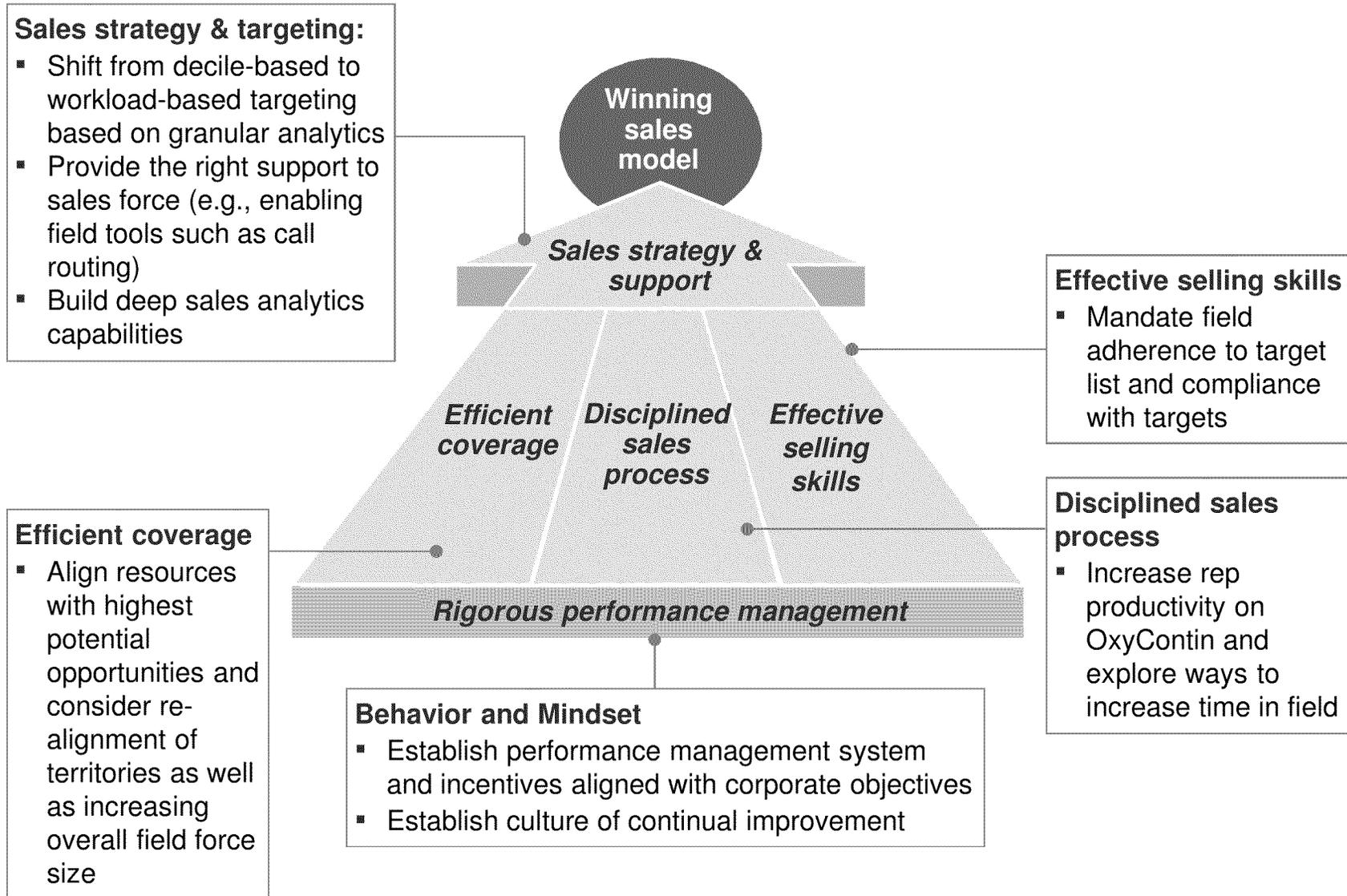


1 Create a senior leadership team and task them to develop a workplan

A winning sales model requires excellence across 5 major levers



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

We recommend comprehensive workstreams addressing both frontline and enabling initiatives

	Initiative	Major objectives
Frontline initiatives	1 Workload targeting	Develop target list with frequency based on workload factoring (e.g., managed care, NBRx)
	2 Call list adherence	Create a program to enable reps to improve call list adherence (e.g., call routing tools)
	3 Rep productivity	Mandate in increase in OxyContin P1s to current target level (55/rep/month) and find ways to increase time in field
	4 Messaging and marketing	Refresh OxyContin messaging, and build front-end sales tools to allow delivery and tracking of tailored messages
	5 Territory and field force optimization	Increase field force size and re-align territories to align to OxyContin potential and adjust market basket
	6 Primary call mix optimization	Optimize call balance between OxyContin and Butrans
Enabling initiatives	7 PMO	Overall project management to oversee workstreams, set timeline, and set targets
	8 Field activation	Coordinate successful rollout of initiatives in the field
	9 Incentive compensation	Revise incentive comp to align with front line initiatives and sales targets
	10 Sales analytic support	Support to sales force initiatives, including impact tracking, and front end sales tools
	11 Training	Create training programs for key initiatives and roll out to field
	12 HR	Support organizational needs, recruitment, and drive change management
	13 Communications	Ensure successful internal communication across the organization
	14 Finance	Manage budget requests and set revenue targets

