UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

IN RE: TAXOTERE (DOCETAXEL) EYE INJURY PRODUCTS LIABILITY LITIGATION	**)** **)** **)** **)**	**MDL NO. 3023** **SECTION "H" (5)**

PRETRIAL ORDER NO. 4

The parties have submitted an agreed upon Plaintiff Fact Sheet ("PFS") and accompanying authorizations, as well as an agreed upon Defendant Fact Sheet ("DFS").

IT IS ORDERED that the documents attached to this Order as Exhibit A will be the operable Plaintiff Fact Sheet and authorizations in this matter; and

IT IS FURTHER ORDERED that the document attached to this Order as Exhibit B will be the operable Defendant Fact Sheet in this matter.

New Orleans, Louisiana this 1st day of May, 2023.

HONORABLE JANE TRICHE MILAZZO
UNITED STATES DISTRICT JUDGE

EXHIBIT A

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

IN RE: TAXOTERE (DOCETAXEL)	**)**	**MDL NO. 3023**
EYE INJURY PRODUCTS	**)**	
LIABILITY LITIGATION	**)**	**SECTION "H" (5)**
	)	

PLAINTIFF FACT SHEET

This Fact Sheet must be completed by each plaintiff who has filed a lawsuit related to the use of Taxotere® (docetaxel) by the plaintiff or a plaintiff's decedent. Please answer every question to the best of your knowledge. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect.

In filling out this form, please use the following definitions: (1) "healthcare provider" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric, or psychological care or advice, and any pharmacy, weight loss center, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care, and/or treatment of the plaintiff or plaintiff's decedent; (2) "document" means any writing or record of every type that is in your possession, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phone-records, non-identical copies, and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

Information provided by plaintiff will only be used for purposes related to this litigation. This Fact Sheet is completed pursuant to the Federal Rules of Civil Procedure governing discovery (or, for state court cases, the governing rules of civil procedure of the state in which the case is pending).

I. GENERAL INFORMATION

A. Attorney and Case Information

Provide the following information for the lawsuit you filed:

1.	Case Caption:	
2.	Court and Docket Number:	
3.	MDL Docket No. (if different):	
4.	Date Lawsuit Filed:	
5.	Plaintiff's Attorney Name:	
6.	Plaintiff's Law Firm Name:	
7.	Attorney's Address (Street, City, and State):	
8.	Attorney's Phone:	
9.	Attorney's Email:	

B. Plaintiff Information

Provide the following information for the individual on whose behalf this action was filed (i.e., the injured person):

1.	Full Name:			
		First	Middle	Last
2.	Current Address:			
3.	City:			
4.	State:			
5.	Zip:			
6.	Prior address(es) in the five (5) years before filing this lawsuit:			
7.	Date of Birth:			
8.	City and State of Birth:			

9.	Social Security Number:	
10.	Maiden or other name(s) used or by which have been known (including dates of same):	
11.	Sex:	□ Male □ Female

C. Representative Information:

1.	On whose behalf are you completing this questionnaire?	□ On behalf of myself (I am the injured person) □ On behalf of someone else (e.g., in behalf of the estate of a deceased person or an incapacitated person)

If you responded to Question C.1. that you are completing this "On behalf of myself (I am the injured person)," please move to Section II. If you answered you are completing this, "On behalf of someone else" in response to Question C.1., please state the following. Please respond with your information.

2.	Full Name:		
		First	Middle Last
3.	Street Address:		
4.	City, State, Zip:		
5.	Capacity in which you are representing the individual (e.g., executor, surviving spouse, power of attorney):		
6.	Have you been appointed as a representative by a court?		
7.	If you were appointed as a representative by a court, identify the following:		
	State:		
	Court:		
	Case Number:		
8.	Relationship to the Represented Person:		
9.	Date of death of the decedent:		
10.	City and state of death of the decedent:		

II. PERSONAL INFORMATION

If you are completing this questionnaire in a representative capacity, please respond to these questions with respect to the person whose medical treatment involved Taxotere® or docetaxel.

A. Relationship Information

1.	Are you currently:	□ Married □ Single □ Engaged □ Divorced □ Significant Other □ Widowed

2.	Have you been married within two years prior to the cancer diagnosis at issue in this litigation?	□ Yes □ No
	If you answered "yes" to Question A.2., for EACH marriage, within two years prior to the cancer diagnosis at issue in this litigation, state the following:	

Spouse's name	Date of Marriage	Date Marriage Ended	Nature of Termination (i.e. Divorce or Death of Spouse)

3.	Do you have children?	□ Yes □ No
	If you answered "yes" to Question A.3., for EACH child, state the following:	

Child's Name	Child's Address	Child's Age

B. Education

1.	For each level of education you completed, check:	□ High School □ Vocational School College: □ A.A. □ B.A./B.S. □ Masters □ Ph.D. □ M.D. Other:

C. Employment

1.	Are you currently employed:	□ Yes □ No
	If you answered "yes" to Question C.1., please state the following:	
2.	Current Employer Name:	
3.	Street Address:	
4.	City, State, Zip:	
5.	Telephone:	
6.	Your position there:	
7.	Are you making a claim for lost wages or lost earning capacity?	□ Yes □ No
	If you answered "yes" to Question C.7., please state the following for EACH employer for the last five (5) years before you started chemotherapy with Taxotere or docetaxel.	

Name of Employer	**Address (City and State)**	**Dates of Employment**	**Annual Gross Income**	**Your Position**
		To □ Present		
		To □ Present		
		To □ Present		

D. Military

1.	Have you ever served in the military?	□ Yes □ No
	If you answered "yes" to Question D.1., please state the following:	
2.	Division:	
3.	Years served:	

E. Disability Claims

1.	Have you ever filed for social security, and/or state or federal disability benefits?	□ Yes □ No
	If you answered "yes" to Question E.1., please state the following:	
2.	Year Claim Filed:	
3.	Court:	
4.	Nature of Claimed Injury:	

5.	Period of Disability:	
6.	Award Amount:	
7.	Year Claim Filed:	
8.	Court:	
9.	Nature of Claimed Injury:	
10.	Period of Disability:	
11.	Award Amount:	

F. Other Lawsuits

1.	Have you filed a lawsuit, relating to any bodily injury OTHER THAN the present suit?	□ Yes □ No
	If you answered "yes" to Question F.1., please state the following:	
2.	Year Claim Filed:	
3.	Court:	
4.	Nature of Claimed Injury:	
5.	Outcome:	
6.	Year Claim Filed:	
7.	Court:	
8.	Nature of Claimed Injury:	
9.	Outcome:	

