FILED
NOV 15 2010
Carol E. Higbee, P.J.Cv.

IN RE: REGLAN LITIGATION

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY

CASE NO. 289

MASTER DOCKET:

CIVIL ACTION

CASE MANAGEMENT ORDER NO. 5

ORDER RE COMPLETION OF FACT SHEET DOCUMENTS AND CERTAIN INTERROGATORIES TO DEFENDANTS

THIS MATTER, having come before the Court at recent Case Management Conferences, and all parties, having been represented by Counsel, and for good cause shown and the parties having

consented to the substance and entry of the Order,

IT IS on this 15 day of NOV, 2010: **ORDERED** as follows:

I. PLAINTIFF FACT SHEET:

1. Each plaintiff in an action filed in the New Jersey *In Re: Reglan Litigation* shall complete and serve upon defendants' counsel of record in that particular case and Defendants' Liaison Counsel a completed Plaintiff Fact Sheet ("PFS") with an executed verification and all requested records release authorizations, which have each been agreed to by the parties and approved by the Court and are attached hereto as Exhibit "A", within 45 days of the entry of this Order for all cases now on file. Thereafter, the completed PFS with an executed verification, records release authorizations and related documents in the form attached as Exhibit "A" shall be served within 45 days from the filing of the first notice of appearance. The documents attached as Exhibit "A" will be posted at the Court's website: http://www.judiciary.state.nj.uslmass-tortlfonns/index.htm.

2. Each plaintiff is required to provide defendants with a PFS that is substantially complete in all respects.

II. DEFENDANT'S FACT SHEET

3. Upon service of a PFS, defendants who have entered an appearance and who have been identified as a manufacturer or distributor of the Reglan or metoclopramide product the plaintiff ingested shall serve upon plaintiff's counsel of record and Plaintiffs' Liaison Counsel a completed "Defendant

Fact Sheet" (DFS), the form of which has been agreed to by the parties and approved by the Court and which is attached hereto as Exhibit "B", within 45 days from the date that the PFS is served on Defendants' Liaison Counsel as prescribed in this Order. Deficiencies in PFS shall not toll the defendant's obligation to file the DFS. If defendant claims that any of the responses or lack thereof in the PFS causes them to be unable to complete any portion of the DFS, the defendant shall complete all sections of DFS they can answer and state in response to any specific answer they cannot respond to why they cannot fully answer and what information called for in the PFS they need in order to respond. The DFS shall be completed and served on a rolling basis. The DFS will be posted at the Court's website: http://www.judiciary.state.nj.uslmass-tortlfonns/index.htm.

4. In all cases where one or more of the brand-name manufacturers is named as a defendant but not identified in the Plaintiff Fact Sheet as a manufacturer of Reglan or metoclopramide that the plaintiff ingested, the brand-name manufacturer(s) shall not be required to answer the DFS. Instead, the brand-name manufacturer(s) shall advise plaintiff whether that defendant detailed Reglan or metoclopramide or, provided Reglan or metoclopramide samples to, any healthcare provider identified in the PFS as someone who dispensed or prescribed Reglan or metoclopramide to plaintiff. However, if the case is later selected to be a bellwether, the brand-name manufacturer(s) shall answer the DFS within 45 days of notice of that determination to that defendant.

5. Nothing in the PFS or the DFS shall be deemed to limit the scope of the inquiry at depositions and admissibility of evidence at trial. The scope of inquiry at depositions shall remain governed by New Jersey law. The admissibility of information in the PFS and the DFS shall be governed by New Jersey law and no objections are waived by virtue of any fact sheet response.

6. Nothing in the PFS or DFS shall limit the scope of the pretrial discovery in any

individual case.

III. CERTAIN INTERROGATORIES TO DEFENDANTS

7. Each defendant that has entered an appearance in an action filed in the New Jersey *In Re: Reglan Litigation* shall complete and serve upon Plaintiffs' Liaison Counsel a set of responses to interrogatories denoted as *Interrogatories to Defendants Regarding Contacts With The State of New Jersey*, with an executed verification, which are attached hereto as Exhibit "C", within 45 days of the entry of this Order. The interrogatories denoted as *Interrogatories to Defendants Regarding Contacts With The State of New Jersey* will be posted at the Court's website: http://www.judiciarv.state.nj.uslmass-tortlfonns/index.htm.

8. Nothing in these interrogatories shall be deemed to limit the scope of the inquiry at the depositions and admissibility of evidence at trial. The scope of inquiry at depositions shall remain governed by New Jersey law. The admissibility of information in these interrogatories shall be governed by New Jersey law and no objections are waived by virtue of any response thereto.

