SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

762000/06

	Index No. ~~560001~~/2005
IN RE: NEW YORK BEXTRA AND CELEBREX PRODUCT LIABILITY LITIGATION	CASE MANAGEMENT ORDER NO. 6
THIS DOCUMENT APPLIES TO ALL CASES	

Plaintiff Fact Sheets And Defendant Fact Sheets

I. Applicability And Scope Of Order

1. This Order governs certain pretrial procedures for cases involving the prescription medications Bextra and Celebrex which are presently or hereafter assigned to this Court ("Coordinated Proceeding"). This Order shall apply to all Plaintiffs who allegedly suffered personal injury from taking Bextra and/or Celebrex in cases currently pending in or that have been or will be originally filed in, or transferred to, this Court and assigned thereto. This Order is binding on all parties and their counsel in all cases currently pending or subsequently made part of these proceedings.

II. Plaintiff Fact Sheets, Documents And Authorizations

2. Plaintiffs' Obligation To Serve Plaintiff Fact Sheets and Responsive Documents.

a. Applicable Plaintiff Fact Sheet. Each individual Plaintiff bound by this Order shall serve upon Defendants' counsel a complete and signed Plaintiff Fact Sheet ("PFS") in the forms set forth in Attachments A (Bextra-only Plaintiffs), B (Celebrex-only Plaintiffs), or C (Plaintiffs who allege taking both Bextra and Celebrex) pursuant to the schedule ordered in paragraph 5 herein. If a Plaintiff initially completes Attachment A or B hereto and

medical records or other information subsequently reveal that Plaintiff took both Bextra and Celebrex, such Plaintiff shall provide the additional information contained in Attachment C within sixty (60) days upon request by any Defendant. Each PFS shall be mailed to Defendants' counsel as follows:

Loren H. Brown
Raymond M. Williams
Attn: Bextra/Celebrex—NY COORD. PROC.
DLA PIPER RUDNICK GRAY CARY US LLP
1251 Avenue of the Americas
New York, New York 10020

b. Responsive Documents. The Plaintiff shall also produce with his or her PFS all documents responsive to the document requests contained therein ("responsive documents"). If neither Plaintiff nor Plaintiff's counsel possess responsive documents, Plaintiff's counsel must inform Defendants' counsel of such in writing concurrently with serving the PFS.

c. Answers Binding As If Interrogatory Responses And Signed Under Penalty Of Perjury. All responses in a PFS are binding on the Plaintiff as if they were contained in responses to interrogatories. Each PFS shall be signed and dated by the Plaintiff or the proper Plaintiff representative under penalty of perjury.

d. Plaintiffs Suing In Representative Or Derivative Capacity. If the Plaintiff is suing in a representative or derivative capacity (e.g., on behalf of an estate, as a survivor, and/or as an assignee or subrogee), the completed PFS and produced responsive documents must provide information about the individual who allegedly took Celebrex and/or Bextra.

3. Plaintiffs' Obligation To Serve HIPAA-Compliant Authorizations.

a. Five Blank Medical Authorizations Served With PFS. Each individual Plaintiff subject to this Order shall serve upon Defendants' counsel designated above along with his or her PFS and responsive documents five originals of the "Authorization for the Release of Medical Records" for all health care providers and other sources of information and records (including but not limited to pharmacies, insurance companies, and/or any applicable state or federal government agencies) (collectively, "custodian of records") in forms as agreed upon by Plaintiffs' and Defendants' Liaison Counsel and contained in CMO No. 7. The "Authorization for the Release of Medical Records" shall distinguish between Plaintiffs asserting no psychological injury and Plaintiffs asserting psychological injury, and each individual Plaintiff shall serve the version that is applicable to that individual Plaintiff. The authorizations shall be dated and signed without setting forth the identity of the custodian of the records or provider of care.

b. Three Blank Employment Authorizations Served With PFS. Each individual Plaintiff subject to this Order shall serve upon Defendants' counsel designated above along with his or her PFS and responsive documents three originals of the "Authorization for the Release of Employment Records" for all employers in forms to be agreed upon by Plaintiffs' and Defendants' Liaison Counsel with respect to Plaintiffs asserting no wage loss claim and Plaintiffs asserting a wage loss claim. The authorizations shall be dated and signed without setting forth the identity of the employer.

c. Custodian-Specific Updated Or Additional Authorizations. If a health care provider, employer, or other custodian of records: (i) has a specific authorization form it requires its patients to use, (ii) requires a more recent authorization than the

authorizations initially provided by Plaintiff, (iii) requires a notarized authorization, or (iv) requires an original signature and the record collection company or companies jointly retained by the parties have already used all original authorizations provided by Plaintiff, then the record collection company or companies retained by the parties shall so notify Plaintiff's counsel and provide such specific authorization(s) and/or new blank authorization(s) to Plaintiff's counsel. Plaintiff shall execute such specific, updated and/or original authorization(s) within thirty (30) days and pursuant to paragraph 3.d. herein, where applicable. Where Plaintiff identifies one of the custodians of record listed in Attachment D hereto in his or her Plaintiff Fact Sheet, such Plaintiff shall execute the applicable custodian-specific authorization for that custodian and provide such authorization along with his or her Plaintiff Fact Sheet, blank authorizations and responsive documents. Plaintiffs' Liaison Counsel shall make the custodian-specific authorizations for the custodians listed in Attachment D available to Plaintiffs' counsel.

d. Plaintiffs Suing In Representative Or Derivative Capacity. If the Plaintiff is suing in a representative or derivative capacity, the authorizations must be signed and produced along with documentation, if any exists, establishing that the signatory is a duly appointed representative or is otherwise permitted to execute authorizations on behalf of the person who allegedly took Celebrex and/or Bextra.

4. Use Of Authorizations.

a. Custodians Listed In PFS. Any record collection company or companies jointly retained by the parties may use the authorizations (including copies of the original blank authorizations) for any health care provider, employer, or other custodian of records identified in the PFS without further notice to the Plaintiff's counsel. Any Plaintiff who has an objection to the collection of records from any health care provider, employer, or other

custodian of records identified in the PFS shall make such objection to Defendants at the time the PFS is provided, or else any such objection to the use of the authorization is waived. This provision shall not waive any right that an individual may have to request the return of the records, to challenge the admissibility of the records, or to otherwise move the Court for appropriate relief.

b. Custodians Not Listed In PFS. If the Defendants wish to use an authorization to obtain records from a custodian that is not identified in the PFS, the record collection company or companies jointly retained by the parties shall provide the Plaintiff's counsel for that particular case with seven days written notice (by facsimile) of the intent to use an authorization to obtain records from that custodian. If Plaintiff's counsel fails to object to the request within seven days (by facsimile), the retained record collection company or companies may use the authorization to request the records from the custodian identified in the notice. If Plaintiff's counsel objects to the use of the authorization to obtain records from the custodian identified in the notice within said seven-day period, such objection must be served on Defendants' counsel designated above in writing (by facsimile) and must identify the legal basis for the objection and describe the nature of the documents to which the objection is asserted in a manner that, without revealing the information allegedly protected, will enable the Defendants to assess the applicability of the asserted protection.

5. Schedule For Serving Plaintiff Fact Sheets, Responsive Documents And Authorizations. Plaintiffs in cases filed prior to the date of entry of this Order shall have sixty (60) days from the date of entry of this Order to serve upon Defendants' counsel designated above a complete and signed PFS, all responsive documents (or a written notice that none are in the possession of Plaintiff or Plaintiff's counsel) and properly executed authorizations. Each

Plaintiff in cases that are filed in the New York Unified Court System and that are or will be subject to this Coordinated Proceeding after the date of entry of this Order shall serve upon Defendants' counsel designated above a complete and signed PFS, all responsive documents (or a written notice that none are in the possession of Plaintiff or Plaintiff's counsel) and properly executed authorizations within sixty (60) days from the date of filing. For the purpose of this paragraph, the "date of filing" is defined as the date on which the case is filed in the New York Unified Court System. Notwithstanding the provisions of this paragraph, in cases that have been filed but where the complaint has not been served upon Defendants, Defendants' receipt of a PFS, responsive documents, authorizations or other such materials served under this paragraph shall not constitute or be deemed consent to personal jurisdiction or a waiver of any service requirement in such cases under applicable law.

6. Provision Of Medical Records To Parties. Plaintiffs' and Defendants' Liaison Counsel shall make available, through an outside vendor(s) jointly selected and hired by Liaison Counsel, all records obtained from any health care provider(s) or other custodian(s) of records through an authorization or subpoena on a secure web site maintained by the outside vendor(s). Such records shall be Bates numbered by the vendor. Plaintiff's counsel in a specific case may access that web site to obtain copies of their clients' records only, and are hereby restricted from accessing or obtaining copies of any other individual's medical records through that web site or vendor. For each set of records Plaintiffs' counsel (or counsel for any other party) wishes to obtain from the vendor(s), Plaintiffs or the other party may be charged any one-time "viewing fees" established by the vendor(s) and agreed to by the parties, plus half of any fee charged by the records custodian, which shall be payable directly to the vendor(s). If a third party (for example, a treating physician defendant or other third party or, as the case may be, a

Plaintiff) also wishes to obtain the records, that party shall be charged one-third of the fee charged by the record custodian, and one-third of the fee paid by each earlier party who obtained the records shall be refunded by the vendor(s). Plaintiffs (or counsel for any other party) will be able to download and copy any and all viewed records for their use at no additional expense. The Defendants shall have no other obligation to provide medical or other records obtained pursuant to the authorization(s) to Plaintiffs, including prior to the deposition of any Plaintiff.

III. Dismissal Of Plaintiffs' Claims For Failure To Comply With Discovery Obligations

7. Notice That Claims May Be Dismissed. Any Plaintiff who fails to comply with any discovery obligations imposed by this Order within the time periods set forth herein may be subject to having his or her claims, as well as any derivative claim(s), dismissed if good cause for such dismissal is shown. Good cause shall exist where there is a material deficiency in responding to required discovery, i.e., one that prejudices Defendants through a failure to provide necessary information, thereby impeding Defendants' access to material and relevant evidence. Any dismissal may be with or without prejudice as the Court may determine in an individual case. Defendants have informed the Court that they intend to move to dismiss with prejudice those cases in which there is a material deficiency in responding to required discovery. The procedure for such motions shall be governed by paragraph 10 herein.