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

A mix of roll out methods needs to be tailored to Purdue’s needs

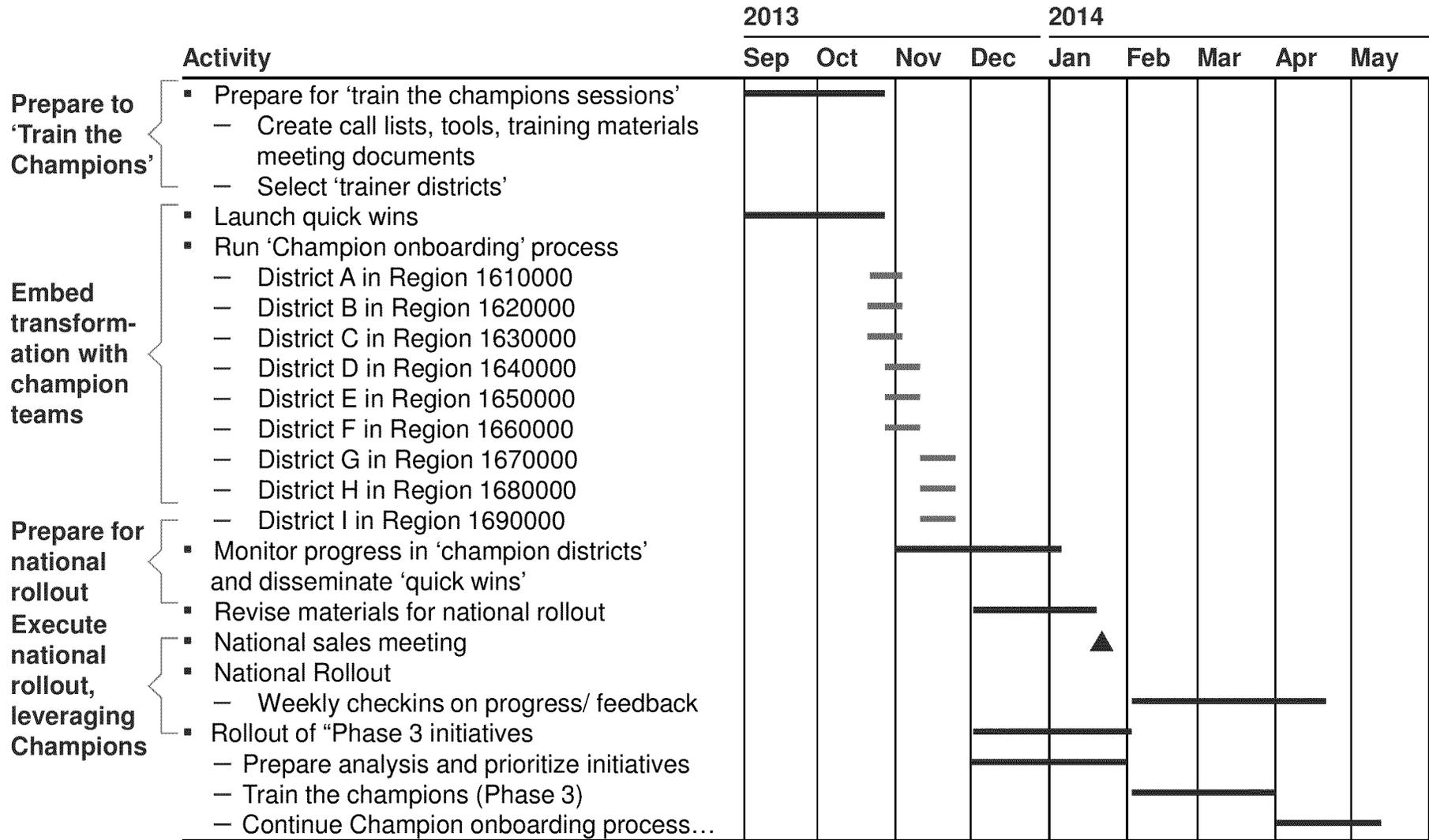
Roll out method	Description	Key considerations
A. “Cell to Cell”	<ul style="list-style-type: none"> Identify one high performance rep per district to develop deep understanding of the transformation Use these reps as trainers for the other reps in their field 	<ul style="list-style-type: none"> Training reps may not be able to train all other reps at the same time, leading to slower roll out Reliance on training reps to successfully perform training Sufficient number of initial “cells” required to ensure fast roll-out
B. “Wildfire”	<ul style="list-style-type: none"> Identify champion reps and use these high performance reps to lead their own “learning teams” of reps Motivate champions and learning teams through competitions 	<ul style="list-style-type: none"> Strong buy in and deep understanding of new approach required by champions Champions operate as entrepreneurs, leading to less “hands on” headquarter involvement
C. “Headquarter rollout”	<ul style="list-style-type: none"> Headquarter implementation team conducts “road shows” to train field force by region/district, in collaboration with cross functional team including sales training and analytics 	<ul style="list-style-type: none"> Headquarter involvement and presence required Less focus on champions/successful reps, leading to potentially lower field buy-in
D. “Pilots First”	<ul style="list-style-type: none"> Roll out new sales approach in select pilot territories Use findings from pilots to drive buy in from field 	<ul style="list-style-type: none"> Pilots delay full roll out, and successful implementation relies on pilot results

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

EXAMPLE - Field activation: Potential rollout schedule (illustrative)



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

EXAMPLE - Field activation: Potential key elements to consider

Key elements of field activation	Rationale
<ul style="list-style-type: none">▪ Champions<ul style="list-style-type: none">– One high performing district per region– Set of champion reps who are “natural pilots” – i.e., high performing and already exhibit many of the future state behaviors– DMAC (DM Advisory Council) and RFTs (Regional Field Trainers)	<ul style="list-style-type: none">▪ Strong buy in and deep understanding of new approach required by champions▪ Champions operate as entrepreneurs and add local/field-oriented credibility, however this is balanced by headquarter involvement for recognition and rewards
<ul style="list-style-type: none">▪ HQ led “road shows”<ul style="list-style-type: none">– Train field force by district, in collaboration with cross functional team including sales training and analytics– ~3 month program of visiting districts, incorporating feedback, and embedding best practices	<ul style="list-style-type: none">▪ Signal strong HQ commitment to sales force transformation▪ Ensure that HQ policies are informed by field perspectives▪ HQ facilitates collection and dissemination of best practices
<ul style="list-style-type: none">▪ Competitive recognition program<ul style="list-style-type: none">– Competition for results among all districts (e.g., largest increase in scripts among high workload physicians)– At key intervals (e.g., 1 month, 3 months, 6 months) the teams with the strongest results present to HQ leadership and get national recognition	<ul style="list-style-type: none">▪ Balances benefits of team-based activity (e.g., collaboration, sharing of best-practices, accountability) with benefits of competition▪ Goes beyond incentive compensation to include recognition by peers and high-level executives can be as powerful a motivator as financial incentives

