UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF LOUISIANA

In Re: TAXOTERE (DOCETAXEL) PRODUCTS LIABILITY LITIGATION

MDL NO. 2740

SECTION "N" (5)

THIS DOCUMENT RELATES TO
ALL CASES

PRETRIAL ORDER NO. 38
[Amending the Plaintiff Fact Sheet and Defendant Fact Sheet]

As the parties began completing the fact sheets, various typographical issues and inconsistencies were discovered in the Plaintiff Fact Sheet (Exhibit "A" to Pretrial Order No. 18, Rec. Doc. 236-1) and the Defendant Fact Sheet (Exhibit "B" to Pretrial Order No. 18, Rec. Doc. 236-2). In response, Plaintiffs' Liaison Counsel submitted revised versions of these documents to the Court for approval.

IT IS ORDERED that the Plaintiff Fact Sheet (Exhibit "A" to Pretrial Order No. 18, Rec. Doc. 236-1)and the Defendant Fact Sheet (Exhibit "B" to Pretrial Order No. 18, Rec. Doc. 236-2) be and are hereby updated in the record to reflect the revised version of these documents.

New Orleans, Louisiana, this 12th day of April 2017

KURT D. ENGELHARDT
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF LOUISIANA

In Re: TAXOTERE (DOCETAXEL) PRODUCTS LIABILITY LITIGATION

MDL NO. 2740

SECTION "N" (5)

THIS DOCUMENT RELATES TO ALL CASES

PLAINTIFF FACT SHEET

This Fact Sheet must be completed by each plaintiff who has filed a lawsuit related to the use of Taxotere® by the plaintiff or a plaintiff's decedent. Please answer every question to the best of your knowledge. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect.

In filling out this form, please use the following definitions: (1) "**healthcare provider**" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric, or psychological care or advice, and any pharmacy, weight loss center, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care, and/or treatment of the plaintiff or plaintiff's decedent; (2) "**document**" means any writing or record of every type that is in your possession, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phone-records, non-identical copies, and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

Information provided by plaintiff will only be used for purposes related to this litigation and may be disclosed only as permitted by the protective order in this litigation. This Fact Sheet is completed pursuant to the Federal Rules of Civil Procedure governing discovery (or, for state court case, the governing rules of civil of the state in which the case is pending).

I. CASE INFORMATION

Attorney Information

Please provide the following information for the civil action that you filed:

Exhibit "A"

1. Caption:_____
2. Court and Docket No.:_____
3. MDL Docket No. (if different):_____
4. Date Lawsuit Filed:_____
5. Plaintiff's Attorney:_____
6. Plaintiff's Law Firm: _____
7. Attorney's Address:_____
8. Attorney's Phone Number:_____
9. Attorney's Email Address:_____

Plaintiff Information

Please provide the following information for the individual on whose behalf this action was filed:

10. Name:_____
11. Street Address:_____
12. City:_____
13. State:_____
14. Zip code:_____
15. Date of Birth:_____
16. Place of Birth:_____
17. Social Security Number:_____
18. Maiden or other names you have used or by which you have been known:

_____

19. Sex: Male: ☐ Female: ☐
20. Race:

Race	☐
American Indian or Alaska Native	☐

Race	☐
Asian	☐
Black or African American	☐
Native Hawaiian or Other Pacific Islander	☐
White	☐

21. Ethnicity:

Ethnicity	☐
Hispanic or Latino	☐
Not Hispanic or Latino	☐

22. Primary Language: _____

Representative Information

If you are completing this questionnaire in a representative capacity (e.g., on behalf of the estate of a deceased person), please state the following:

23. Name:_____

24. Address:_____

25. Capacity in which you are representing the individual:_____

26. If you were appointed as a representative by a court, identify the State, Court and Case Number:

    a) State:_____

    b) Court:_____

    c) Case Number:_____

27. Relationship to the Represented Person:_____

28. State the date of death of the decedent:_____

29. State the place of death of the decedent:_____

30. Are you filling this questionnaire out on behalf of an individual who is deceased and on whom an autopsy was performed? Yes ☐ No☐

If you are completing this questionnaire in a representative capacity, please respond to these questions with respect to the person whose medical treatment involved Taxotere® or Docetaxel.

II. PERSONAL INFORMATION

Relationship Information

1. Are you currently: Married: ☐ Single: ☐ Engaged: ☐ Significant other: ☐ Divorced: ☐ Widowed: ☐ Same sex partner: ☐

2. Have you ever been married? Yes ☐ No☐

3. If yes, for EACH marriage, state the following:

Spouse's Name	Date of Marriage	Date Marriage Ended	Nature of Termination

Education

4. For each level of education you completed, please check below:

High School: ☐ Vocational School: ☐

College: AA: ☐ BA/BS: ☐ Masters: ☐ PhD: ☐ M.D.: ☐ Other:

Employment

5. Are you currently employed? Yes ☐ No☐

6. If yes, state the following:

   a) Current employer name:_____

   b) Address:_____

   c) Telephone number:_____

   d) Your position there:_____

7. Are you making a claim for lost wages or lost earning capacity? Yes ☐ No☐

8. Only if you are asserting a wage loss claim, please state the following for EACH employer for the last seven (7) years:

Name of Employer	Address of Employer	Dates of Employment	Annual Gross Income	Your Position

9. Have you ever been out of work for more than thirty (30) days for reasons related to your health in the last seven (7) years? Yes ☐ No☐

10. If yes, please state the following:

Name of Employer	Dates	Health Reason

YOU MUST ATTACH TAX RETURNS, EMPLOYMENT AUTHORIZATIONS, AND IDENTIFY THE LOSS OF CONSORTIUM PLAINTIFF'S EMPLOYERS IF CLAIMING LOST WAGES OR LOST EARNING CAPACITY DAMAGES.

Worker's Compensation and Disability Claims

11. Within the last ten (10) years, have you ever filed for workers' compensation, social security, and/or state or federal disability benefits? Yes ☐ No☐

12. If yes, then as to EACH application, please state the following:

Year Claim Filed	Court	Nature of Claimed Injury	Period of Disability	Award Amount

Military Service

13. Have you ever served in any branch of the military? Yes ☐ No☐

14. If yes, state the branch and dates of service:

Branch	Dates of Service

15. If yes, were you discharged for any reason relating to your health (whether physical, psychiatric, or other health condition)? Yes ☐ No☐

16. If yes, state the condition:_____

Other Lawsuits

17. Within the last ten (10) years, have you filed a lawsuit, relating to any bodily injury, or made a claim, OTHER THAN the present suit? Yes ☐ No ☐

Computer Use

18. Apart from communications to or from your attorney, have you communicated via email, visited any chat rooms, or publicly posted a comment, message or blog entry on a public internet site regarding your experience with or injuries you attribute to Taxotere®, other chemotherapies, or alopecia/hair loss during the past ten (10) years? You should include all postings on public social network sites including Twitter, Facebook, MySpace, LinkedIn, or "blogs" that address the topics above. Yes ☐ No☐

