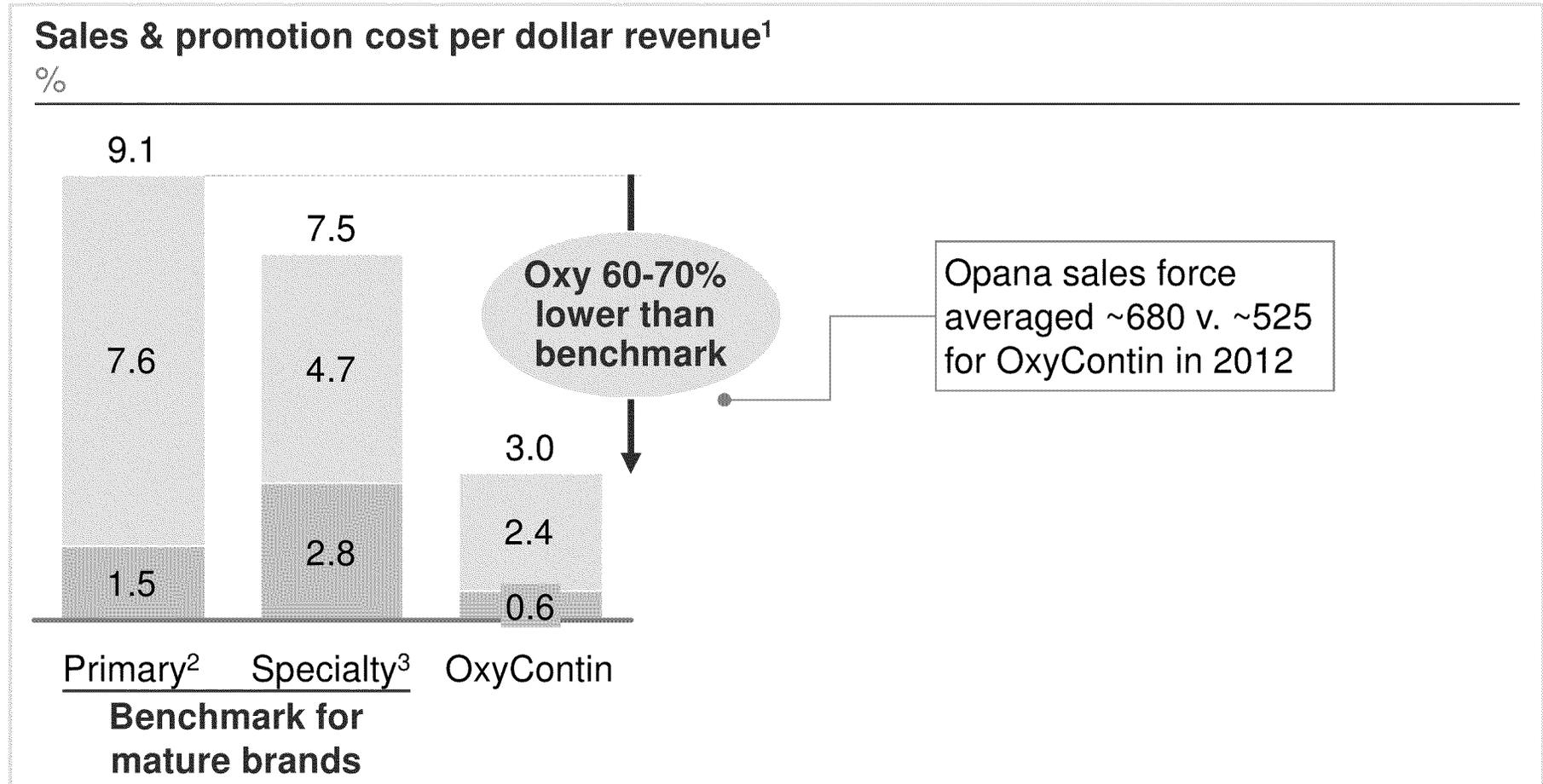


# OxyContin is resourced well below benchmark

■ Sales  
■ Promotion



Last Modified 9/13/2013 11:49 AM Eastern Standard Time

Printed 9/13/2013 12:29 PM Eastern Standard Time

1 DTC cost removed from benchmark set; Sampling is included (~0.4% of revenues); 2012 numbers for Purdue – 2013 allocation may be different  
 2 N=6; average revenue of \$1.9B; average of 3 years before LOE. Average time on market 11 years (range 7-18 years)  
 3 N=4; average revenue of \$1.1B; average of 2 years before LOE

SOURCE: McKinsey Commercial and Medical benchmarking; Purdue Finance; Encuity research; Team analysis

McKinsey & Company | 105

# Contents

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

## Patients play a limited role in the treatment pathway (1/2)

### Key themes

### Supporting evidence

#### Prescribers are concerned about cost to patients

- “I try to get all my patients on EROs, the problem is that going to EROs is a financial burden”- *Anesthesiologist*
- “I would love to use a long-acting narcotic, but (...) it’s expensive- *Internist*
- “They’re still expensive, and patients don’t prefer them. At the end of the day, it’s hard to push for them if you have cheaper drugs” – *Staff Anesthesiologist and Pain Specialist at large hospital*
- “Cost is (my) main driver of decision making”- *Primary care practitioner*
- “Insurance companies will pay...it’s just a huge copay (for the patient). I often warn patients in advance”- *Private Practitioner*
- “The best deals (for patients) out there are where company give (copay) cards saying that patients will pay no more than certain amount” – *Orthopedic surgeon*

#### Some patients are concerned about use of narcotic drugs

- “Usually I don’t have problems, patients have pretty good idea of what’s out there as they were referred and have experience with many pain meds”- *Anesthesiologist*
- “Patient reaction to drug prescribed varies by patient, though usually strongest negative reaction to methadone, heroine, though they also have heard of OxyContin”- *Physical Rehabilitation and Pain specialist*
- “(Some) patients want to avoid narcotics at all cost, but need this to counter drug side effects (of other drugs like NSAIDs)- *Interventional Spine and Pain Management*
- “There are still some people out there who want to avoid narcotics”- *Internist*
- “Some patients are resistant to narcotics, but most want to just control pain. I explain to patients that they may need opioids to control pain”- *Anesthesiologist and Head/Neck surgeon*