10.	Have you filed a claim in the Taxotere (docetaxel) Products Liability Litigation MDL 2740?	□ Yes □ No
	If you answered "yes" to F.10., please identify the case number:	

G. Social Media/Electronic Communication

1.	Has Plaintiff used or maintained any of the following five (5) years prior to Taxotere or docetaxel treatment or any time since treatment: (1) any email accounts; (2) any electronic devices (e.g., desktop or laptop computers, tablets, mobile phones, digital cameras); (3) any other hardware storage devices (e.g., external hard drives, memory cards, USB or thumb drives, CDs/DVDs); (4) any social media (e.g., Facebook, Instagram, TikTok, LinkedIn, Twitter, YouTube, Pinterest, or other online collaboration tools such as Google+ or Yahoo! groups); (5) any website where Plaintiff made online postings (e.g., on a blog, message board, etc.); (6) any cloud storage (e.g., DropBox, Microsoft Office365 Account, Google Drive, iCloud, Amazon Drive, etc.).	□ Yes □ No

If you answered "yes" to Question G.1., Plaintiff shall conduct reasonably diligent searches of the above Electronically Stored Information ("ESI") sources. Reasonably diligent searches may require running search terms; reviewing files, communications, videos, and photographs; or otherwise conducting an actual, physical search of the sources. Plaintiff's counsel shall take an active role in identifying, preserving, collecting, reviewing, and producing all responsive ESI.

Where feasible, Plaintiff or her attorney shall run the following terms through any available search function on the sources identified above. Each term should be run separately: (a) breast cancer; (b) cancer; (c) chemotherapy; (d) chemo; (e) eye; (f) tearing; (g) duct; (h) stenosis; (i) obstruction; (j) lacrimation; (k) conjunctivitis; (l) cataract; (m) vision; (n) taxotere; (o) docetaxel; (p) taxane; (q) sanofi; (r) pharmaceutical; (s) side effect; and (t) warning.

For EACH such piece of electronically stored information, please produce it with your responses to Section IX, DOCUMENT REQUESTS AND AUTHORIZATIONS.

III. PRODUCT IDENTIFICATION

YOU MUST UPLOAD RECORDS DEMONSTRATING USE OF TAXOTERE® OR DOCETAXEL CONCURRENT WITH SUBMISSION OF THIS FACT SHEET.

1.	I have records demonstrating use of Taxotere® or docetaxel:	□ Yes □ No
2.	Please select the name of the drug with which you were treated. Please select all that apply:	

Name of Drug	Yes
Taxotere – Sanofi-Aventis U.S. LLC	□
Docetaxel – Accord Healthcare, Inc.	□
Docetaxel – Actavis LLC f/k/a Actavis Inc. / Actavis Pharma, Inc.	□
Docetaxel – Eagle Pharmaceuticals, Inc.	□
Docetaxel – Hospira Worldwide, LLC f/k/a Hospira Worldwide, Inc. / Hospira, Inc.	□
Docetaxel – Pfizer Inc.	□
Docetaxel – Sagent Pharmaceuticals, Inc.	□
Docetaxel – Sandoz Inc.	□
Docetaxel – Sanofi-Aventis U.S. LLC d/b/a Winthrop US	□
Docefrez – Sun Pharma Global FZE	□
Docefrez – Sun Pharmaceutical Industries, Inc. f/k/a Caraco Pharmaceutical Laboratories, Ltd.	□
Docetaxel – Teikoku Pharma USA, Inc.	□
Unknown	□
Other (Please Describe):	□

IF YOU SELECTED "UNKNOWN" YOU MUST CERTIFY AS FOLLOWS:
I certify that I have made reasonable, good faith efforts to identify the manufacturer of the Taxotere® or docetaxel used in my treatment, including requesting records from my infusion facility, and the manufacturer/labeler either remains unknown at this time or I am awaiting the records: ☐

IV. CANCER DIAGNOSIS AND TREATMENT WITH TAXOTERE® OR DOCETAXEL

1.	When were you first diagnosed with the cancer for which you were prescribed Taxotere® or docetaxel?	
2.	What was the diagnosis for which you were prescribed Taxotere® or docetaxel?	

Diagnosis	**Diagnosed**
Breast Cancer	☐
Non-small cell lung cancer	☐
Prostate cancer	☐
Gastric adenocarcinoma	☐
Head and neck cancer	☐
Other (describe):_____	☐
Tumor Size	**Yes**
TX	☐
TO	☐
Tis	☐
T1	☐
T2	☐
T3	☐
T4 (T4a, T4b, T4c, T4d)	☐
Unknown	☐
Metastasis	**Yes**
Metastasis	☐
Node	**Yes**
Node + NX	☐
Node + NO	☐
Node + N1	☐
Node + N2	☐
Node + N3	☐
Node — (negative)	☐
Other (specify): _____	
Unknown	☐
IF BREAST CANCER, please specify:	
HER2 Status	**Yes**
HER2 + (positive)	☐
HER2 - (negative)	☐
HER2 Status Unknown	☐
Estrogen Status	**Yes**
Estrogen Positive ER+ (positive)	☐
Estrogen Negative ER- (negative)	☐
Estrogen Status Unknown	☐

Progesterone Status	Yes
Progesterone Positive PR+ (positive)	☐
Progesterone Negative PR- (negative)	☐
Progesterone Status Unknown	☐

3.	Please provide the following information regarding your use of Taxotere® or docetaxel:	
	Number of Cycles:	
	Frequency:	□ Weekly □ Every 3 weeks □ Other:_____
	First treatment date:	
	Last treatment date:	
	Dosage (for each cycle):	
	Combined with another chemotherapy drug(s):	□ Yes □ No
	Sequential with another chemotherapy drug(s):	□ Yes □ No
	If used in combination or sequentially with other chemotherapy, specify other chemotherapy drug(s) and prescriber(s):	
	Was your Taxotere® or docetaxel treatment part of a clinical trial?	□ Yes □ No
	If yes, please provide the name and location of the trial site:	

4.	Please identify the Physician(s) who prescribed you Taxotere® or docetaxel:	
Prescribing Physician Name (First, Last)	**Address (Street Address)**	**Address (City and State)**

5.	Please identify the Treatment Facility(ies) where you were treated with Taxotere® or docetaxel	
Treatment Facility Name	**Address (Street Address)**	**Address (City and State)**

6.	Identify EACH state where you resided when you were prescribed Taxotere® or docetaxel:		
State		**From Date**	**To Date**
7.	If the state in which you took Taxotere or docetaxel is different from the state where you resided when you were prescribed Taxotere or docetaxel, please identify EACH state where you resided while you were taking Taxotere® or docetaxel at any time:		
State		**From Date**	**To Date**

