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	:	CASE MANAGEMENT
PRODUCT LIABILITY LITIGATION	:	ORDER NO. 6
	:	
	:	
THE DOCK FAIT ADDITION OF ALL CASES	X	
THIS DOCUMENT APPLIES TO ALL CASES	: v	
	X	

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. <u>Plaintiffs' Obligation To Serve Plaintiff Fact Sheets and Responsive Documents.</u>
- a. <u>Applicable Plaintiff Fact Sheet</u>. 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.
- 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. <u>Plaintiffs Suing In Representative Or Derivative Capacity</u>. 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. <u>Plaintiffs' Obligation To Serve HIPAA-Compliant Authorizations.</u>
- 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. <u>Custodian-Specific Updated Or Additional Authorizations</u>. 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. <u>Plaintiffs Suing In Representative Or Derivative Capacity</u>. 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. <u>Use Of Authorizations.</u>

a. <u>Custodians Listed In PFS</u>. 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. <u>Custodians Not Listed In PFS</u>. 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. <u>Dismissal Of Plaintiffs' Claims For Failure To Comply With Discovery Obligations</u>

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. <u>Notice By Court To Be Jointly Drafted By Parties</u>. 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. <u>Cases Presently Pending In The Coordinated Proceeding</u>. 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. <u>Cases Subsequently Filed And Transferred</u>. 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's counsel), and properly executed authorizations.
- 9. <u>Notice Of Overdue Or Deficient Discovery</u>. 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. <u>Procedure For Dismissal Of Cases With Material Deficiency</u>. 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

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.
- 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. <u>Case-Specific Discovery</u>. 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.

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 ORDERĘD.

Dated: , 200

SHIRLEY WERNER WORNREICH

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COUNTY OF NEW YORK	•	
IN RE: NEW YORK BEXTRA AND CELEBREX PRODUCT LIABILITY LITIGATION	: : : : : : : : : : : : : : : : : : : :	Index No. 560001/2005
THIS DOCUMENT APPLIES TO ALL CASES	x : Y	
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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.	Nam	of person completing this form:				
B.	Pleas	se 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.		u are completing this Fact Sheet in a representative capacity (e.g., on behalf of the e 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?
	5.	
	6.	If you represent a decedent's estate; state:
		Date of Death:
		Address of Place Where Decedent Died:

PER FOR	SON W	OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE HO USED BEXTRA®. IF YOU ARE COMPLETING THIS FACT SHEET ONE ELSE, PLEASE ASSUME THAT "YOU" MEANS THE BEXTRA®
USE	R.	II. CLAIM INFORMATION
A.	Do vo	ou claim that you suffered bodily injury as a result of taking BEXTRA®?
	·	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?

			N	
Are you claimi	ng mental and/or em	notional damages as a re	esult of taking	g BEXTRA®
	If Yes , what most BEXTRA®?	ental and/or emotional	damages do y	ou claim res
from your use	OI BEATRA®!			
If Yes , for each	n provider (including	g but not limited to prime counselors) from whom	nary care phy	sicians,
psychiatrists, p	sychologists, and/or	g but not limited to prim counselors) from whor notional problems, state	n you have s	ought treatm
psychiatrists, p	sychologists, and/or	counselors) from whor	n you have so the followin Dates	ought treatmeng: Medicati
psychiatrists, p	osychologists, and/or cal, psychiatric or en	counselors) from whor notional problems, state	n you have see the following	ought treatmeng: Medicati
psychiatrists, p	osychologists, and/or cal, psychiatric or en	counselors) from whor notional problems, state	n you have so the followin Dates	ought treatmeng: Medicati
psychiatrists, p for psychologi Name	Address	counselors) from whornotional problems, state Condition treated	n you have so the following Dates treated	ought treatme
psychiatrists, p for psychologi Name Are you makin	Address ag a claim for lost wa	Counselors) from whomotional problems, state Condition treated ages or lost earning cap	n you have so the following Dates treated	ought treatmong: Medicati prescrib
psychiatrists, properties for psychologic Name Are you making Yes No	Address Ag a claim for lost wa	counselors) from whornotional problems, state Condition treated	n you have so the following Dates treated acity?	ought treatm ng: Medicat prescri

YORK CIVII PR	actice Law and Rules ("CPLR").
	III. <u>PERSONAL INFORMATION</u>
Maiden or oth	ner names you have used or by which you have been known and da
used those na	ner names you have used or by which you have been known and da
Maiden or oth used those na Current Addr	ner names you have used or by which you have been known and dames:

	Address		Dates of Residence
			40.00
Schools attended:			
Institution	Dates Attended	Course of Study	Diplomas or Degre
	.,,		
	ation: Identify the follo	wing for each employ	er you have had in the
	ation: Identify the follo	wing for each employ Dates of Employmen	Occupation/ Jo
last ten (10) years:		Dates of	Occupation/ Jo
last ten (10) years:		Dates of	Occupation/ Jo
last ten (10) years:		Dates of	Occupation/ Jo
last ten (10) years:		Dates of	Occupation/ Jo
last ten (10) years: Name		Dates of Employmen	Occupation/ Jo
Military Service: Ha National Guard? YesNo	Address	Dates of Employment Em	Occupation/ Jont Duties the military reserve

Insurance / Claim I 1. Has any ins		company p	rovided 1	medical coverage	to you or paid	
medical bil	ls on your behalf	since Janu	ary 1, 19	998 through the p	resent?	
Yes	No If Ye	s, please co	mplete 1	the following:		
Name	Name of Company			Address		
(SSI or SSI				and/or social secu	rity disability	
Type of Claim	Year Claim Filed	Agency Claim		Nature of Disability	Period of Disability	
relating to	any bodily injur			other than in the	present suit,	
Party You Sued/ Made Claim Against	Court in Whi Suit Filed/ Claim Mad	Nu	/Claim mber	Attorney Who Represented You	Nature of Claim and Injury	
<u> </u>						

K.

	adult, have shonesty?	e you been o	convicted of,	or plead guilt	ty to, a felony a	nd/or crime	of fr	aud
Yes_	No	If Yes, p	olease state th	e following:				
1.	Where co	onvicted:						
2.	When co	nvicted:						
3.	Nature of	f felony and	l/or crime:					
		IV.	FAMILY I	NFORMATI	<u>ION</u>			
Marr	iage(s)							
1.	If you are	e or have ev	er been marr	ied, identify t	the following:			
	Spouse's N	Vame	Date of	Date	Date of End	Reason fo		d of
			Birth	Married	of Marriage	Man	lage	
				<u> </u>				
2.	Нас уол	: spouse file	ed a claim for	loss of consc	ortium in this ac	tion?		
۷.			a claim for	1033 01 001130	ntian in ans ac			
	Yes	_ No						
If yo	u have child	dren, please	identify each	child's name	e and date of bir	rth.		
					oer (child, parer			
gran	dparent) ev	er experienc	ced or been d	iagnosed with	any of the foll	owing cond	itions	s?
Plea:	se select Ye nlease prov	s or No for vide the add	each conditional	on. For each	condition for witted in the table :	nich you an following th	.swer nis ch	art.
	prease pro							
1	11			by Family M			Yes	No
				n, or heart bloom	ck sh, or anaphylaxis	3		
			g of the arterie		in, or anaphytaxis	''		
			rheumatoid a					ļ
				ies/coronary aı	rtery disease			
	Bleeding or o			•				

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		ļ
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		ļ <u>.</u>
20. Kidney disease or condition		
21. Peripheral vascular disease or peripheral arterial disease		
22. Phlebitis		ļ
23. Pulmonary embolism/blood clot to the lungs		
24. Pulmonary hypertension		ļ
25. Raynaud's syndrome		ļ
26. Stroke or transient ischemic attack/TIA		<u> </u>
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. <u>BEXTRA® PRESCRIPTION INFORMATION</u>

A.	Prescriber and Pharmacy Information:										
	1.	Who prescr	ribed BEXT	RA® for you?							
	2.	Prescriber's address:									
	3.	Name of pharmacy where prescription filled:									
	4.	Address of pharmacy:									
B.	Ident	ify the follow	ring for each	period of time duri	ng which you took	BEXTRA®:					
	(Dosage 10 mg or 20 mg)	How ofte per day?	!	Date Stopped	Condition for which Prescribed					
C.	Did v	ou receive a	ny samples o	of BEXTRA®?							
	•		_	ease state the follow	ing:						
	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.	Instr	uctions or Wa	arnings: Die	• · · · · · · · · · · · · · · · · · · ·	ritten and/or oral in	formation, including					
	Yes	No	I don't rec	all If Yes, plea	ase state the follow	ing:					
	Iı	nformation R	eceived	Written or Oral	When Received	From Whom Received					

VI. MEDICAL BACKGROUND

Height:
Current Weight:
Weight at the time of the injury described in Section II:
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).
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?

	C	•	•	e) any illicit drugs of ostance and when you	•	ısed it:	
of taki	ic Reactions ng BEXTR on to medici	A®, p	ou are claiming you lease indicate whet	ı suffered any type of her you have you ever	skin reaction a	as a res in aller	ult gic
Yes _	No	Not	Applicable I	f Yes, please state the	following:		
Nam	e of Medica	tion	When Allergy Diagnosed	Symptoms of Allergy	Doctor Diagnosed		gy
·							
Please	select Yes	or No	for each condition.	sed with any of the fo For each condition f ion requested in the ta	or which you a	answer	art:
· · · · · · · · · · · · · · · · · · ·				r That Was Diagnose	d	Yes	No
			m, atrial fibrillation,				
				reaction, rash, or anaphy	(laxis)		ļ
3. Ar	teriosclerosis	/harde	ening of the arteries/s	tenosis			
			is or rheumatoid arth				
5. At	herosclerosis	/block	ed or narrow arteries	coronary artery disease	;		
6. Aı	itoimmune d	iseases	s (e.g., lupus, Sjögren	's, etc.)			ļ
7. Bl	eeding or clo	tting d	lisorders			1	

1.	Automat heart mythin, atrial normation, 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	
	Chest pain/angina	
11.	Chronic obstructive pulmonary disease/COPD/chronic lung disease	
12.	Congenital heart abnormality or condition	
1	Congestive heart failure	
	Deep vein thrombosis/DVT	
	Dermatologic diseases or conditions	
1	Diabetes	
	Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD)	
	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.)		<u> </u>
25. Peripheral vascular disease or peripheral arterial disease		<u> </u>
26. Phlebitis		<u> </u>
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

	Yes	No	_ I don't	recall		_ If Yes,	please sp	ecify the following
	Treatm	ent	Da	ite	T	reating Ph	ysician	Hospital
			ļ					
						,		
	carotid d head/nec	uplex/ultra	sound, M of the he	RI/M ad, bu	RA o	f the head microbub	/neck, an ble study	lung bronchoscopy giogram of the , and Holter monito cify the following:
Dia	agnostic	Reason	for Test	D	ate	Trea	ating	Result of Diagno
	Test					Phys	ician/	Test
						Hos	pital	
				<u> </u>				
		VII	ADDITI	ONAI	. MF	DICATION	ONS	
	. 1.	whether yo	u have ta	ken ar	ny of i	the follow	ing medi	cations in the past to whether you recall
lease	indicate		/ aa tam a	IV IIIC	uicau	on, picasc	murcaic	Wilculer you recair
0) y	ears. If y	ou answer 'ication on a	Yes for and daily ba	sis for	more	than two	months	at a time.
0) y	ears. If ye that med	ication on a	daily ba	sis for	more		months	at a time.
(0) y	ears. If ye that med	ou answer ication on a	daily ba	sis for Yes	No	Don't Recall	months :	at a time. u Recall Daily Use
10) y aking Advi	that med Name of	ication on a Medication n®/Ibuprofe	daily ba	sis for	more	Don't	months :	at a time. u Recall Daily Use
l 0) y aking Advi Alev	tears. If you that med Name of the lile / Motring the lile / Napro	ication on a	n daily ba	sis for	more	Don't	months :	at a time. u Recall Daily Use c Than Two Months

Ascriptin®, Ecotrin®) Celebrex®/Celecoxib

Darvocet/Darvocet-N

Codeine

A.

Name of Medication	Yes	No	Don't	Do You Recall Daily Use for
			Recall	More Than Two Months?
Demerol				
Mobic®/Meloxicam				
Morphine				
OxyContin				
Percocet				
Tylenol®/Acetaminophen				
Ultram®/Tramadol				
Vioxx®/Rofecoxib				
Voltaren®/Cataflam/Diclofenac				
Have you ever experienced any gastomach pain, vomiting, diarrhea, reflux disease/GERD) or any other medications identified in your answedications	constip r side e	ation, ffects	ulcers, he while you	eartburn, reflux, or esophageal uwere taking any of the

В.	Have you ever experienced any gastrointestinal side effects (for example, nausea, stomach pain, vomiting, diarrhea, constipation, ulcers, heartburn, reflux, or esophage 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 s	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).

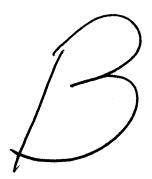
Name	Address	Approximate Dates
	A CONTRACTOR OF THE CONTRACTOR	
	_	

		needed).		3	st ten (10) years (attach		
	Name	Address		Admission Date(s)	Reason for Admission		
C.	Identify each pharm (attach additional sh			medication to you i	n the last ten (10) years		
	Name of Pharmacy	9	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). YesNo
C.	Report of autopsy of decedent (if applicable). YesNo
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®. YesNo
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
	<u>CERTIFICATION</u>
the int my kn the ex custod declar	are under penalty of perjury subject to N.Y. C.P.L.R. 3133(b) (McKinney 2005) that all of formation provided in this Plaintiff Fact Sheet is true, complete and correct to the best of nowledge, that I have supplied all the documents requested in part IX. of this declaration, to stent that such documents are in my possession, custody, or control, or in the possession, dy, or control of my lawyers, and that I have supplied the authorizations attached to this ration. Further, I acknowledge that I must supplement my responses if I learn that they are uplete or incorrect in any material respect.
	Signature:
	Print Name:
	Date:



COU	REME COURT OF THE STATE OF NEW YORK NTY OF NEW YORK	
IN RE	E: NEW YORK BEXTRA AND CELEBREX DUCT LIABILITY LITIGATION	: Index No. 560001/2005 : :
THIS	DOCUMENT APPLIES TO ALL CASES	:
know is true please learn Sheet answe	CELEBREX® PLAINTIFF FACT SHE plaintiff who allegedly suffered personal injury as a straight TRA®) must complete this Fact Sheet. Please answered and correct to the best of your knowledge. If you can be provide as much information as you can. You must that they are incomplete or incorrect in any material at for someone who has died or who cannot complete the er as completely as you can for that person. Please as sary to fully answer these questions.	result of taking CELEBREX® (but not every question to the best of your bath and must provide information that annot recall all of the details requested, t supplement your responses if you respect. If you are completing the Fact the Fact Sheet him/herself, please
	I. CASE INFORMAT	TON
A.	Name of person completing this form:	
B.	Please state the following for the civil action that y	ou filed:

Case caption:

Index Number:

County in which action was originally filed:

1.

2.

3.

	4.	Your attorney:
		Name:
		Firm:
		Address:
		Talankan Number
		Telephone Number: Fax Number:
		E-mail Address:
C.	If you estate	a are completing this Fact Sheet in a representative capacity (e.g., on behalf of the e 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.	heirs of that person:
WHO	O USES SOME	OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE PERSONS OR USED CELEBREX®. IF YOU ARE COMPLETING THIS FACT SHEET CONE ELSE, PLEASE ASSUME THAT "YOU" MEANS THE CELEBREX®
		II. <u>CLAIM INFORMATION</u>
A.	Do y	ou 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?

Are you claiming mental and/or emotional damages as a result of taking CELEBRE.							
	If Yes , what m CELEBREX®?	ental and/or emotional o	damages do y	you claim res			
irom your use of	CLDDDICE.						
		g but not limited to prime counselors) from whom					
psychiatrists, psy	ychologists, and/or	g but not limited to prim counselors) from whom notional problems, state	n you have s	ought treatm			
psychiatrists, psy	ychologists, and/or	counselors) from whom	n you have see the following	ought treatm ng: Medicat			
psychiatrists, ps for psychologica	ychologists, and/or l, psychiatric or er	counselors) from whom notional problems, state	n you have sethe following	ought treatm ng: Medicat			
psychiatrists, ps for psychologica	ychologists, and/or l, psychiatric or er	counselors) from whom notional problems, state	n you have see the following	ought treatm			
psychiatrists, ps for psychologica	ychologists, and/or l, psychiatric or er	counselors) from whom notional problems, state	n you have see the following	ought treatm ng: Medicat			
psychiatrists, ps for psychologica Name	ychologists, and/or ll, psychiatric or er Address	counselors) from whom notional problems, state Condition treated	n you have see the following Dates treated	ought treatm ng: Medicat			
psychiatrists, ps for psychologica Name	ychologists, and/or ll, psychiatric or er Address	counselors) from whom notional problems, state	n you have see the following Dates treated	ought treatm ng: Medicat			
psychiatrists, psychological Name Are you making Yes No	Address a claim for lost wa	Condition treated Condition treated ages or lost earning capa e annual gross income y	n you have so the following Dates treated	ought treatning: Medica prescri			

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").
Tolk Civil Fractice Law and Rules (CFLR).
III. PERSONAL INFORMATION
Name:
Maiden or other names you have used or by which you have been known and dates you used those names:
Current Address:
Social Security Number:
Date and Place of Birth:
Gender: Male Female
EBREX® Only Plaintiff Fact Sheet Page 5 of 17

		Address			Dat	tes of Resider
		•				
	· · · · · ·	· · · · · · · · · · · · · · · · · · ·				
			J. 1			
Schools attended:						
Institution		Dates Attended	Cour	se of Study	Di	iplomas or De
· · · · · · · · · · · · · · · · · · ·						
Employment Info	rmatio	n. Identify the follow	wing for	r each employ	ver v	ou have had i
•		n: Identify the followard	wing for	Dates of		Occupation
last ten (10) years			wing for			ou have had in Occupation Duties
last ten (10) years			wing for	Dates of		Occupation
last ten (10) years			wing for	Dates of		Occupation
last ten (10) years			wing for	Dates of		Occupation
Name		Address		Dates of Employmen	nt	Occupation Duties
Name				Dates of Employmen	nt	Occupation Duties
Name Name Military Service: National Guard? Yes No	Have	Address	ne milita	Dates of Employment Em	the 1	Occupation Duties military reser

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 N	No If Ye	s, please comp	plete the following:				
	Name o	of Company		Addre	SS			
	V 00 N	o If Voc.	nloogo stata the	a fallowing:				
Ту	ype of Claim	Year Claim Filed	Agency Wh Claim File	ere Nature of				
Ту		Year Claim	Agency Wh	ere Nature of				
Ту	pe of Claim Have you ever relating to an	Year Claim Filed	Agency Wh Claim File	lere Nature of Disability	Disability			

L.		adult, have you honesty?	been convicted of,	or plead guil	ty to, a felony a	nd/or crime	of fr	aud		
	Yes _	No If	Yes, please state the	he following:						
	1. Where convicted:									
	2. When convicted:									
	3.	Nature of felor	ny and/or crime:							
			IV. <u>FAMILY I</u>	NFORMAT)	<u>ION</u>					
A.	Marri	age(s)			,					
	1.	If you are or ha	ave ever been mari	ried, identify t	the following:					
		Spouse's Name	Date of Birth	Date Married	Date of End of Marriage	Reason fo		d of		
	2.		se filed a claim for	loss of consc	ortium in this ac	tion?				
В.	If you	Yes No _ have children, r	 please identify each	h child's name	e and date of bir	th.				
	•	, <u>, , , , , , , , , , , , , , , , , , </u>	•							
					•					
C.			owledge, has any erienced or been d					₂ ?		
	_	• /	o for each condition	_	•	•) ,		
	Yes,	please provide th	e additional inform	nation request	ted in the table f	following th	nis ch	art.		
		Con	dition Experienced	l by Family M	lember		Yes	No		
			thm, atrial fibrillatio							
			medication (e.g., sk		h, or anaphylaxis)				
			dening of the arterie							
			itis or rheumatoid ar		. 1.			ļ		
			cked or narrow arter	ies/coronary ar	tery disease					
	6. B	leeding or clotting	disorders					1		

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. <u>CELEBREX® PRESCRIPTION INFORMATION</u>

Yes_	No	If Yes, please	provide the dosa	ge you are current	ly taking:
Presc	riber and Pha	rmacy Informa	tion:		
1.	Who presc	ribed CELEBR	EX® for you?		
2.	Prescriber'	s address:	*** ***		
3.	Name of pl	narmacy where	prescription filled	d:	
4.	Address of	pharmacy:			
Ident	ify the follow	ring for each pe	riod of time durir	ng which you took	CELEBREX®:
	Dosage 00 mg, 200 , or 400 mg)	How often per day?	Date Started	Date Stopped	Condition for which Prescribed
Did y	you receive ar	ny samples of C	ELEBREX®?	.1	
			state the following	ng:	
1.	Who provi	ded the sample	s?		
2.	When were	e samples provi	ded?		
۷,					
3.	What was	the dosage of th	ne samples?		

Yes No I don't recall If Yes, please state the following:							
Inf	ormation :	Received	Written or Ora	I	When eceived	From Who Received	
	A						
		VI. <u>M</u>	EDICAL BACK	GROUND			
Heigh	t:						
Curre	nt Weight:						
Weigh	nt at the tin	me of the inju	y described in Sec	tion II:			
Tobacco Use History: Check the answer and fill in the blanks applicable to your histor of tobacco use. Tobacco use includes smoking cigarettes, cigars, pipes and/or using chewing tobacco/snuff.							
I have never used tobacco.							
	I have no	ever used toba	cco.				
	•	ever used toba bacco in the p					
	I used to	bacco in the p		Date to	bacco use c	eased:	
	I used to	bacco in the pacco use starte	ast.				
	I used to Date tob Amount	bacco in the pacco use starte	ast. ed: age				
	I used to Date tob Amount I current	bacco in the pacco use starte used: on aver-	ast. ed: age o.				
	I used to Date tob Amount I current Date tob	bacco in the praction used: on averably use tobacco	ast. ed: age o.	per day for	r yea		

Yes No If Yes, fill in the appropriate blank with the number of of	drinks that	
best represents your average alcohol consumption during the last 10 years:	arniks mai	•
drinks per week; drinks per month; drinks per yea	r; or	
Other (describe):		
What types of alcohol have you mostly consumed?		
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 la	ast used it:	:
YY	- ditiona?	
Have you ever experienced or been diagnosed with any of the following co	natuons?	
Please select Yes or No for each condition. For each condition for which y	ou answer	art.
Yes, please provide the additional information requested in the table follow	mg uns ci	iait.
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		
 Arteriosclerosis/hardening of the arteries/stenosis Arthritis (osteoarthritis or rheumatoid arthritis) 		
 Arteriosclerosis/hardening of the arteries/stenosis Arthritis (osteoarthritis or rheumatoid arthritis) 		
 Arteriosclerosis/hardening of the arteries/stenosis Arthritis (osteoarthritis or rheumatoid arthritis) Atherosclerosis/blocked or narrow arteries/coronary artery disease 		
 Arteriosclerosis/hardening of the arteries/stenosis Arthritis (osteoarthritis or rheumatoid arthritis) Atherosclerosis/blocked or narrow arteries/coronary artery disease Autoimmune diseases (e.g., lupus, Sjögren's, etc.) 		
 Arteriosclerosis/hardening of the arteries/stenosis Arthritis (osteoarthritis or rheumatoid arthritis) Atherosclerosis/blocked or narrow arteries/coronary artery disease Autoimmune diseases (e.g., lupus, Sjögren's, etc.) Bleeding or clotting disorders Cancer (e.g., colon, lung, breast, skin, other) 		
 Arteriosclerosis/hardening of the arteries/stenosis Arthritis (osteoarthritis or rheumatoid arthritis) Atherosclerosis/blocked or narrow arteries/coronary artery disease Autoimmune diseases (e.g., lupus, Sjögren's, etc.) Bleeding or clotting disorders Cancer (e.g., colon, lung, breast, skin, other) 		
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 Arteriosclerosis/hardening of the arteries/stenosis Arthritis (osteoarthritis or rheumatoid arthritis) Atherosclerosis/blocked or narrow arteries/coronary artery disease Autoimmune diseases (e.g., lupus, Sjögren's, etc.) Bleeding or clotting disorders Cancer (e.g., colon, lung, breast, skin, other) Cardiomyopathy/enlarged heart Chest pain/angina 		
 Atherosclerosis/blocked or narrow arteries/coronary artery disease Autoimmune diseases (e.g., lupus, Sjögren's, etc.) Bleeding or clotting disorders Cancer (e.g., colon, lung, breast, skin, other) Cardiomyopathy/enlarged heart Chest pain/angina Chronic obstructive pulmonary disease/COPD/chronic lung disease 		
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 Arteriosclerosis/hardening of the arteries/stenosis Arthritis (osteoarthritis or rheumatoid arthritis) Atherosclerosis/blocked or narrow arteries/coronary artery disease Autoimmune diseases (e.g., lupus, Sjögren's, etc.) Bleeding or clotting disorders Cancer (e.g., colon, lung, breast, skin, other) Cardiomyopathy/enlarged heart Chest pain/angina Chronic obstructive pulmonary disease/COPD/chronic lung disease Congenital heart abnormality or condition Congestive heart failure Deep vein thrombosis/DVT Dermatologic diseases or conditions Diabetes Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD) 		
 Arteriosclerosis/hardening of the arteries/stenosis Arthritis (osteoarthritis or rheumatoid arthritis) Atherosclerosis/blocked or narrow arteries/coronary artery disease Autoimmune diseases (e.g., lupus, Sjögren's, etc.) Bleeding or clotting disorders Cancer (e.g., colon, lung, breast, skin, other) Cardiomyopathy/enlarged heart Chest pain/angina Chronic obstructive pulmonary disease/COPD/chronic lung disease Congenital heart abnormality or condition Congestive heart failure Deep vein thrombosis/DVT Dermatologic diseases or conditions Diabetes Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD) Heart attack/MI/myocardial infarction 		
 Arteriosclerosis/hardening of the arteries/stenosis Arthritis (osteoarthritis or rheumatoid arthritis) Atherosclerosis/blocked or narrow arteries/coronary artery disease Autoimmune diseases (e.g., lupus, Sjögren's, etc.) Bleeding or clotting disorders Cancer (e.g., colon, lung, breast, skin, other) Cardiomyopathy/enlarged heart Chest pain/angina Chronic obstructive pulmonary disease/COPD/chronic lung disease Congenital heart abnormality or condition Congestive heart failure Deep vein thrombosis/DVT Dermatologic diseases or conditions Diabetes Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD) 		
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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

Y	es	No	I don't	recall		_ If Yes	s, please s	pecify the following:
	Treatm	ent	Da	ite	Т	reating F	hysician	Hospital
								
. (· · · · · · · · · · · · · · · · · · ·			T	Tri :		1	ot limited to C-reactiv
p e c h	rotein (chocard arotid d ead/nec	CRP), che liogram, T luplex/ultr k, CT sca	est X-ray, as EEE (trans-asound, Mondon the he	ingiog esoph RI/Ml ad, bu	ram/cam/cageal RA outlible/	catheterize lecho), en f the head microbul	ration, CT ndoscopy, d/neck, an oble study	scan, MRI, EKG, lung bronchoscopy, giogram of the , and Holter monitor.
_	nostic	Reason	for Test	Da	ate	Phy	eating sician/ spital	Result of Diagnost Test
		VII.	ADDITIO	ONAL	. ME	DICATI	ONS	
10) year	rs by se you rec	lecting Ye	s or No. I	f you	answ	er Yes fo	r any med	cations in the past ter dication, please indication more than two mont
N	lame of	Medication	on	Yes	No	Don't Recall	1	u Recall Daily Use for Than Two Months?
Advil®	/Motrin	®/Ibupro	fen			Recair	141016	, littii 1 AAO 1410111112;
		syn/Napro						
		®, Buffer						
-		otrin®)	,					
		coxib/Par	ecoxib					
Codein	e	· · · · · · · · · · · · · · · · · · ·						
Coucin								

A.

Name of Medication	Yes	No	Don't	Do You Recall Daily Use for
			Recall	More Than Two Months?
Demerol				
Mobic®/Meloxicam				
Morphine				
OxyContin	ļ			
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

	Name	Current	Address	Admission Date(s)	Reason for Admission
•		pharmacy that honal sheets as ne		medication to you i	n the last ten (10) years
	Name of Pha	rmacy		Address of P	harmacy
).	benefits in the	last ten (10) ye	ars, what age		vorkers' compensation t likely to have records
	Name			Addre	SS
		· · · · · · · · · · · · · · · · · · ·			

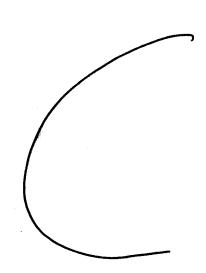
Identify each hospital, clinic, or healthcare facility where you have received inpatient or outpatient treatment or been admitted as a patient during the last ten (10) years (attach

B.

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
the inf my kn the ext custod declar	are under penalty of perjury subject to N.Y. C.P.L.R. 3133(b) (McKinney 2005) that all of formation provided in this Plaintiff Fact Sheet is true, complete and correct to the best of lowledge, that I have supplied all the documents requested in part IX. of this declaration, to tent that such documents are in my possession, custody, or control, or in the possession, dy, or control of my lawyers, and that I have supplied the authorizations attached to this ration. Further, I acknowledge that I must supplement my responses if I learn that they are uplete 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	: : x	
REXTRA® and CELI	EBREXO	80

BEXTRA® <u>and</u> CELEBREX® <u>PLAINTIFF FACT SHEET</u>

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.	Nam	e of person completing this form:
B.	Plea	se 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.		u are completing this Fact Sheet in a representative capacity (e.g., on behalf of the e 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:
PER CON	SON W	OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE THO USES OR USED CELEBREX® AND USED BEXTRA®. IF YOU ARE ING THIS FACT SHEET FOR SOMEONE ELSE, PLEASE ASSUME THAT ANS THE BEXTRA® AND CELEBREX® USER.
		II. <u>CLAIM INFORMATION</u>
A.	Do yo	ou 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?

alread	ly recovered	from that injury	th the injury or condition or condition before you from the injury or condi	took BEXT	
Yes _	No		notional damages as a re		
If Ye:	s for each n	rovider (including	g but not limited to prin	nary care phy	rsicians
for ps	niatrists, psy sychological	chologists, and/or , psychiatric or en	counselors) from whomodional problems, state	m you have see the followir	ought treatment ng:
for ps	iatrists, psy	chologists, and/or	counselors) from whor	m you have s	ought treatment
for ps	niatrists, psy sychological	chologists, and/or , psychiatric or en	counselors) from whomodional problems, state	m you have see the following Dates	ought treatmenting: Medication
for ps	niatrists, psy sychological	chologists, and/or , psychiatric or en	counselors) from whomodional problems, state	m you have see the following Dates	ought treatmenting: Medication
for ps	niatrists, psy sychological Name	chologists, and/or, psychiatric or en Address	counselors) from whomodional problems, state	m you have see the following Dates treated	ought treatmenting: Medication prescribed
Do yo	niatrists, psy sychological Name	chologists, and/or, psychiatric or en Address t you suffered boo	counselors) from whomotional problems, state Condition treated	m you have see the following Dates treated	ought treatmenting: Medication prescribed
Do yo	niatrists, psycychological Name ou claim tha	t you suffered boo	counselors) from whomotional problems, state Condition treated dily injury as a result of	m you have see the following Dates treated	ought treatmenting: Medication prescribed EBREX®?
Do yo	niatrists, psycychological Name ou claim tha	t you suffered boo	counselors) from whomotional problems, state Condition treated lily injury as a result of answer the following:	m you have see the following Dates treated	ought treatmenting: Medication prescribed EBREX®?
Do yo	niatrists, psycychological Name ou claim tha	t you suffered boo	counselors) from whomotional problems, state Condition treated lily injury as a result of answer the following:	m you have see the following Dates treated	ought treatmenting: Medication prescribed EBREX®?
Do yo	niatrists, psycychological Name ou claim tha No What bod	t you suffered boo	counselors) from whomotional problems, state Condition treated lily injury as a result of answer the following:	m you have see the following Dates treated Taking CELI	ought treatment ng: Medication prescribed EBREX®?

	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?						
	alrea	No If Yes, set forth the injury or condition, whether or not you had ady recovered from that injury or condition before you took CELEBREX®, and, if he date you previously recovered from the injury or condition:						
F.	Are	you claiming mental and/or emotional damages as a result of taking CELEBREX®?						
		No If Yes, what mental and/or emotional damages do you claim resulted 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

	nent for each of the) years.		a
(Violati in this a misrepr	ssert claims for the on of N.Y. G.B.L. ction, please provides entation or challe will Practice Law ar	§ 349) Caus de below spenged consul	es of Action a ecific details o mer-oriented a	s contained in the first state of the alleged fra	he Master Compla aud,
	and the state of t				

					And the second

III. PERSONAL INFORMATION

Name:						
Maiden or other names you have used or by which you have been known and dates you used those names:						
Current Address:						
Social Security Number	er:					
Date and Place of Birth	h:					
Gender: Male Fo	emale					
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			
			A STATE OF THE STA			
Schools attended:						
Institution	Dates Attended	Course of Study	Diplomas or Degre			
	· · · · · · · · · · · · · · · · · · ·					

	Name		Address	Dates of Employment	Occupation/ Duties
any r	reason relat	ting to you	r physical, psychiatri	ted or discharged from	ion?

Insui	rance / Cla	im Informa	ation		
	Has any	insurance	or other company pr	ovided medical cover ary 1, 1998 through th	
	Has any medical	insurance bills on yo	or other company pr our behalf since Janu		ne present?
Insur 1.	Has any medical	insurance bills on yo	or other company prour behalf since January If Yes, please co	ary 1, 1998 through th	ne present?
	Has any medical	insurance bills on yo	or other company prour behalf since January If Yes, please co	ary 1, 1998 through the mplete the following:	ne present?
	Has any medical	insurance bills on yo	or other company prour behalf since January If Yes, please co	ary 1, 1998 through the mplete the following:	ne present?
	Has any medical	insurance bills on yo	or other company prour behalf since January If Yes, please co	ary 1, 1998 through the mplete the following:	ne present?

2.	Have you			ers' compensation	n and/or social sec	curity disability
	Yes	_ No _	If Yes , p	please state the fo	ollowing:	
Ту	pe of Clai	m Y	Year Claim Filed	Agency Where Claim Filed	Nature of Disability	
3.	•		filed a lawsu bodily injury		n, other than in th	e present suit,
	Yes	_ No _	If Yes, 1	please state the fo	ollowing:	
1	ty You Su ⁄Iade Clain Against		Court in Which Suit Filed/ Claim Made	Number	Attorney Who Represented You	Nature of Cl and Injury
						
	n adult, ha	ve you	been convicte	ed of, or plead gu	nilty to, a felony a	nd/or crime of f
or ar		10	Ves. please s	tate the following	g:	
	No _	11	r co, prodoc s		<u>-</u>	
			•			
Yes	Where o	convicte	ed:			

IV. FAMILY INFORMATION

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	u 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		<u> </u>
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. <u>BEXTRA® PRESCRIPTION INFORMATION</u>

A .	Prescr	iber and Pharmacy Information:
	1.	Who prescribed BEXTRA® for you?
	2.	Prescriber's address:
	3.	Name of pharmacy where prescription filled:
	4.	Address of pharmacy:

Dosage (10 mg or 20 mg)	How often per day?	Date Started	Date Stopped	Condition fo which Prescrib
Did you receive an	y samples of B	BEXTRA®?		
Yes No	If Yes, please	state the following	ng:	
1. Who provid	ded the sample:	s?		
2. When were	samples provi	ded?		
3. What was t	he dosage of th	ne samples?		
4. How many	samples were	provided?		
Instructions or Wa	rnings: Did yo	ou receive any wri	tten and/or oral inf	formation, includ
but not limited to i		warnings, about B		ime?
	I don't recall_	warnings, about B		ime?
but not limited to i Yes No	I don't recall_	warnings, about B	e state the following	ime? ng: From Whor
Yes No	I don't recall_	warnings, about B	e state the following	ime? ng: From Whor
but not limited to i Yes No	I don't recall_	warnings, about B	e state the following	ime? ng: From Whor
Yes No Information Re	I don't recall_	warnings, about B If Yes, pleas Written or Oral	When Received	ime? ng: From Whor Received
Yes No Information Re	I don't recall_ceived	warnings, about B If Yes, pleas Written or Oral	e state the following	ime? ng: From Whor Received
Yes No Information Re	I don't recall_ceived	warnings, about B If Yes, pleas Written or Oral	When Received	ime? ng: From Whor Received

B.	Presc	riber and Pha	rmacy Inforn	nation:								
	1.	Who prescr	ribed CELEB	REX® for you?								
	2.	Prescriber's	s address:									
	3.	Name of pharmacy where prescription filled:										
	4.	Address of	pharmacy: _									
C.	Ident	ify the follow	ing for each j	period of time durin	ng which you took	CELEBREX®:						
	(10	Dosage 00 mg, 200 , or 400 mg)	How often per day?	Date Started	Date Stopped	Condition for which Prescribed						
D.	Did v	ou receive an	v samples of	CELEBREX®?								
	·		-	se state the following	ng:							
	1.	Who provided the samples?										
	2.	When were samples provided?										
	3.	What was the dosage of the samples?										
	4.		_	e provided?								
E.		actions or Wa	rnings: Did	•		formation, including by time?						
	Yes	No	I don't recal	l If Yes , pleas	se state the following	ng:						
	Ir	nformation Re	ceived	Written or Oral	When Received	From Whom Received						

VII. MEDICAL BACKGROUND

Height:
Current Weight:
Weight at the time of the injury described in Section II:
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).
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?
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:

Have y		cation	When Allergy Diagnosed	Symptoms of Allergy	Docto Diagnose	r Who	
Please			Diagnosed	· -	Diagnose	1 4 11	
Please						d Allei	ſgy
Please							
Please							
Yes, p		s or No	for each condition	osed with any of the fol For each condition for ation requested in the ta	or which you	answer	
				or That Was Diagnosed		Yes]
			n, atrial fibrillation				1
				reaction, rash, or anaphy	laxis)		\perp
			ning of the arteries/			_	_
 Arthritis (osteoarthritis or rheumatoid arthritis) Atherosclerosis/blocked or narrow arteries/coronary artery disease 						\downarrow	
						_	
			(e.g., lupus, Sjögre	n's, etc.)			\downarrow
	eding or c			······································			
			ng, breast, skin, oth	ier)			\downarrow
	rdiomyopa		ged heart			ļ	\downarrow
	est pain/an						\downarrow
				OPD/chronic lung disease	3		1
			rmality or condition	1			\downarrow
	ngestive he						\downarrow
	ep vein thr		······································				\downarrow
		diseases	or conditions				\downarrow
16. Dia		, ,,		1 11 0 000			\downarrow
				eartburn, acid reflux, GER	D)		╀
			ardial infarction		4-4:)	-	+
			ypertension	y valve, prolapse, regurgi	tation)		+
· · · · · · · · · · · · · · · · · · ·	gh choleste		* -				+
				ncluding HIV or AIDS)			+
	lney diseas			including THV of AIDS)		-	+
			ase (cirrhosis, hepat	itis etc)			+
			sease or peripheral			-	+
الان 1 . باست		outai Ul	sease or peripheral	urtoriai disease			+
26. Phi		nbolism/	blood clot to the lui	ngs		_	+
26. Phl 27. Pul							1

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
			4	

- 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.			t attack, a	-	,	-	lung ailn	nents (other than as
	Yes	No	I don't	recall	l	_ If Yes,	please sp	ecify the following:
	Treatm	nent	Da	ate	Ī	reating Pl	hysician	Hospital
						.,		
				···.			··· · · · · · · · · · · · · · · · · ·	
3.	protein (echocard carotid d head/ned	(CRP), che diogram, T duplex/ultr ck, CT sca	est X-ray, and EEE (transfasound, Man of the hear	angiog -esoph IRI/M ead, bu	gram/ nagea IRA o ubble/	catheterized cathe	ation, CT adoscopy, /neck, an ble study	t limited to C-reactive scan, MRI, EKG, lung bronchoscopy, giogram of the , and Holter monitor.
1	gnostic Test	Reasor	n for Test	D	ate	Phys	ating sician/ spital	Result of Diagnostic Test
					······································			
(10) ye	ears by se er you rec	whether yelecting Y e	es or No.	ken ar If you	ny of answ	the follow er Yes for	ring medic any med	cations in the past ten ication, please indicate more than two months
	Name of	Medication	on	Yes	No	Don't Recall		Recall Daily Use for Than Two Months?
Advi	®/Motri	n®/Ibupro	fen					
		syn/Napro						
1 -	in (Bayer ptin®, Ec	r®, Buffer cotrin®)	in®,					
Code	ine					•		
Darve	ocet/Darv	ocet-N						

A.

Name of Medication	Yes	No	Don't	Do You Recall Daily Use for
			Recall	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

	Name	Add	ress		Admission Date(s)	Reason for Admission
C. Identify each pharmacy that has dispensed medication to yo (attach additional sheets as needed).		lication to you i	n the last ten (10) years			
	Name of Pha	armacy			Address of F	Pharmacy
				··· • • • • • • • • • • • • • • • • • •		
).	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)?					
	Na	me			Ad	dress
	A	And the second section is a				

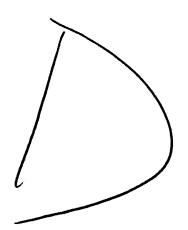
Identify each hospital, clinic, or healthcare facility where you have received inpatient or

B.

X. <u>DOCUMENTS</u>

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
Н.	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
	<u>CERTIFICATION</u>
the in my kr the ex custoo declar	are under penalty of perjury subject to N.Y. C.P.L.R. 3133(b) (McKinney 2005) that all of formation provided in this Plaintiff Fact Sheet is true, complete and correct to the best of nowledge, that I have supplied all the documents requested in part X. of this declaration, to stent that such documents are in my possession, custody, or control, or in the possession, dy, or control of my lawyers, and that I have supplied the authorizations attached to this ration. Further, I acknowledge that I must supplement my responses if I learn that they are uplete 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

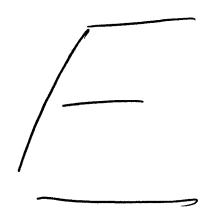
Caremark

CVS

Target

Walgreen's

Wal-Mart



COUN	EME COURT OF THE STATE OF NEW YORK	
IN RE PROD	: NEW YORK BEXTRA AND CELEBREX OUCT LIABILITY LITIGATION	: Index No. 560001/2005 :
THIS	DOCUMENT APPLIES TO ALL CASES	:
	BEXTRA® AND/OR CEI DEFENDANT FACT	
("Pfize verifie Couns substan	For each Plaintiff from whom it has received a sufiff Fact Sheet ("PFS") and substantially complete a ser") must complete this Defendant Fact Sheet ("DF and responsive documents on Plaintiff's cosel within sixty (60) days after receipt of a substantially complete authorizations. Pfizer shall attachary to completely answer the following questions.	authorizations, Defendant Pfizer Inc. FS"). Pfizer shall serve a complete and bunsel of record and Plaintiffs' Liaison ially complete and verified PFS and additional sheets of paper if that is
I.	PLAINTIFF INFORMATION	
	This Defendant Fact Sheet pertains to the following	ing Plaintiff:
	Plaintiff's Full Name:	
	Case Caption:	
	Index No.:	
	County in which the action was originally filed:	
II.	CONTACTS WITH PRESCRIBING HEALT	H CARE PROVIDER
	In the Plaintiff Fact Sheet, Plaintiff identified per	rson(s) who prescribed BEXTRA®

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?
	•

Y es No	Yes	No	
res no	res		

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.	physicians, or anyon	have you been contacted by Plaintiff, any of his/her e else on behalf of Plaintiff and/or concerning Plaintiff and/or CELEBREX®, other than in connection with the
	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

	CERTIFICATION	
that all of the information best of my knowledge an	f perjury subject to N.Y. C.P.L.R. 31: n provided in this Defendant Fact She d that I have supplied all requested do y possession, custody and control (inc	eet is true and correct to the ocuments to the extent that
Signature	Print name	Date