Exhibit R

Message

From: Christen Tingley [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=4BB5885F6E8F42A7B576AF732D67A3C2-CHRISTEN TI]
Sent: 12/20/2017 6:02:00 PM
To: William.Shank@pharma.com; David.Rosen@pharma.com
CC: Anna Draganova [/o=exchangelabs/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=5af5aa9cb15b47138add6a8cbb319281-anna dragan]; Laura Moran [cn=laura moran/ou=nje/ou=northamerica/o=mckinsey]; Arnab Ghatak [cn=arnab ghatak/ou=nje/ou=northamerica/o=mckinsey]; Alice Zheng [cn=alice zheng/ou=svo/ou=northamerica/o=mckinsey]; Emma Kemble [cn=emma kemble/ou=nje/ou=northamerica/o=mckinsey]
Subject: Document synthesis
Attachments: 2017 12_Synthesis of documents_vf.pptx; 20171219 Value story 3.0 vDraft_Condensed.pptx; 20171219 Value story 3.0 vDraft_Full.pptx; 2017 12_Innovative Contracting Synthesis_vF.pptx; 20171214_Task Force_vf.pptx; 2017 12_Ad hoc support synthesis_vf.pptx

Hi Bill and David,

Thank you for making the time to catch-up yesterday. Attached please find a synthesis of the documents from our work together.

Attached you'll find:
+ **Synthesis of documents**: This is document we reviewed yesterday that includes an overview of the documents attached
+ **Payor value prop 3.0**: Attached is the short and the long version of the draft payor value story. [Long version as was submitted to MRL. We included stickies where Helmut had a few additional points of feedback yesterday that can be considered in context of MRL feedback in January]
+ **Innovative Contracting synthesis:** Compendium of innovative contracting documents
+ **Task Force synthesis:** Latest project management documents from Thursday task force meetings
+ **Ad hoc support synthesis**: Compilation of documents to support ad hoc requests

As always, please reach out with questions.

Happy holidays,
Christen

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High impact interventions to rapidly address market access challenges

Innovative Contracts
DRAFT

December 2017

Privileged: This presentation contains draft proposals for discussion by Management and are subject to appropriate Purdue legal and regulatory review before they can be considered final. These materials are confidential and proprietary.

DRAFT

Contents

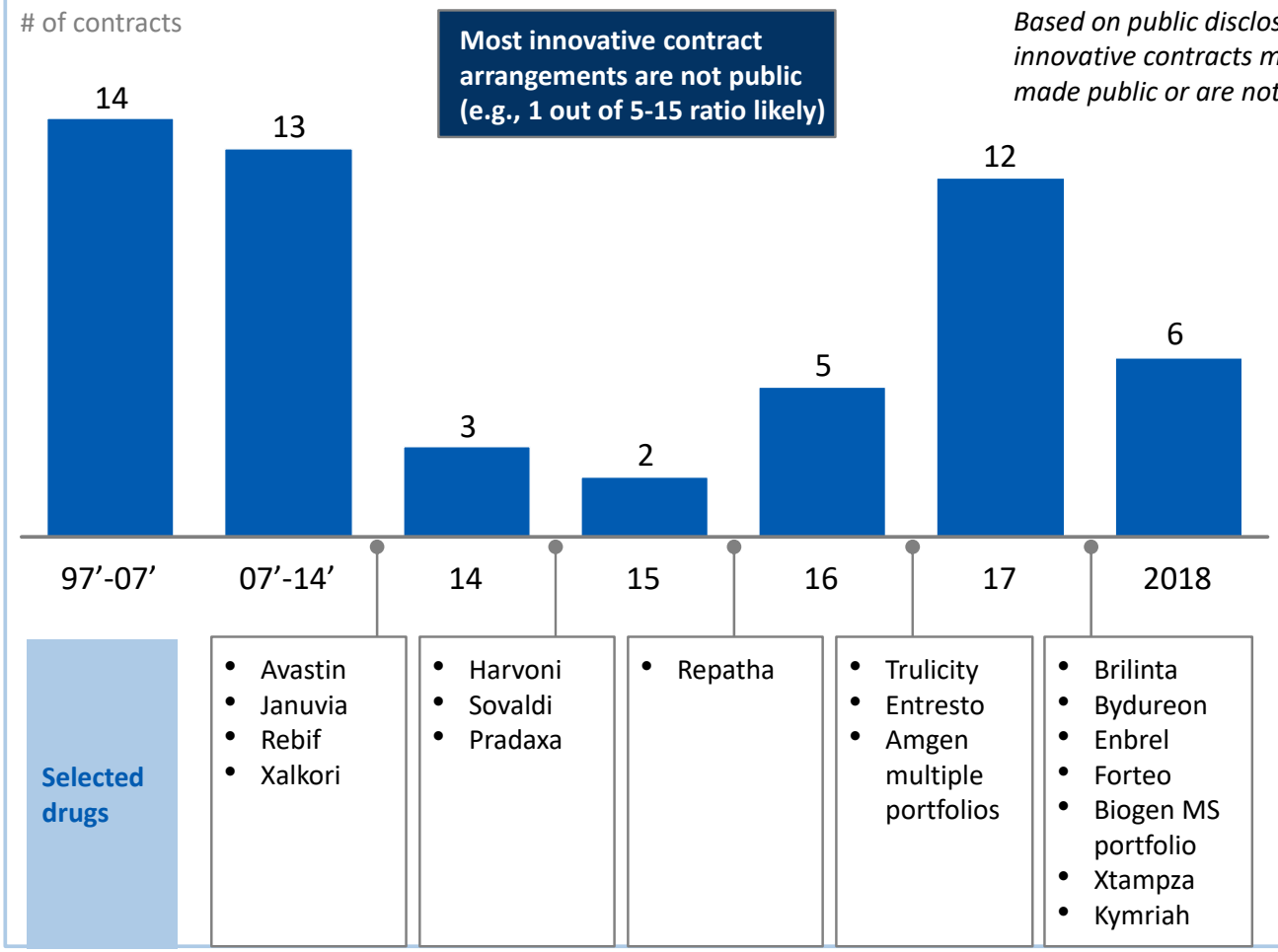
- Overall innovative contracting landscape in the U.S.
- Overall comparison of innovative contracting options
- Details on MME contract baselining
- Details on Event-Based contract baselining
- Details on Per Member Per Month contract baselining

Innovative contracting: early insights

1 What type of contracts are used today, how often and when?	• While innovative contracts are becoming more visible in the U.S., the overall numbers remain low. That being said, **most innovative contracts today are not made public**. • In the past, value contracts were concentrated in a few therapeutic areas – Oncology, hematology, CV, RA. Recently, they are becoming a **common lever for newly launched drugs and in specialty, high-value brands**
2 How are other pharmacos approaching this?	• Two broad types of contracts – **predictability and outcomes-based** – are most common, though there is a wide spectrum of experimentation. • Leading players have a small, easy to communicate **"menu of innovative offerings"** (usually 2-3 options with clear terms that can be communicated in a page each)
3 How are payors/PBMs thinking about them?	• Payors/ PBMS think about this arrangement in terms of **type of risk** (e.g., budgetary, off-label use, dosage, etc) • **Not all payors/PBMs have same appetite.** Cigna and Harvard Pilgrim have been most public about use; of the PBMs, CVS most open; CMS increasingly interested to pursue • **Barriers** for execution are still high – too complex, infrastructure not solid, hard to track
4 What makes sense for Purdue?	• We see **3 main objectives for Purdue** in completing an innovative contract: (1) maintain formulary position/ avoid exclusion, (2) align incentives with payors to address the opioid crisis, and (3) demonstrate publicly its strong commitment • As we consider what type of innovative contract may make sense, it's also important to consider which type of account would make a good partner for this type of contract

1 Overall numbers of innovative contracts in the U.S. remain low but most are not made public

We reviewed 200 publicly available contracts globally since 1994, and found 55 in the U.S.



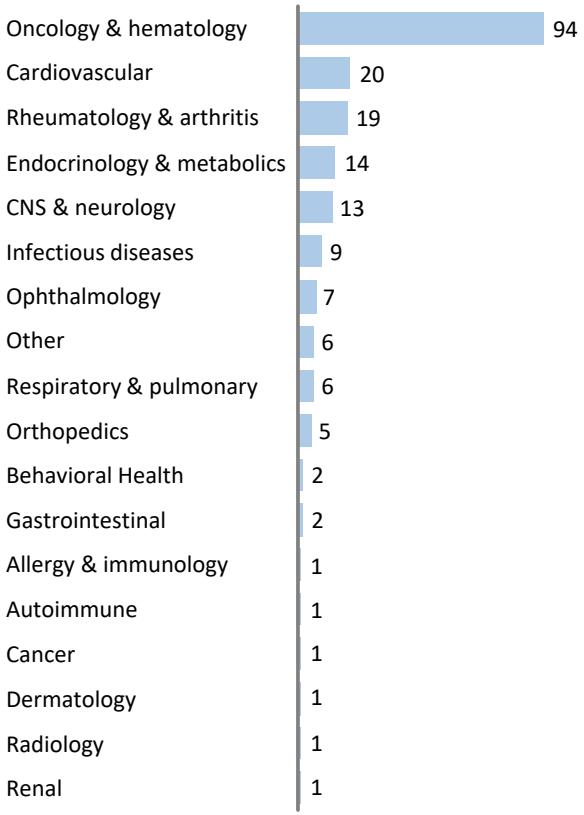
- **Innovative contracts haven't "moved the needle" at scale**
- **However, manufacturers are not always public with such arrangements**

Source: McKinsey Innovative Contracting Database

1 Recently, innovative contracts are a common lever for new launches and "high-budget" brands

Historically, innovative contracts have been concentrated in a few therapeutic areas

# of public contracts executed since 1994 globally[1]



Recently, they are becoming a common lever for newly launched drugs and in specialty, high-value brands[2]

	Partners	Product	Contract type	TA	Size of TA (PMPY)[2]
2015	GILEAD + Cigna	HARVONI (ledipasvir/sofosbuvir)	Based on sustained virologic response	Hepatitis C	$25
2016	NOVARTIS + Cigna + Aetna	Entresto (sacubitril/valsartan) tablets	Based on specific goals to reduce hospitalizations	Heart disease	$35
2017	AMGEN + Harvard Pilgrim HealthCare	Enbrel etanercept	Based on patient compliance, switching / adding drugs, dose escalation, etc.	Inflammatory conditions	$120
2017	AMGEN + Harvard Pilgrim HealthCare	Repatha (evolocumab)	Based on whether Rx expenditure passes a threshold	Heart disease	$35
2017	NOVARTIS + CMS	KYMRIAH (tisagenlecleucel)	Based on pediatric / young adult ALL patients response to Kymriah	Oncology	$60

1 McKinsey analyzed over 200 publicly available contracts

SOURCE: 2016 ESI Drug Trend Report; Pain/inflammation spend is $52 PMPY

2 Predictability and outcomes-based contracts most commonly used for an innovative arrangement

Likely highest priority for Purdue

Spectrum of contracting/ pricing options used in the industry today – not exhaustive set of examples

More Creative

Less Creative

Pricing Options

REGENERON

SANOFI

DUPIXENT

- "Price reset" with no future rebating
- Flat pricing for all products in portfolio
- Disclosure of gross-to-net prices
- Declared limits / stoppage on price increases

Standard rebates

Johnson & Johnson

Remicade INFLIXIMAB

- Portfolio-level rebates
- Brand-specific rebates
- Free stock

Performance-based Rebates

Cigna Aetna

NOVARTIS Entresto

Cigna

GILEAD HARVONI

- Brand-specific market share based rebates
- Brand-specific volume based rebates

Baxter

HyQvia

Predictability Contracts

- "Subscription" models (PMPM population based)
- Patient time-based (e.g., annual) cost caps
- Patient-level total cost caps
- Case-rate pricing
- Population based Volume/revenue caps

Harvard Pilgrim HealthCare

AMGEN Repatha

Outcomes-based Contracts

- Discounts based on total cost of care
- Discounts linked to rates of medical interventions
- Discounts linked to clinical endpoint performance
- Efficacy guarantee for "non-responders"
- Discounts based on operational outcomes (e.g., adherence based)

