UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
ORLANDO DIVISION

IN RE: TASIGNA (NILOTINIB)
PRODUCTS LIABILITY LITIGATION

Case No. 6:21-md-3006-RBD-DAB
(MDL No. 3006)

This document relates to all actions.

ORDER IMPLEMENTING PLAINTIFF FACT SHEET

Before the Court are Plaintiffs' proposed Plaintiff Fact Sheet (Doc. 29-1), Defendant's proposed Plaintiff Fact Sheet (Doc. 30-1), and the parties' joint proposed order implementing the Plaintiff Fact Sheet (Doc. 30-2). As the Court advised at the hearing (Doc. 46), the Court has considered both parties' proposals and fashioned a reasonable Plaintiff Fact Sheet ("PFS"), which is attached hereto as Exhibit 1. This Order is largely in the form of the parties' joint proposed order (Doc. 30-2), with some changes made by the Court.

As such, it is **ORDERED AND ADJUDGED**:

A. Plaintiff Fact Sheet, Authorizations, and Responsive Documents

1. The Court has entered a PFS that includes document requests in Section IX and a variety of Authorizations. *See* Exhibit 1. Each plaintiff shall produce to Defendant a completed PFS, executed Authorizations, and documents responsive to Section IX of the PFS ("Responsive Documents") pursuant to the terms of this Order.

2. A completed PFS, which requires that each plaintiff sign the accompanying Declaration, shall be considered to be interrogatory answers pursuant to Fed. R. Civ. P. 33 and responses to requests for production pursuant to Fed. R. Civ. P. 34, and it will be governed by the standards applicable to written discovery under the Federal Rules of Civil Procedure. The PFS shall be timely supplemented in accordance with Fed. R. Civ. P. 26. As set forth below in Section C, each PFS must be substantially complete. All objections to the admissibility of information contained in the PFS are reserved and therefore no objections shall be lodged in the response to the questions and document requests contained in the PFS.

3. Nothing in this section prohibits a Plaintiff from withholding or redacting information based upon a recognized privilege. If information is withheld or redacted on the basis of privilege, that Plaintiff shall provide Defendant with a privilege log.

4. Nothing in the PFS shall be deemed to limit the scope of inquiry at depositions and admissibility of evidence at trial. The scope of inquiry at depositions shall remain governed by the Federal Rules of Civil Procedure. The admissibility of information in responses to the PFS shall be governed by the Federal Rules of Evidence and no objections to admissibility are waived by virtue of any PFS response.

B. Schedule for PFS Production

1. Each Plaintiff whose case is docketed in this MDL as of the date of entry of this Order shall produce to Defendant a completed PFS, executed Authorizations, and Responsive Documents. Each PFS, along with the executed Authorizations and Responsive Documents, are to be served sixty (60) days from the date of entry of this Order. Each Plaintiff whose case is docketed in this MDL after the date of entry of this Order shall have sixty (60) days from the date the case is docketed in this MDL to produce a completed PFS, executed Authorizations, and Responsive Documents.

2. Service of the PFS and accompanying materials shall be submitted by email to: TasignaFederalPFS@hollingsworthllp.com.

C. PFS Must Be Substantially Complete in All Respects

Every Plaintiff is required to provide Defendant with a PFS that is substantially complete in all respects. Substantially complete in all respects requires a Plaintiff to:

1. Answer all questions in the PFS leaving none blank. A plaintiff may answer questions in good faith by indicating "Not Applicable" or "I don't know" or "Unknown";

2. Include a signed Declaration;

3. Produce duly executed record release Authorizations; and

4. Produce the documents requested in the PFS, to the extent such documents are in the plaintiff's possession, custody, or control.

Failure to satisfy any requirement of this section shall represent a material deficiency in the PFS and subject that Plaintiff's case to potential dismissal with prejudice as set forth in Section F herein.

The Court reminds Defendant, as it did at the hearing (*see* Doc. 46), that any perceived deficiency in the PFS is not sufficient reason to withhold production of the Defendant Fact Sheet ("DFS"). The Court reminds Plaintiffs, as it did at the hearing, that it expects each PFS to be substantially complete. Any perceived deficiencies should be brought to the Court's attention immediately via a joint submission.