19. If yes, please state the following:

Forum Name	Screen Name or User Handle	Date of Post	Substance of Post

20. Are you now or have you ever been a member of an alopecia support group? Yes ☐ No☐

    a) If yes, identify the group by name:_____

    b) When did you join the group?_____

III. PRODUCT IDENTIFICATION

I HAVE RECORDS DEMONSTRATING USE OF TAXOTERE® OR OTHER DOCETAXEL: Yes ☐ No☐

YOU MUST UPLOAD THEM BEFORE YOU SUBMIT THIS FACT SHEET

Taxotere®

1. Were you treated with brand name Taxotere®? Yes ☐ No ☐ Unknown ☐

Other Docetaxel

2. Were you treated with another Docetaxel or generic Taxotere®? Yes ☐ No☐

3. If yes, select all that apply:

Name of Drug	
Docetaxel – Winthrop	☐
Docetaxel – Teva Pharms USA	☐
Docetaxel – Dr. Reddy's Labs Ltd.	☐
Docetaxel – Eagle Pharms	☐
Docetaxel – Actavis Inc.	☐
Docetaxel – Pfizer Labs	☐
Docetaxel – Sandoz	☐
Docetaxel – Accord Healthcare, Inc.	☐
Docetaxel – Apotex Inc.	☐
Docetaxel – Hospira Inc.	☐
Docefrez – Sun Pharma Global, Inc.	☐
Unknown	☐

4. **IF YOU SELECTED "UNKNOWN" YOU MUST CERTIFY AS FOLLOWS:**

   I certify that I have made reasonable, good faith efforts to identify the manufacturer of the Docetaxel used in my treatment, including requesting records from my infusion pharmacy, and the manufacturer either remains unknown at this time or I am awaiting the records: ☐

IV. MEDICAL INFORMATION

Vital Statistics

1. How old are you:_____

2. Age at the time of your alleged injury:_____

3. Current weight:_____

4. Current height:

   Feet:_____ Inches:_____

5. Weight at time of alleged injury:_____

Gynecologic and Obstetric History

6. Have you ever been pregnant? Yes ☐ No ☐

   a) Number of pregnancies:_____

   b) Number of live births:_____

7. If you have children, please state the following for EACH child:

Child's Name	Address	Date of Birth

8. Date of first period (menses):_____ Age:_____

9. Date of last period (menses): _____ Age:_____

10. Are you menopausal, perimenopausal or postmenopausal? Yes ☐ No☐

11. For EACH year for the last seven (7) years before your first treatment with Taxotere® or Docetaxel and since then, who did you see for your annual gynecological exam? Also indicate whether an annual exam was skipped or missed.

Doctor	Office	Year	Skipped or Missed
			☐
			☐
			☐
			☐
			☐
			☐
			☐

12. For EACH year after age 40, or before then if applicable, who did you see for your annual mammogram? Also indicate whether an annual mammogram was skipped or missed.

Doctor	Office	Year	Skipped or Missed
			☐
			☐
			☐
			☐

Doctor	Office	Year	Skipped or Missed
			☐
			☐
			☐

Other Risk Factors

13. Have any family members been diagnosed with breast cancer?

Family Member	Diagnosed	Age at Diagnosis
Mother	☐	
Sister	☐	
Daughter	☐	
Paternal grandmother	☐	
Maternal grandmother	☐	

14. Have you ever been diagnosed as having genes or gene mutations that carry an increased cancer risk (e.g., BRCA1, BRCA2)? Yes ☐ No☐

    a) If yes, which? _____

15. Did you receive radiation treatments or exposure to radiation before the age of 30? Yes ☐ No☐

    a) If yes, describe the particulars of your treatment or exposure:
    _____

Tobacco Use History

For the ten (10) year period before your use of Taxotere® or Docetaxel up to the present, check the answer and fill in the blanks applicable to your history of tobacco use, including cigarettes, cigars, pipes, and/or chewing tobacco/snuff.

16. I currently use tobacco: Yes ☐ No☐

17. I have never used tobacco: Yes ☐ No☐

18. I used tobacco in the ten (10) years before Taxotere® or Docetaxel treatment: Yes ☐ No☐

19. Identify types of tobacco use:

Type	Used	Average Per Day	Duration of Use (Years)
Cigarettes	☐		

Type	Used	Average Per Day	Duration of Use (Years)
Cigars	☐		
Pipes	☐		
Chewing tobacco/snuff	☐		

Prescription Medications

20. Apart from chemotherapy, are there prescription or over-the-counter medications that you took on a regular basis or more than three (3) times in the seven (7) year period before you first took Taxotere®? Yes ☐ No ☐

    For purposes of this question, "regular basis" means that you were directed by a healthcare provider to take a medication for at least forty-five (45) consecutive days.

21. If yes, please provide the following for EACH prescription medication:

Medication	Prescriber	Dates Taken

V. CANCER DIAGNOSIS AND TREATMENT

Cancer Diagnosis & Treatment Generally

1. Have you ever been diagnosed with cancer? Yes ☐ No☐
2. Were you diagnosed with cancer more than once? Yes ☐ No☐
3. Did you undergo any of the following for cancer?

Treatment	Treated
Surgery	☐
Radiation	☐
Chemotherapy	☐

4. For surgery, specify:

Type of Surgery	Treated
Double mastectomy	☐
Left-side mastectomy	☐
Right-side mastectomy	☐
Lumpectomy	☐

Other:_____	☐

5. Please state the following for EACH cancer diagnosis:

Type of Cancer	
Date of Diagnosis	
Primary Oncologist	Name: Address: Dates of Treatment: Treatment:
Primary Oncologist	Name: Address: Dates of Treatment: Treatment:
Primary Oncologist	Name: Address: Dates of Treatment: Treatment:
Treatment Facility	Name: Address: Dates of Treatment: Treatment:
Treatment Facility	Name: Address: Dates of Treatment: Treatment:
Treatment Facility	Name: Address: Dates of Treatment: Treatment:
Treatment Facility	Name: Address: Dates of Treatment: Treatment:

Type of Cancer	
Date of Diagnosis	
Primary Oncologist	Name: Address: Dates of Treatment: Treatment:

Type of Cancer	
Date of Diagnosis	
Primary Oncologist	Name: Address: Dates of Treatment: Treatment:
Primary Oncologist	Name: Address: Dates of Treatment: Treatment:
Treatment Facility	Name: Address: Dates of Treatment: Treatment:
Treatment Facility	Name: Address: Dates of Treatment: Treatment:
Treatment Facility	Name: Address: Dates of Treatment: Treatment:
Treatment Facility	Name: Address: Dates of Treatment: Treatment:

Particulars of Chemotherapy

6. When were you first diagnosed with the condition for which you were prescribed Taxotere® or Docetaxel?_____

7. What was the diagnosis for which you were prescribed Taxotere® or Docetaxel?

Diagnosis	Diagnosed
Breast cancer	☐
Non-small cell lung cancer	☐
Prostate cancer	☐
Gastric adenocarcinoma	☐
Head and neck cancer	☐
Other:_____	☐

8. For breast cancer, specify:

a) Tumor size:

Tumor Size	Yes
TX	☐
T0	☐
Tis	☐
T1	☐
T2	☐
T3	☐
T4 (T4a, T4b, T4c, T4d)	☐

b) Metastasis:_____

c) Node involvement:

Node	Yes
Node + NX	☐
Node + N0	☐
Node + N1	☐
Node + N2	☐
Node + N3	☐
Node – (negative)	☐

d) HER2: + (positive): ☐ - (negative): ☐

e) Estrogen receptor: Positive (ER+): ☐ Negative (ER-): ☐

f) Progesterone receptor: Positive (PR+): ☐ Negative (PR-): ☐

9. Was Taxotere® or Docetaxel the only chemotherapy treatment that you ever received? Yes ☐ No☐ Unknown ☐

10. Have you ever been treated with other chemotherapy drugs, either alone or in combination with or sequentially with Taxotere® or Docetaxel? Yes ☐ No☐ Unknown ☐

11. If yes, check which of the following chemotherapy drugs you took:

Drug	Yes
5-Fluorouracil (Eludex)	☐
Actinomycin	☐
Altretamine (Hexalen)	☐
Amsacrine	☐
Bleomycin	☐

Drug	Yes
Busulfan (Busulfex, Myleran)	☐
Cabazitaxel: Mitoxantrone	☐
Carboplatin (Paraplatin)	☐
Carmustine (BiCNU, Gliadel)	☐
Cetuximab (Erbitux)	☐
Chlorambucil (Leukeran)	☐
Cisplatin (Platinol)	☐
Cyclophosphamide (Neosar)	☐
Cytarabine (Depocyt)	☐
Dacarbazine	☐
Daunorubicin (Cerubidine, DaunoXome)	☐
Doxorubicin (Adriamycin, Doxil)	☐
Epirubicin (Ellence)	☐
Erlotinib (Tarceva)	☐
Etoposide (Etopophos, Toposar)	☐
Everolimus (Afinitor, Zortress)	☐
Faslodex (Fulvestrant)	☐
Gemcitabine (Gemzar)	☐
Hexamethylmelamine (Hexalen)	☐
Hydroxyurea (Hydrea, Droxia)	☐
Idarubicin (Idamycin)	☐
Ifosfamide (Ifex)	☐
L-asparginase (crisantaspase)	☐
Lomustine (Ceenu)	☐
Melphalan (Alkeran)	☐
Mercaptopurine (Purinethol, Purixan)	☐
Methotrexate (Trexall, Rasuvo)	☐
Mitomycin	☐
Mitoxantrone	☐
Nab-paclitaxel (Abraxane): Mitoxantrone	☐
Nitrogen mustard	☐
Paclitaxel (Taxol)	☐
Panitumumab (Vectibix)	☐
Procarbazine (Matulane)	☐
Sorafenib (Nexavar)	☐
Teniposide (Vumon)	☐
Thioguanine (Tabloid)	☐
Thiotepa (Tepadina)	☐
Topotecan (Hycamtin)	☐

Drug	Yes
Vemurafenib (Zelboraf)	☐
Vinblastine	☐
Vincristine (Mariqibo, Vincasar)	☐
Vindesine	☐
Vinorelbine (Alocrest, Navelbine)	☐
Unknown	☐

12. Please provide the following information regarding Taxotere® or Docetaxel:

a) Number of cycles: _____

b) Frequency: Every week ☐ Every three weeks ☐ Other:_____

c) First treatment date:_____

d) Last treatment date:_____

e) Dosage:_____

(1) Combined with another chemotherapy drug: ☐

(2) Sequential with another chemotherapy drug: ☐

(3) If so, describe the combination or sequence:_____

13. Prescribing Physician(s):

Prescribing Physician	Address
	Street: City: State: Zip:
	Street: City: State: Zip:
	Street: City: State: Zip:

14. Treatment Facility:

Treatment Facility	Address
	Street:

	City: State: Zip:
	Street: City: State: Zip:
	Street: City: State: Zip:

15. Identify EACH state where you resided when you began and while taking Taxotere® or Docetaxel:

State	From Date	To Date

16. Was your Taxotere® or Docetaxel treatment part of a clinical trial? Yes ☐ No ☐ Unknown ☐

17. If yes, please provide the name and location of the trial site:

    a) Name of trial site:_____

    b) Location of trial site:_____

VI. CLAIM INFORMATION

Current Status

1. Are you currently taking Taxotere® or Docetaxel? Yes ☐ No☐

2. Are you currently cancer-free? Yes ☐ No☐

3. If no, check those that apply to your CURRENT status:

Current Status	Yes
In remission	☐
Currently receiving chemotherapy	☐
Currently receiving radiation therapy	☐
Currently hospitalized for cancer or cancer-related complications	☐

Current Status	Yes
Currently in home health or hospice care for cancer or cancer-related complications	☐
Cancer returned after taking Taxotere® or Docetaxel	☐

4. When was the last (most recent) date you consulted with an oncologist:_____

Alleged Injury

5. State the injury you allege in this lawsuit and the dates between which you experienced the alleged injury. Check all that apply:

Alleged Injury	Yes	No	From	To
Persistent total alopecia – No hair growth on your head or body after six (6) months of discontinuing Taxotere® or Docetaxel treatment	☐	☐		
Persistent alopecia of your head – No hair growth on your head after six (6) months of discontinuing Taxotere® or Docetaxel treatment. Hair is present elsewhere on your body	☐	☐		
Permanent/Persistent Hair Loss on Scalp	☐	☐		
Diffuse thinning of hair: partial scalp ☐ Top ☐ Sides ☐ Back ☐ Temples ☐ Other:_____	☐	☐		
Diffuse thinning of hair: total scalp ☐ Top ☐ Sides ☐ Back ☐ Temples ☐ Other:_____	☐	☐		
Significant thinning of the hair on your head after six (6) months of discontinuing Taxotere® or Docetaxel treatment – There are visible bald spots on your head no matter how you style your hair	☐	☐		
Moderate thinning of the hair on your head after six (6) months of discontinuing Taxotere® or Docetaxel treatment – There is noticeable hair loss but if you brush or style your hair, the hair loss is less evident	☐	☐		
Small bald area in the hair on your head	☐	☐		
Large bald area in the hair on your head	☐	☐		

Alleged Injury	Yes	No	From	To
Multiple bald spots in the hair on your head	☐	☐		
Change in the texture, thickness or color of your hair after Taxotere® or Docetaxel treatment	☐	☐		
Other:_____	☐	☐		
Permanent/Persistent Loss of Eyebrows	☐	☐		
Permanent/Persistent Loss of Eyelashes	☐	☐		
Permanent/Persistent Loss of Body Hair	☐	☐		
Permanent/Persistent Loss of Genital Hair	☐	☐		
Permanent/Persistent Loss of Nasal Hair	☐	☐		
Permanent/Persistent Loss of Ear Hair	☐	☐		
Permanent/Persistent Loss of Hair in Other Areas Describe:_____	☐	☐		

6. Have you ever received treatment for the injury you allege in this lawsuit? Yes ☐ No☐

Name of Treating Physician	Dates of Treatment	Treatments

7. Were you diagnosed by a healthcare provider for the injury you allege in this lawsuit? Yes ☐ No☐

Name of Treating Physician	Dates of Treatment	Treatments

8. Have you discussed with any healthcare provider whether Taxotere® or Docetaxel caused or contributed to your alleged injury? Yes ☐ No☐

Name of Treating Physician	Dates of Treatment	Treatments

Statement Information

9. Were you ever given any written instructions, including any prescriptions, packaging, package inserts, literature, medication guides, or dosing instructions, regarding chemotherapy, Taxotere® or Docetaxel? Yes ☐ No☐

