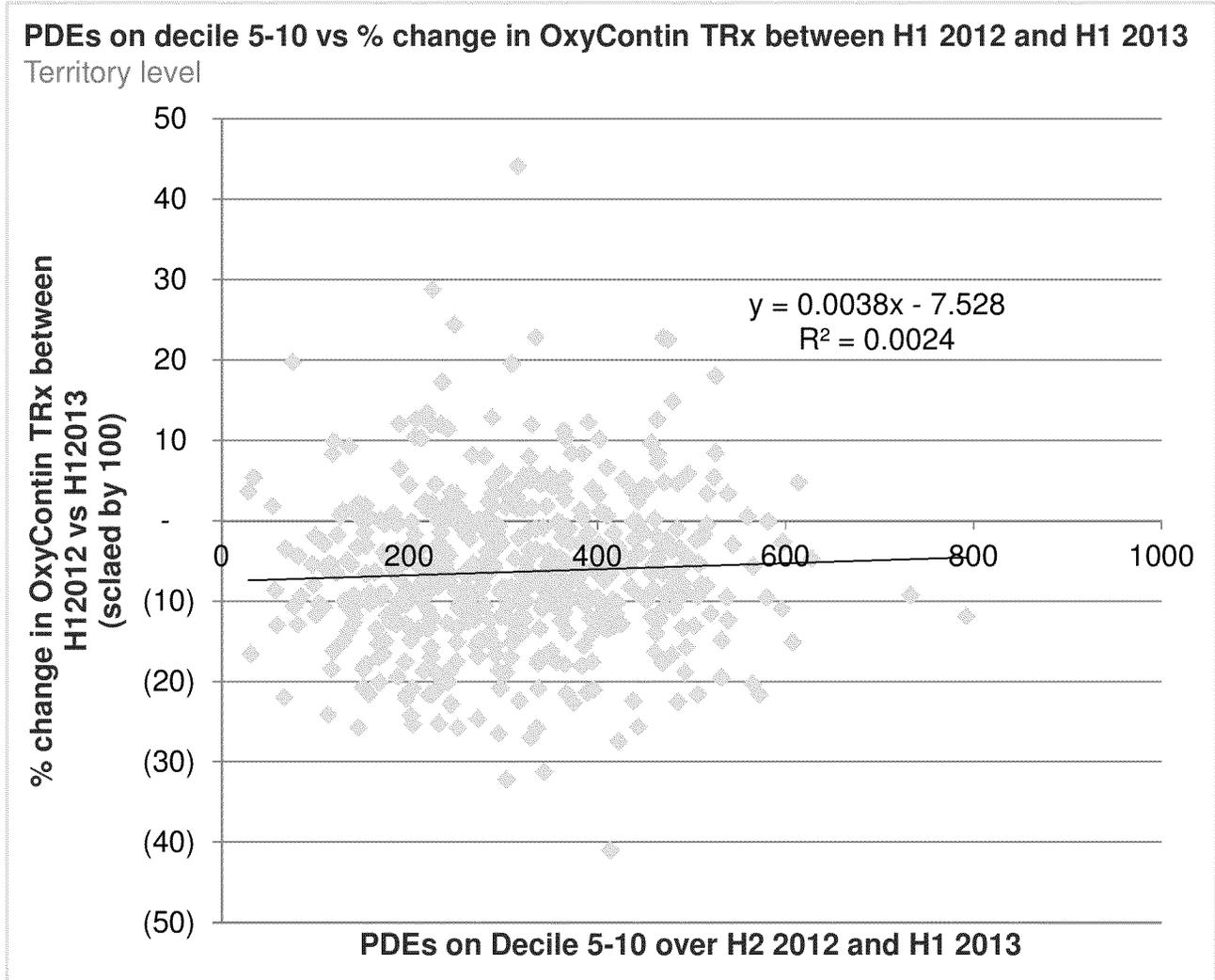
Adherence to the call list is only ~55%



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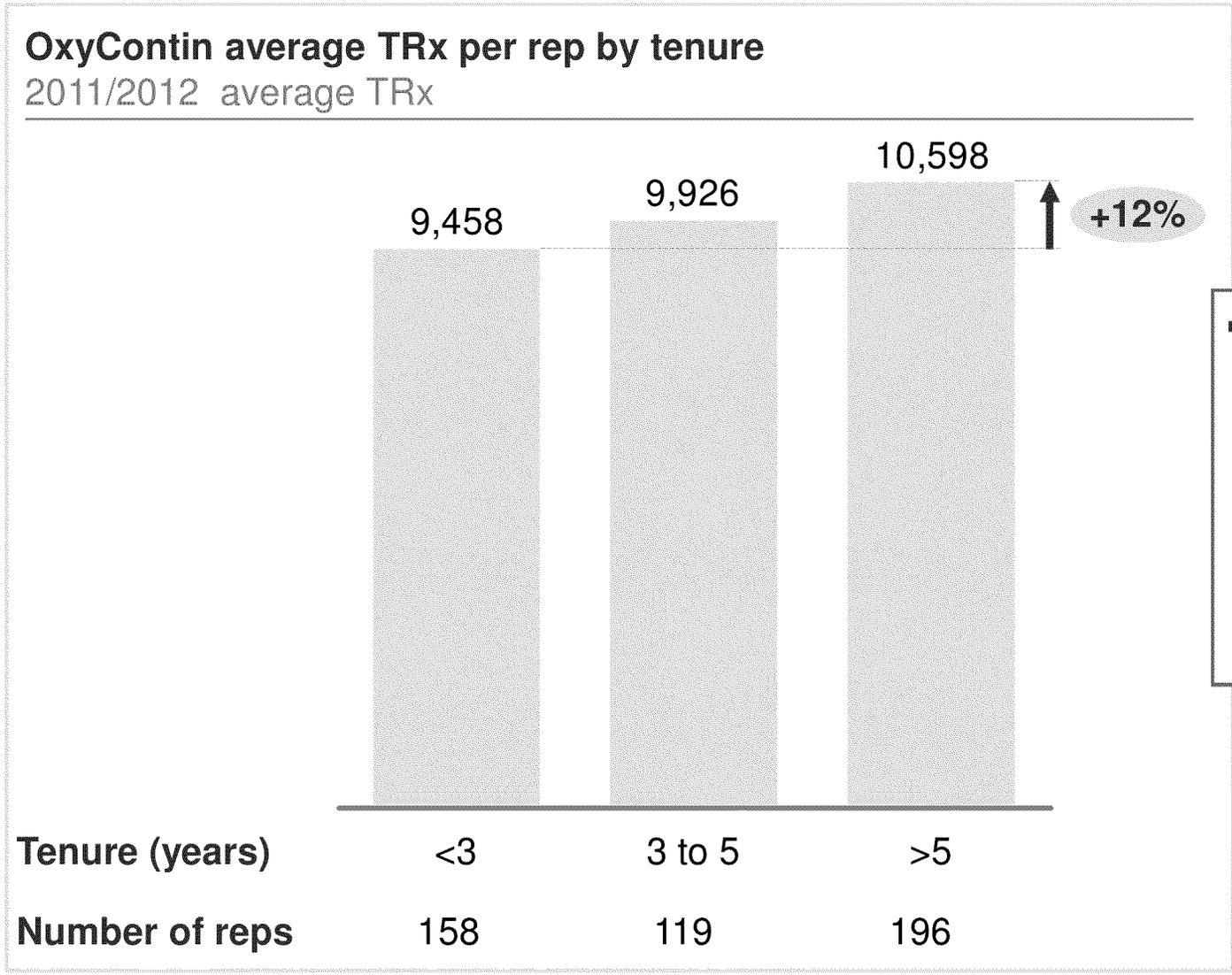
Calls on decile 5-10 prescribers positively correlate with OxyContin growth