9. Nothing in these interrogatories shall limit the scope of the pretrial discovery in any individual case.

V. REMEDY FOR ALLEGED FACT SHEET DEFICIENCIES

10. If a party fails timely to submit a Fact Sheet, or if a Fact Sheet is received in the allotted time but is not substantially complete in all respects, Liaison Counsel shall send a deficiency letter via e-mail to opposing Liaison Counsel and to the individual counsel for the party so involved. The deficiency letter shall include sufficient detail for counsel of record for defendant(s) and/or plaintiff(s) to

meet and confer regarding the alleged deficiency or deficiencies.

11. Not later than fifteen (15) days from the date of transmission of the deficiency letter, the party receiving such letter shall cure the deficiency or deficiencies, or shall advise opposing Liaison Counsel of the desire to conduct a meet and confer to attempt to resolve any disputes regarding the alleged deficiency or deficiencies, which shall be conducted as soon as is reasonably practicable.

12. In the event of the failure, in accordance with paragraph 11 above, to either timely cure the alleged deficiency or deficiencies or to request a meet and confer, an application may be made to the Court in the nature of a motion to compel a further response to the Fact Sheet. In the event that a meet and confer is conducted, but fails to reach a successful conclusion, any party may make an application to the Court in the nature of a motion to compel or motion for a protective order.

13. Nothing herein shall derogate from the rights of any party to pursue any remedies and protections available under the New Jersey Court Rules. However, any discovery motions relating to deficient fact sheets will be strongly disfavored unless the moving party can certify that it has exhausted its remedies under the terms of this Order prior to filing its motion.

IT IS SO ORDERED:

Dated: November 15, 2010

Honorable Carol E. Higbee, P.J. Cv.

EXHIBIT A

IN RE: REGLAN LITIGATION	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: ATLANTIC COUNTY CASE NO. 289 MASTER DOCKET: ATL-L-3865-10 CIVIL ACTION **PLAINTIFF FACT SHEET**

PLAINTIFF FACT SHEET

PLAINTIFF'S NAME: _____

Plaintiff's Attorney (include email address):_____

_____

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

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

I. CASE INFORMATION

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

Case caption and number: _____

Court in which action is pending: _____

Your name: _____

Social Security Number: _____

Current street address: _____

City: _____ State: _____ Zip: _____

How long have you lived at this address? _____

Have you ever lived in the State of New Jersey? Yes: ____ No: ____

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

The name of the person you are representing: _____

If you were appointed by a court, state the:

State, Court Term, and Case Number: _____

Date of Appointment: _____

Your relationship to the represented person: _____

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

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

II. CLAIM INFORMATION

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

1. Prescribing Physician(s):

Name: _____

Specialty: _____

Address: _____

_____

Phone: _____

Conditions treated by this Physician: _____

Name: _____

Specialty: _____

Address: _____

_____

Phone: _____

Conditions treated by this Physician: _____

Name: _____

Specialty: _____

Address: _____

_____

Phone: _____

Conditions treated by this Physician: _____

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

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

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

C. Did you ever ingest Reglan®/metoclopramide in the State of New Jersey? Yes: ____ No: ____ Cannot Recall/Unknown: _____

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

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

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

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

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

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

4. Date(s) of diagnosis of the injury: _____

5. Physician by whom first diagnosed: _____

   a. Address: _____

6. Treating Physician: _____

   a. Address: _____

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

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

   a. Current symptoms: _____

   b. Treating physician(s): _____

c. Address (if not otherwise provided): _____

_____

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

If no, state how and when the injury subsided: _____

_____

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

Yes: ____ No: ____ Cannot Recall/Unknown: _____

If yes, please identify:

Name of physician: _____

Address: _____

Specialty: _____

Date of discussion: _____

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

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

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

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

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

5. _____ I don't recall what I was told.

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

_____

_____

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

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

Yes: ____ No: ____ Cannot Recall/Unknown: _____

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

$ _____

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

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

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

1. Name: _____

Address: _____

City: _____ State: _____ Zip:_____ Phone: _____

Relationship: _____

Information they possess: _____

_____

2. Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Relationship: _____

Information they possess: _____

_____

3. Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Relationship: _____

Information they possess: _____

_____

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

III. PERSONAL INFORMATION OF REGLAN® AND/OR METOCLOPRAMIDE USER

A. Background Information:

1. Name: _____

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

_____

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

ADDRESS	DATES OF RESIDENCE

4. Date of Birth: _____

5. Place of Birth: _____

6. Sex: Male ____ Female ____

7. Have you ever had a driver's license? Yes: ____ No: ____

8. Has your driver's license ever been revoked or limited because of your health or physical condition? Yes: ____ No: ____

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

9. Have you ever served in any branch of the military? Yes: ____ No: ____

   a. Branch and dates of service: _____

   b. Were you discharged for any reason relating to your health or physical condition? Yes: ____ No: ____