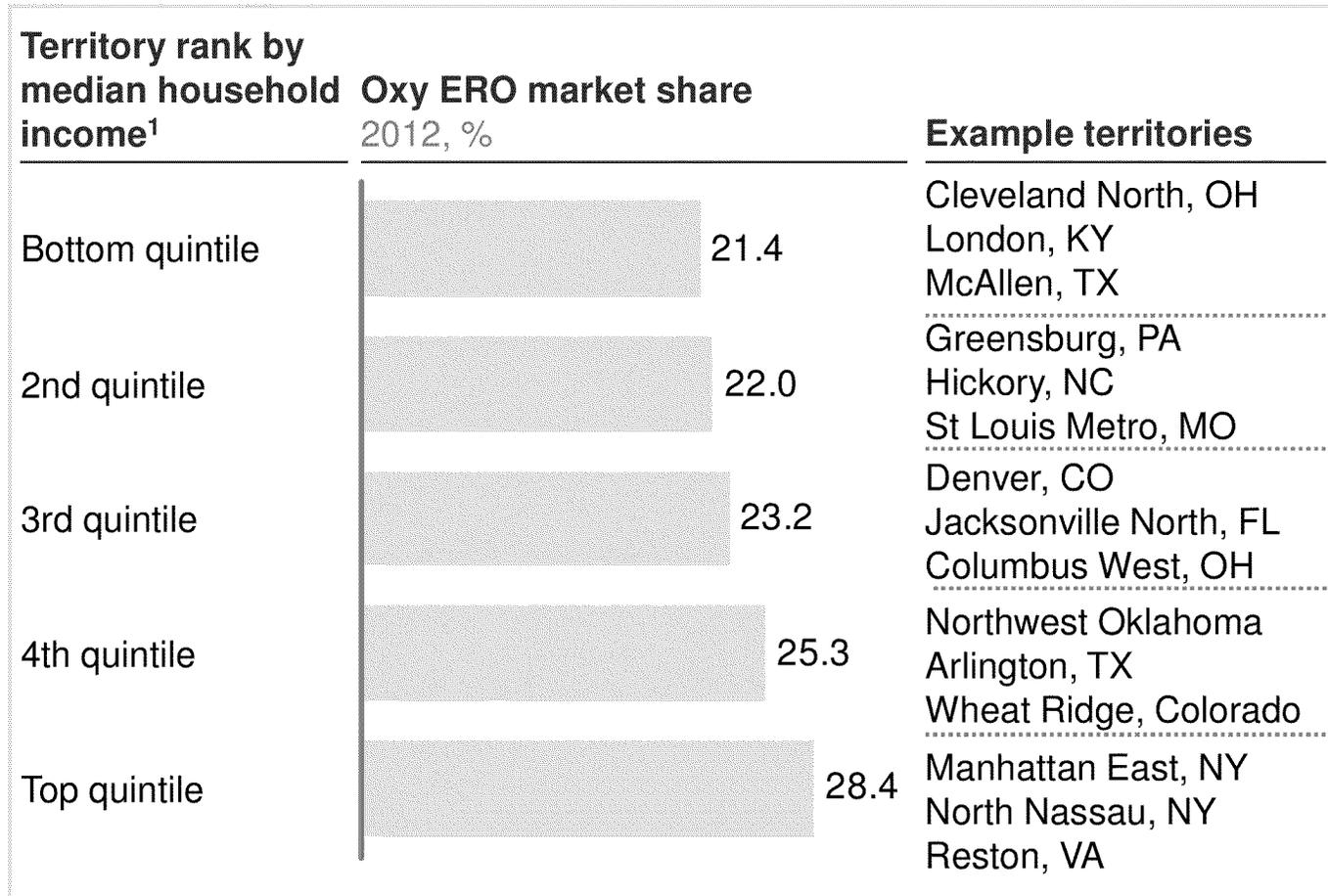
## Patients play a limited role in the treatment pathway (2/2)

Key themes	Supporting evidence
Prescribers consider a <b>variety of factors</b> specific to each patient when treating pain	<ul style="list-style-type: none"> <li>▪ “I (typically) start with NSAIDs if I can, recognizing that NSAIDs are not benign drugs... I am anxious about treating (certain types of patients) with NSAIDs (due to side effects like stomach ulcers)”- <i>Primary care practitioner /internal medicine</i></li> <li>▪ “I start with NSAIDs; if (pain) becomes more chronic, I add Lyrica or Cymbalta, (especially) if pain is nerve related. Opioids are my last resort”- <i>Primary care practitioner</i></li> <li>▪ “(I consider) pain type, drug history, insurance coverage (when prescribing a drug). (I see) most economic issues for opioids”- <i>Anesthesiologist and pain specialist</i></li> <li>▪ “Patients will often have a preference- <i>Attending physician at major hospital</i></li> </ul>

Last Modified 9/13/2013 11:49 AM Eastern Standard Time

Printed 9/13/2013 12:29 PM Eastern Standard Time

# Oxy share of ERO market is significantly higher in territories in which median household income is higher



**May be opportunity to better target programs aimed at co-pay assistance to patients in lower-income areas**

<sup>1</sup> Based on zip-level household income data weighted by population

# Contents

- Market landscape & demand forecast
- Messaging & positioning
- Segmentation & targeting
- Field focus & execution
- Access & availability
- Scientific support
- Commercial spend levels
- Patient funnel
- **Appendix**
  - **Interview notes**

# Overview of prescribers interviewed to date

**Total # of prescribers interviewed:** 20

**Specialty split:** PCPs (7), specialists (13)

**Geographical split:** CA (1), GA (1), IL (1), ME (2), MD (2), MO (1), NH(1), NJ (2), NV(1), NY(4), PA (3), VA (1)

## Details by specialty

- Pain Management and Physical Medicine and Rehabilitation, Director of Pain Management at hospital
- Pain Specialist, private practice
- Medical Director and Principal Investigator at Cancer Pain Management and Palliative Care center, board certified in in Anesthesiology, Pain Medicine and Addiction Medicine
- Board certified in Physical Medicine and Rehabilitation and Pain Management
- Orthopedic surgeon
- Attending physician at major hospital
- Specialist in acute cancer, chronic pain, and anesthesiology
- Chief of Interventional Spine and Pain Management for regional health system
- Medical Director at pain center, trained in Anesthesiology and Head and Neck Surgery
- Physician of internal medicine
- Anesthesiologist and Pain Management Physician and major hospital
- Addiction specialist
- Pain specialist in private practice
- Internist with private practice
- Private practitioner with pain fellowship
- Primary care physician in Family Practice
- Family Practitioner and Assistant Professor at large University
- Primary care physician in larger practice
- Primary care physician in small group practice