Implies that doing 175 more PDEs on deciles 5-10¹ is associated with 0.6 percentage point increase in OxyContin growth rate

1 Which is going from 25th to 75th percentile of PDEs on deciles 5-10

Some variability exists across tenure for average prescriptions per rep



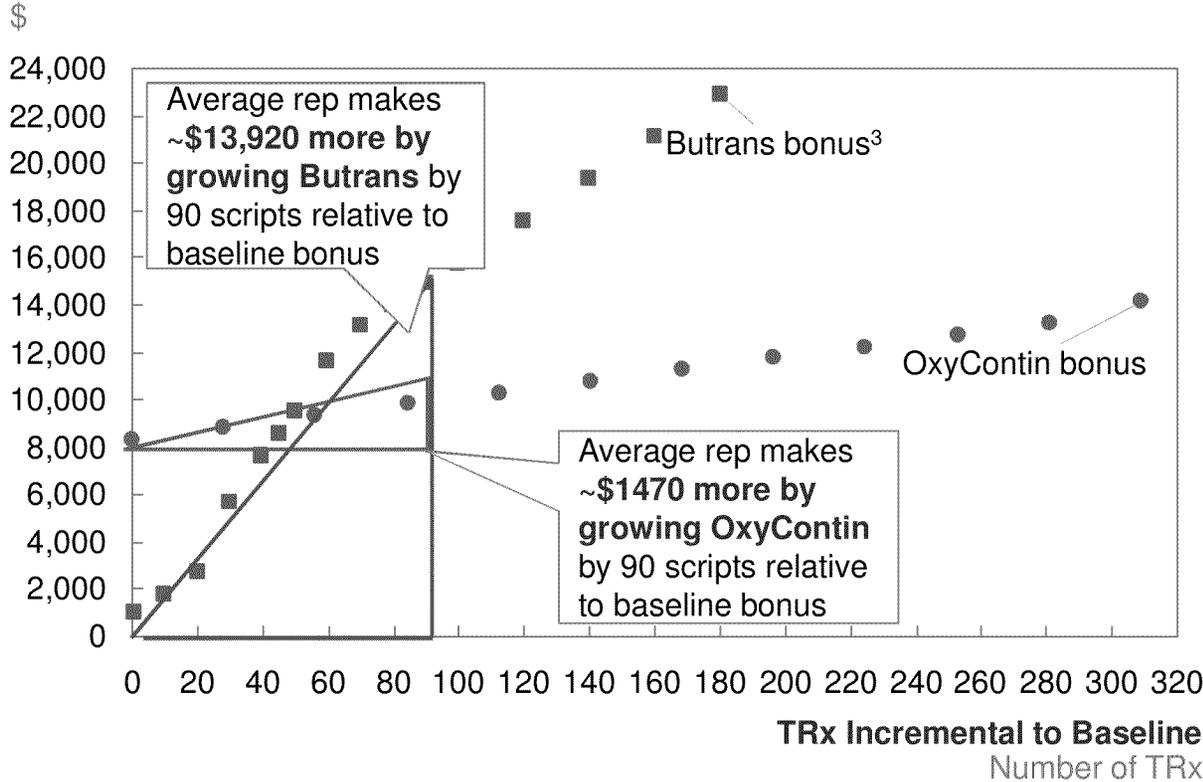
▪ Reps with >5 years tenure are in territories with average 12% higher TRx than reps <5 years (*not controlled for other factors*)

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Incentive comp structure is steeper for Butrans, making each incremental Butrans script more valuable to reps relative to OxyContin

Q3 2013 incentive compensation based on performance of an average rep¹

Quarterly Incentive bonus



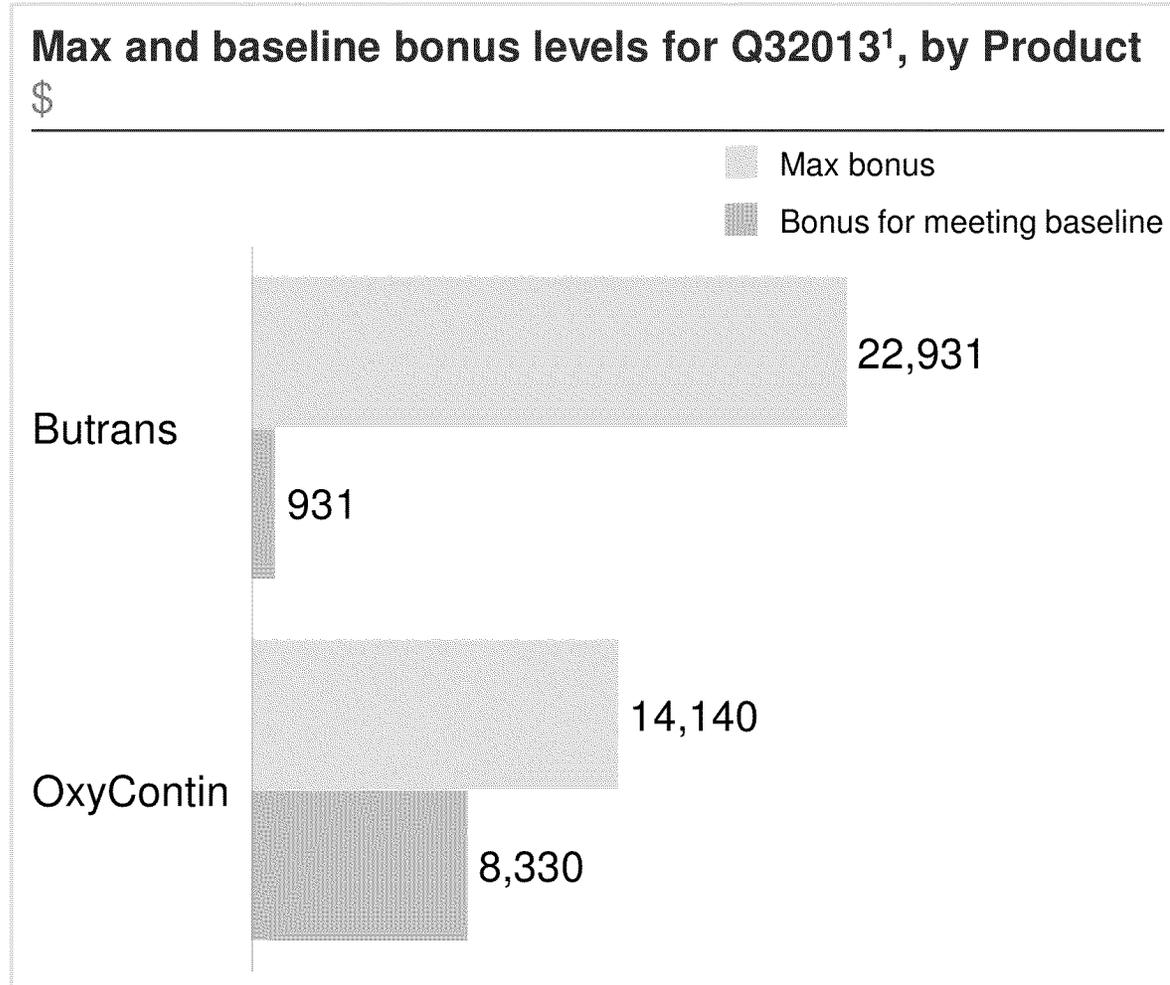
- For average rep, incremental scripts relative to baseline worth far more for Butrans than for OxyContin, because slope of bonus curve is steeper for Butrans
- Purdue, in contrast, makes 67% more if rep sells 90 OxyContin incremental scripts than 90 Butrans incremental scripts (\$30k vs \$18k)²
- Additionally, incentive comp could incorporate call list adherence and rep productivity