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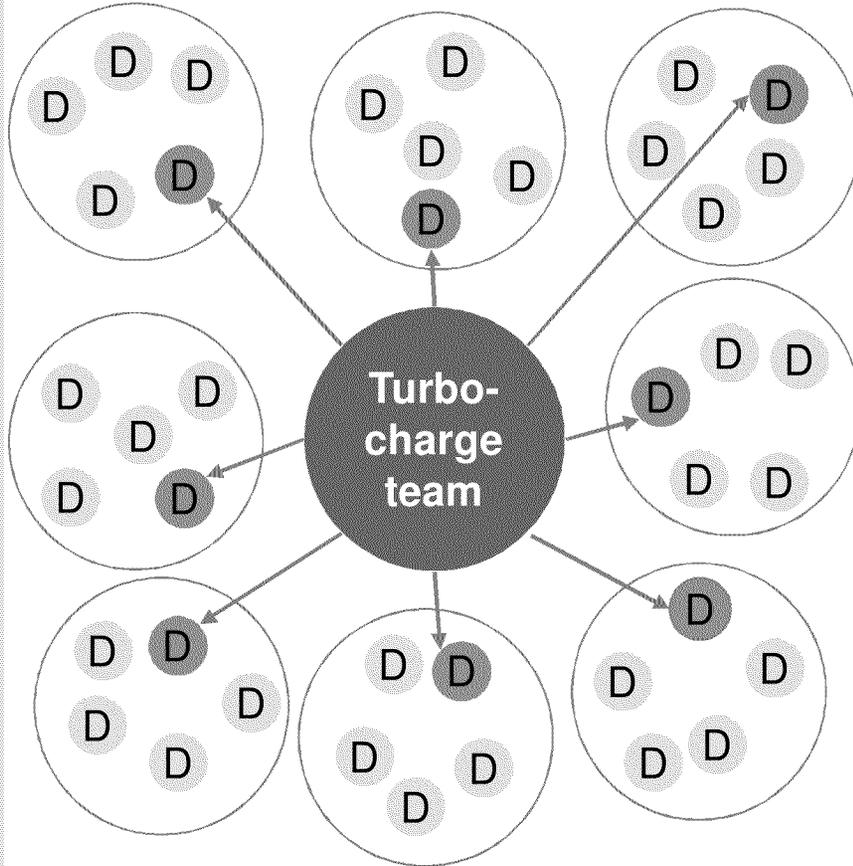
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- 1 Create a senior leadership team and task them to develop a workplan

EXAMPLE - Field activation

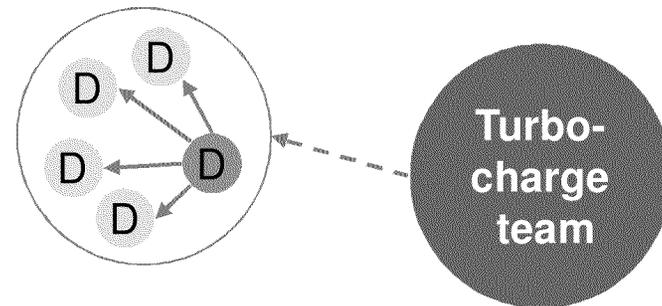
CONCEPTUAL

HQ 'trains the champion districts' through a ~1 week-long change management program with one district from each region...



... After National Sales Meeting, each 'Champion district' helps onboard other districts in its region, with more limited support from the turbocharge team

In each region:



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

EXAMPLE - Field activation: 'Train the champion districts'

■ Details follow

Small cross-functional HQ teams supported by McKinsey will visit one district per region for ~1+ weeks

Sample schedule of champion district embedding process

Day	Key Activities
1-2	<ul style="list-style-type: none">Prepare district level analysis and materials
3	<ul style="list-style-type: none">Meet with DM and RM to walk through analyses supporting sales transformation initiativesGain DM and RM buy-in on initiativesRefine how initiatives will be rolled out in the district
4	<ul style="list-style-type: none">Hold district-wide workshop where rationale for initiatives are explained to repsReps review new target list in workshops
5-7	<ul style="list-style-type: none">Conduct ride-alongs with select reps to gain buy-in and hear inputRefine target list, gather feedback on enablers as needed
8	<ul style="list-style-type: none">Refine local messages to field/ share feedbackDebrief with DM to ensure alignment on next stepsCodify learnings for sharing back to broader effort
Every week	<ul style="list-style-type: none">Districts hold weekly callsField enablement team remains "on call" support for repsHelp district prepare for role in National Sales Meeting

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

EXAMPLE - Field activation: Sample workshop agenda for district reps

Key elements for a successful workshop include...

- Coordinated support – Mix of RM, DM, RFT facilitate workshop together
- Emphasis on transparency – discuss identification and sizing methodology
- Field empowerment – enable reps to modify / eliminate some identified prescribers (e.g., if inaccessible)
- Focus on immediate execution – e.g., incorporate prescribers into call plan via working session

Sample agenda

Activity

- Overview of sales transformation initiatives
 - Share key analyses/ local and national
 - Discuss goals and timing of turbocharge effort
 - Explain role of Champion districts
- Deep dive on sales transformation opportunities, e.g.,
 - High-workload physicians
 - Adherence
 - Call volume
- Integration of the sales transformation initiatives into your business
 - Call cycle planning refresher
 - Discuss best way to incorporate into your business
 - Actual call cycle plan adjustments
- Immediate next steps

2 Establish an incremental revenue goal vs forecast

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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3 Shift Purdue's sales targeting from decile to workload

We recommend shifting from decile-based targeting to workload-based targeting more standard in the industry

Sales targeting approach

Description

From

- Decile-based targeting

- Use market deciles based on TRx to identify biggest writers
- Reps prioritize largest writers and track share over time