# Summary of prescriber interviews

FOR DISCUSSION

Theme	Interview Quotes
<p>Opioids are an <b>effective class of painkillers</b>, although <b>side effects and addiction</b> are a concern</p>	<ul style="list-style-type: none"> <li>▪ “Very good, strong medications, very good relief, only problem is they don’t want them to be first line of treatment” – <i>Medical Director of major pain center</i></li> <li>▪ “Even patients with acute post-surgery pain prefer pain to side effects of those meds” – <i>Physician specializing in pain control</i></li> <li>▪ “If you remove opioids totally from the picture there’s no way to treat a lot of types of pain patients”– <i>Anesthesiologist and pain specialist</i></li> <li>▪ “Short term use of opiates is highly efficacious, however concerns about safety arise for longer-term use” - <i>Medical Director of major pain center</i></li> <li>▪ “Opioids are often the preferred choice for treating long-term treatment, as side effects for NSAIDs can be more severe” – <i>Primary care physician</i></li> </ul>
<p><b>Mixed views on abuse deterrence</b> highlight AD as positive factor, but caution that oral abuse is still possible</p>	<ul style="list-style-type: none"> <li>▪ “Win-win for everyone, as long as price is ok” – <i>Experienced internist and anesthesiologist</i></li> <li>▪ “The FDA decision [on OxyContin] should carry weight...data would very valuable...should be incentive to use this medicine“- <i>Addiction specialist</i></li> <li>▪ “For some people it probably matters, for example first time prescribers and non-specialists. For specialists it doesn’t make much of a difference because they knew before” – <i>Medical Director of major pain center</i></li> <li>▪ “I don’t know how effective abuse deterrence is in practice...Just because you can’t crush something, doesn’t mean you can’t eat all your pills at once” –<i>Primary care physician specializing in internal medicine</i></li> <li>▪ “The only abuse deterrence I would put any stake in is when you add niacin (to prevent oral abuse)”- <i>Anesthesiologist and Pain Management Physician at major hospital</i></li> </ul>

*(See next page for additional quotes)*

Last Modified 9/13/2013 11:49 AM Eastern Standard Time

Printed 9/13/2013 12:29 PM Eastern Standard Time

# Summary of prescriber interviews

FOR DISCUSSION

Theme	Interview Quotes
<p><b>Mixed views on abuse deterrence</b> highlight AD as positive factor, but caution that oral abuse is still possible</p>	<p><i>(continued)</i></p> <ul style="list-style-type: none"> <li>▪ “Abuse deterrence is a good thing...I would choose abuse deterrent drugs every time, IF patient insurance covers it” – <i>Anesthesiologist and Pain Management Physician at major hospital</i></li> <li>▪ “There are several studies on abuse deterrence out there...what we need is information from trustworthy sources” – <i>Anesthesiologist and Head/Neck surgeon</i></li> <li>▪ I had extremely curtailed the prescription for OxyContin, but now that I see the clinical difference, I am much more comfortable writing for it”- <i>Private practitioner with pain management fellowship</i></li> <li>▪ “if there is enough education, we may be using them more frequently, to mitigate abuse (theft, family abuse, patient abuse), in the end it doesn’t really hurt anyone to the extent that I understand the technology”- <i>Family Practitioner</i></li> </ul>

Last Modified 9/13/2013 11:49 AM Eastern Standard Time  
Printed 9/13/2013 12:29 PM Eastern Standard Time

# Summary of prescriber interviews

FOR DISCUSSION

Theme	Interview Quotes
<p><b>Prescribers fear legal consequences</b> (DEA, revoked license) of prescribing opioids, leading to <b>more referrals to pain specialists and decline of prescriber pool</b></p>	<ul style="list-style-type: none"> <li>▪ “The prescriber pool will most probably shrink, as fewer prescribers want to deal with the issues around opioid prescriptions, such as abuse” – <i>Director of Pain Management</i></li> <li>▪ “We see more fear and warnings about opioids, including concerns about legality” – <i>Primary care physician</i></li> <li>▪ “The DEA is always a concern. As long as you keep good records, drug test patients, take appropriate action, I don’t think it’s a problem. In the next few years I’m not sure what’s going to happen though”- <i>Anesthesiologist and Pain Management Physician at major hospital</i></li> <li>▪ “The DEA hasn't really changed anything I do. I am trained and have the proper documentation and know how to monitor patients appropriately. I work with local DEA field agents“- <i>Pain specialist</i></li> <li>▪ “I’ve had investigators from district attorney’s office to get information on patients... People get checked on all the time [by the DEA]...[there is] a lot more scrutiny.” – <i>Pain specialist in private practice</i></li> <li>▪ “The new trend seems to be more PCPs referring pain patients to specialists to insure themselves against issues of overdosing and side effects” – <i>Attending physician at major medical center</i></li> <li>▪ “There seems to be a growing trend of referrals to pain specialists today- Doctors prescribe lower doses of narcotics, and even pain specialists move away from opiates. This is likely driven by increased media attention, high abuse rates, and prescribers fearing regulatory and legal complications” –<i>Medical Director of major pain center</i></li> <li>▪ “Treating chronic pain requires a specialist...on top of that, there are all the DEA and legal concerns about opioid use, (such that) PCPs want specialists to manage that” – <i>Primary care physician</i></li> </ul>

Last Modified 9/13/2013 11:49 AM Eastern Standard Time

Printed 9/13/2013 12:29 PM Eastern Standard Time

# Summary of prescriber interviews

FOR DISCUSSION

Theme	Interview Quotes
<p><b>Prescribers report rising rate of pharmacy access issues, affecting their patients and prescribing behavior</b></p>	<ul style="list-style-type: none"> <li>▪ “[There’s been] a big change in dispensing by pharmacies...Access to oxycodone has been extremely difficult, even for people who are fairly well known to pharmacists... patients get flat out denied several times a week” – <i>Private practitioner in state with tight opioid controls</i></li> <li>▪ “I think [pushback from pharmacies] does impact my prescribing behavior... I will think I don’t want to prescribe this because I’m going to get pushback ... then I will prescribe something that will get less push back... a different drug and/or lower doses” – <i>Primary care physician in small group practice</i></li> <li>▪ “Pharmacies are definitely getting more strict with pill counts too. Sometimes it feels like they’re overstepping their boundaries a little”- <i>Pain specialist in private practice</i></li> <li>▪ “If the # of pills is greater than 120 pills, that generates a call back from the pharmacist”- <i>Private practitioner with pain management fellowship</i></li> <li>▪ “Patients went to many pharmacies [in Manhattan] and most pharmacies don’t dispense OxyContin” – <i>Physician specializing in pain control</i></li> <li>▪ “There is much more communication today amongst pharmacies (on opioid prescriptions), which is becoming a limitation to patients”- <i>Primary care physician</i></li> </ul>

Last Modified 9/13/2013 11:49 AM Eastern Standard Time  
Printed 9/13/2013 12:29 PM Eastern Standard Time