8. Initial Notice Of Discovery Obligations.

a. Notice By Court To Be Jointly Drafted By Parties. Plaintiffs' and Defendants' Liaison Counsel shall meet and confer to draft a notice from the Court to Plaintiffs' counsel regarding the Coordinated Proceeding, which such notice shall describe the status of the litigation, the Plaintiffs' discovery obligations, and any other duties imposed by the Court's various Case Management Orders and which shall enclose copies of the Case Management

Orders applicable to all cases ("the Initial Notice"). Liaison Counsel shall update the Initial Notice from time to time as they see fit or as ordered by the Court. Plaintiffs' Liaison Counsel shall be responsible for transmitting the Initial Notice to Plaintiffs' counsel.

b. Cases Presently Pending In The Coordinated Proceeding. The Initial Notice provided to Plaintiffs' counsel in all cases pending in this Coordinated Proceeding as of the date of this Order shall inform Plaintiffs' counsel in the subject cases that, pursuant to this Case Management Order, Plaintiffs have sixty (60) days to serve upon Defendants' counsel designated above a complete and signed PFS, all responsive documents (or a written notice that none are in the possession of Plaintiff or Plaintiff's counsel) and properly executed authorizations.

c. Cases Subsequently Filed And Transferred. The Initial Notice provided to Plaintiffs' counsel in all cases transferred to or directly filed in this Coordinated Proceeding after the date of this Order shall inform Plaintiffs' counsel that, pursuant to this Case Management Order, Plaintiffs have sixty (60) days from the date of service or the date of transfer as defined in paragraph 5 above to serve upon Defendants' counsel designated above a complete and signed PFS, all responsive documents (or a written notice that none are in the possession of Plaintiff or Plaintiff's counsel), and properly executed authorizations.

9. Notice Of Overdue Or Deficient Discovery. When any Plaintiff has failed to materially comply with their obligations under this Order within the timelines established herein, Defendants' Liaison Counsel or her designee shall send a notice of the material deficiency to the Plaintiff's counsel for the individual whose responses are alleged to be defective ("the deficiency letter"). The deficiency letter shall identify with particularity the alleged material deficiency, state that the Plaintiff will have thirty (30) days to cure the alleged

material deficiency, and state that absent the alleged material deficiency being cured within that time (or within any extension of that time as agreed to by the parties), Defendants may move for dismissal of Plaintiff's claims, including dismissal with prejudice upon an appropriate showing. Plaintiffs' Liaison Counsel or his designee shall be electronically copied with the deficiency letter. This provision shall not be construed to prevent Defendants' Liaison Counsel or her designee from meeting and conferring with Plaintiffs' Liaison Counsel regarding any other deficiencies.

10. Procedure For Dismissal Of Cases With Material Deficiency. The procedure for the motions referenced in paragraph 7 shall be as follows:

a. If Plaintiff's individual counsel responds to the deficiency letter, Defendants' Liaison Counsel or her designee shall meet and confer with such counsel with respect to the purported deficiency.

b. If the parties' meet and confer is unsuccessful, or if Plaintiff's individual counsel does not respond to the deficiency letter and a subsequent meet and confer effort under New York Rules of Court § 202.7 (22 N.Y.C.R.R. 202.7), Defendants' Liaison Counsel or her designee may file a motion (a "compliance motion") with the Special Master (appointed by the Court to hear such disputes) seeking a report and recommendation requiring Plaintiff to comply with this Order within twenty-one (21) days, or face a dismissal motion to be filed with the Court, including dismissal with prejudice, or other sanctions.

c. Such compliance motion shall be heard on an expedited basis. A compliance motion may be noticed twenty-one (21) calendar days before the hearing date, with any opposition to be filed ten (10) calendar days before the hearing and any reply to be filed five (5) calendar days before the hearing.

d. If the Special Master appointed by the Court to hear such disputes determines that Plaintiff's discovery is materially deficient, it shall issue a report and recommendation requiring Plaintiff to comply with this Order within twenty-one (21) days ("the compliance order"), or face dismissal or other appropriate sanctions, as determined by the Court.

e. If Plaintiff does not comply with the compliance order within twenty-one (21) days, Defendants' Liaison Counsel or her designee may file a motion with the Court to dismiss Plaintiff's claims with prejudice or for other appropriate sanctions (a "dismissal/sanctions motion").

f. Such dismissal/sanctions motion shall be heard on an expedited basis. A dismissal motion may be noticed twenty-one (21) calendar days before the hearing date, with any opposition to be filed ten (10) calendar days before the hearing and any reply to be filed five (5) calendar days before the hearing.

g. If the Court determines that Plaintiff has not complied with the compliance order, it may dismiss Plaintiff's claims with or without prejudice, or impose other sanctions, as it deems appropriate.

IV. Defendant Fact Sheet

11. Pfizer Entities' Obligation To Serve Defendant Fact Sheet. Defendants Pfizer Inc., Pharmacia & Upjohn Co., Pharmacia & Upjohn LLC, Pharmacia Corporation, and G.D. Searle LLC (formerly known as G.D. Searle & Co.) (collectively, "the Pfizer Entities"), shall collectively serve upon each Plaintiff's counsel of record (as identified in the PFS) a hard copy of a complete and verified Defendant Fact Sheet in the form set forth in Attachment E. An electronic copy of the Defendant Fact Sheet shall also be served on Plaintiffs' Liaison Counsel's

designee and individual counsel for each Plaintiff for whom an email address has been provided in the Plaintiff Fact Sheet.

12. Schedule For Serving Defendant Fact Sheet. The Pfizer Entities shall provide a complete and verified Defendant Fact Sheet within sixty (60) days after receipt of a substantially complete and verified PFS and substantially complete authorizations, or within sixty (60) days after service of the complaint, whichever is later. If the Pfizer Entities fail to provide a completed and verified Defendant Fact Sheet within that time, Plaintiffs' Liaison Counsel shall provide notice to Defendants' Liaison Counsel by facsimile as provided in paragraph 13 herein. The Pfizer Entities shall have an additional thirty (30) days to cure the deficiency. No other extensions will be granted, absent good cause.

13. Notice Of Overdue Or Deficient Discovery. In the event that the Pfizer Entities have failed to materially comply with their obligations under this Order within the timelines established herein, Plaintiffs' Liaison Counsel shall send a notice of the material deficiency to the Defendants' Liaison Counsel. The notice shall identify with particularity the alleged material deficiency, state that the Pfizer Entities will have thirty (30) days to cure the alleged material deficiency, and state that absent the alleged material deficiency being cured within that time (or within any extension of that time as agreed to by the parties), Plaintiffs' Liaison Counsel may, after meeting and conferring with Defendants' Liaison Counsel, move the Court or Special Master appointed by the Court to hear such disputes for evidentiary or other sanctions. This provision shall not be construed to prevent Plaintiffs' Liaison Counsel or her designee from meeting and conferring with Defendants' Liaison Counsel regarding any other deficiencies.

14. Notice That Court May Impose Sanctions. If the Pfizer Entities fail to comply with any discovery obligations imposed by this Order within the time periods set forth herein, the Pfizer Entities may be subject to such evidentiary or other sanctions as this Court (or Special Master appointed by the Court to hear such disputes) may see fit to impose, upon motion by Plaintiffs' Liaison Counsel, after meeting and conferring with Defendants' Liaison Counsel, if good cause for such sanctions is shown. Good cause shall exist where there is a material deficiency in responding to required discovery, i.e., one that prejudices Plaintiff through a failure to provide necessary information, thereby impeding Plaintiff's access to material and relevant evidence.

V. Other Discovery

15. Case-Specific Discovery. The parties shall meet and confer regarding a further schedule for discovery, a protocol for the selection of certain cases for an initial trial pool of cases to be initially addressed by this Court and case-specific depositions as to those cases.

16. Generic Experts. The parties shall meet and confer regarding the subject of generic expert discovery. The term "generic experts" refers to experts who will testify on issues of general or widespread applicability, including but not limited to those who will testify on general causation. The parties shall meet and confer to agree upon timing for the identification of generic experts, the number of generic experts, the contents of generic experts' reports and the schedule for generic expert discovery and *Daubert / Frye* motions.

SO ORDERED.

Dated: 8/14, 2006

Hon. Shirley W. Kornreich
SHIRLEY WERNER KORNREICH J.S.C.

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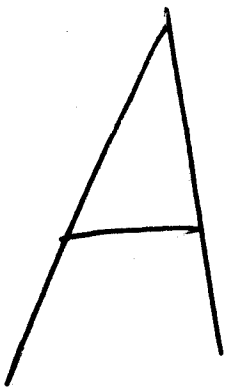


SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

IN RE: NEW YORK BEXTRA AND CELEBREX PRODUCT LIABILITY LITIGATION	Index No. 560001/2005
THIS DOCUMENT APPLIES TO ALL CASES	

BEXTRA®
PLAINTIFF FACT SHEET

Each plaintiff who allegedly suffered personal injury as a result of taking BEXTRA® (but not CELEBREX®) must complete this Fact Sheet. 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. If you are completing the Fact Sheet for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can for that person. Please attach as many sheets of paper as necessary to fully answer these questions.

I. CASE INFORMATION

A. Name of person completing this form: _____

B. Please state the following for the civil action that you filed:

1. Case caption: _____

2. Civil Action Number: _____

3. Court in which action was originally filed: _____

4. Your attorney:

Name: _____

Firm: _____

Address: _____

_____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____

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

1. Maiden or other names you have used or by which you have been known and dates you used those names:

_____

2. Current Address: _____

_____

3. State which individual or estate you are representing, and in what capacity you are representing the individual or estate:

Individual/Estate Representing: _____

Capacity: _____

4. If you were appointed as a representative by a court, state the:

Court Which Appointed You: _____

Date of Appointment: _____

5. What is your relationship to the individual you represent? _____

_____

6. If you represent a decedent's estate, state:

Date of Death: _____

Address of Place Where Decedent Died: _____

_____

7. If you are claiming the wrongful death of a family member, identify any and all heirs of that person:

_____

_____

THE REST OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO USED BEXTRA®. IF YOU ARE COMPLETING THIS FACT SHEET FOR SOMEONE ELSE, PLEASE ASSUME THAT "YOU" MEANS THE BEXTRA® USER.