8.	Are you currently taking Taxotere® or docetaxel?	□ Yes □ No
9.	**Please specify your current cancer status**:	
Not currently receiving treatment and cancer free		□
In remission		□
Currently receiving chemotherapy		□
Currently receiving radiation		□
Currently hospitalized for cancer or cancer related complications		□
Currently in home health or hospice for cancer or cancer related complications		□
Cancer returned		□
Metastatic disease		□

V. OTHER CANCER DIAGNOSES AND TREATMENT(S)

1.	Have you ever been diagnosed with cancer other than the one described above?	□ Yes □ No
2.	Have you been diagnosed with cancer more than once?	□ Yes □ No
3.	Did you undergo any of the following for cancer?	
	Surgery	□ Yes □ No
	Radiation	□ Yes □ No
	Chemotherapy	□ Yes □ No
4.	When was the last (most recent) date you consulted with an oncologist:	

5.	Please state the following for EACH cancer diagnosis:	
Type of Cancer:		
Date of Diagnosis:		
Primary Oncologist:		
Treatment Dates:	To	□ Present
Name (First, Last):		
Street Address:		

City, State, Zip:	
Primary Treatment Facility:	
Treatment Dates:	To ☐ Present
Treatment Type(s):	
Facility Name:	
Street Address:	
City, State, Zip:	
Type of Cancer:	
Date of Diagnosis:	
Primary Oncologist:	
Treatment Dates:	To ☐ Present
Name (First, Last):	
Street Address:	
City, State, Zip:	
Primary Treatment Facility:	
Treatment Dates:	To ☐ Present
Treatment Type(s):	
Facility Name:	
Street Address:	
City, State, Zip:	

For EACH cancer diagnosis identified in response to question 5:			
6.	Did you take any chemotherapy drugs?	☐ Yes ☐ No ☐ Unknown	
	If you answered "yes" to Question 6, please specify for EACH chemotherapy drug:		
Drug Name	**Date(s) of Use**	**For what cancer type(s)**	**Prescriber(s) Name and Address**

VI. PRIOR MEDICAL INFORMATION

1.	Do you now or have you ever worn glasses?	☐ Yes ☐ No
	If you answered "yes" to Question 1, from what year to what year have you worn glasses:	to
2.	Do you now or have you ever worn contacts?	☐ Yes ☐ No
	If you answered "yes" to Question 2, from what year to what year have you worn contacts:	to
3.	Excluding your routine vision examination, have you ever seen a healthcare provider for any eye condition other than the injury alleged in this lawsuit?	☐ Yes ☐ No

	If you answered "yes" to Question 3, please fill out below:		
Name of Healthcare Provider and Facility		**Reason for Visit**	**Approximate Date(s)**

4.	Did you experience tearing before your chemotherapy treatment?	□ Yes □ No
	If you answered "yes" to Question 4, please fill out below:	
	Date(s) of tearing:	
5.	Did you receive treatment?	□ Yes □ No
	If you answered "yes" to Question 5, please fill out below:	
	Date of treatment:	
	Type of Treatment:	
	Healthcare Provider Name:	
	Healthcare Facility	
6.	Were you diagnosed with lacrimal obstruction, including but not limited to punctal stenosis and/or canalicular stenosis before your chemotherapy treatment?	□ Yes □ No
	If you answered "yes" to Question 6, please fill out below:	
	Date(s):	
7.	Did you receive treatment?	□ Yes □ No
	If you answered "yes" to Question 7, please fill out below:	
	Date of treatment:	
	Type of Treatment:	
	Healthcare Provider Name:	
	Healthcare Facility	

8.	**Have you ever experienced or been diagnosed with any of the following eye conditions**

Eye Condition	Yes	No	Date Range
Blurred Vision	☐	☐	
Cloudy Vision	☐	☐	
Dacryoadenitis Acquired/ Inflammation of lacrimal gland	☐	☐	
Ocular hyperemia/bloodshot eyes	☐	☐	
Visual impairment	☐	☐	
Keratoconjunctivitis sicca/dry eye	☐	☐	
Vision loss	☐	☐	
Visual disturbances	☐	☐	
Macular edema	☐	☐	
Edema/swelling of the eye	☐	☐	
Eye irritation	☐	☐	
Eye infection	☐	☐	
Light sensitivity	☐	☐	
Eyes feeling gritty	☐	☐	
Painful/sore eyes	☐	☐	
Eyelid swelling	☐	☐	
Blindness/partial blindness	☐	☐	
Cataracts	☐	☐	
Glaucoma	☐	☐	
Eyelid skin cancer	☐	☐	
Canaliculitis	☐	☐	
Altered color vision	☐	☐	
Ectropion/eyelid drooping	☐	☐	
Canalicular laceration	☐	☐	
Chemical or thermal burn on eye	☐	☐	
Eyelid malposition (trichiasis)	☐	☐	
Conjunctivitis	☐	☐	

9.	**Have you ever received any of the following treatments for an eye condition before your first use of Taxotere® or docetaxel:**

Treatment	Yes	No	Date Range
Steroid drops	☐	☐	
Lasik	☐	☐	
Stents/intubation	☐	☐	
Prescribed eyedrops	☐	☐	

9.	**Have you ever received any of the following treatments for an eye condition before your first use of Taxotere® or docetaxel:**

Treatment	Yes	No	Date Range
Prescribed artificial tears	☐	☐	
Probing and irrigation	☐	☐	
LipiFlow	☐	☐	
Punctal plugs	☐	☐	
Punctal cauterization	☐	☐	
Eye surgery	☐	☐	
Eyelid surgery	☐	☐	
Punctoplasty	☐	☐	
DCR/Dacryocystorhinostomy	☐	☐	
CDCR/ Conjunctivodacryocystorhinostomy/ Jones Tube	☐	☐	
Sinus surgery	☐	☐	
Other: _____	☐	☐	

10.	**If you answered "yes" to Question 8 and/or 9,** please specify:

Name(s) of healthcare provider who diagnosed and/or provided treatment for each eye condition	**Healthcare provider(s)' practice location and address**

11.	**Have you ever had any of the following health conditions:**

Condition	Yes	No	Date Range
Allergies (e.g. allergic rhinitis, seasonal allergies)	☐	☐	
Bell's palsy	☐	☐	
Facial trauma	☐	☐	
Broken bones near the eye	☐	☐	
Broken nose	☐	☐	
Sinus disease	☐	☐	
Rosacea	☐	☐	
Ocular rosacea	☐	☐	
Nasal polyps	☐	☐	