   If yes, state what that condition was: _____

10. Have you ever been rejected from military service for any reason relating to your health or physical condition? Yes: ____ No: ____

11. Have you ever filed a worker's compensation claim? Yes: ____ No: ____

    If yes, please state:

    a. Year claim was filed: _____

    b. Where claim was filed: _____

    c. Claim/docket number, if applicable: _____

    d. Nature of claimed injury: _____

    e. Period of disability: _____

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

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

If yes, please state:

a. Year claim was filed: _____

b. Where claim was filed: _____

c. Nature of disability: _____

d. Period of disability: _____

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

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

If yes, please state:

a. Year claim was filed: _____

b. Where claim was filed: _____

c. Nature of disability: _____

d. Period of disability: _____

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

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

Yes: ____ No: ____ Cannot Recall/Unknown: _____

If yes, please state:

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

_____

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

Yes: ____ No: ____

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

_____

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

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

_____

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

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

_____

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

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

_____

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

Yes: ____ No: ____

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

_____

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

If yes, then answer the following:

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

Yes: ____ No: ____ Cannot Recall/Unknown: _____

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

Yes: ____ No: ____ Cannot Recall/Unknown: _____

If yes, identify the account or accounts you used to make such communications. _____

_____

_____

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

Yes: ____ No: ____ Cannot Recall/Unknown: _____

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

_____

_____

B. Family Information:

1. Have you ever been married? Yes: ____ No: ____

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

   a. Spouse's name: _____

   b. Dates of marriage(s): _____

   c. Date of end of marriage: _____

   d. Reason for end of marriage: _____

   e. Spouse's date of birth: _____

   f. Spouse's occupation: _____

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

4. Please provide the following information for your parents and siblings:

Name	Relationship

5. Please indicate whether, to the best of your knowledge, your ***parents and siblings*** have experienced, been diagnosed with, or treated for any of the following conditions:

Tardive Dyskinesia	Yes: ____	No: ____	Unknown ____
Dystonia	Yes: ____	No: ____	Unknown ____
Chorea	Yes: ____	No: ____	Unknown ____
Myoclonus	Yes: ____	No: ____	Unknown ____
Akathisia	Yes: ____	No: ____	Unknown ____
Tremors	Yes: ____	No: ____	Unknown ____
Movement Disorders	Yes: ____	No: ____	Unknown ____
Tourette's Syndrome	Yes: ____	No: ____	Unknown ____
Neuroleptic Malignant Syndrome	Yes: ____	No: ____	Unknown ____
Parkinson's Disease	Yes: ____	No: ____	Unknown ____
Huntington's Disease	Yes: ____	No: ____	Unknown ____
Schizophrenia	Yes: ____	No: ____	Unknown ____
Psychosis	Yes: ____	No: ____	Unknown ____
Bipolar Disorder	Yes: ____	No: ____	Unknown ____
Restless Leg Syndrome	Yes: ____	No: ____	Unknown ____
Wilson's Disease	Yes: ____	No: ____	Unknown ____
Stiff Persons Syndrome	Yes: ____	No: ____	Unknown ____
Acute Dystonic Reaction	Yes: ____	No: ____	Unknown ____
Blepharospasm	Yes: ____	No: ____	Unknown ____
Acid Reflux	Yes: ____	No: ____	Unknown ____
GERD (gastroesophageal reflux disease)	Yes: ____	No: ____	Unknown ____
Barrett's Esophagus	Yes: ____	No: ____	Unknown ____

Gastroparesis/diabetic gastroparesis	Yes: ____	No: ____	Unknown ____
Esophageal Cancer	Yes: ____	No: ____	Unknown ____
Dementia	Yes: ____	No: ____	Unknown ____
Alzheimer's	Yes: ____	No: ____	Unknown ____
Tic	Yes: ____	No: ____	Unknown ____
Heartburn	Yes: ____	No: ____	Unknown ____
Any type of unusual or uncontrolled movements	Yes: ____	No: ____	Unknown ____
Any type of upper gastrointestinal problem	Yes: ____	No: ____	Unknown ____
Seizures	Yes: ____	No: ____	Unknown ____

C. Educational History:

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

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

D. Employment History:

1. Occupation: _____

2. Current or last employer: _____

3. Employer's Address: _____

_____

4. Dates of Employment: _____

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

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

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

If yes, please state the dates, employer, and health condition. _____

_____

E. Lost Earnings:

1. Do you claim or expect to claim that you will lose future earnings as a result of any condition that you believe was caused by Reglan® and/or metoclopramide? Yes: ____ No: ____

2. Do you claim or expect to claim that you lost earnings or suffered impairment of earning capacity as a result of any condition that you believe was caused by Reglan® and/or metoclopramide? Yes: ____ No: ____

If no, please proceed to Section IV.