D. Authorizations for the Release of Records

1. As set forth above, Authorizations for the Release of Records shall be provided, completed in full but for the date, along with the PFS at the time that the Plaintiff is required to serve a PFS pursuant to this Order.

2. Authorizations shall be executed "in blank" (that is, without setting forth the identity of the custodian of records or provider of care). Defendant and its record copy vender, Strategic Litigation Partners ("SLP"), may address such Authorizations and use them to obtain records for Healthcare Providers and other sources of records (for example, pharmacies, employers, and the like).

3. Defendant and SLP are permitted to date Authorizations before sending to records custodians for healthcare providers or other entities that require Authorizations.

4. In the event that a signed Authorization does not contain the following information with respect to the Plaintiff—or, in the case of an Authorization signed in a representative capacity, the information with respect to the represented party—Defendant and SLP are authorized to fill in the following information:

a. The name and/or address of the Plaintiff, or represented party, at the top of the Authorization;

b. The Social Security Number of the Plaintiff or represented party;

c. The date of birth of the Plaintiff or represented party;

d. The name of defense counsel or SLP as the party to whom records may be released.

5. In the event that an institution or medical provider to whom any Authorization is presented refuses to provide records in response to that Authorization, Defendant shall notify the Plaintiff's individual representative counsel. Should a particular additional or alternative form be required, Defendant will provide it to the Plaintiff's individual representative counsel. The individual

Plaintiff shall execute and return any form required by that institution or provider within thirty (30) days.

6. Defendant's record copy service vendor shall have the right to contact institutions or medical providers to follow up on medical record copying or production.

E. Non-Compliance with PFS Requirements

Any Plaintiff who fails to comply with their PFS obligations under Section C of this Order may be subject to having their claims, as well as any derivative claim(s), dismissed. If a Plaintiff fails to provide a PFS within the time allotted or provides a PFS that is not substantially complete in all material respects, Defendant will send a Notice of Overdue Discovery ("Delinquency Letter") or Notice of Incomplete Discovery ("Deficiency Letter") to that Plaintiff's counsel identifying the discovery overdue and/or the material deficiency. The Plaintiff shall have thirty (30) days after receiving a Delinquency Letter or Deficiency Letter to submit the PFS or cure the alleged deficiency. If that Plaintiff has not provided a completed PFS and/or cured the material deficiency within thirty (30) days after receiving a Delinquency Letter or Deficiency Letter, after meeting and conferring with the Plaintiff's counsel, Defendant may move the Court for an Order dismissing the Complaint without prejudice. The Plaintiff shall have fourteen (14) days from the date of Defendant's motion to file a response either certifying that

the Plaintiff has served upon Defendant and Defendant has received a completed PFS and attaching appropriate documentation of receipt, or to file an opposition to Defendant's motion. If a Plaintiff fails to file a notice or opposition, an Order dismissing the case without prejudice will be entered at the Court's discretion. Unless the Plaintiff has served Defendant with a completed PFS within thirty (30) days after entry of any such Order of Dismissal without prejudice, the Order may be converted to a Dismissal with Prejudice upon Defendant's motion, at the Court's discretion.

If additional time is needed in a specific case for good cause, the parties will meet and confer in good faith to resolve any issues.

The parties are reminded that all motions made pursuant to this Section are subject to the meet and confer requirements of Local Rule 3.01(g).

F. Copies of Records

Defendant or its designee(s) shall make available all records obtained by use of Authorizations to the attorney or record for each individual Plaintiff within thirty (30) days of the receipt of the records.

G. Obligation of PFS

Nothing herein shall preclude the parties from serving reasonable case-specific discovery requests in connection with individual cases that have been identified for trial work-up/bellwether process by the Court, and the parties will

meet and confer to discuss the scope of such discovery and raise any areas of dispute with the Court.

IT IS SO ORDERED.

DONE AND ORDERED in Chambers in Orlando, Florida, on November 2, 2021.