11.	**Have you ever had any of the following health conditions:**		
Condition	**Yes**	**No**	**Date Range**
Hypertension	☐	☐	
Diabetes	☐	☐	
High cholesterol	☐	☐	

VII. CLAIM INFORMATION

A. Injury Alleged

1.	Did you experience tearing during the chemotherapy regimen that included Taxotere® or docetaxel?	□ Yes □ No
	If you answered "yes" to Question A.1., please fill out below:	
	Describe when the tearing started:	
	Did the tearing resolve after finishing the chemotherapy regimen that included Taxotere® or docetaxel?	□ Yes □ No
2.	What injuries do you allege in this lawsuit:	

Alleged Injury	**Yes**	**No**	**Right Eye**	**Left Eye**	**Both Eyes**	**From**	**To**
Stenosis of lacrimal canaliculi	□	□	□	□	□		□ Present
Stenosis of lacrimal punctum	□	□	□	□	□		□ Present
Stenosis of lacrimal sac	□	□	□	□	□		□ Present
Stenosis of lacrimal duct	□	□	□	□	□		□ Present
Obstruction of Lacrimal Duct	□	□	□	□	□		□ Present
Obstruction of Nasolacrimal Duct	□	□	□	□	□		□ Present
Stenosis of nasolacrimal duct	□	□	□	□	□		□ Present
Epiphora	□	□	□	□	□		□ Present
Excessive tearing or epiphora due to obstruction or insufficient drainage	□	□	□	□	□		□ Present
Other:	□	□	□	□	□		□ Present

3.	If you allege that you currently experience tearing/epiphora, please specify whether it occurs:			
Less than once a day	**1-2 times a day**	**3-5 times a day**	**>5 times a day**	**Other (please describe):**
□	□	□	□	

4.	If you allege that you currently experience tearing/epiphora, please specify whether it is accompanied by (check all that apply):	□ Itching □ Pain □ Discharge □ Redness □ Other symptom(s) (please specify): _____

5.	Were you diagnosed by a healthcare provider for the injury you allege in this lawsuit?	□ Yes □ No
	If you answered "yes" to Question A.5., please fill out below:	

Diagnosing Physician Name	**Facility Address (Street Address)**	**Facility Address (City and State)**	**Date of Diagnosis**	**Diagnosis**

6.	Have you discussed with any healthcare provider whether your use of Taxotere or docetaxel caused or contributed to your alleged injury?	□ Yes □ No
	If you answered "yes" to Question A.6., please fill out below:	

Physician Name	**Facility Address (Street Address)**	**Facility Address (City and State)**	**Date of Discussion**	**Nature of Discussion**

7.	Were you ever given any written instructions, including any prescriptions, packaging, package inserts, literature, medication guides, or dosing instructions regarding Taxotere® and/or docetaxel?	□ Yes □ No
	If you answered "yes" to Question A.7., please describe the document(s), if you no longer have them. If you have the documents, please produce them:	

Description of Document(s)	**I have the Document**	**I Do Not Have the Document**
	□	□

8.	Were you given any oral instructions from a healthcare provider regarding your use of Taxotere® or docetaxel?	□ Yes □ No
	If you answered "yes" to Question A.8., please identify each healthcare provider who provided the oral instructions**:**	
	Name of Healthcare Provider:	

9.	Have you ever seen any advertisements (e.g., in magazines or television commercials) for Taxotere® or docetaxel?	□ Yes □ No
	If you answered "yes" to Question A.9., please identify the advertisement or commercial, and approximately when you saw the advertisement or commercial:	

Type of Advertisement or Commercial	**Date of Advertisement or Commercial**

10.	Have you filed a MedWatch Adverse Event Report to the FDA related to the injury you allege in this lawsuit?	□ Yes □ No

B. Treatment History

1.	Have you ever received treatment for the injury you allege in this lawsuit?	□ Yes □ No
	If you answered "yes" to Question B.1., please fill out below:	

Question	**Yes**	**No**	**Name of Healthcare Provider and Facility Name (First, Last)**	**Date(s)**	**Did the treatment improve your tearing**
Have you had a probing and irrigation examination?	□	□			
Have you had placement of stents in your lacrimal system?	□	□			
Have you undergone a DCR (dacryocystorhinostomy)?	□	□			
Have you undergone a CDCR (conjunctiveodacryocystorhinostomy)?	□	□			
Have you taken or been prescribed steroids?	□	□			

Have you ever taken or been prescribed eye drops?	□	□			
Other treatment received (specify): _____	□	□			

C. Mental and/or Emotional Damages

1.	Do you claim that your use of Taxotere® or docetaxel caused or aggravated any psychiatric or psychological condition?	□ Yes □ No
2.	**If you answered "yes" to Question C.1.**, did you seek treatment for the psychiatric or psychological condition?	□ Yes □ No
	If you answered "yes" to Question C.1., please complete the following:	

Provider Name (First, Last)	**Facility Name and Address**	**Date**	**Condition**

D. Medical Expenses

1.	Do you claim that you incurred medical expenses for the alleged injury that you claim was caused by Taxotere® or docetaxel?	□ Yes □ No
	If you answered "yes" to Question D.1., list all of your medical expenses, including amounts billed or paid by insurers and other third-party payors, which are related to any alleged injury you claim was caused by Taxotere® or docetaxel:	

Provider (First, M.I., Last)	**Date**	**Expense**

E. Out-of-Pocket Expenses

1.	Are you making a claim for lost out-of-pocket expenses?	□ Yes □ No
	If you answered "yes" to Question E.1., please identify and itemize all out-of-pocket expenses you have incurred:	

Expense	Expense Amount

VIII. RECORD HOLDER IDENTIFICATION

A. Healthcare Providers

1. Identify each physician, doctor, or other healthcare provider who has provided cancer related or eye treatment to you for any reason in the period of five (5) years before your first treatment with Taxotere® or docetaxel to present and the reason for consulting the healthcare provider or mental healthcare provider.

