UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF KENTUCKY

NORTHERN DIVISION at COVINGTON

INDIANA STATE DISTRICT COUNCIL OF LABORERS AND HOD CARRIERS PENSION AND WELFARE FUND, On Behalf of Itself and All Others Similarly Situated, Plaintiff, vs. OMNICARE, INC., et al., Defendants.	Civil Action No. 2:06-cv-00026-WOB **(Consolidated)** CLASS ACTION

THIRD AMENDED CONSOLIDATED COMPLAINT FOR VIOLATIONS OF §11 OF THE SECURITIES ACT OF 1933

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INTRODUCTION

Lead Plaintiff Laborers District Council Construction Industry Pension Fund and named plaintiff Cement Masons Local 526 Combined Funds ("Plaintiffs"), by their undersigned attorneys, on behalf of themselves and the class they seek to represent, allege the following upon knowledge as to their own acts and upon the investigation conducted by their counsel. The investigation included examining and analyzing information obtained from, *inter alia*, United States Securities and Exchange Commission ("SEC") filings, other court filings related to defendant Omnicare, Inc. ("Omnicare" or the "Company"), including *qui tam* actions against Omnicare alleging violations of the False Claims Act, the Federal Anti-Kickback Statute, the Food, Drug and Cosmetic Act, the Omnibus Budget and Reconciliation Act ("OBRA") and the Medicaid Drug Rebate Statute, public reports, press releases, news articles and other media reports and interviews with former Company employees. Plaintiffs believe that substantial additional evidentiary support will exist for the allegations set forth herein after a reasonable opportunity for discovery.

1. This securities class action is brought on behalf of those who purchased or otherwise acquired the publicly traded securities of Omnicare pursuant or traceable to a false Registration Statement and Prospectus ("Registration Statement") issued in connection with Omnicare's public offering of 12,825,000 shares on or about December 15, 2005 (the "December 2005 Offering" or "Offering").[1] This action asserts violations of §11 of the Securities Act of 1933 ("Securities Act") against Omnicare and its senior insiders, Joel F. Gemunder (CEO, President and Director), David W. Froesel, Jr. (CFO and Senior Vice President), Cheryl D. Hodges (Secretary and Senior Vice President), Edward L. Hutton (Chairman of the Board) and Sandra E. Laney (Director) (collectively, "defendants").

[1] At the same time, Omnicare also raised $750 million of senior subordinated notes and $977.5 million of convertible senior debentures.

2. This case arises out of defendants' false and misleading statements and omissions in the Registration Statement that Omnicare provided its pharmacy services in compliance with all applicable laws and in the best interest of the nursing home residents the Company served. In reality, the Company's arrangements with the nation's largest pharmaceutical companies violated numerous state and federal laws, and placed the Company's bottom line ahead of the health and well-being of the millions of elderly individuals who relied upon Omnicare for its pharmacy services.

SUMMARY OF THE ACTION

3. Omnicare specializes in providing pharmaceutical care to the elderly, and is the largest institutional pharmacy business in the United States. The Company operates in two business segments, Pharmacy Services and Contract Research Organization Services. This case focuses on Omnicare's Pharmacy Services, the Company's core business, which generated approximately $5.1 billion in revenue in 2005, or 97% of the Company's $5.3 billion in total revenue for that year.

4. As part of its Pharmacy Services Division, Omnicare provides consultant pharmacy services in Long Term Care Facilities ("LTCFs"), primarily through an extensive network of pharmacy consultants. During the period from 2000 to 2005, Omnicare employed hundreds of these consultant pharmacists, ostensibly to assist LTCFs and physicians with evaluating monthly patient drug therapy, monitoring drug distribution, complying with state and federal law and implementing clinical and health management programs. By 2005, the Company and its consulting pharmacists were serving approximately 1,452,000 LTCF patients in thousands of facilities throughout the United States.