10. If yes, please describe the documents, if you no longer have them. If you have the documents, please produce them:

Description of Document	I Have the Documents	I Do Not Have the Documents
	☐	☐
	☐	☐
	☐	☐

11. Were you given any oral instructions from a healthcare provider regarding chemotherapy or your use of Taxotere® or Docetaxel? Yes ☐ No☐

12. If yes, please identify each healthcare provider who provided the oral instructions:

Name of Healthcare Provider

13. Have you ever seen any advertisements (e.g., in magazines or television commercials) for Taxotere® or Docetaxel? Yes ☐ No☐

14. If yes, identify the advertisement or commercial, and approximately when you saw the advertisement or commercial:

Type of Advertisement or Commercial	Date of Advertisement or Commercial

15. Other than through your attorneys, have you had any communication, oral or written, with any of the Defendants or their representatives? Yes ☐ No☐

16. If yes, please identify:

Date of Communication	Method of Communication	Name of Representative	Substance of Communication

17. Have you filed a MedWatch Adverse Event Report to the FDA? Yes ☐ No☐

YOU MUST UPLOAD NOW ANY MEDICAL RECORDS IN YOUR POSSESSION DEMONSTRATING ALLEGED INJURY OR PHOTOGRAPHS SHOWING YOUR HAIR BEFORE AND AFTER TREATMENT WITH TAXOTERE® ALONG WITH THE DATE(S) THE PHOTOGRAPHS WERE TAKEN.

Other Claimed Damages

18. Mental or Emotional Damages: Do you claim that your use of Taxotere® or Docetaxel caused or aggravated any psychiatric or psychological condition? Yes ☐ No☐

19. If yes, did you seek treatment for the psychiatric or psychological condition? Yes ☐ No☐

Provider	Date	Condition

20. Medical Expenses: Do you claim that you incurred medical expenses for the alleged injury that you claim was caused by Taxotere® or Docetaxel? Yes ☐ No☐

21. If yes, list all of your medical expenses, including amounts billed or paid by insurers and other third-party payors, which are related to any alleged injury you claim was caused by Taxotere® or Docetaxel:

Provider	Date	Expense

22. Lost Wages: Do you claim that you lost wages or suffered impairment of earning capacity because of the alleged injury that you claim was caused by Taxotere® or Docetaxel? Yes ☐ No☐

23. If yes, state the annual gross income you earned for each of the three (3) years before the injury you claim was caused by Taxotere® or Docetaxel.

Year	Annual Gross Income

24. State the annual gross income for every year following the injury or condition you claim was caused by Taxotere® or Docetaxel.

Year	Annual Gross Income

25. Out-of-Pocket Expenses: Are you making a claim for lost out-of-pocket expenses? Yes ☐ No☐

26. If yes, please identify and itemize all out-of-pocket expenses you have incurred:

Expense	Expense Amount

VII. HAIR LOSS INFORMATION

Background

1. Did you ever see a healthcare provider for hair loss BEFORE taking Taxotere® or Docetaxel? Yes ☐ No ☐

2. Did your hair loss begin during chemotherapy treatment? Yes ☐ No☐

3. If yes, did you FIRST experience hair loss:

   a) After treatment with another chemotherapy agent: ☐

   b) After treatment with Taxotere® or Docetaxel: ☐

4. At any time before or during the hair loss were you:

Condition	Yes	Description
Pregnant	☐	
Seriously ill	☐	
Hospitalized	☐	
Under severe stress	☐	
Undergoing treatment for any other medical condition	☐	

5. When did you FIRST discuss with or see a healthcare provider about your hair loss? _____

6. Have you started any special diets at any time before or during the hair loss? Yes ☐ No ☐ Describe:_____

Hair Loss History

Question	No	Yes	Name of Healthcare Provider
Have you had a biopsy of your scalp to evaluate your hair loss problem?	☐	☐	
Have you had blood tests done to evaluate your hair loss problem?	☐	☐	
Have your hormones ever been checked to evaluate your hair loss problem?	☐	☐	
Have you ever been told by a doctor that you have a thyroid condition?	☐	☐	
Have you ever been treated with thyroid hormone?	☐	☐	
Have you ever been told by a doctor that you have a low iron level?	☐	☐	

7. Have you ever been on endocrine or hormonal therapy, either before or after chemotherapy with Taxotere® or Docetaxel? Yes ☐ No☐

8. If yes, please identify:

Treating Physician	Dates of Treatment	Treatment

9. Do you have any autoimmune diseases? Yes ☐ No☐

10. If yes, check the following which describes you:

Autoimmune Disease	Yes
Lupus	☐
Rheumatoid arthritis	☐
Celiac disease	☐
Type 1 diabetes	☐
Sjogrens disease	☐
Vitiligo	☐
Hashimoto's	☐
Other:_____	☐

11. Were you taking any medications when your hair loss began? Yes ☐ No☐

Medication

Hair Care

12. How often do you wash/shampoo your hair? Every _____ days

13. Check any of the following that apply to you currently or that have in the past:

Hair Treatment	Yes	Period of Time	Frequency
Hair chemically processed or straightened (relaxers, keratin, Brazilian blowout, Japanese straightening, other)	☐		☐ Never ☐ Once a week ☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year
Hair heat processed or straightened (blow drying/ flat ironing, curling)	☐		☐ Never ☐ Once a week ☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year
Hair dyed	☐		☐ Never ☐ Once a week ☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year
Hair highlighted	☐		☐ Never ☐ Once a week ☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year
Braids	☐		☐ Never ☐ Once a week ☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year
Weaves	☐		☐ Never ☐ Once a week ☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year

Tight hairstyles (ponytails)	☐		☐ Never ☐ Once a week ☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year
Extensions	☐		☐ Never ☐ Once a week ☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year
Other:_____	☐		☐ Never ☐ Once a week ☐ 2-3 times a week ☐ Once a month ☐ Once every 1-2 months ☐ A few times a year

14. Have you ever used the following?

Hair Treatment	Yes
WEN Cleansing Conditioners	☐
Unilever Suave Professionals Keratin Infusion	☐
L'Oréal Chemical Relaxer	☐

15. Has your hair care regimen been different in the past? Yes ☐ No☐

a) If yes, describe:_____

Hair Loss Treatment

16. Did you use any other methods to prevent hair loss during chemotherapy?

Hair Treatment	Yes
Folic Acid supplementation	☐
Minoxidil	☐
Other:_____	☐

17. Did you wear a cool cap during chemotherapy treatment? Yes ☐ No☐

18. If yes, which cooling cap did you wear: _____

19. Have you used any over-the-counter medications, supplements, or cosmetic aides for your hair loss? Yes ☐ No☐

20. If yes, please state the following:

Treatment	When was it tried?	How long did you try it?	Did it help?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

21. Has anything helped your hair loss? Yes ☐ No☐

22. If yes, please specify:

Type of Product	Dates of Use	Place of Purchase	Results of Use

23. As of the date you verify your PFS, how long have you had alopecia or incomplete hair re-growth?_____

24. Has any hair regrowth occurred? Yes ☐ No☐

25. Have you ever worn a wig to conceal your hair loss? Yes ☐ No☐

26. Specify:

Dates Used	Period of Use	Place Purchased	Cost of Item

VIII. RECORD HOLDER IDENTIFICATION

Healthcare Providers:

1. Identify each physician, doctor, or other healthcare provider who has provided treatment to you for any reason in the past eight (8) years and the reason for consulting the healthcare provider or mental healthcare provider.