1 Uses Q3 2013 incentive plan. Assumes 232 Butranscripts/ quarter for average rep, and 2809 OxyContinscripts/ quarter for average rep.

2 Assumes average \$267 gross price/ Butranscript and \$447 gross price/ OxyContin script. Lastly assume net revenue (net of rebates and fees) is ~75% of gross price.

3 Balanced portfolio bonus included in Butransbonus calculation as is indexed to Butranscripts

Max level of bonus for Butrans at a higher level than for OxyContin



Max level of bonus for Butrans is 60% higher than for OxyContin

¹ Uses Q3 2013 incentive plan. Assumes 232 Butranscripts/ quarter for average rep, and 2809 OxyContinscripts/ quarter for average rep. Balanced portfolio bonus indexed to Butranscripts

Reps who make more OxyContin P1s on high-decile prescribers generate more OxyContin growth in their territory

ACTUAL DATA

Relationship between TRx growth and P1s on high decile prescribers holds across territories



Sales rep A

Sales rep B

Sales rep B generated 7% more growth...

% change in Oxy TRx, H1 2012 vs H1 2013

0%

7.3%

+7300 bp

by making more Oxy P1s on high decile doctors...

Oxy P1s on high decile MDs (5-10) per mo

23

28

+22%

despite operating in a similar territory to Sales rep A

State

TN

TN

of high-decile docs in territory

70

56

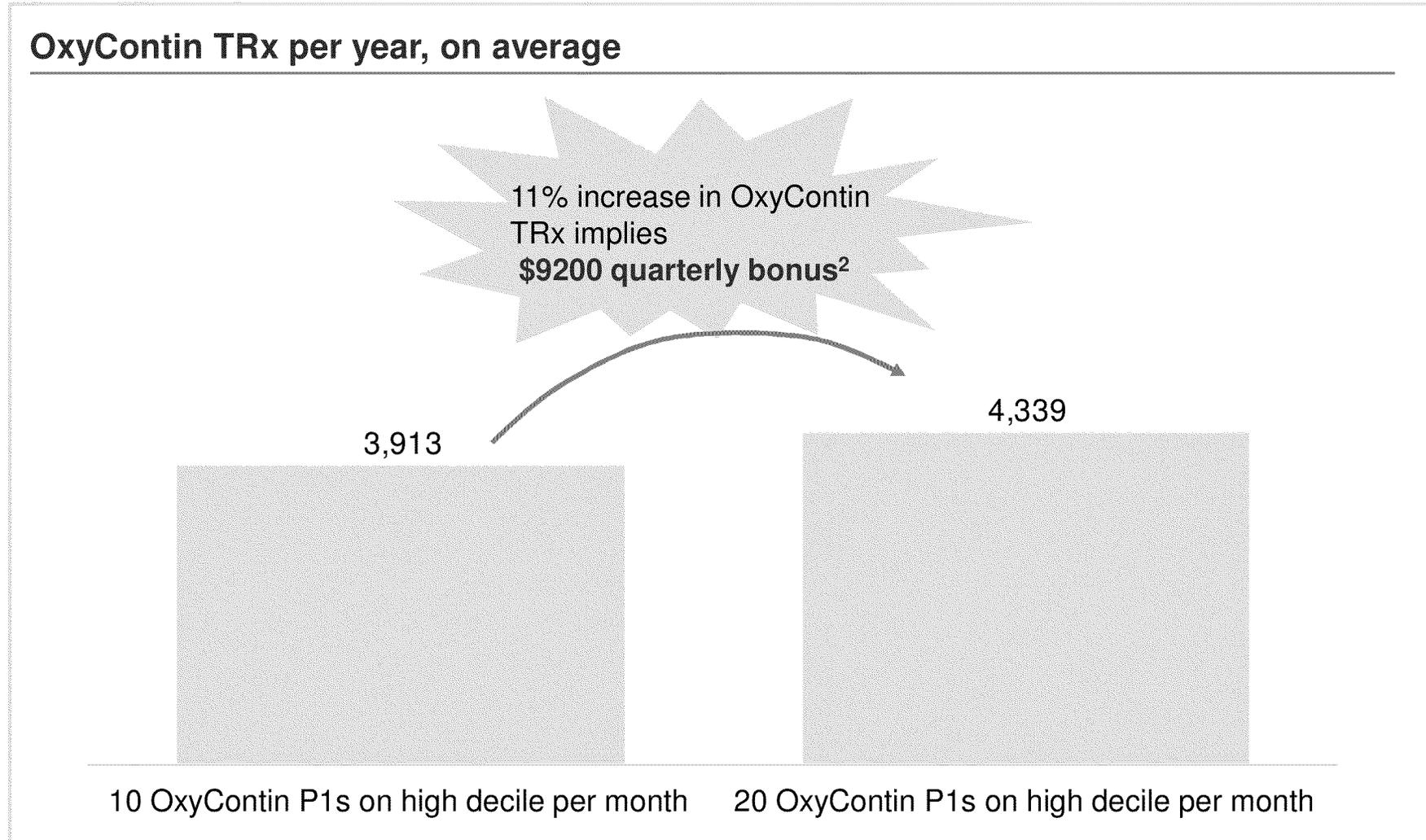
SOURCE: IMS; Purdue sales data

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Going from 10 to 20 OxyContin P1s on high-decile prescribers generates 11% increase in OxyContin scripts¹ – a \$9200 quarterly bonus for avg rep