ROY B. DALTON JR.
United States District Judge

CONFIDENTIAL – SUBJECT TO PROTECTIVE ORDER

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
ORLANDO DIVISION

IN RE: TASIGNA (NILOTINIB)
PRODUCTS LIABILITY LITIGATION

Case No. 6:21-md-3006-RBD-DAB
(MDL No. 3006)

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PLAINTIFF FACT SHEET

INSTRUCTIONS

Please provide the following information regarding yourself or each individual on whose behalf you are making a claim. Each question must be answered to the best of your knowledge. If you do not know or cannot recall the information needed to answer a question, please state so explicitly in response to the question. Do not leave any questions unanswered or blank. In filling out this form, please use the following definitions:

1. **"You"** or **"Your"** refers to the person who used Tasigna®, unless otherwise specified.

2. "**Health care provider**" or "**health care practitioner**" means the following:

   a. Any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, psychiatric, mental, or psychological care or advice.

   b. Any doctor, physician, or surgeon—including, but not limited to, any oncologist, radiologist, pathologist, cardiologist, cardiac surgeon, vascular specialist, vascular surgeon, phlebologist, vein specialist, or osteopath—and any natural health provider, homeopath, paramedic, nurse (registered or otherwise), physiotherapist, physical therapist, massage therapist, acupuncturist, psychologist, psychiatrist, or therapist.

3. "**Document**" means any writing or record of every type that is in your possession, custody, or control or that of your counsel, including but not limited to written documents, cassettes, videotapes, photographs, charts, computer discs or tapes, x-rays, drawings, graphs, phonorecords, nonidentical copies and other data compilations from which information can be obtained and, if necessary, translated by the plaintiff into reasonably

usable form. For the purposes of this fact sheet, the term "Document" shall not include electronically stored information.

You may attach as many sheets of paper as necessary to answer these questions fully. If you have any documents—including, but not limited to, packaging, instructions, or other materials that you are required to produce in response to questions in this Fact Sheet or that relate to Tasigna®, or to the incident, injuries, claims, or damages that are the subject of your complaint—**you must not** dispose of, alter, or modify those documents or materials in any way. You are also required to give all of those documents and materials to your attorney as soon as possible. If you are unclear about these obligations, please contact your attorney.

I. CASE INFORMATION

A. If you are completing this questionnaire on behalf of someone else (*e.g.*, a deceased or incapacitated person), please complete the following:
   1. Your name: _____
   2. Address: _____
      _____
   3. In what capacity are you representing the individual? _____
      _____

If you were appointed by a court, please provide a copy of the order of appointment. If you were named a representative other than by court appointment, attach documentation demonstrating your entitlement to be a representative.

If you are completing this questionnaire in a representative capacity, please respond to the remaining questions on behalf of the person who used Tasigna®. Any questions using the term "You" refer to the person who used Tasigna®. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.

II. PERSONAL INFORMATION

A. Last name: _____
   First name: _____
   Middle name or initial: _____
   Maiden name (if any): _____

Other names, if any, by which you have been known (from prior marriages or otherwise): _____

B. Gender: Male _____ Female _____

C. Social Security number: _____

D. Date and place of birth: _____

E. Identify each home address where you have lived during the last ten (10) years, including time periods of residence and persons, if any, who lived with you:

Prior Address	Approximate Dates You Lived at Address	Persons, If Any, Who Lived with You at Address

[Attach additional sheets as necessary]

F. Please identify every place where you have been employed for a minimum of three (3) months for the period beginning five (5) years prior to your CML diagnosis, including any periods of self-employment. If you are making a claim for lost wages or lost earning capacity, please also provide your salary, annual gross compensation and/or other compensation received:

Employer Name	Employer Address	Approximate Dates of Employment	Title or Occupation	Annual Salary or Wages (if claiming lost wages)	Overtime or Bonus Wages

[Attach additional sheets as necessary]

G. Have you ever been discharged from military service for any reason relating to your medical, physical, psychiatric, or emotional condition?
Yes No
_____ _____
If yes, state what the condition was and who diagnosed it: _____
_____

H. Have you ever been rejected from military service for any reason relating to your medical, physical, psychiatric, or emotional condition?
Yes No
_____ _____
If yes, state the reason(s) you were rejected from military service: _____
_____