II. CLAIM INFORMATION

A. Do you claim that you suffered bodily injury as a result of taking BEXTRA®?

Yes ____ **No** ____ If **Yes**, please answer the following:

1. What bodily injury do you claim resulted from your use of BEXTRA®?

_____

_____

2. When did this injury occur? _____

3. Who diagnosed it? _____

4. Were you hospitalized? _____

Yes ____ **No** ____ If **Yes**, please provide the following information:

a. Date of hospital admission: _____

b. Date of discharge: _____

c. Hospital name and address: _____

_____

5. What damages do you claim you suffered as a result of the injury?

_____

_____

_____

B. Do you claim that your use of BEXTRA® worsened a previously existing injury or condition?

Yes ____ **No** _____ If **Yes**, set forth the injury or condition, whether or not you had already recovered from that injury or condition before you took BEXTRA®, and, if so, the date you previously recovered from the injury or condition:

_____

_____

C. Are you claiming mental and/or emotional damages as a result of taking BEXTRA®?

Yes ____ **No** ____ If **Yes**, what mental and/or emotional damages do you claim resulted from your use of BEXTRA®?

_____

_____

If **Yes**, for each provider (including but not limited to primary care physicians, psychiatrists, psychologists, and/or counselors) from whom you have sought treatment for psychological, psychiatric or emotional problems, state the following:

Name	Address	Condition treated	Dates treated	Medications prescribed

D. Are you making a claim for lost wages or lost earning capacity?

Yes ____ **No** ____ If **Yes**, state the annual gross income you derived from your employment for each of the last five (5) years:

_____

_____

_____

E. If you assert claims for the Fifth (Fraud, Misrepresentation and Suppression) or Sixth (Violation of N.Y. G.B.L. § 349) Causes of Action as contained in the Master Complaint in this action, please provide below specific details of the alleged fraud, misrepresentation or challenged consumer-oriented act or practice as required by the New York Civil Practice Law and Rules ("CPLR").

III. PERSONAL INFORMATION

A. Name: _____

B. Maiden or other names you have used or by which you have been known and dates you used those names:

_____

C. Current Address: _____

_____

D. Social Security Number: _____

E. Date and Place of Birth: _____

F. Gender: Male ____ Female ____

G. Identify each address at which you have resided during the last ten (10) years, and the dates you resided at each one.

Address	Dates of Residence

H. Schools attended:

Institution	Dates Attended	Course of Study	Diplomas or Degrees

I. Employment Information: Identify the following for each employer you have had in the last ten (10) years:

Name	Address	Dates of Employment	Occupation/ Job Duties

J. Military Service: Have you ever served in the military, including the military reserve or National Guard?

Yes ____ **No** ____ If **Yes**, were you ever rejected or discharged from military service for any reason relating to your physical, psychiatric or emotional condition?

Yes ____ **No** ____ If **Yes**, state the condition for which you were rejected or discharged:

_____

K. Insurance / Claim Information

1. Has any insurance or other company provided medical coverage to you or paid medical bills on your behalf since January 1, 1998 through the present?

Yes _____ **No** _____ If **Yes**, please complete the following:

Name of Company	Address

2. Have you ever filed a workers' compensation and/or social security disability (SSI or SSD) claim?

Yes ____ **No** ____ If **Yes**, please state the following:

Type of Claim	Year Claim Filed	Agency Where Claim Filed	Nature of Disability	Period of Disability

3. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury?

Yes ____ **No** ____ If **Yes**, please state the following:

Party You Sued/ Made Claim Against	Court in Which Suit Filed/ Claim Made	Case/Claim Number	Attorney Who Represented You	Nature of Claim and Injury

L. As an adult, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty?

Yes ____ **No** ____ If **Yes**, please state the following:

1. Where convicted: _____

2. When convicted: _____

3. Nature of felony and/or crime: _____

IV. FAMILY INFORMATION

A. Marriage(s)

1. If you are or have ever been married, identify the following:

Spouse's Name	Date of Birth	Date Married	Date of End of Marriage	Reason for End of Marriage

2. Has your spouse filed a claim for loss of consortium in this action?

Yes ____ **No** ____

B. If you have children, please identify each child's name and date of birth.

_____

_____

_____

C. To the best of your knowledge, has **any family member** (child, parent, sibling, or grandparent) ever experienced or been diagnosed with any of the following conditions? Please select **Yes** or **No** for each condition. For each condition for which you answer **Yes**, please provide the additional information requested in the table following this chart.

Condition Experienced by Family Member	Yes	No
1. Abnormal heart rhythm, atrial fibrillation, or heart block		
2. Allergic reaction to medication (e.g., skin reaction, rash, or anaphylaxis)		
3. Arteriosclerosis/hardening of the arteries/stenosis		
4. Arthritis (osteoarthritis or rheumatoid arthritis)		
5. Atherosclerosis/blocked or narrow arteries/coronary artery disease		
6. Bleeding or clotting disorders		

Condition Experienced by Family Member	Yes	No
7. Cardiomyopathy/enlarged heart		
8. Chest pain/angina		
9. Chronic obstructive pulmonary disease/COPD/chronic lung disease		
10. Congenital heart abnormality or condition		
11. Congestive heart failure		
12. Deep vein thrombosis/DVT		
13. Dermatologic diseases or conditions		
14. Diabetes		
15. Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD)		
16. Heart attack/MI/myocardial infarction		
17. Heart valve problems (e.g., murmur, leaky valve, prolapse, regurgitation)		
18. High blood pressure/hypertension		
19. High cholesterol or triglycerides		
20. Kidney disease or condition		
21. Peripheral vascular disease or peripheral arterial disease		
22. Phlebitis		
23. Pulmonary embolism/blood clot to the lungs		
24. Pulmonary hypertension		
25. Raynaud's syndrome		
26. Stroke or transient ischemic attack/TIA		
27. Vasculitis		

For each condition for which you answered **Yes** in the previous chart, please provide the information requested below (attach additional sheets as needed):

Name of Family Member	Condition	Age When Condition Discovered	Cause of Death (if Applicable)

V. BEXTRA® PRESCRIPTION INFORMATION

A. Prescriber and Pharmacy Information:

1. Who prescribed BEXTRA® for you? _____

2. Prescriber's address: _____

3. Name of pharmacy where prescription filled: _____

4. Address of pharmacy: _____

_____

B. Identify the following for each period of time during which you took BEXTRA®:

Dosage (10 mg or 20 mg)	How often per day?	Date Started	Date Stopped	Condition for which Prescribed

C. Did you receive any samples of BEXTRA®?

Yes ____ **No** ____ If **Yes**, please state the following:

1. Who provided the samples? _____

2. When were samples provided? _____

3. What was the dosage of the samples? _____

4. How many samples were provided? _____

D. Instructions or Warnings: Did you receive any written and/or oral information, including but not limited to instructions or warnings, about BEXTRA® at any time?

Yes ____ **No**____ I don't recall____ If **Yes**, please state the following:

Information Received	Written or Oral	When Received	From Whom Received

VI. MEDICAL BACKGROUND

A. Height: _____

B. Current Weight: _____

C. Weight at the time of the injury described in Section II: _____

D. Tobacco Use History: Check the answer and fill in the blanks applicable to your history of tobacco use. Tobacco use includes smoking cigarettes, cigars, pipes and/or using chewing tobacco/snuff.

_____ I have never used tobacco.

_____ I used tobacco in the past.

Date tobacco use started: _____ Date tobacco use ceased: _____

Amount used: on average _____ per day for _____ years.

_____ I currently use tobacco.

Date tobacco use started: _____

Amount currently using: on average _____ per day for _____ years.

_____ I have used different amounts of tobacco at different times (please identify type(s) of tobacco used and dates and frequency of use below).

_____

_____

E. Alcohol Consumption: Do you now drink or have you in the past drunk alcohol (beer, wine, whiskey, etc.)?

Yes ____ **No** ____ If **Yes**, fill in the appropriate blank with the number of drinks that best represents your average alcohol consumption during the last 10 years:

_____ drinks per week; _____ drinks per month; _____ drinks per year; or

Other (describe): _____

_____

What types of alcohol have you mostly consumed?

_____

F. Illicit Drugs: Have you used (even one time) any illicit drugs of any kind?

Yes ____ **No** ____ If **Yes**, identify each substance and when you first and last used it:

_____

G. Allergic Reactions: If you are claiming you suffered any type of skin reaction as a result of taking BEXTRA®, please indicate whether you have you ever experienced an allergic reaction to medicine.

Yes ____ **No** ____ **Not Applicable** ____ If **Yes**, please state the following:

Name of Medication	When Allergy Diagnosed	Symptoms of Allergy	Doctor Who Diagnosed Allergy

H. Have **you** ever experienced or been diagnosed with any of the following conditions? Please select **Yes** or **No** for each condition. For each condition for which you answer **Yes**, please provide the additional information requested in the table following this chart:

Condition You Experienced or That Was Diagnosed	Yes	No
1. Abnormal heart rhythm, atrial fibrillation, or heart block		
2. Allergic reaction to medication (e.g., skin reaction, rash, or anaphylaxis)		
3. Arteriosclerosis/hardening of the arteries/stenosis		
4. Arthritis (osteoarthritis or rheumatoid arthritis)		
5. Atherosclerosis/blocked or narrow arteries/coronary artery disease		
6. Autoimmune diseases (e.g., lupus, Sjögren's, etc.)		
7. Bleeding or clotting disorders		
8. Cancer (e.g., colon, lung, breast, skin, other)		
9. Cardiomyopathy/enlarged heart		
10. Chest pain/angina		
11. Chronic obstructive pulmonary disease/COPD/chronic lung disease		
12. Congenital heart abnormality or condition		
13. Congestive heart failure		
14. Deep vein thrombosis/DVT		
15. Dermatologic diseases or conditions		
16. Diabetes		
17. Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD)		
18. Heart attack/MI/myocardial infarction		
19. Heart valve problems (e.g., murmur, leaky valve, prolapse, regurgitation)		
20. High blood pressure/hypertension		
21. High cholesterol or triglycerides		

Condition You Experienced or That Was Diagnosed	Yes	No
22. Immune system disease or dysfunction (including HIV or AIDS)		
23. Kidney disease or condition		
24. Liver disorder or disease (cirrhosis, hepatitis, etc.)		
25. Peripheral vascular disease or peripheral arterial disease		
26. Phlebitis		
27. Pulmonary embolism/blood clot to the lungs		
28. Pulmonary hypertension		
29. Raynaud's syndrome		
30. Rheumatic Fever		
31. Scarlet Fever		
32. Stroke or transient ischemic attack/TIA		
33. Thyroid condition		
34. Vasculitis		

For each condition for which you answered **Yes** in the previous chart, please provide the information requested below (attach additional sheets as needed):

Condition You Experienced	Date of Onset	Medication/ Treatment	Treating Physician	Current Status of Condition

I. Please indicate whether you have ever received any of the following treatments or procedures and provide the requested information about each.