Key success factor in workload system is adherence to call list

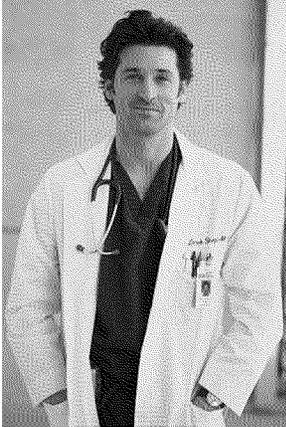
To

- Workload-based targeting

- Use multiple data sets and state-of-the-art analytics to determine most incremental upside for each call
- Target prescribers based on (in addition to ERO decile):
 - New-to-brand writing
 - OxyContin writing
 - Other branded product writing
 - Managed care access
 - Specialty
- Reps prioritize their calls to maximize sales for their territory
- Targeting reflects local micro-market conditions

3 Shift Purdue's sales targeting from decile to workload

Including additional factors such as Gx penetration and NBRx may result in a more optimized call plan

Physician A		Physician B	
			
Market decile¹	10	Market decile	10
Oxy TRx:	348	Oxy TRx:	298
ERO TRx:	1,353	ERO TRx:	1,326
Generic penetration:	28%	Generic penetration	72%
NBRx:	47	NBRx:	24

- Not all physicians in the same market decile are “created equal”
- There may be greater potential in increasing call effort on prescribers with favorable characteristics (low Gx writing, high NBRx, high market access)

¹ Data based on Q1 2013

4 Increase field effort significantly for OxyContin

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 (PDEs¹)
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 calls/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

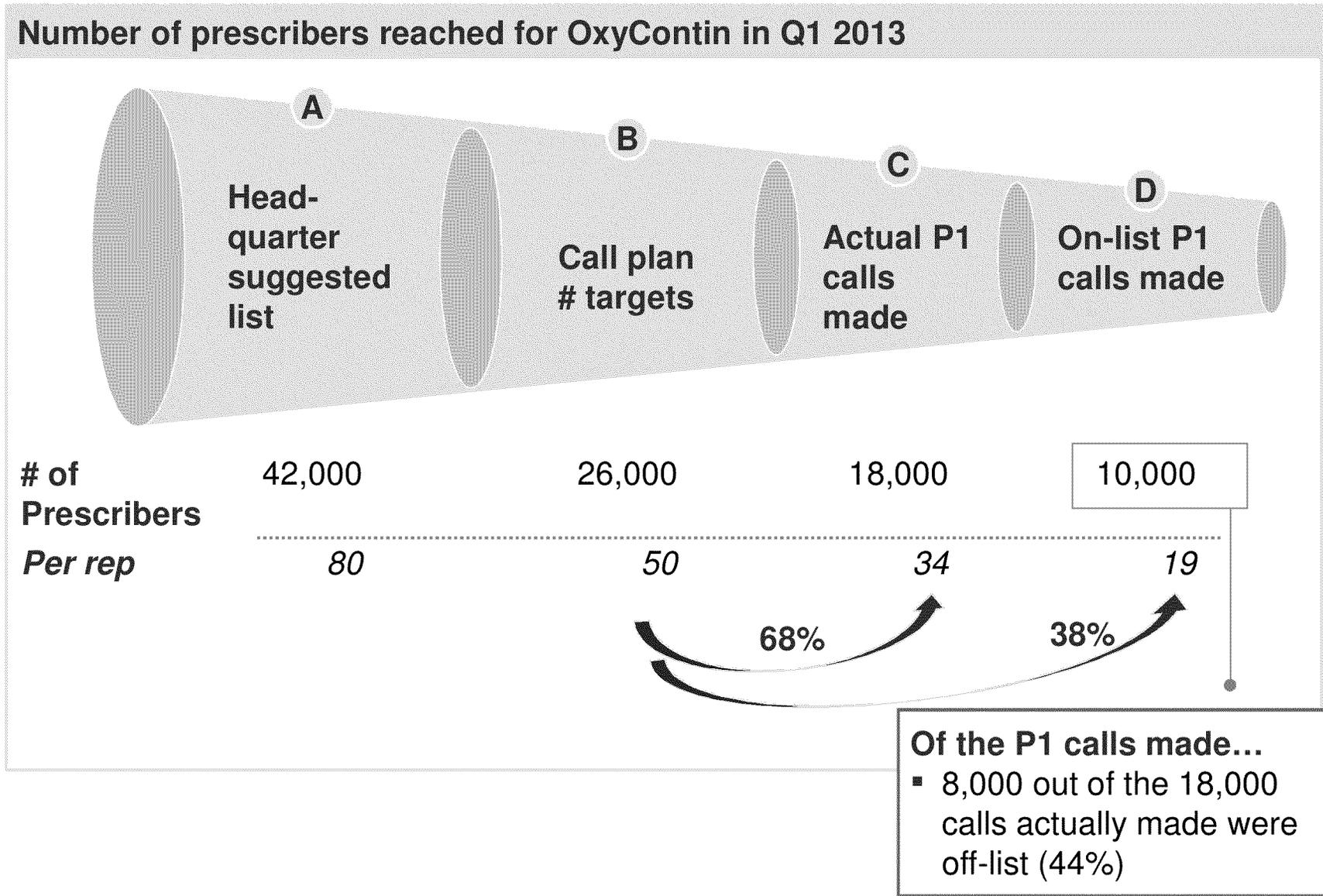
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5 Mandate field compliance with targets and align the incentive program to match OxyContin prioritization

Adherence to the call list is only ~55%



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SOURCE: ZS Associates report; Purdue call data; Team analysis