YOU MUST INCLUDE YOUR ONCOLOGIST, RADIOLOGIST, OPHTHALMOLOGIST, OCULOPLASTIC SURGEON, GYNECOLOGIST (IF APPLICABLE), OBSTETRICIAN (IF APPLICABLE), AND PRIMARY CARE PHYSICIAN, ALONG WITH ANY OTHER HEALTHCARE PROVIDERS IDENTIFIED ABOVE

Name (First, M.I., Last)	Address	Dates	Reason for Consultation
		to ☐ Present	
		to ☐ Present	
		to ☐ Present	
		to ☐ Present	
		to ☐ Present	
		to ☐ Present	
		to ☐ Present	

Name (First, M.I., Last)	Address	Dates	Reason for Consultation
		to ☐ Present	
		to ☐ Present	

B. Hospitals, Clinics, and Other Facilities

2. Identify each hospital, clinic, surgery center, physical therapy or rehabilitation center, or other healthcare facility where you have received inpatient or outpatient treatment (including emergency room treatment) in the period of five (5) years before your first treatment with Taxotere® or docetaxel to present and the reason you received treatment:

YOU MUST INCLUDE THE LOCATIONS FOR SURGERIES, RADIOLOGY, IMAGING, BIOPSIES, CHEMOTHERAPY, CHILD BIRTH OR GYNECOLOGIC PROCEDURES OR TREATMENT, ALONG WITH ANY OTHER HEALTHCARE FACILITIES

Name	Address	Dates	Reason for Treatment
		to ☐ Present	
		to ☐ Present	
		to ☐ Present	
		to ☐ Present	
		to ☐ Present	
		to ☐ Present	
		to ☐ Present	

C. Pharmacies

4. 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 within five (5) years prior to your first treatment with Taxotere® to present:

Name	Address	Dates	Medications
		to	

Name	Address	Dates	Medications
		☐ Present	
		to ☐ Present	
		to ☐ Present	
		to ☐ Present	

D. Insurance Carriers

6. Identify each health insurance carrier which provided you with medical coverage and/or pharmacy benefits for your cancer or the injuries alleged in this lawsuit:

Carrier	Address	Name of Insured and SSN	Policy Number	Dates of coverage
				to ☐ Present
				to ☐ Present
				to ☐ Present
				to ☐ Present
				to ☐ Present
				to ☐ Present

IX. DOCUMENT REQUESTS AND AUTHORIZATIONS

Please state which of the following documents you have in your possession. If you do not have the following documents but believe they might exist in the possession of others, please state who you believe has possession of the documents. Produce all documents in your possession (including writings on paper or in electronic form) and sign authorizations and attach a copy of them to this Fact Sheet.

Type of Document(s)	Yes	No	If No, who do you believe may have the document(s)?
Documents you reviewed to prepare your answers to this Plaintiff Fact Sheet.	☐	☐	
Medical records or non-privileged other documents related to the use of Taxotere® or docetaxel.	☐	☐	
Medical records showing proof of injury.	☐	☐	
Medical records or non-privileged other documents related to your treatment for cancer or any ocular disease, condition or symptom referenced in this Fact Sheet.	☐	☐	
Documents reflecting your use of any prescription drug or medication at any time.	☐	☐	
Documents identifying all chemotherapy drugs that you have taken.	☐	☐	
Documents for any workers' compensation, social security or other disability proceeding at any time.	☐	☐	
Instructions, product warnings, package inserts, handouts or other materials that you were provided or obtained in connection with your use of Taxotere® or docetaxel.	☐	☐	
Advertisements or promotions for Taxotere®.	☐	☐	
Articles discussing Taxotere® or docetaxel.	☐	☐	
Any packaging, container, box, or label for Taxotere® or docetaxel that you were provided or obtained in connection with your use of Taxotere® or docetaxel. *Plaintiffs or their counsel must maintain the originals of these items.*	☐	☐	
Non-privileged documents which mention Taxotere® or docetaxel or any alleged health risks related to Taxotere® or docetaxel.	☐	☐	
Communications or correspondence between you and any representative of the Defendants.	☐	☐	

Type of Document(s)	Yes	No	If No, who do you believe may have the document(s)?
Photographs, drawings, slides, videos, recordings, DVDs, or any other media that show your alleged injury or its effect in your life.	☐	☐	
Journals or diaries related to the use of Taxotere® or docetaxel related to your cancer treatment and/or the injuries you allege in this case. .	☐	☐	
Electronically Stored Information ("ESI") sources responsive to Section II.G., Question No. 18.	☐	☐	
Social media or internet posts to or through any site (including, but not limited to, Facebook, TikTok, LinkedIn, Flickr, Google Plus, Windows Live, YouTube, Twitter, Instagram, Pinterest, blogs, and Internet chat rooms/message boards), emails, text messages, and any other electronic communications relating to Taxotere® or docetaxel or any of your claims in this lawsuit.	☐	☐	
If you claim any medical expenses, bills from any physician, hospital, pharmacy or other healthcare providers.	☐	☐	
Records of any other expenses allegedly incurred as a result of your alleged injury.	☐	☐	
If you are suing in a representative capacity, letters testamentary or letters of administration.	☐	☐	
If you are suing in a representative capacity on behalf of a deceased person, decedent's death certificate.	☐	☐	
If you claim that the injury alleged in this lawsuit has in any way altered your physical appearance, Photographs of you that are representative of you before treatment with Taxotere® or docetaxel.	☐	☐	
If you claim that the injury in this lawsuit has in any way altered your physical appearance, Photographs of you that are representative of you after conclusion of treatment with Taxotere® or docetaxel.	☐	☐	
Signed authorizations for medical records related to any cancer treatment identified herein and all pharmacy records from five (5) years before your first treatment with Taxotere® or docetaxel to present in the forms attached hereto.	☐	☐	

X. PLAINTIFF'S DECLARATION

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that all of the information provided in connection with this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information, and belief at the present time, and on reasonable and diligent searches conducted pursuant to Section II.G., Question No. 18.

_____ _____

Signature Date

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03
(Excluding Psychiatric, Psychological, and Mental Health Treatment Notes/Records)

TO:
Patient Name:
DOB:
SSN:

I, _____ , hereby authorize you to release and furnish to: Shook Hardy & Bacon LLP, Tucker Ellis LLP, Ulmer & Berne LLP, Greenberg Traurig LLP, Arnold & Porter Kaye Scholer LLP, Williams & Connolly LLP, Chaffe McCall LLP, Hinshaw & Culbertson LLP, Kirkland & Ellis LLP and/or their duly assigned agents, copies of the following records and/or information **from the time period of five (5) years prior to Date of Treatment [_____] to the present**:

* All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
* All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
* All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.

****Notwithstanding the broad scope of the above disclosure requests, the undersigned does not authorize the disclosure of notes or records pertaining to psychiatric, psychological, or mental health treatment or diagnosis as such terms are defined by HIPAA, 45 CFR §164.501**.

1. To my medical provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition at a deposition or trial.**

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name:_____ (plaintiff/representative)

Signature: _____ Date

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LIMITED AUTHORIZATION TO DISCLOSE EMPLOYMENT RECORDS AND INFORMATION (HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508)

TO: _____
Name of Employer

_____
Address, City State and Zip Code

RE: Employee Name: _____ AKA: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

I authorize the limited disclosure of my employment records including medical information protected by HIPAA, 45 CFR 164.508, for the purpose of review and evaluation in connection with a legal claim.