YOU MUST INCLUDE YOUR ONCOLOGIST, RADIOLOGIST, DERMATOLOGIST, DERMATOLOGIST-PATHOLOGIST, HAIR LOSS SPECIALIST, GYNECOLOGIST, OBSTETRICIAN, AND PRIMARY CARE PHYSICIAN, ALONG WITH ANY OTHER HEALTHCARE PROVIDERS IDENTIFIED ABOVE

Name	Area or Specialty	Address	Dates	Reason for Consultation

Hospitals, Clinics, and Other Facilities:

2. Identify each hospital, clinic, surgery center, physical therapy or rehabilitation center, or other healthcare facility where you have received inpatient or outpatient treatment (including emergency room treatment) in the past eight (8) years:

YOU MUST INCLUDE THE LOCATIONS FOR SURGERIES, RADIOLOGY, IMAGING, BIOPSIES, CHEMOTHERAPY, CHILD BIRTHS, GYNECOLOGIC PROCEDURES OR TREATMENT, ALONG WITH ANY OTHER HEALTHCARE FACILITIES

Name	Address	Dates	Reason for Treatment

Laboratories:

3. Identify each laboratory at which you had tests run in the past ten (10) years:

Name	Address	Dates	Test	Reason for Tests

Pharmacies:

4. To the best of your recollection, Identify each pharmacy, drugstore, and/or other supplier (including mail order) where you have had prescriptions filled or from

which you have ever received any prescription medication within three (3) years prior to and three (3) years after your first treatment with Taxotere:

Name	Address	Dates	Medications

Retailers:

5. Identify each pharmacy, drugstore, and/or other retailer (including mail order) where you have purchased over-the-counter medications, or hair products in the past ten (10) years:

Name	Address	Dates	Purchases

Insurance Carriers:

6. Identify each health insurance carrier which provided you with medical coverage and/or pharmacy benefits for the last ten (10) years:

Carrier	Address	Name of Insured & SSN	Policy Number	Dates of Coverage

IX. DOCUMENT REQUESTS AND AUTHORIZATIONS

Please state which of the following documents you have in your possession. If you do not have the following documents but know they exist in the possession of others, state who has possession of the documents: Produce all documents in your possession (including writings on paper or in electronic form) and signed authorizations and attach a copy of them to this PFS.

Requests

Type of Document(s)	Yes	No	If No, who has the document(s)?
Documents you reviewed to prepare your answers to this Plaintiff Fact Sheet. *Your attorney may withhold some documents on claims of attorney-client privilege or work product protection and, if so, provide a privilege log*	☐	☐	

Type of Document(s)	Yes	No	If No, who has the document(s)?
Medical records or other documents related to the use of Taxotere® or Docetaxel at any time for the past twelve (12) years.	☐	☐	
Medical records or other documents related to your treatment for any disease, condition or symptom referenced above for any time in the past twelve (12) years.	☐	☐	
Laboratory reports and results of blood tests performed on you related to your hair loss.	☐	☐	
Pathology reports and results of biopsies performed on you related to your hair loss. *Plaintiffs or their counsel must maintain the slides and/or specimens requested in this subpart, or send a preservation notice, copying Defendants, to the healthcare facility where these items are maintained.*	☐	☐	
Documents reflecting your use of any prescription drug or medication at any time within the past eight (8) years.	☐	☐	
Documents identifying all chemotherapy agents that you have taken.	☐	☐	
Documents for any workers' compensation, social security or other disability proceeding at any time within the last five (5) years.	☐	☐	
Instructions, product warnings, package inserts, handouts or other materials that you were provided or obtained in connection with your use of Taxotere®.	☐	☐	
Advertisements or promotions for Taxotere®.	☐	☐	
Articles discussing Taxotere®.	☐	☐	
Any packaging, container, box, or label for Taxotere® or Docetaxel that you were provided or obtained in connection with your use of Taxotere®. *Plaintiffs or their counsel must maintain the originals of these items.*	☐	☐	
Documents which mention Taxotere® or Docetaxel or any alleged health risks related to Taxotere®. *Your attorney may withhold some legal documents, documents provided by your attorney, or documents obtained or created for the purpose of seeking legal advice or assistance on claims of attorney-client privilege or work product protection and, if so, provide a privilege log.*	☐	☐	
Documents obtained directly or indirectly from any of the Defendants.	☐	☐	

Type of Document(s)	Yes	No	If No, who has the document(s)?
Communications or correspondence between you and any representative of the Defendants.	☐	☐	
Photographs, drawing, slides, videos, recordings, DVDs, or any other media that show your alleged injury or its effect in your life.	☐	☐	
Journals or diaries related to the use of Taxotere® or Docetaxel or your treatment for any disease, condition or symptom referenced above at any time for the past twelve (12) years.	☐	☐	
Social media or internet posts to or through any site (including, but not limited to, Facebook, MySpace, LinkedIn, Google Plus, Windows Live, YouTube, Twitter, Instagram, Pinterest, blogs, and Internet chat rooms/message boards) relating to Taxotere® or Docetaxel or any of your claims in this lawsuit.	☐	☐	
If you claim you have suffered a loss of earnings or earning capacity, your federal tax returns for each of the five (5) years preceding the injury you allege to be caused by Taxotere® or Docetaxel, and every year thereafter or W-2s for each of the five (5) years preceding the injury you allege to be caused by Taxotere® or Docetaxel, and every year thereafter.	☐	☐	
If you claim any medical expenses, bills from any physician, hospital, pharmacy or other healthcare providers.	☐	☐	
Records of any other expenses allegedly incurred as a result of your alleged injury.	☐	☐	
If you are suing in a representative capacity, letters testamentary or letters of administration.	☐	☐	
If you are suing in a representative capacity on behalf of a deceased person, decedent's death certificate and/or autopsy report.	☐	☐	
Photographs of you that are representative of your hair composition **before** treatment with Taxotere® or Docetaxel.	☐	☐	
Photographs of you that are representative of your hair composition **during** treatment with Taxotere® or Docetaxel.	☐	☐	
Photographs of you that are representative of your hair composition **six months after conclusion** of treatment with Taxotere® or Docetaxel.	☐	☐	
Photographs of you that are representative of your hair composition **in present day.**	☐	☐	

Type of Document(s)	Yes	No	If No, who has the document(s)?
Signed authorizations for medical records related to any cancer treatment identified herein and all pharmacy records from three (3) years before and three (3) years after your first treatment with Taxotere in the forms attached hereto.	☐	☐	

X. DECLARATION

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that all of the information provided in connection with this Plaintiff Profile Form is true and correct to the best of my knowledge information and belief at the present time.

_____ _____

Signature Date

XI. AUTHORIZATIONS

See next page for Authorizations.