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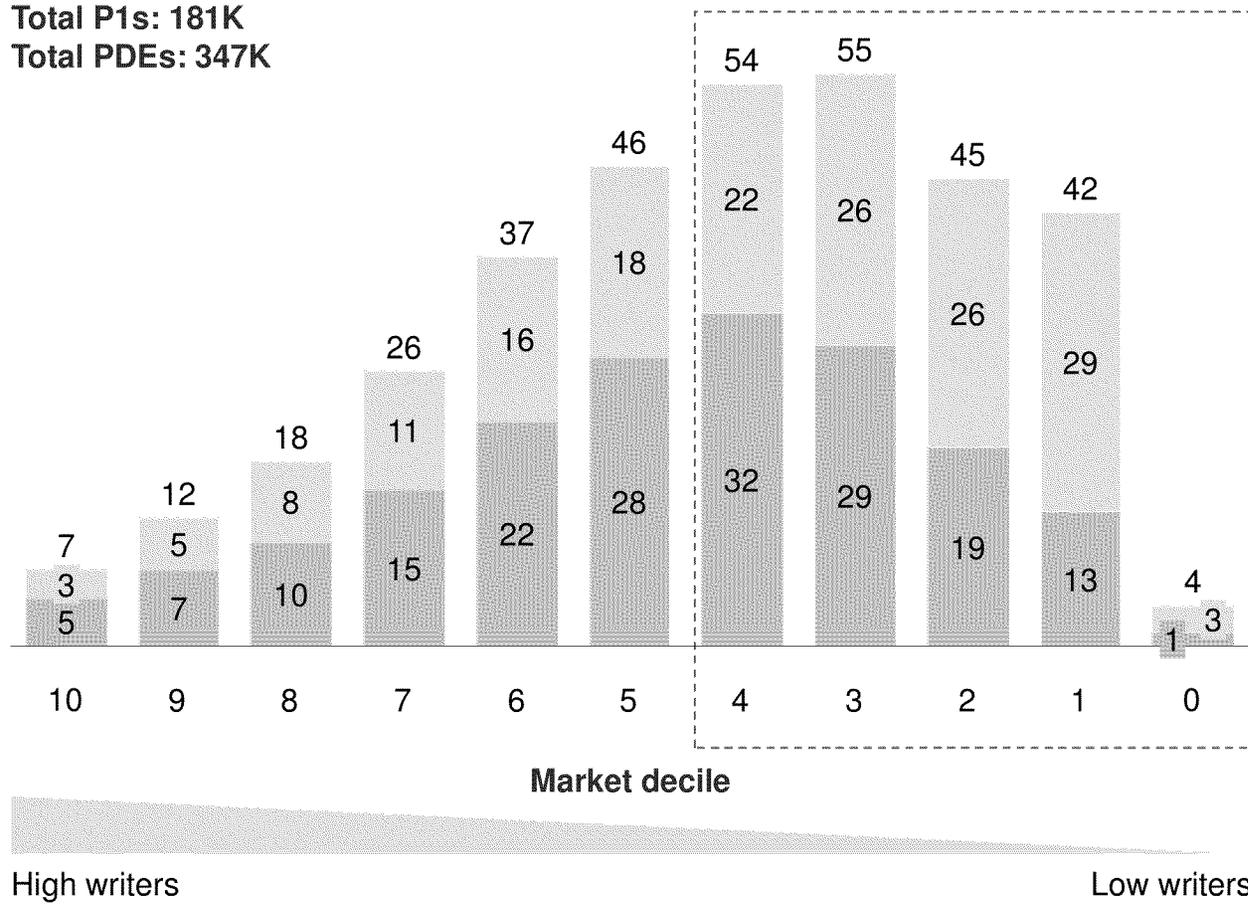
5 Mandate field compliance with targets and align the incentive program to match OxyContin prioritization

Currently, over 50% calls are made to low decile prescribers

- Secondary details (PDE equiv)¹
- Primary details

Number of OxyContin calls by market decile², annualized based on Q1 2013
 Number of Primary Detail Equivalents (PDEs); thousands

Total P1s: 181K
Total PDEs: 347K



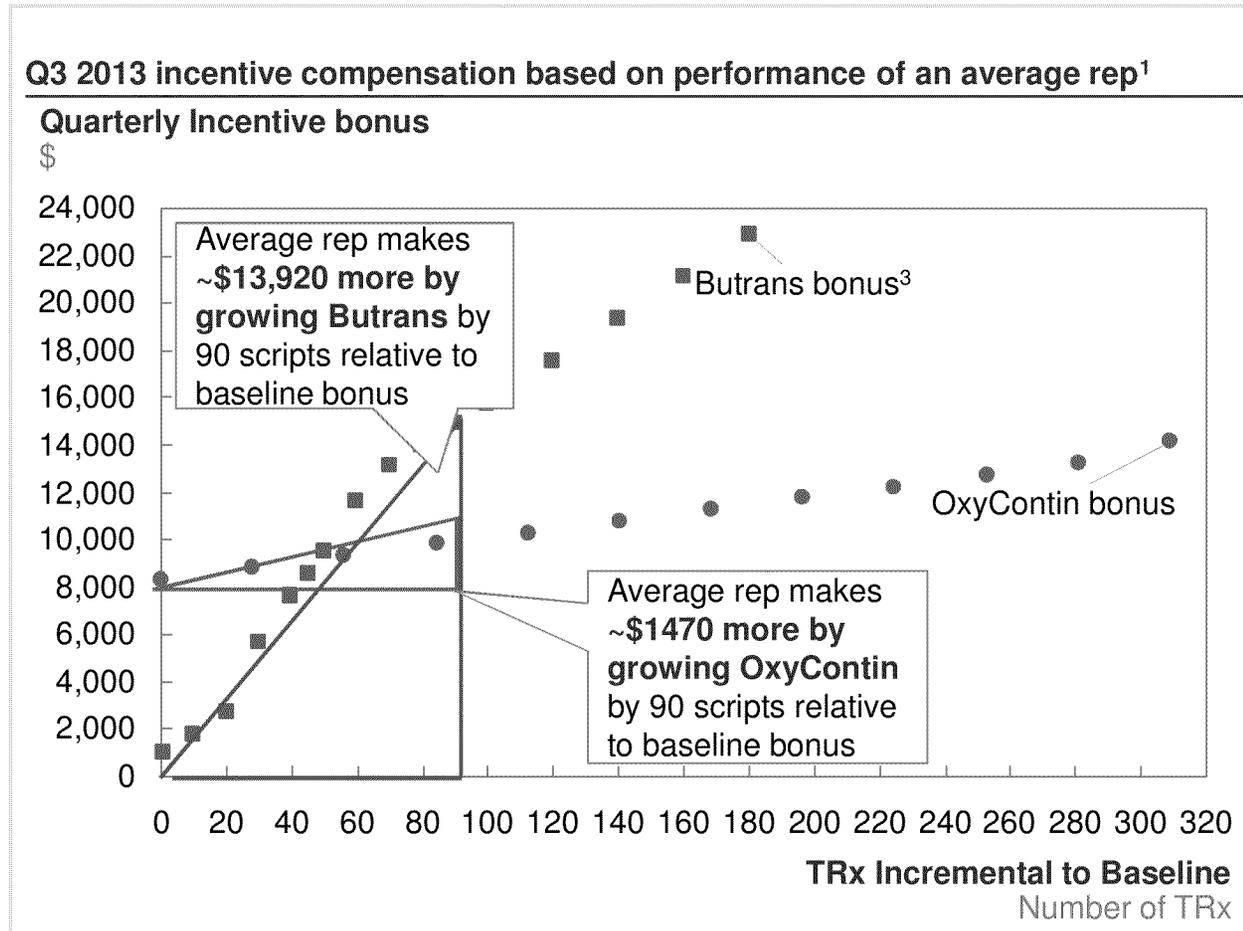
- 52% of OxyContin primary calls (95K) and 57% of primary detail equivalents are made to low-market decile prescribers (0-4)
- Given that there are ~14,000 uncalled physicians in deciles 5-10, there is significant opportunity to shift calls to higher potential prescribers
- Reasons for low-decile calls include:
 - Lack of access to higher-deciles
 - Geographic territory definition
 - Lack of rep call list adherence
 - Opportunism (physician in same office)
 - Calling on KOLs