NOVARTIS

CMS

KYMRIAH (tisagenlecleucel)

Simple ← → More Complex

Contract details can be found in appendix

Source: McKinsey analyzed over 200 publicly available contracts

2 Leading players have a small, easy to communicate "menu of innovative offerings"

Companies most outspoken/ public about use of innovative contracts

Company	Brands in contract[1]	Count of contract since '94
NOVARTIS	Entresto,Gilenya Kisqali, Kmyriah	7
AMGEN	Enbrel, Repatha	6
SANOFI	Actonel, Eloxatin, Praluent	5
MERCK	Januvia, Janumet, Zocor	5
Pfizer	Xalkori	5
AstraZeneca	Brilinta, Bydureon	3

Blinded example of "tear sheets"

Per member per month (PMPM) Guarantee	Event-based rebate	Core metric success rebate
Extra rebate when PMPM exceeds pre-agreed levels	Extra rebate on all units used by patients with occurring event[1]	Staged rebate levels based on patient reaching certain levels of a core metric
Level 1: 5% rebate	Level 1: 6% rebate	5% rebate when metric <20%
Level 2: 7% rebate	Level 2: 8% rebate	6% rebate when metric ≥18%

[1]Disclaimers: Need to be on drug for at least 6 months, no pause, event is defined as X

1 Non-exhaustive

SOURCE: Source: McKinsey Contracting Database

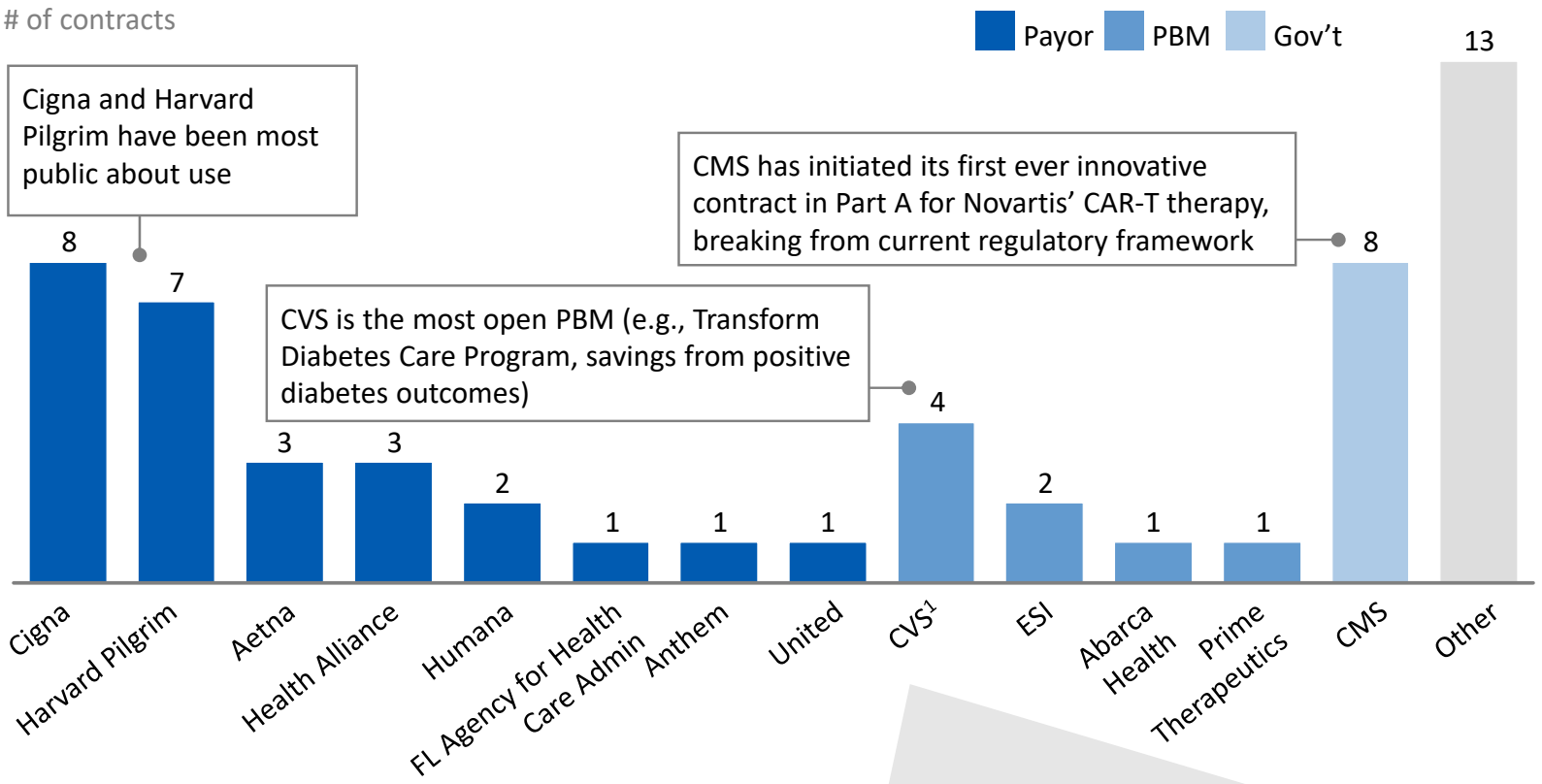
3 PBMs/Payors think about this arrangements in terms of risk

Least applicable
Most applicable

Risks		Applicability to opioids
Budgetary risk	Adoption of a new drug may surpass the payor's expectations and result in a budget shortfall	
Outcome risk	The drug may be ineffective in certain patients	
Dosage risk	Some patients may require higher-than-expected doses to benefit from the drug, or they may need escalating doses if resistance to the drug develops	
Over-utilization risk	The drug may be prescribed in inappropriately high doses or for subgroups of patients who are unlikely to benefit from it	
Off-label risk	The drug may be prescribed for indications or situations (e.g. tooth removal) that are not appropriate	
Adherence risk	The drug's efficacy may be lowered if patients do not comply with their prescribed treatment or do not continue to adhere to that treatment over time	
Safety risk	In some patients, the drug may produce moderate or severe complications that require additional treatment and thus increase the payor's costs	

3 Not all payors have the same appetite for innovative contracts

Published value-based contracts in the U.S. since 1994



"We are exploring new ways to share risk with pharmaceutical manufacturers to ensure that our clients are getting the most possible value from their drug spend by more closely linking the net cost of drugs to the outcomes that those drugs deliver" – CVS Health, Mar 2017

Source: McKinsey Innovative Contracting Database

3 Cigna has historically generally preferred outcomes-based contracts

Outcome-based: Rebate adjustment based on A1c level decrease in patients taking oral anti-diabetic medications and patient adherence

MERCK INVENTING FOR LIFE
Januvia (sitagliptin)
JANUMET®

Outcome-based: Rebate adjustment based on medication adherence ranges and patients with MS being relapse-free

EMD SERONO
Rebif (interferon beta-1a) subcutaneous injection

Outcome-based: Payment structured around sustained virologic response results (at 12 weeks)

GILEAD
HARVONI ledipasvir/sofosbuvir
SOVALDI SOFOSBUVIR 400 mg TABLETS

Outcome-based: Rebate adjustment based on reduced hospitalization/ replication of results

Aetna
NOVARTIS
Entresto™ (sacubitril/valsartan) tablets

April 2009 — April 2011 — Feb 2015 — Feb 2016 — May 2016 — Oct 2017

Outcome-based: Payment structured around clinical outcomes

Aetna
NOVARTIS
GILENYA (fingolimod) capsules 0.5mg

Outcome-based: Payment structured around reduction in LDL-C levels to those seen in clinical trials

AMGEN
Repatha (evolocumab) injection 140 mg/mL

Outcome-based: Payment structured around reduction in LDL-C levels to levels seen in clinical trials

SANOFI
REGENERON
Praluent (alirocumab) Injection
THE FALL OF HIGH CHOLESTEROL

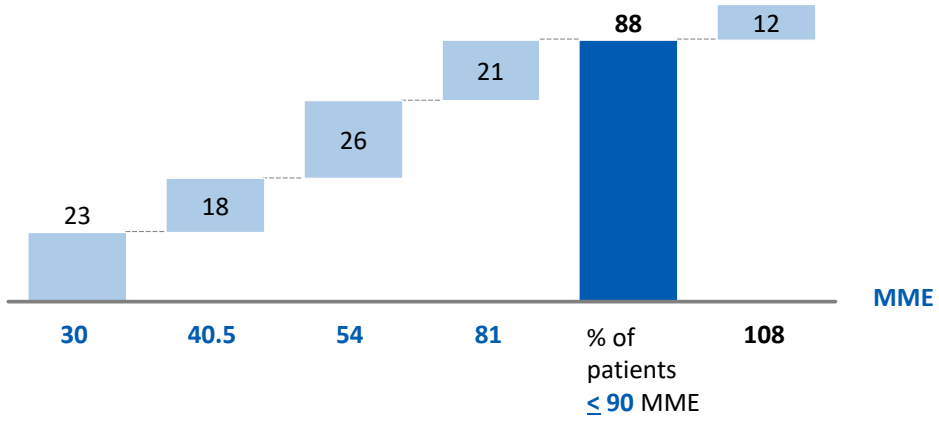
Predictability-based: Payment structured around MME cost caps on opioid

COLLEGIUM Pharmaceutical
Xtampza ER (oxycodone) EXTENDED-RELEASE CAPSULES

3 Example: Cigna's contract with Collegium - Predictability contract structured around MME dosing caps, carrying low risk

Contract type	• Predictability
Structure	• MME dosing cap (potentially 90 MME)[1] – Collegium will reduce cost if average daily dose exceeds a threshold
Objective	• Addresses opioid abuse? – Yes
Additional components	• Cigna builds opioid prescribing profiles of physicians and ACOs and sends that information to doctors so they can see how they compare with their peers, enabling increased transparency and incentives for dosage reduction

% of Rx scripts at various MME dosages of Xtampza (assumes twice a day dosing)[1]



Only ~12% of Xtampza's scripts are at risk

- **Feasibility is high** due to
  - Ease of identifying patients: All Extampza ER patients are in scope
  - Ease of tracking data: Data is tracked through claims, and these capabilities already exist
  - Data trustworthiness: Both Collegium and Cigna believe in accuracy of claims data
- **Incentives are aligned**
  - This contract aligns incentives related to dose reduction and the resulting incidence-of-addiction reduction
- **Value was exchanged, and realized by payor**
  - Since Purdue offered Cigna a 30% rebate, we can assume Collegium offered more
  - Contract creates financial incentives for the drug maker to encourage doctors to prescribe doses lower than 90MME

"Do I think this is going to have a significant impact on overdose deaths? No, I don't see how this step would do that"

