

COURT FILE NO. 2001-07073  
COURT COURT OF KING'S BENCH OF ALBERTA  
JUDICIAL CENTRE CALGARY  
PLAINTIFFS THE CITY OF GRANDE PRAIRIE  
THE CORPORATION OF THE CITY OF BRANTFORD  
DEFENDANTS APOTEX INC. ^

AURO PHARMA INC.

VALEANT CANADA LP/ VALEANT CANADA S.E.C.  
BAUSCH HEALTH, CANADA INC.  
BAUSCH HEALTH COMPANIES INC. ^

BRISTOL-MYERS SQUIBB CANADA CO. ^  
BRISTOL-MYERS SQUIBB COMPANY

ENDO INTERNATIONAL PLC  
ENDO PHARMACEUTICALS INC. ^  
PALADIN LABS INC.

ETHYPHARM INC.

HIKMA CANADA LIMITED  
HIKMA LABS INC.  
HIKMA PHARMACEUTICALS INC.  
HIKMA PHARMACEUTICALS PLC  
WEST-WARD COLUMBUS INC.

JAMP PHARMA CORPORATION

JANSSEN INC.  
JOHNSON & JOHNSON

MARCAN PHARMACEUTICALS INC.

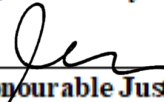
MINT PHARMACEUTICALS INC.

MYLAN II B.V.  
MEDA PHARMA B.V.

^

MYLAN PHARMACEUTICALS ULC

**FIAT**  
**LET THIS 8TH AMENDED**  
**STATEMENT OF CLAIM BE**  
**FILED, this 6th day of February, 2025**

  
The Honourable Justice Poelman

JODDES LIMITED  
PHARMASCIENCE INC.

PRO DOC LTÉE  
BARD PHARMACEUTICALS (1990) INC.  
HUDSON RIVER (DELAWARE) INC.  
HS HOLDINGS INC.  
MN CONSULTING LLC  
MNP CONSULTING LIMITED  
PURDUE FREDERICK INC.  
PURDUE PHARMA  
PURDUE PHARMA INC. ^  
SANDIWAY TRUST COMPANY LIMITED  
WA CANADA L.P.

SANDOZ CANADA INC.

SANIS HEALTH INC. ^

^ SUN PHARMA CANADA INC.  
SUN PHARMACEUTICAL INDUSTRIES INC.  
SUN PHARMACEUTICAL INDUSTRIES LTD.

TEVA CANADA LIMITED  
TEVA PHARMACEUTICAL INDUSTRIES LTD.  
TEVA PHARMACEUTICALS USA, INC. ^

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MCKINSEY & COMPANY CANADA  
PUBLICIS MEDIA CANADA INC.

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ABBOTT LABORATORIES CO. ^ ^

IMPERIAL DISTRIBUTORS CANADA INC.^

KOHL & FRISCH LIMITED ^

L.P.G. PHARMACEUTICAL ADVISORS LTD. ^

METRO INC.

^ JEAN COUTU GROUP ^PJC^ INC.

MCKESSON CANADA CORPORATION  
MCKESSON CORPORATION

BIRCH HILL EQUITY PARTNERS INC.

REXALL PHARMACT GROUP ULC.

NU-QUEST DISTRIBUTION INC.

PROCURITY INC. ^ ^

GEORGE WESTON LTD.

LOBLAWS INC.

LOBLAW COMPANIES LTD.

UNIPHARM WHOLESALE DRUGS LTD.

WAL-MART CANADA CORP.

WAL-MART PHARMACY LIMITED

WAL-MART PHARMACY (B.C.) LIMITED

WAL-MART PHARMACY (SASK.) LIMITED

WAL-MART PHARMACY (NS) LIMITED

*Brought under the Class Proceedings Act*

DOCUMENT

PLEADING

ADDRESS FOR  
SERVICE AND  
CONTACT  
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Counsel for the Plaintiffs

**EIGHTH STATEMENT OF CLAIM**  
(dated November 30, 2024)

**NOTICE TO DEFENDANTS**

You are being sued. You are a Defendant. Go to the end of this document to see what you can do and when you must do it. **Note: State below only facts and not evidence.**

**Statement of Facts Relied On:**

1. The Plaintiffs sue on behalf of Canadian municipalities and their dependent special-purpose bodies who are authorized to, did, and will continue to incur Abatement Costs.

**I. PARTIES**

**A. Plaintiffs**

2. The City of Grande Prairie, a Canadian municipality, was established under Alberta laws.

3. The Corporation of the City of Brantford, a Canadian municipality, was established under Ontario laws.

**B. Defendants**

4. The Defendants carry on business in Alberta and elsewhere in Canada, including through global partnerships. The Plaintiffs rely on Rules 11.25(1), (2), and (3)(a), (c), (d), (g), and (i) of the *Alberta Rules of Court* for service in Canada.

**1. Suppliers**

5. “**Suppliers**”, acting as global partnerships, and pursuant to a common design with other Suppliers and Dealers, manufactured, produced, imported, marketed, or

sold Opioids in Canada.

- (a) **“Apotex”**: Apotex Inc. <sup>^</sup> is an Ontario corporation <sup>^</sup>.
- (b) **“Auro”**: Auro Pharma Inc., is an Ontario business corporation.
- (c) **“Bausch”**: Valeant Canada LP (“Valeant”), a Québec limited partnership, is a division of Bausch Health Companies Inc., a British Columbia corporation. Bausch Health, Canada Inc. is a Canada corporation.  
<sup>^</sup>
- (d) **“BMS”**: BMS Squibb Canada Co. and BMS Squibb Company <sup>^</sup> respectively are a Canada and Delaware corporation with <sup>^</sup> offices in Canada.
- (e) **“Endo”**: Paladin Labs Inc. (“Paladin”), a Canada corporation, and Endo Pharmaceuticals Inc., a Delaware corporation, are subsidiaries of Endo International plc, an Irish company. Endo had branch offices in Canada.
- (f) **“Ethypharm Inc.** is a Québec corporation.
- (g) **“Hikma”**: Hikma Canada Limited, Hikma Labs Inc. (formerly Roxane Laboratories, Inc.), Hikma Pharmaceuticals Inc., and Hikma Pharmaceuticals PLC respectively are Canada, Nevada, Ontario, and British corporations. West-Ward Columbus Inc. (formerly Boehringer Ingelheim Roxane Inc.) is a Delaware corporation. Hikma had <sup>^^</sup> offices in Canada.
- (h) **“Janssen”**: Janssen Inc., an Ontario corporation, is a subsidiary of Johnson & Johnson, a New Jersey corporation with an <sup>^</sup> office in Canada.
- (i) **“JAMP”**: JAMP Pharma Corporation is a Quebec business corporation.
- (j) **“Marcan”**: Marcan Pharmaceuticals Inc. is a Quebec business corporation.
- (k) **“Mint”**: Mint Pharmaceuticals Inc. is an Ontario business corporation.
- (l) **“Mylan”**: Mylan Pharmaceuticals ULC is an Alberta corporation. <sup>^</sup>

Mylan II B.V. (amalgamated with Mylan N.V.) and Meda Pharma B.V. are Dutch companies. Mylan Pharmaceuticals Inc. was a subsidiary of Mylan N.V. Mylan II B.V. and Meda Pharma B.V. operated under the business name Viatris. Mylan had branch offices in Canada.

- (i) **“Pharmascience”**: Pharmascience Inc.,<sup>^^^</sup> a Canadian corporation, is a subsidiary of Joddes Limited, a Canadian corporation.
- (j) **“Pro Doc”**: Pro Doc Limitee / Pro Doc Ltée is a Québec corporation and a subsidiary of ^ Jean Coutu Group ^PJC^ Inc.
- (k) **“Purdue”**: “Purdue” means those entities described below, acting as a global partnership.
- (l) **“Sandoz”**: Sandoz Canada Inc., a Canadian corporation, is a subsidiary of Sandoz International GmbH, a German company with ^offices in Canada.
- (m) **“Sanis”**: Sanis Health Inc. is a Canadian corporation.
- (n) **“Sun”**: ^ Ranbaxy Pharmaceuticals Canada Inc. (“Ranbaxy”), an Ontario corporation ^ became Sun Pharma Canada Inc., an Ontario corporation, and was a subsidiary of SunPharmaceutical Industries Ltd., an India corporation with a branch office in Canada.
- (o) **“Teva”**: Teva Canada Limited, a Canadian corporation, and Teva Pharmaceuticals USA Inc., a Delaware corporation, are subsidiaries of Teva Pharmaceutical Industries Ltd., an Israeli company. Actavis Pharma Company (“Actavis”), a Nova Scotia company, became a Canadian corporation and ultimately amalgamated into Teva Canada Limited. Teva had branch offices in Canada.