# Summary of prescriber interviews

FOR DISCUSSION

Theme	Interview Quotes
<p><b>Managed care access</b> limits prescription choice and available options</p>	<ul style="list-style-type: none"> <li>▪ “Older generic medications are usually better covered, for example methadone” – <i>Medical Director of major pain center</i></li> <li>▪ “OxyContin is a very good drug, good molecule, pretty well tolerated and has a very wide dosage range. It is less widely covered by insurance, which is sad because now it’s actually less abuse-able” – <i>Experienced anesthesiologist</i></li> <li>▪ “Rejections happen more often every day...very frustrating, unclear what insurance will cover what drug” – <i>Physician specializing in pain control</i></li> <li>▪ “Insurance is biggest determinant; payers determine formulary, risk profile of patient, and potential medical problems. Won’t pay for branded one-third of the time.” – <i>Physician operating several pain practices</i></li> <li>▪ “About 20-25% of my chronic pain patients will come back to to tell me that insurance denied the script. Sometimes the pharmacy contacts the physician and asks for a supplemental script, or patients will pay cash difference” – <i>Attending physician at major hospital</i></li> <li>▪ “Physicians get slapped on the wrist (for prescribing more expensive drugs), and need to stay with generics” – <i>Primary care physician</i></li> <li>▪ “Cost is a main driver of deciding what drug to prescribe to patients...Outpatients are still largely driven by cost and tiers, which makes prescribing generics and narcotics the easier choice” – <i>Primary care physician</i></li> </ul>

Last Modified 9/13/2013 11:49 AM Eastern Standard Time

Printed 9/13/2013 12:29 PM Eastern Standard Time

# Summary of prescriber interviews

FOR DISCUSSION

Theme	Interview Quotes
<p>Managing patients on <b>opioids</b> takes increasing amount time and resources</p>	<ul style="list-style-type: none"> <li>▪ “Treating patients with chronic pain now requires much more management, including contract agreements, drug testing, and patient record keeping to avoid legal complications” – <i>Attending physician at major medical center</i></li>   <li>▪ “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)”- <i>Anesthesiologist and Pain Management Physician at major hospital</i></li>   <li>▪ “PCPS are increasing referrals to specialists, partly because of the big hassle around drug testing, pain contracts, and patient monitoring” – <i>Anesthesiologist and Head/Neck surgeon</i></li>   <li>▪ “There is a lot more work involved. At some point there will be too much work”- <i>Pain specialist in private practice</i></li>   <li>▪ “We need these [drug screening] resources because of the nature of our practice”- <i>Pain specialist at major pain clinic</i></li>   <li>▪ “I just don’t want more paperwork...I want to use narcotics, but I use them less due to more oversight”- <i>Family Practitioner</i></li>   <li>▪ “[Prescribing opioids] is a big burden, has made us a little worried...getting cumbersome for what it was worth”- <i>Primary care physician in larger practice</i></li>   <li>▪ “I spend at least 2 hours per week receiving calls from pharmacies [about opioid prescriptions]... and that’s not even counting the calls that my staff is handling... we talk about this often at our office meetings” - <i>Primary care physician in small group practice</i></li> </ul>

Last Modified 9/13/2013 11:49 AM Eastern Standard Time  
Printed 9/13/2013 12:29 PM Eastern Standard Time

# Summary of prescriber interviews

FOR DISCUSSION

Theme	Interview Quotes
<p>Prescribers are writing for <b>fewer pills and lower strengths, and increasingly referring patients to pain specialists</b></p>	<ul style="list-style-type: none"> <li>▪ “I try to use more long-acting opioids (to reduce pill count) and try to prescribe fewer pills and lower strengths... because it’s less to worry about... less potential for addiction and diversion”- <i>Primary care physician in Family Practice</i></li> <li>▪ “[There’s] increased review of physician practice. Many of my colleagues are hesitant and prescribe less. I do too. I just don’t want to take up with the task” – <i>Family Practitioner</i></li> <li>▪ “Made decision about 9 months ago to funnel patients to pain clinics for patients taking medication for chronic use”- <i>Primary care physician in larger practice</i></li> </ul>
<p>Despite AD reformulation, <b>OxyContin brand still carries negative connotation</b> for some doctors</p>	<ul style="list-style-type: none"> <li>▪ “OxyContin is one of the less abuse able EROs on the market today, but the perceived fear on the street and confusion about abuse potential remains high” – <i>Medical Director of major pain center</i></li> <li>▪ “The OxyContin reformulation may be much better, but having said that, many pain doctors are still humans and suffer from emotional inhibition because of all the bad press it had, because it still has the name OxyContin”- <i>Medical Director of major pain center</i></li> </ul>

Last Modified 9/13/2013 11:49 AM Eastern Standard Time

Printed 9/13/2013 12:29 PM Eastern Standard Time

# Summary of prescriber interviews

FOR DISCUSSION

Theme	Interview Quotes
<b>Opioids are usually used after NSAIDs are tried or if NSAIDs pose risk to patient</b>	<ul style="list-style-type: none"> <li>▪ “Treatment decision depends on patient diagnosis, drug history and drugs currently taken, effect of pain on daily functioning” - <i>Medical Director of major pain center</i></li> <li>▪ “Opioids can be a good choice when patients have NSAID specific side effects, such as renal dysfunction or stomach ulcers” – <i>Medical Director of major pain center</i></li> <li>▪ “I start with NSAIDs if I can, recognizing that NSAIDs are not benign drugs... I may try something like Lyrica, then if it’s still not working, try Vicadin or Norco... if they need to be on a maintenance drug, then I will give them an extended release plus breakthrough” - <i>Primary care physician in small group practice</i></li> <li>▪ “Start with NSAIDs... if becoming more chronic, then add Lyrica/Cymbalta if pain is nerve related; opiates are last resort.” –<i>Primary care physician</i></li> </ul>
<b>Additional comments</b>	<ul style="list-style-type: none"> <li>▪ "I see a Medical Science guy once in a while -always informative"- <i>Pain specialist</i></li> <li>▪ "Some reps direct me to sites that helps me navigate prior auths - covermymeds.com - it is helpful"- <i>Pain specialist</i></li> <li>▪ “I want help [from drug manufacturers] with knowing what the coverage status would be and getting prior authorizations” - <i>Primary care physician in small group practice</i></li> <li>▪ “Where things will really go: Knockout genes of pain reception- create a drug that will block the pain receptor and completely take away the pain without the euphoric effects of opioids- that will be really big target”- <i>Pain specialist in private practice</i></li> </ul>

Last Modified 9/13/2013 11:49 AM Eastern Standard Time

Printed 9/13/2013 12:29 PM Eastern Standard Time

## Overview of pharmacists interviewed

**Total # of pharmacists interviewed: 6**

**Chain affiliation: Walgreens (2), CVS (1), Rite-Aid (1), Publix (1), Independent**

**Geographical split: FL (2), IL (1), KY (1), MA (1), NJ (1)**

### Relevant experiences

- Former Pharmacy Manager for a top 3 retail pharmacy chain for 10+ years (until 2013)
- Pharmacy Manager for a major retail pharmacy chain
- Former National Director of Pharmacy Operations at a top 3 retail pharmacy chain
- Member of State Board of Pharmacy
- Clinical coordinator for regional pharmacy chain
- Former Director of Professional Practice at a top 3 retail pharmacy chain , oversaw mail order services (until 2013)