¹ Based on regression accounting for the number of high-decile prescribers in the territory
² Under current Q2 2013 incentive plan

SOURCE: IMS; Purdue sales data; Purdue Q2 2013 Rep incentive plan

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Observations from rep ride-a-longs

Challenges

- Reps given guidance to only speak about **abuse-deterrence label once** with each physician (guidance “not to make it a selling point”)
- Reps **struggling to engage prescribers in focused conversations about OxyContin**
- Reps **overwhelmed by amount of data available, and unable to use it effectively** for call planning and focusing conversations with prescribers
- Observation that rep still had **old version of OxyContin label** without latest section on abuse-deterrence
- Prescribers “not asking” to talk to **MSL**
- Belief that **pharmacies occasionally switching patients** w/o physician call-back
- **Corporatized provider** in area wouldn't write anything unless “**dirt cheap**” – physician view
- **Abuse was seen as a real issue** for each practice and pharmacy visited; the new label was of interest among prescribers and office staff
- **Pharmacy call-backs seen as an unsustainable ‘drag’** on practice economics

Opportunities

- Reps **trying to apply techniques and topics introduced at trainings** (e.g., “challenger” approach)
- One rep attributed extensive dropping of **co-pay cards** at pharmacies to increasing sales in territory
- Talking about availability of **newer strengths** (e.g. 15mg) seen as effective
- One rep able to generate new writers through **persistent calls** each month
- Use of **dinner programs** seen as effective
- Talked about **managed care ‘wins’** (e.g. MedCo part D)
- Spending time with **office manager discussing managed care coverage and processes** useful
- Can use pharmacy stocking report to **ensure pharmacies are carrying all dosages** of OxyContin
- Engaging interested prescribers on the importance of using **tamper resistance formulations** could increase comfort in using OxyContin

SOURCE: Rep ride-a-long field observations

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The revenue upside from sales re-targeting and adherence could be up to \$250M

PRELIMINARY

Based on ZS Response curves

Lever	# of MDs	PDEs per MD		Total PDE change	TRx impact per MD ³	Total impact ⁴	
		Current (Avg.)	Suggested			TRx	Revenue
Increase reach on decile 5-10 MDs not currently called	All	8,700					
	Reachable	~70% ¹					
	MDs reached	6,000	0	12-24 ²	103k	69	411k \$177M
Increase frequency on decile 5-10 MDs with suboptimal call frequency		16,400	10	12-24 ²	152k	24	387k \$166M
Reduce calls on decile 0-4 MDs		43,000	5	0	(110k)	(5)	(210k) (\$90M)
Total impact					145k		587k \$250M

- 145k incremental PDEs could be achieved by either
 - Increasing current Oxy P1 calls from ~37/rep/month to the 50/rep/month (90% of target) plus adding an incremental 65 reps or
 - Keeping productivity at current level and adding ~190 reps. Typically an additional 10-20% reps are required given inefficiencies in real-world geographic deployment, thus the deployed total could be as many as 210-230 reps

- Opportunity for up to \$250M impact from:
 - Targeting high value prescribers
 - Performing budgeted target Oxy P1s
- Assumes no change to Butrans call plan

NOTE: Purdue call numbers based on blended and annualized Q1+Q2

1 15% discount on access, 10% discount on territory misalignment, 11% discount on other MDs not reachable (e.g. Region 0, IR only)

2 24 calls decile 6-10, 12 calls on decile 5; 3 Based on ZS call responsiveness curves by decile; 4 On annualized basis

SOURCE: ZS Associates, IMS, Purdue call data, team analysis

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65 to 190 additional reps will be needed to capture full opportunity depending on the increase in productivity of the sales force

	Description	Additional reps ¹	Estimated impact ²	Rationale/ What you have to believe
1 Optimize and expand³	a Shift calls to high-value prescribers and increase rep productivity to 90% of target (e.g. 50 v. 55 calls/rep/mo); add reps to fill gap	65+	↑ +\$250M ↓	<ul style="list-style-type: none"> Desire to maximize potential opportunity Believe current field force can improve both productivity and adherence
	b Improve targeting, improve productivity by ~20%, and add reps to fill gap	115+		<ul style="list-style-type: none"> Sales force has potential to moderately improve productivity
	c Shift calls to high value prescribers, no change in rep productivity, add reps to fill gap	190-230		<ul style="list-style-type: none"> Believe call list adherence can be improved but challenging to improve productivity Desire quick impact
2 Optimize with current capacity	▪ Shift calls to high-value prescribers and increase rep productivity to 90% of target (e.g. 50 calls/rep/mo); do not add reps	None	+\$220M	<ul style="list-style-type: none"> Believe current field force can improve both productivity and adherence simultaneously

- Estimates do not include haircut for execution
- Additional reps required could be larger to:
 - Account for territory alignment
 - Increase field force size ahead of new product launch

1 Does not account for territory mis-alignment
 2 Pro-forma relative to 1H 2013 performance, annualized
 3 All scenarios assume 24 calls per year on deciles 6-10, 12 calls on Decile 5

Contents

- Market landscape & demand forecast
- Messaging & positioning
- Segmentation & targeting
- Field focus & execution
- **Access & availability**
 - **Pharmacy/wholesale**
 - Managed care
 - Scientific support
 - Commercial spend levels
 - Patient funnel
 - Appendix