1. **Cardiovascular Surgeries.** This includes but is not limited to open heart/bypass surgery, pacemaker implantation, stent placement, vascular surgery, IVC filter placement, carotid (neck artery) surgery, or valve replacement.

Yes _____ **No** _____ I don't recall _____ If **Yes**, please specify the following:

Surgery	Condition	Date	Treating Physician	Hospital

2. Treatment for heart attack, angina (chest pain), or lung ailments (other than as described in your response to question 1 above):

Yes _____ **No** _____ I don't recall _____ If **Yes**, please specify the following:

Treatment	Date	Treating Physician	Hospital

3. **Cardiovascular Diagnostic Tests.** This includes but is not limited to C-reactive protein (CRP), chest X-ray, angiogram/catheterization, CT scan, MRI, EKG, echocardiogram, TEE (trans-esophageal echo), endoscopy, lung bronchoscopy, carotid duplex/ultrasound, MRI/MRA of the head/neck, angiogram of the head/neck, CT scan of the head, bubble/microbubble study, and Holter monitor.

Yes ____ **No** ____ I don't recall _____ If **Yes**, please specify the following:

Diagnostic Test	Reason for Test	Date	Treating Physician/ Hospital	Result of Diagnostic Test

VII. ADDITIONAL MEDICATIONS

A. Please indicate whether you have taken any of the following medications in the past ten (10) years. If you answer **Yes** for any medication, please indicate whether you recall ever taking that medication on a daily basis for more than two months at a time.

Name of Medication	Yes	No	Don't Recall	Do You Recall Daily Use for More Than Two Months?
Advil®/Motrin®/Ibuprofen				
Aleve®/Naprosyn/Naproxen				
Aspirin (Bayer®, Bufferin®, Ascriptin®, Ecotrin®)				
Celebrex®/Celecoxib				
Codeine				
Darvocet/Darvocet-N				

Name of Medication	Yes	No	Don't Recall	Do You Recall Daily Use for More Than Two Months?
Demerol				
Mobic®/Meloxicam				
Morphine				
OxyContin				
Percocet				
Tylenol®/Acetaminophen				
Ultram®/Tramadol				
Vioxx®/Rofecoxib				
Voltaren®/Cataflam/Diclofenac				

B. Have you ever experienced any gastrointestinal side effects (for example, nausea, stomach pain, vomiting, diarrhea, constipation, ulcers, heartburn, reflux, or esophageal reflux disease/GERD) or any other side effects while you were taking any of the medications identified in your answer to question A above?

Yes ____ **No** ____ If **Yes**, please state the following:

Name of Medication	Side Effects	Date(s) Experienced

VIII. MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

A. Identify each doctor or other healthcare provider who has provided treatment to you in the past ten (10) years (attach additional sheets as needed).

Name	Address	Approximate Dates

B. Identify each hospital, clinic, or healthcare facility where you have received inpatient or outpatient treatment or been admitted as a patient during the last ten (10) years (attach additional sheets as needed).

Name	Address	Admission Date(s)	Reason for Admission

C. Identify each pharmacy that has dispensed medication to you in the last ten (10) years (attach additional sheets as needed).

Name of Pharmacy	Address of Pharmacy

D. If you have submitted a claim for social security disability or workers' compensation benefits in the last ten (10) years, what agency or entity is most likely to have records concerning your claim (attach additional sheets as needed)?

Name	Address

IX. DOCUMENTS

Please indicate if any of the following documents and things are currently in your possession, custody, or control, or in the possession, custody, or control of your lawyers, by checking **Yes** or **No**. Where you have indicated **Yes**, please attach the documents and materials to your responses to this Fact Sheet.

A. Records and bills of physicians, hospitals, pharmacies, other healthcare providers, government agencies, insurance companies, or any other entities identified in response to this Fact Sheet. **Yes** ____ **No** ____

B. Decedent's death certificate (if applicable). **Yes** ____ **No** ____

C. Report of autopsy of decedent (if applicable). **Yes** ____ **No** ____

D. Any copies of the packaging, include the bottle, box, and label for BEXTRA® and any unused medication. **Yes** ____ **No** ____

E. Prescriptions or receipts for BEXTRA®. **Yes** ____ **No** ____

F. If you are claiming lost wages or a loss of earning capacity, your W-2 forms for each of the last five (5) years. **Yes** ____ **No** ____

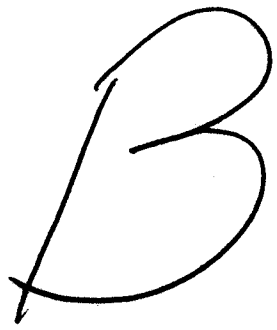
CERTIFICATION

I declare under penalty of perjury subject to N.Y. C.P.L.R. 3133(b) (McKinney 2005) that all of the information provided in this Plaintiff Fact Sheet is true, complete and correct to the best of my knowledge, that I have supplied all the documents requested in part IX. of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration. Further, I acknowledge that I must supplement my responses if I learn that they are incomplete or incorrect in any material respect.

Signature: _____

Print Name: _____

Date: _____



SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

IN RE: NEW YORK BEXTRA AND CELEBREX PRODUCT LIABILITY LITIGATION	Index No. 560001/2005
THIS DOCUMENT APPLIES TO ALL CASES	

CELEBREX®
PLAINTIFF FACT SHEET

Each plaintiff who allegedly suffered personal injury as a result of taking CELEBREX® (but not BEXTRA®) must complete this Fact Sheet. 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. If you are completing the Fact Sheet for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can for that person. Please attach as many sheets of paper as necessary to fully answer these questions.

I. CASE INFORMATION

A. Name of person completing this form: _____

B. Please state the following for the civil action that you filed:

1. Case caption: _____

2. Index Number: _____

3. County in which action was originally filed: _____

4. Your attorney:

Name: _____

Firm: _____

Address: _____

_____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____

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

1. Maiden or other names you have used or by which you have been known and dates you used those names:

_____

2. Current Address: _____

_____

3. State which individual or estate you are representing, and in what capacity you are representing the individual or estate:

Individual/Estate Representing: _____

Capacity: _____

4. If you were appointed as a representative by a court, state the:

Court Which Appointed You: _____

Date of Appointment: _____

5. What is your relationship to the individual you represent? _____

_____

6. If you represent a decedent's estate, state:

Date of Death: _____

Address of Place Where Decedent Died: _____

_____

7. If you are claiming the wrongful death of a family member, identify any and all heirs of that person:

_____

_____

THE REST OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO USES OR USED CELEBREX®. IF YOU ARE COMPLETING THIS FACT SHEET FOR SOMEONE ELSE, PLEASE ASSUME THAT "YOU" MEANS THE CELEBREX® USER.

II. CLAIM INFORMATION

A. Do you claim that you suffered bodily injury as a result of taking CELEBREX®?

Yes ____ **No** ____ If **Yes**, please answer the following:

1. What bodily injury do you claim resulted from your use of CELEBREX®?

_____

_____

2. When did this injury occur? _____

3. Who diagnosed it? _____

4. Were you hospitalized? _____

Yes ____ **No** ____ If **Yes**, please provide the following information:

a. Date of hospital admission: _____

b. Date of discharge: _____

c. Hospital name and address: _____

_____

5. What damages do you claim you suffered as a result of the injury?

_____

_____

_____

B. Do you claim that your use of CELEBREX® worsened a previously existing injury or condition?

Yes ____ **No** _____ If **Yes**, set forth the injury or condition, whether or not you had already recovered from that injury or condition before you took CELEBREX®, and, if so, the date you previously recovered from the injury or condition:

_____

_____

C. Are you claiming mental and/or emotional damages as a result of taking CELEBREX®?

Yes ____ **No** ____ If **Yes**, what mental and/or emotional damages do you claim resulted from your use of CELEBREX®?

_____

_____

If **Yes**, for each provider (including but not limited to primary care physicians, psychiatrists, psychologists, and/or counselors) from whom you have sought treatment for psychological, psychiatric or emotional problems, state the following:

Name	Address	Condition treated	Dates treated	Medications prescribed

D. Are you making a claim for lost wages or lost earning capacity?

Yes ____ **No** ____ If **Yes**, state the annual gross income you derived from your employment for each of the last five (5) years:

_____

_____

_____

E. If you assert claims for the Fifth (Fraud, Misrepresentation and Suppression) or Sixth (Violation of N.Y. G.B.L. § 349) Causes of Action as contained in the Master Complaint in this action, please provide below specific details of the alleged fraud, misrepresentation or challenged consumer-oriented act or practice as required by the New York Civil Practice Law and Rules ("CPLR").

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

III. PERSONAL INFORMATION

A. Name: _____

B. Maiden or other names you have used or by which you have been known and dates you used those names:

_____

C. Current Address: _____

_____

D. Social Security Number: _____

E. Date and Place of Birth: _____

F. Gender: Male ____ Female ____

G. Identify each address at which you have resided during the last ten (10) years, and the dates you resided at each one.