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03
(Excluding Psychiatric, Psychological, and Mental Health Treatment Notes/Records)

TO:
Patient Name:
DOB:
SSN:

I, _____ , hereby authorize you to release and furnish to: Shook Hardy & Bacon LLP, Keogh Cox & Wilson Ltd., Ulmer & Berne LLP, Greenberg Traurig LLP, Wheeler Trigg O'Donnell LLP, Adams and Reese LLP, Chaffe McCall LLP, Quinn Emanuel Urquhart & Sullivan LLP, Morrison & Foerster LLP, Leake & Anderson LLP, Hinshaw & Culbertson LLP, Kirkland & Ellis LLP and/or their duly assigned agents, copies of the following records and/or information **from the time period of twelve (12) years prior to the date on which the authorization is signed**:

* All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
* All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
* All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.

****Notwithstanding the broad scope of the above disclosure requests, the undersigned does not authorize the disclosure of notes or records pertaining to psychiatric, psychological, or mental health treatment or diagnosis as such terms are defined by HIPAA, 45 CFR §164.501**.

1. To my medical provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition at a deposition or trial.**

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name:_____ (plaintiff/representative)

Signature: _____ Date

LIMITED AUTHORIZATION TO DISCLOSE EMPLOYMENT RECORDS AND INFORMATION (HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508)

TO: _____
Name of Employer

_____
Address, City State and Zip Code

RE: Employee Name: _____ AKA: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

I authorize the limited disclosure of my employment records including medical information protected by HIPAA, 45 CFR 164.508, for the purpose of review and evaluation in connection with a legal claim.

This authorization only authorizes release of records and/or information from the time period of seven (7) years **prior to the date on which this authorization is signed.** I expressly request that all entities identified above disclose full and complete records from the time period of seven (7) years prior to the date on which this authorization is signed, including the following:

This will authorize you to furnish copies of all applications for employment; resumes; records of all positions held; job descriptions of positions held; wage and income statements and/or compensation records; wage increases and decreases; evaluations, reviews and job performance summaries; W-2s; employee health files, and correspondence and memoranda regarding the undersigned.

I authorize you to release the information to:

_____
Name (Records Requestor)

_____
Street Address City State and Zip Code

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requestor at that time.

I acknowledge the right to revoke this authorization by writing to you at the above referenced address. However, / understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

_____
Signature of Employee or Personal Representative Date Name of Employee or Personal Representative

_____
Description of Personal Representative's Authority to Sign for Employee (attach documents that show authority)

LIMITED AUTHORIZATION FOR RELEASE OF WORKERS' COMPENSATION RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all workers' compensation records of any sort **for any workers' compensation claims filed within the last ten (10) years**, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning:

_____
Name of Claimant

whose date of birth is _____ and whose social security number is _____

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

Records Requestor
_____
Representative Capacity (e.g., attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

This authorization only authorizes release of documents and records from the period of ten (10) years prior to the date on which this authorization is signed. This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date: _____ _____

Claimant Signature
[NAME]

Date: _____ _____

Witness Signature

LIMITED AUTHORIZATION FOR RELEASE OF DISABILITY CLAIMS RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all records of disability claims of any sort **for any disability claim(s) filed within the last ten (10) years**, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning:

_____
Name of Claimant

whose date of birth is _____ and whose social security number is _____

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

Records Requestor
_____
Representative Capacity (e.g., attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

This authorization only authorizes release of documents and records from the period of ten (10) years prior to the date on which this authorization is signed. This authorization does not authorize you to disclose anything other than documents and records to anyone.

Date: _____ _____

Claimant Signature
[NAME]

Date: _____ _____

Witness Signature

FOR RELEASE OF
HEALTH INSURANCE RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all insurance claims applications and benefits, and all medical, health, hospital, physicians, nursing or allied health professional reports, records or notes, invoices and bills, in your possession that pertain to the named insured identified below. **This authorization only authorizes release of Health Insurance records and/or information from the time period of ten (10) years prior to the date on which this authorization is signed.**

_____
Name of Claimant

whose date of birth is_____and whose social security number is _____

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

Records Requestor
_____
Representative Capacity (e.g., attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

This authorization only authorizes release of documents and records from the period of ten (10) years prior to the date on which this authorization is signed. This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requestor named above has executed the acknowledgement at the bottom of this authorization.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date: _____ _____
Claimant Signature
[NAME]

Date: _____ _____
Witness Signature

LIMITED AUTHORIZATION TO DISCLOSE PSYCHIATRIC, PSYCHOLOGICAL AND/OR MENTAL HEALTH TREATMENT NOTES/RECORDS
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO:
Patient Name:
DOB:
SSN:

I, _____ , hereby authorize you to release and furnish to: Shook Hardy & Bacon LLP, Keogh Cox & Wilson Ltd., Ulmer & Berne LLP, Greenberg Traurig LLP, Wheeler Trigg O'Donnell LLP, Adams and Reese LLP, Chaffe McCall LLP, Quinn Emanuel Urquhart & Sullivan LLP, Morrison & Foerster LLP, Leake & Anderson LLP, Hinshaw & Culbertson LLP, Kirkland & Ellis LLP and/or their duly assigned agents, copies of the following records and/or information **from the time period of ten (10) years prior to the date on which the authorization is signed:**

- All "psychotherapy notes", as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501. Under HIPAA, the term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's record. This authorization does not authorize ex parte communication concerning same.

1. To my medical and/or mental health provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, mental health history, care, treatment, diagnosis, prognosis, information revealed by or in the medical or mental health records, or any other matter bearing on his or her medical, psychological, or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, mental health history, care, treatment, diagnosis, prognosis, information revealed by or in the medical or mental health records, or any other matter bearing on my medical, psychological, or physical condition at a deposition or trial.**

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name:_____ (plaintiff/representative)

Signature: _____ Date _____

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

IN RE: TAXOTERE (DOCETAXEL) PRODUCTS LIABILITY LITIGATION	**MDL NO. 2740** **SECTION "N" (5)**
THIS DOCUMENT RELATES TO: **ALL CASES**	**HON. KURT D. ENGELHARDT**

DEFENDANT FACT SHEET – PRODUCT IDENTIFICATION

Within seventy-five (75) days of receiving a substantially completed Plaintiff Fact Sheet ("PFS"), Defendants Sanofi S.A., Aventis Pharma S.A., and Sanofi-Aventis U.S., LLC, and Winthrop US (collectively referred to as "Defendants") must complete and serve this Defendant Fact Sheet ("DFS") and identify or provide DOCUMENTS and/or data responsive to the questions set forth below for each such Plaintiff. Defendants must supplement their responses to the extent that additional information is provided by Plaintiff in a supplemental PFS, within sixty (60) days of receiving the supplemental information. In the event the DFS does not provide YOU with enough space to complete YOUR responses or answers, please attach additional sheets if necessary. Please identify any DOCUMENTS that YOU are producing as responsive to a question or request by bates number.

DEFINITIONS & INSTRUCTIONS

As used herein, "YOU," "YOUR," or "YOURS" means the responding DEFENDANTS.

"DEFENDANTS" shall mean and refer to those companies involved in the development, manufacture and distribution of the drugs known as Taxotere (Docetaxel) including Sanofi S.A., Aventis Pharma S.A., Sanofi-Aventis U.S., LLC, and Winthrop US shall each answer each document request and question that not only calls for YOUR knowledge, but also for all knowledge that is available to YOU by reasonable inquiry, including inquiry of YOUR "officers," "directors," "agents," "employees," and attorneys.