Findings on pharmacy and wholesale access

PRELIMINARY

- **A number of issues at the pharmacy and wholesale level are significantly impacting patient access:**
 - **Pharmacists are increasingly turning away opioid patients, especially at chain pharmacies**
 - Major pharmacies have implemented **stringent guidelines on opioid dispensing**, including pill count limits and requirements that patient must have filled same script at same pharmacy previously
 - **Walgreen's has eliminated incentives for pharmacists to dispense controlled substances** as part of its DEA settlement
 - **Pharmacists increasingly calling back physicians**, creating additional work and hassle for physicians
 - **Distributors are keeping a tight hold on supply of all controlled substances**, with pharmacies unable to order more than historical levels without risking being cut off
 - **There are reports of wholesalers cutting off pharmacies altogether**
- **Using available data, we have evaluated the extent of the access issue**
 - Patient calls to the **Medical Service line on access issues** have been increasing – though this represents only a fraction of the potential impact
 - Analysis of patient survey data collected by the Pain Care Forum shows **direct evidence of patients having difficulty filling opioid prescriptions**
 - Share of redeemed OxyContin savings cards **fell sharply for CVS in Q3 2012 and for Walgreens in Q2 2013**
 - **Walgreen's purchasing has been declining at a rate far faster than other pharmacies, with an acceleration in the March-June 2013 time period after the Good Faith Dispensing policy was rolled out in full**
 - Walgreen's estimated monthly retail purchasing of OxyContin declined ~2% (in units) from Q1 2013 to Q2 2013 compared to a 1% decrease over the same period for all other pharmacies
 - In addition, **fewer Walgreens stores are purchasing high-dosage (60mg, 80mg) OxyContin** and overall purchases of high-strength OxyContin is falling faster as Walgreen's relative to other pharmacies
 - There is little evidence that mail order is increasing to offset retail pharmacy access issues

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Access issues at pharmacy and distributor level

PRELIMINARY

● Low impact ● High impact

	Actions impacting access	Potential size of impact
1 Pharmacies	a Turn away patients who raise 'flags', which may include: <ul style="list-style-type: none"> – Living far from pharmacy, or prescription was written far from the pharmacy – Being new patients – Having a prescription for >120 units 	●
	b Call back physicians to verify prescription and to discuss treatment plan	◐
	c Modify Rx to fewer tabs (must call back physician)	◐
	d Stock out of opioids (either because limited deliveries imposed by distributors or HQ)	◐
	e Choose not to carry opioids at all	◐
2 Wholesalers	a DEA actions have led to several wholesale distribution facilities being barred from shipment of class 2 drugs for periods of time	◐
	b Halt C2 shipments to pharmacies that order 'too much', as measured by dosing units and molecule type (compared to historical purchase levels and purchase of non-controlled substances)	◐
	c Limit volume of C2 shipments to pharmacies (e.g., only allow orders up to historical purchase levels +10%)	◐

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SOURCE: Purdue interviews; Pharmacist interviews

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Guidelines established by major pharmacy chains and increased work associated with filling opioid prescriptions have restricted patient access

Pharmacy chains are implementing guidelines for which patients can fill opioid prescriptions, increasing pharmacists' risk of filling opioid prescriptions...

Common mandatory requirements

- Government ID
- No previous failed attempt to fill the prescription at another pharmacy belonging to same chain
- Clear PDMP check, in states where available

Additional flags

- Has not previously filled a prescription for the same medicine and dosage at same pharmacy
- Quantity is 120 units or more
- Patient on medication for 6 months or more
- Lives far from the pharmacy
- Prescription not filled on time
- Paid through cash/ credit card rather than insurance

... moreover, pharmacists report increased work and hassle associated with filling opioid prescriptions

- “We kind of discourage [the opioid business]... **it’s more headaches than it’s worth** for the low profits [and] if you give one patient one prescription [for an opioid], they bring their friends” – *Clinical coordinator at Publix (FL)*
- “Stress load is high- they aren’t insuring techs [and] it used to take 10-15 mins to fill a prescription, now it takes a lot longer... Pharmacy also not providing enough support to fill these prescriptions... **80% of the time, they just refuse patients.**” – *Clinical coordinator at Publix (FL)*
- “With budget cuts and staffing cuts – we don’t have time to handle everything... **it’s easier to turn away patients... my personal turn away rate for opioids is about 5%**” – *Former Pharmacy Manager at Walgreens (KY)*

Walgreens has eliminated pharmacists' incentives to fill opioid prescriptions as part of its DEA settlement

Settlement and Memorandum of Agreement
Addendum: Prospective Compliance
Section 6

“Beginning in 2014, Walgreens will **exclude any accounting for controlled substance prescriptions dispensed by a particular pharmacy from bonus computations** for pharmacists and pharmacy technicians at that pharmacy”

Possible that this has already been implemented, given other elements of the settlement (e.g., GFD) appears to have been implemented before the settlement was finalized and made public

SOURCE: DEA website (http://www.justice.gov/dea/divisions/mia/2013/mia061113_attach.pdf)

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Pharmacies are calling back physicians to verify prescription and to discuss treatment plan

PRELIMINARY

Pharmacists are calling back physicians more frequently to verify and scrutinize prescriptions...

"It used to be that prescriber decided what drugs patients get, now pharmacists are now questioning the decision... for example, we had a case today where the patient was on IR, and we called the doctor back to suggest he change the prescription to 80/20 ER/IR"
– Former senior pharmacy director at CVS (FL)

"We are now asking doctors to modify prescriptions... for example, if we think the patient isn't opioid tolerant already, we will call the doctor."
– Former Walgreens Pharmacy Manager (KY)

"Pharmacist should look for different flags: In a certain market area? IR and ER? Days supplied? Proximity of the patient to the pharmacy and prescriber? Does the prescription look altered? Is this a valid DEA number? Is this a valid prescriber? ... Then he calls the prescriber to validate for every TRx (requirement in the last year or two)"
– Former senior pharmacy director at CVS (FL)

... which leads to increased work and irritation for the physician, potentially decreasing OxyContin prescriptions

"Patients went to many pharmacies [in Manhattan] and most pharmacies don't dispense OxyContin"
– Physician specializing in pain control

Potential for negative feedback loop

"The patient population is annoying, the documentation is annoying. A lot of my colleagues decide to stop doing opioid prescription later in their career (because they are tired of the hassle)"
– Anesthesiologist and Pain Management Physician at major hospital

"PCPS are increasing referrals to specialists, part because of the big hassle around drug testing, pain contracts, and patient monitoring"
– Anesthesiologist and Head/Neck surgeon

SOURCE: Pharmacist expert interviews during week of 7/15/2013; Prescriber interviews during June and July 2013