6. Suppliers manufactured, marketed, and sold Opioids in Canada under the following generic and brand names:

	Generic Name	Brand Name	Supplier
(a)	buprenorphine		Mylan Pharmascience <u>Purdue (Bard)</u> Teva
		Belbuca® Butrans®	Purdue
(b)	codeine		^ Apotex ^^ <u>Janssen</u> Pharmascience ^Sandoz ^ Teva ^
		<u>Procet</u> <u>Pronal</u>	<u>Pro Doc</u>
		Codeine Contin	Purdue
(c)	fentanyl		Apotex <u>Hikma</u> Mylan Pharmascience Pro Doc Sandoz Sun ( <u>Ranbaxy</u> ) Teva (Actavis)
		Abstral®	Endo (Paladin)
		Duragesic®	Janssen
		Fentora™	Teva
(d)	hydrocodone		Teva Pharmascience
		<u>Codofen®</u> <u>Ibucodone</u>	<u>Endo (Paladin)</u>
		Hycodan® Hycomine	<u>BMS</u>

(e)	hydromorphone		Apotex <u>Boehringer</u> Hikma ( <u>Roxane</u> ) Pharmascience Purdue (Bard) Sandoz Teva ^
		Jurnista®	Janssen
		Dilaudid® Hydromorph Contin® Palladone®	Purdue
(f)	meperidine		Sandoz
(g)	methadone		<u>Apotex</u> <u>Bausch</u> <u>JAMP</u>
		Metadol®	Endo (Paladin)
(h)	morphine		<u>Boehringer</u> <u>Hikma (Roxane)</u> Pharmascience Purdue (Bard) Sandoz Sanis Teva
		Statex®	Endo (Paladin)
		M-Ediat® M-Eslon <u>Zomorph®</u>	Ethypharm
		MSContin®	Purdue
		M.O.S.	Valeant
(i)	normethadone	Cophylac®	<u>Bausch</u>
(j)	opium		Pharmascience Sandoz

(k)	oxycodone		Apotex <u>Hikma (Roxane)</u> Pharmascience Pro Doc Sandoz <u>Saniroxs</u> Sun ( <u>Ranbaxy</u> ) Teva
		Endocet® Endodan® Percocet® Percodan®	<u>BMS</u>
		^ OxyContin® OxyNEO® Targin®	Purdue
(l)	oxymorphone	<u>Opana®</u>	<u>Endo (Paladin)</u>
		Numorphan®	<u>BMS</u>
(m)	tapentadol		<u>Apotex</u> <u>Janssen</u> <u>Auro</u> <u>JAMP</u> <u>Marcan</u> <u>Mint</u>
		Nucynta®	Endo
		Nucynta®	Janssen
(n)	<u>tramadol</u>		<u>Apotex</u> <u>Mylan</u> <u>Teva (Actavis)</u> <u>Pharmascience</u> <u>Pro Doc</u> <u>Sandoz</u> <u>Sanis</u> <u>Sun</u> <u>Teva</u>
		<u>Ralivia®</u>	<u>Bausch</u>

	<u>Tramacet®</u>	<u>Janssen</u>
	<u>Ultram®</u>	
	<u>Tridural®</u>	<u>Endo (Paladin)</u>
	<u>Zytram®</u>	<u>Purdue</u>

7. Each Supplier was also a Dealer.

^

## **2. Purdue**

8. Purdue had one of the largest market shares of opioids sold in Alberta and in Canada and were one of the first to implement the misrepresentations and neglect alleged herein, conspiring with other Defendants alleged to have caused nuisance and other damages to the Plaintiffs. They have taken steps to withdraw profits from those sales from Canada, and declare bankruptcy in the US, and claim CCAA protection in Canada. As such, the allegations against them are set out in greater detail, below

9. Purdue manufactured, exported, imported, distributed, marketed, and sold Opioids throughout the world, including in Canada, for profit. Each bound or attempted to bind the others to plea agreements, bankruptcy, and other regulatory proceedings throughout the world.

10. Purdue was divided into four divisions that were overseen by separate governing bodies with their own boards (each with Sackler and non-Sackler family members) and who operated through affiliated entities and partners:

(a) in the United States, by Purdue Pharma L.P.;

(b) in the United Kingdom, by Napp Pharmaceutical Holdings Limited;

- (c) in Germany, by Geschäftsführers of Mundipharma Verwaltungsgesellschaft mbH, a general partner of Mundipharma Germany (MvmbH), which had a branch office in Canada; and
- (d) elsewhere, by other affiliates or partners, the ownership of which was split between 'Class A' and 'Class B' directing Sackler and non-Sackler family members (named below). In Canada, they were MNP and MN.

(a) Purdue Canada

11. In Canada, Purdue acted through Purdue Pharma, an Ontario limited liability partnership.

(a) Purdue Pharma Inc. ("**Purdue GP**"), a Canadian corporation, is a general partner of Purdue Pharma.

(b) Purdue Frederick Inc. ("**PF Canada**") is a Canadian corporation. Jonathan and Richard each owned 50% of the shares.

(c) Canadian Partnership Trust, a Jersey, Channel Islands trust, was a limited partner in Purdue Pharma. Its trustee is Sandiway Trust Company Limited, and its beneficiaries included Ilene, Kathe, Mortimer DA, and Theresa. Its 'Class A' directors included Ilene, Kathe, Mortimer DA, Samantha, and Theresa.

(d) WA Canada L.P., a Delaware limited partnership, was a limited partner in Purdue Pharma and owned shares of Purdue Pharma ULC, a British Columbia corporation. Richard was a partner in WA Canada L.P.

12. Bard Pharmaceuticals (1990) Inc. ("**Bard**") is a Canadian corporation. PF Canada owned all the shares of Bard ^.

13. Purdue Canada reported to the MNP/MN boards. MNP/MN made

recommendations to Purdue Canada that Purdue Canada followed.

(a) MNP Consulting Limited (“**MNP**”) is a Delaware corporation. MNP is an acronym for “Mundipharma-Napp-Purdue.”

(i) MNP operated as a supervisory board over Purdue Pharma.

(ii) MNP approved the distribution of funds from Purdue Canada entities to trusts with Sackler family members as beneficiaries.

(iv) HS Holdings Inc., a Delaware corporation, owned 100% of the shares of MNP. Sackler and non-Sackler family members owned shares of MNP.

(b) In 2019, MN Consulting LLC (“**MN**”), a Bermuda company, took over the role of MNP. Hudson River (Delaware) Inc., a Delaware corporation, owns shares of MN.

14. The MNP/MN boards included members of the Sackler family. Until 2017, Purdue US and the MNP/MN boards consisted of the same Sackler and non-Sackler family members and met at the same places and times.

(b) Purdue US

15. Purdue Pharma L.P. (“**Purdue US**”) was a limited partnership created under Delaware laws.

(a) Purdue GP executed Opioids supply agreements between Purdue Pharma and Purdue US.

(b) Purdue US owned the Canadian patent for OxyContin®.

(c) Purdue US’s partners were American corporations who directly or indirectly owned all securities of the Purdue Defendants.

16. P.F. Laboratories Inc. (“**PFL**”) is a New Jersey corporation. It

manufactured OxyContin® that was distributed in Canada.

(c) Sackler and Non-Sackler Family

17. Sackler family members were divided into ‘Class A’ and ‘Class B’ controlling directors based upon their sibling lineage. Sackler and non-Sackler family members controlled and directed Purdue affiliates and partners.

(a) From 1996, when OxyContin® was first marketed in Canada, the Sackler and non-Sackler family members directly directed Purdue’s conduct throughout the world, including in Canada.

(b) From at least 2003, Sackler and non-Sackler family members directly and indirectly directed Purdue’s conduct through boards of directors. The boards were the primary Purdue decision-making bodies and acted under the control and direction of Sackler and non-Sackler family members.

**3. Consultants**

18. Consultants advised and counseled Suppliers and Dealers in manufacturing, marketing, and selling Opioids throughout North America.

(a) **“McKinsey”**: McKinsey & Company Canada, a Nova Scotia unlimited company, and McKinsey & Company, Inc. Canada and McKinsey & Company, Inc. United States, Delaware corporations, operated as a global partnership throughout North America, including in Canada, pursuant to a common design.

(b) **“Publicis”**: Publicis Media Canada Inc., a Canadian corporation, and Publicis Health, LLC, a Delaware corporation, are units of Publicis Groupe SA, a French *Société anonyme*. Publicis operated as a global partnership, including throughout North America and in Canada, pursuant to a common design, under the

name “Publicis Health”.

19. McKinsey designed (or helped design) the marketing plans and programs that contained False or Misleading Representations that Suppliers and Dealers used to promote the sale of Opioids throughout Alberta and Canada. Those plans and programs caused or contributed to the Opioid Crisis.

20. Beginning in 2004, McKinsey and Publicis aided and counseled Purdue in marketing Opioids throughout Alberta and Canada through the use of False or Misleading Representations that were made through training videos for sales representatives, patient vignettes, unbranded websites, and other sources. Publicis implemented McKinsey’s “Evolve to Excellence” campaign and strategy for Purdue that targeted healthcare practitioners who prescribed the most Opioids.

21. McKinsey for example is reportedly facing Criminal Conspiracy charges in the United States for its role as alleged herein. News reports (Reuters, for example, including an October, 2024 report), confirm settlements agreed to by McKinsey, including a Class Action settlement approved in US Federal Court in San Francisco for \$78 Million paid to Health insurers; and another for \$641 Million to settle claims by US State Attorneys; and another in the amount of \$230 Million to settle cases with US First Nations; and another \$500 Million reportedly (October 2024) to settle Criminal Conspiracy charges in the US.

22. McKinsey and Publicis also designed and implemented marketing plans and programs for other Suppliers, including Endo and Janssen, and increased the prescription and sales of Opioids throughout Alberta and Canada, including in Canadian municipalities. The plans and programs were similar to those they

created for Purdue. They engaged in the making of False or Misleading Representations.

#### **4. Dealers**

23. “Dealers” sold Opioids to Institutions and individuals in Canadian municipalities.

(a) Abbott Laboratories Co., a Nova Scotia company, ^ and Abbott Laboratories Inc., a Delaware corporation, are subsidiaries of Abbott Laboratories, an Illinois corporation with offices in Canada. They operated as a global partnership throughout North America, including in Canada, pursuant to a common design.

(b) Imperial Distributors Canada Inc. is an Alberta corporation.

^

(c) Kohl & Frisch Limited is an Ontario corporation.