I. Have you filed a worker's compensation claim in the last ten (10) years?
Yes No
_____ _____
If yes, please state:
1. Year the claim was filed: _____
2. Company and/or court where the claim was filed: _____
_____
3. Nature of the injury or disability claimed: _____
_____
4. Amount awarded? _____
5. Period of disability? _____

[If you filed multiple claims, please copy and complete this question for each]

J. Have you filed a Social Security or other disability claim in the last ten (10) years?
Yes No
_____ _____
If yes, please state:
1. Year the claim was filed: _____
2. Company and/or court where the claim was submitted: _____
_____
3. Nature of the injury or disability claimed: _____
_____
4. Amount awarded? _____

5. Period of disability? _____

[If you filed multiple claims, please copy and complete this question for each]

K. Have you ever been denied life insurance for reasons relating to your cardiovascular health?

Yes No

_____ _____

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

_____

[Attach additional sheets as necessary]

L. Have you ever been denied medical insurance for reasons relating to your cardiovascular health?

Yes No

_____ _____

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

_____

[Attach additional sheets as necessary]

M. Have you ever brought a personal injury lawsuit against anyone, aside from the present suit?

Yes No

_____ _____

If yes, for each such lawsuit, please state:

a. When and where the lawsuit was filed: _____

_____

b. Case number: _____

c. Nature of the claims in the lawsuit: _____

_____

d. Outcome: _____

_____

[Attach additional sheets as necessary]

N. Have you ever missed work for more than thirty (30) days for reasons related to your cardiovascular health?

Yes No

_____ _____

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

_____

[Attach additional sheets as necessary]

O. Identify all social/professional networking websites with which you have been registered for the period beginning five (5) years prior to your use of Tasigna® through the present, including usernames and the approximate range of dates of use for each (this includes, but is not limited to, Facebook, Twitter, MySpace, LinkedIn, Instagram, TikTok, Reddit, Quora, Digg, Pinterest, Snapchat, Google+, Tumblr, YouTube, Facebook Live, Periscope, Vimeo, Flipboard):

Social/Professional Networking Website	Username(s)	Approximate Dates of Use

P. Have you ever been married?

Yes _____ No _____

If yes, for each spouse/former spouse state:

1. Spouse's name: _____
2. Approximate dates of marriage: _____

_____

3. If applicable, why did the marriage end (*e.g.*, divorce, death)? _____

_____

Q. Identify (1) each secondary school, college, university, or trade school, you have attended in your lifetime, (2) the approximate dates of attendance, and (3) diplomas, degrees, or certificates of completion awarded:

Name of School	Approximate Dates of Attendance	Diploma, Degree, or Certificate of Completion Awarded

III. TASIGNA® USE

A. Complete the following information concerning your use of Tasigna®:

Approximate Dates of Tasigna Use	Physician(s) who prescribed Tasigna®	Address, and Specialty of the Prescribing Physician(s)

[Attach additional sheets as necessary]

B. Were you given any written warnings or instructions, including any packaging, package inserts, pamphlets, or brochures **before** you received Tasigna®?

Yes No I do not recall

_____ _____ _____

1. **If yes**, please provide the name, address, and specialty of the person who gave you the instructions or warnings: _____

_____

_____

2. **If yes**, what were the warnings or instructions? _____

_____

_____

3. Do you still have this information?
   Yes _____ No _____

   If yes, attach it to your responses. If no, what happened to it? _____

C. Who prescribed Tasigna® for you (provide name, address, and specialty)?

_____

_____

1. Did the physician(s) who prescribed Tasigna® explain to you the reasons why it was prescribed? _____
2. What did they tell you? _____

[Attach additional sheets as necessary]

D. Have you ever seen or received any advertising materials regarding the promotion of Tasigna®?
   Yes _____ No _____ I do not recall _____

1. **If yes**, approximately when and where did you see this material? ___
2. Describe the advertising you saw: _____

E. To the best of your knowledge, have you ever had any communications with Novartis Pharmaceuticals Corporation ("NPC") or their representatives regarding Tasigna®?
   Yes _____ No _____

   If yes, then please describe the communication: _____

F. To the best of your knowledge, has anyone else—including any of your physicians, family members, or others—ever contacted NPC on your behalf about Tasigna®?