5. Several months prior to the Offering, in August 2005, Omnicare acquired its largest rival, NeighborCare, Inc., ("NeighborCare"), and as a result, saw the Company's share price double in 2005 (from almost $30.00 per share earlier in 2005 to nearly $60 per share at the time of the

Offering). Omnicare conducted the December 2005 Offering to take advantage of this higher stock price. In the Offering, Omnicare issued 12,825,000 shares at $59.72 per share, generating proceeds in excess of $880,795,300.[2]

6. Plaintiffs' §11 claims in this case arise out of the Registration Statement issued in connection with the Offering and Omnicare's Annual Report on Form 10-K for the fiscal year ended December 31, 2004, incorporated by reference therein, which contained false and misleading statements and omissions regarding: (1) the legality of Omnicare's arrangements with pharmaceutical manufacturers; and (2) the pharmaceutical services Omnicare provided to patients. With regard to Omnicare's legal compliance, Omnicare's Registration Statement told investors that Omnicare was required to "comply with federal and state laws which govern financial and other arrangements between healthcare providers," including "the federal anti-kickback statute." More specifically, the Registration Statement explained that Omnicare was "subject to federal and state laws that prohibit some types of direct and indirect payments between healthcare providers. These laws, commonly known as the fraud and abuse laws, prohibit payments intended to induce or encourage the referral of patients to, or the recommendation of, a particular provider of items or services." This was true.

7. But defendants went a step further in the Registration Statement and its incorporated documents, falsely and misleadingly assuring investors that Omnicare was ***in compliance*** with these laws, stating, for example:

- "We believe that our contracts with pharmaceutical manufacturers ***are legally and economically valid arrangements that bring value to the healthcare system and the patients that we serve***."

[2] This total amount raised includes the overallotment exercised by the Underwriters of the Offering on January 12, 2006.

- "***We believe our contract arrangements with other healthcare providers, our pharmaceutical suppliers and our pharmacy practices are in compliance with applicable federal and state laws***."

- "We expend considerable resources in connection with our compliance efforts. We believe that ***we are in compliance in all material respects with state and federal regulations applicable to our business***."

8. In addition to the false and misleading statements regarding the legality of Omnicare's arrangements with drug manufacturers, the Registration Statement and its incorporated documents also falsely and misleadingly stated that Omnicare delivered its pharmaceutical services in the best interests of its patients to maintain and improve patient care, for instance, stating:

- "Federal and state regulations mandate that long-term care facilities, in addition to providing a source of pharmaceuticals, retain consultant pharmacist services ***to monitor and report on prescription drug therapy in order to maintain and improve the quality of resident care***."

- "We provide consultant pharmacist services, which" include "assistance to the nursing facility in complying with state and federal regulations as they pertain to drug use" and "***monthly drug regimen reviews for each resident in the facility to assess the appropriateness and efficacy of drug therapies, including a review of the resident's current medication usage, monitoring drug reactions to other drugs or food, monitoring lab results and recommending alternate therapies, dosing adjustments or discontinuing unnecessary drugs***."

- "When required and/or specifically requested by the physician or patient, ***branded drugs are dispensed and generic drugs are substituted in accordance with applicable state and federal laws as requested by the physician or resident. Subject to physician approval and oversight, and in accordance with our pharmaceutical care guidelines, we also provide for patient-specific therapeutic interchange of more efficacious and/or safer drugs for those presently being prescribed***."

9. But defendants omitted the following material facts, among others, from the Registration Statement, which demonstrated that Omnicare had no reasonable basis for the above statements, and thereby rendered those statements false and misleading:

- Defendants solicited and negotiated illegal kickback arrangements with some of the country's largest drug manufacturers and received improper cash incentives in exchange for promoting and increasing market share for particular drugs, in violation of the Federal Anti-Kickback Statute and False Claims Act, as detailed herein at ¶¶53-144;

- Defendants colluded with drug manufacturers to impermissibly disguise illegal kickbacks as "data fees," "educational funding," and "grants" in order to avoid and manipulate the "Best Price" of particular drugs in violation of the Medicaid Drug Rebate Statute and False Claims Act, as detailed herein at ¶¶70-81; 99-110;