(d) “Loblaws”: consists of the following Defendants:

(i) George Weston Ltd., an Ontario business corporation, is a Canadian holding company. Founded by George Weston in 1882, the company today consists of the Choice Properties real estate investment trust and Loblaw Companies Limited, Canada's largest supermarket retailer, in which it maintains a controlling interest.

(ii) Loblaw Companies Ltd, an Ontario business corporation, Loblaws operates three drugstore chains, the largest being Shoppers Drug Mart Inc.

(iii) Loblaws Inc., is an Ontario business corporation which owns and operates the largest supermarket chain in Canada.

(iv) Shopper Drug Mart Inc., an Ontario business corporation, which has stores in ten provinces and two territories, while also

operating under the name Pharmaprix in Quebec.

(v) L.P.G. Pharmaceutical Advisors Ltd. is an Ontario corporation that carries on business under the name L.P.G. Inventory Solutions.

(e) “Metro”: consists of the following Defendants:

(i) Metro Inc., a Quebec, Société par actions ou compagnie, operates approximately 640 pharmacies primarily under the Jean Coutu, Brunet, Metro Pharmacy and Food Basics Pharmacy banners.

(ii) The Jean Coutu Group (PJC) Inc., a Quebec, Société pas actions ou compagnie, has more than 400 franchised locations in New Brunswick, Ontario, and Quebec under the PJC Jean Coutu, PJC Clinique, ad PJC Santé banners.

(f) “McKesson”: consists of the following Defendants:

(i) McKesson Corporation is a United States, Delaware corporation and wholly owns McKesson Canada Corporation.

(ii) McKesson Canada Corporation is a Nova Scotia, unlimited company, and is the owner of pharmacy chain, Rexall. It operates, supports or directs pharmacies across Canada under the banner brands The Medicine Shoppe, Proxim, Uniprix, IDA, Guardian, Remedy's Rx.

(iii) Rexall Pharmacy Group ULC, a British Columbia company, has approximately 385 pharmacies across Canada.

(iv) Medicine Shoppe Canada Corporation is a Nova Scotia, unlimited company.

(v) Birch Hill Equity Partners, Inc., an Ontario business corporation, announced on September 5, 2024, that it had entered

an agreement with McKesson Corporation to acquire Rexall Pharmacy Group.

(g) Nu-Quest Distribution Inc. is a Newfoundland and Labrador Corporation.

(h) Procurity Inc. is a Manitoba corporation.

(i) uniPHARM Wholesale Drugs Ltd. is a British Columbia corporation.

(j) “Wal-Mart”: consists of the following Defendants:

(i) Wal-Mart Inc. is a United States, Delaware corporation.

(ii) Wal-Mart Canada Corp. is a Nova Scotia unlimited liability company.

(iii) Wal-Mart Pharmacy Limited is an Alberta business corporation.

(iv) Wal-Mart Pharmacy (Sask.) Limited, is a Saskatchewan business corporation.

(v) Wal-Mart Pharmacy Limited is an Ontario business corporation.

(vi) Wal-Mart Pharmacy (BC.) Limited, is a British Columbia company.

(vii) Wal-Mart Pharmacy (NS.) Limited, is a Nova Scotia limited company.

## **5. The Canadian Opioid Crisis**

24. The Supplier and Dealer Defendants all marketed their products and disseminated their misrepresentations in the Provinces of Alberta and Ontario. The Distributors Defendants all distributed opioids and failed to meet their regulatory obligations in both Alberta and Ontario.

25. Grande Prairie and Brantford, like municipalities across the country, have been ravaged by the national opioid crisis.

26. Canada has faced a steady increase in fatal drug overdoses, the majority of which are attributable to prescription opioids or other opioids that patients often began abusing after becoming addicted to prescription opioids.

27. The Representative Plaintiffs' Communities have been hit hard by the opioid crisis.

28. Specific to the City of Grand Prairie:

(a) In the third quarter of 2019, there were 19 opioid related deaths in the City of Grande Prairie.

(b) The use of their supervised consumption site increased by roughly 30% over the previous quarter.

(c) Over 100 people entered methadone treatment programs in the City in Q3 of 2019.

(d) The city's crime rate is on the increase and was recently ranked the 9th most dangerous city in Canada by Mclean's Magazine.

(e) There were 286 EMS responses to opioid related issues in Q3 of 2019, taxing the city's ambulances and fire services.

(f) The City facilitated 42 community outreach and education workshops.

(g) Despite a concerted program by the city to combat homelessness, homelessness is on the increase, and by far the most common cause of homelessness was substance abuse.

(h) The opioid crisis also indirectly affected the city's budget by

decreasing property values, decreasing productivity of its citizenry, and thereby eroding its tax base and income.

29. Specific to the City of Branford:

(a) In the first twelve (12) days of 2020 alone, Brantford experienced 17 overdoses, including four (4) that were fatal and that occurred in a single day.

(b) In 2017, there was a 213% increase in opioid-related deaths when compared to 2016.

(c) In 2019, there were at least 35 opioid-related deaths – including three deaths in a single weekend.

(d) There were 170 opioid-related emergency department visits in 2019, an increase of 16% compared to the previous year.

(e) In an effort to combat overdoses, the City of Brantford distributed 5,174 Naloxone kits in 2019, an increase of over 40%.

(f) Despite having lower than average rates of cannabis or cocaine trafficking that continue to decrease, Brantford has experienced an increase in trafficking of other controlled substances, including opioids.

(g) In 2017, Brantford was ranked as having the second highest rate of opioid poisoning hospitalizations in the entire country.

(h) Despite a concerted program by the city to combat homelessness, homelessness is on the increase, and by far the most common cause of homelessness was substance abuse.

(i) The opioid crisis also indirectly affected the city's budget by decreasing property values, decreasing productivity of its citizenry, and thereby eroding its tax base and income.

## II. CAUSE OF ACTION

### A. Competition Act

30. On behalf of class members, the Plaintiffs sue Suppliers under the *Competition Act*, RSC 1985, c C-34, ss 36, 45, and 52.

#### **1. Made False or Misleading Representations**

31. To promote the over-prescription, diversion, use, and sale of Opioids throughout North America, including in Canada, Suppliers made or engaged in the making of “**False or Misleading Representations**” throughout North America, including in Canada.

#### (a) Abuse

##### *(i) abuse risk*

32. Suppliers represented that Opioids are less likely to be abused than other forms of pain relief. Opioids are *not* less likely to be abused than other forms of pain relief.

##### *(ii) newer formulations*

33. Suppliers represented that newer Opioid formulations, successfully deterred abuse. Such formulations did *not* successfully deter abuse.

34. In a feigned response to concerns and criticisms that initial formulations of Opioids were addictive and prone to abuse, around 2010, Suppliers developed and promoted “abuse-deterrent formulations” (“**ADFs**”) to persuade Canadian healthcare practitioners that they could continue to safely prescribe Opioids.

35. Suppliers introduced ADFs not to deter Opioids abuse, but because the patents on their original formulations expired, and ADFs had subsisting patents.

36. ADFs were more likely to be abused than original formulations of Opioids because ADFs had lower bioavailability of the opioid active ingredient and thus prompted users to chew, cut, grind, inject, and snort the Opioid to get a faster release of the active ingredient into their bloodstreams.

37. ADFs did not reduce opioid abuse, as a large number of users who were addicted to earlier versions of Opioids shifted to other opioids such as heroin.

38. Suppliers' False or Misleading Representations regarding ADF Opioids exacerbated and prolonged the Opioid Crisis.

(b) Not Addictive

39. Before 1996, healthcare practitioners were reluctant to prescribe opioids because, based on consistent and reliable clinical and scientific evidence, they were rightfully and widely considered to be too addictive to treat long-term chronic pain. They were primarily prescribed for short-term acute pain and for terminal ^ patients.

40. From 1996, Suppliers represented that the risk of addiction was low or non-existent when Opioids were taken as prescribed by patients with long-term chronic pain. The risk of addiction was in fact high for all users of Opioids.

41. Suppliers did not conduct, or did not disclose, addiction risk studies with their Canadian applications for market authorization.

42. In representing that the risk of addiction from Opioids was small or non-existent, Suppliers relied on a 1 paragraph letter to the editor, Jane Porter & Herschel Jick, MD, *Addiction Rare in Patients Treated with Narcotics*, 302(2)

New Eng. J. Med. 123 (Jan. 10, 1980), that declared the incidence of addiction “rare” for patients treated with opioids.

(a) The authors analyzed a database of hospitalized patients who were given opioids in a controlled setting to ease suffering from acute pain. Porter and Jick considered a patient not addicted if there were no signs of addiction noted in patients’ records.

(b) Dr. Jick submitted the statistics to the New England Journal of Medicine as a letter because the data was not robust enough to publish as a study.

43. For more than a decade after its publication, the letter was largely ignored in the scientific literature. Beginning with Purdue’s introduction of OxyContin®, and when making False or Misleading Representations, Suppliers repeatedly cited the letter when falsely representing that Opioids were not addictive. Dr. Jick told Suppliers that “that’s not in any shape or form what we suggested in our letter”.

44. Due to Suppliers’ activities described below, citations of the letter then multiplied. The enormous impact of Suppliers’ misleading amplification of the letter was documented in another letter published in the New England Journal of Medicine on June 1<sup>st</sup>, 2017 that described the way the letter had been irresponsibly cited and “grossly misrepresented.” Suppliers nevertheless continue to cite the letter to support their making of False or Misleading Representations.

45. Below are detailed descriptions included in the false or misleading representations alleged herein

*(i) other forms of pain relief*

46. Suppliers represented that Opioids were less addictive than other forms of

pain relief. Opioids were *not* less addictive than other forms of pain relief.