Address	Dates of Residence

H. Schools attended:

Institution	Dates Attended	Course of Study	Diplomas or Degrees

I. Employment Information: Identify the following for each employer you have had in the last ten (10) years:

Name	Address	Dates of Employment	Occupation/ Job Duties

J. Military Service: Have you ever served in the military, including the military reserve or National Guard?

Yes ____ **No** ____ If **Yes**, were you ever rejected or discharged from military service for any reason relating to your physical, psychiatric or emotional condition?

Yes ____ **No** ____ If **Yes**, state the condition for which you were rejected or discharged:

_____

K. Insurance / Claim Information

1. Has any insurance or other company provided medical coverage to you or paid medical bills on your behalf since January 1, 1998 through the present?

Yes _____ **No** _____ If **Yes**, please complete the following:

Name of Company	Address

2. Have you ever filed a workers' compensation and/or social security disability (SSI or SSD) claim?

Yes ____ **No** ____ If **Yes**, please state the following:

Type of Claim	Year Claim Filed	Agency Where Claim Filed	Nature of Disability	Period of Disability

3. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury?

Yes ____ **No** ____ If **Yes**, please state the following:

Party You Sued/ Made Claim Against	Court in Which Suit Filed/ Claim Made	Case/Claim Number	Attorney Who Represented You	Nature of Claim and Injury

L. As an adult, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty?

Yes ____ **No** ____ If **Yes**, please state the following:

1. Where convicted: _____

2. When convicted: _____

3. Nature of felony and/or crime: _____

IV. FAMILY INFORMATION

A. Marriage(s)

1. If you are or have ever been married, identify the following:

Spouse's Name	Date of Birth	Date Married	Date of End of Marriage	Reason for End of Marriage

2. Has your spouse filed a claim for loss of consortium in this action?

Yes ____ **No** ____

B. If you have children, please identify each child's name and date of birth.

_____

_____

_____

C. To the best of your knowledge, has **any family member** (child, parent, sibling, or grandparent) ever experienced or been diagnosed with any of the following conditions? Please select **Yes** or **No** for each condition. For each condition for which you answer **Yes**, please provide the additional information requested in the table following this chart.

Condition Experienced by Family Member	Yes	No
1. Abnormal heart rhythm, atrial fibrillation, or heart block		
2. Allergic reaction to medication (e.g., skin reaction, rash, or anaphylaxis)		
3. Arteriosclerosis/hardening of the arteries/stenosis		
4. Arthritis (osteoarthritis or rheumatoid arthritis)		
5. Atherosclerosis/blocked or narrow arteries/coronary artery disease		
6. Bleeding or clotting disorders		

Condition Experienced by Family Member	Yes	No
7. Cardiomyopathy/enlarged heart		
8. Chest pain/angina		
9. Chronic obstructive pulmonary disease/COPD/chronic lung disease		
10. Congenital heart abnormality or condition		
11. Congestive heart failure		
12. Deep vein thrombosis/DVT		
13. Dermatologic diseases or conditions		
14. Diabetes		
15. Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD)		
16. Heart attack/MI/myocardial infarction		
17. Heart valve problems (e.g., murmur, leaky valve, prolapse, regurgitation)		
18. High blood pressure/hypertension		
19. High cholesterol or triglycerides		
20. Kidney disease or condition		
21. Peripheral vascular disease or peripheral arterial disease		
22. Phlebitis		
23. Pulmonary embolism/blood clot to the lungs		
24. Pulmonary hypertension		
25. Raynaud's syndrome		
26. Stroke or transient ischemic attack/TIA		
27. Vasculitis		

For each condition for which you answered **Yes** in the previous chart, please provide the information requested below (attach additional sheets as needed):

Name of Family Member	Condition	Age When Condition Discovered	Cause of Death (if Applicable)

V. CELEBREX® PRESCRIPTION INFORMATION

A. Are you currently taking CELEBREX®?

Yes ____ **No** ____ If **Yes**, please provide the dosage you are currently taking:

_____

B. Prescriber and Pharmacy Information:

1. Who prescribed CELEBREX® for you? _____

2. Prescriber's address: _____

3. Name of pharmacy where prescription filled: _____

4. Address of pharmacy: _____

_____

C. Identify the following for each period of time during which you took CELEBREX®:

Dosage (100 mg, 200 mg, or 400 mg)	How often per day?	Date Started	Date Stopped	Condition for which Prescribed

D. Did you receive any samples of CELEBREX®?

Yes ____ **No** ____ If **Yes**, please state the following:

1. Who provided the samples? _____

2. When were samples provided? _____

3. What was the dosage of the samples? _____

4. How many samples were provided? _____

E. Instructions or Warnings: Did you receive any written and/or oral information, including but not limited to instructions or warnings, about CELEBREX® at any time?

Yes ____ **No**____ I don't recall____ If **Yes**, please state the following:

Information Received	Written or Oral	When Received	From Whom Received

VI. MEDICAL BACKGROUND

A. Height: _____

B. Current Weight: _____

C. Weight at the time of the injury described in Section II: _____

D. Tobacco Use History: Check the answer and fill in the blanks applicable to your history of tobacco use. Tobacco use includes smoking cigarettes, cigars, pipes and/or using chewing tobacco/snuff.

_____ I have never used tobacco.

_____ I used tobacco in the past.

Date tobacco use started: _____ Date tobacco use ceased: _____

Amount used: on average _____ per day for _____ years.

_____ I currently use tobacco.

Date tobacco use started: _____

Amount currently using: on average _____ per day for _____ years.

_____ I have used different amounts of tobacco at different times (please identify type(s) of tobacco used and dates and frequency of use below).

_____

_____

E. Alcohol Consumption: Do you now drink or have you in the past drunk alcohol (beer, wine, whiskey, etc.)?

Yes ____ **No** ____ If **Yes**, fill in the appropriate blank with the number of drinks that best represents your average alcohol consumption during the last 10 years:

_____ drinks per week; _____ drinks per month; _____ drinks per year; or

Other (describe): _____

What types of alcohol have you mostly consumed?

_____

F. Illicit Drugs: Have you used (even one time) any illicit drugs of any kind?

Yes ____ **No** ____ If **Yes**, identify each substance and when you first and last used it:

_____

G. Have **you** ever experienced or been diagnosed with any of the following conditions? Please select **Yes** or **No** for each condition. For each condition for which you answer **Yes**, please provide the additional information requested in the table following this chart:

Condition You Experienced or That Was Diagnosed	Yes	No
1. Abnormal heart rhythm, atrial fibrillation, or heart block		
2. Allergic reaction to medication (e.g., skin reaction, rash, or anaphylaxis)		
3. Arteriosclerosis/hardening of the arteries/stenosis		
4. Arthritis (osteoarthritis or rheumatoid arthritis)		
5. Atherosclerosis/blocked or narrow arteries/coronary artery disease		
6. Autoimmune diseases (e.g., lupus, Sjögren's, etc.)		
7. Bleeding or clotting disorders		
8. Cancer (e.g., colon, lung, breast, skin, other)		
9. Cardiomyopathy/enlarged heart		
10. Chest pain/angina		
11. Chronic obstructive pulmonary disease/COPD/chronic lung disease		
12. Congenital heart abnormality or condition		
13. Congestive heart failure		
14. Deep vein thrombosis/DVT		
15. Dermatologic diseases or conditions		
16. Diabetes		
17. Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD)		
18. Heart attack/MI/myocardial infarction		
19. Heart valve problems (e.g., murmur, leaky valve, prolapse, regurgitation)		
20. High blood pressure/hypertension		
21. High cholesterol or triglycerides		
22. Immune system disease or dysfunction (including HIV or AIDS)		
23. Kidney disease or condition		

Condition You Experienced or That Was Diagnosed	Yes	No
24. Liver disorder or disease (cirrhosis, hepatitis, etc.)		
25. Peripheral vascular disease or peripheral arterial disease		
26. Phlebitis		
27. Pulmonary embolism/blood clot to the lungs		
28. Pulmonary hypertension		
29. Raynaud's syndrome		
30. Rheumatic Fever		
31. Scarlet Fever		
32. Stroke or transient ischemic attack/TIA		
33. Thyroid condition		
34. Vasculitis		

For each condition for which you answered **Yes** in the previous chart, please provide the information requested below (attach additional sheets as needed):

Condition You Experienced	Date of Onset	Medication/ Treatment	Treating Physician	Current Status of Condition

H. Please indicate whether you have ever received any of the following treatments or procedures and provide the requested information about each.

1. **Cardiovascular Surgeries**. This includes but is not limited to open heart/bypass surgery, pacemaker implantation, stent placement, vascular surgery, IVC filter placement, carotid (neck artery) surgery, or valve replacement.

Yes _____ **No** _____ I don't recall _____ If **Yes**, please specify the following:

Surgery	Condition	Date	Treating Physician	Hospital

2. Treatment for heart attack, angina (chest pain), or lung ailments (other than as described in your response to question 1 above):

Yes _____ **No** _____ I don't recall _____ If **Yes**, please specify the following:

Treatment	Date	Treating Physician	Hospital

3. **Cardiovascular Diagnostic Tests.** This includes but is not limited to C-reactive protein (CRP), chest X-ray, angiogram/catheterization, CT scan, MRI, EKG, echocardiogram, TEE (trans-esophageal echo), endoscopy, lung bronchoscopy, carotid duplex/ultrasound, MRI/MRA of the head/neck, angiogram of the head/neck, CT scan of the head, bubble/microbubble study, and Holter monitor.

Yes ____ **No** ____ I don't recall _____ If **Yes**, please specify the following:

Diagnostic Test	Reason for Test	Date	Treating Physician/ Hospital	Result of Diagnostic Test

VII. ADDITIONAL MEDICATIONS

A. Please indicate whether you have taken any of the following medications in the past ten (10) years by selecting **Yes** or **No**. If you answer **Yes** for any medication, please indicate whether you recall ever taking that medication on a daily basis for more than two months at a time.