3. Give your best estimate of time or wage you have lost from work as a result of any condition you claim was caused by Reglan® and/or metoclopramide and the amount of income which you lost: _____

_____

_____

IV. LIST OF HEALTHCARE PROVIDERS

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

Name: _____

Dates of Service: _____

Specialty (if known): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Reason for Treatment: _____

_____

Name: _____

Dates of Service: _____

Specialty (if known): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Reason for Treatment: _____

Name: _____

Dates of Service: _____

Specialty (if known): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Reason for Treatment: _____

_____

Name: _____

Dates of Service: _____

Specialty (if known): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Reason for Treatment: _____

_____

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

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

Name: _____

Dates of Service: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Name: _____

Dates of Service: _____

Specialty (if known): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Name: _____

Dates of Service: _____

Specialty (if known): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

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

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

1. Name: _____ Approximate dates: _____

Reason for treatment: _____

Street address: _____

City: _____ State: _____ Zip: _____

2. Name: _____ Approximate dates: _____

Reason for treatment: _____

Street address: _____

City: _____ State: _____ Zip: _____

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

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

1. Name: _____

Street address: _____

City: _____ State: _____ Zip: _____

2. Name: _____

Street address: _____

City: _____ State: _____ Zip: _____

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

V. MEDICAL BACKGROUND

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

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

_____

_____

_____

_____

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

C. Current height and weight: _____

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

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

1. Health conditions, including but not limited to:

Tardive Dyskinesia	Yes: ____	No: ____	Unknown ____
Dystonia	Yes: ____	No: ____	Unknown ____
Chorea	Yes: ____	No: ____	Unknown ____
Myoclonus	Yes: ____	No: ____	Unknown ____
Akathisia	Yes: ____	No: ____	Unknown ____
Tremors	Yes: ____	No: ____	Unknown ____
Movement Disorders	Yes: ____	No: ____	Unknown ____
Tourette's Syndrome	Yes: ____	No: ____	Unknown ____
Neuroleptic Malignant Syndrome	Yes: ____	No: ____	Unknown ____
Stroke	Yes: ____	No: ____	Unknown ____
Parkinson's Disease	Yes: ____	No: ____	Unknown ____
Huntington's Disease	Yes: ____	No: ____	Unknown ____

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

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

Specific condition/disorder: _____

Symptoms: _____

Date(s) of onset: _____

Date(s) of diagnosis: _____

Diagnosis Physician: _____

Address (if not otherwise provided): _____

Treating Physician: _____

Address (if not otherwise provided): _____

Medication and/or Treatment: _____

Current Status of Condition: _____

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

F. Drinking History:

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

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

_____ Daily

_____ Weekly

_____ Monthly

_____ Other (explain: _____)

G. Smoking History:

1. Have you ever smoked cigarettes? Yes: ____ No: ____

If yes, state the amount smoked: _____ packs per day for _____ years during the years _____.

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

If yes, state the product smoked: _____ and amount smoked: _____ for _____ years during the years _____.

H. Drug Use History:

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

Stimulants Yes: ____ No: ____ Unknown ____

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

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

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

The product(s): _____

Dates of ingestion(s): _____

Dosage of each ingestion: _____

Prescriber: _____

Pharmacy: _____

The product(s): _____

Dates of ingestion(s): _____

Dosage of each ingestion: _____

Prescriber: _____

Pharmacy: _____

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

VI. DOCUMENTS

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

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

1. If you have been the claimant or subject of any personal injury lawsuit, worker's compensation, Social Security or other disability proceeding in the 5 years prior to ingestion of Reglan® and/or metoclopramide to present, all documents relating to such proceeding.

2. Copies of all medical records, bills, and any other documents from physicians, healthcare providers, hospitals, pharmacies, or others who have provided treatment to you in the 5 years prior to ingestion of Reglan® and/or metoclopramide to present, or that you otherwise identified in this Fact Sheet.

3. If you have ever had any radiological studies of the head, neck, or spine done in the 5 years prior to ingestion of Reglan® and/or metoclopramide to present, and you are in possession of such studies. If you are not in possession of such radiological studies, provide where these studies were done.

4. All insurance records, bills, letters, or other documents constituting, concerning, or relating to product use instructions, product warnings, package inserts, pharmacy handouts, or other materials distributed with or provided to you in connection with your use of Reglan® and/or metoclopramide.

5. Copies of advertisements, brochures, pamphlets, web pages, or other promotional material for Reglan® and/or metoclopramide.