As used herein, the phrase "HEALTHCARE PROVIDER" means: any physician or other individual healthcare provider, health care facility, clinic, hospital or hospital pharmacy identified by full name and address in PFS Section Sections V.13 and V.14 who administered, prescribed, and/or dispensed Taxotere (Docetaxel) to the Plaintiff.

"REMUNERATION" means anything of value, directly or indirectly, overtly or covertly, in cash or in kind, including but not limited to monetary payment, compensation, incentives, preceptorship fees, gifts, entertainment, sports and/or concert tickets, speaker fees, grants, SAMPLES, reimbursement assistance, beneficiary inducements, wellness programs, patience assistance

Exhibit "B"

programs, transportation and/or lodging assistance, adherence to treatment regimen programs, incentives or inducements to remain in network, navigator/care coordination programs, end of life and/or palliative care programs, third party payments of premiums, or any other inducements or programs.

As used herein, the term "DOCUMENT" shall, consistent with Federal Rule of Civil Procedure 34(a)(1)(A), refer to any "designated documents or electronically stored information – including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations – stored in any medium form which information can be obtained either directly or, if necessary, after translation by the responding party into a reasonably usable form."

If YOU are aware that any DOCUMENT that was, or might have been, responsive to any sections of this DFS which concern or relate to Plaintiff or Plaintiff's Named Facilities was destroyed, erased, surrendered or otherwise removed from YOUR possession, custody or control, at any time, provide, to the maximum extent possible, the following information: (a) the nature of the DOCUMENT (e,g., letter, memorandum, contract, etc.,) and a description of its subject matter; (b) the author or sender of the DOCUMENT; (c) the recipient(s) of the DOCUMENT; (d) the date that the DOCUMENT was authored, sent and received; (e) the circumstances surrounding the removal of the DOCUMENT from YOUR custody, possession or control; and (f) the identity of the person(s) having knowledge of such removal from YOUR custody, possession or control.

As used herein, "KEY OPINION LEADER" or "THOUGHT LEADER" shall mean and refer to physicians, often academic researchers, who are believed by DEFENDANTS to be effective at transmitting messages to their peers and others in the medical community. This term shall mean and refer to any doctors or medical professionals hired by, consulted with, or retained by DEFENDANTS to, amongst other things, consult, give lectures, respond to media inquiries, conduct clinical trials, write articles or abstracts, sign their names as authors to articles or abstracts written by others, sit on advisory boards and make presentations on their behalf at regulatory meetings or hearings.

The phrase "SAMPLES" refers to any medication or unit of a prescription drug not intended to be sold, which is given to promote the drug's sales. This includes any vouchers or coupons that provide for the HEALTHCARE PROVIDERS or patients access to the medication for a specified period of time.

"PATIENT ASSISTANCE PROGRAM" means programs created by drug companies, such as Sanofi, to offer free or low cost drugs to individuals who are unable to pay for their medication. These Programs may also be called indigent drug programs, charitable drug programs or medication assistance programs.

The phrase "SALES REPRESENTATIVE" means any person presently or formerly engaged or employed by YOU whose job duties include calling on physicians or other health care professionals, healthcare facilities, hospitals, and/or physician practice groups; promoting drugs manufactured or licensed by YOU to physicians or other HEALTH CARE PROVIDERS; distributing drug SAMPLES to physicians or other HEALTH CARE PROVIDERS. "SALES REPRESENTATIVE" also includes those who occupy positions titled "Professional Sales Representative," "Sales Professional," "Specialty Sales Representative," "Senior Sales

Representative," "Senior Health Care Representative," "Professional Representative," "Health Care Representative," "Institutional" or "Managed Care" sales representative, "Oncology Sales Representative," "Medical Service Representative," and "Medical Sales Representative" or any other titles used by Defendants and any of its divisions SALES REPRESENTATIVE also includes any contract employees or SALES REPRESENTATIVES from other companies involved in the promotion or co-promotion of Taxotere (Docetaxel) .

The phrase "SALES MANAGER" means any person presently or formerly engaged or employed by YOU whose job duties include managing SALES REPRESENTATIVES and/or the promotion or marketing of pharmaceutical products in a specific geographic region. "SALES MANAGER" includes those who occupy positions titled "District Sales Manager," "Senior Regional Sales Manager," "Regional Sales Manager," "Area Business Manager", "Business Manager," or any other titles YOU use or have used in the past for managers involved in the promotion or marketing of Taxotere (Docetaxel).

The phrase "MEDICAL SCIENCE LIAISON(S)" means any person presently or formerly engaged or employed by YOU for the purpose of sales support and direct field communication with physicians or other HEALTH CARE PROVIDERS about medical and science information related to Taxotere (Docetaxel), and opinion leader management. This includes employees with the titles of "Medical Science Liaison (MSL)," "Clinical Education Consultant (CEC)" or any other titles YOU use or have used in the past for these employees.

The phrase "MARKETING ORGANIZATION REPRESENTATIVE," means any person presently or formerly engaged or employed by YOU for the purpose of generating interest in Taxotere (Docetaxel) by creating and implementing a marketing campaign(s) to reach physicians or other HEALTHCARE PROVIDERS. This includes employees with the title of "Marketing Representative" or any other titles YOU use or have used in the past for these employees.

The phrase "CALL NOTES" means any and all writings, notations, electronically stored information, memoranda, DOCUMENTS, emails, database entries and reports or records, internal communications and any other information reflecting any contact with HEALTHCARE PROVIDERS, and/or information about or referring to HEALTHCARE PROVIDERS related to Taxotere (Docetaxel), oncology, or the treatment of cancer and chemotherapy.

The phrase "TARGETING INFORMATION" means any information the company uses to identify a particular person, group of people, type of health care provider or demographic within a larger audience regarding the promotion of Taxotere (Docetaxel). This includes documentation, including electronically stored information, designating particular campaigns, PROMOTIONAL MATERIAL and/or other promotional efforts directed toward particular types or specialties of healthcare providers (e.g., oncologists) and/or specifically identified healthcare providers.

I. CASE INFORMATION

This DFS pertains to the following case:

Case caption:_____

Civil Action No._____

Court in which action was originally filed:_____

Date this DFS was completed:_____

II. SALE OF TAXOTERE (DOCETAXEL) TO DISPENSER (HOSPITAL/PHARMACY) DIRECTLY AND/OR THROUGH GROUP PURCHASING ORGANIZATIONS

A. Did YOU sell, distribute, deliver or otherwise provide Taxotere (Docetaxel) to, any HEALTHCARE PROVIDER, either directly or pursuant to a Group Purchasing Organization ("GPO"), identified by the Plaintiff in Sections V.13 and V.14 of the PFS, during the time period of twenty-four (24) months preceding Plaintiff's first administration of Taxotere through the Plaintiff's last administration of Taxotere (Docetaxel)?

Yes_____ No_____

B. If YOUR answer is "Yes" to Question A. above, please provide a list of all deliveries or shipments of Taxotere (Docetaxel) sold, distributed or otherwise provided to each of the HEALTHCARE PROVIDERS, as identified by the Plaintiff in Sections V.13 and V.14 of the PFS, for the time period spanning from twenty-four (24) months prior to Plaintiff's first administration of Taxotere (Docetaxel) through Plaintiff's last administration of Taxotere (Docetaxel). Please include the name of each HEALTHCARE PROVIDER, the date of shipment/distribution of Taxotere (Docetaxel), and the amount of Taxotere (Docetaxel) distributed on said date.