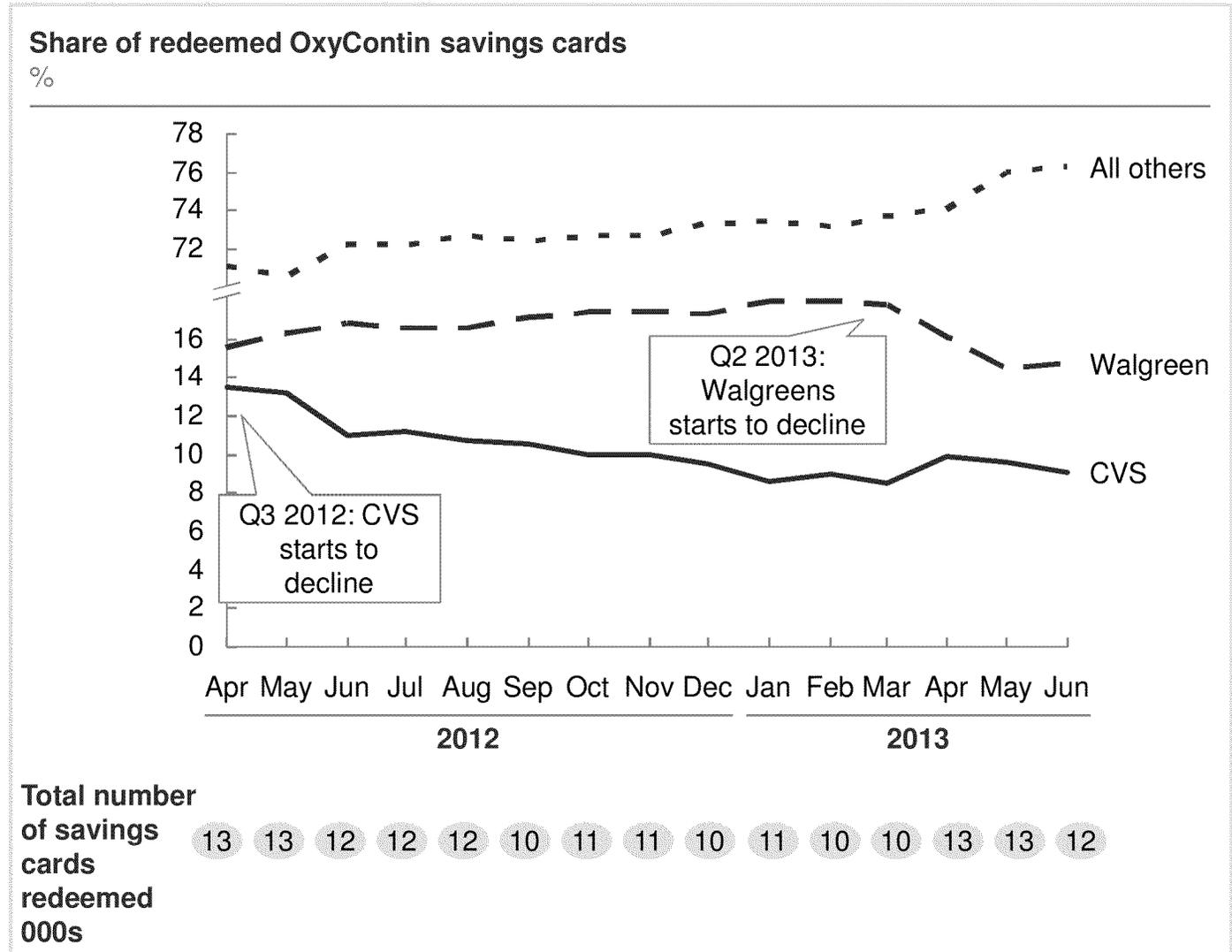
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Share of savings cards redeemed started to decline in Q3 2012 for CVS and Q2 2013 for Walgreens

PRELIMINARY - IN VALIDATION



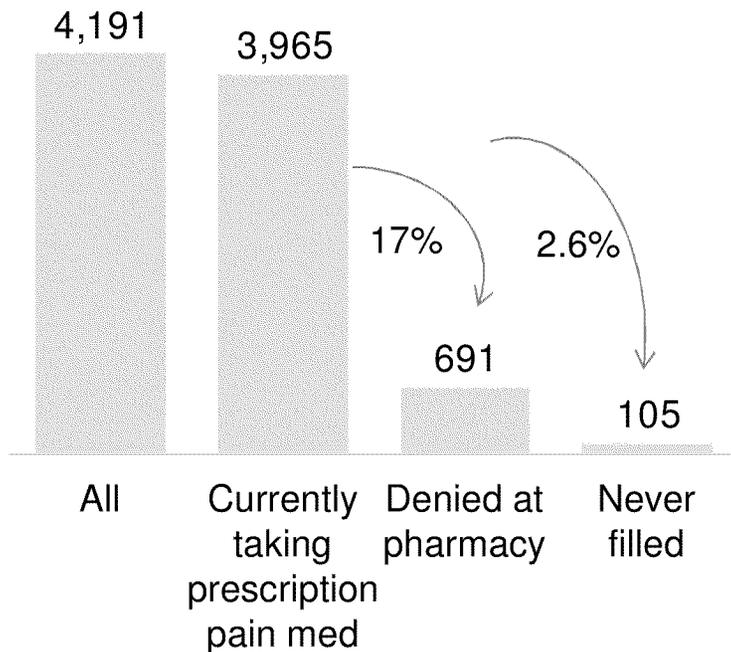
- CVS' share of redeemed savings cards starts declining in Q3 2012, coinciding with its national rollout of dispensing policy for controlled substances
- Walgreens' share of redeemed savings cards starts to decline in Q2 2013, coinciding with the national rollout of GFD

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Analysis of patient data collected by the Pain Care Forum shows direct evidence of patients having difficulty filling opioid prescriptions PRELIMINARY

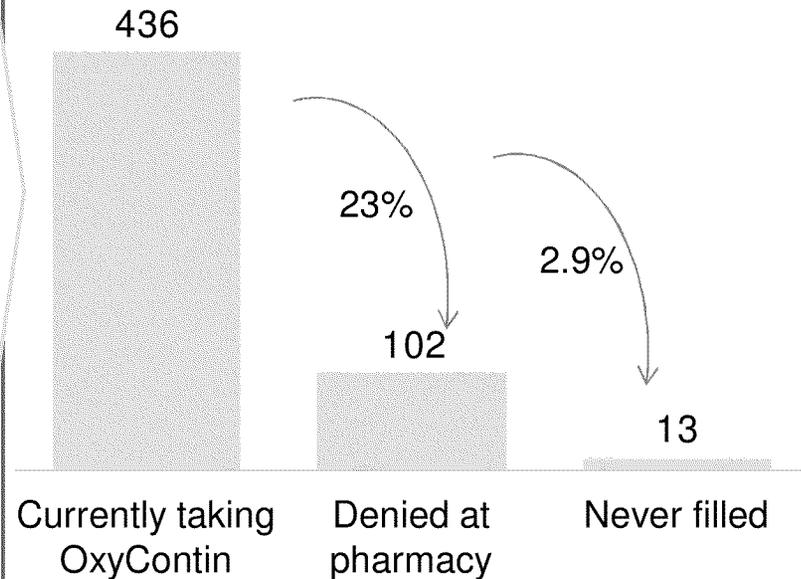
Among respondents, 95% are currently taking prescription pain meds and of those, 17% report having been denied filling a prescription...