6. Copies of the entire packaging, including the pills, bottle, box, and label for the Reglan® and/or metoclopramide you allege caused you injury and any remaining medication. (Plaintiff must maintain the originals of the items requested in this subpart.)

7. All statements obtained from or given by any person having knowledge of facts relevant to the subject of this litigation.

8. All documents relating to your purchase of Reglan® and/or metoclopramide, including, but not limited to, receipts, prescriptions, or records of purchase.

9. Any documents on which you relied in deciding to take Reglan® and/or metoclopramide.

10. All documents in your possession which you believe were provided to you (not to your lawyer) by defendant.

11. Representative photographs, drawings, slides or videos depicting the injuries you alleged Reglan® and/or metoclopramide caused.

12. All entries in journals, diaries, notes, letters, emails, or other documents written by you or received by you relating to your injuries, your use of Reglan® and/or metoclopramide, or the injuries you alleged Reglan® and/or metoclopramide caused (excluding privileged materials).

13. All documents relating to any communication by you to or from the Food & Drug Administration ("FDA"), including but not limited to on-line, telephoned, mailed, or faxed communications to the FDA's MedWatch program, regarding Reglan® and/or metoclopramide, including the dates of such communications.

14. If you claim you have suffered a loss of earnings or earning capacity, your federal W-2s for each of the last five (5) years.

15. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other healthcare provider.

16. Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable).

17. Decedent's death certificate and autopsy report (if applicable

VERIFICATION

I, _____, declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief and that I have supplied all the documents requested in Part VI of this Plaintiff Fact Sheet, to the extent that such documents are in my possession, and that I have signed and supplied the authorizations attached to this Verification.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respects incomplete or incorrect.

_____ _____

Signature Date

Sworn and subscribed before me
This _____ day of _____

_____

Notary Public

EXHIBIT B

	:	
	:	
	:	**SUPERIOR COURT OF NEW JERSEY** **LAW DIVISION: ATLANTIC COUNTY**
IN RE	:	**CASE NO. 289**
REGLAN LITIGATION	:	**CIVIL ACTION**
	:	**DEFENDANT FACT SHEET**
	:	
	:	

DEFENDANT'S FACT SHEET

For each case, the Defendants (Both Brand Name and Generic Name) must complete this Defendant's Fact Sheet ("DFS") and identify or provide documents and/or provide documents and/or data relating to each Plaintiff responsive of the question set forth below to the best of Defendants' knowledge. In completing this DFS, you are under oath and must provide information that is true and correct to the best of your knowledge. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect. You must also supplement your responses in the event that additional information is provided from the Plaintiff. The DFS shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order.

In the event that DFS does not provide enough space for complete responses or answers, please attach additional sheets if necessary. Please identify any documents that you are producing responsive to a question or as required with Bates-Stamp identifiers.

This DFS must be completed and served on all counsel representing a Plaintiff in the action identified in Section I below. Complete fact sheets must be answered and served 60 days after the date that the Plaintiff's Fact Sheet (PFS) is served on Defendants.

To the extent that a response to the DFS is contained in previously produced documents, the responding Defendant may answer by referencing the previously produced document(s). Such reference must contain sufficient information and/or instructions, including Bates numbers, to allow Plaintiff to access the answer requested with minimal effort.

Each document request and interrogatory not only calls for knowledge but also for all knowledge that is available to you by reasonable inquiry, including inquiry of your officers, directors AND employees.

As used herein, the terms, "you," "your", or "yours" means the responding Defendants unless

defined to include a third party.

As used herein, "provided" means sold, distributed, shipped, delivered or otherwise placed into the stream of commerce.

As used herein, the phrase "Dispensing/Prescribing/Treating Healthcare Provider" means each of Plaintiff's physicians, medical providers, practices, clinics, persons or entities who treated Plaintiff and/or prescribed or dispensed Reglan®/Metoclopramide to Plaintiff.

As used herein, the phrase "Promotional Items" means any and all promotion items, marketing devices, freebies, merchandise, handouts, meals, or any other items related to Reglan®/Metoclopramide, including, but not limited to, physical items marked with the Reglan®/Metoclopramide trademark, such as: anatomical models, notepads, post-it-notes, pens, flashlights, other day-to-day office supplies of any type, models for patient demonstration, diagnostic tools and aids, medical assessment and dosage calculators, pharmacy and pharmacist tools, patient compliance tools, custom medical calculators and software, branded apparel (such as, but not limited to, shirts, hats, etc.), leather portfolios, prescription pads, picture frames, letter openers, clipboards, water bottles, coffee mugs/cups, pocket/pen lights, key chains, badge-holders, bags, travel accessories, and other "freebies" provided to Dispensing/Prescribing Healthcare Providers. (This list is not meant to be exhaustive.)