47. In materials they produced or sponsored, Suppliers omitted known risks of chronic opioid therapy and emphasized, exaggerated, or misrepresented risks of competing products so that healthcare practitioners would prescribe Opioids instead of non-opioid products such as over-the-counter acetaminophen or over-the-counter and prescription NSAIDs.

*(ii) long-term use*

48. Suppliers represented that the risk of addiction from long-term Opioid use was low. The risk of addiction from chronic Opioid use was *not* low.

*(iii) screening tools*

49. Suppliers represented that the risk of addiction from Opioids could be easily identified with screening tools. The risk of addiction from Opioids could *not* be easily identified with such tools.

50. In materials they produced or sponsored, Suppliers asserted that to the extent that some patients were at risk of opioid addiction (stemming from personal or family histories of substance use, mental illness, trauma, or physical and sexual abuse, etc.), healthcare providers could effectively identify and monitor those patients by using screening tools and questionnaires.

51. One example was the Opioid Risk Tool, created by Dr. Lynn Webster, a KOL. The Opioid Risk Tool was a 5 question, 1 minute screening tool that relied on patient self-reports and that purportedly allowed doctors to manage the risk that their patients would abuse or become addicted to opioids.

52. There was no consistent and reliable scientific evidence that screening tools were a reliable way to identify high-risk patients or that patients who had such screening could take Opioids long-term without becoming addicted.

*(iv) easily managed*

53. Suppliers represented that the risk of addiction from Opioids could be easily managed, including through patient-physician agreements. The risk of addiction from Opioids could *not* be easily managed.

*(v) pseudoaddiction*

54. Suppliers represented that signs of addiction from long-term Opioid use were simply “pseudoaddiction” that could be treated with more Opioids. Signs of addiction from chronic Opioid use were *not* simply “pseudoaddiction” that could be treated with more Opioids.

55. Suppliers instructed patients and prescribers that signs of addiction were actually indications of untreated pain, and that the appropriate response was to prescribe even more Opioids and at higher doses. There was no consistent and reliable evidence that “pseudoaddiction” was distinct from addiction.

(c) Diversion

56. Suppliers represented that the risk of Diversion from Opioids was lower than other forms of pain relief. The risk of Diversion from Opioids was *not* lower than other forms of pain relief.

57. From 1996, due to the Defendants’ breaches as described herein, large quantities of Opioids were diverted to those to whom they had not been prescribed.

58. Drugs diverted to the illicit market were frequently diverted for sale to other provinces.

(d) Effective

*(i) improves functioning*

59. Suppliers represented that long-term Opioid use improved functioning. Long-term Opioid use did not improve functioning.

60. From and after 1996, there was no consistent and reliable evidence that Opioids were capable of improving patients' function and quality of life with long term use, and credible and strong evidence to the contrary.

61. At all times, the consistent and reliable evidence was that long term Opioid use, including at increasingly higher doses, worsened pain, functioning, general health, mental health (anxiety, depression, post-traumatic stress disorder, and substance abuse), and social functioning in comparison to other forms of pharmaceutical and non-pharmaceutical pain relief.

*(ii) long term use*

62. Suppliers represented that long term Opioids use for chronic pain was effective. Long term Opioids use for chronic pain was *not* effective.

*(iii) 12 hours*

63. Suppliers represented that certain Opioid formulations provided 12 hours of pain relief. No Opioid provided 12 hours of pain relief.

64. Suppliers promoted Opioids as “extended release”, but the opioid active ingredients did not enter the body on a linear rate. They released a greater

proportion of the opioid upon administration, and the release gradually tapered.

(a) The initial rush of nearly half of the powerful opioid triggered a powerful psychological response. OxyContin® thus behaved more like an immediate release Opioid which was more addictive.

(b) The initial rush of the active ingredient meant that there was less of it at the end of the dosing period, resulting in the drug not lasting for a full 12 hours and the onset of user withdrawal symptoms.

65. The reduced release of the active ingredient over time meant that it no longer provided pain relief towards the end of the dose, and “extended-release” Opioids did not last for the 12 hours for which Suppliers promoted them.

(a) The failure to provide 12 hours relief rendered “extended release” Opioids more dangerous because patients began to experience withdrawal symptoms followed by a euphoric rush with their next dose, a cycle that fueled a craving for Opioids and that caused addiction.

(b) Patients exacerbated the cycle by taking their next dose ahead of schedule or resorting to a ‘rescue dose’ of another Opioid, thereby increasing the amount of Opioids they took.

(e) Increased Doses

66. Suppliers represented that Opioid doses could perpetually be increased without limit and without a greater risk of abuse, addiction, Diversion, tolerance, and withdrawal. Perpetually increasing Opioid doses in fact created a higher risk of abuse, addiction, Diversion, tolerance, and withdrawal.

67. In materials they distributed in Canada, Suppliers instructed healthcare practitioners that they could safely and perpetually prescribe increased doses of

Opioids to achieve patient pain relief.

68. The consistent and reliable evidence was that increasing opioid doses increases the risk of serious adverse events, including death from overdose.

(f) Tolerance

69. Suppliers represented that Opioids were less likely to cause tolerance than other pain medications. Opioids were not less likely to cause tolerance than non-Opioid pain medications.

(g) Withdrawal

(i) symptoms

70. Suppliers represented that Opioids were less likely to cause withdrawal symptoms than other forms of pain relief. Opioids were *not* less likely to cause withdrawal symptoms than other forms of pain relief.

(ii) managed

71. Suppliers represented that Opioid withdrawal could be easily managed. Opioid withdrawal could *not* be easily managed.

(iii) tapering

72. Suppliers represented that Opioid withdrawal could be avoided by tapering. Opioid withdrawal could *not* be avoided by tapering.

73. Suppliers falsely represented that, while patients could become physically dependent on Opioids, physical dependence was not the same as addiction, and that such dependence could be easily managed (if and when pain relief was no longer desired) by gradually tapering patient doses.

74. In their materials that contained False or Misleading Representations, Suppliers did not disclose the extreme difficult and painful effects that patients experienced upon ceasing Opioids use, and that such adverse effects made it less likely that patients would be able to stop using Opioids.

## **2. To the Public**

75. Suppliers publicly and systemically made False or Misleading Representations throughout North America, including in Canada, in multiple ways, including the following.

### (a) Advertisements

#### *(i) medical journals*

76. Suppliers placed advertisements containing False or Misleading Representations in medical journals.

77. Suppliers published millions of dollars of print advertisements in multiple North American medical journals (including the Canadian Medical Association Journal) that were aimed at general practitioners and specialists and that contained False or Misleading Representation.

#### *(ii) branded*

78. Suppliers engaged in widespread “branded” advertising campaigns that promoted specific Opioids and their indications using False or Misleading Representations, but that also contained regulatory-mandated “fair balance” statements of contraindications and warnings.

79. Suppliers also targeted consumers in pamphlets, videos, or other publications that patients could view in their physician’s offices and that contained

False or Misleading Representations.

*(iii) unbranded*

80. Suppliers also promoted Opioids through “unbranded advertising” to generally promote opioids without specifically naming a particular Opioid. Suppliers’ unbranded advertising was aimed at creating “disease awareness” and encouraging consumers to talk to their doctors about a specific condition to treat with Opioids, but without promoting a specific Opioid and without providing balanced disclosures about the limits and risks of Opioids.

(b) Educational Materials

81. Suppliers authored and distributed educational materials to Canadian healthcare practitioners at private and public presentations and seminars.

*(i) students*

82. Suppliers provided medical and pharmacy students in Canadian universities with textbooks that contained the False or Misleading Representations and paid their universities to make the use of such textbooks mandatory in standard professional school curriculum.

*(ii) doctors*

83. Suppliers distributed False and Misleading Misrepresentations through thousands of Continuing Medical Education courses (“CMEs”) throughout North America. Many CMEs were held in Canada, and Canadian healthcare practitioners traveled to the US to attend others.

84. CMEs were professional education programs provided to healthcare practitioners who were required to attend a certain number and type each year to

keep their licenses. CMEs were delivered in person, online, or through written publications. CMEs were regularly taught by KOLs who were highly respected in their fields and especially influential with doctors.

85. Suppliers sponsored CMEs for doctors and healthcare practitioners that were delivered thousands of times throughout North America., for example:

(a) Endo's *Chronic Opioid Therapy: Understanding Risk While Maximizing Analgesia, Persistent Pain in the Older Adult, and Overview of Management Options* (co-sponsored by Purdue);

(b) Purdue's *Managing Patient's Opioid Use: Balancing the Need and Risk, Chronic Pain Management and Opioid Use: Easing Fears and Managing Risks, and Improving Outcomes*; and

(c) Teva's *Opioid-Based Management of Persistent & Breakthrough Pain*.

86. Supplier-driven False or Misleading Representations in CMEs had a direct and immediate effect on prescribers' views about Opioids.

87. Front Groups sponsored CME programs and paid KOLs to give talks at CMEs to support chronic opioid therapy.

(iii) *Patients*

88. Suppliers sponsored, developed, and distributed patient guidebooks that contained False or Misleading Representations. Examples included Endo's *Understanding Your Pain: Taking Oral Opioid Analgesics*, Janssen's *Finding Relief: Pain Management for Older Adults*, and Purdue's *A Guide to Your New Pain Medicine and How to Become a Partner Against Pain*.

(a) Front Groups

89. Patient advocacy organizations and professional societies played a significant role in setting guidelines for pain treatment, raising disease awareness, and educating the public. They were vehicles through which Suppliers reached Canadian patients and Opioids prescribers.

90. Such organizations and societies were presented as credible, independent, and neutral “**Front Groups**” that had significant influence across North America; but Suppliers funded and used Front Groups to make False or Misleading Representations. Suppliers made substantial payments to ^ ^ executives, staff members, and advisory board members affiliated with the Front Groups.