- Defendants were warned by Omnicare's attorneys (including the Company's "regular outside counsel for transactional matters involving potential health fraud and abuse issues") on multiple occasions, and in connection with at least two different arrangements with pharmaceutical manufacturers (*e.g.*, IVAX and Mariner), that the Company's kickback agreements were illegal, as detailed herein at ¶¶114-120; 206, 210-212;

- Defendants conspired with drug manufacturers, and directed the Company's consultant pharmacists, to illegally market drugs like Risperdal and Depakote for off-label use in violation of (i) the Federal Anti-Kickback Statute; (ii) the Nursing Home Reform Act (Omnibus Budget Reconciliation Act); (iii) the False Claims Act; and (iv) the Food, Drug, and Cosmetic Act, which strictly forbids off-label marketing, as detailed herein at ¶¶144-164;

- Defendants improperly and intentionally switched patients from one form of a drug to another more profitable form, including switching two 7.5mg Buspirone anti-anxiety tablets for one 15mg tablet, switching Fluoxetine anti-depression tablets for capsules, and switching Ranitidine heartburn capsules for tablets, and, as a result, submitted illegal Medicaid reimbursement claims to federal and state governments in violation of the False Claims Act, as detailed herein at ¶¶165-201;

- Defendants conspired with LTCFs to enter into illegal contracts where Omnicare paid LTCFs millions of dollars in illegal kickbacks in exchange for Omnicare retaining pharmacy service contracts at those LTCFs, in violation of the Federal Anti-Kickback Statute, as detailed herein at ¶¶202-215; and

- Defendants conspired with LTCFs to engage in illegal "swapping" kickback schemes wherein defendants intentionally offered commercially unreasonable, below fair-market-value prices for prescription drugs to LTCFs for their Medicare Part A patients in exchange for the opportunity to provide the same drugs, at substantially higher, market-driven cost, to the LTCFs Medicaid and (eventually Medicare Part D) patients, and charged Medicare and Medicaid programs higher prices than it charged the LTCFs in violation of the Federal Anti-Kickback Statute and False Claims Act, as detailed herein at ¶¶216-224.

10. At their core, plaintiffs' §11 allegations are that, contrary to defendants' assertions in Omnicare's Registration Statement, defendants ignored the needs of Omnicare's patients and engaged in these illegal activities to generate revenues and profit at Omnicare's LTCFs without regard for the health and well-being of the Company's vulnerable elderly patient base, and in blatant

violation of several federal and state statutes enacted to prevent such abusive practices. Defendants' various schemes included soliciting and negotiating numerous illegal kickback arrangements with large pharmaceutical manufacturers, paying kickbacks to nursing homes, illegally switching drugs and engaging in illegal drug "swapping" schemes in the years leading up to the Offering. But defendants omitted all of these material facts from the Registration Statement, which collectively showed that defendants had no reasonable basis for their statements that "we believe" Omnicare was in compliance with applicable laws and administered its services in the best interests of its patients. Indeed, defendants themselves negotiated and implemented these illegal arrangements with drug manufacturers. Defendants themselves devised the illegal drug switching in order to achieve revenue and profit targets. In fact, defendants were aware that Omnicare had previously been fined for the same illegal drug switching scheme. Furthermore, the Company's own attorneys warned defendants that Omnicare's arrangements with some of its drug manufacturers and LTCFs were illegal.

11. From 2000 (and prior), until the time of the December 2005 Offering, Omnicare's *modus operandi* was to put the interests of the more than 1.4 million aged and ailing LTCF residents who relied on Omnicare for their pharmaceutical needs second to achieving higher revenue and profit goals for the Company. Complaints filed against Omnicare and numerous pharmaceutical manufacturers by the U.S. and several states reveal that Omnicare repeatedly violated the Federal Anti-Kickback Statute by engaging in illegal kickback schemes with many of the nation's largest branded and generic drug manufacturers, including, among others, Johnson & Johnson ("J&J"), Abbott Laboratories, Inc. ("Abbott"), IVAX Pharmaceuticals ("IVAX"), and Amgen, Inc. ("Amgen"), in order to increase profits at the expense of Omnicare's LTCF patients.