Number of respondents



...OxyContin patients, making up 10% of prescription drug patients in the survey, report denial rates of 23%

Number of respondents



1 E.g., only including those who identified themselves as currently taking prescription pain medication

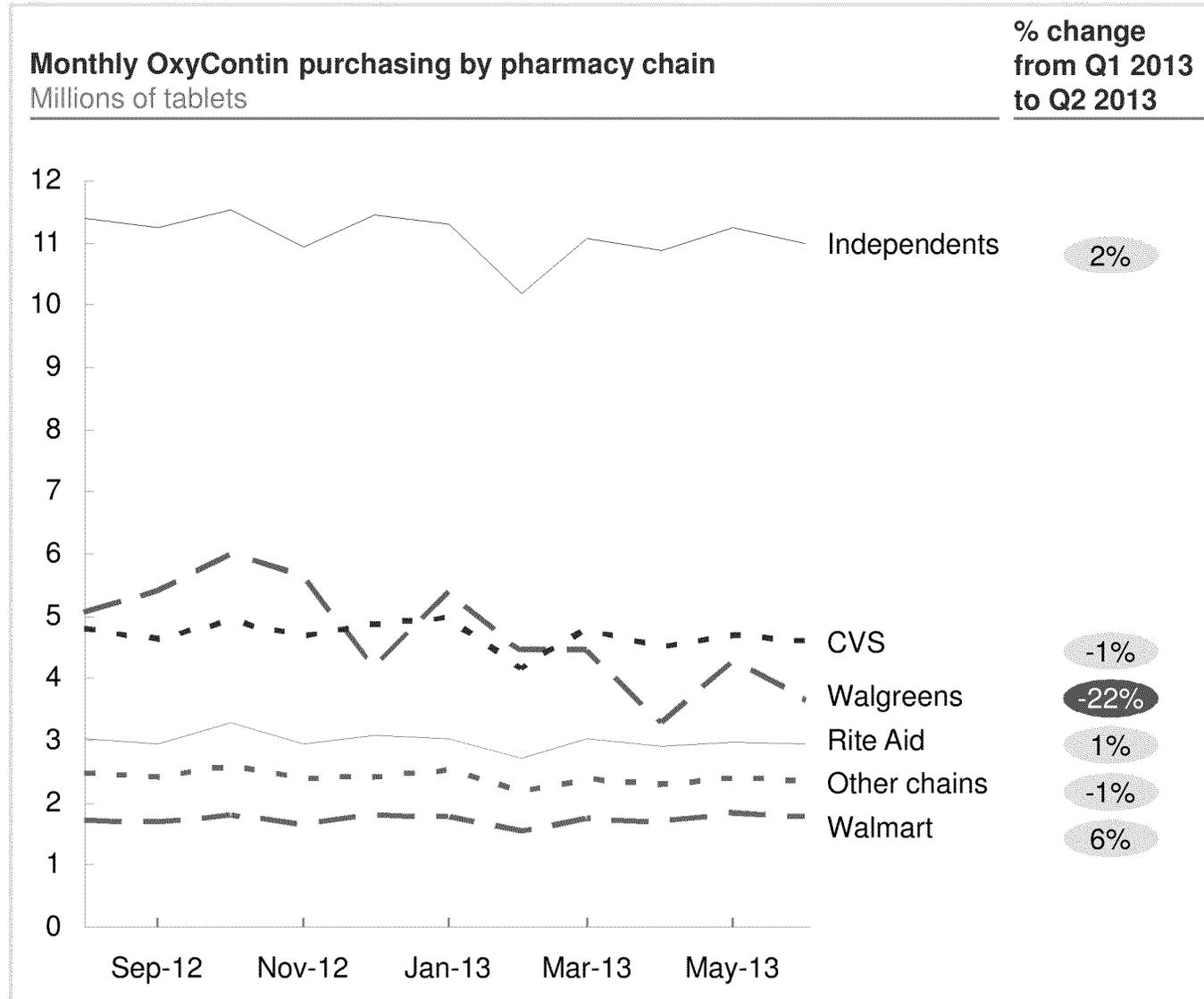
Note: Survey respondents were found by sending survey link to email list of National Fibromyalgia & Chronic Pain Association and other organizations; also posted via social media. Responses analyzed here were collected between 6/22/2013 – 8/9/2013, but survey collection still ongoing at the time of analysis. 40 states are represented in the survey

Source: Pain Care forum survey data

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Walgreens purchasing of OxyContin has fallen more relative to purchasing by other chains and independent pharmacies



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- Walgreens purchasing declined by 22% between Q1 and Q2 2013 (time of GFD implementation¹), far outpacing the overall market decline of 3% over the same time period
- ~70% of the decline in OxyContin tablets over the Mar- Jun 2013 time period is attributable to Walgreens

¹ Good Faith Dispensing policy, elements of which are described in the previous slides in this section

SOURCE: Market Visibility; OMS

The number of Walgreens pharmacies purchasing high-dosage OxyContin has fallen significantly...

Number of WAG stores with any purchase of OxyContin, by dosage
of stores

	Oct – Dec 2012	Apr – Jun 2013	Change	% Change
10 mg	4944	4331	-613	-12.4%
20 mg	5646	4993	-653	-11.6%
30 mg	3666	3044	-622	-17.0%
40 mg	4988	4299	-689	-13.8%
60 mg	3046	2399	-647	-21.2%
80 mg	3865	3190	-675	-17.5%
Any dosage	6943	6661	-282	-4.1%