– VP of community relations at Novus Medical Detox Center

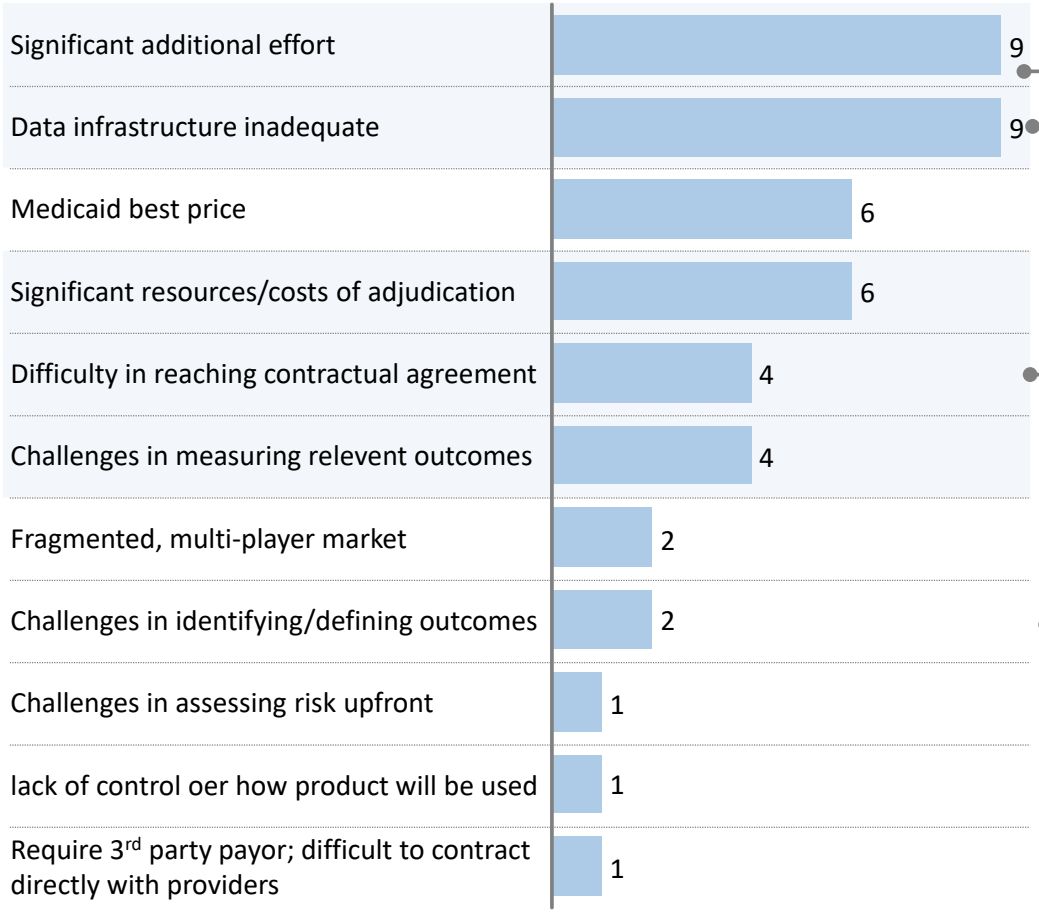
1 According to Purdue word-of-mouth Source: IMS data

3 Barriers for execution remain high in the eyes of payors/ PBMS

Detail on next page

Top barriers cited in the use of risk-sharing agreements in the US

Participant responses, n=15



*"It can take the same amount of **time to do 1 innovative contract** as it would **to do 2 or 3 standard contracts**." (Director Specialty Pharma, PBM)*

***Getting the data is not easy**, but it is doable, at least in the places where we have integrated medical systems. (VP, US Payor)*

***"Complexity involved in these agreements ends up killing the conversation."** (US Payor)*

*Our conversations **didn't hit the point of talking about outcomes** or pay for performance." (US Payor)*

Source: Payor, PBM interviews, Garrison, Louis P., Jr. "Private Sector Risk-Sharing Agreements in the United States: Trends, Barriers, and Prospects."American Journal of Managed Care (2015)

4 We see three main objectives for Purdue in completing an innovative contract

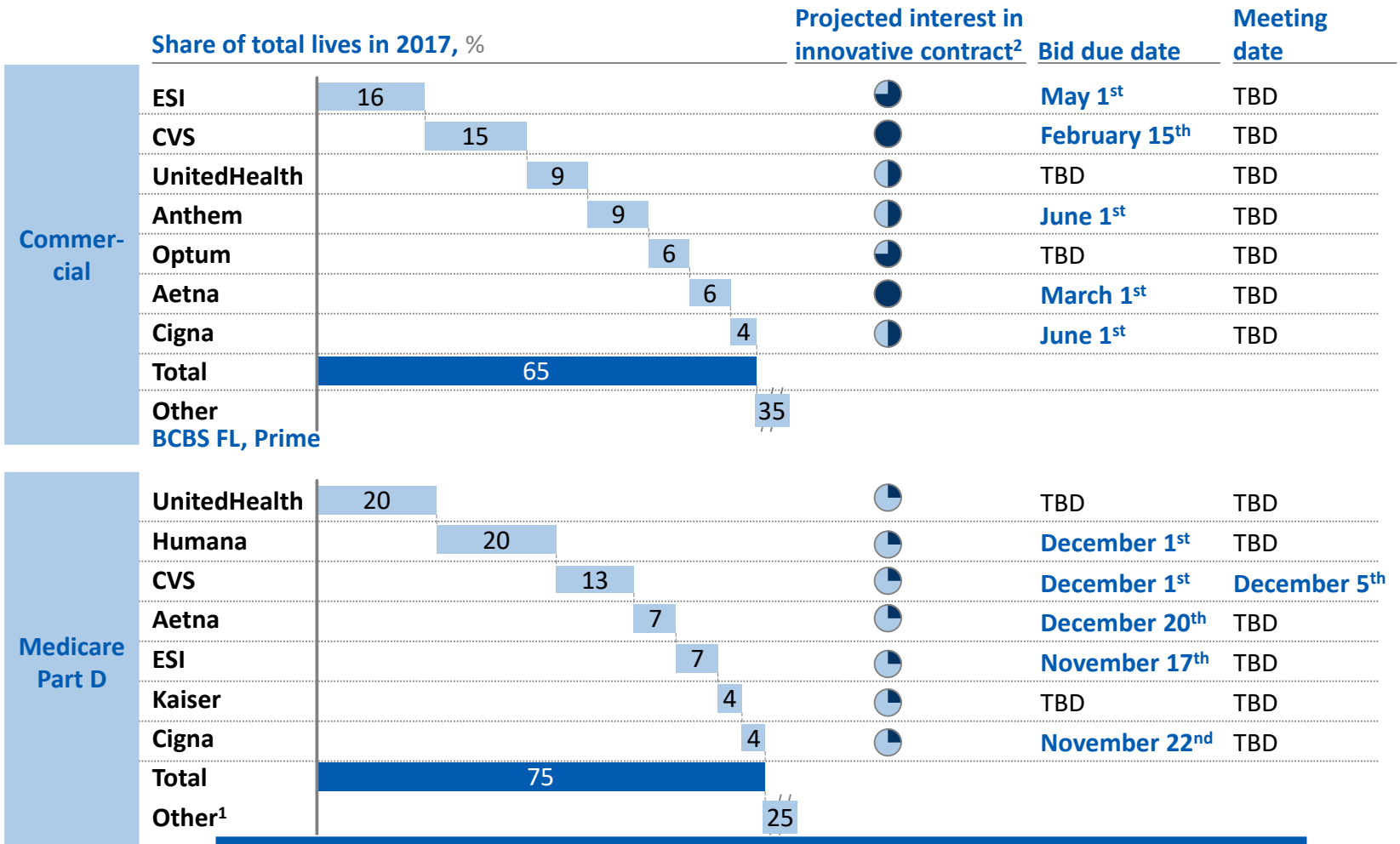
Proposed Purdue objective

	Usual pharmaco objectives	Opportunity
"Hard benefits" (easier to quantify)	**Resolve differences** in perceived value	• Improve reimbursement of product when highly confident of outcomes
	Realize premium for **predictability**	• Tailor reimbursement to give partner confidence in payment risk
	Create competitive advantage/stickiness	• Develop stickiness with payors to maintain formulary position next year, and future years
	Maintain price discipline	• Reduce exposure to pricing / rebating wars in drug class by pricing to value
	Align incentives (adherence, outcomes)	• Align incentives with payors to address the opioid crisis
	Access high-quality **real-world data**	• Work with partners to leverage patient data sets to full demonstrate value
	Build **capabilities** for the future	• Test contract structure and build capabilities within org
	Enhance **relationships**	• Demonstrate strong and trusted partnerships with key customers
"Softer benefits" (harder to quantify)	Demonstrate innovation / PR	• Publicly communicate role in addressing opioid epidemic in partnership with payors

Execute a contract quickly to demonstrate public commitment (e.g. 4-6 months)

4 Current meeting and bids due calendar for top accounts

Strong interest
Limited interest



- Top 7 accounts comprise for 65% of total Commercial and 75% of total Medicare Part D lives
- Focus on commercial accounts and engaging Aetna Part D prior to bid grid due dates

Source: MMIT 2017, Purdue internal discussions 1 includes BCBS of FL 2 Interested based on number of publicly available innovative contracts, public knowledge of payer/PBM focus on opioid crisis, and expert interviews

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We have considered three innovative contracting options

	Morphine Milligram Equivalent (MME) contract offering	Event-Based Contract offering	Per Member Per Month (PMPM) contract offering
Our goal	Reduce high daily doses (e.g. MME > 90)	Reduced opioid use disorder (OUD[1])/ overdose (OD) incidents linked to OxyContin	Reduce PMPM spend on OxyContin
Measure targeted	**High dose**	**OUD[1] and OD**	**PMPM spend**
Offer to you	Scaled rebates linked to **average daily dose**	Rebate given per **OUD/OD incident**	Scaled rebates linked to **PMPM spend decreases relative to target**

Options selected because they create formulary placement stickiness, align incentives with payor to address the crisis, and demonstrate innovation to public

1 CDC Definition: "'sometimes referred to as 'opioid abuse or dependence' or 'opioid addiction,' OUD is a problematic pattern of opioid use that causes significant impairment or distress." https://www.cdc.gov/drugoverdose/prevention/opioid-use-disorder.html

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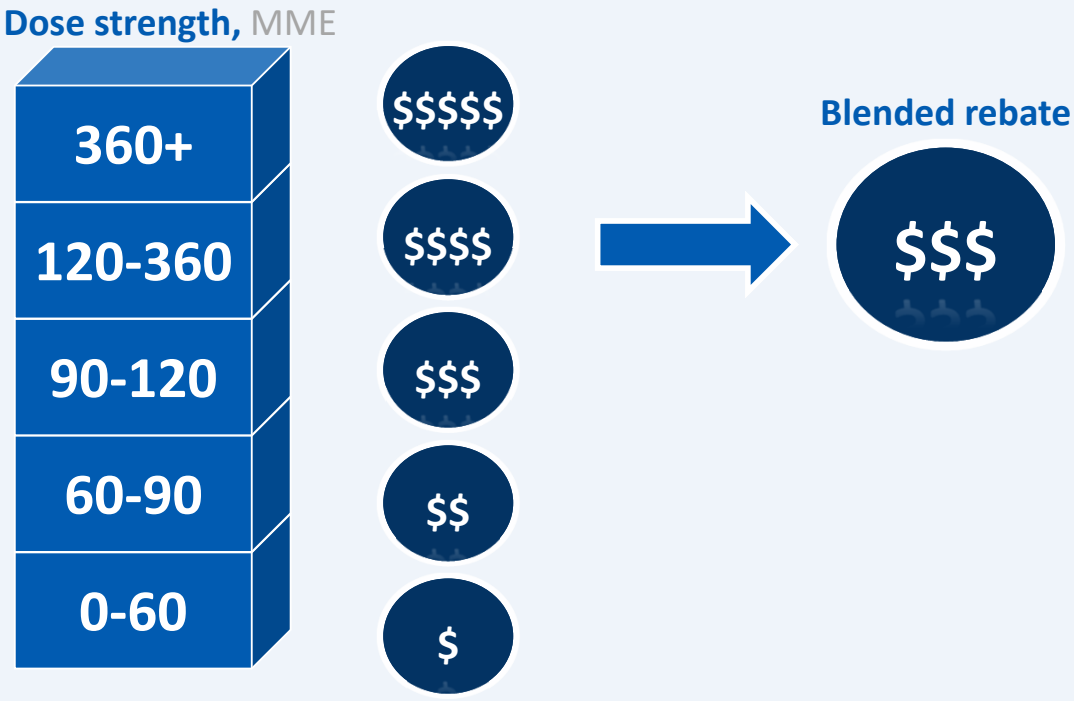
Purdue's Morphine Milligram Equivalent (MME) contract offering

We are committed to lowering average daily doses on OxyContin and will provide higher rebates on prescriptions with higher dose strengths

No base rebate provided

Blended rebate based on MME dose distribution

Illustrative



Disclaimer: Rebate will be set according to an account's individual MME dose distribution