Name of Healthcare Provider	Date of Shipment Distribution	Amount of Taxotere Distributed

C. Please provide all DOCUMENTS reflecting sale or purchase agreements regarding Taxotere (Docetaxel) between DEFENDANTS and the HEALTHCARE PROVIDERS identified by Plaintiff in Section Sections V.13 and V.14 of the PFS in effect during the time period spanning from twenty-four (24) months prior to Plaintiff's first administration of Taxotere (Docetaxel) through Plaintiff's last administration of Taxotere (Docetaxel).

D. Please provide all DOCUMENTS, including product labels, patient information packets, order forms, purchase orders, billing records, invoices, and other DOCUMENTS related to the shipments of Taxotere (Docetaxel) shipped to the HEALTHCARE PROVIDERS identified by Plaintiff in Sections V.13 and V.14 of the PFS for the time period spanning from twenty-four (24) months prior to Plaintiff's first administration of Taxotere (Docetaxel) through to Plaintiff's last administration of Taxotere (Docetaxel), and associate each label with the code numbers to which they are applicable. With regard to product labels, identification of the labels that applied to applicable lot numbers or dates is acceptable.

III. COMMUNICATIONS AND CONTACTS WITH PLAINTIFF'S HEALTHCARE PROVIDERS

A. For each HEALTHCARE PROVIDER identified in Sections V.13 and V.14 of the PFS:

1. Identify by name all of Defendants' SALES REPRESENTATIVES, MARKETING ORGANIZATIONS REPRESENTATIVES, MEDICAL SCIENCE LIAISONS, and/or any other detail persons ("Representative") who came in contact with any of Plaintiff's HEALTHCARE PROVIDER(S) in connection with Taxotere (Docetaxel) during the timeframe for which such records are available, namely 1996 to present.

Name of Representative	Title

2. Identify the time period, and specifically the dates, during which the Representative had any such contact with the HEALTHCARE PROVIDER.

Name of Representative	Healthcare Provider	Dates of Contact

3. If the Representative is no longer an employee, Defendants will provide the dates of employment for the employee and will also provide the last known address, telephone number, and email address for the Representative.

Name of Representative	Dates of Employment	Last Known Address	Telephone Number	Email Address

4. For each Representative, provide the names of the Representative's Supervising/District SALES MANAGER. If the Representative's Supervising District SALES MANAGER is no longer an employee, Defendants will provide the dates of employment for the employee and will also provide the last known address, telephone number, and email address for the former employee.

Supervising/District SALES MANAGER	**Current or Former Employee**	**Dates of Employment**	**Last Known Address**	**Telephone Number**	**Email Address**

B. For each Defendants' Sale Representatives, MARKETING ORGANIZATION REPRESENTATIVES, MEDICAL SCIENCE LIAISONS, and/or any other detail persons ("Representative"), previously identified in Section III.A of this DFS please produce the following:

1. His/her complete CALL NOTES for each such contact that relates to (a) Taxotere (Docetaxel); and/or (b) hair loss; and/or (c) permanent hair loss and/or alopecia.

2. Produce all emails or other written correspondence with the HEALTHCARE PROVIDER(S) that relates to (a) Taxotere (Docetaxel); and/or (b) hair loss; and/or (c) permanent hair loss and/or alopecia.

3. Produce any and all TARGETING INFORMATION related to the HEALTHCARE PROVIDER(S) identified by Plaintiff in Sections V.13 and V.14 of the PFS.

C. For the HEALTHCARE PROVIDERS identified by Plaintiff in Sections V.13 and V.14 of the PFS, please provide the following information related to SAMPLES of Taxotere (Docetaxel):

1. The date(s) on which such SAMPLES of Taxotere (Docetaxel) were provided;

2. The date(s) on which the Taxotere (Docetaxel) was provided through a PATIENT ASSISTANCE PROGRAM;

3. The amount, dosage, and lot numbers of such SAMPLES and/or Taxotere (Docetaxel) provided through a PATIENT ASSISTANCE PROGRAM;

4. The name(s) of the DEFENDANT representative(s) and/or department who provided such SAMPLES Taxotere (Docetaxel);

5. The name(s) of the DEFENDANT representative(s) and/or department who provided Taxotere (Docetaxel) through a PATIENT ASSISTANCE PROGRAM.

HEALTHCARE PROVIDER	Date(s) Shipped and/or Provided	Amount and Dosage	Lot Number	Representative Who Provided

IV. CONSULTING WITH PLAINTIFF'S HEALTHCARE PROVIDER

For each HEALTHCARE PROVIDER identified in Plaintiff's PFS, please answer the following:

A. If the HEALTHCARE PROVIDER has been consulted, retained, or compensated by Defendants as a "KEY OPINION LEADER," "THOUGHT LEADER," member of a "speaker's bureau," "clinical investigator," "consultant," advisory board member or in a similar capacity or otherwise has or had a financial relationship with or has been provided REMUNERATION by DEFENDANTS, please state the following for each:

1. Identify the HEALTHCARE PROVIDER.

2. Identify the date(s) that the HEALTHCARE PROVIDER was consulted, retained, or compensated.

3. State the nature of the affiliation.

4. State the type amount of REMUNERATION provided to the HEALTHCARE PROVIDER.

HEALTHCARE PROVIDER	Date(s) Consulted, Retained, or Compensated	Nature of Affiliation	REMUNERATION

5. Please identify and produce any and all consulting agreements/contracts and/or retainer agreements/contracts entered into by DEFENDANTS with the HEALTHCARE PROVIDERS identified in Sections V.13 and V.14 of the PFS.

V. PLAINTIFF'S HEALTHCARE PROVIDER'S PRACTICES

A. Provide all chemotherapy related prescriber-level data designed to track prescribing or treating practices that YOU obtained on Plaintiff's HEALTHCARE PROVIDERS identified in Sections V.13 and V.14 of the PFS.

B. Was the HEALTHCARE PROVIDER(S) identified in Sections V.13 and V.14 of the PFS involved in any clinical trial sponsored by DEFENDANTS related to the treatment of cancer?

_____Yes _____ No

If yes, provide the final Investigator Protocol related to any such trial(s).

C. Did the Plaintiff's HEALTHCARE PROVIDER ever report any adverse events to DEFENDANTS as they pertain to Taxotere (Docetaxel)?

_____ Yes _____ No

If yes, provide all DOCUMENTS related to the adverse event report/MedWatch form.

CERTIFICATION

I am employed by _____, one of the DEFENDANTS in this litigation. I am authorized by _____ [name of other DEFENDANTS] to execute this certification on each corporation's behalf. The foregoing answers were prepared with the assistance of a number of individual, including counsel for DEFENDANTS, upon whose advice and information I relied. I declare under penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Defendant Fact Sheet is true and correct to the best of my knowledge and that I have supplied all requested DOCUMENTS to the extent that such DOCUMENTS are in my possession, custody and control (including the custody and control of my lawyers).

_____	_____	_____
Signature	Print Name	Date