# Summary of pharmacist interviews

Key takeaways	Quotes
DEA actions have had a <b>“chilling effect”</b> on pharmacy chains, distributors, and pharmacists; this is made <b>even worse by lack of specific requirements</b>	<ul style="list-style-type: none"> <li>▪ “DEA has taken a strong role in deciding how pain medications are dispensed, having a ‘chilling effect’ on pharmacists who fear losing their jobs or their license” – <i>Former senior pharmacy director at CVS (FL)</i></li> <li>▪ “No they have not [put out specific requirements or regulations]... that’s the unfortunate part, if they specify the requirement, it would clarify things... they speak in riddles “corresponding responsibility” – <i>Former senior pharmacy director at CVS (FL)</i></li> <li>▪ “Walgreens [having] 7 pharmacies shut down sent shockwaves through the industry” – <i>Former senior pharmacy director at Walgreens (IL)</i></li> <li>▪ “[It’s] somewhat sad – pharmacists now feel very vulnerable about their own pharmacy license and their jobs. They turn away patients who are looking for those controlled substances and pharmacists who work for chains don’t have any incentive to take any risk whatsoever” – <i>Former senior pharmacy director at Walgreens (IL)</i></li> </ul>
Pharmacists <b>observe increasing fear among prescribers about quantity and dosage</b>	<ul style="list-style-type: none"> <li>▪ “Doctors are afraid, so they stop prescribing” – <i>Clinical coordinator at Publix (FL)</i></li> <li>▪ “In Illinois – [the state board is] already writing letters to those who are prescribing more than their peers, making doctors more cognizant about how much and how many pills they are prescribing “ – <i>Former senior pharmacy director at Walgreens (IL)</i></li> <li>▪ “OxyContin dropped off the map from where they were 5 years ago... Doctors are afraid to write them... a few are resistant but most are unwilling to write or go to morphines... they give least amount that they can, weakest dose that he can. He used to write 60, now he’ll give you 30”- <i>Pharmacy Manager at RiteAid (MA)</i></li> </ul>
<b>Significant increase in due diligence and paperwork</b> associated with C2 drugs	<ul style="list-style-type: none"> <li>▪ “Walgreens and CVS now need to fill in paperwork in triplicates [for opioid prescriptions]” – <i>Clinical coordinator at Publix (FL)</i></li> <li>▪ ““There’s a lot more paperwork... need to check SS number, driver’s license” – <i>Former Pharmacy Manager at Walgreens (KY)</i></li> </ul>

Last Modified 9/13/2013 11:49 AM Eastern Standard Time

Printed 9/13/2013 12:29 PM Eastern Standard Time

# Summary of pharmacist interviews

Key takeaways	Quotes
<p>Pharmacists report <b>turning away patients</b>, especially those with suspicious prescriptions or new patients <b>because of risk associated with opioids, perception that patients will “bring their friends”, and associated paperwork burden</b></p>	<ul style="list-style-type: none"> <li>▪ “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” – <i>Clinical coordinator at Publix (FL)</i></li> <li>▪ “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.” – <i>Clinical coordinator at Publix (FL)</i></li> <li>▪ “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%” – <i>Former Pharmacy Manager at Walgreens (KY)</i></li> </ul>
<p><b>Walgreen’s and CVS’ internal memos</b> on C2 drugs increases oversight and stresses “reasonable quantity”, but may not be setting mandatory national limits on tablets/ Rx or strength mix</p>	<ul style="list-style-type: none"> <li>▪ “The 2 largest chains – [making up] 80% of total dispensing – released internal memos, 1.5 year ago for one, 6-8 months for the other – <i>Former senior pharmacy director at CVS (FL)</i></li> <li>▪ “Pharmacies would fill set number of prescriptions per day – if they reach that number of prescriptions for the day, they tell patients that they are stocked out. Similar limits on pills per script, or number of high-dosage pills” – <i>Former senior pharmacy director at CVS (FL)</i></li> <li>▪ “Walgreens looks at how much each pharmacy is purchasing, and controls by generating monthly reports and sending company reps out to pharmacy to scrutinize... I don’t know of specific caps for tablets/ Rx or scripts per week, I don’t think it wouldn’t be automatic cap” – <i>Former senior pharmacy director at Walgreens (IL)</i></li> <li>▪ “There’s not a [official] limit... technically it is up to pharmacists judgment... but the pharmacists are scared because they don’t want to lose their job or their license... my supervisor says if you are not turning away some patients, you’re not doing your job” – <i>Former Pharmacy Manager at Walgreens (KY)</i></li> </ul>

Last Modified 9/13/2013 11:49 AM Eastern Standard Time

Printed 9/13/2013 12:29 PM Eastern Standard Time

# Summary of pharmacist interviews

Key takeaways	Quotes
<p><b>Some individual pharmacies or districts are likely self-imposing TRx or pill limits per week</b></p>	<ul style="list-style-type: none"> <li>▪ “It’s possible that local District Manager is using a personal number for limit pills/ script” - <i>Former senior pharmacy director at Walgreens (IL)</i></li> <li>▪ “ I won’t fill an opioid until 2 days before the previous prescription runs out... “that’s a personal/ professional standard, not a Rite-Aid policy” – <i>Pharmacy Manager at RiteAid (MA)</i></li> </ul>
<p><b>Lack of flexibility in supply to the pharmacy, constricted both by chain HQ and distributor</b></p>	<ul style="list-style-type: none"> <li>▪ “Distributors only fills X of all scheduled II narcotics... this restriction from distributors became prominent when DEA took action against some CVS stores 2 years ago in Sanford – <i>Former senior pharmacy director at CVS (FL)</i></li> <li>▪ “There’s an internal panel that look at patient utilization, prescribers pattern and recommend that they cut off some patients or prescribers - retail might be told to “back down” if orders go up too much” – <i>Senior pharmacy director at CVS (FL)</i></li> <li>▪ “You get to the end of the year, the Feds put a limit for a chain in the area, and if the stores reach that max, they can’t get any more... we just know that they put limits (we can order 8 but we might get 2), but we don’t have any visibility” – <i>Clinical coordinator at Publix (FL)</i></li> <li>▪ We are no longer allowed to increase orders for C2... corporate has policies on how much each pharmacy can get per week.” – <i>Former Pharmacy Manager at Walgreens (KY)</i></li> </ul>
<p><b>Questionable metrics seem to be used by DEA and distributors, leading to anecdotal gross constrictions in supply</b></p>	<ul style="list-style-type: none"> <li>▪ There are “war stories out there [about supply] ... a small town in Illinois has only a Walmart, CVS, and an independent pharmacy... Walmart and CVS sat together and decided not to serve OxyContin anymore... the wholesaler sees volume driven up at the independent, and then the distributor cuts off the independent. This happened pretty recently” – <i>Former senior pharmacy director at Walgreens (IL)</i></li> </ul>

Last Modified 9/13/2013 11:49 AM Eastern Standard Time  
Printed 9/13/2013 12:29 PM Eastern Standard Time