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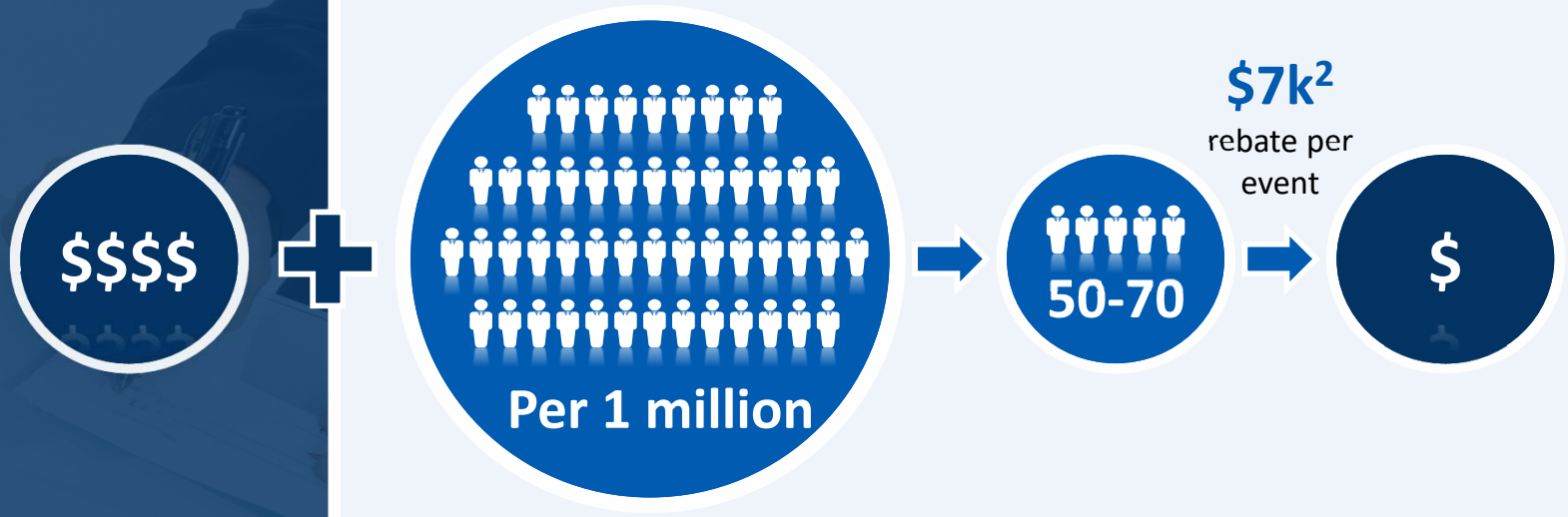
Purdue's Event-Based Contract offering

We believe in our technology: We will pay additional rebates on any new OxyContin related overdose or opioid use disorder diagnosis

Provide a base agreed-upon rebate

Provide an additional rebate based on actual incidence

Illustrative



Base rebate

members in plan

OxyContin-related OD/OUD events[1]

Additional rebate for events[3]

- **Disclaimer:** First diagnosis of opioid-related overdose (OD) or opioid use disorder (OUD) based on ICD codes and OxyContin script within 1 month of event
  - ICD-10 codes F11, T40.0 , T40.2, T40.3, T40.4F11
  - ICD-9 codes 304.0, 304.7, 305.5, 965.00, 965.02, 965.09
- Rebate is linked to excess medical costs (e.g. ~$14K over 1 year, or OxyContin prescription costs per year ~$6K)

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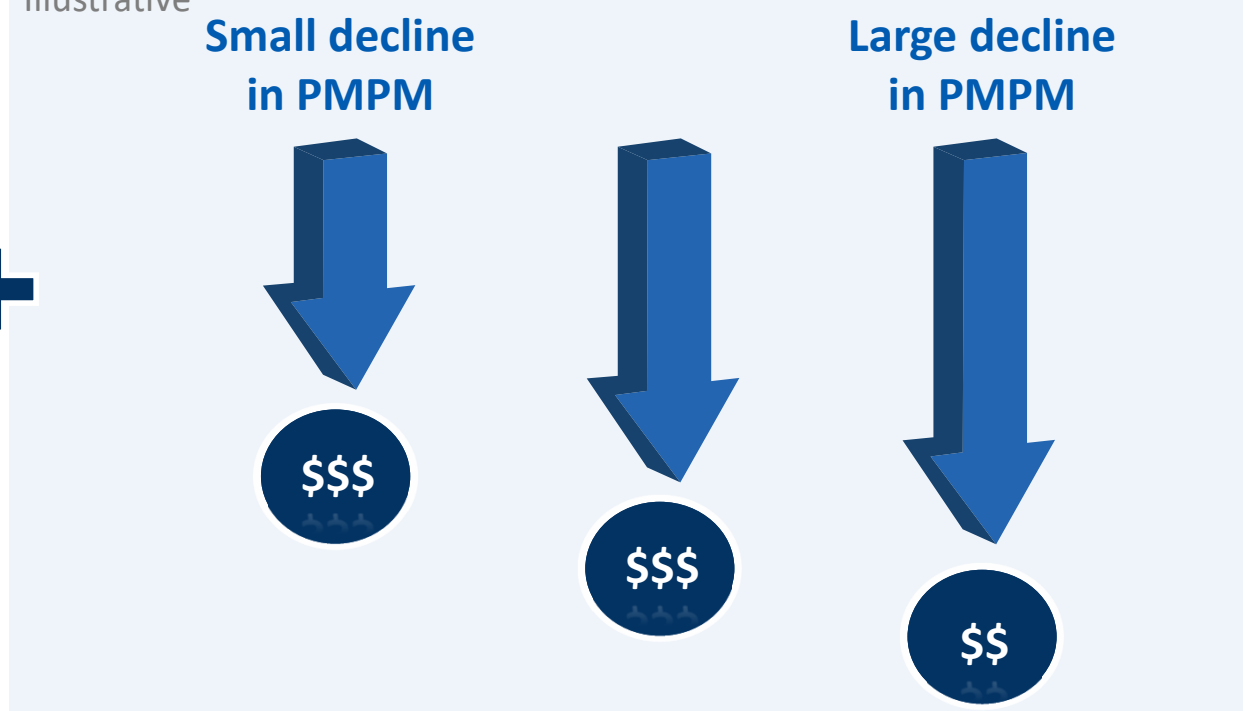
Purdue's Per Member Per Month (PMPM) contract offering

We are committed to lowering your PMPM spend on OxyContin and will link additional rebates to reductions in PMPM

Provide a base agreed-upon rebate

Provide an additional rebate based on PMPM decline

Illustrative



Disclaimer: Rebate will be set according to an individual account's PMPM

When we evaluate the three options against key criteria, we see the MME and Event-Based as more attractive options

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Strong alignment with criteria
Less strong alignment with criteria

Evaluation criteria	1 Purdue's MME contract offering	2 Purdue's Event-Based contract offering	3 Purdue's Per Member Per Month (PMPM) contract offering
Addresses opioid crisis intervention points	Targets high doses	Targets overdose use disorder (OUD[1])/ overdose (OD) incidence	Targets reduction in PMPM
Predictability of spend	Predictable trend in MME	Incidences are low[2]	Unpredictable, complex trend
Allows for same or better performance than traditional contract	Strategic negotiating leverage	Limited upside	Limited upside
Ease of implementation	Easy to track	Easy to track	Significant challenges to predicting metric

1 CDC Definition: "'sometimes referred to as 'opioid abuse or dependence' or 'opioid addiction,' OUD is a problematic pattern of opioid use that causes significant impairment or distress." https://www.cdc.gov/drugoverdose/prevention/opioid-use-disorder.html
2 Potential for unintended consequences of increased rates depending on stakeholder actions

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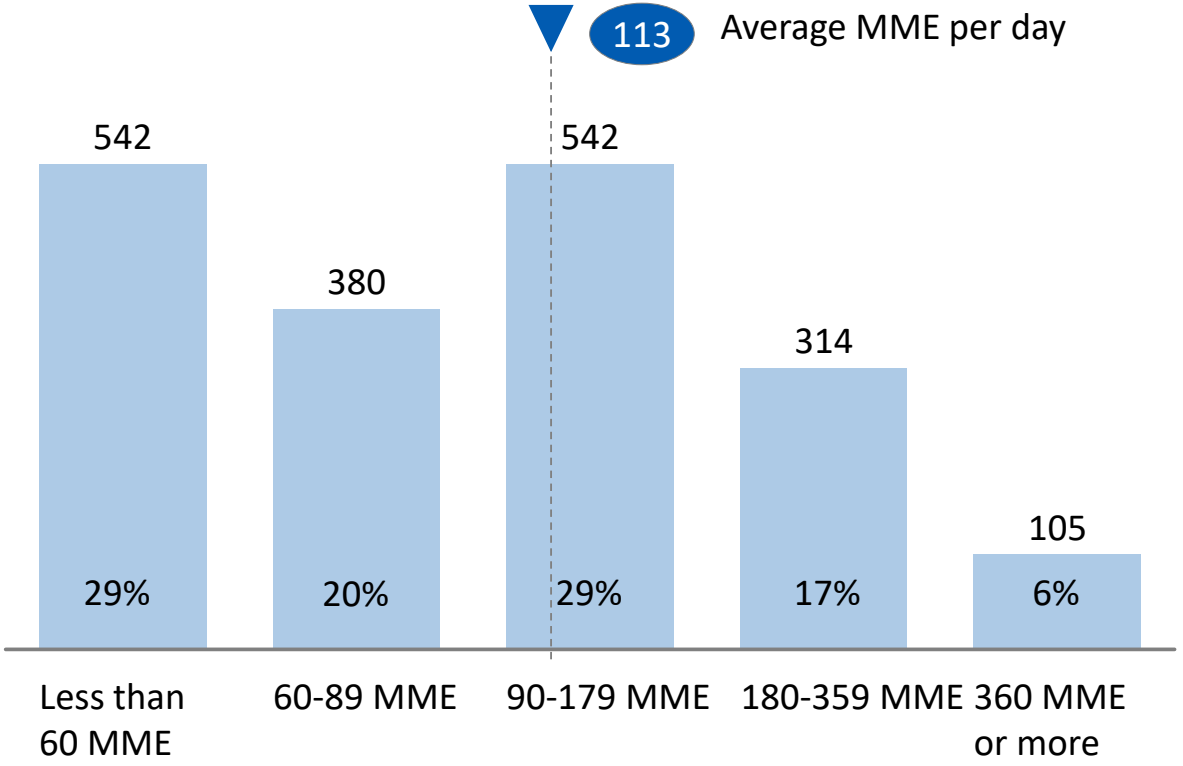
Baselining the MME metric: Important facts to understand when designing an MME contract

		Key facts	Implications
MME basics	1	**The average OxyContin MME per day is 113 in 2017** • 51% scripts are ≥90 MME per day, the CDC recommended daily dose limit • 22% of scripts are ≥ 180 MME per day	MME is a good choice for a metric to **show direct linkages to opioid crisis** management
	2	**The average MME per day and the distribution of scripts by MME per day does not vary significantly by indication** • Ave daily MMEs are around ~110-120 MME for cancer, back pain, osteoarthritis, which represent 68% of scripts	**No need to exclude specific indications**, which simplifies the tracking and analytics for contract execution
	3	**The average daily MME has dropped by almost 10% annually between 2015-2017** • Share of scripts shifted from ≥180 daily MME to <60 daily MME by 11 percentage points between 2015-2017	**Need to design several rebate tiers**, with low rebate rates for<60 MME and high rates for ≥180 MME
Part D	4	**Innovative contracts are less common in Medicare** given the additional regulations and government oversight in Medicare • 11% of publicly identified contracts are affiliated with Medicare book	**Likely harder to generate interest in Med D accounts**
Basics behind CVS part D	5	**Estimated net sales without a contract** ($74M) are **higher than the current proposed contract** ($54M) for 2019	Ideal design will **keep expected net sales at least above $54M**

1 Current average is 113 daily MME with 51% of scripts above 90 MME per day

2017 OxyContin distribution of scripts by daily MME[2]

Thousands of scripts[1]