91. Suppliers controlled or influenced Front Groups by providing funding to them and to the KOLs who served on their boards. Front Groups put out CMEs, patient education materials, and treatment guidelines that contained False or Misleading Representations.

92. Suppliers actively guided, reviewed, edited, and approved materials issued by Front Groups. The materials contained False or Misleading Representations.

*(i) American*

93. Suppliers substantially funded the American Academy of Pain Medicine (“**AAPM**”) and the American Pain Society (“**APS**”). AAPM’s presidents included Drs. Fine, Fishman, Haddox, and Webster.

94. The AAPM issued a “consensus” statement that contained False or Misleading Representations. Dr. J. David Haddox, the Chair of the Committee that issued the statement, was a paid speaker for Purdue, and Dr. Portenoy was the sole

consultant for the Committee.

95. AAPM and APS issued their own treatment guidelines that contained False or Misleading Representations.

(a) 14 of the 21 panel members who drafted the guidelines, including Dr. Fine, received support from Endo, Janssen, Purdue, and Teva; 9 received support from Endo, 9 from Janssen, 6 from Purdue, and 8 from Teva.

(b) Suppliers widely cited and promoted the guidelines without disclosing the financial backing of the authors of the guidelines.

(c) The guidelines influenced scientific literature on Opioids and were cited in academic literature that was available or published in Canada.

96. Endo, Purdue, and Teva were members of the Council and presented CMEs to Canadian doctors who attended its annual event in Palm Springs.

97. Endo, Janssen, and Purdue funded the American Geriatrics Society (“AGS”). The AGS Board of Directors were paid physician consultants and speakers for Suppliers. KOLs served in leadership positions within the AGS. The AGS contracted with Endo, Janssen, and Purdue to create and disseminate guidelines that contained False or Misleading Representations.

98. Suppliers provided the American Pain Foundation (“APF”) with more than \$10 million in grants and funding.

(a) Endo provided substantial assistance to, and exercised editorial control over, the False or Misleading Representations that the APF conveyed through its National Initiative on Pain Control (“NIPC”) and its website. Endo developed NIPC curriculum and workshops, developed and reviewed

NIPC content, and distributed NIPC and APF materials.

(b) Purdue entered into a “Master Consulting Services” Agreement with the APF that allowed it to control APF’s work on promotional projects.

(c) Purdue and Teva sponsored APF’s *Treatment Options: A Guide for People Living with Pain* and Purdue sponsored APF’s *A Policymaker’s Guide to Understanding Pain & Its Management*, each of which contained False or Misleading Representations.

99. A few days after the U.S. Senate Finance Committee began looking into the APF to determine the financial and other links between Suppliers and the APF, the APF’s board dissolved the organization, and it thereafter ceased to exist.

100. Suppliers gave grants to the Federation of State Medical Boards (“FSMB”). Drs. Fine and Fishman were on the Board of Advisors. The FSMB’s book, *Responsible Opioid Prescribing*, which Endo, Purdue, and Teva sponsored, contained False or Misleading Representations. 163,131 copies were distributed throughout North America by state and provincial medical boards (and from provincial boards, to Opioids prescribers in Canada).

101. Suppliers and the AAPM and APS provided the U.S. Pain Foundation (“USPF”) with millions of dollars.

(ii) *Canadian*

102. Suppliers funded the Chronic Pain Association of Canada, Canadian Pain Coalition, and People in Pain Network. Their publications adapted those of the AAPM, AGS, APF, APS, FSMB, and USPF for use in Canada, and similarly contained False or Misleading Representations.

(d) Press Releases

103. Suppliers issued press releases in North America that announced the launch of their Opioids and that contained False or Misleading Representations.

(b) Product Labels

104. Suppliers drafted and distributed product monographs throughout Canada for each Opioid, each of which contained False or Misleading Representations.

(c) Sales Representatives

105. Suppliers made False or Misleading Representations through sales representatives.

106. Suppliers created materials, memos, modules, and videos to train their sales representatives on how to communicate False or Misleading Representations to Canadian prescribing healthcare practitioners.

107. Sales representatives conducted thousands of one-on-one meetings with prescribing healthcare practitioners in Canada. In those meetings, Suppliers made False or Misleading Representations.

108. Sales representatives provided Canadian healthcare practitioners and patients with visual aids and written materials that Suppliers created and that contained False or Misleading Representations.

(d) Speakers' Bureaus

109. In addition to making sales calls, Suppliers employed sales representatives to

identify Canadian pain specialists and other physicians to serve as paid speakers on their speakers' bureaus and to attend dinner speaking programs that were paid for by Suppliers.

110. Suppliers made hundreds of payments to Canadian specialist and other physicians for participating on speakers' bureaus and for providing consulting and other services.

111. Suppliers graded their speakers and gave them future opportunities based on the number of post-program Opioids prescriptions by attendees.

(e) Websites

112. Suppliers made False or Misleading Representations on Supplier, Opioid, and other websites that were accessible to, and accessed by, Canadian patients and prescribers of Opioids.

(i) Studies

113. Using paid ghostwriters and KOLs, Suppliers authored, commissioned, and sponsored studies that contained False or Misleading Representations and that were published in academic, medical, and scientific literature that Suppliers presented as independent, objective research, and through which Suppliers intended to (and did) reverse the longstanding reluctance of Canadian healthcare practitioners to prescribe opioids.

114. Suppliers further published or commissioned review articles, letters to the editor, commentaries, case-study reports, and newsletters that contained False or Misleading Representations and that attacked other publications (and their authors) that contradicted or raised concerns about the falsity of the False or Misleading

Representations.

115. This literature was intended to serve Suppliers' marketing (rather than medical and scientific) goals and was used to persuade Canadian prescribers that the benefits of long-term Opioids use outweighed the risks.

116. Using Front Groups, KOLs, and third-party consultants, Suppliers arranged for the serial citation and placement of this literature in other journals.

117. Suppliers made sure that this literature was disseminated and widely cited in other medical literature, even when Suppliers knew that the literature distorted the significance or meaning of the underlying study.

(j) Key Opinion Leaders

118. Suppliers paid Key Opinion Leaders ("**KOLs**") to disseminate False and Misleading Representations throughout North America in articles, books, CMEs, speeches, and webinars that they wrote or presented.

119. Suppliers poured significant funds and resources into a marketing campaign that widely cited and promoted KOLs and their publications to increase prescriptions of Opioids for long-term chronic pain.

(a) Suppliers cited to, distributed, and marketed KOL articles and studies as if they were independent medical literature.

(b) Suppliers did not acknowledge or distribute independent publications that were critical of long-term use of Opioids for the treatment of chronic pain.

**3. To Promote the Use of Opioids**

120. When and after Purdue introduced OxyContin® into Canada in 1996, Suppliers began making False or Misleading Representations. Opioid prescribing multiplied, primarily in patients using Opioids for long-term pain management. Opioids became a first-line therapy for the long-term treatment of chronic pain.

121. Suppliers' False or Misleading Representations caused widespread inappropriate and unnecessary prescriptions of Opioids for non-indicated uses that were filled in pharmacies in Canadian municipalities.

122. In order to fundamentally shift Canadian practitioners' perceptions about using Opioids for long-term treatment of chronic pain, with the intent of increasing the sales of Opioids, with knowledge that increased sales would lead to ^ abuse, addiction, and misuse, and acting in furtherance of a common design, Suppliers designed and executed a North American marketing strategy that had as its foundation the making of False or Misleading Representations.

123. Lacking independent scientific research to support False or Misleading Representations, Suppliers turned to marketing techniques pioneered by Purdue to create misconceptions in the medical community and to ultimately reverse the long-settled understanding of the risks and benefits of opioids.

124. As a result of Suppliers' False or Misleading Representations, Opioid prescriptions multiplied in Canada even as the percentage of patients visiting a doctor for pain remained constant. Before OxyContin® was introduced into Canada, a small minority of opioid sales were for chronic pain.

(a) Between 2000 and 2010, as a result of the False and Misleading Representations, Opioid prescriptions doubled and NSAID and

acetaminophen prescriptions declined by 25%.

(b) By 2018, 4.6 million Canadians were prescribed Opioids per year.

(c) Today, 80-90% of Opioids are used for chronic pain, and they are now the most common treatment for long-term chronic pain in Canada.

125. Suppliers' making of False or Misleading Representations dramatically increased their sales of Opioids well above the legitimate medical demand and need for opioid therapy.

#### **4. Knowingly or Recklessly**

126. Suppliers knew there was no consistent and reliable evidence for their False or Misleading Representations; nevertheless, they knowingly promoted those falsehoods in order to increase sales of their Opioids.

(a) Suppliers had access to scientific studies, detailed prescription data, and reports of adverse events (including reports of addiction, hospitalization, and deaths), all of which made clear the harms from long-term Opioids use, including addictions, overdoses, and deaths.

(b) Opioids were highly addictive and responsible for a long list of serious adverse outcomes, including death. Health Canada and other regulators warned Suppliers of these risks.

(c) Suppliers continued to make False or Misleading Representations in Canada after they were fined, penalized, and sued by North American regulators for making False or Misleading Representations.

127. Suppliers spent millions of dollars to market their drugs to Canadian prescribing healthcare practitioners.

(a) Suppliers continued making False and Misleading Representations

because they in specific instances, and more generally, changed prescribers' reluctance to prescribe opioids, led them to prescribe Opioids, and persuaded them to continue prescribing Opioids or to switch to ADFs.

(b) Each Supplier tracked the impact of their False or Misleading Representations to measure their success in changing practitioners' perceptions and prescribing practices for Opioids.