Yes No

_____ _____

1. **If yes**, provide each person's name and address_____

_____

_____

G. Have you ever visited any website (including any social/professional networking websites) regarding Tasigna®?

Yes No

_____ _____

If yes, identify all websites visited and approximate dates of visit: _____

_____

_____

IV. CLAIMED INJURIES

A. Please identify the injuries you are seeking damages for as a result of your use of Tasigna®, both physical and psychological (if applicable):

1. Full description of injury: _____

_____

_____

2. Do you still have that injury or illness?

Yes No

_____ _____

3. On what date did symptoms of that injury first appear? _____

_____

B. Have you had discussions with any physician(s) or other health care practitioner(s) about whether your illness/injury is related to the use of Tasigna®?

Yes No

_____ _____

If yes, please identify:

Name of doctor: _____

Address: _____

Specialty: _____

Approximate Date of Discussion(s): _____

Please summarize the discussion:

_____

_____

C. If you are making a claim for present or past psychological or emotional injury as a consequence of using Tasigna®, please summarize your claim._____

_____

1. Do you still have that injury?
   Yes No
   _____ _____
2. When did symptoms first appear? _____

   _____

   _____
3. Have you received treatment for this injury?

   _____
4. **If yes**, when did you first contact a doctor or healthcare professional concerning this injury? _____

   _____
5. Who did you contact first (provide the name, address, and specialty of the physician)? _____

   _____

V. ECONOMIC DAMAGES

A. Are you making a claim for lost wages or earning capacity?
   Yes No **If no**, skip to Section VI.
   _____ _____

B. State the total amount of time that you have missed from work as a result of the injuries you claim are related to your use of Tasigna®.
   Approximate time lost: _____
   Approximate income lost: $_____

C. Are you seeking recovery for any out of pocket expenses associated with any health condition(s) you claim are related to your use of Tasigna®?
   Yes No
   _____ _____

If yes, please identify and itemize all out of pocket expenses: _____

_____

_____

VI. MEDICAL BACKGROUND

A. Height: _____
State your weight at the following times:
Weight at the time you started taking Tasigna®: _____
Current weight: _____

B. Please provide the name, address, specialty, and approximated dates of care for **each** physician or healthcare practitioner whom you have consulted, seen, or are currently seeing for examination, evaluation, diagnosis, or treatment of any condition, injury, physical infirmity, disability, sickness, ailment, or affliction for the period beginning five (5) years prior to your CML diagnosis through the present (Novartis Pharmaceuticals Corporation ("NPC") reserves its right to seek information dating further back in time as needed on a case-specific basis):

Name of Doctor and Institution	Address	Condition(s) Treated	Approximate Dates of Care

[Attach additional sheets as necessary]

C. Please provide the following information with respect to your diagnosis for Chronic Myeloid Leukemia:

1. Date you were diagnosed with Chronic Myeloid Leukemia: _____

2. Identify which healthcare professionals listed in Question VI(B) above diagnosed you with, or treated you for, Chronic Myeloid Leukemia: _____

3. Please complete the following with regard to medication(s), other than Tasigna®, prescribed to treat your Chronic Myeloid Leukemia:

Medication	Prescribing Physician(s)	Approximate Dates of Use

[Attach additional sheets as necessary]

4. Has any health care professional ever informed you that you have achieved a Major Molecular Response ("MMR")?

Yes _____ No _____ Unknown _____

If yes, please identify the approximate date and health care professional who told you that you had achieved MMR (provide the name and address of each physician): _____

5. Has any health care professional ever informed you that you have achieved a Treatment-Free Remission ("TFR")?

Yes _____ No _____ Unknown _____

If yes, please identify the approximate date and health care professional who told you that you had achieved TFR (provide the name and address of each physician): _____

D. Have you participated in any clinical trials or taken any experimental drugs for treatment of your Chronic Myeloid Leukemia?