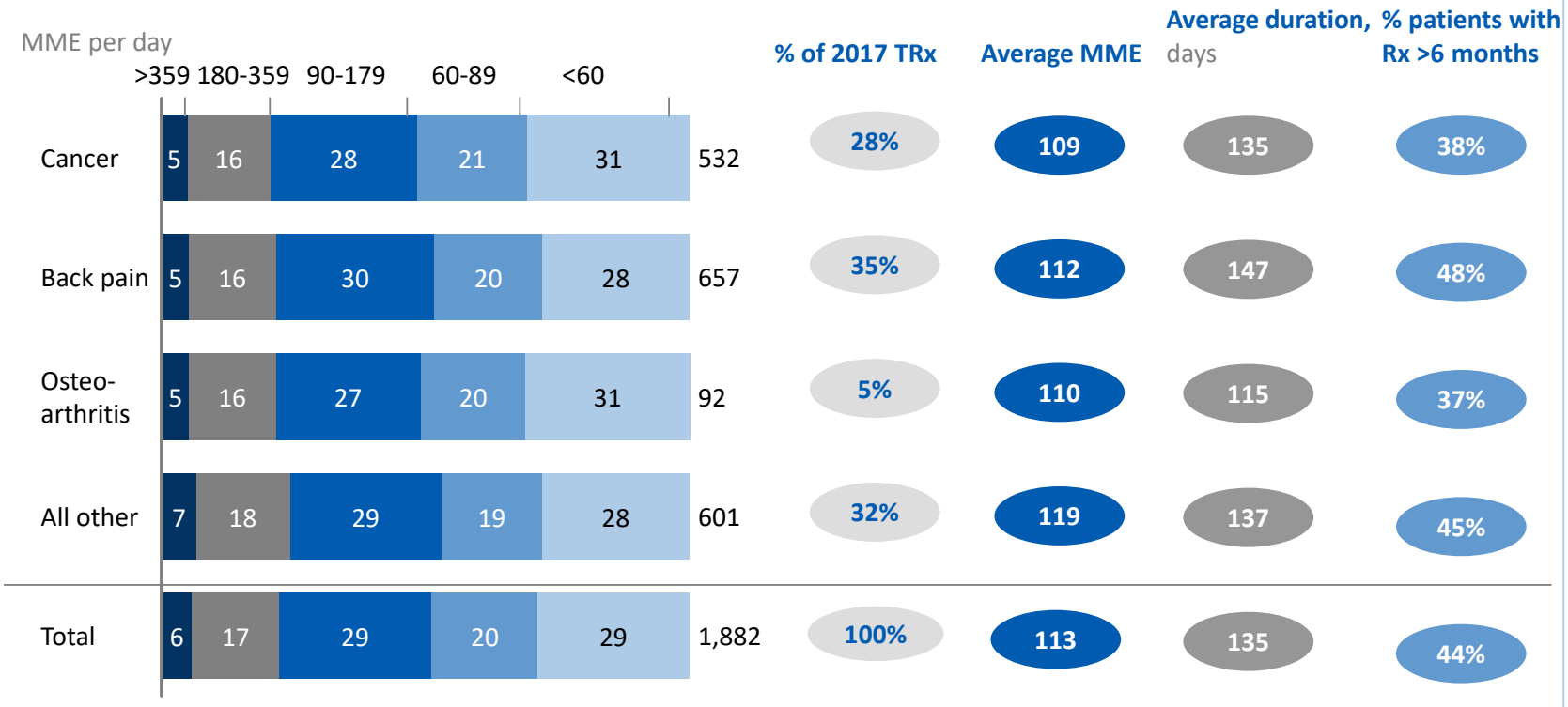
- 49% of scripts <90 MME per day
- 22% of scripts are ≥180 MME per day
- 6% of scripts are ≥360 MME per day

1 Includes third party insurance, cash, and Medicaid patients included in the APLD data set
2 MME calculated using CDC MME conversion factor of 1.5 https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

SOURCE: IMS APLD 2017 January - July

2 Little variation in daily MME distribution or average MME by indication

2017 OxyContin distribution of scripts by daily MME[1], Trx '000s



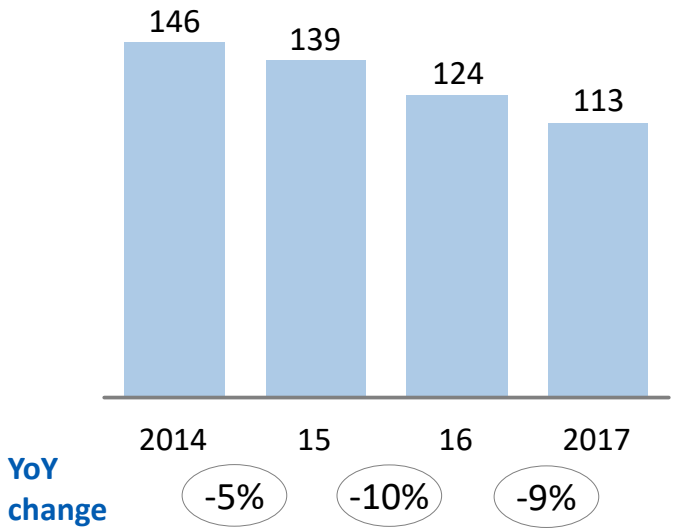
- Average MME is consistent across indications, with cancer staying below the average
- Duration varies more, with back having patients on prescriptions longer than Osteoarthritis

Source: APLD 2017 January – July

1 Indication determined by ICD 9 and ICD 10 codes

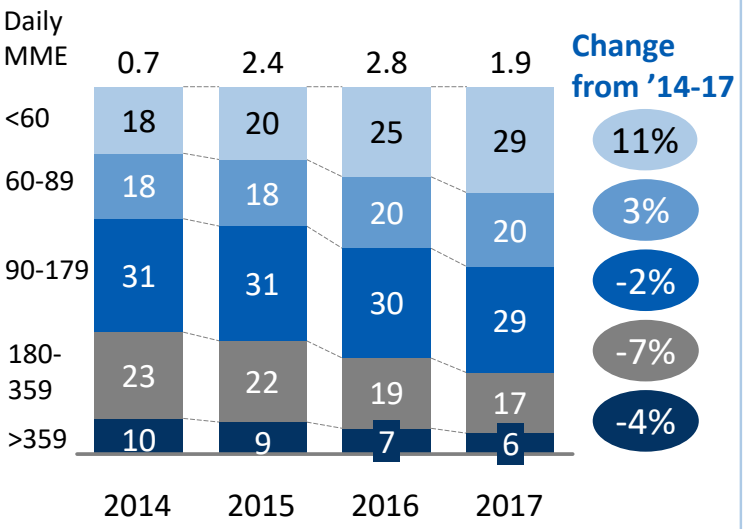
3 Average MME has declined by almost 10% annually since 2015

Annual average daily MME



Average has declined almost 10% annually since 2015, and the rate of decline has not yet flattened

OxyContin TRx by daily MME, % of scripts



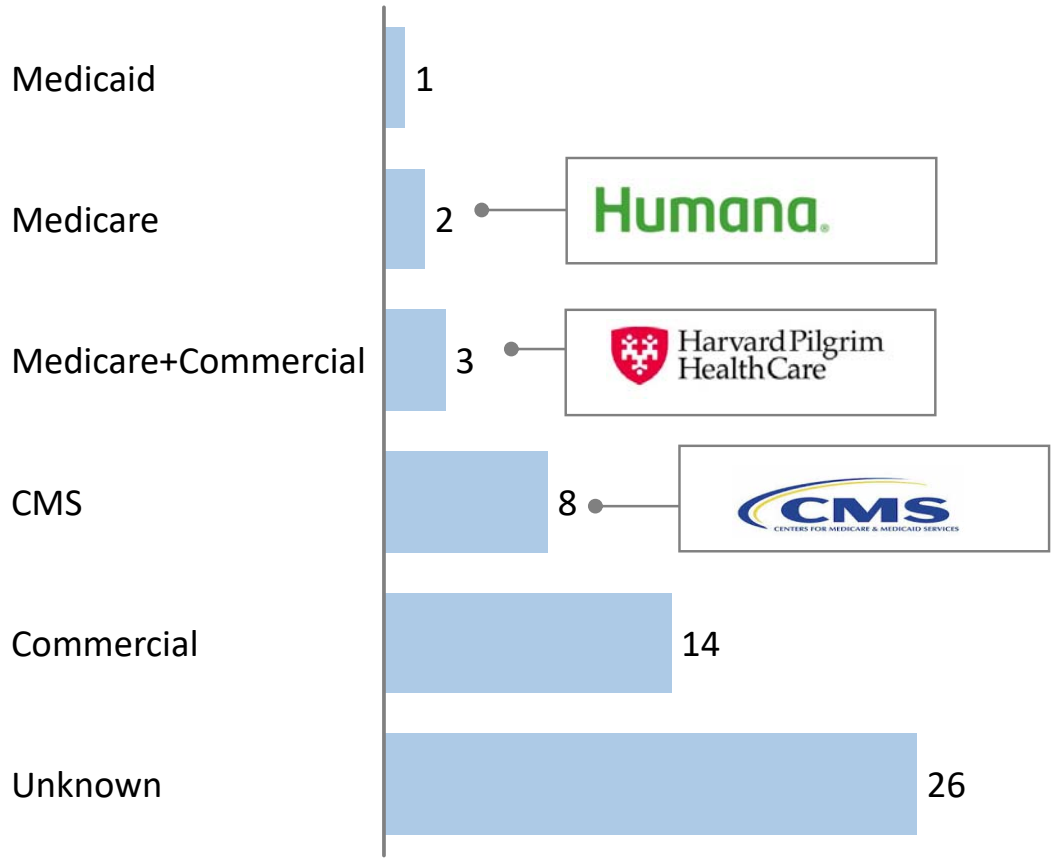
There is a shift from scripts above 180 MME per day to scripts below 60 MME pear day at a about 4 points per year since 2015

SOURCE: IMS APLD

4 Innovative contracts are less common in Medicare

Published value-based contracts in the U.S. since 1994

Contract count



5 out of the 46 (11%) contracts, excluding CMS contracts, are affiliated with Medicare

SOURCE: Publicly available contracts; -- McKinsey Innovative Contracting Database

5 Baselining the projected CVS Medicare Part D contract has implications for the contract structure in 2019

Basics on CVS Med D account

- CVS is a **top three account** in Medicare Part D, covering 13% of lives
- CVS has a **reputation for being aggressive**, with rates usually among the highest in Med D
- Benefit design is unique with a large patient cost share increase expected between branded tiers
  - **Tier 3 is the preferred branded tier** with a **copay of $46** per script
  - **Tier 4 is the non-preferred branded** tier with **49% coinsurance** (e.g. average $260 out of pocket OxyContin patients)

Basics on our contract with CVS

- Contract has transitioned to fixed rate, with a **realized rebate of 53% in 2018**
- We are on Tier 3 with Nucynta ER
- Bids are due December 1st, and the Purdue team is **expecting an increase of 2-4%**