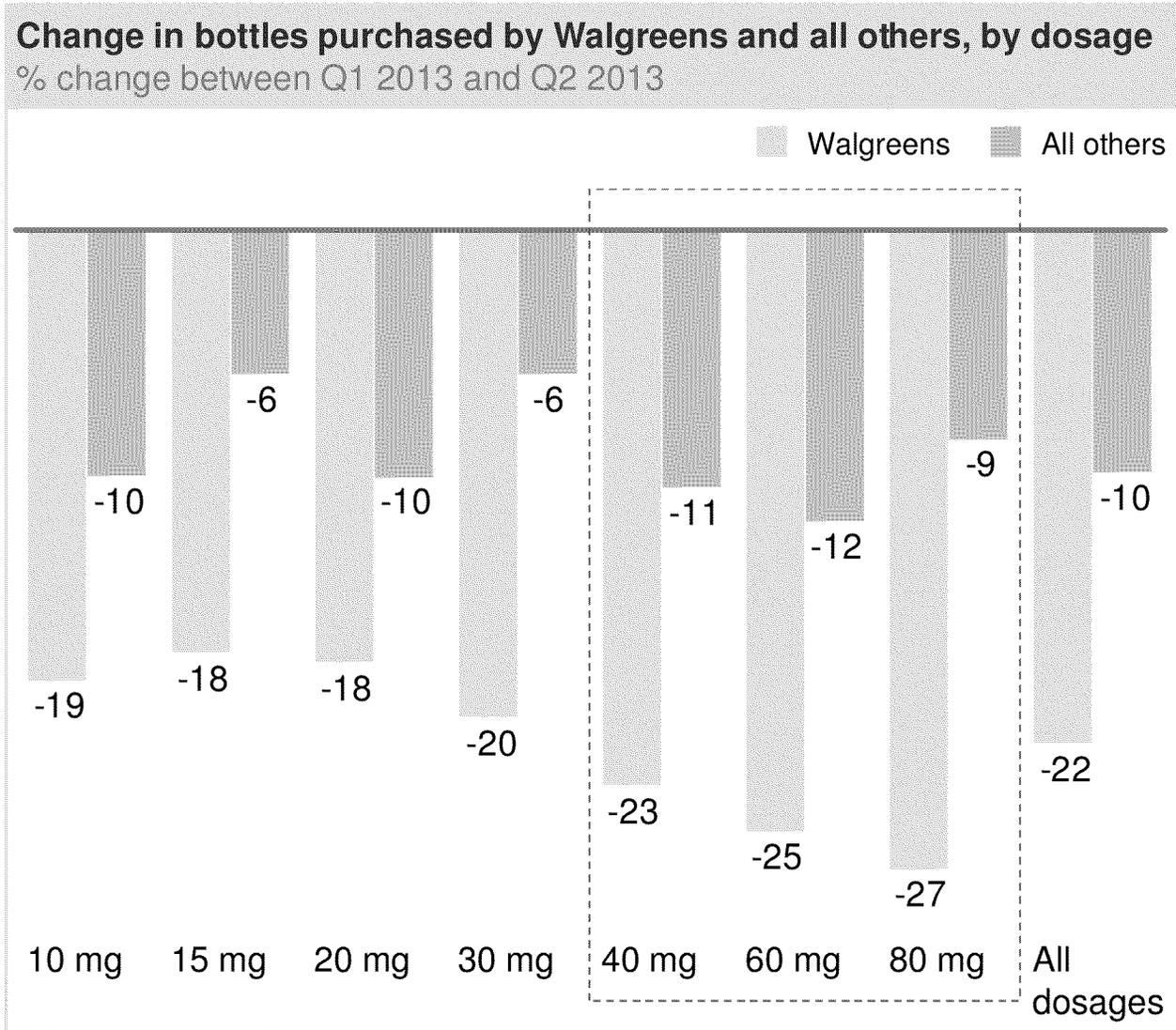
■ Number of stores purchasing have **fallen the most between Q4 2012 and Q2 2013 for the high dosages**

SOURCE: OMS

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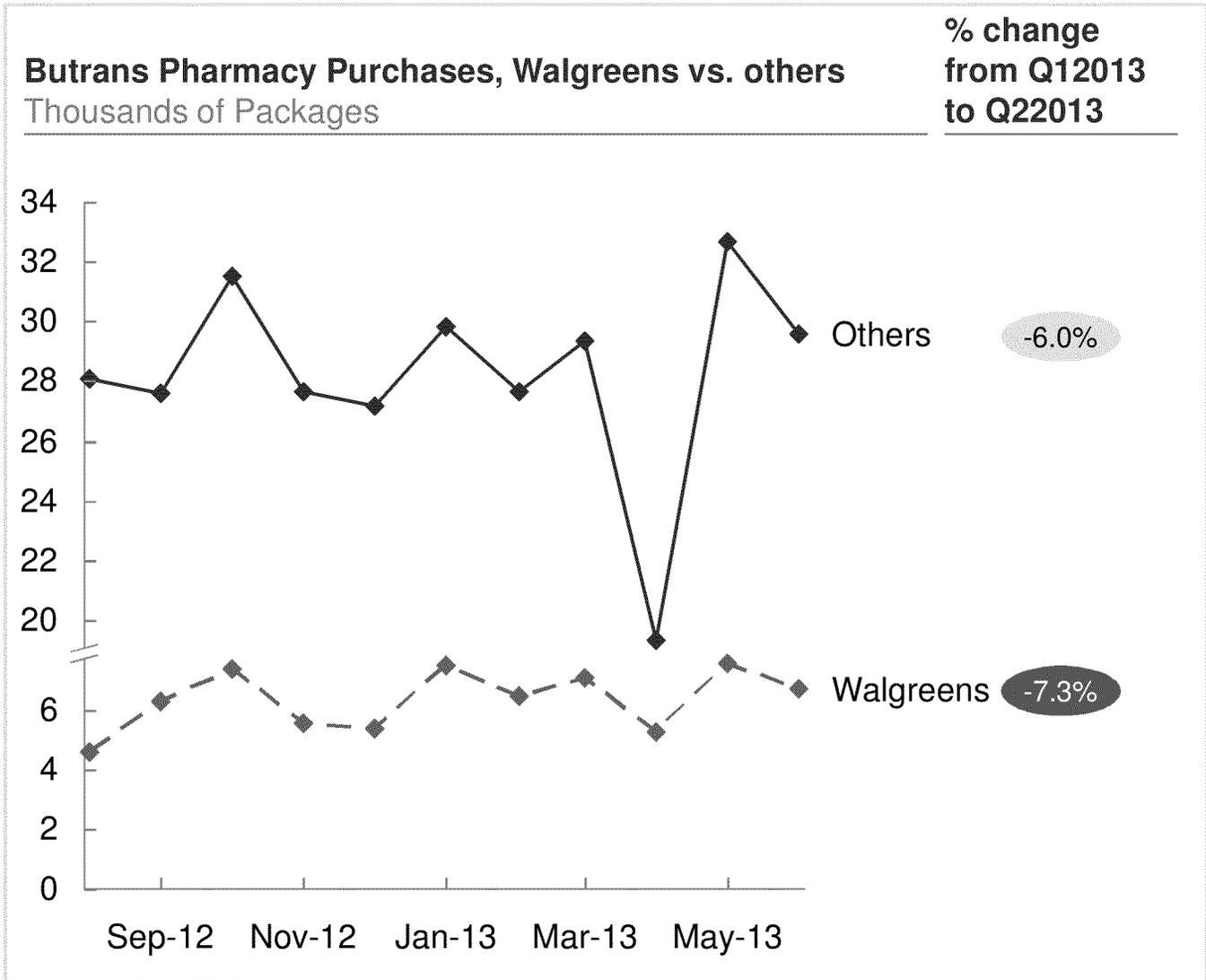
...and Walgreen's purchasing declined much more steeply for high-dosage OxyContin



- 40, 60 and 80mg units declined ~25% faster than 10mg units
- Overall market tended to see faster declines in high-dosage units, but Walgreens showed a far faster decline in high dosage units

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Walgreens' purchasing of Butrans also declined more compared other pharmacies, but not to same extent as OxyContin



- Walgreens' purchasing of Butrans has also declined more between Q1 and Q2 2013 compared to other pharmacies

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