As used herein regarding Dispensing/Prescribing/Treating Healthcare Provider, the phrases "significant contact" and "significant relationships" mean the following instances and/or occurrences:

(1) the provider has received anything over $100.00 in value from Defendant or anyone on Defendants behalf;
(2) the provider participated in any study or clinical trial as a principal investigator or supervising doctor at any study site which was sponsored by Defendant or on Defendant's behalf;
(3) the provider authored, co-authored or contributed to any publication sponsored by the Defendant or on the Defendants' behalf;
(4) the provider had expenses reimbursed by Defendant or on Defendant's behalf;
(5) the provider has spoken on behalf of Defendant or its products;
(6) the provider has served in any capacity on any advisory board, etc. at Defendant's invitation;
(7) the provider has functioned in any capacity promoting Defendant's products; or
(8) the provider has ever been employed by or under contract to Defendant.

With regard to marketing/retailing information, answering Defendants may provide Plaintiff with a mutually agreeable affidavit stating Defendant did not do these things (i.e. market, retail, etc.).

I. Case Information

This DFS pertains to the following case:

Case Caption: _____

Civil Action No: _____

Date DFS completed: _____

Please provide the following information on the person or persons who provide information responsive to the questions posed in this DFS.

A. _____
Name

_____
Current Position (If no longer employed, last position with Defendant)

_____
City of Employment (If no longer employed, city of residence)

B. _____
Name

_____
Current Position (If no longer employed, last position with Defendant)

_____
City of Employment (If no longer employed, city of residence)

C. _____
Name

_____
Current Position (If no longer employed, last position with Defendant)

_____
City of Employment (If no longer employed, city of residence)

D. _____

Name

_____

Current Position (If no longer employed, last position with Defendant)

_____

City of Employment (If no longer employed, city of residence)

E. _____

Name

_____

Current Position (If no longer employed, last position with Defendant)

_____

City of Employment (If no longer employed, city of residence)

F. _____

Name

_____

Current Position (If no longer employed, last position with Defendant)

_____

City of Employment (If no longer employed, city of residence)

II. Contacts with Dispensing/Dispensing/Prescribing Healthcare Provider

In Plaintiff's Fact Sheet, they identify persons or entities that prescribed or dispensed Reglan®/Metoclopramide to the Plaintiff. For each Dispensing/Prescribing Healthcare Provider identified, please state the following:

A. Dear Doctor Letters

For any "Dear Doctor" or "Dear Healthcare Provider" or "Dear Pharmacist" letter that you contend was actually sent to the Plaintiff's Dispensing/Prescribing Healthcare providers concerning Reglan®/Metoclopramide, please provide:

1. The letter (or its exact contents);

2. Date(s) sent; and

3. Any document, database, or list which tends to show recipient was sent and/or received the letter.

B. **Other Contacts**

In Plaintiff's Fact Sheet, Plaintiff(s) identified Plaintiff's Dispensing/Prescribing/ Treating Healthcare Provider(s). Please identify all significant contacts and/or relationships between the Dispensing/Prescribing/Treating Healthcare Provider and Defendants or Defendant's agents or representatives by providing the following information for each such contact:

1. Name of Dispensing/Prescribing/Treating Healthcare Provider contacted.

2. Date(s) of contact or relationship;

3. Reason for or nature of contact or relationship (i.e. sales call, response to adverse event report, etc.);

4. Name and position of person (at the time) who was the primary contact person Defendant's behalf or the person primarily responsible on Defendant's behalf, for the relationship or contact; and

5. Provide any notes, documents or other materials reflecting such contact or relationship including but not limited to electronic data but excluding raw clinical data for non-Reglan/metoclopramide products.

C. **Promotional and Sales Materials**

Please identify any and all prmotional and sales materials provided to the Dispensing/Prescribing Healthcare Provider(s) by providing the following information:

1. Name of Dispensing/Prescribing/Treating Healthcare Provider;

2. A description of each prmotional/sales material provided;

3. Identity of person/department approving the providing of such material; and

4. The dates that each type of promotional/sales material was provided.

D. **Promotional/Educational Events**

Provide the following for every promotional or educational event Plaintiffs'

Dispensing/Prescribing Healthcare Providers ever attended, including, but not limited to, lunches, dinner meetings, grand rounds, golf tournaments, movies, CMEs which you sponsored, promoted, or contributed to the sponsorship or promotion.