1 PDEs calculated as 1.0 x P1 calls + 0.5 x P2 calls
 2 Market decile based on ER-IR market basket as defined by ZS Associates

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- 5 Mandate field compliance with targets and align the incentive program to match OxyContin prioritization

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



- 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 Butransscripts/ quarter for average rep, and 2809 OxyContinscripts/ quarter for average rep.

² Assumes average \$267 gross price/ Butransscript 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

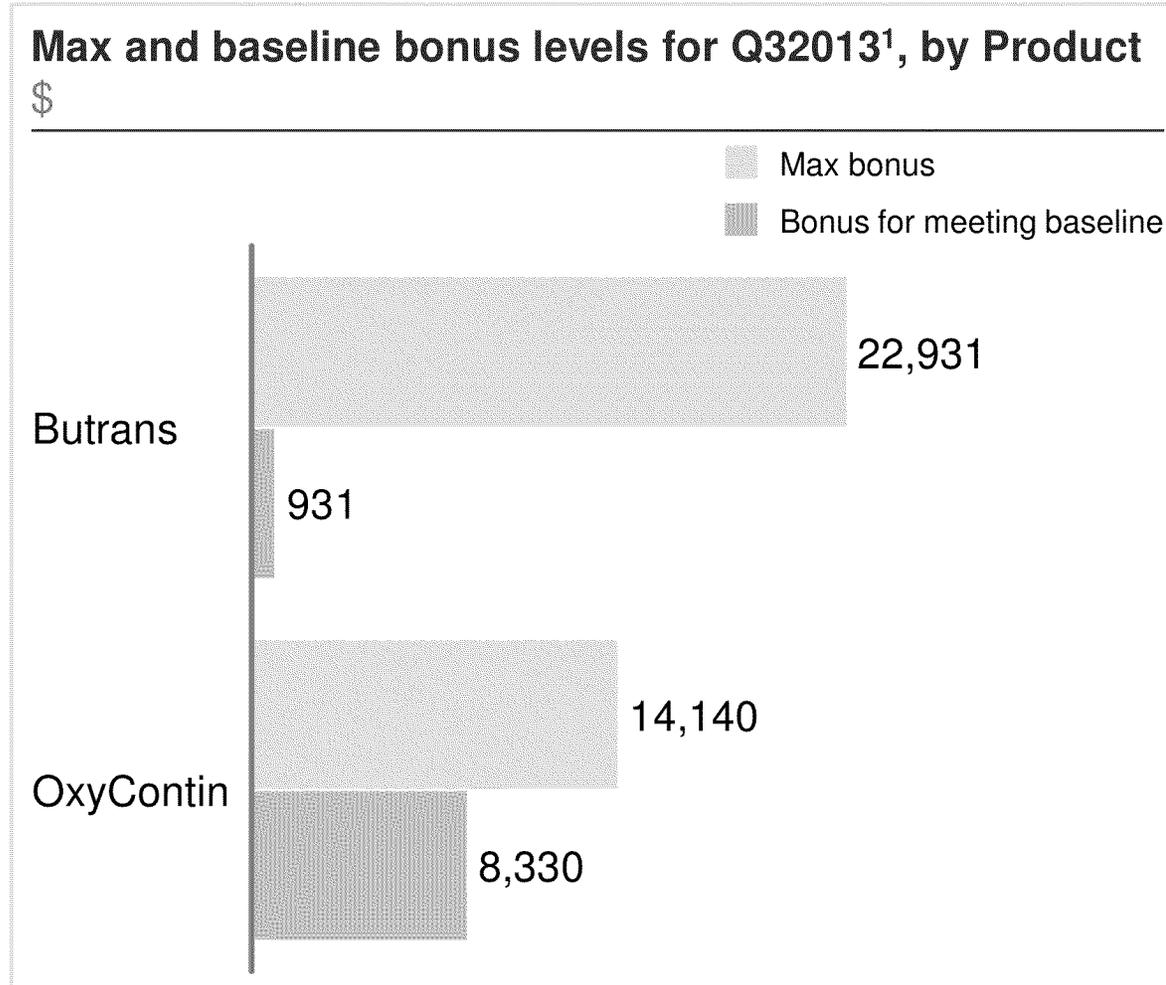
SOURCE: Purdue sales; Purdue Budget; team analysis