12. The Company's varied and numerous kickback schemes were masterminded and implemented at Omnicare's highest levels of management, thereby enabling Omnicare to receive tens of millions of dollars in kickbacks between 2000 and 2005.[3] Defendants' illegal conduct is alleged by relators in various *qui tam* actions, is corroborated by former Omnicare employees contacted by plaintiffs during their investigation, as well as by the United States Department of Justice ("DOJ"), which investigated the relators' claims and concluded that Omnicare had indeed "***solicited and received kickbacks from pharmaceutical manufacturers to recommend the use of their drugs to elderly patients in nursing homes, including powerful antipsychotic drugs used to control their behavior***." Ex. 8 (Tony West, Assistant Attorney General for the Civil Division of the DOJ); *see also* Ex. 9. Moreover, Omnicare's own attorneys advised defendants that the Company's kickback agreements were illegal, warning, for example, that a proposed arrangement with pharmaceutical company IVAX, "on its face, ***has all the characteristics of a kickback***." *See* Ex. 7, ¶20.

13. In order to effectuate its illegal kickback schemes, Omnicare utilized extensive "therapeutic interchange" programs designed to increase sales of high-profit drugs to LTCF patients.[4] These therapeutic initiatives undermined the independence of Omnicare's consulting pharmacists, subverting their intended watchdog function of ensuring that nursing homes complied

[3] *Kammerer v. Omnicare, Inc.*, No. 05-11518-RGS (D. Mass. Dec. 5, 2008); *Maguire v. Omnicare, Inc.*, No. 02-cv-11436-RGS (D. Mass. June 21, 2005); *Lisitza v. Omnicare, Inc.*, No. 01 C 7433 (N.D. Ill. Jan. 23, 2003); *United States of America, ex rel. McCoyd v. Abbott Laboratories*, No. 1:07-cv-00081-JPJ-PMS (W.D. Va. Dec. 22, 2014); *United States of America, et al., ex rel. Kurnik v. Amgen, Inc.*, No. 11-cv-01464-JFA (D.S.C. June 14, 2011); *Kammerer v. Omnicare, Inc. and IVAX Pharms., Inc.*, No. 05-cv-11519-RAS (D. Mass. Mar. 4, 2014). An exhibit index is attached before Exhibit 1.

[4] Therapeutic "initiatives," "interchanges" and "interventions" are used interchangeably and are also referred to as "clinical" or "health management" initiatives designed to steer physicians and patients towards specific drugs.

with OBRA regulations and, instead, turned them into *de facto* extensions of the drug manufacturers' sales forces. These therapeutic interchange programs, far from being in the patients' best interests, also resulted in drugs being marketed by the drug manufacturers and administered by Omnicare pharmacists for off-label uses. Consequently, the kickback arrangements exposed Omnicare's elderly LTCF patients to dangerous off-label uses in violation of the Food, Drug, and Cosmetics Act.

14. A complaint filed against J&J by the United States Attorney's Office in the District of Massachusetts and the DOJ on behalf of the United States Department of Health and Human Services demonstrates Omnicare's illegal promotion of J&J drugs for off-label use, in violation of the Federal Anti-Kickback Statute and the Food, Drug, and Cosmetic Act. Ex. 4.[5] The J&J complaint revealed troubling and detailed examples of Omnicare's illegal promotion of J&J drugs in exchange for kickbacks. Allegations in the J&J action are corroborated by similar illegal conduct alleged in a separate complaint, filed against Abbott by the United States Attorney's Office in the Western District of Virginia on behalf of the United States Department of Health and Human Services. Ex. 5.[6]

15. The FDA strictly forbids drug manufacturers from advertising that a drug is safe and effective for unapproved uses or unapproved patient populations. Documents unsealed in the U.S. actions against J&J and Abbott demonstrate that Omnicare, on its own initiative, as well as at the urging of the pharmaceutical manufacturers, conducted therapeutic initiatives that targeted drugs, including J&J's Risperdal and Abbott's Depakote, for off-label use in violation of the Food, Drug and Cosmetic Act in order to effectuate kickback arrangements with those manufacturers. Exs. 4-5.