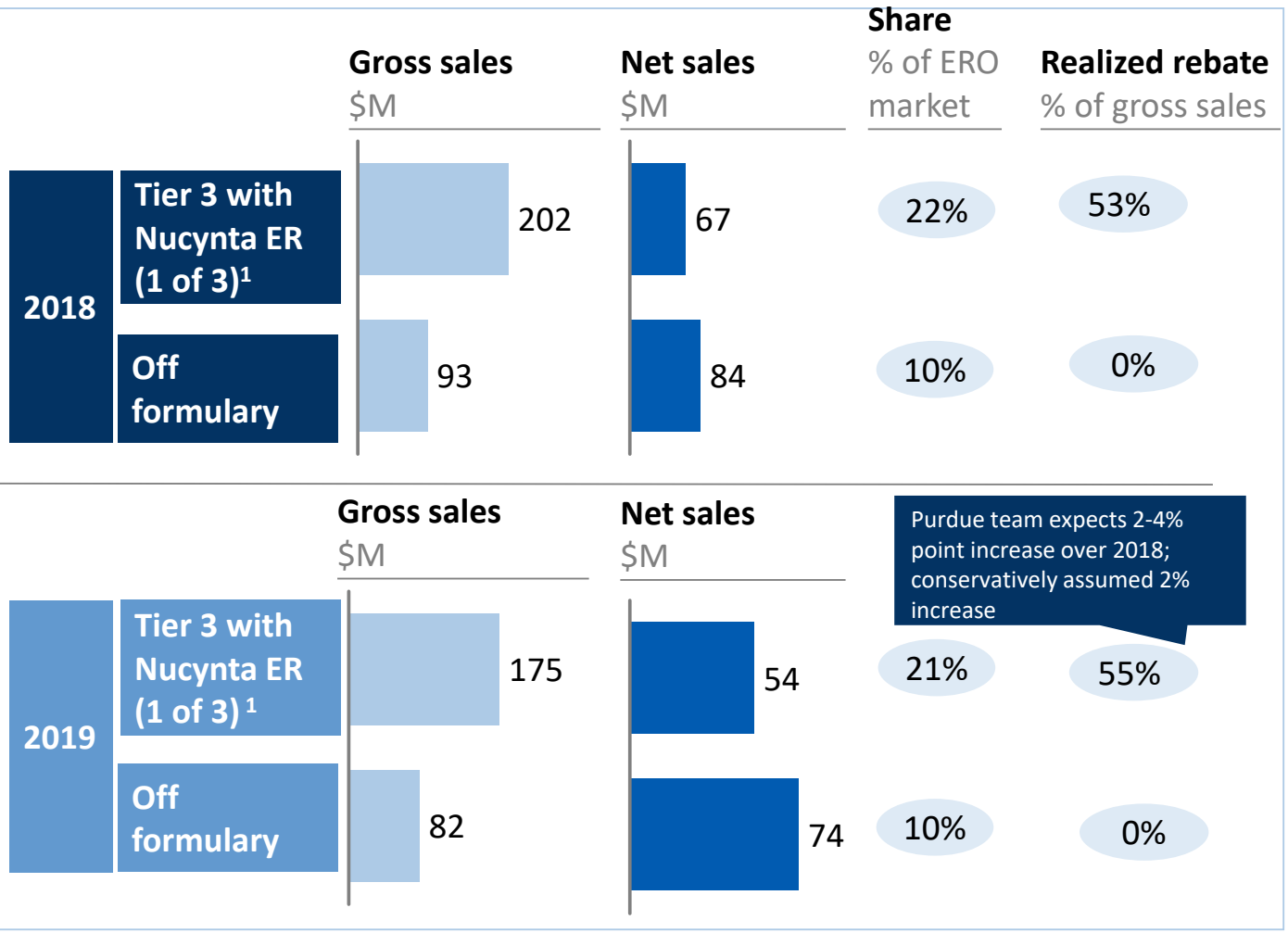
Implications

- Ideally, we want a contract design that **does not increase rates beyond 1 or 2 points** beyond 2018 rate of 53%

5 Baselining the current CVS Med D contract, we see that contracted net sales are below break-even

Not actual rate offers
- Hypothetical terms
- Negotiated terms

Assumptions between '18-19
- **Market**: 9% decline in ERO market
- **Share:** 1% decline in CVS Med D share in status quo
- **Rebate rate**: 2% point increase in rate
- **GTN**: Add 14% to payor rebate for donut hole coverage, admin fee



1 Fingertip formulary for 2018; Tier three with Nucynta ER, Emeda, and Purdue brands; Xtampza not covered in 2018

SOURCE: Purdue's CVS Med D Model 2018

Design: There is potential for impact at CVS Med D with an innovative contract

1. MME contract enables a more strategic play with CVS Med D by providing negotiating leverage
   - Option 1: Maintains rebates no more than 1-2 points above 2018 rates
   - Option 2: Optimizes net sales by providing broader range of rebates and more leverage in negotiations

2. CMS Medicare Part D has highest net cost to plan in the initial coverage phase
   - Plan net spend for non-LIS patients is $185 per script in the initial coverage phase relative to $11 per script under catastrophic coverage
   - Plan net spend for LIS patients is $204 per script in the initial coverage phase relative to $13 per script under catastrophic coverage

3. Higher rebates on scripts with higher MME per day are more valuable to PBM/plan in initial stage of Part D coverage where plan has highest liability
   - The difference in per script rebate between Option 1 rebates and the traditional rebate is $42 per script at the highest MME per day scripts and (-$19) per script at the lowest MME per day script

4. Net Sales for Option 2 in a 1 of 1 contract only increase net sales by 2% relative to 1 of 3 offering, indicating that 1 of 1 ask is not incrementally much more valuable under current share assumptions

Disclaimer: Rates modeled are directional and should not be taken as actual offers. Additional modelling with payor-level data is required to develop payor rebate rate recommendations

1 MME contract enables a more strategic play with CVS Med D, providing negotiating leverage

Rebate rate, % of gross sales

Directional rates

Percent of scripts by daily MME % of scripts in 2017[1]		Traditional '19 rates	Option 1: Ensure low increase in rates	Option 2: Optimize net sales
<60	29	55%	45%	20%
60-<90	20	55%	51%	35%
90-<180	29	55%	55%	53%
≥180	17	55%	57%	57%
>-360	6	55%	57%	58%
Blended rate %		55%	55%	50%
Net sales $M		54.5	55.0	62.9

MME contracts communicate commitment to addressing opioid crisis

Advantages of the MME contract

- Provides structure to limit rate increases to 2 points
- Enables offering 57, maintaining blended rate two points above 2018 rates

- With a more aggressive lower rebate, contract can close the gap by enticing payor with higher rebates where script value is highest

1 Distribution of scripts done at national level and is not specific to CVS Med D

2 CVS Medicare Part D has highest net cost to plan in the initial coverage phase

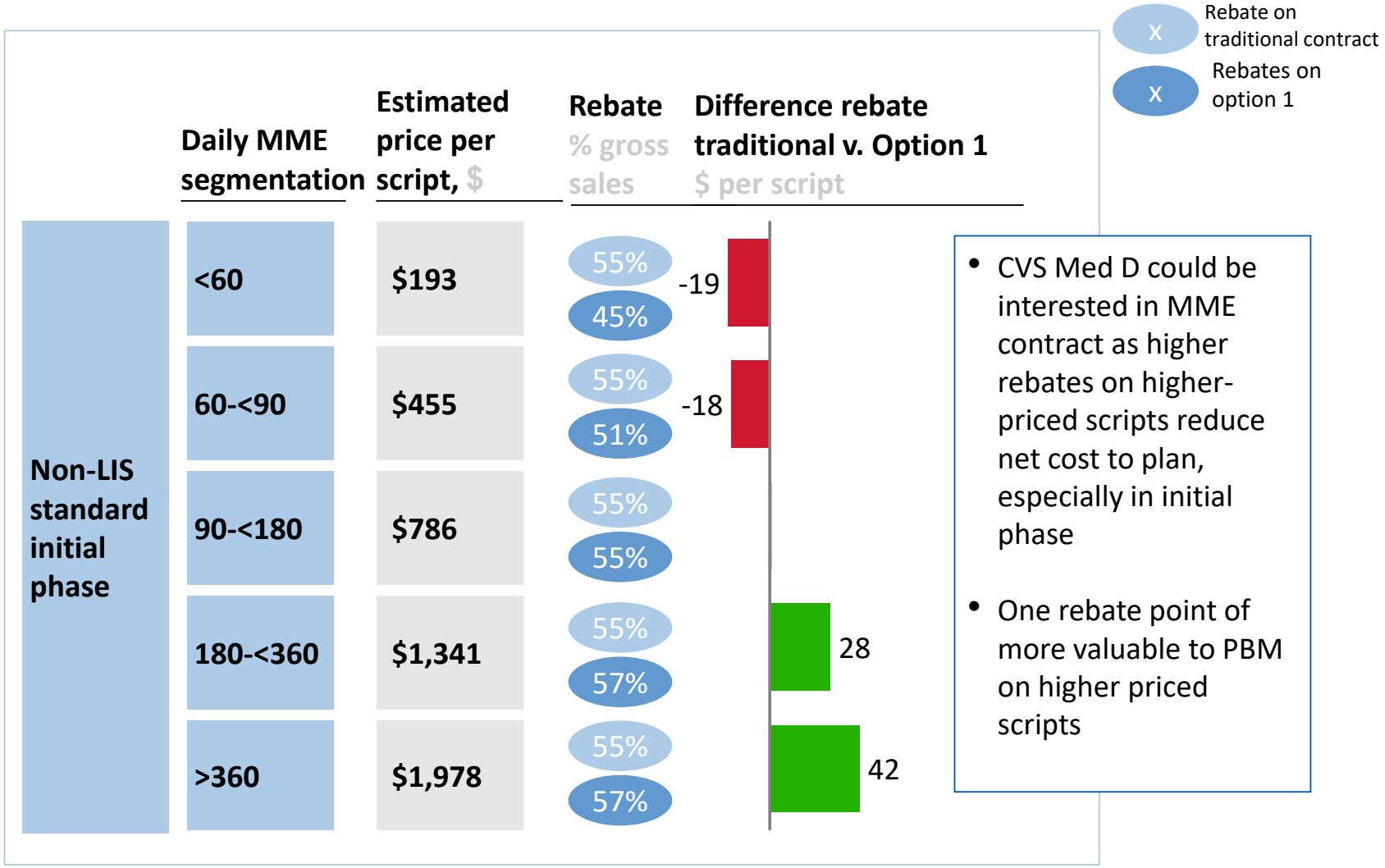
For a typical patient in CVS Medicare Part D plan

		Retail price per script[1]	Patient contribution[1]	CMS subsidy	Pharma coverage gap payment	Pharma rebate to plan + admin fee [2]	Plan net spend per script
Non-LIS standard	Initial cover.	$530	$46	n/a	n/a	$300	$185
	Gap		$186	n/a	$265	$300	-$220[4]
	Cat.[3]		$27	$424	n/a	$68	$11
LIS	Initial cover.		$8.35	$37.65	n/a	$280	$204
	Gap		$8.35	$442	n/a	$67	$13
	Cat.[3]		$0	$451	n/a	$66	$13

Part D plans, including CVS Med D, have highest liability for claims in the initial coverage phase due to distribution of pharma and CMS contributions

1 Assumes 2018 standard silverscript benefit. LIS copay shown for dual eligible (Kaiser PDP fact sheet 2016), non-LIS assumes 25% coinsure in initial coverage phase, 35% coinsure. in gap and 5% in catastrophic 2 Assumes 54.9% base rebate and 5% admin fee with even split of base rebate between CMS and plan based on relative contribution (CMS rebate not shown)
3 Catastrophic coverage 4 CMS and manufacturer settle accounting annually (pharmaco does not make any money on the coverage stage)

3 Higher rebates on scripts with higher MME per day is more valuable to plan in initial stage with highest plan liability



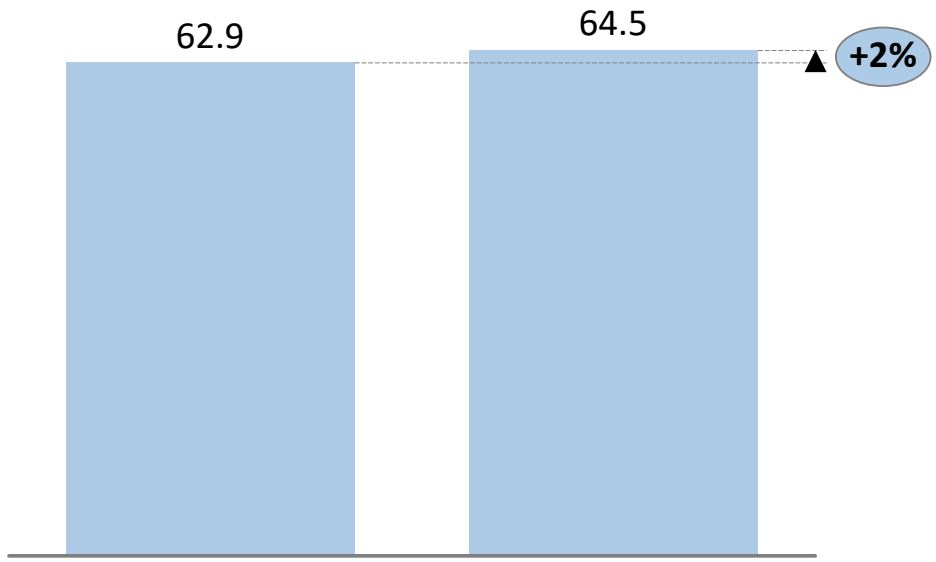
- CVS Med D could be interested in MME contract as higher rebates on higher-priced scripts reduce net cost to plan, especially in initial phase
- One rebate point of more valuable to PBM on higher priced scripts