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- 5 Mandate field compliance with targets and align the incentive program to match OxyContin prioritization

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 Butransscripts/ quarter for average rep, and 2809 OxyContinscripts/ quarter for average rep. Balanced portfolio bonus indexed to Butransscripts

7 Consider the addition of ~65-230 OxyContin reps and other options

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 expand ³	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

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8 Improve physician awareness and understanding of new label, primarily through medical and appropriate training of sales reps

Awareness of abuse deterrence and impact on prescribing varies amongst prescribers (1/3)

Key themes	Supporting evidence
Prescriber awareness of abuse deterrence and label change is mixed	<ul style="list-style-type: none"> ▪ “I am only vaguely aware of abuse deterrence”- <i>Primary care practitioner</i> ▪ “In the end it doesn’t really hurt anyone, to the extent that I understand the technology” – <i>Private practitioner and assistant professor at large medical school</i> ▪ “I know (abuse deterrent reformulations) exist”- <i>Family practitioner</i> ▪ “For some people (abuse deterrence) probably matters, such as first time prescribers and non-specialists, but for specialists, (the label change) probably doesn’t make much of a difference because they were already aware of the reformulation (before the label change)- <i>Anesthesiologist and Head/Neck surgeon</i> ▪ “I knew already since 2010 about (OxyContin’s abuse deterrence), so the new labeling doesn’t make big difference” – <i>Physical Rehabilitation and Pain specialist</i>
Most prescribers are concerned about abuse, but attempt to establish measures to protect themselves	<ul style="list-style-type: none"> ▪ “(Concern about abuse) hasn’t changed that much, because (prescribers in practice) follow preferred and recommended guidelines- <i>Chief of Interventional Spine and Pain Management at major hospital</i> ▪ “(Abuse is) main concern in every practice...and we need (abuse monitoring) resources because of the nature of our practice” – <i>Pain specialist in private practice</i> ▪ “I’m always worried about (abuse) and definitely see it”- <i>Internist</i> ▪ “If I get an inkling, I check immediately and warn the patient” – <i>Family doctor in family group practice</i> ▪ “I worry about diversion...same thing for Adderall, valium, etc...”- <i>Family practitioner in private practice</i>

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8 Improve physician awareness and understanding of new label, primarily through medical and appropriate training of sales reps

Awareness of abuse deterrence and impact on prescribing varies amongst prescribers (2/3)

Key themes	Supporting evidence
Opinions on impact/efficacy of abuse deterrence vary	<ul style="list-style-type: none">▪ “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>▪ 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>▪ “It’s a win-win for everyone, as long as the price is ok” – <i>Physician at major hospital</i>▪ “(I would) certainly (prescribe abuse deterrent formulations)...you never know who you’re dealing with”- <i>Internist</i>▪ “(OxyContin reformulation is a) much better reformulation...but having said that, many pain doctors are still humans and suffer from emotional inhibition bc of all the bad press it had, bc it still has the name OxyContin”- <i>Anesthesiologist with fellowship in pain management</i>▪ “(Abuse deterrent formulations) are good faith effort to show reasonable response to the abuse issues”- <i>Chief of Interventional Spine management at large hospital</i>▪ “These are (nonetheless) control substances, whether they can be abused or not, we have to assume they are abused”- <i>Family practitioner in private practice</i>

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SOURCE: McKinsey prescriber interviews

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8 Improve physician awareness and understanding of new label, primarily through medical and appropriate training of sales reps

Awareness of abuse deterrence and impact on prescribing varies amongst prescribers (3/3)

Key themes	Supporting evidence
Concerns remain that technology does not address oral abuse	<ul style="list-style-type: none"> ▪ “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> ▪ “No formulation on the market that is overdose resistant” - <i>Pain Management and Physical Medicine and Rehabilitation</i> ▪ 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>
Less informed prescribers ask for additional information and education around abuse deterrent formulations	<ul style="list-style-type: none"> ▪ “The FDA decision [on OxyContin] should carry weight...data would very valuable...should be incentive to use this medicine“- <i>Addiction specialist</i> ▪ “There are several studies on abuse deterrence out there...what we need is information from trustworthy sources” – <i>Anesthesiologist and Head/Neck surgeon</i> ▪ “(It would be good) if pharma companies made it more clear that this drug is now a preferred medicine”- <i>Private practitioner and assistant professor at large medical school</i> ▪ “I haven’t seen any data that shows effectiveness of abuse deterrence... not statistics” – <i>Family practitioner</i> ▪ “I want to see that (the drug) is not diverted and used on the street...I don’t find the (existing) data all that compelling”- <i>Anesthesiologist and Pain Specialist at large hospital</i> ▪ “If there is enough education, we may be using them more frequently, to mitigate abuse” – <i>Family doctor in family group practice</i>

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8 Improve physician awareness and understanding of new label, primarily through medical and appropriate training of sales reps

Current MSL practices at Purdue and industry practice

	<u>Current Purdue practice</u>	<u>Industry practice</u>
Payors	<ul style="list-style-type: none">▪ Avoid bringing in MSLs unless payor makes unsolicited request	<ul style="list-style-type: none">▪ MSLs target payors for delivery of medical content related to product
Prescribers	<ul style="list-style-type: none">▪ MSLs do not target any prescribers (including KOLs) to deliver OxyContin-related medical information	<ul style="list-style-type: none">▪ MSLs target KOLs for delivery of medical content related to product▪ MSLs may also target other prescribers who have unmet medical information needs