(c) Suppliers purchased prescribing and survey data from Data Vendors. IQVIA Canada's data allowed Suppliers to precisely track the rates of initial and renewal prescriptions of Opioids by individual healthcare practitioners, so that they could provide False or Misleading Representations to specific practitioners.

(d) Suppliers monitored doctors' prescribing patterns before and after sales representative visits, CME's, and speaker programs.

(e) Suppliers' internal documents show that they knew they were influencing prescribing practitioners and increasing the number of Opioids prescriptions in Canada.

## **5. Loss or Damage**

128. Class members were responsible for providing a variety of municipal services to promote and protect the health, safety, and well-being of individuals within their communities including services for law enforcement, ambulance, and firefighting; social services for families and children; and low-income housing and public assistance.

129. Suppliers' False or Misleading Representations caused or exacerbated the Opioid Crisis and ^:

(a) caused class members to unnecessarily incur, and to continue to incur,

Abatement Costs;

(b) required class members to reallocate financial and other resources from traditional municipal priorities and programs to costs and expenses to abate or mitigate the Opioid Crisis; and

(c) led to a reduction in real property values within Canadian municipalities that resulted in a loss of tax revenues. Class members lost additional tax revenue from the failure of Opioids addicts to pay property taxes due to Opioid-associated dysfunctionality.

**B. Conspiracy Against All Defendants**

130. The Defendants Conspired To Engage In The Wrongful Conduct Complained Of Herein and Intended To Benefit Both Independently and Jointly From Their Conspiracy.

131. Purdue created a market for the use of opioids for a range of common aches and pains by misrepresenting the risks and benefits of its opioids, but it was not alone. The Suppliers, already manufacturers of prescription opioids, positioned themselves to take advantage of the opportunity Purdue created, developing both branded and generic opioids to compete with OxyContin, while, together with Purdue and each other, misrepresenting the safety and efficacy of their products. These misrepresentations are described in greater detail in Sections below.

132. Endo, which already sold Percocet and Percodan, was the first to submit an application for a generic extended-release oxycodone to compete with OxyContin. At the same time, Endo sought FDA approval for another potent opioid, immediate-release and extended release oxymorphone, branded as

Opana and Opana ER. In and around 1999, Endo essentially reached back into its inventory, dusted off a product it had previously shelved after widespread abuse, and pushed it into the marketplace with a new trade name, Opana. The clinical trials submitted with Endo's first application for approval of Opana were insufficient to demonstrate efficacy, and some subjects in the trials overdosed and had to be revived with naloxone. Endo later agreed to withdraw Opana ER from the market.

133. Janssen, which already marketed the Duragesic (fentanyl) patch for severe pain, also joined Purdue in pursuit of the broader chronic pain market. It sought to expand the use of Duragesic through, for example, advertisements proclaiming, "It's not just for end stage cancer anymore!" Janssen also developed a new opioid compound called tapentadol in 2009, marketed as Nucynta for the treatment of moderate to severe pain. Janssen launched the extended-release version, Nucynta ER, for treatment of chronic pain in 2011.

134. By adding additional opioids or expanding the use of their existing opioid products, Suppliers took advantage of the market created by Purdue's aggressive promotion of OxyContin and reaped enormous profits.

135. As Purdue developed OxyContin, it sought to encourage the long-term use of Opioids for widespread chronic conditions, like back pain, migraines and arthritis in order to expand its market and profits. As described in greater detail below, Suppliers, with the help of Consultants, subsequently developed and promoted a narrative that pain was undertreated and should be made a higher priority by healthcare practitioners. Defendants began vigorously marketing long-acting Opioids as less addictive, less subject to abuse and diversion and less likely to cause tolerance and withdrawal than other pain medications.

Defendants promoted these Opioids as safe, effective and appropriate for long-term use for routine pain conditions.

136. The Suppliers and Dealers agreed among themselves to set up, develop, and fund an unbranded promotion and Supplier and Dealer network to promote the use of opioids for the management of pain in order to mislead physicians, patients, health care providers, and health care payors through misrepresentations and omissions regarding the appropriate uses, risks, and safety of opioids, to increase sales, revenue, and profit from their opioid products.

137. This interconnected and interrelated network relied on the Supplier and Dealer collective use of unbranded Supplier and Dealer materials, such as KOLs, scientific literature, CMEs, patient education materials, and Front Groups developed and funded collectively by the Supplier and Dealer Defendants intended to mislead consumers and medical providers of the appropriate uses, risks, and safety of opioids.

138. Consultants helped design marketing plans and programs that contained False and Misleading Representations and coached Supplies and Dealers on how to adopt and implement them. With the help of Consultants, Supplier and Dealer schemed to increase opioid prescriptions, sales, revenues and profits centered around the development, the dissemination, and reinforcement of nine false propositions: (1) that addiction is rare among patients taking opioids for pain; (2) that addiction risk can be effectively managed; (3) that symptoms of addiction exhibited by opioid patients are actually symptoms of an invented condition dubbed “pseudo addiction”; (4) that withdrawal is easily managed; (5) that increased dosing presents no significant

risks; (6) that long-term use of opioids improves function; (7) that the risks of alternative forms of pain treatment are greater than the adverse effects of opioids; (8) that use of time-released dosing prevents addiction; and (9) that abuse-deterrent formulations provide a solution to opioid abuse.

139. The Suppliers and Dealers knew that none of these propositions is true and that there was no evidence to support them.

140. Each Supplier and Dealer worked individually and collectively to develop and actively promulgate these nine false propositions in order to mislead physicians, patients, health care providers, and healthcare payors regarding the appropriate uses, risks, and safety of opioids.

141. What is particularly remarkable about the Suppliers and Dealers effort is the seamless method in which the Suppliers and Dealers joined forces to achieve their collective goal: to persuade consumers and medical providers of the safety of opioids, and to hide their actual risks and dangers. In doing so, the Supplier and Dealer Defendants effectively built a new – and extremely lucrative – opioid marketplace for their select group of industry players.

142. The Supplier and Dealer Defendants' unbranded promotion and Supplier and Dealer network was a wildly successful Supplier and Dealer tool that achieved Supplier and Dealer goals that would have been impossible to have been met by a single or even a handful of the network's distinct corporate members.

143. For example, the network members pooled their vast Supplier and Dealer funds and dedicated them to expansive and normally cost-prohibitive

Supplier and Dealer ventures, such as the creation of Front Groups. These collaborative networking tactics allowed each Supplier and Dealer Defendant to diversify its Supplier and Dealer efforts, all the while sharing any risk and exposure, financial and/or legal, with other Supplier and Dealer Defendants.

144. The most unnerving tactic utilized by the Supplier and Dealer Defendants' network, was their unabashed mimicry of the scientific method of citing "references" in their materials. In the scientific community, cited materials and references are rigorously vetted by objective unbiased and disinterested experts in the field, scientific method, and an unfounded theory or proposition would, or should, never gain traction.

145. Supplier and Dealer Defendants put their own twist on the scientific method: they worked together to manufacture wide support for their unfounded theories and propositions involving opioids. Due to their sheer numbers and resources, the Supplier and Dealer Defendants were able to create a false consensus through their materials and references.

146. An illustrative example of the Supplier and Dealer Defendants' utilization of this tactic is the wide promulgation of the Porter & Jick Letter, which declared the incidence of addiction "rare" for patients treated with opioids. The authors had analyzed a database of hospitalized patients who were given opioids in a controlled setting to ease suffering from acute pain. These patients were not given long-term opioid prescriptions or provided opioids to administer to themselves at home, nor was it known how frequently or infrequently and in what doses the patients were given their narcotics. Rather, it appears the patients were treated with opioids for short periods of time under in-hospital doctor supervision.

147. Nonetheless, Supplier and Dealer Defendants widely and repeatedly cited this letter as proof of the low addiction risk in connection with taking opioids in connection with taking opioids despite its obvious shortcomings. Supplier and Dealer Defendants' egregious misrepresentations based on this letter included claims that less than one percent of opioid users became addicted.

148. Supplier and Dealer Defendants' collective misuse of the Porter & Jick Letter helped the opioid manufacturers convince patients and healthcare providers that opioids were not a concern. The enormous impact of Supplier and Dealer Defendants' misleading amplification of this letter was well documented in another letter published in the NEJM on June, 1, 2017, describing the way the one-paragraph 1980 letter had been irresponsibly cited and, in some cases, "grossly misrepresented." In particular, the authors of this letter explained:

(a) [W]e found that a five-sentence letter published in the Journal in 1980 was heavily and uncritically cited as evidence that addiction was rare with long-term opioid therapy. We believe that this citation pattern contributed to the North American opioid crises by helping to shape a narrative that allayed prescribers' concerns about the risk of addiction associated with long-term opioid therapy...

149. By knowingly misrepresenting the appropriate uses, risks, and safety of opioids, the Supplier and Dealer Defendants committed overt acts in furtherance of their conspiracy.

150. Defendants targeted family physicians with marketing, who were the most likely to see patients with chronic pain conditions and least likely to have

the training necessary to be in a position to verify the Suppliers' marketing representations about the safety and effectiveness of Opioids.

151. Defendants spent hundreds of millions of dollars to "educate" doctors on the use of Opioids for treating chronic pain over the long term and stated that the risk of addiction was less than one percent. Purdue, the company behind OxyContin, had a yearly promotional budget of \$14 million in Canada for its Opioid Products. In 2016, Purdue gave Canadian doctors more than \$2 million as part of marketing efforts - double the amount per capita that the drug company gave to prescribers in the US.

152. Defendants' marketing campaigns also targeted students training to enter the medical profession. Inaccuracies and false claims were disseminated in print advertisements in medical journals, such as the Canadian Medical Association Journal, which is mailed to almost every physician in Canada.