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[5] *United States of America, ex rel. Lisitza and Kammerer v. Johnson & Johnson*, No. 07-10288-RGS (D. Mass. Jan. 15, 2010).

[6] *United States of America, ex rel. McCoyd v. Abbott Laboratories, Inc.*, No. 1:07-cv-00081-JPJ-PMS (W.D. Va. Dec. 22, 2014).

The J&J and Abbott complaints also demonstrate that defendants were personally negotiating Omnicare's relationship with J&J to promote Risperdal in exchange for rebates. *See, e.g.*, Ex. 10 at JNJ298613 (September 25, 2001 memorandum stating that defendant and CEO Gemunder advised J&J executives that Omnicare would continue to support Risperdal).

16. With respect to Risperdal, J&J obtained FDA approval of the drug ***only*** for the treatment of schizophrenia, and the FDA ***specifically rejected*** Risperdal for the treatment of elderly patients with dementia. This unequivocal denial notwithstanding, defendants and J&J jointly developed initiatives pursuant to their illegal kickback arrangements to push Risperdal on nursing home patients with dementia. Exs. 11 at JNJ001100; 12 at OMNI-MA035232; 13 at JNJ001036; 35 at JNJ301399. As predicted in the FDA's denial of the use of Risperdal to treat elderly dementia sufferers, Omnicare's off-label promotion of Risperdal was linked to increased incidence of cerebrovascular adverse events, including stroke and even death. Similarly, use of Abbott's prescription drug, Depakote, was not FDA approved for use in elderly patients, as dangerous health issues, such as hepatotoxicity (drug-induced liver damage), had not yet been evaluated in geriatric patients undergoing Depakote therapy. Thus, the drug could not yet be considered safe for Omnicare's LTCF patients. But this did not stop defendants from pushing Depakote on its elderly patient population in order to reap lucrative kickback payments from Abbott.

17. Omnicare's illegal conduct also extended to improperly switching drugs from one form (*i.e.*, tablets or capsules) or one dosage (*e.g.* 7.5 mg to 15 mg) to another, not in the patient's interest, but solely to increase the Company's profits. Omnicare's drug switching practices were designed solely to increase revenue and reimbursements received from state and federal agencies through improper Medicare and Medicaid reimbursements, not to improve the health of the patients affected. Further, defendants were aware that drug switching was illegal, as Omnicare had

previously violated the False Claims Act, which prohibits submitting false claims for reimbursement to Medicaid or Medicare, including claims related to the prescription of one type of dose of a drug over a less profitable form. For example, in 2004, Omnicare paid a $1 million fine to the State of Maine for improperly switching patients from Ranitidine tablets costing $15.10 per month to Ranitidine capsules costing $82.77 per month in order to increase Omnicare's profits from Medicaid reimbursements. Ex. 14.

18. Omnicare also violated the Federal Anti-Kickback Statute by ***paying*** tens of millions of dollars to LTCFs to induce them to enter into or maintain pharmacy services contracts with Omnicare. Exs. 15-16.[7] These contracts for pharmacy services were Omnicare's financial lifeline, as they provided Omnicare with its primary vehicle for delivering pharmacy services to LTCF patients.

19. Several whistleblower actions filed against Omnicare detail the Company's willingness to violate the law in order to secure these contracts. *Id.* For example, in 2004, Omnicare was threatened with the loss of its pharmacy service contracts with Mariner Health Care ("Mariner") nursing homes, a contract which generated approximately $150 million in revenue per year for Omnicare. In order to salvage its Mariner contracts, the Company entered into sham acquisitions resulting in Omnicare paying nearly $50 million in kickbacks to Mariner, ***even though Omnicare's own attorneys warned senior management – unequivocally, and on several different occasions – that the transaction violated federal law***. *See* Ex. 15, ¶34. In that same year, Omnicare engaged in a similar manipulation with Total Pharmacy whereby Omnicare acquired Total Pharmacy and paid

[7] *United States of America, ex rel. Resnick v. Omnicare, Inc.*, No. 06-cv-10149-RGS (D. Mass. Mar. 4, 2009); *United States of America and the States of Florida and Illinois, ex rel. Nehls v. Omnicare, Inc.*, No. 07-C-5777 (N.D. Ill. Dec. 21, 2010).