Name of Medication	Yes	No	Don't Recall	Do You Recall Daily Use for More Than Two Months?
Advil®/Motrin®/Ibuprofen				
Aleve®/Naprosyn/Naproxen				
Aspirin (Bayer®, Bufferin®, Ascriptin®, Ecotrin®)				
Bextra®/Valdecoxib/Parecoxib				
Codeine				
Darvocet/Darvocet-N				

Name of Medication	Yes	No	Don't Recall	Do You Recall Daily Use for More Than Two Months?
Demerol				
Mobic®/Meloxicam				
Morphine				
OxyContin				
Percocet				
Tylenol®/Acetaminophen				
Ultram®/Tramadol				
Vioxx®/Rofecoxib				
Voltaren®/Cataflam/Diclofenac				

B. Have you ever experienced any gastrointestinal side effects (for example, nausea, stomach pain, vomiting, diarrhea, constipation, ulcers, heartburn, reflux, or esophageal reflux disease/GERD) or any other side effects while you were taking any of the medications identified in your answer to question A above?

Yes ____ **No** ____ If **Yes**, please state the following:

Name of Medication	Side Effects	Date(s) Experienced

VIII. MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

A. Identify each doctor or other healthcare provider who has provided treatment to you in the past ten (10) years (attach additional sheets as needed).

Name	Current Address	Approximate Dates

B. Identify each hospital, clinic, or healthcare facility where you have received inpatient or outpatient treatment or been admitted as a patient during the last ten (10) years (attach additional sheets as needed).

Name	Current Address	Admission Date(s)	Reason for Admission

C. Identify each pharmacy that has dispensed medication to you in the last ten (10) years (attach additional sheets as needed).

Name of Pharmacy	Address of Pharmacy

D. If you have submitted a claim for social security disability or workers' compensation benefits in the last ten (10) years, what agency or entity is most likely to have records concerning your claim (attach additional sheets as needed)?

Name	Address

IX. DOCUMENTS

Please indicate if any of the following documents and things are currently in your possession, custody, or control, or in the possession, custody, or control of your lawyers, by checking **Yes** or **No**. Where you have indicated **Yes**, please attach the documents and materials to your responses to this Fact Sheet.

A. Records and bills of physicians, hospitals, pharmacies, other healthcare providers, government agencies, insurance companies, or any other entities identified in response to this Fact Sheet. **Yes** ____ **No** ____

B. Decedent's death certificate (if applicable). **Yes** ____ **No** ____

C. Report of autopsy of decedent (if applicable). **Yes** ____ **No** ____

D. Any copies of the packaging, include the bottle, box, and label for CELEBREX® and any unused medication. **Yes** ____ **No** ____

E. Prescriptions or receipts for CELEBREX®. **Yes** ____ **No** ____

F. If you are claiming lost wages or a loss of earning capacity, your W-2 forms for each of the last five (5) years. **Yes** ____ **No** ____

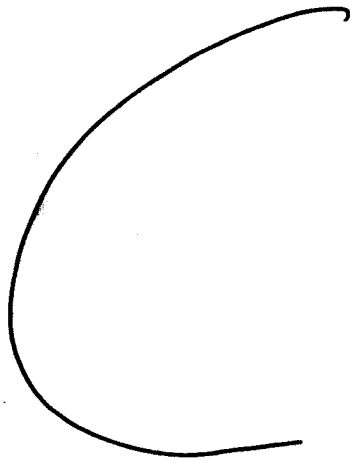
CERTIFICATION

I declare under penalty of perjury subject to N.Y. C.P.L.R. 3133(b) (McKinney 2005) that all of the information provided in this Plaintiff Fact Sheet is true, complete and correct to the best of my knowledge, that I have supplied all the documents requested in part IX. of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration. Further, I acknowledge that I must supplement my responses if I learn that they are incomplete or incorrect in any material respect.

Signature: _____

Print Name: _____

Date: _____



SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

IN RE: NEW YORK BEXTRA AND CELEBREX PRODUCT LIABILITY LITIGATION	Index No. 560001/2005
THIS DOCUMENT APPLIES TO ALL CASES	

BEXTRA® and CELEBREX®
PLAINTIFF FACT SHEET

Each plaintiff who allegedly suffered personal injury as a result of taking BEXTRA® and CELEBREX® must complete this Fact Sheet. 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. If you are completing the Fact Sheet for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can for that person. Please attach as many sheets of paper as necessary to fully answer these questions.

I. CASE INFORMATION

A. Name of person completing this form: _____

B. Please state the following for the civil action that you filed:

1. Case caption: _____

2. Index Number: _____

3. County in which action was originally filed: _____

4. Your attorney:

Name: _____

Firm: _____

Address: _____

_____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____

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

1. Maiden or other names you have used or by which you have been known and dates you used those names:

_____

2. Current Address: _____

_____

3. State which individual or estate you are representing, and in what capacity you are representing the individual or estate:

Individual/Estate Representing: _____

Capacity: _____

4. If you were appointed as a representative by a court, state the:

Court Which Appointed You: _____

Date of Appointment: _____

5. What is your relationship to the individual you represent? _____

_____

6. If you represent a decedent's estate, state:

Date of Death: _____

Address of Place Where Decedent Died: _____

_____

7. If you are claiming the wrongful death of a family member, identify any and all heirs of that person:

_____

_____

THE REST OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO USES OR USED CELEBREX® AND USED BEXTRA®. IF YOU ARE COMPLETING THIS FACT SHEET FOR SOMEONE ELSE, PLEASE ASSUME THAT "YOU" MEANS THE BEXTRA® AND CELEBREX® USER.

II. CLAIM INFORMATION

A. Do you claim that you suffered bodily injury as a result of taking BEXTRA®?

Yes ____ **No** ____ If **Yes**, please answer the following:

1. What bodily injury do you claim resulted from your use of BEXTRA®?

_____

_____

2. When did this injury occur? _____

3. Who diagnosed it? _____

4. Were you hospitalized? _____

Yes ____ **No** ____ If **Yes**, please provide the following information:

a. Date of hospital admission: _____

b. Date of discharge: _____

c. Hospital name and address: _____

_____

5. What damages do you claim you suffered as a result of the injury?

_____

_____

_____

B. Do you claim that your use of BEXTRA® worsened a previously existing injury or condition?

Yes ____ **No** _____ If **Yes**, set forth the injury or condition, whether or not you had already recovered from that injury or condition before you took BEXTRA®, and, if so, the date you previously recovered from the injury or condition:

_____

_____

C. Are you claiming mental and/or emotional damages as a result of taking BEXTRA®?

Yes ____ **No** ____ If **Yes**, what mental and/or emotional damages do you claim resulted from your use of BEXTRA®?

_____

_____

If **Yes**, for each provider (including but not limited to primary care physicians, psychiatrists, psychologists, and/or counselors) from whom you have sought treatment for psychological, psychiatric or emotional problems, state the following:

Name	Address	Condition treated	Dates treated	Medications prescribed

D. Do you claim that you suffered bodily injury as a result of taking CELEBREX®?

Yes ____ **No** ____ If **Yes**, please answer the following:

1. What bodily injury do you claim resulted from your use of CELEBREX®?

   _____

   _____

2. When did this injury occur? _____

3. Who diagnosed it? _____

4. Were you hospitalized? _____

Yes ____ **No** ____ If **Yes**, please provide the following information:

a. Date of hospital admission: _____

b. Date of discharge: _____

c. Hospital name and address: _____

_____

5. What damages do you claim you suffered as a result of the injury?

_____

_____

_____

E. Do you claim that your use of CELEBREX® worsened a previously existing injury or condition?

Yes ____ **No** _____ If **Yes**, set forth the injury or condition, whether or not you had already recovered from that injury or condition before you took CELEBREX®, and, if so, the date you previously recovered from the injury or condition:

_____

_____

F. Are you claiming mental and/or emotional damages as a result of taking CELEBREX®?

Yes ____ **No** ____ If **Yes**, what mental and/or emotional damages do you claim resulted from your use of CELEBREX®?

_____

_____

If **Yes**, for each provider (including but not limited to primary care physicians, psychiatrists, psychologists, and/or counselors) from whom you have sought treatment for psychological, psychiatric or emotional problems, state the following:

Name	Address	Condition treated	Dates treated	Medications prescribed

G. Are you making a claim for lost wages or lost earning capacity?

Yes ____ **No** ____ If **Yes**, state the annual gross income you derived from your employment for each of the last five (5) years:

_____

_____

_____

H. If you assert claims for the Fifth (Fraud, Misrepresentation and Suppression) or Sixth (Violation of N.Y. G.B.L. § 349) Causes of Action as contained in the Master Complaint in this action, please provide below specific details of the alleged fraud, misrepresentation or challenged consumer-oriented act or practice as required by the New York Civil Practice Law and Rules ("CPLR").

_____

_____

_____

_____

_____

_____

_____

_____

_____

III. PERSONAL INFORMATION

A. Name: _____

B. Maiden or other names you have used or by which you have been known and dates you used those names:

_____

C. Current Address: _____

_____

D. Social Security Number: _____

E. Date and Place of Birth: _____

F. Gender: Male ____ Female ____

G. Identify each address at which you have resided during the last ten (10) years, and the dates you resided at each one.

Address	Dates of Residence

H. Schools attended:

Institution	Dates Attended	Course of Study	Diplomas or Degrees

I. Employment Information: Identify the following for each employer you have had in the last ten (10) years:

Name	Address	Dates of Employment	Occupation/ Job Duties

J. Military Service: Have you ever served in the military, including the military reserve or National Guard?

Yes ____ **No** ____ If **Yes**, were you ever rejected or discharged from military service for any reason relating to your physical, psychiatric or emotional condition?

Yes ____ **No** ____ If **Yes**, state the condition for which you were rejected or discharged:

_____

K. Insurance / Claim Information

1. Has any insurance or other company provided medical coverage to you or paid medical bills on your behalf since January 1, 1998 through the present?

Yes _____ **No** _____ If **Yes**, please complete the following:

Name of Company	Address

2. Have you ever filed a workers' compensation and/or social security disability (SSI or SSD) claim?

Yes ____ **No** ____ If **Yes**, please state the following:

Type of Claim	Year Claim Filed	Agency Where Claim Filed	Nature of Disability	Period of Disability

3. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury?