1. Dispensing/Prescribing Healthcare Provider;

2. Promotional/educational event (describe);

3. Date of event;

4. Location of event; and

5. All documents reflecting Defendants' involvement in the event.

E. Identify the person or persons who provided information responsive to this section or any subparts.

III. Plaintiff's Dispensing/Prescribing Healthcare Provider's Dispensing/Prescribing/ Reporting Practices

In Plaintiff's Fact Sheet, Plaintiff identifies their Dispensing/Prescribing Healthcare Providers. For each listed provider, please state and produce the following:

A. Do you have or have you had access to any database or information which purports to track any of Plaintiff's Dispensing/Prescribing/Treating Healthcare Provider's Dispensing/Prescribing practices with respect to Reglan®/Metoclopramide?

B. Did the Dispensing/Prescribing/Treating Healthcare Provider(s) ever report any Adverse Events to Defendants as they pertain to Reglan®/Metoclopramide?

_____Yes _____No

C. If the answer to "B" is yes, please provide all information and materials pertaining to said report and the response.

D. Identify the person(s) who provided information responsive to this Section or any of its subparts.

IV. Plaintiff's Medical Condition

A. Have you initiated contact with any of Plaintiff's physicians concerning any injury or condition of the Plaintiff?

_____Yes _____No

B. Have you been contacted by Plaintiff, any of their physicians, or anyone on behalf of Plaintiff concerning Plaintiff?

_____Yes _____No

C. Provide the details of any "yes" answer, including dates and individuals involved in contact. Identify and provide documents.

D. Is there a Med Watch form that refers or relates to Plaintiff?

_____Yes _____No

E. Identify the person or persons who provided information responsive to this Section or any of its subparts.

V. Advertising

A. Did you advertise Reglan®/Metoclopramide in the Media Market that Plaintiff lived at the time that (s)he used Reglan®/Metoclopramide?

_____Yes _____No

B. If your answer to the preceding question is "yes," please identify the identity of the media outlet and the dates that the advertisements ran.

1. Identity of the advertisement and intended media marketplace;

2. Nature of media (print or television);

3. Identify of the media outlet; and

4. Dates that adverisements ran.

C. Did you advertise Reglan®/Metoclopramide in the Media Market that any of Plaintiff's Dispensing/Prescribing/Treating Healthcare Providers' offices were located at the time that Plaintiff used Reglan®/Metoclopramide?

_____Yes _____No

D. If you answer to the preceding question is "yes," please identify the identity of the

media outlet and the dates that the advertisements ran.

1. Identity of the advertisement and intended media marketplace;

2. Nature of media (print or television);

3. Identity of the media outlet; and

4. Dates that advertisements ran.

E. Identify the person or persons who provided information responsive to this Section or any of its subparts.

VI. Third Parties

A. Name each and every prescribing physician, treating physician and/or dispensing individual or entity that you believe is a necessary and proper party to this litigation and state the factual basis for such belief.

B. Name each and every prescribing physician, treating physician and/or dispensing individual or entity that you believe caused or contributed to the injuries or damages of Plaintiff and state the factual basis for such belief.

C. Name and address of any individual or entity that Defendant has indemnified or offered to indemnify or proposed to indemnify in this case or in any case involving Reglan and/or metoclopramide;

D. Name of any individual or entity that Defendant has offered to pay for or provide legal defense in whole or in part in this case or in any case involving Reglan and/or metoclopramide; and

E. Identify the person or persons who provided information responsive to this Section or any of its subparts.

VII. Patient Assistance

A. Was Plaintiff enrolled in any of Reglan®/Metoclopramide patient assistance or reimbursement programs?

B. Did you advertise Reglan®/Metoclopramide on the internet (Defendant hosted websites and non-Defendant hosted websites) during the time frame Plaintiff took Reglan®/Metoclopramide?

C. If yes to any of the above, please provide details and any documents related to

Plaintiff's enrollment or participation.

D. Identify the person or persons who provided information responsive to this Section or any of its subparts.

VIII. Supplemental Document Production

Defendants shall provide the following:

1. Call notes for all of the Plaintiffs' providers who were called upon by any Brand and/or Generic Named Defendants or Brand and/or Generic Named Defendants-contracted employee regarding Reglan®/Metoclopramide.

2. Detail, sample and voucher history of Reglan®/Metoclopramide for the Plaintiff's healthcare providers.

3. All documents in Brand and/or Generic Named Defendant's custody or conrol that recorded, tracked and/or anlyzed the Plaintiff's healthcare provider's prescriptions of Reglan®/Metoclopramide.

4. Information concerning any payments by Brand and/or Generic Named Defendants to the Plaintiff's healthcare providers for speaking engagements or research relating to Reglan®/Metoclopramide.

5. Information from the Brand and/or Generic Named Defendants response center reflecting requests by the Plaintiff's prescriber for information about Reglan®/Metoclopramide.