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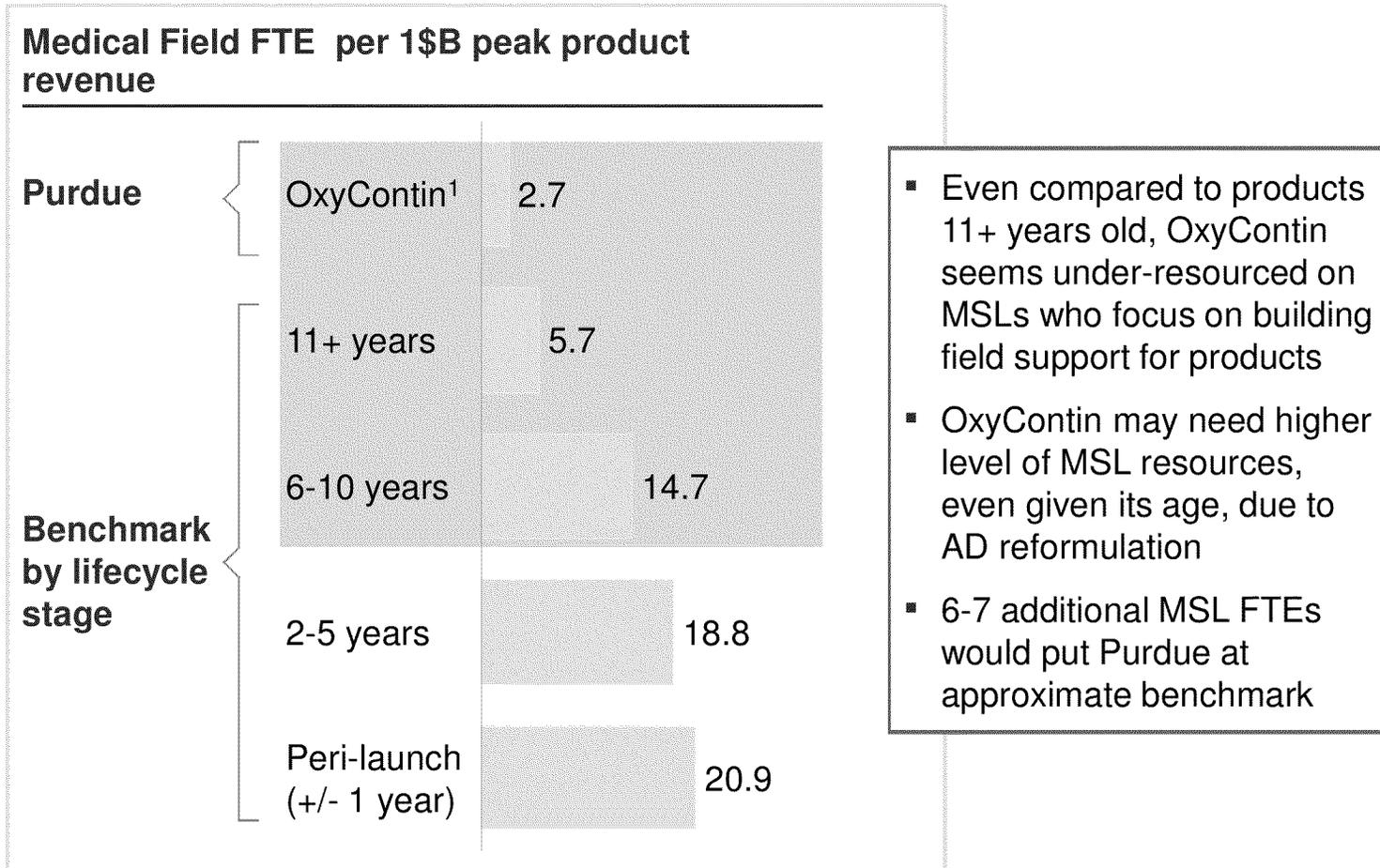
SOURCE: Purdue HECON; Purdue national payor accounts; Purdue Medical Affairs; McKinsey experts

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8 Improve physician awareness and understanding of new label, primarily through medical and appropriate training of sales reps

OxyContin appears somewhat under-resourced on MSLs compared to industry benchmarks

■ Most relevant comparisons



1 6 MSLs for \$2.2 bn net OxyContin sales in 2012. Only MSLs dedicated to field information dissemination were counted.

SOURCE: Purdue Medical Affairs; McKinsey benchmarks

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9 New prescriber segmentation should be developed in light of the new label

New OxyContin label can be used in messaging for specific groups of prescribers

Characteristics of prescribers who may be most impacted by OxyContin AD messaging

- Limited or no awareness of abuse deterrent formulations
- Low Oxy share of ERO
- High Oxy decliners with stable ERO writing
- Writers in areas of high abuse or high DEA activity

SOURCE: McKinsey team analysis

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Payor interviews indicate varied levels of awareness about reformulation, and particular lack of knowledge of how AD can affect opioid patient economics

Theme	Interview quotes
Differing levels of awareness about AD reformulation	<ul style="list-style-type: none"> ▪ “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” – <i>Pharmacy Director (5.5 mn lives)</i> ▪ “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” – <i>Regional Medical Director (212k lives)</i> ▪ “[OxyContin] did show that ‘drug liking’ among potential abusers [was lower]” – <i>Pharmacy Operations Manager (1.2 mn lives)</i>
Payors aren’t looking at cost of opioid users separately	<ul style="list-style-type: none"> ▪ “We don’t track PMPM for opioid users... it’s mostly generic, and we don’t even do it for OxyContin” – <i>Pharmacy Director (5.5 mn lives)</i> ▪ We haven’t tracked PMPM costs for opioid users... we’re more tracking ER visits [which are related] – <i>Regional Medical Director (212k lives)</i>
Even with AD benefits, cost savings of generics is heavy counterweight to using more expensive AD formulations	<ul style="list-style-type: none"> ▪ “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” – <i>Pharmacy Director (5.5 mn lives)</i> ▪ “I could see improving access to AD drugs... but it’s difficult to know how these will be treated vs cost savings of generics” – <i>Regional Medical Director (212k lives)</i> ▪ “We want most people to be on generics and selective use of AD for vulnerable populations” – <i>Pharmacy Operations Manager (1.2 mn lives)</i>

- Lack of tracking of opioid patient costs suggests payors have not thought about the potential financial benefits of using AD formulations
- Interviews suggest that Purdue can add value to payors by bringing new HECON and Medical data

SOURCE: Payor expert interviews; team analysis

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