# Summary of pharmacist interviews

Key takeaways	Quotes
Pharmacists have a positive view of AD technologies but cost is an issue	<ul style="list-style-type: none"> <li>▪ “These AD technologies are very costly for patients” – <i>Former senior pharmacy director at CVS (FL)</i></li> <li>▪ “The rub is that they are available but often insurance plan doesn’t cover them... PAs often in place and then doctors are so stressed out ... it all comes down to money” – <i>Clinical coordinator at Publix (FL)</i></li> <li>▪ “Robberies went down when deterrent formulations went down, they aren’t going for the OxyContin AD” –<i>Pharmacy Manager at RiteAid (MA)</i></li> </ul>
Protocol for dispensing opioids has become more stringent	<ul style="list-style-type: none"> <li>▪ “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? Known to the pharmacy? What is the frequency? The Pharmacist goes to DEA website to verify if prescriber has a valid DEA number and whether there was a sanction against a prescriber). Then call the prescriber to validate for EVERY TRx (requirement in the last year or two)” - <i>Former senior pharmacy director at CVS (FL)</i></li> </ul>
Dimensions that pharmacies are conservative on	<ul style="list-style-type: none"> <li>▪ <b>Quantity:</b> “First thing that we look at is the quantity... if you’re starting, they are going to give you 20 or 30... if you bring in a prescription for 180 or 240 for the first time, then that’s a flag.” – <i>Clinical coordinator at Publix (FL)</i></li> <li>▪ <b>Dosage:</b> “If someone comes in with 80mgs, they aren’t going to fill it unless they have a history of lower dosages” –<i>Pharmacy Manager at RiteAid (MA)</i></li> </ul>

Last Modified 9/13/2013 11:49 AM Eastern Standard Time Printed 9/13/2013 12:29 PM Eastern Standard Time

# Summary of pharmacist interviews

Key takeaways	Quotes
<p><b>Mail order</b> is currently a more reliable channel for patients to access opioid drugs</p>	<ul style="list-style-type: none"> <li>▪ “Direct to channel opioids are already being done – the only issue is interstate commerce, because the dispensing state might differ from prescribing state; Typically the dispensing state’s laws prevail but also have to consider the most stringent state” – <i>Former senior pharmacy director at CVS (FL)</i></li> <li>▪ “To get an opioid prescription filled by mail, patient needs to mail the prescription and it is scrutinized... [it takes] 5-7 days to fill. Mail order patients have more reliable access to drugs because mail order have more visibility into the supply – <i>Former senior pharmacy director at CVS (FL)</i></li> </ul>
<p>Some see DEA as potential partner for AD manufacturers</p>	<ul style="list-style-type: none"> <li>▪ I don’t see that AD is getting a differentiated treatment yet, but I do think that it might have a positive, differentiated effect down the road → DEA may be a driver – <i>Former senior pharmacy director at Walgreens (IL)</i></li> </ul>

Last Modified 9/13/2013 11:49 AM Eastern Standard Time  
Printed 9/13/2013 12:29 PM Eastern Standard Time

# Overview of payors interviewed

**Total # of payors interviewed: 3**

**Geographical split:** Northeast (1), California (1), Southeast (1)

## Details of payors interviewed

- Payor expert 1
  - In managed care for over 20 years
  - Pharmacy Operations Manager, RPh
  - Current payor:
    - Commercial only
    - 1.2 mn lives
    - Open 3-tier formulary design
- Payor 2
  - Worked in several large payors
  - Regional Medical Director, MD
  - Current payor:
    - 60% Commercial, 40% Med D
    - 212k lives
    - Very tight prior authorization system
- Payor 3
  - 10 years in managed care
  - Pharmacy Director, PharmD
  - Current payor:
    - 75% Commercial, 20% Medicaid, 5% Med D
    - 5.5 mn lives

# Summary of Payor Interviews

FOR DISCUSSION

Theme	Interview Quotes
<p>Management of the pain category overall is <b>stable in outlook</b> – rebates mentioned as one reason why <b>OxyContin stays on Preferred Branded Tier</b></p>	<ul style="list-style-type: none"> <li>▪ “There isn’t a lot of management [of this category right now]” – Payor 1</li> <li>▪ “I do think aggressive management towards generics leveling off in pain.. but I do see payors really looking for opioid-like analgesic that’s not addictive” – Payor 2</li> <li>▪ “I think this category is pretty much settled... we’ve only just added some step edits to increase generic utilization... Oxycontin has been on preferred tier for very long time... really no plans to move it anywhere because we would lose rebates and also it was recently reformulated with abuse deterrance” – Payor 3</li> </ul>
<p><b>Lack of differentiation among opioids in the market, but wide range of options is important</b></p>	<ul style="list-style-type: none"> <li>▪ No products that really stand out/ differentiated... but important to have wide range of opioids available for prescribers... important from a clinical perspective because people react differently to pain medications and have allergies – Payor 3</li> <li>▪ Patients will perceive that the generics don’t work as well... but as payors we haven’t seen studies that show that generics don’t work as well... we need to see studies that it doesn’t work... that hasn’t been borne out – Payor 2</li> <li>▪ All drugs are equivalent of pain relief but different levels of euphoria (morphine- low, oxy – high) – Payor 1</li> </ul>
<p><b>Pain is a relatively important category in formulary, but behind oncology and other higher-cost drug types</b></p>	<ul style="list-style-type: none"> <li>▪ “Pain is 4-5% of my total spend – somewhat important but heavily driven by generics... [there’s] no differentiation among pain medication – it’s one big bucket” - Payor 1</li> <li>▪ “Pain is somewhere in the middle... pain isn’t the most expensive medication (except for OxyContin)... but it has high utilization... not like RA, MS, etc that are “budget busters” which require more attention” – Payor 3</li> </ul>
<p><b>Differing levels of awareness about AD reformulation</b></p>	<ul style="list-style-type: none"> <li>▪ “[OxyContin] did show that ‘drug liking’ among potential abusers [was lower]” – Payor 1</li> <li>▪ “There was some data about AD... but at best, I would say it was inconclusive... it showed that you can’t do XYZ to the pill but it wasn’t definitive from a real-world perspective” – Payor 3</li> <li>▪ “I haven’t seen anything that has blown me away... the jury is still out... I don’t think the sample sizes are large enough for our kind of population” – Payor 2</li> </ul>

Last Modified 9/13/2013 11:49 AM Eastern Standard Time  
Printed 9/13/2013 12:29 PM Eastern Standard Time