This authorization only authorizes release of records and/or information from the time period of five (5) years prior to the date on which this authorization is signed. I expressly request that all entities identified above disclose full and complete records from the time period of five (5) years prior to the date on which this authorization is signed, including the following:

This will authorize you to furnish copies of all applications for employment; resumes; records of all positions held; job descriptions of positions held; wage and income statements and/or compensation records; wage increases and decreases; evaluations, reviews and job performance summaries; W-2s; employee health files, and correspondence and memoranda regarding the undersigned.

I authorize you to release the information to:

_____
Name (Records Requestor)

_____
Street Address City State and Zip Code

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requestor at that time.

I acknowledge the right to revoke this authorization by writing to you at the above referenced address. However, / understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

_____
Signature of Employee or Personal Representative Date Name of Employee or Personal Representative

_____
Description of Personal Representative's Authority to Sign for Employee (attach documents that show authority)

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LIMITED AUTHORIZATION FOR RELEASE OF WORKERS' COMPENSATION RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all workers' compensation records of any sort **for any workers' compensation claims filed within the last ten (10) years**, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning:

_____
Name of Claimant

whose date of birth is _____ and whose social security number is _____

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

Records Requestor
_____
Representative Capacity (e.g., attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

This authorization only authorizes release of documents and records from the period of ten (10) years prior to the date on which this authorization is signed. This authorization does not authorize you to disclose anything other than documents and records to anyone.

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This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date: _____ _____

Claimant Signature
[NAME]

Date: _____ _____

Witness Signature

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LIMITED AUTHORIZATION FOR RELEASE OF
DISABILITY CLAIMS RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all records of disability claims of any sort **for any disability claim(s) filed within the last ten (10) years**, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning:

_____
Name of Claimant

whose date of birth is _____ and whose social security number is _____

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

Records Requestor _____
Representative Capacity (e.g., attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

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This authorization only authorizes release of documents and records from the period of ten (10) years prior to the date on which this authorization is signed. This authorization does not authorize you to disclose anything other than documents and records to anyone.

Date: _____ _____

Claimant Signature
[NAME]

Date: _____ _____

Witness Signature

FOR RELEASE OF
HEALTH INSURANCE RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all insurance claims applications and benefits, and all medical, health, hospital, physicians, nursing or allied health professional reports, records or notes, invoices and bills, in your possession that pertain to the named insured identified below. **This authorization only authorizes release of Health Insurance records and/or information from the time period of ten (10) years prior to the date on which this authorization is signed.**

_____
Name of Claimant

whose date of birth is_____and whose social security number is _____

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

Records Requestor_____
Representative Capacity (e.g., attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

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This authorization only authorizes release of documents and records from the period of ten (10) years prior to the date on which this authorization is signed. This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requestor named above has executed the acknowledgement at the bottom of this authorization.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date: _____ _____

Claimant Signature
[NAME]

Date: _____ _____

Witness Signature

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LIMITED AUTHORIZATION TO DISCLOSE PSYCHIATRIC, PSYCHOLOGICAL AND/OR MENTAL HEALTH TREATMENT NOTES/RECORDS
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO:
Patient Name:
DOB:
SSN:

I, _____ , hereby authorize you to release and furnish to: Shook Hardy & Bacon LLP, Tucker Ellis LLP, Ulmer & Berne LLP, Greenberg Traurig LLP, Williams & Connolly LLP, Chaffe McCall LLP, Hinshaw & Culbertson LLP, Kirkland & Ellis LLP and/or their duly assigned agents, copies of the following records and/or information **from the time period of ten (10) years prior to the date on which the authorization is signed:**

- All "psychotherapy notes", as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501. Under HIPAA, the term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's record. This authorization does not authorize ex parte communication concerning same.

1. To my medical and/or mental health provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, mental health history, care, treatment, diagnosis, prognosis, information revealed by or in the medical or mental health records, or any other matter bearing on his or her medical, psychological, or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, mental health history, care, treatment, diagnosis, prognosis, information revealed by or in the medical or mental health records, or any other matter bearing on my medical, psychological, or physical condition at a deposition or trial.**

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name:_____ (plaintiff/representative)

Signature: _____ Date _____

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EXHIBIT B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

IN RE: TAXOTERE (DOCETAXEL) EYE INJURY PRODUCTS LIABILITY LITIGATION	**MDL NO. 3023**
	SECTION "H" (5)
	HON. JANE T. MILAZZO
This Document Relates to:	
All Cases	

DEFENDANT FACT SHEET

PRODUCT IDENTIFICATION

Within seventy-five (75) days of receiving a substantially completed Plaintiff Fact Sheet ("PFS"), the relevant[1] Defendant or Defendants (collectively referred to as "Defendants") must complete and serve this Defendant Fact Sheet ("DFS") and identify or provide DOCUMENTS and/or data responsive to the questions set forth below for each such Plaintiff. Defendants must supplement their responses to the extent that additional information is provided by Plaintiff in a supplemental PFS, within sixty (60) days of receiving the supplemental information. In the event the DFS does not provide YOU with enough space to complete YOUR responses or answers, please attach additional sheets if necessary. Please identify any DOCUMENTS that YOU are producing as responsive to a question or request by bates number.

DEFINITIONS AND INSTRUCTIONS

As used herein, "YOU," "YOUR," or "YOURS" means the responding DEFENDANTS.

"DEFENDANTS" or "DEFENDANT" shall mean and refer to those companies involved in the development, manufacture, and distribution of the drugs known as Taxotere (Docetaxel) named in the operative Master Long Form Complaint against Sanofi US Services Inc. and Sanofi-Aventis U.S. LLC and/or Sandoz Inc., Accord Healthcare, Inc., Hospira Worldwide, LLC f/k/a Hospira Worldwide, Inc., Hospira, Inc., Sun Pharma Global FZE, Sun Pharmaceutical Industries, Inc. f/k/a Caraco Pharmaceutical Laboratories Ltd., Pfizer Inc., Actavis LLC f/k/a Actavis Inc., Actavis Pharma, Inc., Sagent Pharmaceuticals, Inc., Eagle Pharmaceuticals, Inc., and Teikoku Pharma USA, Inc. The relevant DEFENDANT or DEFENDANTS shall each answer each document request and question that not only calls for YOUR knowledge, but also for all knowledge that is available to YOU by reasonable inquiry, including inquiry of YOUR "officers," "directors," "agents," "employees," and attorneys.