Yes _____ No _____

If yes, please indicate when you participated in such trials, where the trials took place, and which drugs you took. _____

_____

_____

E. Have you ever experienced or been diagnosed with any of the following:

	Yes	No	I Do Not Know
Acute Coronary Syndrome			
Atherosclerosis			
Arteriosclerosis			
Blood Clot			
Cancer (other than Chronic Myeloid Leukemia)			
Cardiac Arrhythmia			
Cardiovascular Disease			
Chronic Kidney Disease			
Circulatory Issues			
Coronary Artery Disease			
Covid-19			
Diabetes			
Heart Attack / Myocardial Infarction			
Heart Disease			
High Blood Pressure			
High Blood Cholesterol and/or Triglycerides			
Hyperthyroidism and/or Hypothyroidism			
Obesity			
Peripheral Artery Disease			
Peripheral Vascular Disease			
Stroke			

F. For each of the conditions you answered "**Yes**" to in Question VI(E) above, please provide the following:

Condition	Healthcare Provider That Diagnosed or Treated You	Healthcare Provider's Address	Brief Description of Treatment Provided (Including Any Medication(s) Prescribed)*	Approximate Dates of Treatment/Dates of Prescription(s)

*The types of medications you should include in this table include but are not limited to:

Anticoagulants (blood thinners)
Antiplatelet medications
ACE inhibitors
Angiotensin II receptor blockers
Angiotensin receptor-neprilysin inhibitors
Beta blockers
Calcium channel blockers
Cholesterol-lowering medications
Diuretics
Vasodilators

[Attach additional sheets as necessary]

G. To the best of your knowledge, state whether you underwent any of the following tests, procedures, or surgeries **before** the injury you allege you suffered occurred:

	Yes	No
Ablation		
Angiogram		
Angioplasty		
Atherectomy		
Bypass Surgery		
Endarterectomy		
Organ Transplant		
Sclerotherapy		
Stent Placement		
Transmyocardial Revascularization (TMR)		
Pacemaker		

H. For each test, procedure, or surgery for which you answered "**yes**" above, please identify the treating physician and approximate date of the test, procedure, or surgery.

Procedure	Treating Physician	Approximate Date

[Attach additional sheets as necessary]

VII. TOBACCO AND ALCOHOL USE

A. Tobacco Use History

1. Smoking status (including cigarettes, cigars, pipe tobacco, and vapes or e-cigarettes) (check applicable):

Current Smoker	Past Smoker	Non-Smoker
___	___	___

2. If you checked "Current Smoker" or "Past Smoker," please identify the tobacco product(s) you have smoked (check applicable):

Cigarettes	Cigars	Pipe Tobacco	Vapes	Other
___	___	___	___	___

If "Other," please specify: _____

3. If you checked "Current Smoker," how much do you smoke and for how many years?
   _____ packs/cigarettes/cigars/pipes per day for _____ years
4. If you checked "Past Smoker," how much did you smoke and approximately what dates did you start and stop smoking?
   _____ packs/cigarettes/cigars/pipes per day from _____ to _____
5. Do you currently use, or have you ever used, any other products containing nicotine not identified in the questions above (for example, nicotine gum)?
   Yes No
   _____ _____
   If yes, please state:
   a. Type of product: _____
   b. Quantity/frequency of use: _____
   c. Time period of use: _____
6. Do you currently live with, or have you ever lived with, anyone who smokes tobacco?
   Yes No
   _____ _____
   If yes, please state:
   a. Name of tobacco user and relationship to you: _____
   _____
   b. Type of tobacco product: _____
   c. Approximate quantity and frequency of use in your presence: ___
   _____
   d. Approximate dates of use: _____

B. Alcohol History
1. Do you currently drink alcohol (beer, wine, whiskey, etc.)?
   Yes No
   _____ _____
   If yes, check which represents your current alcohol consumption
   _____ 1-5 drinks per week
   _____ 6-10 drinks per week
   _____ 11-14 drinks per week
   _____ 15 or more drinks per week
   _____ Other (Describe: _____)

2. Have you consumed alcohol (beer, wine, whiskey, etc.) in the period of five (5) years prior to your CML diagnosis through present?