SOURCE: Part D modeling; priceRx, APLD data

4 Limited increase in share at CVS Med D reduces attractiveness of 1 of 1 ask

Estimated 2019 net sales

$M



Assumptions

- **Opana ER removed from market:** 40% of brand's scripts shift to preferred brands evenly
- **Brands off-formulary**: Other Tier 3 preferred brands, Nucynta ER (1.1% of ERO share) and Embeda (0.8% of ERO share) move off formulary
- **Share shift**: Brands moving off formulary lose 65% of share, greater than average off-formulary share shift given CVS Med D dramatic benefit design
- **OxyContin:** Captures 40% of the share shift from brands moving off-formulary, remaining share shift attributed to generics

DRAFT

Contents

- Overall innovative contracting landscape in the U.S.
- Overall comparison of innovative contracting options
- Details on MME contract baselining
- Details on Event-Based contract baselining
- Details on Per Member Per Month contract baselining

DRAFT

Important considerations when designing an Event-Based Contract

	Key facts	Implications
1 **Total event volume**	• There are **~1200 OD/OUD opioid events per million members in a year**[1]	• OD/OUD events **can be tracked** determine an incidence rate
2 **Attributing to OxyContin**	• **4% of OD/OUDs involve any level of OxyContin,** mostly (>90%) without other EROs	• OxyContin-related OD/OUD events can be **defined in a simple way**
3 **Defining an event rate**	• Today there are **~50 events** of OxyContin-related OD/OUDs **per million members per year**[2] and has grown by 5% annually between 2014-16	• **2019** rates expected to be around **60 events per a million members** per year, with a sensitivity of 45-75 events per million members
4 **Rebate per event**	• **Meaningful rebate amounts** per OD/OUD event can vary from **~$6k** (cost of OxyContin[3]) to **~$14k** (excess medical costs[4])	• Need to determine **which payment amount** is optimal
5 **Exposure for top accounts**	• For top 7 accounts, rebate exposure ranges from ~$3-15M per year, with the exception of CVS and ESI	• Exposure could vary if **projected OD/OUD rates differ from expected**

1 Defined as first occurrence for overdose or opioid use disorder ICD-10 codes F11, T40.0 , T40.2, T40.3, T40.4F11 || ICD-9 codes 304.0, 304.7, 305.5, 965.00, 965.02, 965.09
2 Defined as any level of OxyContin use, including with other ERO combinations
3 Based on estimated monthly Rx cost of $530
4 Kirson et al, "Economic Burden of Opioid Abuse: Updated Findings." JMCP vol 23, No 4, April 2017

SOURCE: Truven MarketScan 2012-2016, Literature search, TBD for plan sizes

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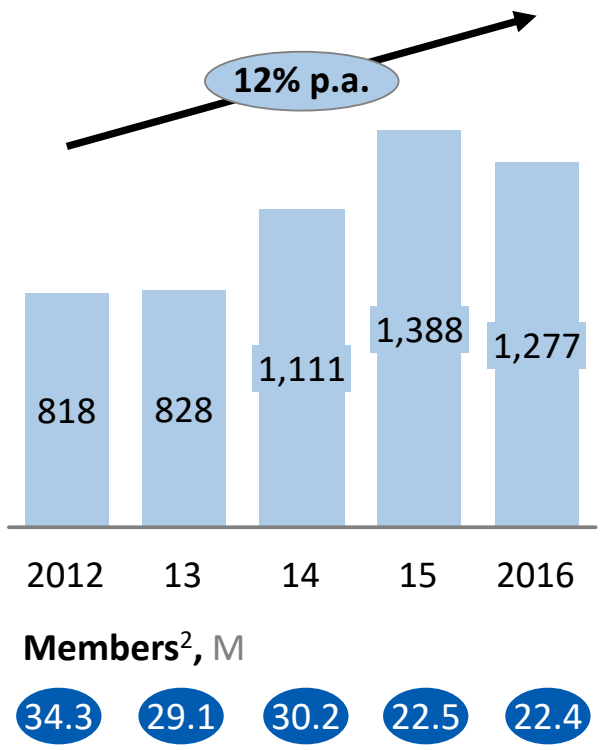
1 There are ~1200 opioid OD/OUD events per million members in a year in a Commercial population

Defining the OD/OUD metric

	Definition
Opioid OD/OUD case	• First **diagnosis of opioid OD or OUD based on ICD codes** – ICD-10 codes F11, T40.0 , T40.2, T40.3, T40.4F11[1] – ICD-9 codes 304.0, 304.7, 305.5, 965.00, 965.02, 965.09
Attribution to OxyContin	• Any Oxycontin use, including **combinations with IRs or other ERs**
Proximity to OxyContin exposure	• Last OxyContin pills supplied **within 1 month of event** • Event occurs **after OxyContin is initiated**

Rate of any opioid-related OD/OUDs[1] in a Commercial population

Per 1 million members[2]



1 Defined as first occurrence for overdose or opioid use disorder ICD-10 codes F11, T40.0 , T40.2, T40.3, T40.4F11 || ICD-9 codes 304.0, 304.7, 305.5, 965.00, 965.02, 965.09. Includes events associated with IROs, EROs, and cases when no opioid script has been filled a month before 2 Normalized to full years of member enrollment (i.e. total patient-months of coverage divided by 12)

SOURCE: Truven MarketScan 2012-2016

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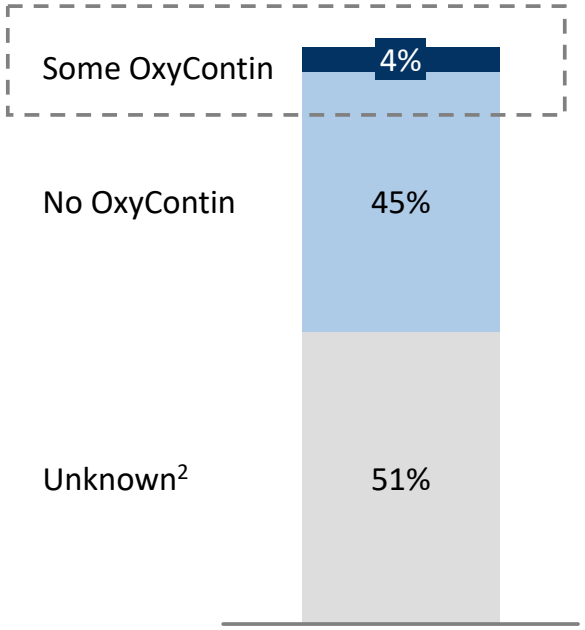
2 Approximately 4% of opioid OD/OUDs involve OxyContin

OD/OUD events by drug exposure[1], 2012-2016, % of total events

Details to follow



- **OxyContin exposure is defined as:**
  - Last OxyContin pill dispensed within 1 month of event
  - Any drug combination involving OxyContin (including other EROs)

1 Defined as first occurrence for ICD-10 code F11, T40.0 , T40.2, T40.3, T40.4F11 or ICD-9 codes 304.0, 304.7, 305.5, 965.00, 965.02, 965.09; opioid use assessed by 30 day exposure based on patient's personal prescriptions prior to event occurrence
2 Indicates lack of opioid prescriptions within 30 days of event

SOURCE: Truven MarketScan 2012-2016

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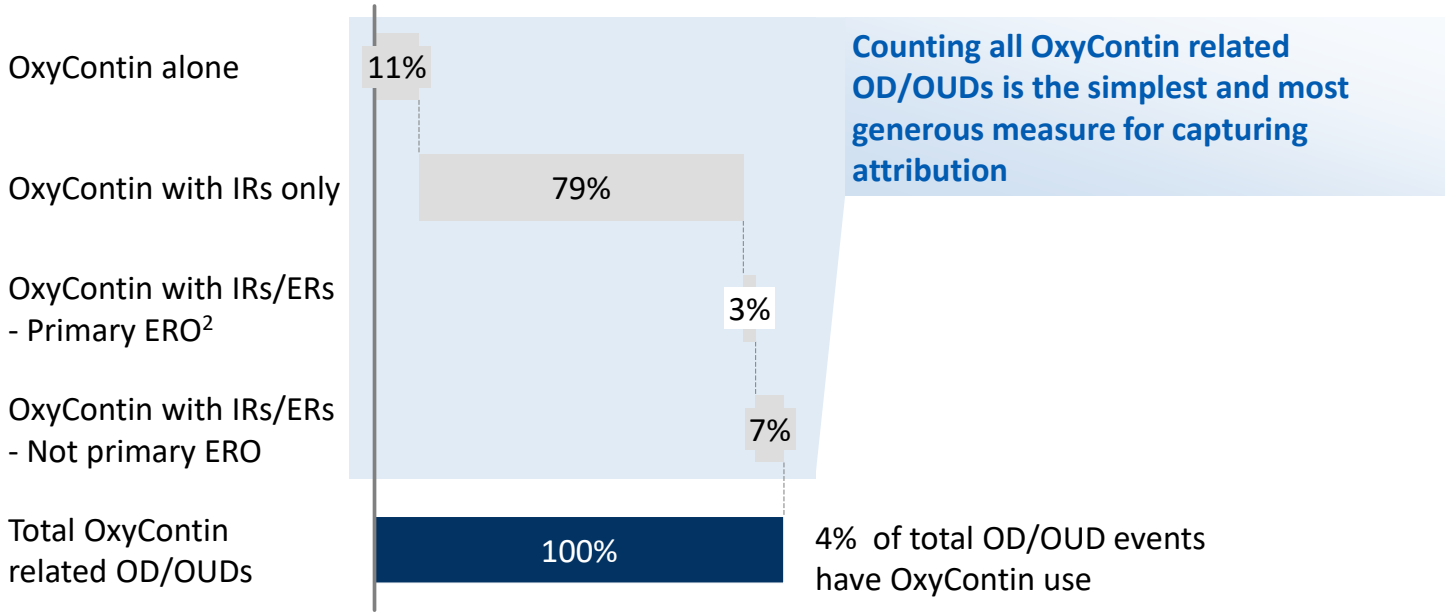
2 The 4% of OxyContin related OD/OUD's counts all OxyContin related use

OxyContin related OD/OUD events[1] by drug combination, 2012-2016, % of total events



1 Defined as first occurrence for ICD-10 code F11, T40.0 , T40.2, T40.3, T40.4F11 or ICD-9 codes 304.0, 304.7, 305.5, 965.00, 965.02, 965.09; opioid use assessed by 30 day exposure based on patient's personal prescriptions prior to event occurrence
2 OxyContin constituted >70% of ERO days supplied in preceding 3 months
3 Indicates lack of opioid prescriptions within 30 days of event

SOURCE: Truven MarketScan 2012-2016

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3 In 2019, the base case rate of OD/OUDs is projected to be ~60 events per million members with a range of sensitivity