[1] As set forth in Case Management Order No. 14 ("Service of Plaintiff Fact Sheet and Defendant Fact Sheets"), Defendants are not required to submit a DFS absent the production of product identification evidence pursuant to the Product Identification Order. *See id.* ¶ 12.

As used herein, the phrase "HEALTHCARE PROVIDER" means: any physician or other individual healthcare provider, health care facility, clinic, hospital or hospital pharmacy identified by full name and address in PFS Section IV who administered, prescribed, and/or dispensed Taxotere (Docetaxel) to the Plaintiff.

"REMUNERATION" means anything of value, directly or indirectly, overtly or covertly, in cash or in kind, including but not limited to monetary payment, compensation, incentives, preceptorship fees, gifts, entertainment, sports and/or concert tickets, speaker fees, grants, SAMPLES, reimbursement assistance, beneficiary inducements, wellness programs, patience assistance programs, transportation and/or lodging assistance, adherence to treatment regimen programs, incentives or inducements to remain in network, navigator/care coordination programs, end of life and/or palliative care programs, third party payments of premiums, or any other inducements or programs.

As used herein, the term "DOCUMENT" shall, consistent with Federal Rule of Civil Procedure 34(a)(1)(A), refer to any "designated documents or electronically stored information – including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations – stored in any medium from which information can be obtained either directly or, if necessary, after translation by the responding party into a reasonably usable form."

If YOU are aware that any DOCUMENT that was, or might have been, responsive to any sections of this DFS which concern or relate to Plaintiff or Plaintiff's Named Facilities was destroyed, erased, surrendered or otherwise removed from YOUR possession, custody or control, at any time, provide, to the maximum extent possible, the following information: (a) the nature of the DOCUMENT (e,g., letter, memorandum, contract, etc.,) and a description of its subject matter; (b) the author or sender of the DOCUMENT; (c) the recipient(s) of the DOCUMENT; (d) the date that the DOCUMENT was authored, sent and received; (e) the circumstances surrounding the removal of the DOCUMENT from YOUR custody, possession or control; and (f) the identity of the person(s) having knowledge of such removal from YOUR custody, possession or control.

As used herein, "KEY OPINION LEADER" or "THOUGHT LEADER" shall mean and refer to physicians, often academic researchers, who are believed by DEFENDANTS to be effective at transmitting messages to their peers and others in the medical community. This term shall mean and refer to any doctors or medical professionals hired by, consulted with, or retained by DEFENDANTS to, amongst other things, consult, give lectures, respond to media inquiries, conduct clinical trials, write articles or abstracts, sign their names as authors to articles or abstracts written by others, sit on advisory boards and make presentations on their behalf at regulatory meetings or hearings.

The phrase "SAMPLES" refers to any medication or unit of a prescription drug not intended to be sold, which is given to promote the drug's sales. This includes any vouchers or coupons that provide for the HEALTHCARE PROVIDERS or patients access to the medication for a specified period of time.

"PATIENT ASSISTANCE PROGRAM" means programs created by drug companies, such as Sanofi, to offer free or low cost drugs to individuals who are unable to pay for their medication. These Programs may also be called indigent drug programs, charitable drug programs or medication assistance programs.

The phrase "SALES REPRESENTATIVE" means any person presently or formerly engaged or employed by YOU whose job duties include calling on physicians or other health care professionals, healthcare facilities, hospitals, and/or physician practice groups; promoting drugs manufactured or licensed by YOU to physicians or other HEALTH CARE PROVIDERS; and/or distributing drug SAMPLES to physicians or other HEALTH CARE PROVIDERS. "SALES REPRESENTATIVE" also includes those who occupy positions titled "Professional Sales Representative," "Sales Professional," "Specialty Sales Representative," "Senior Sales Representative," "Senior Health Care Representative," "Professional Representative," "Health Care Representative," "Institutional" or "Managed Care" sales representative, "Oncology Sales Representative," "Medical Service Representative," and "Medical Sales Representative" or any other titles used by DEFENDANTS and any of their divisions SALES REPRESENTATIVE also includes any contract employees or SALES REPRESENTATIVES from other companies involved in the promotion or co-promotion of Taxotere (Docetaxel) .

The phrase "SALES MANAGER" means any person presently or formerly engaged or employed by YOU whose job duties include managing SALES REPRESENTATIVES and/or the promotion or marketing of pharmaceutical products in a specific geographic region. "SALES MANAGER" includes those who occupy positions titled "District Sales Manager," "Senior Regional Sales Manager," "Regional Sales Manager," "Area Business Manager", "Business Manager," or any other titles YOU use or have used in the past for managers involved in the promotion or marketing of Taxotere (Docetaxel).

The phrase "MEDICAL SCIENCE LIAISON(S)" means any person presently or formerly engaged or employed by YOU for the purpose of sales support and direct field communication with physicians or other HEALTH CARE PROVIDERS about medical and science information related to Taxotere (Docetaxel), and opinion leader management. This includes employees with the titles of "Medical Science Liaison (MSL)," "Clinical Education Consultant (CEC)" or any other titles YOU use or have used in the past for these employees.

The phrase "MARKETING ORGANIZATION REPRESENTATIVE" means any person presently or formerly engaged or employed by YOU for the purpose of generating interest in Taxotere (Docetaxel) by creating and implementing a marketing campaign(s) to reach physicians or other HEALTHCARE PROVIDERS. This includes employees with the title of "Marketing Representative" or any other titles YOU use or have used in the past for these employees.

The phrase "CALL NOTES" means any and all writings, notations, electronically stored information, memoranda, DOCUMENTS, emails, database entries and reports or records, internal communications and any other information reflecting any contact with HEALTHCARE PROVIDERS, and/or information about or referring to HEALTHCARE PROVIDERS related to Taxotere (Docetaxel), oncology, or the treatment of cancer and chemotherapy.

The phrase "TARGETING INFORMATION" means any information YOU use to identify a particular person, group of people, type of health care provider or demographic within a larger audience regarding the promotion of Taxotere (Docetaxel). This includes documentation, including electronically stored information, designating particular campaigns, PROMOTIONAL MATERIAL and/or other promotional efforts directed toward particular types or specialties of healthcare providers (e.g., oncologists) and/or specifically identified healthcare providers.

I. CASE INFORMATION

This DFS pertains to the following case:

Case Caption:_____

Civil Action No._____

Court in which action was originally filed:_____

Date this DFS was completed:_____

II. SALE OF TAXOTERE (DOCETAXEL) TO DISPENSER (HOSPITAL/PHARMACY) DIRECTLY AND/OR THROUGH GROUP PURCHASING ORGANIZATIONS

A. Did YOU sell, distribute, deliver or otherwise provide Taxotere (Docetaxel) to, any HEALTHCARE PROVIDER, either directly or pursuant to a Group Purchasing Organization ("GPO"), identified by the Plaintiff in Sections IV.47 and IV.48 of the PFS, during the time period of twenty-four (24) months preceding Plaintiff's first administration of Taxotere (Docetaxel) through the Plaintiff's last administration of Taxotere (Docetaxel)?