# Summary of Payor Interviews

FOR DISCUSSION

Theme	Interview Quotes
<p><b>Even with AD benefits, cost savings of generics is heavy counterweight</b> to using more expensive AD formulations</p>	<ul style="list-style-type: none"> <li>▪ “We want most people to be on generics and selective use of AD for vulnerable populations” – Payor 1</li> <li>▪ “If it could be proven that the product decreases/ eliminates abuse deterrence, yes, payors would consider it... but bottom line is very important, just having clinical advantage might not be enough” – Payor 3</li> <li>▪ I could see access improving access to AD drugs... but it’s difficult to know how these will be treated vs cost savings of generics – Payor 2</li> </ul>
<p><b>Payors aren’t looking at cost of opioid users separately</b></p>	<ul style="list-style-type: none"> <li>▪ We don’t track PMPM for opioid users... it’s mostly generic, and we don’t even do it for OxyContin – Payor 3</li> <li>▪ We haven’t tracked PMPM costs for opioid users... we’re more tracking ER visits [which are related] – Payor 2</li> </ul>
<p><b>Somewhat aware of pharmacy-level access issues</b></p>	<ul style="list-style-type: none"> <li>▪ [It’s a pain for a ] pharmacy to get C2s... a lot of pharmacies don’t stock C2s...we can look at certain pharmacies and sometimes tell doctors which pharmacies carry certain medicines – Payor 1</li> <li>▪ No, haven’t heard of pharmacy access issues for legitimate products – Payor 3</li> <li>▪ I have heard of pharmacies not filling prescription.... But they call the doctor that should take care of it – Payor 2</li> </ul>
<p><b>Mixed opinions on whether prescribing behavior is changing</b></p>	<ul style="list-style-type: none"> <li>▪ “Addictions are #1 public health issue in this country... Doctors don’t want to prescribe as much opiates because of addiction... doctors are more judicious then they used to be...particullary in the area of back pain” – Payor 2</li> <li>▪ No change in prescribing patterns that [I’ve] noticed... maybe the change has been so slow – Payor 3</li> </ul>
<p><b>No strict criteria for categorizing drug classes as “genericized”</b></p>	<ul style="list-style-type: none"> <li>▪ Each category is unique... [there is] no blanket “genericized” class” – Payor 1</li> <li>▪ No blanket label for completely “genericized”... case by case basis – Payor 3</li> </ul>

Last Modified 9/13/2013 11:49 AM Eastern Standard Time

Printed 9/13/2013 12:29 PM Eastern Standard Time

# Summary of Payor Interviews

FOR DISCUSSION

Theme	Interview Quotes
<b>Some variation in how payors use step edits vs PAs vs tiers</b>	<ul style="list-style-type: none"> <li>▪ “[We impose] step edits if trying to encourage physicians to follow a logical process... PAs are much more restrictive... ensures that the patient has the right clinical condition for the expensive drug” – Payor 1</li> <li>▪ If we have 2+ products with comparable clinical efficacy, then we might put in step edits... step edits are used to steer patients to generics” – Payor 3</li> <li>▪ Higher tier is 1<sup>st</sup> option, then prior auth, step edit – Payor 2</li> </ul>
<b>Payors work with PBMs to flag potential opioid abusers in their patient population</b>	<ul style="list-style-type: none"> <li>▪ “We work with PBMs to combat it as best as we can, to track patients and physicians who might be abusing” – Payor 3</li> <li>▪ “PBM does claims processing, runs the reports (but we do pharmacy design)... identifies potential abusers by looking at number of prescriptions, doctor shopping, pharmacy-shopping... but not measuring abuse costs” – Payor 1</li> </ul>
<b>Mixed responses to novel contracting arrangements between manufacturers and payors, with pay-for-performance having highest appeal</b>	<ul style="list-style-type: none"> <li>▪ “I haven’t actively participate in any collaborations [with manufacturers]... our lawyers don’t allow it” – Payor 1</li> <li>▪ “Innovative contracting [is] not a good opportunity because pharmacos are restricted in what they can do, and payors are restricted in what they can accept... even for pay-for-performance, there needs to be significant collaboration and integration to track data...[and I’m] not very optimistic about it” – Payor 3</li> <li>▪ “Pay for performance always works... if they put some performance guarantee in there” – Payor 2</li> </ul>

Last Modified 9/13/2013 11:49 AM Eastern Standard Time  
Printed 9/13/2013 12:29 PM Eastern Standard Time

# Summary of Payor Interviews

FOR DISCUSSION

Theme	Interview Quotes
Open to considering a flat pricing approach from branded drugs	<ul style="list-style-type: none"> <li>▪ “Lots of drugs have flat pricing – we like it because [it’s] easier to model pricing” – Payor 1</li> <li>▪ “Going to flat pricing is quite common... especially drugs used in Primary Care... we try to take advantage of that sometimes by splitting the pill in half... give the patient a pill cutter and have them pay only half the copay” – Payor 3</li> </ul>
Other	<ul style="list-style-type: none"> <li>▪ “[We are] concerned if every drug has to go AD [due to regulations]... then drug cost will go up 15-20%.. what I don’t want to see is that we are required to write AD for a 75-year old cancer patient... a doc might say I’m only going to prescribe AD because I want to say that I’m being careful.” – Payor 1</li> <li>▪ “[There will be] pharmacy access challenges in bringing new drugs onto the market, [because] pharmacies don’t want to stock unless there is a use.” – Payor 1</li> </ul>

Last Modified 9/13/2013 11:49 AM Eastern Standard Time  
Printed 9/13/2013 12:29 PM Eastern Standard Time

**WORKING DRAFT**

Last Modified 9/13/2013 12:30 PM Eastern Standard Time

Printed 9/13/2013 12:30 PM Eastern Standard Time

# OxyContin growth opportunities



Phase II Final Report: Recommendations  
Sept 13, 2013

CONFIDENTIAL AND PROPRIETARY

Any use of this material without specific permission of McKinsey & Company is strictly prohibited

McKinsey&Company

# We have performed a deep diagnostic on OxyContin growth opportunities and identified areas of opportunity

## Project objectives

- Identify key opportunities to drive near-term OxyContin performance
- Build plans to capture priority opportunities



## Phase 1: Diagnostic phase

- 1 Market landscape
- 2 Messaging & positioning
- 3 Segmentation & targeting
- 4 Field execution & focus
- 5 Access & availability
- 6 Scientific support
- 7 Commercial spend levels
- 8 Patient funnel

## Phase 2: Priorities and recommendations

- 1 Turbocharge the Purdue sales engine
- 2 Messaging
- 3 HECON/payor
- 4 Access & availability
- 5 Commercial resourcing/benchmarking
- 6 Market demands and forecasting
- 7 Moving forward