Yes ____ **No** ____ If **Yes**, please state the following:

Party You Sued/ Made Claim Against	Court in Which Suit Filed/ Claim Made	Case/Claim Number	Attorney Who Represented You	Nature of Claim and Injury

L. As an adult, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty?

Yes ____ **No** ____ If **Yes**, please state the following:

1. Where convicted: _____

2. When convicted: _____

3. Nature of felony and/or crime: _____

IV. FAMILY INFORMATION

A. Marriage(s)

1. If you are or have ever been married, identify the following:

Spouse's Name	Date of Birth	Date Married	Date of End of Marriage	Reason for End of Marriage

2. Has your spouse filed a claim for loss of consortium in this action?

Yes ____ **No** ____

B. If you have children, please identify each child's name and date of birth.

_____

_____

_____

C. To the best of your knowledge, has **any family member** (child, parent, sibling, or grandparent) ever experienced or been diagnosed with any of the following conditions? Please select **Yes** or **No** for each condition. For each condition for which you answer **Yes**, please provide the additional information requested in the table following this chart.

Condition Experienced by Family Member	Yes	No
1. Abnormal heart rhythm, atrial fibrillation, or heart block		
2. Allergic reaction to medication (e.g., skin reaction, rash, or anaphylaxis)		
3. Arteriosclerosis/hardening of the arteries/stenosis		
4. Arthritis (osteoarthritis or rheumatoid arthritis)		
5. Atherosclerosis/blocked or narrow arteries/coronary artery disease		
6. Bleeding or clotting disorders		
7. Cardiomyopathy/enlarged heart		
8. Chest pain/angina		
9. Chronic obstructive pulmonary disease/COPD/chronic lung disease		
10. Congenital heart abnormality or condition		
11. Congestive heart failure		
12. Deep vein thrombosis/DVT		
13. Dermatologic diseases or conditions		
14. Diabetes		
15. Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD)		
16. Heart attack/MI/myocardial infarction		
17. Heart valve problems (e.g., murmur, leaky valve, prolapse, regurgitation)		

Condition Experienced by Family Member	Yes	No
18. High blood pressure/hypertension		
19. High cholesterol or triglycerides		
20. Kidney disease or condition		
21. Peripheral vascular disease or peripheral arterial disease		
22. Phlebitis		
23. Pulmonary embolism/blood clot to the lungs		
24. Pulmonary hypertension		
25. Raynaud's syndrome		
26. Stroke or transient ischemic attack/TIA		
27. Vasculitis		

For each condition for which you answered **Yes** in the previous chart, please provide the information requested below (attach additional sheets as needed):

Name of Family Member	Condition	Age When Condition Discovered	Cause of Death (if Applicable)

V. BEXTRA® PRESCRIPTION INFORMATION

A. Prescriber and Pharmacy Information:

1. Who prescribed BEXTRA® for you? _____

2. Prescriber's address: _____

3. Name of pharmacy where prescription filled: _____

4. Address of pharmacy: _____

_____

B. Identify the following for each period of time during which you took BEXTRA®:

Dosage (10 mg or 20 mg)	How often per day?	Date Started	Date Stopped	Condition for which Prescribed

C. Did you receive any samples of BEXTRA®?

Yes ____ **No** ____ If **Yes**, please state the following:

1. Who provided the samples? _____

2. When were samples provided? _____

3. What was the dosage of the samples? _____

4. How many samples were provided? _____

D. Instructions or Warnings: Did you receive any written and/or oral information, including but not limited to instructions or warnings, about BEXTRA® at any time?

Yes ____ **No**____ I don't recall____ If **Yes**, please state the following:

Information Received	Written or Oral	When Received	From Whom Received

VI. CELEBREX® PRESCRIPTION INFORMATION

A. Are you currently taking CELEBREX®?

Yes ____ **No** ____ If **Yes**, please provide the dosage you are currently taking:

_____

B. Prescriber and Pharmacy Information:

1. Who prescribed CELEBREX® for you? _____

2. Prescriber's address: _____

3. Name of pharmacy where prescription filled: _____

4. Address of pharmacy: _____

_____

C. Identify the following for each period of time during which you took CELEBREX®:

Dosage (100 mg, 200 mg, or 400 mg)	How often per day?	Date Started	Date Stopped	Condition for which Prescribed

D. Did you receive any samples of CELEBREX®?

Yes ____ **No** ____ If **Yes**, please state the following:

1. Who provided the samples? _____

2. When were samples provided? _____

3. What was the dosage of the samples? _____

4. How many samples were provided? _____

E. Instructions or Warnings: Did you receive any written and/or oral information, including but not limited to instructions or warnings, about CELEBREX® at any time?

Yes ____ **No**____ I don't recall____ If **Yes**, please state the following:

Information Received	Written or Oral	When Received	From Whom Received

VII. MEDICAL BACKGROUND

A. Height: _____

B. Current Weight: _____

C. Weight at the time of the injury described in Section II: _____

D. Tobacco Use History: Check the answer and fill in the blanks applicable to your history of tobacco use. Tobacco use includes smoking cigarettes, cigars, pipes and/or using chewing tobacco/snuff.

_____ I have never used tobacco.

_____ I used tobacco in the past.

Date tobacco use started: _____ Date tobacco use ceased: _____

Amount used: on average _____ per day for _____ years.

_____ I currently use tobacco.

Date tobacco use started: _____

Amount currently using: on average _____ per day for _____ years.

_____ I have used different amounts of tobacco at different times (please identify type(s) of tobacco used and dates and frequency of use below).

_____

E. Alcohol Consumption: Do you now drink or have you in the past drunk alcohol (beer, wine, whiskey, etc.)?

Yes ____ **No** ____ If **Yes**, fill in the appropriate blank with the number of drinks that best represents your average alcohol consumption during the last 10 years:

_____ drinks per week; _____ drinks per month; _____ drinks per year; or

Other (describe): _____

What types of alcohol have you mostly consumed?

_____

F. Illicit Drugs: Have you used (even one time) any illicit drugs of any kind?

Yes ____ **No** ____ If **Yes**, identify each substance and when you first and last used it:

_____

G. Allergic Reactions: If you are claiming you suffered any type of skin reaction as a result of taking BEXTRA®, please indicate whether you have you ever experienced an allergic reaction to medicine.

Yes ____ **No** ____ **Not Applicable** ____ If **Yes**, please state the following:

Name of Medication	When Allergy Diagnosed	Symptoms of Allergy	Doctor Who Diagnosed Allergy

H. Have **you** ever experienced or been diagnosed with any of the following conditions? Please select **Yes** or **No** for each condition. For each condition for which you answer **Yes**, please provide the additional information requested in the table following this chart:

Condition You Experienced or That Was Diagnosed	Yes	No
1. Abnormal heart rhythm, atrial fibrillation, or heart block		
2. Allergic reaction to medication (e.g., skin reaction, rash, or anaphylaxis)		
3. Arteriosclerosis/hardening of the arteries/stenosis		
4. Arthritis (osteoarthritis or rheumatoid arthritis)		
5. Atherosclerosis/blocked or narrow arteries/coronary artery disease		
6. Autoimmune diseases (e.g., lupus, Sjögren's, etc.)		
7. Bleeding or clotting disorders		
8. Cancer (e.g., colon, lung, breast, skin, other)		
9. Cardiomyopathy/enlarged heart		
10. Chest pain/angina		
11. Chronic obstructive pulmonary disease/COPD/chronic lung disease		
12. Congenital heart abnormality or condition		
13. Congestive heart failure		
14. Deep vein thrombosis/DVT		
15. Dermatologic diseases or conditions		
16. Diabetes		
17. Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD)		
18. Heart attack/MI/myocardial infarction		
19. Heart valve problems (e.g., murmur, leaky valve, prolapse, regurgitation)		
20. High blood pressure/hypertension		
21. High cholesterol or triglycerides		
22. Immune system disease or dysfunction (including HIV or AIDS)		
23. Kidney disease or condition		
24. Liver disorder or disease (cirrhosis, hepatitis, etc.)		
25. Peripheral vascular disease or peripheral arterial disease		
26. Phlebitis		
27. Pulmonary embolism/blood clot to the lungs		
28. Pulmonary hypertension		

Condition You Experienced or That Was Diagnosed	Yes	No
29. Raynaud's syndrome		
30. Rheumatic Fever		
31. Scarlet Fever		
32. Stroke or transient ischemic attack/TIA		
33. Thyroid condition		
34. Vasculitis		

For each condition for which you answered **Yes** in the previous chart, please provide the information requested below (attach additional sheets as needed):

Condition You Experienced	Date of Onset	Medication/ Treatment	Treating Physician	Current Status of Condition

I. Please indicate whether you have ever received any of the following treatments or procedures and provide the requested information about each.

1. **Cardiovascular Surgeries**. This includes but is not limited to open heart/bypass surgery, pacemaker implantation, stent placement, vascular surgery, IVC filter placement, carotid (neck artery) surgery, or valve replacement.

Yes _____ **No** _____ I don't recall _____ If **Yes**, please specify the following:

Surgery	Condition	Date	Treating Physician	Hospital

2. Treatment for heart attack, angina (chest pain), or lung ailments (other than as described in your response to question 1 above):

Yes _____ **No** _____ I don't recall _____ If **Yes**, please specify the following:

Treatment	Date	Treating Physician	Hospital

3. **Cardiovascular Diagnostic Tests.** This includes but is not limited to C-reactive protein (CRP), chest X-ray, angiogram/catheterization, CT scan, MRI, EKG, echocardiogram, TEE (trans-esophageal echo), endoscopy, lung bronchoscopy, carotid duplex/ultrasound, MRI/MRA of the head/neck, angiogram of the head/neck, CT scan of the head, bubble/microbubble study, and Holter monitor.

Yes ____ **No** ____ I don't recall _____ If **Yes**, please specify the following:

Diagnostic Test	Reason for Test	Date	Treating Physician/ Hospital	Result of Diagnostic Test

VIII. ADDITIONAL MEDICATIONS

A. Please indicate whether you have taken any of the following medications in the past ten (10) years by selecting **Yes** or **No**. If you answer **Yes** for any medication, please indicate whether you recall ever taking that medication on a daily basis for more than two months at a time.