Yes No

_____ _____

If yes, please check which represents your greatest alcohol consumption over an extended period (six (6) months or greater) within the period of five (5) years prior to your CML diagnosis through present?

_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 11-14 drinks per week
_____ 15 or more drinks per week
_____ Other (Describe: _____)

When was this period? _____

VIII. FACT WITNESSES

A. Please identify all persons, other than your healthcare providers, you believe possess information concerning your injury and/or your current medical condition, and for each person provide the following:

Name	Address	Description of Information You Believe the Person Possesses

IX. DOCUMENTS

Please attach the following documents to this declaration, to the extent that such documents are currently in your possession, custody, or control or that of your lawyers. You are not required to produce documents that you have previously already produced to NPC.

A. Produce a signed copy of the release form attached as Ex. 1, leaving blank the name to whom the release is directed, authorizing NPC to obtain medical records from each health care practitioner, hospital, clinic, or any other facility or health care provider who later becomes known to NPC who has examined you, treated you, or consulted with other health care practitioners regarding your medical or mental condition at any time. Plaintiff will provide one blank authorization with the understanding that it will be duplicated to send to other doctors and/or institutions. In the instance that an institution-specific authorization or wet-ink signature is required, plaintiff agrees to provide it within 30 days of the request.

B. For each health care practitioner who has examined you, treated you, or consulted with other health care practitioners regarding your medical or mental condition at any time, at or in affiliation with a Veteran's Administration facility, produce an executed copy of the release form attached as Ex. 1, authorizing NPC to obtain medical records from each health care practitioner.

C. If you are claiming psychological, psychiatric, or emotional injuries. For each psychologist, psychiatrist or other mental health care practitioner who has examined or treated you for any psychological, psychiatric, or emotional injuries, illnesses and/or conditions allegedly suffered as a result of your treatment with Tasigna®, produce an executed copy of the release form attached as Ex. 2, authorizing NPC to obtain your psychotherapy notes generated by any such mental health care practitioner.

D. A copy of all medical records from any health care provider who treated you for any disease, condition, or symptom referred to in any or your responses to the questions above.

E. If you have been the claimant or subject of any worker's compensation, Social Security, or other disability proceeding, all documents relating to such proceeding(s).

F. Produce executed copies of each of the authorizations, attached as Ex. 3, authorizing NPC to obtain all documents discussing, describing or memorializing your requests for Social Security, disability insurance, or workers' compensation benefits, if applicable.

G. If you claim you have suffered a loss of earnings or earning capacity, produce your federal tax returns for each of the years from the period beginning five (5) years prior to your CML diagnosis to the present.

H. If you claim you have suffered a loss of earnings or earning capacity, produce executed copies of each of the authorizations, attached as Ex. 4, authorizing NPC to obtain your Federal and State income tax returns for each of the five (5) years prior to your CML diagnosis to the present.

I. For all past and present employers identified herein, produce two executed copies of the release form attached as Ex. 5, permitting NPC to obtain your employment records, including W-2 forms.

J. If you have served in the military, produce an executed copy of the release form attached as Ex. 6, permitting NPC to obtain your military personnel, service, and health records.

K. Copies of all documents from any healthcare provider (as defined above) or others discussing, describing, relating to, or memorializing your treatment with Tasigna® or to any condition you claim is related to the use of Tasigna®.

L. All documents relating to product use instructions, product warnings, package inserts, handouts, or other materials distributed with or provided to you in connection with your use of Tasigna®.

M. All photographs, drawings, journals, slides, or videos relating to your alleged injury.

N. Any diary, calendar, notes, letters, personal journals, or any other writing or recording made by you, or by any other person, describing, discussing, explaining or referring to the injuries, damages, or causes of action alleged by you in the Complaint.

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

P. Decedent's death certificate (if applicable).

DECLARATION

I declare under penalty of perjury that all of the information provided in connection with this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information, and belief at the present time. I further acknowledge that I have an obligation to supplement the above responses if I become aware of additional responsive information, or if I learn that they are in some material respects incomplete or incorrect.

_____ _____

Signature Date