153. The aggressive marketing efforts of the Suppliers were incredibly successful. there was a dramatic increase in prescriptions of both long-acting and short-acting Opioids in Canada, including for treatment of chronic pain. Defendants' conduct created a public health crisis and a public nuisance.

154. The Defendants promoted, and profited from, their misrepresentations about the risks and benefits of opioids for chronic pain even though they knew that their marketing was false and misleading. The history of opioids, as well as research and clinical experience over the last 20 years, established that opioids were highly addictive and responsible for a long list of very serious adverse outcomes. Health Canada and other regulators warned Defendants of these risks. The Defendants had access to scientific studies,

detailed prescription data, and reports of adverse events, including reports of addiction, hospitalization, and deaths-all of which made clear the harms from long-term opioid use and that patients are suffering from addiction, overdoses, and death in alarming numbers. More recently, Health Canada, the FDA and CDC issued pronouncements based on existing medical evidence that conclusively expose the known falsity of these Defendants' misrepresentations.

155. The marketing scheme to increase opioid prescriptions centered around nine categories of misrepresentations. Suppliers disseminated these misrepresentations through various channels, including through advertising, sales representatives, purportedly independent organizations these defendants funded and controlled, "Front Groups," so-called industry "Key Opinion Leaders," and Continuing Medical Education ("CME") programs.

156. Suppliers' misrepresentations fall into the following nine categories:

- (a) The risk of addiction from chronic opioid therapy is low.
- (b) To the extent there is a risk of addiction, it can be easily identified and managed.
- (c) Signs of addictive behavior are "pseudoaddiction," requiring more opioids.
- (d) Opioid withdrawal can be avoided by tapering.
- (e) Opioid doses can be increased without limit or greater risks.
- (f) Long-term opioid use improves functioning.
- (g) Alternative forms of pain relief pose greater risks than opioids.
- (h) OxyContin provides twelve hours of pain relief.
- (i) New formulations of certain opioids successfully deter abuse.

157. Each of these propositions was false. Suppliers knew this, but they nonetheless set out to convince physicians, patients, and the public at large of the truth of each of these propositions in order to expand the market for their opioids.

158. The categories of misrepresentations are offered to organize the numerous statements the Suppliers made and to explain their role in the overall marketing effort, not as a checklist for assessing each Supplier's liability. While each Supplier deceptively promoted their opioids specifically, and, together with other Suppliers, opioids generally, not every Supplier propagated (or needed to propagate) each misrepresentation.

159. Each Suppliers' conduct, and each misrepresentation, contributed to an overall narrative that aimed to--and did--mislead doctors, patients, and payors about the risk and benefits of opioids. While this claim endeavors to document examples of each Supplier's misrepresentations and the manner in which they were disseminated, they are just that-examples.

160. To falsely promote their opioids, the Suppliers paid and cultivated a select circle of doctors who were chosen and sponsored by the Suppliers for their supportive messages. As set forth below, pro-opioid doctors have been at the hub of the Suppliers' well-funded, pervasive marketing scheme since its inception and were used to create the grave misperception that science and respected medical professionals favored the broader use of opioids. These doctors include Dr. Russell Portenoy and Dr. Lynn Webster, as set forth in this section, as well as Dr. Perry Fine and Dr. Scott Fishman (hereinafter "KOLs").

161. In return for their pro-opioid advocacy, the Suppliers' KOLs received money, prestige, recognition, research funding, and avenues to publish. For example, Dr. Webster has received funding from Endo, Purdue, and Cephalon. Dr. Fine has received funding from Janssen, Cephalon, Endo, and Purdue.

162. Continuing Medical Education courses ("CMEs") were offered to doctors. Doctors are required to attend a certain number and, often, type of CME programs each year as a condition of their licensure. These programs are delivered in person, often in connection with professional organizations' conferences, and online, or through written publications. Sometimes, Canadian doctors would travel to the US to attend these conferences, and sometimes they were delivered locally. Doctors rely on CMEs not only to satisfy licensing requirements.

163. The Suppliers engaged in widespread advertising campaigns touting the benefits of their branded drugs. The Suppliers published print advertisements in a broad array of medical journals, ranging from those aimed at specialists.

164. The Suppliers also targeted consumers in their advertising. They knew that physicians are more likely to prescribe a drug if a patient specifically requests it. They also knew that this willingness to acquiesce to such patient requests holds true even for opioids and for conditions for which they are not approved.

165. Suppliers also aggressively promoted opioids through "unbranded advertising" to generally tout the benefits of opioids without specifically naming a particular brand-name opioid drug. Instead, unbranded advertising is usually

framed as "disease awareness"-encouraging consumers to "talk to your doctor" about a certain health condition.

166. Defendants created a body of false, misleading, and unsupported medical and popular literature about opioids that (a) understated the risks and overstated the benefits of long-term use; (b) appeared to be the result of independent, objective research; and (c) was likely to shape the perceptions of prescribers, patients, and payors. This literature served marketing goals, rather than scientific standards, and was intended to persuade doctors and consumers that the benefits of long-term opioid use outweighed the risks.

167. Suppliers specifically targeted their marketing at three vulnerable populations-the elderly, veterans and First Nations. Suppliers necessarily expected a return on the enormous investment they made in their deceptive marketing scheme and worked to measure and expand their success. Their own documents show that they knew they were influencing prescribers and increasing prescriptions. Studies also show that in doing so, they fueled an epidemic of addiction and abuse.

168. Endo, for example directed the majority of its marketing budget to sales representatives-with good results: 84% of its prescriptions were from the doctors they detailed. Moreover, as of 2008, cancer and post-operative pain accounted for only 10% of Opana ER's uses; virtually all of Endo's opioid sales-and profits-were from a market that did not exist ten years earlier.

169. Independent research demonstrates a close link between opioid prescriptions and opioid abuse. For example, a 2007 study found "a very strong correlation between therapeutic exposure to opioid analgesics, as measured by

prescriptions filled, and their abuse." It has been estimated that 60% of the opioids that are abused come, directly or indirectly, through physicians' prescriptions. There is a parallel relationship between the availability of prescription opioid analgesics through legitimate pharmacy channels and the diversion and abuse of these drugs and associated adverse outcomes. The opioid epidemic is "directly related to the increasingly widespread misuse of powerful opioid pain medications."

170. Suppliers agreed among themselves to set up, develop, and fund an unbranded promotion and marketing network to promote the use of opioids for the management of pain in order to mislead physicians, patients, health care providers, and health care payors through misrepresentations and omissions regarding the appropriate uses, risks, and safety of opioids, to increase sales, revenue, and profit from their opioid products.

171. This interconnected and interrelated network relied on the Suppliers collective use of unbranded marketing materials, such as KOLs, scientific literature, CMEs, patient education materials, and Front Groups developed and funded collectively by the Suppliers intended to mislead consumers and medical providers of the appropriate uses, risks, and safety of opioids.

172. The Suppliers collective marketing scheme to increase opioid prescriptions, sales, revenues and profits centered around the development, the dissemination, and reinforcement of nine false propositions: (1) that addiction is rare among patients taking opioids for pain; (2) that addiction risk can be effectively managed; (3) that symptoms of addiction exhibited by opioid patients are actually symptoms of an invented condition dubbed "pseudo addiction"; (4) that withdrawal is easily managed; (5) that increased dosing

presents no significant risks; (6) that long-term use of opioids improves function; (7) that the risks of alternative forms of pain treatment are greater than the adverse effects of opioids; (8) that use of time-released dosing prevents addiction; and (9) that abuse-deterrent formulations provide a solution to opioid abuse. Suppliers knew that none of these propositions is true and that there was no evidence to support them.

173. Each Supplier worked individually and collectively to develop and actively promulgate these nine false propositions in order to mislead physicians, patients, health care providers, and healthcare payors regarding the appropriate uses, risks, and safety of opioids.

174. In addition, and on an even broader level, all Defendants took advantage of the industry structure, including end-running its internal checks and balances, to their collective advantage. Defendants agreed among themselves to increasing the supply of opioids and fraudulently increasing the quotas that governed the manufacture and supply of prescription opioids. Defendants did so to increase sales, revenue, and profit from their opioid products.

175. The interaction and length of the relationships between and among the Defendants reflects a deep level of interaction and cooperation between Defendants in a tightly knit industry. Suppliers and Dealers were not two separate groups operating in isolation or two groups forced to work together in a closed system. The Defendants operated together as a united entity, working together on multiple fronts, to engage in the unlawful sale of prescription opioids.

176. Defendants collaborated to expand the opioid market in an interconnected and interrelated network in the following ways, as set forth more fully below and in section below, including, for example, membership in the Healthcare Distribution Alliance ("HDA").

177. Defendants knew that their own conduct could be reported by other Defendants and that their failure to report suspicious orders they filled could be brought to the attention of authorities. As a result, Defendants had an incentive to communicate with each other about the reporting or suspicious orders to ensure consistency in their dealings with authorities.

### **C. Negligence**

#### **1. Duty**

178. Dealers owed Canadian municipalities a duty of care to take reasonable steps to prevent the Diversion of Opioids in their communities, including to:

- (a) know the ‘client’ in the community who placed the order for Opioids;
- (b) monitor for Unusual Orders;
- (c) detect and identify potentially Unusual Orders;
- (d) further investigate potentially Unusual Orders;
- (e) refuse or reject Unusual Orders; and
- (f) report Unusual Orders to Health Canada and Diversion-related activity (including theft and unusual loss of Opioids) to local police forces.

179. Opioids diverted from one community were frequently found in others and found their way to interprovincial drug traffickers who transported and sold diverted drugs in other provinces.