Name of Medication	Yes	No	Don't Recall	Do You Recall Daily Use for More Than Two Months?
Advil®/Motrin®/Ibuprofen				
Aleve®/Naprosyn/Naproxen				
Aspirin (Bayer®, Bufferin®, Ascriptin®, Ecotrin®)				
Codeine				
Darvocet/Darvocet-N				

Name of Medication	Yes	No	Don't Recall	Do You Recall Daily Use for More Than Two Months?
Demerol				
Mobic®/Meloxicam				
Morphine				
OxyContin				
Percocet				
Tylenol®/Acetaminophen				
Ultram®/Tramadol				
Vioxx®/Rofecoxib				
Voltaren®/Cataflam/Diclofenac				

B. Have you ever experienced any gastrointestinal side effects (for example, nausea, stomach pain, vomiting, diarrhea, constipation, ulcers, heartburn, reflux, or esophageal reflux disease/GERD) or any other side effects while you were taking any of the medications identified in your answer to question A above?

Yes ____ **No** ____ If **Yes**, please state the following:

Name of Medication	Side Effects	Date(s) Experienced

IX. MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

A. Identify each doctor or other healthcare provider who has provided treatment to you in the past ten (10) years (attach additional sheets as needed).

Name	Address	Approximate Dates

B. Identify each hospital, clinic, or healthcare facility where you have received inpatient or outpatient treatment or been admitted as a patient during the last ten (10) years (attach additional sheets as needed).

Name	Address	Admission Date(s)	Reason for Admission

C. Identify each pharmacy that has dispensed medication to you in the last ten (10) years (attach additional sheets as needed).

Name of Pharmacy	Address of Pharmacy

D. If you have submitted a claim for social security disability or workers' compensation benefits in the last ten (10) years, what agency or entity is most likely to have records concerning your claim (attach additional sheets as needed)?

Name	Address

X. DOCUMENTS

Please indicate if any of the following documents and things are currently in your possession, custody, or control, or in the possession, custody, or control of your lawyers, by checking **Yes** or **No**. Where you have indicated **Yes**, please attach the documents and materials to your responses to this Fact Sheet.

A. Records and bills of physicians, hospitals, pharmacies, other healthcare providers, government agencies, insurance companies, or any other entities identified in response to this Fact Sheet. **Yes** ____ **No** ____

B. Decedent's death certificate (if applicable). **Yes** ____ **No** ____

C. Report of autopsy of decedent (if applicable). **Yes** ____ **No** ____

D. Any copies of the packaging, include the bottle, box, and label for BEXTRA® and any unused medication. **Yes** ____ **No** ____

E. Any copies of the packaging, include the bottle, box, and label for CELEBREX® and any unused medication. **Yes** ____ **No** ____

F. Prescriptions or receipts for BEXTRA®. **Yes** ____ **No** ____

G. Prescriptions or receipts for CELEBREX®. **Yes** ____ **No** ____

H. If you are claiming lost wages or a loss of earning capacity, your W-2 forms for each of the last five (5) years. **Yes** ____ **No** ____

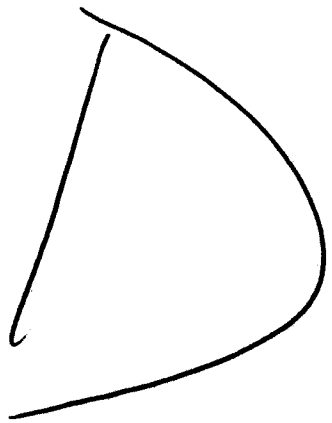
CERTIFICATION

I declare under penalty of perjury subject to N.Y. C.P.L.R. 3133(b) (McKinney 2005) that all of the information provided in this Plaintiff Fact Sheet is true, complete and correct to the best of my knowledge, that I have supplied all the documents requested in part X. of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration. Further, I acknowledge that I must supplement my responses if I learn that they are incomplete or incorrect in any material respect.

Signature: _____

Print Name: _____

Date: _____



ATTACHMENT D

LIST OF CUSTODIAN-SPECIFIC AUTHORIZATIONS

- U.S. Social Security Administration – Form for Requesting Social Security Earnings Records

- U.S. Social Security Administration – Form for Requesting Social Security Disability Records

- Pharmacy-Specific Authorizations:

  Albertson's

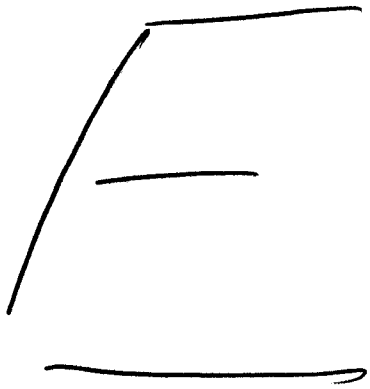
  Caremark

  CVS

  Target

  Walgreen's

  Wal-Mart



SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

IN RE: NEW YORK BEXTRA AND CELEBREX PRODUCT LIABILITY LITIGATION	Index No. 560001/2005
THIS DOCUMENT APPLIES TO ALL CASES	

BEXTRA® AND/OR CELEBREX®
DEFENDANT FACT SHEET

For each Plaintiff from whom it has received a substantially complete and verified Plaintiff Fact Sheet ("PFS") and substantially complete authorizations, Defendant Pfizer Inc. ("Pfizer") must complete this Defendant Fact Sheet ("DFS"). Pfizer shall serve a complete and verified DFS and responsive documents on Plaintiff's counsel of record and Plaintiffs' Liaison Counsel within sixty (60) days after receipt of a substantially complete and verified PFS and substantially complete authorizations. Pfizer shall attach additional sheets of paper if that is necessary to completely answer the following questions.

I. PLAINTIFF INFORMATION

This Defendant Fact Sheet pertains to the following Plaintiff:

Plaintiff's Full Name: _____

Case Caption: _____

Index No.: _____

County in which the action was originally filed: _____

II. CONTACTS WITH PRESCRIBING HEALTH CARE PROVIDER

In the Plaintiff Fact Sheet, Plaintiff identified person(s) who prescribed BEXTRA® and/or CELEBREX® to Plaintiff (hereinafter "prescribing healthcare provider"). For each prescribing healthcare provider identified, state the following:

A. **"Dear Doctor" or "Dear Healthcare Provider" Letters:** For each "Dear Doctor" or "Dear Healthcare Provider" letter that was sent to Plaintiff's

prescribing healthcare provider regarding BEXTRA® and/or CELEBREX®, if any, please:

1. Identify the master letter sent, including Bates numbers.

2. State the date of each master letter.

3. State the person to whom the letter was sent.

4. State the address where it was sent.

B. Samples: For each prescribing healthcare provider, please state to your knowledge whether Pfizer or its representatives ever provided him or her BEXTRA® and/or CELEBREX® samples. If the answer is "yes," please provide the following information if available:

1. State the number of BEXTRA® and/or CELEBREX® samples provided to the prescribing healthcare provider and the dosages provided.

2. State the date(s) that they were provided to the prescribing healthcare provider.

3. State the lot numbers for the samples provided on each date identified.

4. State the identity of the person or persons who provided the samples.

5. Produce a copy of any document reflecting or memorializing all BEXTRA® and/or CELEBREX® samples provided to Plaintiff's prescribing healthcare provider.

C. Other Contacts

1. For each prescribing healthcare provider identified, please provide the following information relating to contacts regarding BEXTRA® and/or CELEBREX® between any Pfizer sales representatives or "detail persons" and that provider of which you have knowledge:

Plaintiff's Prescribing Health Care Provider	Pfizer representative or "detail person"	Date(s) of Contact

2. For each sales representative or "detail person" identified above, please identify and produce notes, if any, from any BEXTRA® and/or

CELEBREX®-related calls to each prescribing healthcare provider identified in the PFS of which you have knowledge and which are available to you.

III. CONSULTING WITH PLAINTIFF'S PRESCRIBING HEALTH CARE PROVIDER

A. In the Plaintiff Fact Sheet, Plaintiff identified his or her prescribing healthcare provider(s). If you have ever paid or provided consideration to any of Plaintiff's prescribing healthcare providers on the subject of CELEBREX® and/or BEXTRA® as a "key opinion leader," a member of Pfizer's speaker program, or as a member of a Pfizer cardiovascular advisory board, please state:

1. The identity of the prescribing healthcare provider.

2. The dates the prescribing healthcare provider was so affiliated with Pfizer.

3. Each expense, honoraria and fees paid to the prescribing healthcare provider, if available.

4. Please identify (and produce) any consulting agreements and contracts related to any such payments or consideration.

5. Please identify (and produce) all documents or data provided by Pfizer to the prescribing healthcare provider relating to such payments or consideration and concerning any and all potential risks of BEXTRA® and/or CELEBREX® of which you have knowledge.

B. To your knowledge, has Plaintiff's prescribing healthcare provider ever contacted you to request information concerning BEXTRA® and/or CELEBREX®, their indications, effects and/or cardiovascular or other risks?

Yes____ No ____

If your answer is "yes," please identify the healthcare provider who contacted you, the date(s) of the contact, and the substance of any such requests. Please also identify and attach any document which is related or otherwise refers to the communication by Plaintiff's prescribing healthcare provider regarding BEXTRA® and/or CELEBREX® of which you have knowledge.

IV. PLAINTIFF'S MEDICAL CONDITION

A. To your knowledge, have you been contacted by Plaintiff, any of his/her physicians, or anyone else on behalf of Plaintiff and/or concerning Plaintiff regarding BEXTRA® and/or CELEBREX®, other than in connection with the present lawsuit?

Yes _____ No _____

If your answer is "yes," please state:

1. The name of the person(s) who contacted you.

2. The person(s) who was contacted.

B. Please produce a copy of any MedWatch form which refers or relates to Plaintiff, including backup documentation concerning Plaintiff and any evaluation you did concerning the Plaintiff.

CERTIFICATION

I declare under penalty of perjury subject to N.Y. C.P.L.R. 3133(b) (McKinney 2005) 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