# Overview of key recommendations (1/2)

## Key Recommendations

**Turbocharge  
the Purdue  
sales engine**

- 1 Create a senior team to lead effort and task them to develop a detailed workplan within 30 days
- 2 Establish an incremental revenue goal vs forecast (e.g., \$150M annualized incremental stretch goal by July 2014) and set regular progress reviews with the appropriate groups
- 3 Shift Purdue's sales targeting from decile to workload (industry norm that more precisely defines the value of physicians) incorporating measures beyond total ERO prescriptions
- 4 Increase field effort significantly for OxyContin through improved productivity and closely measure changes in sales
- 5 Take actions to drive field adherence with recommended call targets, including adjustment of the incentive compensation to reflect the greater field effort on OxyContin
- 6 Perform similar analyses for Butrans and the near term pipeline to align on a portfolio level field resourcing plans to ensure that the sales transformation builds a strategic platform for the future
- 7 Explicitly consider the strategic addition of ~65-230 OxyContin reps and various options (e.g., a CSO overlay to get increased frequency). There are multiple factors to be considered including leadership perspectives on: 1) desire for a lower risk approach to delivering the near term forecast 2) how much change the current organization can realistically deliver 3) required resources for Butrans and expected future pipeline

**Messaging**

- 8 Significantly improve physician awareness and understanding of the new label, primarily through medical resources and training of the sales reps on ways to appropriately involve Medical
- 9 Develop new prescriber segmentation in light of the new label to target AD messaging

**HECON/  
payor**

- 10 Build/refine HECON messages and pro-actively engage with payors

# Overview of key recommendations (2/2)

## Key Recommendations

### Access & availability

- 11 Significantly increase insight on pharmacy-level dynamics through purchasing of new data (e.g., pharmacy segmentation in OMS, EMR data on prescriptions written) and create a working team with responsibility for monitoring the situation on a monthly basis
- 12 Initiate direct executive committee level engagement with pharmacy leadership to show urgency and build a win-win partnership for patients
- 13 In parallel, aggressively explore alternative distribution options (e.g., pharmacy direct mail order) via a senior level cross-functional team
- 14 Develop a comprehensive Part D strategy that includes review of the rebate plan and local field surge to mitigate commercial plan spillover
- 15 Incorporate differential local market access conditions into standard DM business planning, including partnering with managed care Account Executives for planning

### Commercial resourcing/ bench-marking

- 16 As part of the upcoming cycle, broadly consider increasing current resourcing levels for OxyContin, with clear business cases and ROIs

### Market demand & forecasting

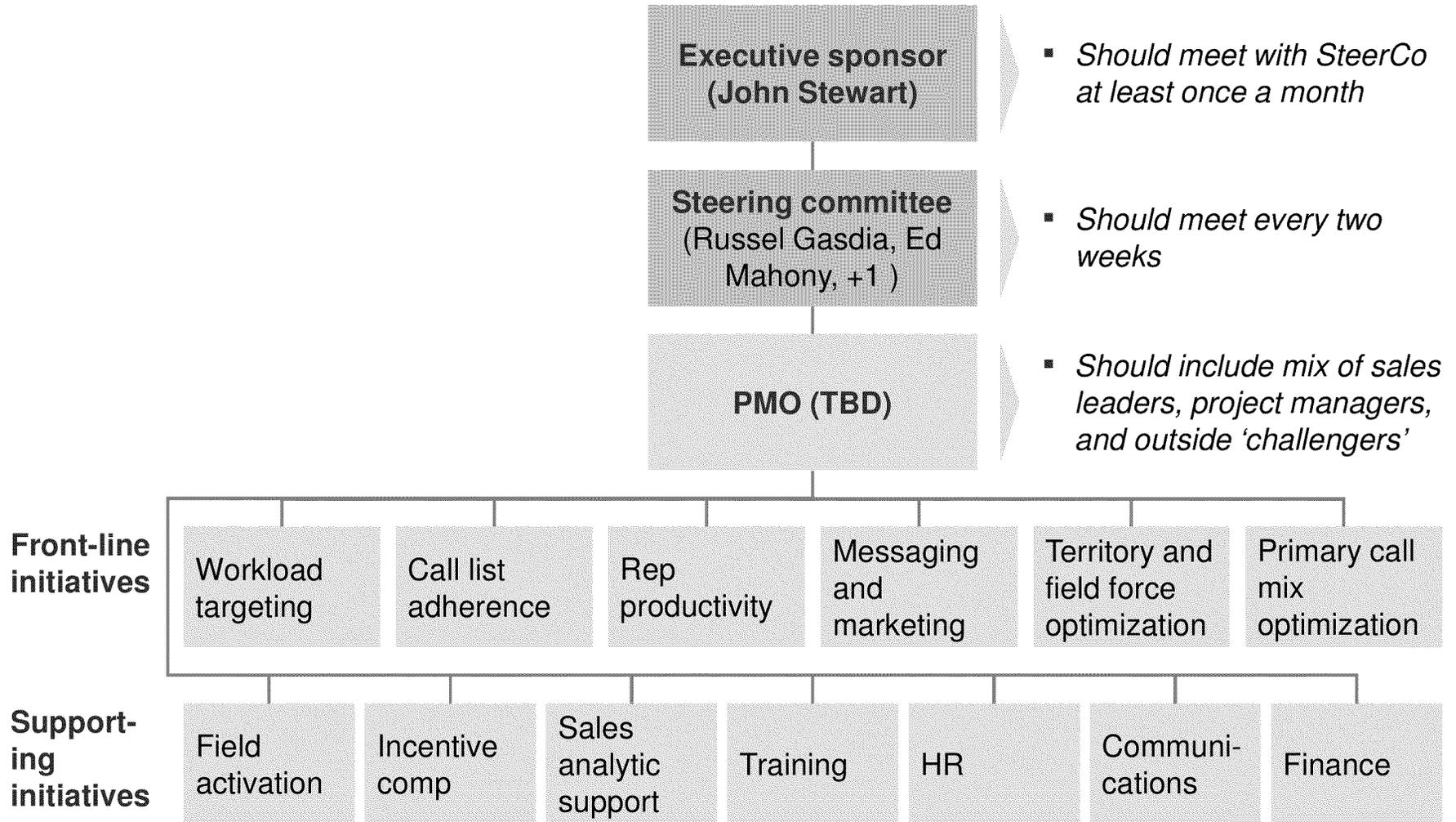
- 17 Increase market research efforts particularly in quantifying emerging marketplace dynamics, including additional resources to purchase new data (e.g., corporatized providers, complete formulary status) and additional capacity to analyze the data and recommend specific actions
- 18 Shift to more 'local market analyses' (regional marketing) to uncover the most relevant insights and opportunities that may not be noticed/incorporated at the national level
- 19 Consider establishing a Sales Analytics function to 'own' and deliver improved tools and insights to the field, working in close partnership with the FAMR group

# Contents

- **Turbocharge Purdue sales engine**
- Messaging
- HECON
- Access & availability
- Commercial resourcing/benchmarking

1 Create a senior leadership team and task them to develop a workplan

## Purdue should establish a governance structure to manage the transformation



Last Modified 9/13/2013 12:30 PM Eastern Standard Time

Printed 9/13/2013 12:30 PM Eastern Standard Time