Scenario currently used for projections

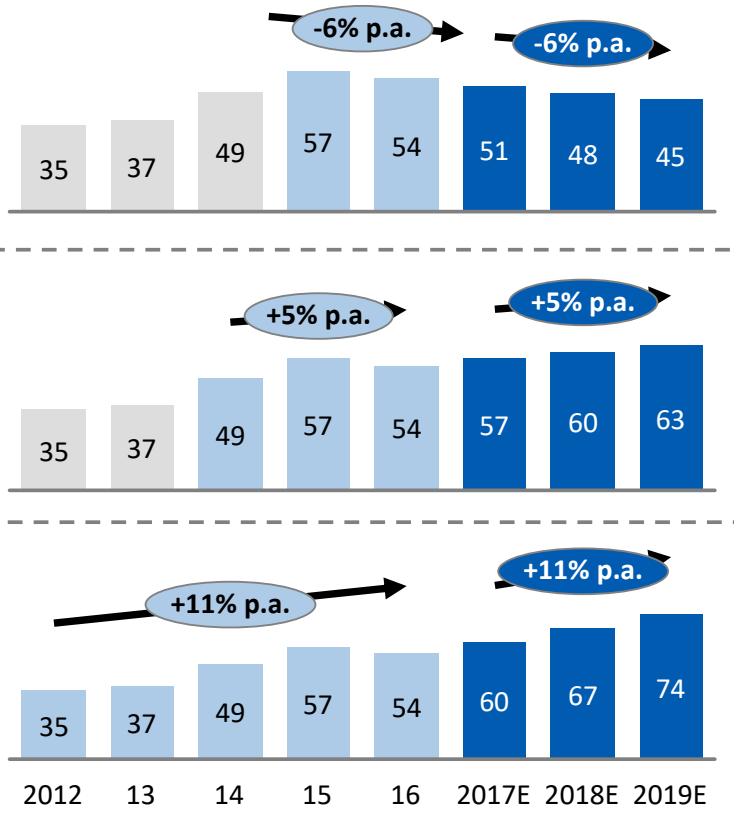
Used for projection | Projection

Projected OxyContin-related OD/OUD rate[1], per million members

Upside: Assume **decline** in past 1 year continues

Base case: Assume **moderate growth** in past 3 years (2014-2016) continue

Downside: Assume **higher growth** in past 5 years continues



- **There is a sensitivity of 45-75 events per million members based on historical trends**

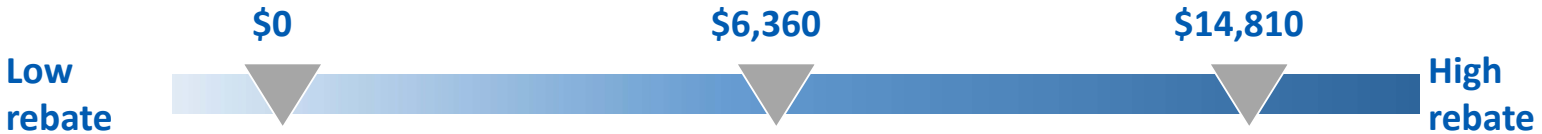
1 Event defined by ICD 9 and 10 codes. Attribution to OxyContin defined as last OxyContin pill dispensed within 1 month of event, regardless of drug combination.

SOURCE: Truven MarketScan 2012-2016, TBD for membership

DRAFT

4 Meaningful rebate amounts per OD/OUD event could vary from ~$6k to ~$14k

Event-based rebate



Status quo
No additional event-based rebate

Drug costs
Cost for 1 year of OxyContin[1]

Medical costs
Excess medical costs for 1 year related to abuse[2]

Literature agrees on ~$10-20k excess costs incurred by Rx opioid abusers in the year surrounding inciting event (e.g OD or OUD diagnosis)[3]

Further consider is needed of the rebate level that best balances meaningfulness of rebate and financial protection

1 Monthly estimate of $530 per Purdue
2 Kirson et al, "Economic Burden of Opioid Abuse: Updated Findings." JMCP vol 23, No 4, April 2017
3 Based on Truven data. Lower figures ~$10k are from 2011 analyses; $14K is from Kirson et al from 2012-2016 data

SOURCE: Literature search, Purdue

DRAFT

5 Exposure in 2019 for top 7 Commercial accounts could range from $3-15M with the exception of ESI and CVS

Commercial account	Membership[1] M	Expected 2019 OxyContin events[2], #	Exposure at ~$6k rebate per event[3], $M	Exposure at ~$14k rebate per event[4], $M
ESI	38.3	2,402	15.3	35.6
CVS	39.6	2,484	15.8	36.8
UnitedHealth	14.0	880	5.6	13.0
OptumRx	12.1	758	4.8	11.2
Anthem	11.6	725	4.6	10.7
Aetna	9.4	588	3.7	8.7
Kaiser	7.5	468	3.0	6.9
Total	**132.4**	8,306	52.8	123.0

1 Based on last available membership in Nov 2017 from MMIT. Not projected to 2019.
2 Projection to 2019 based on 2016 rate in Truven Commercial database projected at 2014-2016 CAGR. Event defined by ICD 9 and 10 codes. Attribution to OxyContin defined as last OxyContin pill dispensed within 1 month of event, regardless of drug combination.
3 Estimated annual cost of OxyContin. Monthly estimate of $530 per Purdue
4 Excess medical cost for one year. Kirson et al, "Economic Burden of Opioid Abuse: Updated Findings." JMCP vol 23, No 4, April 2017
5 FY 2019 net sales estimated 2019

SOURCE: Truven MarketScan 2012-2016, TBD for membership

Exhibit S

Message

From: John Goldie [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=88A68A9A81B348FB8558F71371EAE616-JOHN GOLDIE]
Sent: 12/6/2017 2:40:00 PM
To: Amir Golan [/o=exchangelabs/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=afe6a4f07e3342cd9103a2cc7ba9b4ab-amir golan]
CC: Abhi Hazarika [cn=abhi hazarika/ou=nyo/ou=northamerica/o=mckinsey]; Albert G Lee [/o=exchangelabs/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=7b0a6091493f4179bad0f855c6dbc894-albert g le]; Arnab Ghatak [/o=exchangelabs/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=ee5107d994d14d18b8ece4c0e247cc7b-arnab ghata]; Greg Graves [cn=greg graves/ou=phl/ou=northamerica/o=mckinsey]; Jeff Smith [/o=exchangelabs/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=d76f8a177e354a69901636fb7356e8b1-jeff smith]; Martin Elling [/o=exchangelabs/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=6b33c3264f744b04af05fa59341271be-martin elli]; Matteo Foderaro [cn=matteo foderaro/ou=nyo/ou=northamerica/o=mckinsey]; Yang Wang-NJE [/o=exchangelabs/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=6e84645b2e374020ae691c61378c179c-yang wang-n]
Subject: Re: Project Scottsdale: Debrief from today - great meeting with Craig and leadership team and thorough debrief from finance

Thanks for the thorough update Amir,

Few thoughts on my end:

+ On the 3 NewCos might be good to sketch out on 1 page our understanding of their scope/remit and get it front of Paul soon
+ On looking at G&A by sub-function, definitely leverage the benchmarking file I updated to Box that I worked on with Jon in the summer. Its true that on traditional benchmarks won't find a ton of opportunity (prob some in IT, Legal org, PAC), so this is why other creative approaches might be needed.
+ I don't think Legal fees would be in scope. Its worth checking this with Maria.
+ Are they going to give us FTEs by sub-function (including in commrecial, medical, etc...)/

Best,

John

John Goldie
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o: (212) 446-7349
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Amir Golan---12/06/2017 12:00:42 AM---Team, High momentum, uber productive day today- we had a very good meeting with

From: Amir Golan/NJE/NorthAmerica/MCKINSEY
To: Greg Graves/PHL/NorthAmerica/MCKINSEY@mckinsey, Arnab Ghatak/NJE/NorthAmerica/MCKINSEY@mckinsey, John Goldie/NYO/NorthAmerica/MCKINSEY@mckinsey, Jeff Smith/BOS/NorthAmerica/MCKINSEY@mckinsey, Abhi Hazarika/NYO/NorthAmerica/MCKINSEY@mckinsey, Martin Elling/NJE/NorthAmerica/MCKINSEY@mckinsey
Cc: Albert G Lee/NYO/NorthAmerica/MCKINSEY@mckinsey, Yang Wang-NJE/NJE/NorthAmerica/MCKINSEY@mckinsey, Matteo Foderaro/NYO/NorthAmerica/MCKINSEY@mckinsey
Date: 12/06/2017 12:00 AM
Subject: Project Scottsdale: Debrief from today - great meeting with Craig and leadership team and thorough debrief from finance

Team,
High momentum, uber productive day today- we had a very good meeting with Craig, Paul, Brianne, Jon, and Tej, followed by deep dives of the overall spend by the finance team. Here is my quick summary of both, and our team's next steps:

Kickoff meeting with Craig, Paul, Brianne, Jon, Tej

- Overall very positive and collaborative meeting- entire team was very engaged and the discussion resonated with them. This was also reiterated in side conversations with Tej and Brianne
- Craig understands that Purdue has to go through significant change ("this is the changes we should have done 5 years ago"), given the expected significant decline in sales (they understand this will be significant, for e.g. expect a dramatic reduction in R&D)
- The objective for us is the board document Craig will present to the board on January 29
  - They will need to submit the front section by Jan 19
  - We heard that ~40 pages is fine, although prior docs were significantly shorter
- Craig hopes to share vision for Purdue moving forward, including:
  - Significant cost reductions to bridge decline in sales
  - NewCo – vision for a new entity that will house growth opportunities
    - Ingoing is that NewCo will have focus on quick-turnaround projects (505b2)
    - NewCo will be mostly sourcing assets and outsourcing development – will require strong BD capabilities, including R&D assessment
    - There is also a perspective on a small (3-4 heads) VC type capability, but with no upfront funding – every investment will go through the board
    - NewCo and legacy Purdue will share multiple services (including sales force if needed)
- Our mandate is very broad, especially on the cost reduction side – we heard that we should consider everything in scope and are expected to come with new perspectives
- A key question we will analyze is the optimal number of reps – the internal analysis is 350 (this is also driven by a contractual obligation to promote Symproic (250 reps for next 3 years) – we will also analyze what is the "opportunity" to try to exit this obligation

Finance overview meetings

- We met with the finance team members responsible for all OpEx spend: commercial, R&D, medical, G&A
- Meetings were very productive, going through the key line items and the files they shared with us
- Overall OpEx budgeted for 2018 is $633M: S&P - $225M, R&D- $129M, G&A - $124M, Legal fees - $83M, Medical - $51M (other - $21M)
- Key insights:
  - Seems that there is high potential in R&D – they have only 4 projects and expect at least 2 to terminate in Q1. For e.g. -key question around LEM-insomnia program that will read out a phase 3 in Q1 and may require another phase 3 to prove superiority over current treatment (budgeted for ~$40)
  - Non-sales force organization seems slim, but we are waiting for additional data here
  - G&A likely has some potential, but not the entire amount is in scope (~$25M of corporate communication project that was recently approved by the board). There may be a potential for $10-15M here
  - We heard a lot of noise about "legacy decisions" here that may be driven by shareholders – legacy, highly compensated FTEs in areas like facilities

Next steps for the team

- Sales force – we will analyze optimal number of reps with/without the Symproic constraint – we are still waiting on some data here, and will likely drive a lot of insight from a meeting with Marv (expected on Thursday)
- R&D – we will analyze what spend is required given the very limited pipeline, and following development of initial perspective, will bring it to the R&D leadership
- G&A – we are using the following approaches:

- Analyzing by sub-functions, using both benchmarks and some critical thinking
- Looking at overall G&A as % of net sales and as G&A FTE/total FTEs to highlight an overall trend to account

- We will continue to push on the other functions, but given the information we have there is limited potential in medical and legal fees (TBC)

- We will update you on upcoming client meetings. There is high likelihood that we will target a working session with Brianne, Tej, Paul, Jon, focused on "legacy company costs" towards end of next week

Amir

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Klarissa_Moffett@mckinsey.com

Exhibit T

Message

From: Martin Elling [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=6B33C3264F744B04AF05FA59341271BE-MARTIN ELLI]
Sent: 7/4/2018 12:10:13 PM
To: A G [drarnabghatak@gmail.com]
Subject: Re: [EXT]Re: Howdy

Have a great fourth. M

> On Jul 4, 2018, at 2:01 PM, A G <drarnabghatak@gmail.com> wrote:
>
> Thanks for the heads up. Will do.
>
>> On Jul 4, 2018, at 7:57 AM, Martin Elling <martin_elling@mckinsey.com> wrote:
>>
>> Just saw in the FT that Judy Lewent is being sued by states attorneys general for her role on the Purdue Board. It probably makes sense to have a quick conversation with the risk committee to see if we should be doing anything other that eliminating all our documents and emails. Suspect not but as things get tougher there someone might turn to us. M
>>
>>