Yes _____ No _____

B. If YOUR answer is "Yes" to Question A. above, please provide a list of all deliveries or shipments of Taxotere (Docetaxel) sold, distributed or otherwise provided to each of the HEALTHCARE PROVIDERS, as identified by the Plaintiff in Sections IV.47 and IV.48 of the PFS, for the time period spanning from twenty-four (24) months prior to Plaintiff's first administration of Taxotere (Docetaxel) through Plaintiff's last administration of Taxotere (Docetaxel). Please include the name of each HEALTHCARE PROVIDER, the date of shipment/distribution of Taxotere (Docetaxel), and the amount of Taxotere (Docetaxel) distributed on said date.

Name of Healthcare Provider	Date of Shipment Distribution	Amount of Taxotere Distributed

C. Please provide all DOCUMENTS reflecting sale or purchase agreements regarding Taxotere (Docetaxel) between DEFENDANTS and the HEALTHCARE PROVIDERS identified by Plaintiff in Section Sections IV.47 and IV.48 of the PFS in effect during the time period spanning from twenty-four (24) months prior to plaintiff's first administration of Taxotere (Docetaxel) through Plaintiff's last administration of Taxotere (Docetaxel).

D. Please provide all DOCUMENTS, including product labels, patient information packets, order forms, purchase orders, billing records, invoices, and other DOCUMENTS related to the shipments of Taxotere (Docetaxel) shipped to the HEALTHCARE PROVIDERS identified by Plaintiff in Sections IV.47 and IV.48 of the PFS for the time period spanning from twenty-four (24) months prior to Plaintiff's first administration of Taxotere (Docetaxel) through to Plaintiff's last administration of Taxotere (Docetaxel), and associate each label with the code numbers to which they are applicable. With regard to product labels, identification of the labels that applied to applicable lot numbers or dates is acceptable.

III. COMMUNICATIONS AND CONTACTS WITH PLAINTIFF'S HEALTHCARE PROVIDERS

A. For each DEFENDANT'S SALES REPRESENTATIVES, MARKETING ORGANIZATION REPRESENTATIVES, MEDICAL SCIENCE LIAISONS, and/or any other detail persons who came in contact with any of Plaintiff's HEALTHCARE PROVIDER(S) in connection with Taxotere (Docetaxel) during the timeframe for which such records are available, please produce the following:

1. His/her complete CALL NOTES for each such contact that relates to (a) Taxotere (Docetaxel); and/or (b) ocular injuries; and/or (c) epiphora/excessive tearing; and/or (d) "lacrimal duct obstruction."

2. Produce all emails or other written correspondence with the HEALTHCARE PROVIDER(S) that relates to (a) Taxotere (Docetaxel); and/or (b) ocular injuries; and/or (c) epiphora and/or excessive tearing; and/or (d) "lacrimal duct obstruction."

3. Produce any and all TARGETING INFORMATION related to the HEALTHCARE PROVIDER(S) identified by Plaintiff in Sections V.13 and V.14 of the PFS.

B. For the HEALTHCARE PROVIDERS identified by Plaintiff in Sections V.13 and V.14 of the PFS, please provide the following information related to SAMPLES of Taxotere (Docetaxel):

1. The date(s) on which such SAMPLES of Taxotere (Docetaxel) were provided;

2. The date(s) on which the Taxotere (Docetaxel) was provided through a PATIENT ASSISTANCE PROGRAM;

3. The amount, dosage, and lot numbers of such SAMPLES and/or Taxotere (Docetaxel) provided through a PATIENT ASSISTANCE PROGRAM**;**

4. The name(s) of the DEFENDANT representative(s) and/or department who provided such SAMPLES of Taxotere (Docetaxel);

5. The name(s) of the DEFENDANT representative(s) and/or department who provided Taxotere (Docetaxel) through a PATIENT ASSISTANCE PROGRAM.

HEALTHCARE PROVIDER	Date(s) Shipped and/or Provided	Amount and Dosage	Lot Number	Representative Who Provided

IV. CONSULTING WITH PLAINTIFF'S HEALTHCARE PROVIDER

For each HEALTHCARE PROVIDER identified in Plaintiff's PFS, please answer the following:

A. If the HEALTHCARE PROVIDER has been consulted, retained, or compensated by Defendants as a "KEY OPINION LEADER," "THOUGHT LEADER," member of a "speaker's bureau," "clinical investigator," "consultant," advisory board member or in a similar capacity or otherwise has or had a financial relationship with or has been provided REMUNERATION by DEFENDANTS, please state the following for each:

1. Identify the HEALTHCARE PROVIDER.

2. Identify the date(s) that the HEALTHCARE PROVIDER was consulted, retained, or compensated.

3. State the nature of the affiliation.

4. State the amount of REMUNERATION provided to the HEALTHCARE PROVIDER.

HEALTHCARE PROVIDER	Date(s) Consulted, Retained or Compensated	Nature of Affiliation	REMUNERATION

5. Please identify and produce any and all consulting agreements/contracts and/or retainer agreements/contracts entered into by DEFENDANTS with the HEALTHCARE PROVIDERS identified in Sections IV.47 and IV.48 of the PFS.

V. PLAINTIFF'S HEALTHCARE PROVIDER PRACTICES

A. Provide all chemotherapy related prescriber-level data designed to track prescribing or treating practices that YOU obtained on Plaintiff's HEALTHCARE PROVIDERS identified in Sections IV.47 and IV.48 of the PFS.

B. Did the Plaintiff's HEALTHCARE PROVIDER ever report any adverse events to DEFENDANTS as they pertain to Taxotere (Docetaxel)?

_____ Yes _____ No

If yes, provide all DOCUMENTS related to the adverse event report/MedWatch form.

CERTIFICATION

I am authorized by _____ [name of other DEFENDANTS] to execute this certification on each corporation's behalf. The foregoing answers were prepared with the assistance of a number of individuals, including counsel for DEFENDANTS, upon whose advice and information I relied. I declare under penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Defendant Fact Sheet is true and correct to the best of my knowledge and that I have supplied all requested DOCUMENTS to the extent that such DOCUMENTS are in my possession, custody and control (including the custody and control of my lawyers).

_____	_____	_____
Signature	Print Name	Date