6. Any and all documents reviewed, referred to or relied on in answering this Defendant Fact Sheet.

7. Any document sent to or received from any of Plaintiff's Dispensing/ Prescribing/Treating Healthcare Providers.

8. Any document reflecting any actual communication between you and Plaintiff's Dispensing/Prescribing/Treating Healthcare Providers concerning risks of injury from Reglan and/or metoclopramide.

9. Any documents reflecting any contracts, payments or actual communications between you and any of Plaintiff's Dispensing or Prescribing Healthcare Providers regarding Reglan®/Metoclopramide.

10. Any and all Adverse Event Reports, related to Reglan and/or metoclopramide, for Plaintiff and all back-up and follow-up data and analysis(es), including, but not limited to, any and all correspondence to or from the FDA regarding Plaintiff or any of Plaintiff's Dispensing/Prescribing/Treating Healthcare Providers.

11. Any document that purports to describe Plaintiff's Dispensing/Prescribing/ Treating physicians' practices.

12. All MedWatch forms which relate to Plaintiff for Plaintiff's Dispensing/ Prescribing/Treating physicians.

13. All IMS data for Plaintiff's dispensing pharmacies regarding Reglan®/Metoclopramide.

IX. Alternate Causation

1. Based upon the responses contained in Plaintiff's Fact Sheet, do you claim that the injury set forth by the plaintiff was caused by something other than Reglan®/Metoclopramide?

_____Yes _____No

2. If your answer to the preceding question is "yes," please identify the specific basis for such claim, including, without limitation, any pharmaceutical product(s), over the counter product(s), physical condition or any and all other matter(s) which form the basis for such claim.

EXHIBIT C

IN RE: REGLAN LITIGATION	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: ATLANTIC COUNTY CASE NO. 289 MASTER DOCKET: ATL-L-3865-10 CIVIL ACTION **INTERROGATORIES TO DEFENDANTS REGARDING CONTACTS WITH THE STATE OF NEW JERSEY**

The following Interrogatories regarding contacts with the State Of New Jersey are herewith propounded to Defendants pursuant to Case Management Order No. 5:

1. Were you, any of your predecessor(s), your corporate subsidiary(ies), your former corporate subsidiary(ies), your parent company owning a controlling interest in you or former parent company owning a controlling interest in you a New Jersey business entity (by example, a Corporation, Limited Liability Company, Limited Liability Partnership, etc.) during the time periods plaintiff indicated in their Fact Sheet that they ingested Reglan and/or metoclopramide?

_____Yes _____No

(i) If yes, please provide the dates and specific name(s) of the business entity(ies).

2. Did you, any of your predecessor(s), your corporate subsidiary(ies), your former corporate subsidiary(ies), your parent company owning a controlling interest in you or former parent company owning a controlling interest in you ever maintain a principal place of business in the State of New Jersey during the time periods plaintiff

indicated in their Fact Sheet that they ingested Reglan and/or metoclopramide?

_____Yes _____No

(i) If yes, please provide the dates and specific name(s) of the business entity(ies) which maintained such a principal place of business in the State of New Jersey.

3. Did you, any of your predecessor(s), your corporate subsidiary(ies), your former corporate subsidiary(ies), your parent company owning a controlling interest in you or former parent company owning a controlling interest in you ever maintain executive offices in the State of New Jersey during the time periods plaintiff indicated in their Fact Sheet that they ingested Reglan and/or metoclopramide?.

_____Yes _____No

(i) If yes, please provide the dates and specific name(s) of the business entity(ies) which maintained such executive offices.

4. Did you, any of your predecessor(s), your corporate subsidiary(ies), your former corporate subsidiary(ies), your parent company owning a controlling interest in you or former parent company owning a controlling interest in you ever conduct marketing and/or sales activities pertaining to Reglan and/or metoclopramide, including, but not limited to, maintaining an office where marketing and/or sales activities were conducted, in the State of New Jersey during the time periods plaintiff indicated in their Fact Sheet that they ingested Reglan and/or metoclopramide where the ?

_____Yes _____No

(i) If yes, please provide the dates, types of marketing and/r sales activities, specific name(s) of the business entity(ies) conducting such activities and the locations of any marketing and/or sales activities.

5. Did you, any of your predecessor(s), your corporate subsidiary(ies), your former corporate subsidiary(ies), your parent company owning a controlling

interest in you or former parent company owning a controlling interest in you ever operate, maintain and/or own a manufacturing facility in the State of New Jersey during the time periods plaintiff indicated in their Fact Sheet that they ingested Reglan and/or metoclopramide?

_____Yes _____No

(i) If yes, please provide the dates, specific name(s) of the business entity(ies) which operated, maintained and/or owned such a manufacturing facility and the location of such manufacturing facility.

CERTIFICATION

I hereby certify under the penalties of perjury that the foregoing answers to interrogatories are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____
Date

_____
TITLE:
BY: