

IN THE CHANCERY COURT OF HINDS COUNTY, MISSISSIPPI
FIRST JUDICIAL DISTRICT

THE STATE OF MISSISSIPPI

PLAINTIFF

V.

CIVIL ACTION NO. 02005-2021

DEFENDANTS ^{5/2}

ABBOTT LABORATORIES, INC.;
ABBOTT PHARMACEUTICALS;
ALCON LABORATORIES, INC.;
ALLERGAN, INC.;
ALPHARMA, INC.;
PUREPAC PHARMACEUTICAL CO.;
ALPHA THERAPEUTIC CORP.;
AMGEN, INC.;
IMMUNEX CORPORATION;
ANDRX PHARMACEUTICALS, INC.;
ASTRAZENECA PHARMACEUTICALS, L.P.;
ASTRAZENECA L.P.;
AVENTIS PHARMACEUTICALS, INC.;
AVENTIS BEHRING, L.L.C.;
ZLB BEHRING, L.L.C.;
DERMIK LABORATORIES, INC.;
BARR PHARMACEUTICALS, INC.;
BARR LABORATORIES, INC.;
BAXTER INTERNATIONAL, INC.;
BAXTER HEALTHCARE CORPORATION;
BAYER CORPORATION;
BAYER PHARMACEUTICALS CORPORATION;
BAYER HEALTHCARE, LLC;
BIOVAIL PHARMACEUTICALS, INC.;
BOEHRINGER INGELHEIM CORPORATION;
BOEHRINGER INGELHEIM PHARMACEUTICALS, INC.;
ROXANE LABORATORIES, INC.;
BEN VENUE LABORATORIES, INC.;
B. BRAUN OF AMERICAN, INC.;
MCGRAW, INC.;
BRISTOL-MYERS SQUIBB COMPANY;
ONCOLOGY THERAPEUTICS NETWORK CORP.;
CHIRON CORP.;
DEY INC.;
EISAI INC.;
ELI LILLY AND COMPANY;
ELKINS-SINN, INC.;

FILED
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BY _____ D.C.

ENDO PHARMACEUTICALS INC.;
FOREST LABORATORIES, INC.;
FOREST PHARMACEUTICALS;
FUJISAWA HEALTHCARE, INC.;
FUJISAWA USA, INC.;
GENZYME CORPORATION;
GILEAD SCIENCES, INC.;
GLAXOSMITHKLINE, P.L.C.;
SMITHKLINE BEECHAM CORPORATION;
GLAXO WELLCOME, INC.;
HOFFMAN-LAROCHE, INC.;
ROCHE LABORATORIES, INC.;
IVAX CORPORATION;
IVAX PHARMACEUTICALS INC.;
JOHNSON & JOHNSON;
ALZA CORPORATION;
JANSSEN PHARMACEUTICAL PRODUCTS, L.P.;
ORTHO-MCNEIL PHARMACEUTICAL INC.;
ORTHO BIOTECH PRODUCTS, L.P.;
MCNEIL-PPC, INC.;
KING PHARMACEUTICALS, INC.;
MONARCH PHARMACEUTICALS, INC.;
K-V PHARMACEUTICAL COMPANY;
ETHEX CORPORATION;
MEDIMMUNE, INC.;
MERCK & CO., INC.;
MYLAN LABORATORIES, INC.;
MYLAN PHARMACEUTICALS, INC.;
UDL LABORATORIES, INC.;
NOVARTIS CORPORATION;
SANDOZ, INC.;
NOVO NORDISK PHARMACEUTICALS, INC.;
ORGANON PHARMACEUTICALS USA, INC.;
PAR PHARMACEUTICAL COS., INC.;
PURDUE PHARMA, L.P.;
SANOFI-SYNTHELADO, INC.;
SCHERING-PLOUGH CORP.;
WARRICK PHARMACEUTICALS INDUSTRIES, LTD.;
SERONO, INC.;
TAKEDA PHARMACEUTICALS NORTH AMERICA, INC.;
TAP PHARMACEUTICAL PRODUCTS, INC.;
TEVA PHARMACEUTICALS USA, INC.;
NOVOPHARM USA, INC.;

SICOR PHARMACEUTICALS, INC.;
WATSON PHARMACEUTICALS, INC.;
WATSON LABORATORIES, INC.;
WATSON PHARMA, INC.;
WYETH, INC.; AND
WYETH PHARMACEUTICALS, INC.

COMPLAINT

Plaintiff, the State of Mississippi, by and through its Attorney General (hereinafter “the State”) files this Complaint against the above-named Defendants and alleges, on information and belief, the following:

I. Introduction

1. This action is brought in the public interest for and on behalf of the People of the State of Mississippi, by Jim Hood, Mississippi Attorney General, pursuant to the Mississippi Medicaid Fraud Control Act, the Mississippi Regulation of Business for Consumer Protection Act, and the common-law authority of the Attorney General to represent the People of the State of Mississippi.

2. Mississippi, like all other States, has elected to provide prescription drug coverage to its over 720,000 poor and disabled Medicaid beneficiaries. Unfortunately, this benefit has become one of Medicaid’s most expensive. Over the past four years, nationwide State Medicaid officials have cited prescription drugs as one of the top three Medicaid cost drivers along with enrollment growth and rising medical care costs generally. Nationally, Medicaid expenditures for prescription drugs have grown at more than twice the rate of overall Medicaid spending from fiscal year (FY) 1997 to 2001. Federal drug expenditures in the fee-for-service component of the Medicaid program grew at a real (inflation-adjusted) average annual rate of 15.5 percent between fiscal years 1998 and

2004, reaching \$18.4 billion in 2004. Total nationwide State spending stood at \$12.2 billion in 2004—for a combined spending level of \$30.6 billion in FY 2004. Currently, Medicaid accounts for nearly one in five dollars spent on prescription drugs in the United States. It is predicted that Medicaid drug expenditures will continue to increase by an average of 12.7 percent per year through 2011.

3. Mississippi's experience with the skyrocketing cost of prescription drugs has mirrored that of the national trend. From FY 1999 to FY 2002, Mississippi's Medicaid program experienced an average annual increase of 26% in its prescription drug program. Only after taking drastic measures, such as limiting the number of prescriptions from 10 to 7 per month per beneficiary, did Mississippi gain a temporary reprieve, with prescription drug costs leveling out at \$552 million in FY 2003. However, this respite was short-lived with the State finding itself in a \$268 million Medicaid deficit in FY 2004. The largest portion of this deficit was attributed to the upward pressure of prescription drug costs.

4. After the long and contentious process of filling the Medicaid deficit, the Mississippi Legislature and Governor were again forced to curb the advancing tide of prescription drug costs. With little alternative, legislation was passed further reducing the number of prescription drugs per month from 7 to 5 per beneficiary, for an estimated savings of \$34 million a year.

5. Mississippi's recent history with sharply increasing prescription drug costs is not only similar to that of other states because of the devastating impact on the State's budget and the lives of its most vulnerable citizens, but also because all states share a common source of this crisis: *the intentional and covert abuse of the reimbursement system for prescription drugs by the Defendant pharmaceutical manufacturers ("the Defendants")*. The Defendants have taken advantage of the

enormously complicated and non-transparent market for prescription drugs by engaging in an unlawful scheme to cause the State of Mississippi to pay inflated prices for prescription drugs. The scheme involves the publication by the Defendants to other purchasers of phony “average wholesale prices” (“AWPs”), which are relied on by the State in calculating the reimbursement rate for providers of prescription drugs, such as physicians and pharmacies. The Defendants set the AWPs for their products artificially high in order to attract providers and thus gain market share for their products, with the State picking up the tab. The Defendants have reinforced this tactic with other deceptive practices such as covert discounts, kickbacks and rebates to providers, and the use of various other devices to keep secret the prices of their drugs currently available in the marketplace. The Defendants’ fraudulent pricing and marketing of their prescription drugs have resulted in the Mississippi Division of Medicaid’s (“Division”) paying grossly excessive prices for the Defendants’ prescription drugs.

6. Fair and honest pricing is a vital matter for the State and its citizens. The State is accountable to its citizens and taxpayers for how it spends limited State funds, and it is obligated to pursue any party whose unlawful conduct has led to the overspending of these funds. Further, the State is responsible for protecting its most vulnerable citizens who depend on the Medicaid program for their health and safety, and it is obligated to pursue any party whose unlawful conduct would jeopardizing this literally life-sustaining program.

7. Consequently, the State of Mississippi, by and through Jim Hood, Mississippi Attorney General, seeks to permanently enjoin the Defendants from continuing to engage in their fraudulent and deceptive drug pricing acts and practices; to obtain a full accounting of all the State and taxpayer moneys absconded by the Defendants; to recover compensatory damages and/or

restitution on behalf of the State of Mississippi and its residents; and to impose civil penalties and punitive damages upon the Defendants for their fraudulent, illegal and unconscionable acts.

II. Parties

8. This action is brought for and on behalf of the sovereign State of Mississippi and its citizens, by and through Jim Hood, the duly elected and current Attorney General of the State of Mississippi, pursuant to, *inter alia*, the provisions of Mississippi's Medicaid Fraud Control Act, Miss. Code Ann. § 43-13-219 *et. seq.*, Mississippi's Regulation of Business for Consumer Protection Act, Miss. Code Ann. § 75-24-19, and the common law and statutory authority of the Attorney General to represent the State of Mississippi and its residents.

9. Defendant, Abbott Laboratories, Inc. ("Abbott"), is an Illinois corporation engaged in the business of manufacturing and selling pharmaceuticals. Abbott's principal place of business is located at 100 Abbott Park Road, Abbott Park, IL 60064-6400.

10. Defendant, Abbott Pharmaceuticals ("Abbott Pharma"), a wholly owned subsidiary of Abbott, is a corporation engaged in the business of manufacturing and selling pharmaceuticals. Abbott Pharma's principal place of business is located at 100 Abbott Park Road, Abbott Park, IL 60064-6400.

11. Defendant, Alcon Laboratories, Inc. ("Alcon"), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Alcon's principal place of business is located at 6201 S. Freeway (T1-3), Fort Worth, TX 76115.

12. Defendant, Allergan, Inc. ("Allergan"), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Allergan's principal place of business is located at 2525 Dupont Drive, Irvine, CA 92612.

13. Defendant, Alharma, Inc. (“Alharma”), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Alharma’s principal place of business is located at One Executive Drive, Fort Lee, NJ 07024.

14. Defendant, Purepac Pharmaceutical Co. (“Purepac”), a subdivision of Alharma, is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Purepac was acquired by Alharma in December 2001. Purepac’s principal place of business is located at 14 Commerce Dr., Ste. 301, Cranford, NJ 07016.

15. Defendant, Alpha Therapeutic Corp. (“Alpha”), is a California corporation engaged in the business of manufacturing and selling pharmaceuticals. Alpha’s principal place of business is located at 2410 Lillyvale Ave., Los Angeles, CA 90032.

16. Defendant, Amgen, Inc. (“Amgen”), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Amgen’s principal place of business is located at One Amgen Drive, Thousand Oaks, CA 91320-1799.

17. Defendant, Immunex Corporation (“Immunex”), a wholly owned subsidiary of Amgen, is a Washington State corporation engaged in the business of manufacturing and selling pharmaceuticals. Immunex’s principal place of business is located at 51 University Street, Seattle, WA 98101.

18. Defendant, Andrx Pharmaceuticals, Inc. (“Andrx”), is a Florida corporation engaged in the business of manufacturing and selling pharmaceuticals. Andrx’s principal place of business is located at 4955 Orange Drive, Daive, FL 33314.

19. Defendant, AstraZeneca Pharmaceuticals, L.P. (“AstraZeneca Pharma”), is a Delaware limited partnership engaged in the business of manufacturing and selling pharmaceuticals.

AstraZeneca Pharma's principal place of business is located at 1800 Concord Pike, Wilmington, DE 19850-5437.

20. Defendant, AstraZeneca L.P. ("AstraZeneca"), is a Delaware limited partnership engaged in the business of manufacturing and selling pharmaceuticals. AstraZeneca's principal place of business is located at 725 Chesterbrook Boulevard, Wayne, PA 19087.

21. Defendant, Aventis Pharmaceuticals, Inc. ("Aventis Pharma"), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Aventis Pharma's principal place of business is located at 300-400 Somerset Corporate Boulevard, Bridgewater, NJ 08807-2854

22. Defendant, Aventis Behring, LLC ("Aventis Behring"), a wholly owned subsidiary of Aventis Pharma, is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Aventis Behring's principal place of business is located at 1020 First Ave., King of Prussia, PA 19406-0901.

23. Defendant, ZLB Behring, L.L.C. ("ZLB"), a wholly owned subsidiary of Aventis Pharma, is a Delaware limited liability company engaged in the business of manufacturing and selling pharmaceuticals. ZLB's principal place of business is located at 1020 First Avenue, P.O. Box 61501, King of Prussia, PA 19406-0901.

24. Defendant, Dermik Laboratories, Inc. ("Dermik"), a wholly owned subsidiary of Aventis Pharm, is a Pennsylvania corporation engaged in the business of manufacturing and selling pharmaceuticals. Dermik's principal place of business is located at 1050 Westlakes Drive, Berwyn, PA 19312.

25. Defendant, Barr Pharmaceuticals, Inc. (“Barr Pharma”), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Barr Pharma’s principal place of business is located at 400 Chestnut Ridge Rd., Woodcliff Lake, NJ 07677.

26. Defendant, Barr Laboratories, Inc. (“Barr Lab”), a wholly owned subsidiary of Barr Pharma, is a New York corporation engaged in the business of manufacturing and selling pharmaceuticals. Barr Lab’s principal place of business is located at 2 Quaker Road, P.O. Box 2900, Pomona, NY 10970-0519.

27. Defendant, Baxter International, Inc. (“Baxter”), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Baxter’s principal place of business is located at One Baxter Pkwy., Deerfield, IL 60015.

28. Defendant, Baxter Healthcare Corporation (“Baxter Healthcare”), a wholly owned subsidiary of Baxter, is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Baxter Healthcare’s principal place of business is located at One Baxter Parkway, Deerfield, IL 60015.

29. Defendant, Bayer Corporation (“Bayer”), a wholly owned United States subsidiary of a German corporation, Bayer AG, is an Indiana corporation engaged in the business of manufacturing and selling pharmaceuticals. Bayer’s principal place of business is located at 100 Bayer Road, Pittsburgh, PA 15205-9741.

30. Defendant, Bayer Pharmaceuticals Corporation (“Bayer Pharma”), a wholly owned subsidiary of Bayer, is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Bayer Pharma’s principal place of business is located at 400 Morgan Lane, West Haven, CT 06516.

31. Defendant, Bayer Healthcare, LLC (“Bayer Healthcare”), a wholly owned subsidiary of Bayer, is a Delaware limited liability company engaged in the business of manufacturing and selling pharmaceuticals. Bayer Healthcare’s principal place of business is located at 511 Benedict Avenue, Tarrytown, NY 10591.

32. Defendant, Biovail Pharmaceuticals, Inc. (“Biovail”), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Biovail is a wholly owned subsidiary of Biovail Corporation, a Canadian corporation whose principal place of business is located at 7150 Mississauga Road, Mississauga, Ontario, Canada, L5N 8M5. Biovail’s principal place of business is located at 700 Route 202/206 North Bridgewater, NJ 08807.

33. Defendant, Boehringer Ingelheim Corporation (“Boehringer Ingelheim”), is a Nevada corporation engaged in the business of manufacturing and selling pharmaceuticals. Boehringer Ingelheim’s principal place of business is located at 900 Ridgebury Rd., Ridgefield, CT 06877.

34. Defendant, Boehringer Ingelheim Pharmaceuticals, Inc. (“Boehringer Pharma”), a wholly owned subsidiary of Boehringer Ingelheim, is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Boehringer Pharma’s principal place of business is located at 900 Ridgebur Rd., Ridgefield, CT 06877.

35. Defendant, Roxane Laboratories, Inc. (“Roxane”), a wholly owned subsidiary of Boehringer Ingelheim, is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Roxane’s principal place of business is located at 1809 Wilson Rd., Columbus, OH 43216-6532.

36. Defendant, Ben Venue Laboratories, Inc. (“Ben Venue”), a wholly owned subsidiary of Boehringer Ingelheim, is a Delaware corporation engaged in the business of manufacturing and

selling pharmaceuticals. Ben Venue's principal place of business is located at 300 Northfield Road, Bedford, OH 44146.

37. Defendant, B. Braun of American, Inc. ("Braun"), a wholly owned subsidiary of B. Braun Melsunder Aktiengesellschaft, a German corporation, is a Pennsylvania corporation engaged in the business of manufacturing and selling pharmaceuticals. B. Braun's principal place of business is located at 824 12th Ave., Bethlehem, PA 18018-027.

38. Defendant, McGraw, Inc. ("McGraw"), a wholly owned subsidiary of Braun, is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. McGraw's principal place of business is located at 824 12th Ave., Bethlehem, PA 18018-0027.

39. Defendant, Bristol-Myers Squibb Company ("Bristol-Myers"), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Bristol-Myers' principal place of business is located at 345 Park Avenue, New York, NY 10154-0037.

40. Defendant, Oncology Therapeutics Network Corp. ("Oncology Therapeutics"), a wholly owned subsidiary of Bristol-Myers, is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Oncology Therapeutics' principal place of business is located at 395 Oyster Point Boulevard, Suite 405, South San Francisco, CA 94080.

41. Defendant, Chiron Corp. ("Chiron"), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Chiron's principal place of business is located at 4560 Horton St., Emeryville, CA 94608-2916.

42. Defendant, Dey Inc. ("Dey"), formerly Dey Laboratories, a/k/a Dey, L.P., is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Dey

is an indirect subsidiary of Merck KgaA, a German pharmaceutical conglomerate. Dey's principal place of business is located at 2751 Napa Valley Corporate Drive, Napa, CA 94558.

43. Defendant, Eisai Inc. ("Eisai"), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Eisai is a U.S. pharmaceutical subsidiary of Tokyo-based Eisai Co., Ltd. Eisai's principal place of business is located at 500 Frank W. Burr Boulevard, Teaneck, NJ 07666.

44. Defendant, Eli Lilly and Company ("Eli Lilly"), is a Indiana corporation engaged in the business of manufacturing and selling pharmaceuticals. Eli Lilly's principal place of business is located at Lilly Corporate Center, Indianapolis, IN 46285.

45. Defendant, Elkins-Sinn, Inc. ("Elkins-Sinn"), is a New Jersey corporation engaged in the business of manufacturing and selling pharmaceuticals. Elkins-Sinn's principal place of business is located at Two Esterbrook Ln., Cherry Hill, NJ 08003-4009.

46. Defendant, Endo Pharmaceuticals Inc. ("Endo"), a subsidiary of Endo Pharmaceuticals Holdings Inc., is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Endo's principal place of business is located at 100 Painters Drive, Chadds Ford, PA 19317.

47. Defendant, Forest Laboratories, Inc. ("Forest"), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Forest's principal place of business is located at 909 Third Ave., New York, NY 10022.

48. Defendant, Forest Pharmaceuticals ("Forest Pharma"), a wholly owned subsidiary of Forest Laboratories, is headquartered in St. Louis, Missouri and is in the business of manufacturing

and selling pharmaceuticals. Forest Pharma's principal place of business is located at 13600 Shoreline Drive, St. Louis, MO 63045.

49. Defendant, Fujisawa Healthcare, Inc. ("Fujisawa"), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Fujisawa's principal place of business is located at Three Parkway North, Deerfield, IL 60015.

50. Defendant, Fujisawa USA, Inc. ("Fujisawa USA"), a wholly owned subsidiary of Fujisawa, is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Fujisawa USA's principal place of business is located at Three Parkway North, Deerfield, IL 60015.

51. Defendant, Genzyme Corporation ("Genzyme"), is a Massachusetts corporation engaged in the business of manufacturing and selling pharmaceuticals. Genzyme's principal place of business is located at 500 Kendall Street, Cambridge, MA 02142.

52. Defendant, Gilead Sciences, Inc. ("Gilead"), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Gilead's principal place of business is located at 333 Lakeside Drive, Foster City, CA 94404.

53. Defendant, GlaxoSmithKline, P.L.C. ("GSK"), created through the merger of Glaxo Wellcome, P.L.C. and SmithKlineBeecham P.L.C., is a British corporation engaged in the business of manufacturing and selling pharmaceuticals. GSK's principal place of business is located at 980 Great West Road, Brentford, Middlesex, EN, TW8 9, U.K.

54. Defendant, SmithKline Beecham Corporation ("SmithKline"), a wholly owned subsidiary of GSK, is a Delaware corporation engaged in the business of manufacturing and selling

pharmaceuticals. SmithKline's principal place of business is located at One Franklin Plaza, Philadelphia, PA 19102.

55. Defendant, Glaxo Wellcome, Inc. ("Glaxo Wellcome"), a wholly owned subsidiary of GSK, is a North Carolina corporation in the business of manufacturing and selling pharmaceuticals. Glaxo Wellcome's primary place of business is located at 5 Moore Drive, Research Triangle Park, NC 27709.

56. Defendant, Hoffman-LaRoche, Inc. ("Hoffman-LaRoche"), is a New Jersey corporation in the business of manufacturing and selling pharmaceuticals. Hoffman-LaRoche's principal place of business is located at 340 Kingsland Street, Nutley, NJ 07110-1199.

57. Defendant, Roche Laboratories, Inc. ("Roche"), a wholly owned subsidiary of Hoffman-LaRoche, is a Delaware corporation in the business of manufacturing and selling pharmaceuticals. Roche's principal place of business is located at 340 Kingsland Street, Nutley, NJ 07110-1199.

58. Defendant, Ivax Corporation ("Ivax"), is a Florida corporation engaged in the business of manufacturing and selling pharmaceuticals. Ivax's principal place of business is located at 4400 Biscayne Blvd., Miami, FL 33137.

59. Defendant, Ivax Pharmaceuticals Inc. ("Ivax Pharma"), a wholly owned subsidiary of Ivax, is a Florida corporation engaged in the business of manufacturing and selling pharmaceuticals. Ivax Pharma's principal place of business is located at 4400 Biscayne Blvd., Miami, FL 33137.

60. Defendant, Johnson & Johnson (“J&J”), is a New Jersey corporation engaged in the business of manufacturing and selling pharmaceuticals. J&J’s principal place of business is located at One Johnson & Johnson Plaza, New Brunswick, NJ 08933.

61. Defendant, ALZA Corporation (“ALZA”), a wholly owned subsidiary of J&J, is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. ALZA’s principal place of business is located at 1900 Charleston Road, Mountain View, CA 94039.

62. Defendant, Janssen Pharmaceutical Products, L.P. (“Janssen”), a wholly owned subsidiary of J&J, is a New Jersey corporation engaged in the business of manufacturing and selling pharmaceuticals. Janssen’s principal place of business is located at 1125 Trenton-Harbourton Road, Titusville, NJ 08560.

63. Defendant, Ortho-McNeil Pharmaceutical Inc. (“Ortho-McNeil”), a wholly owned subsidiary of J&J, is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Ortho-McNeil’s principal place of business is located at 1000 U.S. Route 202 South, Raritan, NJ 08869.

64. Defendant, Ortho Biotech Products, L.P. (“Ortho Biotech”), a wholly owned subsidiary of J&J, is a Delaware limited partnership engaged in the business of manufacturing and selling pharmaceuticals. Ortho Biotech’s principal place of business is located at 700 U.S. Highway 202, Raritan, NJ 08869.

65. Defendant, McNeil-PPC, Inc. (“McNeil”), a wholly owned subsidiary of J&J, is a New Jersey corporation engaged in the business of manufacturing and selling pharmaceuticals. McNeil’s principal place of business is located at 7050 Camp Hill Road, Fort Washington, PA 19034.

66. Defendant, King Pharmaceuticals, Inc. (“King”), is a Tennessee corporation engaged in the business of manufacturing and selling pharmaceuticals. King’s principal place of business is located at 501 Fifth St., Bristol, TN 37620.

67. Defendant, Monarch Pharmaceuticals, Inc. (“Monarch”), a wholly owned subsidiary of King, is a Tennessee corporation engaged in the business of manufacturing and selling pharmaceuticals. Monarch’s principal place of business is located at 501 Fifth Street, Bristol, TN 37620.

68. Defendant, K-V Pharmaceutical Company (“K-V”), is a Delaware corporation engaged in the manufacturing and selling of pharmaceuticals. K-V’s principal place of business is located at 2503 South Hanley Road, St. Louis, MO 63144.

69. Defendant, Ethex Corporation (“Ethex”), a wholly owned subsidiary of K-V, is a Delaware corporation engaged in the business of manufacturing and selling of pharmaceuticals. Ethex’s principal place of business is located at 10888 Metro Court, St. Louis, MO.

70. Defendant, MedImmune, Inc. (“MedImmune”), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. MedImmune’s principal place of business is located at One MedImmune Way, Gaithersburg, MD 20878.

71. Defendant, Merck & Co., Inc. (“Merck”), is a New Jersey corporation engaged in the business of manufacturing and selling pharmaceuticals. Merck’s principal place of business is located at One Merck Drive, P.O. Box 100, Whitehouse Station, NJ 08889-0100.

72. Defendant, Mylan Laboratories, Inc. (“Mylan”), is a Pennsylvania corporation engaged in the business of manufacturing and selling pharmaceuticals. Mylan’s principal place of business is located at 1500 Corporate Drive, Suite 400, Canonsburg, PA 15317.

73. Defendant, Mylan Pharmaceuticals, Inc. (“Mylan Pharma”), a wholly owned subsidiary of Mylan, is a West Virginia corporation engaged in the business of manufacturing and selling pharmaceuticals. Mylan Pharma’s principal place of business is located at 1500 Corporate Drive, Suite 400, Canonsburg, PA 15317.

74. Defendant, UDL Laboratories, Inc. (“UDL”), a wholly owned subsidiary of Mylan, is a Illinois corporation engaged in the business of manufacturing and selling pharmaceuticals. UDL’s principal place of business is located at 1500 Corporate Drive, Suite 400, Canonsburg, PA 15317.

75. Defendant, Novartis Corporation (“Novartis”), is a New Jersey corporation engaged in the business of manufacturing and selling pharmaceuticals. Novartis’ principal place of business is located at One Health Plaza, East Hanover, NJ 07936.

76. Defendant, Sandoz, Inc. (“Sandoz”), a wholly owned subsidiary of Novartis, formerly known as Geneva Pharmaceuticals, Inc., is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Sandoz’s principal place of business is located at 506 Carnegie Center, Suite 400, Princeton, NJ 08540.

77. Defendant, Novo Nordisk Pharmaceuticals, Inc. (“Novo”), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Novo’s principal place of business is located at 100 College Road West, Princeton, NJ 085040.

78. Defendant, Organon Pharmaceuticals USA, Inc. (“Organon”), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Organon’s principal place of business is located at 56 Livingston Ave, Roseland, NJ 07068.

79. Defendant, Par Pharmaceutical Cos., Inc. (“Par”), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Par’s principal place of business is located at One Ram Ridge Road, Spring Valley, NY 10977.

80. Defendant, Purdue Pharma, L.P. (“Purdue”), is a corporation engaged in the business of manufacturing and selling pharmaceuticals. Purdue’s principal place of business is located at One Stamford Forum, 201 Tresser Boulevard, Stamford, CT.

81. Defendant, Sanofi-Synthelabo, Inc. (“Sanofi-Synthelabo”), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Sanofi-Synthelabo’s principal place of business is located at 90 Park Avenue, New York, NY 10016.

82. Defendant, Schering-Plough Corp. (“Schering”), is a New Jersey corporation engaged in the business of manufacturing and selling pharmaceuticals. Schering’s principal place of business is located at 2000 Galloping Hill Rd., Kenilworth, NJ 07033-0530.

83. Defendant, Warrick Pharmaceuticals Industries, Ltd. (“Warrick”), a wholly owned subsidiary of Schering, is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Warrick’s principal place of business is located at 12125 Moya Boulevard, Reno, NV 89506.

84. Defendant, Serono, Inc. (“Serono”), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Serono’s principal place of business is located at One Technology Place, Rockland, MA 02370.

85. Defendant, Takeda Pharmaceuticals North America, Inc. (“Takeda”), is a corporation engaged in the business of manufacturing and selling pharmaceuticals. Takeda’s principal place of business is located at 475 Half Day Road, Suite 500, Lincolnshire, IL 60069.

86. Defendant, TAP Pharmaceutical Products, Inc. (“TAP”), is a joint venture between Abbott and Takeda Chemical Industries, Ltd., engaged in the business of manufacturing and selling pharmaceuticals. TAP is a Delaware corporation whose principal place of business is located at Bannackburn Lake Office Plaza, 2355 Waukegan Rd., Deerfield, IL 60015.

87. Defendant, Teva Pharmaceuticals USA, Inc. (“Teva”), is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Teva’s principal place of business is located at 650 Cathill Road, Sellersville, PA 18960. Teva is a subsidiary of an Israeli corporation, Teva Pharmaceutical Industries, Ltd.

88. Defendant, Novopharm USA, Inc. (“Novopharm”), a wholly owned subsidiary of Teva, is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Novopharm’s principal place of business is located at 165 E. Commerce Dr., Ste. 100-201, Schaumburg, IL 60173-5326.

89. Defendant, Sicor Pharmaceuticals, Inc. f/k/a Gensia Sicor Pharmaceuticals, Inc., (“Sicor”), a wholly owned subsidiary of Teva, is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Sicor’s principal place of business is located at 19 Hughes, Irvine, CA 92618-1902.

90. Defendant, Watson Pharmaceuticals, Inc. (“Watson”), is a Nevada corporation engaged in the business of manufacturing and selling pharmaceuticals. Watson’s principal place of business is located at 311 Bonnie Circle, Conrona, CA 02880.

91. Defendant, Watson Laboratories, Inc. (“Watson Labs”), a wholly owned subsidiary of Watson, is a Nevada corporation engaged in the manufacturing and selling of pharmaceuticals. Watson Lab’s principal place of business is located at 311 Bonnie Circle, Corona, CA 92880.

92. Defendant, Watson Pharma, Inc. (“Watson Pharma”), a wholly owned subsidiary of Watson, is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Watson Pharma’s principal place of business is located at 311 Bonnie Circle, Corona, CA 92880.

93. Defendant, Wyeth, Inc. (“Wyeth”), formerly American Home Products Corp., is a Delaware corporation engaged in the business of manufacturing and selling pharmaceuticals. Wyeth’s principal place of business is located at Five Diralda Farms, Madison, NJ 07940.

94. Defendant, Wyeth Pharmaceuticals, Inc. (“Wyeth Pharma”), a wholly owned subsidiary of Wyeth, is a Delaware corporation engaged in the manufacture and sale of pharmaceuticals. Wyeth Pharma’s principal place of business is located at 500 Arcola Road, Collegeville, PA.

III. Jurisdiction and Venue

95. Jurisdiction is proper in this Court pursuant to Miss. Code Ann. § 9-5-81 and Section 159 of the Mississippi Constitution in addition to the fact that all the claims asserted herein arise exclusively under Mississippi statutory or common law.

96. This Court has personal jurisdiction over each Defendant because each of the Defendants resides in Mississippi, does business in Mississippi, purposefully directs or directed its actions toward Mississippi, and/or had the requisite minimum contacts with Mississippi necessary to constitutionally permit the Court to exercise jurisdiction.

97. Venue is proper pursuant to Miss. Code Ann. § 11-11-3 due to the fact that substantial alleged acts of the Defendants which caused injury to the State and its citizens occurred in Hinds

County; the Division, which oversees the State Medicaid program, is located in Hinds County; and the State regularly and systematically conducts business in Hinds County.

IV. Medicaid Coverage of Prescription Drugs

A. Marketplace for Prescription Drugs

98. The marketplace for prescription drugs is extremely complex and non-transparent. It is composed of many layers, entities and products. However, what is consistent throughout the prescription drug marketplace is the Defendants' absolute influence and control over prices. In order to comprehend how the Defendants have been able to so covertly perpetrate their illegal scheme, one needs a basic understanding of the structure of the prescription drug marketplace. The drugs themselves are manufactured by enormous and extremely profitable pharmaceutical corporations, such as the Defendants. However, the Defendants typically do not distribute their products directly, but rather rely on wholesalers to warehouse and distribute their drugs. The Defendants sell their products to these wholesalers at a wholesale acquisition cost ("WAC") which the Defendants establish. The Defendants intend the WAC of a product to be understood by the marketplace as the average price paid by a wholesaler to a manufacturer for a given drug. Each drug has a National Drug Code ("NDC"); currently, there are over 65,000 NDCs. The Defendants report a WAC for each NDC to an industry reporting service, such as First DataBank (a/k/a Blue Book), Medical Economics, Inc. (a/k/a Red Book), and Medispan. The wholesalers then resell the drugs to providers, such as physicians, pharmacies and hospitals, at what is known as the "actual acquisition cost." The providers then resell the drugs to their patients when the drugs are prescribed, administered or dispensed.

99. When these patients are Medicaid beneficiaries, the Medicaid program ultimately pays for these drugs according to a formula that derives from what is known as average wholesale price (“AWP”). AWP is an artificial sticker price established, not by the market, not by the providers or wholesalers, but by the Defendants. The Defendants intend AWP to be understood by the marketplace as the average price charged by wholesalers to providers for a given drug. The Defendants report an AWP for each NDC to the Blue Book, the Red Book, and/or Medispan.

100. Thus, the market structure for prescription drugs differs in two respects from most markets.

101. First, in most markets, demand for a product is determined by the ultimate consumers of the product. In contrast, in the prescription drug market, the decision to use a prescription drug is made by the provider who treats, cares for, and/or supplies the patient with the drug. Physicians prescribe, and sometimes even administer, drugs to their patients. Hospitals and nursing homes supply and administer drugs to patients in their facilities. Pharmacies supply prescription drugs to patients. Each of these providers has enormous power over which drugs a Medicaid beneficiary receives. Physicians’ influence extends to which drugs they seek to prescribe. Hospitals’ and nursing homes’ influence extends to which drugs they seek to provide to patients. Pharmacies’ influence extends to which drugs they seek to stock and thus make available to patients.

102. Second, in most markets, the ultimate consumer of the product pays for it directly from his or her pocket. In contrast, in the prescription drug market, most payments for drugs are made by “payors” such as the State of Mississippi through Medicaid. In fact, nationally, Medicaid is the largest payor for prescription drugs, representing 14 percent (one seventh) of the drug market.

103. These two unique factors create a situation where the Defendants, through the establishment of a drug's AWP, get to determine the reimbursement Medicaid will ultimately pay a provider for choosing to utilize their product, i.e. a drug.

B. Medicaid's Coverage & Mississippi's Reimbursement of Prescription Drugs

104. Authorized under Title XIX of the Social Security Act, Medicaid is a means-tested entitlement program administered by the States and financed by both the Federal and State governments which provides health care insurance to more than 44 million low-income and disabled individuals. 42 U.S.C. 1396 *et seq.* While Medicaid does not require States to cover prescription drugs, all 50 States and the District of Columbia currently provide such coverage. 42 U.S.C. 1396d(a)(12).

105. Medicaid payments for outpatient prescription drugs include three components: acquisition cost, dispensing fee, and a rebate. The acquisition cost covers the drug itself, while the dispensing fee covers the pharmacist's cost of filling the prescription and the rebate is simply the mechanism for reducing the effective price of the drug below the traditional acquisition cost.

106. The acquisition cost is where AWP comes into play. The Federal Government, through the Centers for Medicare and Medicaid Services ("CMS"), sets maximum drug reimbursement limits within which each State determines its own pharmacy reimbursement formulas. For multiple source drugs with a sufficient number of equivalent products and at least three suppliers, CMS sets specific Federal upper limit (FUL) amounts. 42 CFR § 447.331-332. Specifically, FUL equals 150 percent of the lowest published price for the least costly version of the drug listed in a national pricing compendia. 42 CFR § 447.331 Multiple source drugs include both generic drugs and brand name drugs for which generic alternatives are available. For all other drugs,

including single source drugs (i.e. brand name drugs for which no therapeutic equivalent exists) and multiple source drugs without a FUL, payment established by a State may not exceed the estimated acquisition cost (“EAC”) plus a reasonable dispensing fee or the providers’ usual and customary charges to the general public. 42 CFR § 447.331(b). The EAC is established by the State.

107. In complying with the framework established by the Federal Government, Mississippi reimburses multiple source drugs at the lowest of the FUL plus a dispensing fee, the EAC as determined by the Division plus a dispensing fee, or the providers’ usual and customary charge to the general public. Miss. Code Ann. § 43-13-117(9)(b) The payment for covered drugs, other than multiple source drugs with an FUL, is the lower of the EAC cost plus a dispensing fee, or the providers’ usual and customary charge to the general public. Miss. Code Ann. § 43-13-117(9)(b) EAC has been set at 12% of AWP. Provider Policy Manual 31.04. Prior to FY 2002, EAC was 10% of AWP.

V. Scheme to Defraud Mississippi Medicaid Program

A. AWP Scheme

108. The Defendants knowingly, willfully, and/or intentionally provided or caused to be provided false and extraordinarily inflated AWP to the Blue Book, the Red Book, and/or Medispan with the intent and knowledge that the Division would unknowingly rely on these fabricated AWPs published by these reporting services and pay providers exorbitant amounts for their drugs.

109. The Defendants knowingly, willfully and/or intentionally provided or caused to be provided false and inflated AWP information for their drugs to the Blue Book, Red Book and Medispan (for examples see Exhibit A). These price reporting services do not independently determine the Defendants’ AWPs. The Defendants knowingly, willfully and/or intentionally

represented, through their acts and omissions, that the AWP information provided to the reporting services was true and correct and could be fully and completely relied upon by the Division as the average price charged by wholesalers to providers for a Defendant's given drug, when in fact, the AWP information was grossly overstated. So prevalent was this fraudulent scheme that a June 10, 1996 issue of *Barron's*, entitled, "Hooked on Drugs," reported that the industry insiders joke that AWP really means "Ain't What's Paid." Office of Inspector General ("OIG"), "Medicaid Pharmacy-Actual Acquisition Cost of Generic Prescription Drug Products," (A-06-97-00011) (August 1997).

110. The Defendants at all times were aware of the State of Mississippi's formula for reimbursing providers for the provision of drugs under the State's Medicaid program, as set forth above, as well as the formula's reliance on AWP.

111. The Defendants were aware that the State of Mississippi relied upon the pricing information they provided to nationally known price reporting services in determining the amount the Division would reimburse providers for providing drugs to Medicaid beneficiaries and that the Division's reliance would result in its paying excessive amounts for these drugs to providers. In fact, a 2002 OIG report entitled "Medicaid Pharmacy-Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products" (A-06-02-00041), "found that the data upon which States base pharmacy reimbursement overstate pharmacy acquisition costs." OIG, "Variation in State Medicaid Drug Prices" (OEI-05-02-00681) (September 2004).

112. The Defendants had a duty to report pricing information that fairly and accurately reflected the AWP of their products rather than artificially inflated prices that fraudulently increased Medicaid reimbursement payments to providers.

113. The State of Mississippi obtained the Defendants' published AWP information from Blue Book, Red Book and Medispan.

114. The State of Mississippi, as well as numerous other payors, did rely upon the pricing information provided by the Defendants to Blue Book, Red Book and Medispan as true and correct. In fact, before the House Energy and Commerce Committee, Subcommittee on Oversight and Investigation, George M. Reeb, Assistant Inspector General for CMS, noted that "one reason States continue to rely on AWP . . . is that States lack access to alternative, more accurate price information." *Medicaid Prescription Drug Reimbursement: Why the Government Pays Too Much: Hearing Before the House SubComm. on Oversight and Investigations, 108th Cong., December 7, 2004.*

115. The State of Mississippi used the Defendants' false and inflated AWPs reported in the Blue Book, Red Book and Medispan in reimbursing providers for the provision of drugs to Medicaid beneficiaries under the State Medicaid program and did, in fact, pay excessive amounts to providers due to the Defendants' fraudulent scheme.

B. Marketing of the Spread

116. The difference between the actual price at which a wholesaler sells a Defendant's drug to a provider and the AWP established by a Defendant is known as the "spread" or alternatively, the "return to practice" or "return on investment." Another way to think of it is that the spread is the net difference between the actual acquisition cost and the AWP, which is pocketed by the provider. Unfortunately, as noted in Chairman Joe Barton's (R-TX) opening statement before the House Energy and Commerce Committee hearing on AWP, the "existence of substantial spreads remains a fixture of Medicaid prescription reimbursement." *Medicaid Prescription Drug Reimbursement:*

Why the Government Pays Too Much: Hearing Before the House SubComm. on Oversight and Investigations, 108th Cong., December 7, 2004.

117. Each of the Defendants intentionally and purposefully created and widened the “spread” on their products by decreasing the actual acquisition cost and increasing the AWP of their products. As noted by Patrick J. O’Connell, Chief of the Civil Medicaid Fraud Section of the Office of the Attorney General of Texas, in his testimony to the Senate Finance Committee regarding Texas’ litigation in the area of AWP:

The evidence we have discovered in the lawsuits as well as in our pre-litigation investigations shows that some manufacturers make conscious, deliberate business decisions to create enhanced spreads and to market the sale of their products based on the spreads.

Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net, 108th Cong., June 29, 2005.

118. Each of the Defendants intentionally and purposefully created and widened the “spread” on their drugs to increase the individual market share of their drugs, thereby increasing their own profits. Between 1997 and 2002, the Congressional Budget Office estimate that “the average markup [on a prescription drug] increased by nearly 60 percent—rising from \$8.70 to \$13.80 per prescription, or by about 9.7 percent per year.” Congressional Budget Office, “Medicaid’s Reimbursements to Pharmacies for Prescription Drugs,” (December 2004). By marketing the “spread” on their products, the Defendants intended to induce providers to purchase their drugs, knowing that the larger “spreads” would allow the provider to pocket more money from the State in the form of higher Medicaid reimbursements. George Grob, Deputy Inspector General of the Department of Health and Human Services, referred to this trend as “upside-down economics,” i.e. the drug company that receives the highest market share is the one with the highest AWP. *Medicare*

Drug Reimbursements: A Broken System for Patients and Taxpayers: Joint Hearing before the SubComm. on Health and the SubComm. on Oversight and Investigations of the House Energy and Commerce Com., 107th Cong., September 21, 2001. This marketing practice was recently disclosed in a December 7, 2004 hearing before the House Subcommittee of Oversight and Investigation of the House Energy and Commerce Committee, where the Chairman of the full committee, Representative Barton, stated:

During the course of this investigation, the committee has uncovered evidence that several manufacturers either inflate their AWP's or actively market their products, not based on the lowest price, but on the difference between price and the reimbursement amount, better known in the industry as the spread. . . . Data obtained by the committee from five of the largest retail pharmacy chains reveals that during the period of July 1, 2002 to June 20, 2003, the average acquisition costs for seven widely prescribed generic drugs was 22 cents, while the average Medicaid reimbursement just for those drugs alone was 56 cents, more than double the cost.

Medicaid Prescription Drug Reimbursement: Why the Government Pays Too Much: Hearing Before the House SubComm. on Oversight and Investigations, 108th Cong., December 7, 2004.

119. One might expect the spreads on drugs to be limited to single-source drugs. Clearly, the Defendants have created "spreads" for single-source drugs. When accounting for the explosion in Medicaid expenditures for prescription drugs, the CBO noted that "the largest single factor contributing to the rapid increase in markups [in the cost of prescription drugs reimbursed under Medicaid] was the use of newer single-source brand name drugs, which had somewhat higher average markups than did older brand-name drugs." "Medicaid's Reimbursement to Pharmacies for Prescription Drugs," (December 2004). However, generic multi-source drugs are also highly susceptible to markups. In particular, the CBO noted that "since the average markup on generic drugs is close to that on brand-name drugs, reimbursements for generic drugs provided an estimated

47 percent of total revenue from markups on Medicaid drugs in 2002.” “Medicaid’s Reimbursement to Pharmacies for Prescription Drugs,” (December 2004). The reason for this phenomena is that as competition increases among generic drugs, the Defendants compete on the basis of who can offer the highest “spread.” Former Chairman of the House Energy and Commerce Committee, and now current president of PHARMA, Representative Billy Tauzin (R-LA) noted this rather bizarre trend in his opening statement to a hearing on AWP in September of 2001:

Think about this with me for a second. We introduced generic drugs into the system to create competition. Do you know what happens to the system when a generic drug comes into play? Evidence we have that we will develop today indicates that when a generic drug comes into competition with a patent drug finally, the price doesn’t come down. The price goes up because both of the drug companies understand that if they are going to sell that drug to the doctor, they have got to give them a bigger spread. So they are in competition to give them a bigger spread, and they both post higher and higher artificial wholesale prices . . .

It is a game that turns ordinary economics on its head. As competition comes into the field, prices go up.

Medicare Drug Reimbursements: A Broken System for Patients and Taxpayers: Joint Hearing before the SubComm. on Health and the SubComm. on Oversight and Investigations of the House Energy and Commerce Com., 107th Cong., September 21, 2001.

120. The current Chairman of the House Energy and Commerce Subcommittee on Health, Representative Nathan Deal (R-GA) reiterated this position, noting:

In many instances, AWP bears little or no resemblance to what pharmacists really pay for drugs. This is especially true for generic drugs. In a recent report, CBO estimated the average “mark-up” between what Medicaid pays the pharmacy for each prescription and what the pharmacy or wholesaler actually pays for the drug has dramatically increased. They estimated that between 1997 and 2002, the average mark-up on generic drugs increased by nearly 79% per prescription.

Generic drugs have a critical role to play in containing soaring drug costs. My concern, however, is that because of AWP, Medicaid is missing out on a large

portion of these cost savings. I want to increase Medicaid's use of generic drugs, but not at the expense of rapidly increasing drug costs.

Medicaid Prescription Drugs: Examining Options for Payment Reform: the SubComm. on Health and the SubComm. on Health of the House Energy and Commerce Com., 109th Cong., June 22, 2005.

121. Mark Jones, President of Ven-A-Care, provided an example of how "spreads" are used in the generic drug market by the Defendants to gain market share at the expense of Medicaid:

I think more importantly than how they make it up [AWP] is what they're doing with it. Basically, in the generic marketplace right now manufacturers are always in control of their prices. They own every price that's ever published. It's theirs. They are taking those published prices, using the difference between what they're selling it [the generic drug] for and what the end buyer is going to bill the program, gets reimbursed for, as their marketing tool to sell their drugs. So that's called the spread. A manufacturer reports price, \$125 is the AWP, Medicaid uses that \$125 to reimburse whoever's billing it, yet they sell it for \$90. Well, the difference between \$90 and \$125 is the spread. That's the financial incentive that these companies use to sell their drugs, because you're talking about a generic market. You're talking about marketplace in general where there's seven or eight manufacturers of the same drug.

Medicaid Prescription Drug Reimbursement: Why the Government Pays Too Much: Hearing Before the House SubComm. on Oversight and Investigations, 108th Cong., December 7, 2004.

122. The inflated AWP of each of the Defendants' drugs greatly exceeds the actual acquisition cost of the drugs in addition to a generous markup. As again noted by Chairman Barton in his opening statement, "the primary beneficiaries of the current [Medicaid] reimbursement structure are the retail pharmacies. . . . Indeed, evidence gathered by the committee suggests that Medicaid reimbursement is more generous than that of most private payers." *Medicaid Prescription Drug Reimbursement: Why the Government Pays Too Much: Hearing Before the House SubComm. on Oversight and Investigations*, 108th Cong., December 7, 2004. Thus, each of the Defendants' AWP for these drugs bears no relation to any price acceptable within the marketplace.

C. Other Incentives

123. In addition to fraudulently inflating the AWP's they reported to the Blue Book, the Red Book, and/or Medispan, the Defendants used free goods, educational grants, and other incentives to induce providers to purchase, prescribe, administer and supply their drugs to Medicaid beneficiaries. All of these unreported incentives lowered the actual acquisition cost of the Defendants' drugs and thus further expanded the "spread" between the actual acquisition cost of a drug and what the Division reimbursed a provider under the Medicaid program. These incentives thus increased the Defendants' market share and profits. The Defendants provided these additional incentives fully aware that they were impermissible.

D. Concealment of Actual Cost:

124. It would appear from the extensive nature of the Defendants' scheme that the State of Mississippi would be aware of the Defendants' fraudulent acts. However, just the opposite is the case. Up until recently, the Defendants have been able to succeed in their drug-pricing scheme for more than a decade by utilizing the complexities of the drug marketplace and its reimbursement system to purposely conceal their scheme from the State of Mississippi as well as the Federal Government.

125. The sheer size of the drug marketplace and its complexities have worked to the advantage of the Defendants. As noted, there are over 65,000 NDC-numbered drugs whose AWP's may, and often do, change at any time. There are no Federal regulations setting forth how a drug's AWP is set or how often it must be updated. As noted above, many of the products with the most inflated AWP's are generic drugs which one would intuitively expect to have lower cost. As a

consequence, just to track the current published prices of drugs utilized by Mississippi Medicaid beneficiaries requires resources and expertise that the State lacks.

126. In addition, the Defendants have found ways to sell their drugs in the marketplace that hide their true price. For example, upon agreeing on a quantity and price of a drug with a provider, or group of providers, the Defendants purport to sell the agreed-upon drugs to wholesalers with whom they have a contractual arrangement, at the WAC price. The WAC may be, and usually is, higher than the price agreed upon by the provider and the drug manufacturer. The wholesaler then ships the product to the provider, charging the provider the (lower) price originally agreed upon by the drug manufacturer and the provider. When the wholesaler receives payment from the provider, it charges the manufacturer the price for handling and any applicable rebates and discounts, and sends a bill to the manufacturer, called a “charge-back,” for the difference between the WAC and the price actually paid by the provider. These charge-backs (or shelf adjustments, or other economic inducements) are kept secret, so that it appears that the wholesaler actually purchased the drug at the higher WAC price. Also, as noted above, some of the Defendants have hidden their real drug prices by providing incentives, such as free drugs, grants and gifts to providers as a means of reducing the overall price of their drugs while not accounting for these incentives when reporting the AWP of their drugs. Chairman of the House Ways and Means’ Subcommittee on Health, Representative Nancy Johnson (R-CT), noted the impact this had on reliability of AWP, stating:

The problem is that AWP’s do not reflect the actual price paid by purchasers. . . . The AWP’s are often far greater because they do not reflect the discounts, rebates, or so-called charge backs that manufacturers and wholesalers customarily offer to providers.

“Medicare Payments for Currently Covered Prescription Drugs,”: Hearing Before the House Ways and Means Comm. SubComm. on Health, 107th Cong., September 26, 2002.

127. Further, the Defendants use their complicated internal structures to hide their scheme from external scrutiny as well as potential internal whistleblowers. Schering Plough whistleblower Beatrice Manning noted this strategy in her testimony before the Senate Finance Committee, stating that:

I want now to turn to some key points that may explain why this scheme and others like it could continue so long without detection. First, work was organized such that it was quite difficult for any one person to put together the entire scheme, unless one was working at the top levels of the organization. The Medicaid pricing unit was located in an entirely different location, had no contact with ITG[Integrated Therapeutics Group, a subsidiary of Schering Plough responsible for contracting with providers], and wouldn't have seen ITG contracts. Even within ITG, work was intentionally "solo'ed." I would have done outcomes analysis, showing for instance, that treating allergies results in fewer hospitalizations for asthma, and I might have presented these findings to HMOs and PBMs, but I wasn't involved in structuring the health management "deals" between ITG and those entities. In reality, we were doing good work— ITG's health management programs continually won awards and were recognized by firms like JD Powers as top programs. The work I did was being presented at medical meetings and being published in refereed medical journals. Frankly, for the average person it's hard to believe that your good work is in reality nothing more than a bribe.

Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net, 108th Cong., June 29, 2005.

128. Also, the Defendants further inhibit the ability of the State of Mississippi to learn the true cost of their drugs by requiring confidentiality provisions in their sales agreements with providers.

129. Also, the Defendants consider their drug pricing information proprietary, thus restricting the State of Mississippi's access to such critical information.

130. Also, the Defendants further complicate Mississippi's ability to track drug prices by treating separate categories of purchasers differently. Thus, for the same drug, pharmacies are given one price, while hospitals are given another and physicians yet another.

131. More indicative of the Defendants' fraudulent intent, many purposefully keep two sets of records: one with the inflated prices and another with the actual prices. Such industry practice was discussed by Mr. O'Connell's testimony before the Senate Finance Committee:

We also found that some manufacturers actually kept two sets of computer records with prices: one, with inflated prices that are reported to the price reporting services like First Data Bank, or in Texas' case, directly to the Medicaid Program; and another with real contract prices that are used in every day business transactions with the manufacturer's customers.

Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net, 108th Cong., June 29, 2005.

132. The practice of keeping two sets of books was verified by Ms. Manning at the same hearing, who testified that, "I want to stress that this scheme did not result from public corruption or inadequate Medicaid auditing. In essence, two sets of books were being kept." *Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net*, 108th Cong., June 29, 2005.

133. Also, for a long time the Defendants have concealed their motive for utilizing inflated AWP's to increase their market share. This exchange between House Energy and Commerce Chairman Joe Barton and Leslie Paoletti of Roxane Laboratories, Inc. provides an example of the difficulty the Federal Government has had in rooting out the purpose behind the Defendants' fraudulent scheme:

Chairman Barton: Uh, this is Document Number 0199-02002, the second page of the document 0200 states that Roxanne's bid for Furosemide business was rejected, not because the sales price was too high but solely because the AWP was too low. Are AWP and/or reimbursement factors in negotiations with retail customers. Wanna talk about that? That document?

Ms. Paoletti: Uh, Furosemide was a very unique situation for us in that there were some changes in the market that allowed opportunities for us to potentially gain new business. When we tried to gain the new business we were repeatedly told that our

AWP was out of line with our competitors and upon looking at that discovered that they were significantly below our competitors such that regardless of how low our contract price was no one would buy the product.

Chairman Barton: So AWP, I mean, I guess what I see here is that AWP is how you get market share and the higher it is the better chance you have to get market share because somebody is making money on the spread. The people making the money are the purchasers, right?

Ms. Paoletti: I would disagree with that. I think it is, or in our experience its been a rare occasion that customers have discussed any of that with us and this occasion it is my impression that the only reason it was discussed was because we were out of line. They weren't asking us to increase the spread over what the current market was. They were just asking us to be on a level playing field.

Chairman Barton: Okay. Uh, I'll try and tell you Tab this one is. There is a Tab 39. If you will go to that. . . . It says here . . . , this is to Judy Waterier from Anthony Tivolareo. It says Judy as you know Caremark had shown interest with our Furosemide back in April. After a review of our AWP's on the products the opportunity was dead. Our AWP's are 78% below the rest of the industry. I am not aware of any competitor with AWP's below a hundred dollars for bottles of 40 mg thousands. Milan and Xenith are approximately 120, our is 29. Caremark commented that they could not possible award the product to us unless we increased our AWP's. Janet Miller also added that Roxane has a history of having AWP's out of sync with the rest of the industry. I don't now why we have to wait until our customers complain before we adjust an AWP. Major customers, Walgreen's, Wal-Mart, CVS, Medico, Caremark expect their leading suppliers to retain their AWP's. Not executing this core competency reflects negatively on Roxane and promotes a perception of Roxane not understanding industry dynamics. I hope this helps. They would appear to me to reference more than just Furosemide. Does it appear that way to you?

Ms. Paoletti: No he does say that we have a history. I'm not sure what he is basing that on. Typically, we set our pricing and we don't monitor our AWP's once they are set.

Chairman Barton: And why would he say, I don't know why we have to wait until our customers complain before we adjust it, an AWP? In this case he is referencing Furosemide and weren't able to get business.

...

Chairman Barton: Okay, if you would turn to Tab 38 in the binder. This document also notes that when AWP is out of line with the rest of the market it is a bigger issue than a straight price. This e-mail goes on to mention concerns associated with a decision to raise AWP including scrutiny and consumer backlash. Can you discuss those concerns?

Ms. Paoletti: Any time pharmaceutical companies do a price increase, it's scrutinized. The AWP in particular because that is one of the prices that is publicly available for everyone to see.

Chairman Barton: But it appears in this case at least to, in order to get market share . . . am I missing it? In order to get market share you're having to increase your AWP.

Ms. Paoletti: We were having to bring it in line with our competitors, yes. They weren't asking us to raise it above our competitors. That was not my impression.

Chairman Barton: What effect does raising the AWP have on the price that they pay for the product?

Ms. Paoletti: The customer? It would not have an impact on the price that they paid.

Chairman Barton: So what is the benefit to them for a higher AWP set by you which I assume is an arbitrarily set AWP?

Ms. Paoletti: Well in this case they weren't buying our product. They were buying the competitors' products whose was much higher. So in that case there would have not been an impact on what they were currently buying versus what.

Chairman Barton: No, my point is, your incentive to raise the AWP is to get market share, is it not?

Ms. Paoletti: In this case it was to bring ourselves inline so we could actually compete on a contract price.

Chairman Barton: Right. So you get more market share?

Ms. Paoletti: Sure.

Medicaid Prescription Drug Reimbursement: Why the Government Pays Too Much: Hearing Before the House SubComm. on Oversight and Investigations, 108th Cong., December 7, 2004.

134. Interestingly, for years the Defendants denied they inflated their AWP's. As the following congressional testimony bears out, now the Defendants claim they have no choice but to inflate their products' AWP's. Mr. Jones, of Ven-A-Care of the Florida Keys, Inc., noted:

Over the time period that we've been investigating this, we've heard drug manufacturers first claim that they didn't know where AWP came from, it wasn't their number, and then that evolved into, "Yes, we set the AWP's," and then we heard drug manufacturers say, "We don't know anything about marketing the spread. We're not interested in marketing the spread. We're only interested in the price that we charge our customer." But we finally evolved into, "Yes, there is a spread out there, and yes, we do market it." And now we're at the point with this industry where they're saying, "Look, it's so messed up, everybody wants to buy drugs based solely on the spread value, and we can't stop it even if we want to."

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135. Of course, the inflated AWP's themselves have provided the Defendants the incentive they needed to keep most providers silent. Essentially, the nature of the Defendants' scheme permits all providers to make some profit from the Defendants' "spreads," because all of them are reimbursed on the basis of the AWP for at least some of the drugs they sell or administer. Thus, providers are under no incentive to disclose a scheme that is lining their pockets.

136. Even Congress has been stonewalled; even the United States government has had the wool pulled over its eyes as to the Defendants' scheme. Not until the passage of the Medicare Modernization Act in 2003 did Congress finally address the issue of AWP in Medicare. Despite this fact, Congress has been unable to act to curb the Defendants' abuse of AWP in the Medicaid program. This despite the hearings, studies and investigations that will be presented later showing clear abuse of Medicaid's reimbursement formula by the Defendants.

137. However, one of the single largest factors keeping States like Mississippi in the dark

is their lack of access to the actual acquisition cost of the Defendants' drugs. In noting the cause of the variation among State Medicaid programs' drug prices, OIG noted that it "fundamentally stems from States' lack of access to pharmacies' true acquisition costs." OIG, "Variation in State Medicaid Drug Prices," (OEI-05-02-00681) (September 2004).

138. In the end, OIG describes the States' reliance on flawed AWP as a result of the fact that:

States have few alternative sources for drug prices. Actual sales data are proprietary, and only three States indicated that they regularly obtain additional price information from drug manufacturers, pharmacies, or other sources. One State criticized the "obfuscation of price" by drug manufactures.

OIG, "State Strategies to Contain Medicaid Drug Costs," (OEI-05-02-00680) (October 2003).

139. Of course, while it is true that Mississippi may have been helpless to free itself from the abuses of AWP due to the covert nature of the Defendants' behavior, it is important to note that the State has not sat idly by and allowed prescription drug prices to completely dismantle its Medicaid budget. The State, in a bipartisan fashion, has taken real affirmative steps to mitigate the damages caused by increasing Medicaid drug expenditures. In particular, during the FY 2002 legislative session, Mississippi lowered its dispensing fee by a dollar to \$3.91, increased beneficiary co-payments by \$2.00 to \$3.00 per brand name prescription, decreased the number of prescriptions per beneficiary, mandated the use of generic drugs when an equivalent generic was available, required prior authorization for certain classes of drugs, and limited the quantity of prescriptions dispensed to a 34-day supply. As already noted, in FY 2004 the State further limited the number of prescription drugs per beneficiary.

VI. Government Action

A. Office of Inspector General

140. The OIG has led the charge in uncovering the Defendants' abuses of AWP through extensive research and investigations.

141. In a report issued in April of 1997, the OIG reviewed the brand name pricing information from 315 pharmacies from 11 states. Based on the results of this data, the OIG estimated that actual acquisition costs for brand name drugs were a national average of 18.3 percent below AWP. The OIG calculated a savings of as much as \$225 million for 100 drugs with the greatest amount of Medicaid reimbursements in Calendar Year 1994, if reimbursement changes were made. OIG, "Medicaid Pharmacy-Actual Acquisition Cost of Prescription Drug Products for Brand Name Drugs," (A-06-96-00030)(April 1997).

142. In a report issued in August of 1997, the OIG decided to look and see whether the same abuses of AWP in the brand-name market were also indicative of the generic drug market. Specifically, the OIG reviewed the generic pricing information from 314 pharmacies from 11 states. Based on the results of this data, the OIG estimated that actual acquisition costs for generic drugs were a national average of 42.5 percent below AWP. The OIG calculated a savings as much as \$145.5 million in Calendar Years 1994 and 1995 for 200 generic drugs with the greatest amount of Medicaid reimbursement in each year. OIG, "Medicaid Pharmacy-Actual Acquisition Cost of Generic Prescription Drug Products," (A-06-97-00010)(August 1997).

143. The OIG revisited the abuse of AWPs in 2001 and found that things had only gotten worse. In a report issued in August 2001, the OIG reviewed the pricing information from 216 pharmacies in 8 states. Based on the results of this data, the OIG estimated that actual acquisition

costs for brand name drugs nationwide averaged 21.84 percent below AWP in 1999. The OIG's review showed that from 1994 to 1999 there was an increase of 19.3 percent in the average discount below AWP for brand name drugs. For the 200 brand name drugs with the greatest amount of Medicaid reimbursement in 1999, the OIG calculated that as much as \$1.08 billion could have been saved if reimbursement had been based on a 21.84 percent average discount from AWP. OIG, "Medicaid Pharmacy-Actual Acquisition Cost of Brand Name Prescription Drug Products," (A-06-00-00023) (August 2001).

144. Honing in on specific costly areas of pharmacological treatment, the OIG investigated the abuses of AWP in Medicaid's coverage of HIV/AIDS medications. In a report issued in July 2001, the OIG compared the net prices that ten State Medicaid agencies paid for 16 HIV/AIDS antiretroviral drugs to the prices paid by other government purchasers. Based on the results of this data, the OIG concluded that Medicaid pays up to 33 percent more than other Federal Government drug discount programs for HIV/AIDS drugs. OIG, "Cost Containment of Medicaid HIV/AIDS Drug Expenditures" (OEI-05-99-00611) (July 2001).

145. In a March 2002 report, to follow up on its August 1997 report on the abuse of AWP in the generic market, the OIG reviewed the generic pricing information from 217 pharmacies in 8 states. Based on the results of this data, the OIG concluded that significant savings could be realized on generic prescription drugs reimbursed by States under the Medicaid program. Specifically, the OIG estimated that pharmacy actual acquisition cost nationwide for generic drugs averaged 65.93 percent below AWP. Thus, the review showed an increase of over 55 percent in the average discount below AWP for generic drugs from 1994 to 1999. For the 200 generic drugs with the greatest amount of Medicaid reimbursement in 1999, the OIG calculated that as much as \$470

million could have been saved if reimbursement had been based on a 65.93 percent average discount from AWP. OIG, “Medicaid Pharmacy - Actual Acquisition Cost of Generic Prescription Drug Products” (A-06-01-00053) (March 2002).

146. Again, focusing in on specific costly area of pharmacological treatment, the OIG investigated the abuses of AWP in Medicaid’s coverage of mental health medications. In a report issued in August 2003, the OIG compared Medicaid’s average net costs for 25 mental health drugs from ten State Medicaid agencies to four other Federally-discounted prices for the same 25 drugs. Based on the results of this data, the OIG concluded that the ten State Medicaid agencies reviewed paid more than other government purchasers for the 25 mental health drugs reviewed. As a result of the price differences, the ten State Medicaid agencies paid, on average, between \$47 million and \$126 million more for the drugs than other Federal purchasers. OIG, “Medicaid’s Mental Health Drug Expenditures” (OEI-05-02-00080) (August 2003).

147. In a report issued in September 2004, the OIG reviewed the FY 2001 State Medicaid prescription drug reimbursement data of forty-two states for a sample of 28 national drug codes. The OIG found substantial variations in States’ payments for the drugs investigated that translated into overspending by Medicaid. Based on the State data, the OIG estimated that, overall, Medicaid could have saved as much as \$86.7 million in fiscal year 2001 alone if all States had reimbursed at the same price as the lowest paying State for each of the drugs reviewed. The State of Mississippi stuck out as a State that was clearly being abused by the Defendants. It was determined that Mississippi could save \$2,484,232, or 16.7 percent, on just the 28 drugs investigated. The OIG concluded that:

Most importantly, the factors that drive variability in drug prices across States stem from States’ lack of access to pharmacies’ true acquisition costs. Because they lack information about such costs, States rely on estimated acquisition costs [for

Mississippi and most states that is AWP], usual and customary charges, and maximum allowable costs as proxies for pharmacies' acquisition cost. These proxies are deficient because they are not necessarily linked to the prices at which pharmacies purchase drugs. The wide variation in State Medicaid prices results from the deficiencies in these proxies for estimating pharmacies' acquisition costs.

OIG, "Variation in State Medicaid Drug Prices" OIG (OEI-05-02-00681) (September 2004).

148. Most recently, the OIG issued two reports in June 2005 investigating AWP. The first report examined the differences between the published prices States use to set Medicaid reimbursement rates, i.e AWP, and statutorily defined prices calculated from actual sales transactions for drugs reimbursed by Medicaid, in this case AMP. In general, the report concluded that AMP is substantially lower than both AWP and WAC. Specifically, the report found that at the median, AMP is 59 percent lower than AWP. For generic drugs, AMP is 70 percent lower than AWP at the median. In comparison, AMP is 23 percent lower than AWP at the median for single source brands and 28 percent lower for multisource brands. OIG, "Medicaid Drug Price Comparisons: Average Manufacturer Price to Published Prices" OIG (OEI-05-05-00240) (June 2005).

149. The second report examined the differences between AWP and average sales price (ASP), i.e. a statutorily defined price based on actual sales transactions. In general, the report concluded that ASP is substantially lower than AWP. Specifically, the report found that for 2,077 national drug codes with ASAP and AWP data, ASP is 49 percent lower than AWP at the median. For 1,152 generic national drug codes, ASP is 68 percent less than AWP at the Median. OIG, "Medicaid Drug Price Comparisons: Average Sales Price to Average Wholesale Price" OIG (OEI-03-05-00200) (June 2005).

150. The OIG's consistent findings that AWP is not representative of the actual acquisition costs of the Defendants' drugs has led the OIG to continually denounce use of AWPs. George M.

Reeb, Assistant Inspector General for CMS, remarked, “reimbursement [for prescription drugs] should reliably reflect the actual costs of the drug to the pharmacy and be grounded in information that can be validated.” *Medicaid Prescription Drug Reimbursement: Why the Government Pays Too Much: Hearing Before the House SubComm. on Oversight and Investigations*, 108th Cong., December 7, 2004. This opinion was reiterated recently and succinctly by Robert A. Vito, Regional Inspector General for Evaluation and Inspections, Philadelphia Office of Inspector General, U.S. Department of Health and Human Services when he testified before the Senate Finance Committee that, “in short, the Medicaid program is vulnerable to abuse and continues to pay too much for prescription drugs compared to prices available in the marketplace.” *Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net*, 108th Cong., June 29, 2005.

B. Department of Justice

151. The U.S. Department of Justice (DOJ) has sought to assist States in weeding out the corruption in the drug marketplace. Specifically, after extensive investigation in conjunction with the National Association of Medicaid Fraud Control Units (NAMFCU), in 2001 the DOJ announced a number of AWP that were vastly overstated. The DOJ and NAMFCU transmitted this information to First Data Bank along with what it believed were the correct AWP for the targeted drugs. (See Exhibit B.)

C. Congressional Hearings

152. Congress has delved deep into the Defendants’ abuses of AWP in both the Medicare and Medicaid programs. In particular, the House Energy and Commerce Committee has led the charge in uncovering the abuses by the Defendants. At a hearing on the abuses of AWP in the

Medicare program, then Oversight and Investigations Subcommittee Chairman Jim Greenwood (R-PA), now president of BIO, found that:

A billion dollars of taxpayer dollars is wasted every year in this [Medicare] program because under current Federal law and regulations, Medicare is paying for drugs at AWP. AWP, or average wholesale price, could also be an acronym for “ain’t what’s paid.” It is quite clear that despite its name, AWP is not the average wholesale price at which these drugs are sold to health care providers or anything close to it. To the contrary, it appears that for many of these drugs, AWP is simply an artificial price established by certain drug manufacturers and reported to industry trade publications for purposes of third-party reimbursement, a price which bears little, if any, relationship to what is actually paid for these drugs by health care providers.

Medicare Drug Reimbursements: A Broken System for Patients and Taxpayers: Joint Hearing before the SubComm. on Health and the SubComm. on Oversight and Investigations of the House Energy and Commerce Com., 107th Cong., September 21, 2001.

153. It was not long before the House Energy and Commerce Committee followed the Defendants’ trail of abuse of AWP from the Medicare program to the Medicaid program. In late 2004, the House Energy and Commerce Subcommittee on Oversight and Investigation studied the Defendants’ abuses of State Medicaid programs. At that hearing, Chairman Barton began his testimony with the following example:

during our investigation, the committees obtained documents showing that during the summer of 2002, one drug manufacturer’s direct sales price of 2000 20 Mg. capsules of fluoxetine, the generic version of the popular antidepressant Prozac, was \$82.62, while the Average Wholesale Price was more than \$5,300. Let me repeat that. The generic version, \$82.62, but the Average Wholesale Price was \$5,300.

Medicaid Prescription Drug Reimbursement: Why the Government Pays Too Much: Hearing Before the House SubComm. on Oversight and Investigations, 108th Cong., December 7, 2004. Vice Chairman of the Committee, Greg Walden (R-OR), echoed the Chairman’s concerns over AWP, noting:

We've allowed a system to develop where AWP, a number not defined by statute or regulation, has become the reimbursement standard for the vast majority of Medicaid prescription drug programs. Because AWP is not, in many cases, reflective of actual market prices, it opens the door for the abuses that we will hear about today. At the very least, it serves to deny taxpayers the full benefit of price competition in the generic marketplace.

Medicaid Prescription Drug Reimbursement: Why the Government Pays Too Much: Hearing Before the House SubComm. on Oversight and Investigations, 108th Cong., December 7, 2004. The Committee provided the following additional examples of abuses of AWP by drug manufacturers:

DRUG	NDC	AWP	FUL FUL DATE	CURRENT COST	AWP SPREAD	FUL SPREAD
FLUOXENTINE 10 mg	00378 42100 1	\$259.85	\$58.50 12/1/02	\$4.25	\$254.05	\$54.25
DOXAZOSIN 1mg	00172 36850 6	\$91.92	\$59.18 1/22/02	\$7.15	\$84.77	\$52.03
ALBUTEROL INH 17 gm	59930 15600 1	\$21.41	\$15.00 3/11/03	\$4.25	\$17.16	\$10.75
BUSPIRONE HCL 10 mg	00378 11500 1	\$134.50	\$39.42 12/1/02	\$7.95	126.55	\$31.47
IPRATROPIUM BROMIDE .02%, 2.5ml, 25's	49502 06852 4	\$44.10	\$14.625 11/2/03	\$3.50	\$40.60	\$11.13
RANITIDINE 150mg, 1000	00781 18831 0	\$1480.00	\$341.10 1/22/02	\$44.92	\$1435.08	\$296.18
TAMOXIFEN 20mg	00054 48341 3	\$113.77	\$58.27	\$8.13	\$105.64	\$50.14
CEFACLOR 500 mg	00172 47710 6	\$389.45	\$129.00 1/22/02	\$42.10	\$347.35	\$86.90

DRUG	NDC	AWP	FUL FUL DATE	CURRENT COST	AWP SPREAD	FUL SPREAD
AZATHIOPRINE 50 mg	00054 40842 5	\$131.08	NONE	\$32.99	\$98.09	N/A
ATENOLOL 50 mg	00781 15060 1	\$83.42	\$8.85 12/1/02	\$4.65	\$78.77	\$4.20

154. In seeking to remedy future abuses, the House Energy and Commerce Committee Subcommittee on Health held a hearing on June 22, 2005 to look at possible legislative solutions. At that hearing, Subcommittee Chairman Deal reiterated his disdain for the Defendants' abuse of Medicaid, noting that "what is truly outrageous is that these [drug] prices are rising because states are paying prices for prescription drugs based on manufacturer reported Average Wholesale Prices or 'AWP.' As my former colleague, Jim Greenwood, noted several years ago, AWP could also stand for 'Ain't What's Paid.'" *Medicaid Prescription Drugs: Examining Options for Payment Reform: the SubComm. on Health and the SubComm. on Health of the House Energy and Commerce Com.,* 109th Cong., June 22, 2005.

155. The Senate is also seeking to uproot the Defendants' abuses of Medicaid's reimbursement of prescription drugs. On June 29, 2005 the Senate Finance Committee held a hearing on fraud and abuse in the Medicaid system, devoting a full panel to the issue of AWP. In his opening statement, Chairman Chuck Grassley (R-IA) remarked frankly about what had been learned due to recent regulatory and legal investigations into Medicaid reimbursement of prescription drugs and noted that "drug pricing is an area of Medicaid with significant levels of waste, fraud and

abuse” and that recent “settlements are evidence of systemic, industry-wide problems that need to be addressed.” *Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net*, 108th Cong., June 29, 2005.

D. Settlements

156. The Federal Government has entered into numerous settlements with various Defendants for their abuses of AWP and other scams to swindle millions of dollars from State Medicaid programs in order to increase their market share and profits.

157. In February 2001, Bayer agreed to settle with the United States for \$14 million in connection with Bayer’s AWP pricing and Medicaid rebate practices relating to six drugs. The government alleged that Bayer set and reported AWPs for the drugs at levels far higher than the actual acquisition costs of the products; that Bayer made misrepresentations to the Medicaid programs of several States; and knowingly misreported and underpaid Medicaid rebates for certain drugs. As part of the settlement, Bayer entered a five-year corporate integrity agreement (“CIA”) with the OIG.

158. In October 2001, TAP agreed to pay \$875 million to resolve its Medicare and Medicaid liability for violating Federal law governing the use of drug samples. In addition, TAP allegedly set and reported AWPs for its prostate cancer drug Lupron, at levels far higher than the actual acquisition cost of the majority of its customers and caused those customers to receive excess reimbursement from Medicare and Medicaid. TAP also allegedly underpaid rebate amounts due to the States under the Medicaid drug rebate statute.

159. In April 2003, Bayer agreed to pay \$257.2 million in criminal fines and civil assessments to settle a False Claims Act case relating to the Medicaid drug rebate program. Bayer

agreed to plead guilty to charges that it violated Federal law by failing to report certain information to the FDA. The case focused on Bayer's failure to include certain sales to Kaiser Permanente Medical Care (an HMO) in its calculation of Best Price reported for purposes of the Medicaid drug rebate program. The drug rebate program requires drug manufacturers to report their Best Prices to CMS and to pay rebates to State Medicaid programs based on those reported prices.

160. In April 2003, GSK settled a Medicaid drug rebate case for almost \$88 million, based on facts similar to the above mentioned Bayer April 2004 settlement. GSK also entered into a 5-year CIA with the OIG.

161. In June of 2003, AstraZeneca entered into a global settlement in which it agreed to pay a total of almost \$355 million and enter a 5-year CIA with OIG to resolve its criminal and civil liabilities relating to the marketing and pricing of its prostate cancer drug, Zoladex. AstraZeneca pled guilty to conspiracy to violate the Prescription Drug Marketing Act by causing the submission of reimbursement claims for Zoladex that had been provided free of charge as samples. The Government also alleged that AstraZeneca paid illegal remuneration (in various forms including grants, travel and entertainment) to induce the purchase of Zoladex; that AstraZeneca created and marketed an AWP spread between the Medicare reimbursement for Zoladex and its cost; and that AstraZeneca misreported and underpaid Medicaid rebates for Zoladex.

162. In 2004, Schering-Plough Corporation agreed to pay \$345.5 million as part of a global settlement with the Federal Government and entered into a 5-year corporate integrity agreement (CIA) with the OIG. As part of the settlement, Schering-Plough agreed to pay \$293 million to resolve its civil and administrative liabilities in connection with illegal and fraudulent pricing of its allergy drug Claritin under the Medicaid drug rebate program. The civil portion of the case focused

on Schering-Plough's alleged failure to include the value of certain incentives offered to two managed care organizations in Schering-Plough's determination of the best price reported for purposes of the Medicaid drug rebate program. By failing to include the value of the incentives in its determination of best price, Schering-Plough allegedly underpaid rebates due to the States and overcharged entities that purchased drugs at ceiling prices that are based on Medicaid drug rebate prices. With regard to the criminal portion of the case, a subsidiary of Schering-Plough, the Schering Sales Corporation, pled guilty to a kickback charge and was sentenced to pay a \$52.5 million criminal fine. Schering Sales Corporation was charged with paying a kickback of almost \$2 million in order to keep Claritin on the formulary of a managed care organization.

163. While a portion of the federal settlement proceeds from the above-described cases has been returned to the States, including Mississippi, the State has not been compensated fully for its losses from the wrongful conduct that these guilty pleas or civil settlements evidence.

VII. Damages

A. Damages to State

164. The foreseeable and intended consequences of the Defendants' conduct has been to bilk the State of Mississippi and its taxpayers out of millions of Medicaid dollars through their fraudulent scheme.

165. In particular, the AWP scheme has cost the State of Mississippi millions of dollars in excess Medicaid payments made for medications as a direct result of the illegal AWP scheme. The Division has been driven to near bankruptcy by the Defendants' actions, and only by taking drastic measures to curb the fiscal hemorrhaging of the State's Medicaid Program has the Governor and Legislature been able to continue the provision of these vital services.

166. The State seeks to recover these costs, actual damages and/or restitution as well as injunctive relief to halt the Defendants' pilfering of this vital State program.

B. Damages to Taxpayers

167. The foreseeable and intended consequences of the Defendants' conduct has also resulted in increased strain on the wallets and personal budgets of Mississippi's taxpayers whose income taxes go to fund Mississippi's Medicaid Program. As noted, the "spreads" between AWP and actual acquisition costs of the Defendants' drugs have markedly increased over the years. This strain on the budget of Mississippi's Medicaid Program has only led to increased pressures on those willing to fund the program with their tax dollars.

C. Damages to Beneficiaries

168. The foreseeable and intended consequences of the Defendants' conduct has also resulted in injuries to the poor and disabled beneficiaries of the Mississippi Medicaid Program. The direct result of the Defendants' actions has been the reduction of pharmaceutical benefits.

169. Also, the Defendants have influenced providers to administer, supply and prescribe drugs based on financial incentives as opposed to medical necessity. Specifically, as Chairman Greenwood summarized the findings of the House Energy and Commerce Committee's Subcommittee on Oversight and Investigation's hearing on the impact of the Defendants' abuses of AWP:

Of even greater concern to America's seniors than the impact of having to pay inflated copayments on drugs based on prices that are sometimes tens or hundreds of times higher than what their health care provider actually paid for the drugs is that they also may have had the quality of their health care adversely affected by this perverse system. We will hear how the profits available for utilizing certain drugs appear to be improperly affecting some health care providers' clinical decisions,

influencing them to provide unnecessary care and utilize drugs based on profit margins rather than therapeutic efficiency.

Medicare Drug Reimbursements: A Broken System for Patients and Taxpayers: Joint Hearing before the SubComm. on Health and the SubComm. on Oversight and Investigations of the House Energy and Commerce Com., 107th Cong., September 21, 2001.

VIII. Causes of Action

A. Count 1: State Medicaid Fraud

170. The State hereby repeats, incorporates by reference and realleges each and every allegation set forth above in this Complaint. 

171. The Defendants violated Miss. Code Ann. § 43-13-129. The Defendants knowingly made false statements and representations regarding the AWP of their drugs. The Defendants knowingly and intentionally failed to disclose the material fact that the AWPs of their products were vastly overstated. The Defendants' statements, representations and omissions were made in order to obtain or increase payments made under the Medicaid program. The Defendants' acts and omissions are punishable by a fine not to exceed five hundred dollars (\$500.00) for each individual false statement or false representation or failure to disclose a material fact.

172. The Defendants violated Miss. Code Ann. § 43-13-131.  The Defendants, through intentionally, fraudulently and deceitfully misrepresenting their products' AWPs, influenced Medicaid recipients, i.e. a Medicaid providers, to elect their products over products with lesser AWPs, for the purpose and with the intent to obtain or increase Medicaid's payment to said providers. The Defendants' acts are punishable by a fine not exceeding five hundred dollars (\$500.00) for each separate incident.

173. The Defendants violated the Mississippi Medicaid Fraud Control Act, Miss. Code Ann. § 43-13-207. The Defendants offered kickbacks and bribes to providers in the form of outrageous AWP's for the furnishing of their products to beneficiaries for which payment was made by Medicaid.

174. The Defendants violated the Mississippi Medicaid Fraud Control Act, Miss. Code Ann. § 43-13-211. The Defendants entered into agreements, combinations and conspiracies to defraud the State by obtaining or aiding providers in obtaining payments for false, fictitious or fraudulent claims for Medicaid benefits in the form of falsifying their products' AWP's.

175. The Defendants violated the Mississippi Medicaid Fraud Control Act, Miss. Code Ann. § 43-13-213. The Defendants' falsifying of their products' AWP's resulted in providers making, presenting or causing to be made or presented claims for Medicaid benefits which the Defendants knew were false, fictitious or fraudulent due to the inflated AWP's contained therein.

176. Violations of the Mississippi Fraud Control Act result in direct liability by the Defendants to the State, including forfeiture, civil penalties equal to the full amount received by the Defendants, plus an additional civil penalty equal to triple the full amount received by the Defendants. Miss. Code Ann. § 43-13-225

B. Count 2: Deceptive Trade Practices

177. The State hereby repeats, incorporates by reference and realleges each and every allegation set forth above in this Complaint.

178. The Defendants violated Mississippi law prohibiting unfair and deceptive trade practices. Specifically, the Defendants violated Miss Code Ann. § 75-24-5, and knowingly and intentionally committed unfair and deceptive trade practices, by falsely and fraudulently advertising

the AWP's of their products well above their actual acquisition costs with the intent not to sell them as advertised. Further, the Defendants violated Miss Code Ann. § 75-24-5 by intentionally misrepresenting the facts concerning the reasons for, existence of, or amounts of price reductions provided to providers.

179. Violations of Mississippi law prohibiting unfair and deceptive trade practices results in restitution, as well as other injunctive relief. Miss. Code Ann. § 75-24-11. Also, Mississippi law provides for civil penalties not to exceed Ten Thousand Dollars (\$10,000.00) per violation for unfair and deceptive trade practices. Miss Code Ann. § 75-24-19

C. Count 3: False Advertising

180. The State hereby repeats, incorporates by reference and realleges each and every allegation set forth above in this Complaint.

181. The Defendants violated Mississippi's prohibition of false advertising. Specifically, the Defendants violated Miss Code Ann. § 97-23-1 by misrepresenting the true nature of its business by representing in the Blue Book, the Red Book, and/or Medispan and other mediums that they sold their products at average wholesale prices, when clearly the AWP's established for their products were not set at the wholesale or even actual acquisition cost.

182. Further, the Defendants violated Miss. Code Ann. § 97-23-3 by intentionally and knowingly making, publishing, disseminating, circulating or placing before the public AWP's for their products which were untrue, deceptive and misleading due to their inflated and exorbitant nature.

D. Count 4: Crimes Against Sovereignty:

183. The State hereby repeats, incorporates by reference and realleges each and every allegation set forth above in this Complaint.

184. The Defendants violated Miss. Code Ann. § 97-7-10. Specifically, the Defendants defrauded the State of Mississippi and the Division by knowingly and willfully falsifying the AWP's of their products in documents relied on by the State and the Division in paying Medicaid claims, as well as concealing or covering up their scheme to falsify their AWP's and market the "spread" on their products.

185. Further, the Defendants violated Miss. Code Ann. § 97-7-13 by entering into a conspiracy with one another and with providers to defeat, by unlawful and fraudulent means, the payment of the correct amount for Medicaid prescription drug claims, thus costing the State of Mississippi millions of dollars.

E. Count 5: Mail Fraud

186. The State hereby repeats, incorporates by reference and realleges each and every allegation set forth above in this Complaint.

187. The Defendants committed mail fraud, Miss Code Ann. § 97-19-83. Specifically, the Defendants having devised or intending to devise a scheme through the inflation and fraudulent publishing of their products' AWP's, and seeking to defraud the State of Mississippi of millions of dollars, transmitted and caused to be transmitted by mail, telephone, etc, and other means of communication false AWP's across county or State jurisdictional lines.

F. Count 6: Restraint of Trade

188. The State hereby repeats, incorporates by reference and realleges each and every allegation set forth above in this Complaint.

189. The Defendants have unfairly violated Mississippi statutory law protecting trade. Specifically, the Defendants violated Miss. Code Ann. § 97-23-85, by conspiring with one another

and providers to set high AWP for their products, prevented other pharmaceutical manufacturers whose products did not have inflated AWP from trading or doing business with providers. This conspiracy allowed the Defendants to block other competitors out of the marketplace and protect, if not expand, their market share.

190. Also, the Defendants violated Miss. Code Ann. § 97-23-33, due to their willful and malicious printing, circulating and distributing of inflated AWP with the purpose and design being to wilfully and maliciously interfere with, or prevent, other pharmaceutical manufacturers whose products did not have inflated AWP from lawfully selling their products to providers.

191. Also, the Defendants violated Miss. Code Ann. § 75-21-1 by working with one another as well as providers to fraudulently increase the AWP on their products and thus increase the price of their products to the State of Mississippi. The Defendants' actions were also intended to hinder competition in the sale of their products by competitors by blocking out of the market those who would sale drugs at their actual AWP.

G. Count 7: Common Law Fraud

192. The State hereby repeats, incorporates by reference and realleges each and every allegation set forth above in this Complaint.

193. The Defendants committed common law fraud against the State and its agency, the Division. The Defendants reported or caused to be reported AWP for their products on a periodic and continuing basis for publication and dissemination to State Medicaid agencies, such as Mississippi's Division. Defendants knew that the AWP information which they provided and caused to be reported was false. Defendants misrepresented the pricing information with the intent of inducing the Division to rely on the false information in setting prescription drug reimbursement

rates. The Division reasonably relied on the false pricing data in setting prescription drug reimbursement rates and making payment based on said rates. The Defendants' misrepresentations are continuing, as they regularly and periodically continue to issue false and inflated AWP information for publication by the industry reporting services. As a result of the Defendants' fraudulent conduct, the State has been damaged by paying grossly excessive amount for Defendants' prescription drugs.

194. By engaging in acts and practices described above, the Defendants have engaged and continue to engage in repeated fraudulent acts and practices in violation of Mississippi common law.

195. Defendants' conduct was and is knowing, intentional, gross, oppressive, malicious, wanton, and/or committed with the intention to cause injury.

H. Count 8: Unjust Enrichment

196. The State hereby repeats, incorporates by reference and realleges each and every allegation set forth above in this Complaint.

197. As a result of the false and misleading statements and representations regarding drug prices contained in each Defendant's reporting of AWPs, the Division has paid excessive amounts in connection with purchases or reimbursements of purchases of the Defendants' prescription drugs.

198. The Defendants knew that medical providers who obtained Medicaid reimbursements for the Defendants' drug products were not entitled to improperly inflated reimbursement rates that were based on the Defendants' false AWPs.

199. As a result of the excessive payments to providers by the Division of all or part of the "spread," the Defendants obtained increased sales and market share for their products, and, therefore, increased profits, and were unjustly enriched at the expense of the State and the Division.

200. The Defendants knew they were not entitled to the profits that resulted from the sales obtained through the use of the spreads they created, and the Defendants should be required to account for and make restitution to the State of all such amounts obtained through the use of such spreads.

IX. Prayer for Relief

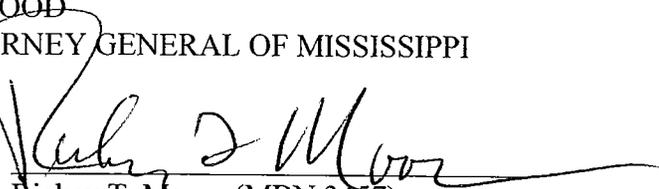
WHEREFORE, PREMISES CONSIDERED, Plaintiff, the State of Mississippi, by and through Jim Hood, its duly elected Attorney General, requests that this Court grant the following relief against the Defendants as follows:

- (1) an order enjoining each and every Defendant from continuing the fraudulent, deceptive and/or unfair acts or practices complained of herein, and requiring correcting measures;
- (2) an award of compensatory damages to the State in such amount as is proved at trial;
- (3) an award of all civil penalties provided for by statute;
- (4) an award of punitive damages;
- (5) an accounting of all profits or gains derived in whole or in part by each Defendant through its fraudulent, unfair and/or deceptive acts or practices complained of herein;
- (6) a constructive trust of the moneys illegally and impermissibly obtained from the Defendants' scheme;
- (7) an order imposing a constructive trust on and/or requiring disgorgement by each Defendant of all profits and gains earned in whole or in part through the fraudulent, unfair and/or deceptive acts or practices complained of herein;
- (8) an award of costs and prejudgment interest; and
- (9) such other and further relief as the Court may deem appropriate ad just.

RESPECTFULLY SUBMITTED, this the 20th day of October, 2005.

JIM HOOD
ATTORNEY GENERAL OF MISSISSIPPI

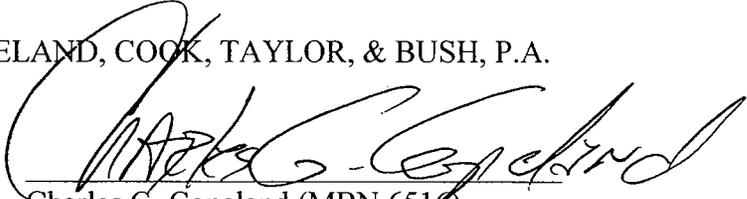
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DEPARTMENT OF JUSTICE 2001 NUMBERS

Name of Defendant	Drug	AWP	Actual Acquisition Cost	Spread	% Spread
Abbott Laboratories, Inc.	Acetylcysteine	\$35.87	\$21.90	\$13.97	64%
Abbott Laboratories, Inc.	Acyclovir	\$1,047.38	\$349.05	\$698.33	200%
Abbott Laboratories, Inc.	Amikacin Sulfate	\$994.84	\$125.00	\$807.84	697%
Abbott Laboratories, Inc.	Calcitriol (Calcijex)	\$1,390.66	\$1,079.00	\$311.66	29%
Abbott Laboratories, Inc.	Cimetidine Hydrochloride	\$214.34	\$35.00	\$179.34	512%
Abbott Laboratories, Inc.	Clindamycin Phosphate	\$340.52	\$75.35	\$265.17	352%
Abbott Laboratories, Inc.	Dextrose	\$239.97	\$3.91	\$236.06	6037%
Abbott Laboratories, Inc.	Dextrose Sodium Chloride	\$304.38	\$1.93	\$302.45	15671%
Abbott Laboratories, Inc.	Diazepam	\$28.50	\$2.03	\$26.47	1304%
Abbott Laboratories, Inc.	Furosemide	\$74.52	\$14.38	\$60.14	418%
Abbott Laboratories, Inc.	Gentamicin Sulfate	\$64.42	\$0.51	\$63.91	12531%
Abbott Laboratories, Inc.	Heparin Lock Flush	\$38.30	\$13.60	\$24.70	182%
Abbott Laboratories, Inc.	Metholprednisolone Sodium Succinate	\$34.08	\$2.30	\$31.78	1382%
Abbott Laboratories, Inc.	Sodium Chloride	\$670.89	\$3.22	\$667.67	20735%
Abbott Laboratories, Inc.	Tobramycin Sulfate	\$150.52	\$2.94	\$147.58	5020%
Abbott Laboratories, Inc.	Vancomycin Hydrochloride	\$382.14	\$4.98	\$377.16	7574%
Immunex Corporation (a wholly owned subsidiary of Amgen)	Leucovorin Calcium	\$137.94	\$14.58	\$123.36	346%
Baxter International, Inc.	Dextrose	\$928.51	\$2.25	\$926.26	41167%
Baxter International, Inc.	Sodium Chloride	\$928.51	\$1.71	\$926.80	54199%
Boehringer Ingelheim Pharmaceuticals, Inc. (a wholly owned subsidiary of Boehringer Ingelheim)	Leucovorin Calcium	\$184.40	\$2.76	\$181.64	6581%
Boehringer Ingelheim Pharmaceuticals, Inc. (a wholly owned subsidiary of Boehringer Ingelheim)	Acyclovir Sodium	\$528.00	\$207.00	\$321.00	155%

Boehringer Ingelheim Pharmaceuticals, Inc. (a wholly owned subsidiary of Boehringer Ingelheim)	Amikacin Sulfate	\$437.50	\$65.53	\$372.17	570%
Boehringer Ingelheim Pharmaceuticals, Inc. (a wholly owned subsidiary of Boehringer Ingelheim)	Mitomycin	\$128.05	\$51.83	\$76.22	147%
Boehringer Ingelheim Pharmaceuticals, Inc. (a wholly owned subsidiary of Boehringer Ingelheim)	Cytarabine	\$62.50	\$3.55	\$58.95	1661%
Boehringer Ingelheim Pharmaceuticals, Inc. (a wholly owned subsidiary of Boehringer Ingelheim)	Doxorubicin HCl	\$945.98	\$139.75	\$805.23	577%
Boehringer Ingelheim Pharmaceuticals, Inc. (a wholly owned subsidiary of Boehringer Ingelheim)	Etoposide	\$110.00	\$8.45	\$101.55	1202%
Boehringer Ingelheim Pharmaceuticals, Inc. (a wholly owned subsidiary of Boehringer Ingelheim)	Methotrexate Sodium	\$68.80	\$2.63	\$66.17	2516%
Boehringer Ingelheim Pharmaceuticals, Inc. (a wholly owned subsidiary of Boehringer Ingelheim)	Vinblastine Sulfate	\$212.50	\$8.19	\$204.31	2495%
B. Braun of America, Inc. (a wholly owned subsidiary of B. Braun Melsunder Aktiengesellschaft)	Sodium Chloride	\$11.33	\$1.49	\$9.84	660%
Bristol-Myers Squibb Company	Etoposide (Vepesid)	\$136.49	\$34.30	\$102.19	298%
Dey, Inc.	Albuterol Sulfate	\$30.25	\$9.17	\$21.08	230%
Dey, Inc.	Ipratropium Bromide .2mg	\$44.10	\$8.52	\$35.58	355%
Dey, Inc.	Acetylcysteine	\$59.88	\$25.80	\$34.08	132%
Dey, Inc.	Cromolyn Sodium	\$42.00	\$23.01	\$18.99	82%
Dey, Inc.	Metaproterenol Sulfate	\$30.75	\$11.29	\$19.46	172%

Exhibit A

Pharmacia Corporation (a wholly owned subsidiary of Pfizer)	Etoposide	\$157.65	\$9.47	\$148.18	1565%
Sicor Pharmaceuticals, Inc. f/k/a Gensia Sicor Pharmaceuticals, Inc. (a wholly owned subsidiary of Teva)	Tobramycin Sulfate	\$342.19	\$6.98	\$335.21	4802%
Watson Pharmaceuticals, Inc.	Vancomycin HCl	\$70.00	\$6.98	\$63.02	1567%

Exhibit A

EXHIBIT

tabbles

B

Program Memorandum Intermediaries/Carriers

Department of Health and
Human Services (DHHS)
HEALTH CARE FINANCING
ADMINISTRATION (HCFA)

Transmittal AB-00-86

Date: SEPTEMBER 8, 2000

CHANGE REQUEST 1232

SUBJECT: An Additional Source of Average Wholesale Price Data in Pricing Drugs and Biologicals Covered by the Medicare Program

The purpose of this Program Memorandum (PM) is to provide you with an alternative source of average wholesale price data (attached) for some drugs and biologicals covered by the Medicare program. The first attachment includes data for 32 drugs that you are to consider in determining the Medicare payment allowances for your January 2001 quarterly update. The second attachment includes data for 14 oncology drugs and 3 clotting factors that are not to be implemented in that same quarterly update.

The payment allowance for drugs and biologicals covered by the Medicare program is described in PM AB-99-63. That PM states that drugs and biologicals not paid on a cost or prospective payment basis are paid based on the lower of the billed charge or 95 percent of the average wholesale price reflected in sources such as the Red Book, Blue Book, or Medispan. Examples of drugs that are paid on this basis are drugs furnished incident to a physician's service, drugs furnished by pharmacies under the durable medical equipment benefit, covered oral anti-cancer drugs, and drugs furnished by independent dialysis facilities that are not included in the end stage renal disease composite rate payment. While the Blue Book is no longer available, another publication, Price Alert, is available. Also, there are electronic versions of the same data.

The data in the attachments have come from the United States Department of Justice (DOJ) and the National Association of Medicaid Fraud Control Units (NAMFCU). They are an alternative source of average wholesale price data for certain drugs, which has recently become available to HCFA. These data have been compiled for about 400 national drug codes (NDC) representing about 50 different chemical compounds. These data are from wholesalers' catalogs that list the prices at which the wholesaler sells the respective products. The DOJ has indicated that these are more accurate wholesale prices for these drugs. Furthermore, the DOJ has indicated that because purchasers often receive further discounts below the advertised wholesale catalog price, either from a wholesaler or from the drug manufacturer directly, actual acquisition costs may be lower. The DOJ indicates that some physicians and suppliers obtain drugs at prices lower than the wholesale catalog prices through Group Purchasing Organizations (GPO). For example, the DOJ data from wholesale catalogs indicates an average wholesale price of \$22 for one albuterol sulfate NDC which is substantially less than the \$73 average wholesale price in the Redbook and compares to \$15 from a GPO. These data are generally consistent with findings from OIG reports.

There has been correspondence with some members of congress on this subject. Under separate cover, we will send you a letter from the Administrator to Members of Congress, which places in context the issue of pricing drugs covered under the existing Medicare drug benefit and this new source.

DOJ and NAMFCU have provided these data to First Data Bank, a company that compiles average wholesale prices for most State Medicaid programs. On May 1, 2000, First Data Bank provided these new average wholesale prices to State Medicaid programs. Some States have already implemented these new average wholesale prices while others have not.

HCFA-Pub. 60AB

You are to consider these alternative wholesale prices as another source in determining your January, 2001 quarterly update for the 32 drugs (Attachment 1), as per PM AB-99-63. These drugs account for 75 percent of Medicare spending and 70 percent of savings (based on DOJ data) for the drugs on the complete DOJ list. However, we have some concern about access to care related to the DOJ's wholesale prices for 14 chemotherapy drugs and 3 clotting factors (Attachment 2), due to other Medicare payment policies associated with the provision of these drugs for the treatment of cancer and hemophilia. Therefore, you are not to consider at this time using the DOJ data for these drugs (Attachment 2) to establish your Medicare allowances while we further review these concerns and develop alternative policies. For the drugs shown in Attachment 2, use your usual source of average wholesale prices in your next quarterly update.

The data in these attachments may not represent all of the NDCs for a drug or biological in applying the pricing rules described in PM AB-99-63; if you decide to use these data, then you must use solely these data as the source of average wholesale prices in establishing your Medicare payment allowances for the drugs in Attachment 1.

You are to report by October 15, 2000, your usual source as well as the source you intend to use for the January 2001 updates. Also, you are to provide a list of what the updates would be for the source(s) you identify as usual and for January 2001 updates, and the percentage difference, if any, for all the drugs listed in Attachment 1 and 2 (source for drugs in Attachment 2 can not be DOJ data). You are to submit these reports electronically to a special mailbox being established for this purpose. The e-mail address for this mailbox is DOJAWP@hcfra.gov.

For the drugs in Attachment 1, we may provide additional guidance by the end of October, which could affect your January 2001 updates. We will provide guidance in subsequent correspondence that concerns your future drug updates, and on Medicare allowances for the drugs listed in Attachment 2 as any necessary adjustments to other payments related to the provision of these drugs are being carried out. We will also convey how we plan to adjust Medicare allowances under the outpatient prospective system for drugs that are both subject to the AWP rules and paid on a passthrough basis.

The enclosed data show a price for each NDC that is an average of the wholesale prices in the catalogs of the various wholesale companies that are also shown. The DOJ indicates that these wholesalers have toll-free numbers (included in Attachment 1) and the capacity to supply drugs via overnight delivery to any place in the country. If you decide to use these data and if a physician or supplier indicates that they cannot obtain one of these products for the average wholesale price in this new source, you may explain to the physician or supplier that one or more of the wholesale companies in the attachment have indicated to the DOJ that they supply these drugs at or below these prices. You may give the physician or supplier the name and toll-free number of the wholesaler(s). You may also give the name and telephone number of the manufacturer of the drug (available in the Red Book) as DOJ has indicated that manufacturers often supply the drugs directly. Some of the manufacturers also have web pages on the Internet. Physicians or suppliers who are members of a GPO might also obtain these drugs through that organization at or below these average wholesale prices. However, you should not imply in any way that the physician or supplier is required to change their procedure for obtaining drugs. Further, you should indicate that you are not advocating the use of these sources and do not assume any liability for the choice of source by the physician or supplier.

Sections 1842(o) and 1833(a)(1)(S) of the Social Security Act (the Act) require the Medicare program to set payment allowances for drugs and biologicals at the lower of the actual amount billed or 95 percent of the average wholesale price. The attached data represent another source of average wholesale prices for the products on the attached list. Therefore, use of this new source of average wholesale prices in Attachment 1 is not an inherent reasonableness adjustment under paragraphs (8) and (9) of section 1842(b) of the Act.

The procedure for processing intermediary claims has not changed. As described in PM AB-97-25, all carriers will continue to furnish free of charge their drug payment allowance updates for all drugs and biologicals directly to the fiscal intermediaries in their jurisdiction. Carriers should contact the fiscal intermediaries to determine the preferred method of transmission. Carriers are to send this information to all fiscal intermediaries with whom they routinely deal. To further clarify, fiscal intermediaries must use each carrier's drug payment allowances for claims submitted under that carrier's jurisdiction.

Attachments (3)

The effective date for this (PM) is September 8, 2000.

The implementation date for this PM is September 8, 2000.

These instructions should be implemented within your current operating budget.

This PM may be discarded September 1, 2001.

If you have any questions contact Robert Nlemann at 410-786-4531.

Attachment 1 – If you decide to use these data, use solely these data to update the HCPCS billing codes that correspond to the drugs on this list.

Drug Name	Prod/Mfr	Measurements	NDC	Wholesaler	Average Wholesale (AWP)
Acetylcysteine	(Abbott Hosp.)/SOL, IH	10%, 30 ml, 3s	00074-3307-03	MK	\$21.90
Acetylcysteine	(Abbott Hosp.)/SOL, IH	20%, 4 ml, 30 ml, 3s	00074-3308-03	MK, BB	\$18.75
Acetylcysteine	(Dey)/SOL, IH	10%, 4ml, 12s	49502-0181-04	MK	\$25.80
Acetylcysteine	(Dey)/SOL, IH	10%, 10 ml, 3s	49502-0181-10	MK	\$15.27
Acetylcysteine	(Dey)/SOL, IH	10%, 30 ml, 3s	49502-0181-30	MK	\$41.97
Acetylcysteine	(Dey)/SOL, IH	20%, 100 ml, ea	49502-0182-00	MK	\$75.90
Acetylcysteine	(Dey)/SOL, IH	20%, 4 ml, 12s	49502-0182-04	MK	\$31.08
Acetylcysteine	(Dey)/SOL, IH	20%, 10 ml, 3s	49502-0182-10	MK	\$18.57
Acetylcysteine	(Dey)/SOL, IH	20%, 30 ml, 3s	49502-0182-30	MK	\$50.64
Acetylcysteine	(Faulding)/SOL, IH (VIAL)	10%, 4 ml, 10s	61703-0203-04	MK, BB	\$13.50
Acetylcysteine	(Faulding)/SOL, IH (VIAL)	10%, 30 ml, 10s	61703-0203-31	BB	\$91.00
Acetylcysteine	(Faulding)/SOL, IH (VIAL)	10%, 4 ml, 10s	61703-0204-04	MK, BB	\$19.50
Acetylcysteine	(Faulding)/SOL, IH (VIAL)	10%, 30 ml, 10s	61703-0204-31	MK	\$91.00
Acyclovir Sodium	(Abbott Hosp.)/(Vial, Flip-top)	500 mg, 10s	00074-4427-01	BB, MK	\$349.05
Acyclovir Sodium	(Abbott Hosp.)/(Vial, Flip-top)	1000 mg, 10s	00074-4452-01	BB, MK	\$700.10
Acyclovir Sodium	(App)/INJ, IJ (Vial)	50 mg/ml, 10 ml	63323-0325-10	MK	\$15.00
Acyclovir Sodium	(App)/INJ, IJ (Vial)	50 mg/ml, 20 ml	63323-0325-20	MK	\$28.00
Acyclovir Sodium	(App)/PDI	15s, 500 mg, ea	63323-0105-10	MK	\$37.15
Acyclovir Sodium	(App)/PDI	15s, 1000 mg, ea	63323-0105-20	MK	\$75.13
Acyclovir Sodium	(Bedford)/PDI, IJ (S.D.V.)	500 mg, 10s	55390-0612-10	BB, ASD, R	\$207.00
Acyclovir Sodium	(Bedford)/PDI, IJ (S.D.V.)	1000 mg, 10s	55390-0613-20	BB, ASD, R, OS	\$401.75
Acyclovir Sodium	(Faulding)/PDI, IJ	500 mg, 10s	61703-0311-20	FI	\$89.00
Acyclovir Sodium	(Faulding)/PDI, IJ	1000 mg, 10s	61703-0311-43	FI	\$179.50
Acyclovir Sodium	(Fujisawa/APP)/PDI, IJ (VIAL)	500 mg, 10s	63323-0105-10	BB, MK	\$371.50
Acyclovir Sodium	(Fujisawa/APP)/PDI, IJ (VIAL)	1000 mg, 10s	63323-0110-20	BB, MK	\$751.80
Acyclovir Sodium	(Fujisawa/APP)/PDI, IJ (VIAL)	500 mg, 10s	63323-0325-10	BB	\$150.00
Acyclovir Sodium	(Fujisawa/APP)/PDI, IJ (VIAL)	1000 mg, 10s	63323-0325-20	BB, MK	\$280.00
Acyclovir Sodium	(Gensia)/PDI, IJ (VIAL)	500 mg, 10s	00703-8104-03	BB	\$100.00
Acyclovir Sodium	(Gensia)/PDI, IJ (VIAL)	1000 mg, 10s	00703-8105-03	BB	\$186.00
Albuterol Sulfate	(Dey)/SOL, IH	0.5%, 20 ml	49502-0196-20	BB, MK	\$5.91
Albuterol Sulfate	(Dey)/SOL, IH	0.083%, 3 ml, 25s, UD	49502-0697-03	BB, MK	\$9.17
Albuterol Sulfate	(Dey)/SOL, IH	0.083%, 3ml, 30s, UD	49502-0697-33	BB, MK	\$11.01
Albuterol Sulfate	(Dey)/SOL, IH	0.083%, 3ml, 60s, UD	49502-0697-60	BB, MK	\$22.01
Albuterol Sulfate	(Schein)/SOL, IH	0.5%, 20 ml	00364-2530-55	BB, MK	\$7.62
Albuterol Sulfate	(Wanick)/SOL, IH	0.083%, 3ml, 60s	59930-1500-06	BB, MK, AND	\$21.92
Albuterol Sulfate	(Wanick)/SOL, IH	0.083%, 3ml, 25s, UD	59930-1500-08	BB, MK, AND	\$9.16
Albuterol Sulfate	(Wanick)/SOL, IH	0.5%, 20 ml	59930-1515-04	BB, MK	\$5.65
Amikacin Sulfate	(Abbott Hosp.)/(Vial, Flip-top)	50 mg/ml, 2 ml, 10s	00074-1955-01	BB	\$125.00
Amikacin Sulfate	(Abbott Hosp.)/(Vial, Flip-top)	250 mg/ml, 2 ml, 10s	00074-1956-01	BB, MK	\$150.00

Amikacin Sulfate	(Abbott Hosp.)/(Vial, Flitop)	250 mg/ml, 4 ml, 10s	00074-1957-01	BB, MK	\$320.00
Amikacin Sulfate	(Apothecon) Amikln/INJ, IJ (Vial)	250 mg/ml, 2 ml	00015-3020-20	FI, MK	\$17.31
Amikacin Sulfate	(Apothecon) Amikln/INJ, IJ (Vial)	250 mg/ml, 4 ml	00015-3023-20	FI, MK	\$34.49
Amikacin Sulfate	(Bedford)/INJ, IJ (S.D.V., P.F.)	250 mg/ml, 2 ml, 10s	55390-0226-02	BB, MK, FI	\$45.33
Amikacin Sulfate	(Bedford)/INJ, IJ (S.D.V., P.F.)	250 mg/ml, 4 ml, 10s	55390-0226-04	BB, MK, FI	\$125.33
Amikacin Sulfate	(Faulding Pharm.)/INJ, IJ (VIAL)	50 mg/ml, 2 ml, 10s	61703-0201-07	MK	\$295.00
Amikacin Sulfate	(Faulding Pharm.)/INJ, IJ (VIAL)	250 mg/ml, 4 ml, 10s	61703-0202-04	BB, MK	\$890.00
Amikacin Sulfate	(Faulding Pharm.)/INJ, IJ (VIAL)	250 mg/ml, 2 ml, 10s	61703-0202-07	BB, MK	\$450.00
Amikacin Sulfate	(Faulding Pharm.)/INJ, IJ (VIAL)	250 mg/ml, 3 ml, 10s	61703-0202-08	MK	\$600.00
Amikacin Sulfate	(Genia)/INJ, IJ (S.D.V.)	50 mg/ml, 2 ml, 10s	00703-9022-03	BB, OS	\$72.68
Amikacin Sulfate	(Genia)/INJ, IJ (S.D.V.)	250 mg/ml, 2 ml, 10s	00703-9032-03	BB, MK	\$70.00
Amikacin Sulfate	(Genia)/INJ, IJ (Vial)	250 mg/ml, 4 ml, 10s	00703-9040-03	BB	\$140.00
Amphotercin B	(Apothecon) Fungzone/PDI, IJ	50 mg, ea	00003-0437-30	FI	\$6.20
Amphotercin B	(Genia)/PDI, IJ (S.D.V.)	50 mg, ea	00703-9785-01	BB	\$9.80
Amphotercin B	(Pharmacia/Upjohn) Amphocin/PDI, IJ	50 mg, ea	00013-1405-44	ASD	\$16.00
Calcitriol	(Abbott Hosp) Calcijex/INJ, IJ (AMP)	1mcg/ml, 1ml, 100s	00074-1200-01	FI	\$1,079.00
Calcitriol	(Abbott Hosp) Calcijex/INJ, IJ (AMP)	2 msp/ml, 1 ml, 100s	00074-1210-01	FI	\$2,009.35
Cimetidine Hydrochloride	(Abbott Hosp.)/INJ, IJ	300 mg/50 ml, 50 ml, 48s	00074-7447-16	MK	\$120.00
Cimetidine Hydrochloride	(Abbott Hosp.)/INJ, IJ (ADD- VANTAGE)	150 mg/ml, 2 ml, 25s	00074-7446-02	MK, BB	\$35.00
Cimetidine Hydrochloride	(Abbott Hosp.)/INJ, IJ (VAIL, FLIPTOP)	150 mg/ml, 2 mg/ml, 2 ml, 10s	00074-7444-01	ASD, BB, MK, OTH, FI	\$11.72
Cimetidine Hydrochloride	(Abbott Hosp.)/INJ, IJ (VAIL, FLIPTOP)	150 mg/ml, 8 ml, 10s	00074-7445-01	ASD, BB, MK, OS	\$30.00
Clindamycin Phosphate	(Abbott Hosp.)/(Vial, Flitop)	150 mg/ml, 2 ml, 25s	00074-4050-01	FI	\$75.35
Clindamycin Phosphate	(Abbott Hosp.)/(Vial, Flitop)	150 mg/ml, 4 ml, 25s	00074-4051-01	BB	\$174.00
Clindamycin Phosphate	(Pharmacia/Upjohn) Cleocin/INJ, IJ	150 mg/ml, 2 ml, 25s	00009-0870-26	BB, MK	\$61.20
Clindamycin Phosphate	(Pharmacia/Upjohn) Cleocin/INJ, IJ	150 mg/ml, 4 ml, 25s	00009-0775-26	BB, MK	\$126.00
Clindamycin Phosphate	(Add-Vantage)	150 mg/ml, 4 ml, 25s	00009-3124-03	BB, MK	\$126.00
Clindamycin Phosphate	(Add-Vantage)	150 mg/ml, 6 ml, 25s	00009-0902-18	BB, MK	\$162.00
Clindamycin Phosphate	(Add-Vantage)	150 mg/ml, 6 ml, 25s	00009-3447-03	BB, MK	\$162.00
Clindamycin Phosphate	(Add-Vantage)	150 mg/ml, 4 ml, 25s	00009-0728-09	BB, MK	\$259.20
Cromolyn Sodium	(Dey)/SOL, IH	10 mg/ml, 2ml, 60s.	49502-0689-02	BB, MK	\$23.01

Cromolyn Sodium	(Dey)/SOL, IH	UD 10 mg/ml, 2ml, 120s.	49502-0689-12	BB, MK	\$45.71
Dexamethasone Acetate	(Schein)/INJ, IJ (M.D.V.)	UD 8 mg/ml, 5 ml	00364-6699-53	FI	\$11.50
Dexamethasone Sodium Phosphate	(Etkina-Sin)/(M.D.V.)	10 mg/ml, 10 ml	00641-2277-41	FI, OS	\$2.65
Dexamethasone Sodium Phosphate	(Fujisawa/APP)/INJ, IJ (VIAL)	4 mg/ml, 1 ml ea	00469-1650-00	BB	\$0.66
Dexamethasone Sodium Phosphate	(Fujisawa/APP)/INJ, IJ (VIAL)	4 mg/ml, 5 ml	00469-1650-20	BB	\$1.67
Dexamethasone Sodium Phosphate	(Fujisawa/APP)/INJ, IJ (VIAL)	30 ml	00469-1650-50	BB	\$10.00
Dexamethasone Sodium Phosphate	(Fujisawa/APP)/INJ, IJ (VIAL)	4 mg/ml, 5 ml	63323-0165-05	OTN	\$0.90
Dexamethasone Sodium Phosphate	(Fujisawa/APP)/INJ, IJ (VIAL)	30 ml	63323-0165-30	FI	\$10.00
Dexamethasone Sodium Phosphate	(Fujisawa/APP)/INJ, IJ (VIAL), (M.D.V.)	30 ml	63323-0165-01	BB	\$0.66
Dexamethasone Sodium Phosphate	(Schein)/INJ, IJ (M.D.V)	4 mg/ml, 5 ml ea	00364-6681-32	BB	\$1.08
Dextrose	(Abbott Hosp.)/(ADVANTAGE, LIFECARE)	5%, 50 ml	00074-7100-13	BB, TRI	\$3.22
Dextrose	(Abbott Hosp.)/(ADVANTAGE)	5%, 250 ml	00074-7100-02	TRI	\$4.12
Dextrose	(Abbott Hosp.)/(ADVANTAGE, LIFECARE)	5%, 100 ml	00074-7100-23	TRI	\$3.22
Dextrose	(Abbott Hosp.)/(LIFECARE)	250 ml	00074-1522-02	TRI, FI	\$3.63
Dextrose	(Abbott Hosp.)/(LIFECARE)	5%, 150 ml	00074-7922-61	BB, TRI	\$1.46
Dextrose	(Abbott Hosp.)/(LIFECARE)	5%, 50 ml	00074-7923-36	BB, TRI	\$1.45
Dextrose	(Abbott Hosp.)/(LIFECARE)	5%, 100 ml	00074-7923-37	ASD	\$1.45
Dextrose	(Abbott Hosp.)/(LIFECARE/PLASTIC)	(1000 ml container), 1000 ml	00074-1518-05	BB, FI, OTN, TRI, OS	\$14.54
Dextrose	(Abbott Hosp.)/(LIFECARE/PLASTIC)	(1000 ml container), 1000 ml	00074-1519-05	ASD, OS, FI, OTN, TRI	\$13.71
Dextrose	(Abbott Hosp.)/(LIFECARE/PLASTIC)	5%, 500 ml	00074-1522-03	ASD, OS, FI, OTN, TRI	\$3.87
Dextrose	(Abbott Hosp.)/(LIFECARE/PLASTIC)	(1000 ml container), 500 ml	00074-1536-03	BB	\$9.19
Dextrose	(Abbott Hosp.)/(LIFECARE/PLASTIC)	(1000 ml container), 50%, 500 ml	00074-5645-25	BB, AHF	\$3.69
Dextrose	(Abbott Hosp.)/(LIFECARE/PLASTIC)	(1000 ml container), 70%, 500 ml	00074-5647-25	BB, OS, FI	\$4.26
Dextrose	(Abbott Hosp.)/(LIFECARE/PLASTIC)	(Bulk Package), 70%, 2000 ml	00074-7120-07	BB	\$13.60
Dextrose	(Abbott Hosp.)/(LIFECARE/PLASTIC)	(1000 ml container), 500 ml	00074-7918-19	BB	\$8.81
Dextrose	(Abbott Hosp.)/(LIFECARE/PLASTIC)	5%, 250 ml	00074-7922-02	BB	\$1.54
Dextrose	(Abbott Hosp.)/(LIFECARE/PLASTIC)	5%, 500 ml	00074-7922-03	BB, TRI	\$1.61

Dextrose	(Abbott Hosp.) /(LIFECARE/PLASTIC)	5%, 1000 ml	00074-7922-09	BB, TRI	\$2.34
Dextrose	(Abbott Hosp.) /(LIFECARE/PLASTIC)	(2000 ml container), 50%, 1000 ml	00074-7936-17	BB, FI, OTM, TRI, OS	\$11.24
Dextrose	(Abbott Hosp.) /(LIFECARE/PLASTIC)	(1000 ml container), 50%, 500 ml	00074-7936-19	ASD, OTM, FI, TRI, OS	\$7.09
Dextrose	(Abbott Hosp.)/INJ, U, (50/150 ML PART FILL)	5%, 50 ml	00074-1523-01	BB, OTM, FI, TRI, OS	\$3.91
Dextrose	(Baxter)/(QUAD PACK, MINI-BAG)	5%, 100ml	00338-0017-18	BB, TRI	\$1.55
Dextrose	(Baxter)/(BULK PACKAGE)	50%, 2000 ml	00338-0031-06	BB, TRI	\$21.60
Dextrose	(Baxter)/(BULK PACKAGE)	70%, 2000 ml	00338-0719-06	ASD, OS	\$13.31
Dextrose	(Baxter)/(GLASS FULL FILL)	70%, 1000 ml	00338-0348-04	TRI, FI	\$6.20
Dextrose	(Baxter)/(GLASS UNDERFILL)	70%, 500 ml	00338-0032-13	TRI	\$8.16
Dextrose	(Baxter)/(MINI-BAG PLUS)	5%, 50 ml	00338-0551-11	TRI	\$3.17
Dextrose	(Baxter)/(MULTI-PACK, MINI- BAG)	5%, 50 ml	00338-0017-31	TRI	\$1.80
Dextrose	(Baxter)/(MULTI-PACK, MINI- BAG)	5%, 100ml	00338-0017-38	TRI	\$1.55
Dextrose	(Baxter)/(QUAD PACK, MINI- BAG)	5%, 25 ml	00338-0017-10	TRI	\$1.80
Dextrose	(Baxter)/(QUAD PACK, MINI- BAG)	5%, 50 ml	00338-0017-11	TRI, FI	\$1.55
Dextrose	(Baxter)/(SINGLE PACK MINI-BAG)	250 ml	00338-0016-02	TRI	\$3.39
Dextrose	(Baxter)/(SINGLE PACK MINI-BAG)	150 ml	00338-0017-01	FI, TRI	\$1.50
Dextrose	(Baxter)/(SINGLE PACK MINI-BAG)	250 ml	00338-0017-02	FI, TRI	\$1.50
Dextrose	(Baxter)/(SINGLE PACK MINI-BAG)	500ml	00338-0017-03	BB, TRI	\$1.47
Dextrose	(Baxter)/(SINGLE PACK MINI-BAG)	1000 ml	00338-0017-04	FI, TRI	\$2.11
Dextrose	(Baxter)/(SINGLE PACK MINI-BAG)	5%, 100ml	00338-0017-48	FI, TRI	\$1.55
Dextrose	(Baxter)/(SINGLE PACK MINI-BAG)	10%, 250 ml	00338-0023-02	BB	\$1.69
Dextrose	(Baxter)/(SINGLE PACK MINI-BAG)	5%, 50 ml	00338-0017-41	TRI, FI	\$2.25
Dextrose	(McGaw)/(1000 ML GLASS W/ STOPPER)	50%, 500 ml	00264-1280-55	TRI	\$4.07
Dextrose	(McGaw)/(EXCEL)	5%, 1000 ml	00264-7510-00	TRI, OTM, ASD, OS	\$2.20
Dextrose	(McGaw)/(EXCEL)	500 ml	00264-7510-10	TRI, OTM, ASD, OS	\$1.69
Dextrose	(McGaw)/(EXCEL)	5%, 250 ml	00264-7510-20	TRI, OTM, ASD, OS	\$1.59
Dextrose	(McGaw)/(EXCEL)	10%, 1000 ml	00264-7520-00	TRI	\$1.99
Dextrose	(McGaw)/(GLASS CONTAINER, 1000 ML)	500 ml	00264-1290-50	TRI	\$7.15
Dextrose	(McGaw)/(GLASS CONTAINER, 1000 ML)	70%, 500 ml	00264-1292-55	TRI	\$5.28

Dextrose	(McGaw)/(GLASS W/ AIR TUBE)	70%. 2000 ml	00264-1129-50	TRI	\$18.35
Dextrose	(McGaw)/(GLASS W/SOLID STOPPER)	70%. 1000 ml	00264-1290-55	TRI	\$6.62
Dextrose	(McGaw)/(GLASS W/SOLID STOPPER)	50%. 500 ml	00264-1281-55	TRI	\$2.76
Dextrose	(McGaw)/(W/SOLID STOPPER, GLASS)	50%. 2000 ml	00264-1285-55	TRI	\$11.32
Dextrose	(McGaw)/INJ, IJ (100 ML PAB)	50 ml	00264-1510-31	TRL OTN	\$1.61
Dextrose	(McGaw)/INJ, IJ (150 ML PAB)	5%. 100 ml	00264-1510-32	TRL OTN	\$1.62
Dextrose with Sodium Chloride	(Abbott Hosp.)	5%-0.45%. 250 ml	00074-7926-02	TRI, FL, OS	\$1.80
Dextrose with Sodium Chloride	(Abbott Hosp.)	500 ml	00074-7926-03	TRI, OTN, ASD, FL, OS	\$1.96
Dextrose with Sodium Chloride	(Abbott Hosp.)	1000 ml	00074-7926-09	TRI, OTN, ASD, FL, OS	\$2.66
Dextrose with Sodium Chloride	(Abbott Hosp.)	5%-0.9%. 250 ml	00074-7941-02	TRI	\$1.93
Dextrose with Sodium Chloride	(Abbott Hosp.)	500 ml	00074-7941-03	TRL OTN, ASD, FL, OS	\$1.85
Dextrose with Sodium Chloride	(Abbott Hosp.)	1000 ml	00074-7941-09	BB, OTN, ASD, FL, OS	\$2.24
Dextrose with Sodium Chloride	(Baxter)	5%-0.45%. 250 ml	00338-0085-02	TRI, FI	\$2.47
Dextrose with Sodium Chloride	(Baxter)	500 ml	00338-0085-03	TRI, FI	\$1.90
Dextrose with Sodium Chloride	(Baxter)	1000 ml	00338-0085-04	FI	\$2.25
Dextrose with Sodium Chloride	(Baxter)	5%-0.9%. 250 ml	00338-0089-02	TRI	\$2.93
Dextrose with Sodium Chloride	(Baxter)	500 ml	00338-0089-03	FI	\$2.00
Dextrose with Sodium Chloride	(Baxter)	1000 ml	00338-0089-04	FI	\$2.25
Dextrose with Sodium Chloride	(McGaw)	1000 ml	00264-7610-00	TRI, FI	\$2.10
Dextrose with Sodium Chloride	(McGaw)	500 ml	00264-7610-10	TRI, FI	\$1.81
Dextrose with Sodium Chloride	(McGaw)	5%-0.9%. 250 ml	00264-7610-20	TRI	\$1.78
Dextrose with Sodium Chloride	(McGaw)	1000 ml	00264-7612-00	TRI, FL, ASD	\$1.85
Dextrose with Sodium Chloride	(McGaw)	500 ml	00264-7612-10	TRI, FI	\$1.85
Dextrose with Sodium Chloride	(McGaw)	5%-0.45%. 250 ml	00264-7612-20	TRI, FI	\$1.89
Diazepam	(Abbott Hosp.)/(CARPUJECT LWER LOCK)	5 mg/ml, 2 ml, ea C-IV	00074-1273-32	BB	\$2.03
Diazepam	(Abbott Hosp.)/(CARPUJECT, 22GX1-1/4")	5 mg/ml, 2ml, ea C-IV	00074-1273-02	BB, FI	\$2.12

Diazepam	(Abbott Hosp.)/(VIAL FLIPTOP)	5 mg/ml. 10 ml. ea. C-IV	00074-3213-01	OTN. MK	\$2.50
Diazepam	(Abbott Hosp.)/INJ, IJ (AMP)	5 mg/ml. 2ml. EA C- IV	00074-3210-32	BB	\$1.49
Diazepam	(Schein)/INJ, IJ (S.D.V.) (M.D.V.)	5 mg/ml. 10 ml. ea. C-IV	00364-0825-54	ASD	\$2.50
Furosemide	(Abbott Hosp.)/INJ, IJ (VIAL PF, FLIPTOP)	10 mg/ml. 2 ml 25s	00074-6102-02	ASD. BB. MK	\$14.38
Furosemide	(Abbott Hosp.)/INJ, IJ (VIAL PF, FLIPTOP)	10 mg/ml. 4 ml 25s	00074-6102-04	OS. ASD. OTN. BB. MK	\$20.28
Gentamicin Sulfate	(Abbott Hosp.)/(Vial, Fliptop)	40 mg/ml. 2 ml	00074-1207-03	OTN. BB. OS. R	\$0.51
Gentamicin Sulfate	(FujiSawa)/(Bulk Package)	40 mg/ml. 50 ml	00469-1000-60	MK. BB	\$7.00
Gentamicin Sulfate	(FujiSawa)/(Bulk Package)	40 mg/ml. 50 ml	63323-0010-50	MK. BB	\$7.00
Gentamicin Sulfate	(FujiSawa)/INJ, IJ (M.D.V.)	40 mg/ml. 20 ml	00469-1000-40	OTN	\$5.40
Gentamicin Sulfate	(FujiSawa)/INJ, IJ (M.D.V.)	40 mg/ml. 20 ml	63323-0010-20	BB. MK	\$3.50
Gentamicin Sulfate	(Schein)/(M.D.V.)	40 mg/ml. 20 ml	00364-6739-55	BB	\$2.63
Gentamicin Sulfate	(Schein)/INJ, IJ (S.D.V.)	40 mg/ml. 2 ml	00364-6739-48	BB	\$1.18
Heparin Lock Flush	(Abbott Hosp.)/INJ, IJ (VIAL FLIPTOP)	10 u/ml. 10 ml 25s	00074-1151-70	OS. OTN	\$13.60
Heparin Lock Flush	(Abbott Hosp.)/INJ, IJ (VIAL FLIPTOP)	100 u/ml. 10 ml 25s	00074-1152-70	ASD. OS. R. OTN	\$13.43
Heparin Lock Flush	(Abbott Hosp.)/INJ, IJ (VIAL FLIPTOP)	30 ml. 25s	00074-1152-78	ASD. OS. OTN	\$21.07
Hydrocortisone Sodium Succinate	(Pharmacia/Upjohn) Solu- Cortel/ (ACT-O-VIAL)	100 mg. ea	00009-0900-13	BB. MK. ASD. BB. R. OS	\$1.55
Hydrocortisone Sodium Succinate	(Pharmacia/Upjohn) Solu- Cortel/ (ACT-O-VIAL)	250 mg. ea	00009-0909-08	ASD. R. BB. MK	\$2.65
Hydrocortisone Sodium Succinate	(Pharmacia/Upjohn) Solu- Cortel/ (ACT-O-VIAL)	500 mg. ea	00009-0912-05	ASD. MK. BB. OS. R	\$5.89
Hydrocortisone Sodium Succinate	(Pharmacia/Upjohn) Solu- Cortel/ (ACT-O-VIAL)	1000 mg. ea	0009-0920-03	Fl. MK	\$11.57
Immune Globulin	(Alpha Therapeutics) Venoglobulin-S 10%/INJ, IJ (10 gm/Vial, w/Admin. Set)	100 mg/ml. 100 ml	49669-1623-01	R	\$780.00
Immune Globulin	(Alpha Therapeutics) Venoglobulin-S 10%/INJ, IJ (20 gm/Vial, w/Admin. Set)	100 mg/ml. 200 ml	49669-1624-01	R	\$1,560.00
Immune Globulin	(Alpha Therapeutics) Venoglobulin-S 10%/INJ, IJ (5 gm/Vial, w/Admin. Set)	100 mg/ml. 50 ml	49669-1622-01	R	\$390.00
Immune Globulin	(Baxter Hyland/Immuno) Gammagard S/D/PDI, IJ	2.5 gm. ea	00944-2620-02	R	\$175.00
Immune Globulin	(Baxter Hyland/Immuno) Gammagard S/D/PDI, IJ	5.0 gm. ea	00944-2620-03	R	\$350.00
Immune Globulin	(Baxter Hyland/Immuno) Gammagard S/D/PDI, IJ	10.0 gm. ea	00944-2620-04	R	\$700.00
Immune Globulin	(Bayer) Gamimune N10%/INJ, KJ (10 gm/Vial)	100 mg/ml. 100 ml	00026-0648-71	R. ASD. OS. Bayer Wholesale	\$727.50
Immune Globulin	(Bayer) Gamimune N10%/INJ, KJ (20 gm/Vial)	100 mg/ml. 200 ml	00026-0648-24	R. OS. Bayer Wholesale	\$1,503.33
Immune Globulin	(Bayer) Gamimune N10%/INJ, KJ (5 gm/Vial)	100 mg/ml. 50 ml	00026-0648-20	R. ASD. OS. Bayer Wholesale	\$362.50

Immune Globulin	(Centon) Gamma-P.I.V./PDI, IJ (w/diluent)	5 gm. ea	00053-7486-05	Health Coalition, ASD, OS	\$296.67
Immune Globulin	(Centon) Gamma-P.I.V./PDI, IJ (w/diluent)	10 gm. ea	00053-7486-10	Health Coalition, ASD, OS	\$593.33
Iron Dextran	(Schein)/INJ, IJ (S.D.V.)	50 mg/ml, 2 ml	00364-3012-47	ASD, OS, FL, OTN	\$24.69
Lorazepam	(Abbott Hosp.)/(HYPAX SYRINGE)	2 mg/ml, 1ml, C-IV	00074-6776-01	BB	\$3.60
Lorazepam	(Abbott Hosp.)/(VIAL)	4 mg/ml, 1ml, C-IV	00074-1539-01	MK	\$3.80
Lorazepam	(Abbott Hosp.)/(VIAL)	4 mg/ml, 10ml, C-IV	00074-1539-10	MK	\$30.00
Lorazepam	(Abbott Hosp.)/(VIAL)	2 mg/ml, 10ml, C-IV	00074-1985-10	BB	\$25.83
Lorazepam	(Abbott Hosp.)/(VIAL, FLUPTOP)	2 mg/ml, 1ml, C-IV	00074-6778-01	BB, R	\$2.98
Lorazepam	(Abbott Hosp.)/(VIAL, FLUPTOP)	4 mg/ml, 1ml, C-IV	00074-6779-01	BB	\$3.80
Lorazepam	(Abbott Hosp.)/(VIAL, FLUPTOP)	2 mg/ml, 10ml, C-IV	00074-6780-01	ASD, OBN, R	\$24.42
Lorazepam	(Abbott Hosp.)/(VIAL, FLUPTOP)	4 mg/ml, 10ml, C-IV	00074-6781-01	BB, R	\$28.75
Lorazepam	(Abbott Hosp.)/INJ, U (VIAL)	2 mg/ml, 1ml, C-IV	00074-1985-01	MK	\$3.00
Lorazepam	(Wyeth-Ayerst) Abvan/(M.D.V.)	4 mg/ml, 10ml, C-IV	00008-0570-01	R	\$48.00
Lorazepam	(Wyeth-Ayerst) Abvan/(M.D.V.)	2 mg/ml, 10ml, C-IV	00008-0581-01	R	\$29.50
Lorazepam	(Wyeth-Ayerst) Abvan/(S.D.V.)	2 mg/ml, 1ml, C-IV	00008-0581-04	R	\$8.85
Lupron	(Tap) Lupron Depot/(3 Month Formulation)	22.5 mg. ea	00300-3336-01	ASD, FL, OTN, OS	\$1,447.60
Lupron	(Tap) Lupron Depot/(3 Month Formulation)	11.25 mg. ea	00300-3343-01	R	\$1,149.00
Lupron	(Tap) Lupron Depot/(4 Month Formulation)	30 mg. ea	00300-3673-01	R, ASD, OS	\$1,902.80
Lupron	(Tap) Lupron Depot/PDI, IJ (S.D.V.)	7.5 mg. ea	00300-3629-01	ASD, OS, FL, OTN	\$482.52
Lupron	(Tap) Lupron Depot/PDI, IJ (S.D.V.)	3.75 mg. ea	00300-3639-01	R, OS	\$406.00
Metoprolenol Sulfate	(Dey)/SOL, IH (SULFATE FREE)	0.6%, 2500 ml, 25s. UD	49502-0676-03	BB, MK	\$11.29
Metoprolenol Sulfate	(Dey)/SOL, IH (SULFATE FREE)	0.4%, 2500 ml, 25s. UD	49502-0678-03	BB, MK	\$11.29
Methylprednisolone Sodium Succinate	(Abbott Hosp.) A-Methapred/PDI, IJ (UNIVIAL)	1 gm. ea	00074-5631-08	OTN	\$16.75
Methylprednisolone Sodium Succinate	(Abbott Hosp.) A-Methapred/PDI, IJ (UNIVIAL)	40 mg. ea	00074-5684-01	OTN	\$2.30
Methylprednisolone Sodium Succinate	(Abbott Hosp.) A-Methapred/PDI, IJ (UNIVIAL)	125 mg. ea	00074-5685-02	OTN	\$3.35
Methylprednisolone Sodium Succinate	(Abbott Hosp.) A-Methapred/PDI, IJ (ADVANTAGE)	500 mg. ea	00074-5601-44	OTN	\$9.40
Methylprednisolone Sodium Succinate	(Pharmacia/Upjohn) Solu-Medrol/(ACT-O-VIAL)	125 mg. ea	00009-0190-09	BB, OS	\$2.52
Methylprednisolone Sodium Succinate	(Pharmacia/Upjohn) Solu-Medrol/(ACT-O-VIAL)	500 mg. ea	00009-0765-02	BB	\$5.51

Methylprednisolone Sodium Succinate	(Pharmacia/Upjohn) Solu-Medrol/(ACT-O-VIAL)	1 gm. ea	00009-3389-01	BB, ASD, R, OS	\$11.39
Methylprednisolone Sodium Succinate	(Pharmacia/Upjohn) Solu-Medrol/(VIAL)	1 gm. ea	00009-0698-01	BB, R, OS	\$11.69
Methylprednisolone Sodium Succinate	(Pharmacia/Upjohn) Solu-Medrol/(VIAL)	500 mg. ea	00009-0758-01	BB, R, OS	\$6.37
Methylprednisolone Sodium Succinate	(Pharmacia/Upjohn) Solu-Medrol/(W/DILUENT)	2 gm. ea	00009-0796-01	BB, R	\$14.41
Methylprednisolone Sodium Succinate	(Pharmacia/Upjohn) Solu-Medrol/(W/DILUENT)	500 mg. ea	00009-0887-01	ASD	\$6.17
Methylprednisolone Sodium Succinate	(Pharmacia/Upjohn) Solu-Medrol/PDI, U (ACT-O-VIAL)	40 mg. ea	00009-0113-12	ASD, BB, OS	\$1.45
Mitomycin	(Bedford)/PDI, U (S.D.V.)	5 mg. ea	55390-0251-01	R, OS, ASD	\$51.83
Mitomycin	(Bedford)/PDI, U (S.D.V.)	20 mg. ea	55390-0252-01	R, ASD, OS	\$146.67
Mitomycin	(Faulding)/DI, U	20 mg. ea	61703-0306-50	ASD, OS	\$134.00
Pentamidine Isethionate	(FujiSawa) Nebupent/PDR, III (S.D.V., P.F.)	300 mg. ea	57317-0210-06	R	\$36.00
Pentamidine Isethionate	(FujiSawa) Nebupent/PDR, III (S.D.V., P.F.)	300 mg. ea	63323-0877-15	R	\$36.00
Pentamidine Isethionate	(Gensko)/PDI, U (S.D.V.)	300 mg. ea	00053-1000-05	R	\$29.00
Sodium Chloride	(Abbott Hosp.)/(ADD-VANT, LIFECARE P.F.)	0.9%, 50 ml	00074-7101-13	TRI, BB	\$3.22
Sodium Chloride	(Abbott Hosp.)/(ADD-VANT, LIFECARE P.F.)	0.9%, 100 ml	00074-7101-23	TRI, BB	\$3.22
Sodium Chloride	(Abbott Hosp.)/(ADD-VANT, LIFECARE)	0.9%, 250 ml	00074-7101-02	TRI, BB	\$4.19
Sodium Chloride	(Abbott Hosp.)/(LIFECARE)	0.9%, 50 ml	00074-7984-36	TRI, ASD, OS, OTN, R	\$1.45
Sodium Chloride	(Abbott Hosp.)/(LIFECARE)	0.9%, 100 ml	00074-7984-37	TRI, ASD, OS, OTN, R	\$1.45
Sodium Chloride	(Abbott Hosp.)/(LIFECARE, PLASTIC CONT)	0.9%, 500 ml	00074-7983-03	R, ASD, BB, OS	\$1.69
Sodium Chloride	(Abbott Hosp.)/(LIFECARE, PLASTIC CONT)	0.9%, 1000 ml	00074-7983-09	R, ASD, BB, OS	\$2.17
Sodium Chloride	(Abbott Hosp.)/(LIFECARE, PLASTIC)	0.9%, 250 ml	00074-1583-02	TRI, OTN, R, OS	\$1.94
Sodium Chloride	(Abbott Hosp.)/(LIFECARE, PLASTIC)	0.9%, 250 ml	00074-7983-02	R, ASD, BB	\$1.41
Sodium Chloride	(Abbott Hosp.)/(LIFECARE, PLASTIC)	0.9%, 150 ml	00074-7983-61	R, ASD, OS, OTN	\$1.43
Sodium Chloride	(Baxter)/(MINI-BAG PLUS)	0.9%, 50 ml	00338-0553-11	TRI	\$3.32
Sodium Chloride	(Baxter)/(MINI-BAG PLUS)	0.9%, 100 ml	00338-0553-18	TRI	\$3.17
Sodium Chloride	(Baxter)/(MULTI PACK, MINI-BAG)	0.9%, 50 ml	00338-0049-31	TRI, R	\$1.55
Sodium Chloride	(Baxter)/(MULTI PACK, MINI-BAG)	0.9%, 100 ml	00338-0049-38	TRI, R	\$1.55
Sodium Chloride	(Baxter)/(QUAD PACK, MINI-PACK)	0.9%, 50 ml	00338-0049-11	TRI	\$1.80
Sodium Chloride	(Baxter)/(QUAD PACK, MINI-PACK)	0.9%, 100 ml	00338-0049-18	TRI	\$1.80
Sodium Chloride	(Baxter)/(SINGLE PACK, MINI-BAG)	0.9%, 150 ml	00338-0049-01	TRI, R	\$1.51

Sodium Chloride	(Baxter)/(SINGLE PACK, MINI-BAG)	0.9%, 250 ml	00338-0049-02	TRI, FI	\$1.49
Sodium Chloride	(Baxter)/(SINGLE PACK, MINI-BAG)	0.9%, 500 ml	00338-0049-03	TRI, FI	\$1.58
Sodium Chloride	(Baxter)/(SINGLE PACK, MINI-BAG)	0.9%, 1000 ml	00338-0049-04	TRI, FI	\$2.03
Sodium Chloride	(Baxter)/(SINGLE PACK, MINI-BAG)	0.9%, 50 ml	00338-0049-41	TRI	\$1.71
Sodium Chloride	(Baxter)/(SINGLE PACK, MINI-BAG)	0.9%, 100 ml	00338-0049-48	TRI, FI	\$1.55
Sodium Chloride	(McGaw)	50 ml	00264-1800-31	TRI, FI	\$1.49
Sodium Chloride	(McGaw)/(150 ML PAB)	0.9%, 100 ml	00264-1800-32	TRI, FI	\$1.49
Sodium Chloride	(McGaw)/(EXCEL)	0.9%, 1000 ml	00264-7800-00	TRI, OTN, FL, ASD	\$2.19
Sodium Chloride	(McGaw)/(EXCEL)	0.9%, 500 ml	00264-7800-10	TRI, OTN, FL, ASD	\$1.53
Sodium Chloride	(McGaw)/(EXCEL)	0.9%, 250 ml	00264-7800-20	TRI, OTN, FL, ASD	\$1.51
Testosterone Cypionate	(Pharmacia/Upjohn) Depo-Testosterone	200 mg/ml, 1 ml, C-III	00009-0417-01	BB, OTN	\$11.79
Testosterone Cypionate	(Pharmacia/Upjohn) Depo-Testosterone	200 mg/ml, 10 ml, C-III	00009-0417-02	BB, OTN	\$24.78
Testosterone Enanthate	(Scheln)/INJ, U (M.D.V.)	200 mg/ml, 10 ml, C-II	00364-6617-54	ASD, MK, R	\$13.39
Tobramycin Sulfate	(Abbott Hosp.)/(SRN)	40 mg/ml, 2 ml	00074-3583-01	BB	\$5.84
Tobramycin Sulfate	(Abbott Hosp.)/(Vial, Bulk)	40 mg/ml, 50 ml	00074-3590-02	BB, MK	\$109.64
Tobramycin Sulfate	(Abbott Hosp.)/(Vial, Flitop)	40 mg/ml, 2 ml	00074-3578-01	BB, MK	\$4.99
Tobramycin Sulfate	(Abbott Hosp.)/INJ, U (Vial Flitop)	10 mg/ml, 2 ml	00074-3577-01	BB, MK	\$2.94
Tobramycin Sulfate	(Gensia)/INJ, U (M.D.V.)	40 mg/ml, 2ml	00703-9402-04	FL, MK	\$6.98
Tobramycin Sulfate	(Gensia)/INJ, U (M.D.V.)	40 mg/ml, 30 ml	00703-9416-01	R	\$36.90
Vancomycin Hydrochloride	(Abbott Hosp.)/(BULK VIAL)	5 gm. ea	00074-6509-01	FL, MK, BB	\$41.24
Vancomycin Hydrochloride	(Abbott Hosp.)/(VIAL, FLIPTOP)	500 mg, 10s. ea	00074-4332-01	FL, OTN, MK, BB, OS	\$4.98
Vancomycin Hydrochloride	(Abbott Hosp.)/(VIAL, FLIPTOP)	1 gm, 10s. ea	00074-6533-01	FL, ASD, OS, MK, BB	\$9.05
Vancomycin Hydrochloride	(Abbott Hosp.)/(VIAL, FLIPTOP)	1 gm, 10s. ea	00074-6535-01	FL, OTN, MK, BB	\$12.17
Vancomycin Hydrochloride	(Abbott Hosp.)/PDI, U (ADD-VANTAGE)	500 mg, 10s. ea	00074-6534-01	FL, MK, BB	\$5.09
Vancomycin Hydrochloride	(FujiSawa) Lyphocin/PDI U (VIAL)	500 mg. ea	00469-2210-30	BB, MK	\$7.00
Vancomycin Hydrochloride	(FujiSawa) Lyphocin/PDI U (VIAL)	1 gm. ea	00469-2840-40	BB, MK	\$13.00
Vancomycin Hydrochloride	(FujiSawa) Lyphocin/PDI U (VIAL)	5 gm. ea	00469-2951-00	BB	\$71.50
Vancomycin Hydrochloride	(FujiSawa) Lyphocin/PDI U (VIAL)	1 gm. ea	63323-0284-20	BB, MK	\$13.00
Vancomycin Hydrochloride	(FujiSawa) Lyphocin/PDI U (VIAL)	5 gm. ea	63323-0295-41	BB	\$71.50
Vancomycin Hydrochloride	(FujiSawa) Lyphocin/PDI U (VIAL)	10 gm. ea	63323-0314-61	MK	\$143.00

Vancomycin Hydrochloride	(Fujiwara) Lymphocin/PDI IJ (VIAL)	500 mg. ea	63323-2210-30	BB, MK	\$7.00
Vancomycin Hydrochloride	(Lederle Std. Prod.) Vancoled/PDI INJ, IJ	5 gm. ea	00205-3154-05	MK, BB	\$45.09
Vancomycin Hydrochloride	(Lederle Std. Prod.) Vancoled/PDI INJ, IJ	1 gm. 10s. ea	00205-3154-15	MK, BB	\$9.02
Vancomycin Hydrochloride	(Lederle Std. Prod.) Vancoled/PDI INJ, IJ	500 mg. 10s. ea	00205-3154-88	MK, BB	\$4.51
Vancomycin Hydrochloride	(Scheln)/PDI, IJ (M.D.V.)	1 gm. 10s. ea	00364-2473-91	OTN	\$12.90
Vancomycin Hydrochloride	(Scheln)/PDI, IJ (S.D.V.)	500 mg. 10s. ea	00364-2472-33	MK	\$3.84
Winrho SDF	(Nabi) rho (d) immune globulin/ (VIAL).	5000 iu. ea	60492-0024-01	ASD, FL, OTN, OS	\$505.56
Winrho SDF	(Nabi) rho (d) immune globulin/PDI, IJ (S.D.V.)	600 iu. ea	60492-0021-01	ASD, FL, OS	\$64.96
Winrho SDF	(Nabi) rho (d) immune globulin/PDI, IJ (S.D.V.)	1500 iu. ea	60492-0023-01	ASD, FL, OTN, OS	\$152.30

Wholesaler Information**ASD = ASD Specialty Healthcare (1-800-746-6273)****BB = Bergen Brunswick (1-800-746-6273)****FI = Florida Infusion (1-800-624-0152)****MK = McKesson (1-888-782-6156)****OS = Oncology Supply (1-800-633-7555)****OTN = Oncology Therapeutics Network (1-800-482-6700)****TRI = Triad Medical (1-800-999-8633)****ANDA = ANDA (1-800-331-2632)****Biomed Plus 3/99 = Biomed Plus, Inc. (1-800-809-2308)****FFF = FFF Enterprises (1-800-843-7477)****Bayer Wholesale = Bayer Wholesale (1-203-812-2000)****Health Coalition = Health Coalition (1-800-454-7283)**

Attachment 2 - Do not use these data to update the HCPCS billing codes that correspond to the drugs on this list. Instead, use your usual source for average wholesale prices.

Drug Name	Prod/Manf	Measurements	NDC	Wholesaler	Average Wholesale (AWP)
Anti-Inhibitor Coagulant Complex	(NABI) AutoPlex T/PDI, IJ (390-1050 FECU)	ea	59730-6059-07	Biomed Plus 3/99	1.06
Anzemet/Dolasetron Mesylate	(Hoechst Marion)/INJ, IJ (VIAL)	20 mg/ml, 5 ml	00088-1206-32	OS	\$74.08
Bleomycin Sulfate	(Bristol-Myer Onc/Imm) Blexonane/PDI, IJ (VI)	15 u, ea	00015-3010-20	FL OS, ASD	\$255.37
Bleomycin Sulfate	(Bristol-Myer Onc/Imm) Blexonane/PDI, IJ (VI)	30 u, ea	00015-3063-01	FL OS	\$509.29
Bleomycin Sulfate	(Pharmacia/Upjohn)/PD I, IJ (VIAL)	15 u, ea	00013-1616-78	ASD, FL OS	\$158.67
Bleomycin Sulfate	(Pharmacia/Upjohn)/PD I, IJ (VIAL)	30 u, ea	00013-1636-86	ASD, FL OS	\$322.00
Cisplatin	(APP)/INJ, IJ	1 mg/ml, 50 mg, 50 ml	63323-0103-51	OS, FI	\$150.98
Cisplatin	(APP)/INJ, IJ	1 mg/ml, 200 mg, 200 ml	63323-0103-64	OS, FI	\$603.50
Cisplatin	(APP)/INJ, IJ	1 mg/ml, 100 mg, 100 ml	63323-0103-65	OS, FI	\$301.50
Cyclophosphamide	(Bristol-Myer Onc/Imm) Cytoxan Lyophilized/PDI, IJ (VIAL)	100 mg, ea	00015-0539-41	ASD, OS, OTN	\$4.18
Cyclophosphamide	(Bristol-Myer Onc/Imm) Cytoxan Lyophilized/PDI, IJ (VIAL)	200 mg, ea	00015-0546-41	ASD, OS, OTN	\$7.03
Cyclophosphamide	(Bristol-Myer Onc/Imm) Cytoxan Lyophilized/PDI, IJ (VIAL)	500 mg, ea	00015-0547-41	ASD, OS, OTN	\$11.59
Cyclophosphamide	(Bristol-Myer Onc/Imm) Cytoxan Lyophilized/PDI, IJ (VIAL)	1gm, ea	00015-0548-41	ASD, OS, OTN	\$23.19
Cyclophosphamide	(Bristol-Myer Onc/Imm) Cytoxan Lyophilized/PDI, IJ (VIAL)	2 gm, ea	00015-0549-41	ASD, OS, OTN	\$45.83
Cyclophosphamide	(Pharmacia/Upjohn) Neosar/PDI, IJ, (S.D.V.)	100 mg, ea	00013-5606-93	ASD, OTN, OS, FI	\$3.92
Cyclophosphamide	(Pharmacia/Upjohn) Neosar/PDI, IJ, (S.D.V.)	200 mg, ea	00013-5616-93	ASD, FI, OS, OTN	\$5.06
Cyclophosphamide	(Pharmacia/Upjohn) Neosar/PDI, IJ, (S.D.V.)	500 mg, ea	00013-5626-93	ASD, FI, OS, OTN	\$7.33

Cyclophosphamide	(Pharmacia/Upjohn) Neosar/PDI, IJ, (S.D.V.)	1 gm. ea	00013-5636-70	ASD, FI, OTN, OS	\$11.24
Cyclophosphamide	(Pharmacia/Upjohn) Neosar/PDI, IJ, (S.D.V.)	2 gm. ea	00013-5646-70	ASD, FI, OTN, OS	\$21.60
Cytarabine	(Bedford)/PDI, IJ (VIAL)	100 mg. ea	55390-0131-10	ASD, OS, FI, MK, BB, OTN	\$3.55
Cytarabine	(Bedford)/PDI, IJ (VIAL)	500 mg. ea	55390-0132-10	ASD, OS, FI, OTN, MK, BB	\$11.46
Cytarabine	(Bedford)/PDI, IJ (VIAL)	1 gm. ea	55390-0133-01	ASD, OS, FI, OTN, MK, BB	\$23.64
Cytarabine	(Bedford)/PDI, IJ (VIAL)	2 gm. ea	55390-0134-01	ASD, OS, FI, OTN, BB, MK	\$47.94
Cytarabine	(Bedford)/PDI, IJ (VIAL)	100 mg. ea	55390-0806-10	BB	\$3.50
Cytarabine	(Bedford)/PDI, IJ (VIAL)	500 mg. ea	55390-0807-10	BB	\$10.50
Cytarabine	(Bedford)/PDI, IJ (VIAL)	1 gm. ea	55390-0808-01	BB	\$22.00
Cytarabine	(Bedford)/PDI, IJ (VIAL)	2 gm. ea	55390-0809-01	BB	\$44.00
Cytarabine	(Faulding)/INJ, IJ (S.D.V., P.F.)	(P.F., BULK PACKAGE) 20 mg/ml, 50 ml	61703-0303-50	BB, MK	\$39.00
Cytarabine	(Faulding)/INJ, IJ (S.D.V., P.F.)	20 mg/ml, 25 ml	61703-0304-25	ASD, BB, FI, OS	\$12.63
Cytarabine	(Faulding)/INJ, IJ (S.D.V., P.F.)	20 mg/ml, 5 ml (M.D.V.)	61703-0305-09	BB, MK, FI	\$4.62
Cytarabine	(Pharmacia/Upjohn) Cytosar-U/PDI, IJ (M.D.V.)	100 mg. ea	00009-0373-01	ASD, OS, OTN, FI, MK	\$4.06
Cytarabine	(Pharmacia/Upjohn) Cytosar-U/PDI, IJ (M.D.V.)	500 mg. ea	00009-0473-01	ASD, OS, OTN, FI, MK	\$13.18
Cytarabine	(Pharmacia/Upjohn) Cytosar-U/PDI, IJ (M.D.V.)	30 ml vial, 1 gm. ea	00009-3295-01	ASD, OS, OTN, FI, MK	\$25.11
Cytarabine	(Pharmacia/Upjohn) Cytosar-U/PDI, IJ (M.D.V.)	2 gm. ea	00009-3296-01	ASD, OS, OTN, FI, MK	\$49.82
Cytarabine	(Scheln)/PDI, IJ (M.D.V.)	100 mg. ea	00364-2467-53	BB, MK	\$4.16
Cytarabine	(Scheln)/PDI, IJ (M.D.V.)	500 mg. ea	00364-2468-54	BB, MK, OTN	\$12.14
Doxorubicin Hydrochloride	(Bedford)/INJ, IJ (M.D.V.)	2 mg/ml, 100 ml	55390-0238-01	FI, OTN	\$139.75
Doxorubicin Hydrochloride	(Bedford)/INJ, IJ (S.D.V.)	2 mg/ml, 5 ml	55390-0235-10	FI, OTN	\$10.35
Doxorubicin Hydrochloride	(Bedford)/INJ, IJ (S.D.V.)	10 ml	55390-0236-10	FI, OTN	\$20.20
Doxorubicin Hydrochloride	(Bedford)/INJ, IJ (S.D.V.)	25 ml	55390-0237-01	FI, OTN, OS	\$37.97
Doxorubicin Hydrochloride	(Bedford)/PDI, IJ (S.D.V.)	10 mg	55390-0231-10	FI, OTN	\$9.68
Doxorubicin Hydrochloride	(Bedford)/PDI, IJ (S.D.V.)	20 mg	55390-0232-10	FI, OTN	\$18.48
Doxorubicin Hydrochloride	(Bedford)/PDI, IJ (S.D.V.)	50 mg. ea	55390-0233-01	FI, OTN, OS	\$35.92
Doxorubicin Hydrochloride	(Fujiisawa/APP)/(VIAL)	2 mg/ml, 100 ml	00469-1001-61	ASD	\$140.00

Doxorbiclin Hydrochloride	(Fujisawa/APP)(VIAL)	2 mg/ml, 100 ml	63323-0101-61	OS	\$117.15
Doxorbiclin Hydrochloride	(Fujisawa/APP)(VIAL)	2 mg/ml, 5 ml	00469-8830-20	OS	\$7.35
Doxorbiclin Hydrochloride	(Fujisawa/APP)(VIAL)	10 ml	00469-8831-30	OS	\$14.70
Doxorbiclin Hydrochloride	(Fujisawa/APP)(VIAL)	25 ml	00469-8832-50	ASD	\$35.00
Doxorbiclin Hydrochloride	(Fujisawa/APP)(VIAL)	2 mg/ml, 5 ml	63323-0883-05	OS	\$7.35
Doxorbiclin Hydrochloride	(Fujisawa/APP)(VIAL)	10 ml	63323-0883-10	OS	\$14.70
Doxorbiclin Hydrochloride	(Fujisawa/APP)(VIAL)	25 ml	63323-0883-30	ASD	\$34.00
Doxorbiclin Hydrochloride	(Genso)(M.D.V.)	2 mg/ml, 100 ml	00703-5040-01	ASD, OS	\$142.00
Doxorbiclin Hydrochloride	(Genso)(M.D.V.)	2 mg/ml, 5 ml	00703-5043-03	ASD, OS, 88	\$12.63
Doxorbiclin Hydrochloride	(Genso)(M.D.V.)	25 ml	00703-5046-01	ASD, OS	\$35.50
Doxorbiclin Hydrochloride	(Pharmacia/Upjohn)	2 mg/ml, 100 ml	00013-1164-83	ASD, OS, F.I.	\$150.86
Doxorbiclin Hydrochloride	(Pharmacia/Upjohn)	150 mg, 60	00013-1116-83	ASD, OS, F.I.	\$113.75
Doxorbiclin Hydrochloride	(Pharmacia/Upjohn)	2 mg/ml, 5 ml	00013-1136-91	ASD, OS, F.I.	\$8.49
Doxorbiclin Hydrochloride	(Pharmacia/Upjohn)	10 ml	00013-1146-91	ASD, OS, F.I.	\$16.74
Doxorbiclin Hydrochloride	(Pharmacia/Upjohn)	25 ml	00013-1156-79	ASD, F.I., OIN	\$37.80
Doxorbiclin Hydrochloride	(Pharmacia/Upjohn)	37,500 ml	00013-1176-87	ASD, F.I., OIN	\$59.59
Doxorbiclin Hydrochloride	(Pharmacia/Upjohn)	10 mg, 60	00013-1084-91	ASD, F.I., OIN	\$8.24
Doxorbiclin Hydrochloride	(Pharmacia/Upjohn)	50 mg, 60	00013-1104-79	ASD, OS, F.I.	\$37.15
Etoposide	(Bedord)(M.D.V.)	20 mg/ml, 5 ml	55390-0291-01	F.I., OS	\$8.45
Etoposide	(Bedord)(M.D.V.)	25 ml	55390-0292-01	F.I., OS	\$45.13
Etoposide	(Bedord)(M.D.V.)	50 ml	55390-0293-01	OS, F.I.	\$87.43
Etoposide	(Bristol-Myer Onc/Trm)	7.5 ml	00015-3084-20	OS	\$51.45
Etoposide	(Bristol-Myer Onc/Trm)	20 mg/ml, 5 ml	00015-3095-20	OS	\$34.30
Etoposide	(Genso)(BULK PACKAGE)	20 mg/ml, 50 ml	00703-5668-01	ASD, OS	\$78.63
Etoposide	(Genso)(M.D.V.)	20 mg/ml, 25 ml	00703-5646-01	ASD, OS	\$40.00

Etoposide	(Gensta)/INJ, IJ (M.D.V. POLYMER)	20 mg/ml, 5 ml	00703-5653-01	ASD, OS	\$7.00
Etoposide	(Pharmacia/Upjohn) Toposar/INJ, IJ (M.D.V.)	20 mg/ml, 5 ml	00013-7336-91	ASD, OS, FI	\$9.47
Etoposide	(Pharmacia/Upjohn) Toposar/INJ, IJ (M.D.V.)	10 ml	00013-7346-94	ASD, OS, FI	\$19.00
Etoposide	(Pharmacia/Upjohn) Toposar/INJ, IJ (M.D.V.)	25 ml	00013-7356-88	ASD, OS, FI	\$44.00
Factor IX	(Centeon) Mononine/Factor IX Coagulation Factor PDI, IJ	1 u. ea	00053-7668-01	ASD 3/99	\$0.79
Factor IX	(Centeon) Mononine/Factor IX Coagulation Factor PDI, IJ	1 u. ea	00053-7668-02	ASD 3/99	\$0.79
Factor IX	(Centeon) Mononine/Factor IX Coagulation Factor PDI, IJ	1 u. ea	00053-7668-04	ASD 3/99	\$0.79
Factor IX	(Genetics Inst.) Benefix/Factor IX Coagulation Factor PDI, IJ (S.D.V. w/diluent, 1000 u)	1 u. ea	58394-0001-01	ASD 2/00	\$0.81
Factor IX	(Genetics Inst.) Benefix/Factor IX Coagulation Factor PDI, IJ (S.D.V. w/diluent, 1000 u)	1 u. ea	58394-0002-01	ASD 2/00	\$0.81
Factor IX	(Genetics Inst.) Benefix/Factor IX Coagulation Factor PDI, IJ (S.D.V. w/diluent, 1000 u)	1 u. ea	58394-0003-01	ASD 2/00	\$0.81
Factor VIII	(Baxter Hyland/Immuno) Recombinant/anti- hemophilic factor, human PDI, IJ (approx. 1000 u/Vial)	1 u. ea	00944-2938-01	Biomed Plus, all sizes, 3/99	\$0.92
Factor VIII	(Baxter Hyland/Immuno) Recombinant/anti- hemophilic factor, human PDI, IJ (approx. 1000 u/Vial)	1 u. ea	00944-2938-02	Biomed Plus, all sizes, 3/99	\$0.92
Factor VIII	(Baxter Hyland/Immuno) Recombinant/anti- hemophilic factor, human PDI, IJ (approx. 1000 u/Vial)	1 u. ea	00944-2938-03	ASD, all sizes 3/99	\$0.78
Factor VIII	(Bayer Pharm) Koate HP/anti-hemophilic factor, human PDI, IJ (approx 1000 u/Vial)	1 u. ea	00026-0664-50	ASD all sizes 3/99	\$0.42

Factor VIII	(Bayer Pharm) Koate HP/anti-hemophilic factor, human PDI, IJ (approx 1500 u/Vial)	1 iu. ea	00026-0664-60	ASD all sizes 3/99	\$0.42
Factor VIII	(Bayer Pharm) Koate HP/anti-hemophilic factor, human PDI, IJ (approx 250 u/Vial)	1 iu. ea	00026-0664-20	ASD all sizes 3/99	\$0.42
Factor VIII	(Bayer Pharm) Koate HP/anti-hemophilic factor, human PDI, IJ (approx 500 u/Vial)	1 iu. ea	00026-0664-30	ASD all sizes 3/99	\$0.42
Factor VIII	(Bayer Pharm) Kogenate/anti-hemophilic factor, recombinant PDI, IJ	1 iu. ea	00026-0670-20	Biomed Plus, all sizes, 3/99	\$0.92
Factor VIII	(Bayer Pharm) Kogenate/anti-hemophilic factor, recombinant PDI, IJ	1 iu. ea	00026-0670-30	Biomed Plus, all sizes, 3/99	\$0.92
Factor VIII	(Bayer Pharm) Kogenate/anti-hemophilic factor, recombinant PDI, IJ	1 iu. ea	00026-0670-50	Biomed Plus, all sizes, 3/99	\$0.92
Factor VIII	(Centeon) Bloclate/anti-hemophilic factor, recombinant PDI, IJ	1 iu. ea	00053-8110-01	Biomed Plus, all sizes 3/99	\$0.91
Factor VIII	(Centeon) Bloclate/anti-hemophilic factor, recombinant PDI, IJ	1 iu. ea	00053-8110-02	(unit) FFF, 8/99	\$0.86
Factor VIII	(Centeon) Bloclate/anti-hemophilic factor, recombinant PDI, IJ	1 iu. ea	00053-8110-04	ASD, all sizes 3/99	\$0.78
Factor VIII	(Centeon) Helixate/anti-hemophilic factor, recombinant PDI, IJ	1 iu. ea	00053-8120-01	ASD, all sizes 3/99	\$0.78
Factor VIII	(Centeon) Helixate/anti-hemophilic factor, recombinant PDI, IJ	1 iu. ea	00053-8120-02	(unit) FFF, 8/99	\$0.86
Factor VIII	(Centeon) Helixate/anti-hemophilic factor, recombinant PDI, IJ	1 iu. ea	00053-8120-04	Biomed Plus, all sizes 3/99	\$0.91
Factor VIII	(Centeon) Monoclate-P/anti-hemophilic factor, human PDI, IJ	1 iu. ea	00053-7656-01	ASD all sizes 2/00	\$0.70
Factor VIII	(Centeon) Monoclate-P/anti-hemophilic factor, human PDI, IJ	1 iu. ea	00053-7656-02	ASD all sizes 2/00	\$0.70
Factor VIII	(Centeon) Monoclate-P/anti-hemophilic factor, human PDI, IJ	1 iu. ea	00053-7656-04	ASD all sizes 2/00	\$0.70
Fluorouracil	(Fujiwara/APP)/INJ, IJ (VIAL)	50 mg/ml, 10 ml	63323-0117-10	OS, FI	\$1.20
Fluorouracil	(Fujiwara/APP)/INJ, IJ (VIAL)	1gm, 20 ml	63323-0117-20	OS, FI	\$2.60

Fluorouracil	(Fujisawa/APP)/INJ, IJ (VIAL)	2.5 gm. 50 ml	63323-0117-51	OS, FI	\$6.00
Fluorouracil	(Fujisawa/APP)/INJ, IJ (VIAL)	5 gm. 100 ml	63323-0117-61	OS, FI	\$11.00
Fluorouracil	(Pharmacia/Upjohn) Adrucil/INJ, IJ (VIAL)	50 mg/ml. 10 ml	00013-1036-91	ASD, OS, OTN, FI	\$1.47
Fluorouracil	(Pharmacia/Upjohn) Adrucil/INJ, IJ (VIAL)	50 ml	00013-1046-94	ASD, OTN, FI	\$8.15
Fluorouracil	(Pharmacia/Upjohn) Adrucil/INJ, IJ (VIAL)	100 ml	00013-1056-94	ASD, OTN, FI, OS	\$14.44
Kytril	(SK Beecham Pharm.)/INJ, IJ (S.D.V.)	1 mg/ml. 1 ml	00029-4149-01	FI, OS, OTN, ASD	\$139.04
Kytril	(SK Beecham Pharm.)/INJ, IJ (S.D.V.)	1 mg/ml. 4 ml	00029-4152-01	FI, OTN, ASD, OS	\$555.67
Leucovorin Calcium	(Abbot Hosp.)/(VIAL FLUPTOP 30 ML)	10 mg/ml. 25 ml	00074-4541-04	FI, OTN, ASD, OS	\$8.56
Leucovorin Calcium	(Abbot Hosp.)/INJ, IJ (VIAL, FLUPTOP)	10mg/ml. 10ml	00074-4541-02	FI, OTN, OS	\$3.85
Leucovorin Calcium	(Bedford)/PDI, IJ (VIAL)	50 mg. 10s ea	55390-0051-10	FI, OTN, ASD, OS	\$2.76
Leucovorin Calcium	(Bedford)/PDI, IJ (VIAL)	100 mg. 10s ea	55390-0052-10	FI, OTN, ASD, OS	\$3.24
Leucovorin Calcium	(Bedford)/PDI, IJ (VIAL)	200 mg. ea	55390-0053-01	FI, OTN, ASD, OS	\$8.19
Leucovorin Calcium	(Gensia)/PDI, IJ (P.F. VIAL)	100 mg. ea	00703-5140-01	OTN, ASD, OS	\$3.49
Leucovorin Calcium	(Gensia)/PDI, IJ (P.F. VIAL)	350 mg. ea	00703-5145-01	OTN, ASD, OS	\$15.83
Leucovorin Calcium	(Immunex)/PDI, IJ (P.F.)	350 mg. ea	58406-0623-07	OTN, FI, OS	\$14.58
Methotrexate Sodium	(Bedford)/INJ, IJ (S.D.V.)	25 mg/ml. 2 ml. ea	55390-0031-10	ASD, OTN, FI	\$2.63
Methotrexate Sodium	(Bedford)/INJ, IJ (S.D.V.)	25 mg/ml. 4 ml. ea	55390-0032-10	ASD, OTN, FI	\$3.65
Methotrexate Sodium	(Bedford)/INJ, IJ (S.D.V.)	25 mg/ml. 8 ml. ea	55390-0033-10	ASD, OTN, FI	\$5.03
Methotrexate Sodium	(Bedford)/INJ, IJ (S.D.V.)	25 mg/ml. 10 ml. ea	55390-0034-10	ASD, OTN, FI	\$5.70
Methotrexate Sodium	(Immunex) LPF/INJ, IJ (S.D.V., P.F.)	25 mg/ml. 8 ml	58406-0683-12	ASD, OS, OTN, FI	\$5.84
Methotrexate Sodium	(Immunex) LPF/INJ, IJ (S.D.V., P.F.)	25 mg/ml. 2 ml	58406-0683-15	ASD, ASD, OS, FI	\$2.91
Methotrexate Sodium	(Immunex) LPF/INJ, IJ (S.D.V., P.F.)	25 mg/ml. 10 ml	58406-0683-16	ASD, OTN, FI, OS	\$7.10
Methotrexate Sodium	(Immunex) LPF/INJ, IJ (S.D.V., P.F.)	25 mg/ml. 4 ml	58406-0683-18	FI, MK, OTN, OS	\$4.32
Methotrexate Sodium	(Immunex)/INJ, IJ (VIAL, L.P.F.)	25 mg/ml. 2 ml	58406-0681-14	ASD, OS, OTN, FI	\$3.43
Methotrexate Sodium	(Immunex)/PDI, IJ (S.D.V.)	1 gm. ea	58406-0671-05	OS, OTN, MK	\$45.97
Vinblastine Sulfate	(Bedford)/PDI, IJ (VIAL)	10 mg. ea	55390-0091-10	ASD, OS, OTN, FI	\$8.19
Vinblastine Sulfate	(Faulding)/INJ, IJ (VIAL)	10 mg. ea	61703-0310-18	ASD	\$7.95

Vinblastine Sulfate	(FujiSawa/APP)	1 mg/ml, 10 ml	00469-2780-30	ASD, OS	\$9.00
Vinblastine Sulfate	(FujiSawa/APP)	1 mg/ml, 10 ml	63323-0278-10	OTN, FI	\$10.93
Vincristine Sulfate	(Faulding)/INJ, IJ (S.D.V., P.F.)	1 mg/ml, 1 ml	61703-0309-06	ASD, OS, OTN, FI	\$4.34
Vincristine Sulfate	(Faulding)/INJ, IJ (S.D.V., P.F.)	1 mg/ml, 2 ml	61703-0309-16	ASD, OS, OTN, FI	\$7.60
Vincristine Sulfate	(Pharmacia/Upjohn) Vincasar/INJ, IJ (VIAL)	1 mg/ml, 1 ml	00013-7456-86	ASD, OTN, FI, OS	\$5.10
Vincristine Sulfate	(Pharmacia/Upjohn) Vincasar/INJ, IJ (VIAL)	1 mg/ml, 2 ml	00013-7466-86	ASD, OTN, FI, OS	\$8.35
Zofran	(Cerenex)/INJ, IJ (M.D.V.)	2 mg/ml, 20 ml	000173-0442-00	FI, OTN, ASD, OS	\$169.06
Zofran	(Cerenex)/INJ, IJ (PREMIXED BAG)	30 mg/50ml, 50 ml	000173-0461-00	FI, OTN, FI, OS	\$128.09
Zofran	(Cerenex)/INJ, IJ (S.D.V.)	2 mg/ml, 2 ml	000173-0442-02	FI, OTN, OS	\$22.61