180. Abatement Costs were a reasonably foreseeable consequence of the breach

of Dealers' duty of care. Dealers could access detailed Opioids prescription and sales data, broken down by postal code, Institution, prescriber, and patient. In addition to their own record keeping obligations described in the next paragraph:

(a) Data Vendors could provide Dealers with national, provincial, regional, and local prescriber- and patient-level data that allowed to track healthcare practitioner prescribing patterns and Opioids sales. Such information would allow Dealers to view, analyze, compute, and track all Opioids sales to Institutions, including those of their competitors.

(b) Data Vendors could provide Dealers with charts analyzing the weekly Opioids prescribing patterns of physicians and the purchases of Opioids by Institutions from each Dealer, organized by municipality.

181. Dealers were in a relationship of proximity to Canadian municipalities.

(a) The *Controlled Drugs and Substances Act*, SC 1996, c 19 was intended to prevent Diversion in Canadian communities. Dealers were required to maintain effective controls against Diversion and to design and operate a system to identify, report, and halt Unusual Orders.

(b) Dealers were required to register as licensed dealers of Opioids under the *Narcotics Control Regulations*, CRC, c-1041, s 10 and to:

(c) keep records of quantities of Opioids provided or sold and the name and address of the purchaser (s 28.1);

(d) record the names of the healthcare practitioner who prescribed the Opioid and the patient who filled the prescription in pharmacies operated by Dealers (ss 38-39);

(e) take necessary measures to ensure the security of any Opioids in their possession (s 27);

(i) report suspicious transactions related to Diversion (s 27.3); and

(ii) promptly report any loss or theft of Opioids (s 27.1).

## **2. Breach**

182. Each Dealer breached its statutory duties and, in doing so, breached its duty of care. Each Dealer:

(a) did not have adequate “know your client” questionnaires, information intake systems, and verification standards. In particular, they obtained inadequate information about

(i) the number of individuals, Institutions, and prescribing health care practitioners in their clients’ communities;

(ii) the names and locations of healthcare practitioners and patients whose prescriptions their clients filled,

(iii) the number of patients to whom their clients provided Opioids,

(iv) alternative Dealers from whom their clients purchased Opioids,

(v) the number of Opioids their clients historically ordered, and

(vi) the number of Opioids that were in their clients’ inventories.

(b) had inadequate record-keeping and computer systems to monitor for Unusual Orders;

(c) disregarded information they obtained that indicated potentially Unusual Orders;

(d) did not act upon such information to further investigate potentially Unusual Orders;

(e) filled orders that, with the exercise of reasonable care, would have been determined to be Unusual Orders; and

(f) did not report Unusual Orders to Health Canada and law enforcement, and did not cooperate with local police forces to investigate and prosecute Diversion-related activities.

183. In breach of its duty of care, each Dealer sold unreasonable amounts of Opioids to Institutions and Individuals in each Canadian municipality.

### **3. Causation of Harm**

184. Because each Dealer and Pharmacy breached its duty of care, Canadian municipalities experienced an Opioid Crisis that cause, in whole or in part, among other things, damage to municipal property, Abatement Costs, a reduction in real property values that resulted in lost tax revenue, and trespass and nuisance-type injury.

#### **C. Nuisance**

185. Suppliers' False and Misleading Representations, and Dealers' and Pharmacies' failure to detect and deter Unusual Orders and prevent diversion of its sales, caused or contributed to the Opioid Crisis, and endangered and unreasonably interfered with the lives, safety, and health of the residents of Canadian municipalities. <sup>^</sup> The Plaintiffs claim the reasonable costs of abating the Opioid Crisis.

186. The Opioid Crisis has caused homelessness, trespasses, interference with public and private property and access thereto, and overall substantial and unreasonable interference with use, enjoyment and comfort of convenience, without limiting the foregoing, of lands, public transit, parks, roadways and other public facilities and property or an interest therein, causing both a loss of use and of amenity. Without limitation to the forgoing, such activity has caused unreasonable interference with the public's interest in questions of health, safety, morality and convenience. The foregoing constitutes both a Private and

a Public Nuisance.

187. The foregoing has caused the Plaintiffs special damages, economic loss and damage to its property. This includes damage to parks, transit stops and transit vehicles, roadways, rights of ways and buildings.

188. This interference for example has caused ridership and use of public transit to be reduced, thereby causing, for example, transit systems to be underutilized to the point that the viability of expansion of same to serve all communities has changed, making levels of planning to be undermined and reimagined, at significant cost. There have been transit projects costing millions of dollars having to be redirected or abandoned, causing significant loss and damage. Reduced ridership of transit also causes congestion on the roads, and increases in green house gases – again at a cost to the Plaintiffs.

189. The public nuisance-i.e., the opioid epidemic--created, perpetuated, and maintained by Defendants can be abated and further recurrence of such harm and inconvenience can be abated by, inter alia,

(a) educating prescribers (especially primary care physicians and the most prolific prescribers of opioids) and patients regarding the true risks and benefits of opioids, including the risk of addiction, in order to prevent the next cycle of addiction;

(b) providing addiction treatment to patients who are already addicted to opioids; and

(c) making naloxone widely available so that overdoses are less frequently fatal.

190. It is the manufacturer of a drug that has primary responsibility to assure

the safety, efficacy, and appropriateness of a drug's labeling, marketing, and promotion. All companies in the supply chain of a controlled substance are primarily responsible for ensuring that such drugs are only distributed and dispensed to appropriate patients and not diverted. These responsibilities exist independent of any Health Canada regulation, to ensure that their products and practices meet both federal and provincial consumer protection laws and regulations. As registered manufacturers and distributors of controlled substances, Defendants are placed in a position of special trust and responsibility and are uniquely positioned, based on their knowledge of prescribers and orders, to act as a first line of defense.

### III. RELIEF

191. On behalf of Canadian municipalities, the Plaintiffs therefore claim against the Defendants, jointly and severally:

- (a) compensatory, aggravated, and punitive damages;
- (b) general damages to include time, energy and planning, coordinating and execution, of programs and reactions to Homelessness, addiction reduction and treatment, policing and enforcing the law, lost morale and employee confidence, safety and participation, in the Billions of Dollars Canada wide;
- (c) special damages in an amount to be proved at trial, and include direct and indirect loss of and damage to property, expense incurred to remediate the Opioid crisis, in part as described herein and as Abatement Costs
- (d) future Abatement Costs;
- (e) interest; and
- (f) costs.

DATED this 3rd day of December, 2024.



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**Schedule “A”**

*Additional Definitions Employed in This Claim*

**“Abatement Costs”** were and are municipal expenditures from 1996 that were associated with opioid abuse, addiction, overdoses, and withdrawal that Canadian municipalities would not have incurred but for the Defendants’ breaches of duties described herein, including (but not limited to) costs of:

- (a) police, emergency, fire, health, prosecution, rehabilitation, and other services related to crime, social disturbances, domestic violence, and Opioid overdoses;
- (b) emergency paramedic services, including pre-hospital care and hospital transportation to municipal residents and occupants suffering from Opioid addiction and overdose;
- (c) purchasing methodone, naloxone, and Opioids to provide to opioid addicts as a medically appropriate emergency response;
- (d) cleanup and surveillance of public streets, parks, and private residences for illicit Opioids-related activity;
- (e) emergency shelter and low income housing for the homeless;
- (f) public health programs established to respond to the Opioid Crisis;
- (g) services for families impacted by Opioid addiction and abuse;
- (h) community outreach and education workshops;
- (i) opioid addict behavioural modification services, including opioid abuse therapy, harm reduction, and overdose prevention services to opioid addicts within the community; and
- (j) salaries for personnel to staff Opioid response departments.

**“Data Vendors”** are information data companies, including ArcLight, Health Information Services, Health Science, IMS Health, IQVIA, McKesson, NDS Pharmaceutical Data Services, Scriptline, SDI Health, Source Healthcare Analytics, Verispan, Wolters Kluwer, and their predecessors and successors.

**“Diversion”** is the acquisition and use of Opioids for other than legitimate medical, scientific, and industrial uses by individuals within Canadian municipalities who were not prescribed Opioids, including children, criminals, and opioid addicts.

**“Institutions”** include hospitals (including cancer and non-cancer treatment facilities), medical offices and clinics (general practices and pain- specialists), and pharmacies in Canadian municipalities.

**“Opioid Crisis”** was and continues to be a social epidemic in Canadian municipalities of widespread inappropriate and unnecessary prescribing of Opioids, including for non-indicated uses, and consequent opioid abuse, addiction, Diversion, and overdose fatalities, and associated conduct including property use conversion and increased crime (prostitution and personal and property crime to provide opioid addicts with money to buy more Opioids), and was and is a public nuisance.

**“Unusual Orders”** were orders of Opioids originating from Institutions in Canadian municipalities that were unreasonably excessive in frequency or volume based on the population and number of Institutions in the municipality and deviations from the Institution’s historical orders, and include “suspicious transactions” under the *Narcotics Control Regulations*, CRC, c 1041.

#### **NOTICE TO THE DEFENDANTS**

You only have a short time to do something to defend yourself against this claim:

- 20 days if you are served in Alberta
- 1 month if you are served outside Alberta but in Canada
- 2 months if you are served outside Canada.

You can respond by filing a *Statement of Defence* or a *Demand for Notice* in the office of the clerk of the Court of King’s Bench at Calgary, Alberta, AND serving your *Statement of Defence* or a *Demand for Notice* on the Plaintiffs’ address for service.

#### **WARNING**

If you do not file and serve a *Statement of Defence* or a *Demand for Notice* within your time period, you risk losing the law suit automatically. If you do not file, or do not serve, or are late in doing either of these things, a Court may give a judgment to the Plaintiff against you.