$6.4 million in kickbacks to one of its owners for arranging to extend the duration of the pharmacy services contracts with Omnicare from one to ten years. *See* Ex. 16, ¶96.

20. Omnicare also conspired with its LTCFs to engage in illegal "swapping" arrangements, wherein Omnicare intentionally provided its LTCFs with significant discounts on prescription drugs for Medicare Part A patients in exchange for the LTCF agreeing to provide the same drugs at substantially higher prices to the LTCF's Medicaid (and eventually Medicare Part D) patients. The rates charged to the LTCFs for Medicare Part A patients were financially unreasonable and significantly below Omnicare's "usual and customary" rate, which is the rate Omnicare would charge Medicaid providers. Defendants charged LTCFs lower prices and recorded substantial losses on LTCF contracts for Medicare Part A patients in order to entice LTCFs to refer Medicaid and Medicare Part D patients to Omnicare, which violated the Federal Anti-Kickback Statute and the False Claims Act. Ex. 17.[8]

21. In addition to the false and misleading statements and omissions regarding legal compliance that defendants made without a reasonable basis, the Prospectus and incorporated documents falsely and misleadingly assured investors that Omnicare's contracts with manufacturers were "***legally and economically valid arrangements that bring value to the healthcare system and the patients that we serve***." And concealing the profit-driven nature of its therapeutic initiatives, defendants instead falsely advised investors that Omnicare was dedicated to improving the quality of

[8] *United States of America, the State of California, the State of Colorado, the State of Connecticut, the State of Delaware, the State of Florida, the State of Georgia, the State of Hawaii, the State of Illinois, the State of Indiana, the State of Louisiana, the State of Maryland, the Commonwealth of Massachusetts, the State of Michigan, the State of Minnesota, the State of Montana, the State of Nevada, the State of New Hampshire, the State of New Jersey, the State of New Mexico, the State of New York, the State of North Carolina, the State of Oklahoma, the State of Rhode Island, the State of Tennessee, the State of Texas, the Commonwealth of Virginia, the State of Wisconsin, and the District of Columbia, ex rel. Silver v. Omnicare, Inc.*, No. 1:11-cv-01326-NLH-JS (D.N.J. Sept. 19, 2013) (Dkt. No. 65).

resident care and that its therapeutic interchanges were meant to "***provide [patients with] . . . more efficacious and/or safer drugs than those presently being prescribed***." These statements were false and misleading in that Omnicare omitted the material fact that the Company instructed its pharmacists to engage in the Risperdal and Depakote initiatives to prescribe these drugs for off-label purposes, not to improve patient care and not in the best interests of the patients, but to increase Omnicare's revenues. In addition, these statements regarding patient care were further false and misleading because Omnicare omitted the material fact that it had undertaken a drug switching program directed by defendants, to switch patients improperly and illegally from one form of a drug to a more profitable form.

JURISDICTION AND VENUE

22. The claims asserted herein arise under and pursuant to §11 of the Securities Act, 15 U.S.C. §77k.

23. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. §1331 and §22 of the Securities Act.

24. Venue is proper in this District pursuant to §22 of the Securities Act. The false and misleading Registration Statement was issued from this District. During the relevant period, *i.e.*, the time period covered by the Offering (2000 to 2005), Omnicare's executive officers were located in Covington, Kentucky, where the day-to-day operations of the Company were directed and managed. In 2012, Omnicare moved its executive offices to Cincinnati, Ohio.

PARTIES

25. Plaintiff Laborers District Council Construction Industry Pension Fund purchased 1,210 shares of Omnicare common stock at $59.72 per share on December 12, 2005 in Omnicare's Offering, as set forth in the Certification filed with the Court on October 31, 2006 (Dkt. No. 35).

26. Plaintiff Cement Masons Local 526 Combined Funds purchased 790 shares of Omnicare common stock at $59.72 per share on December 12, 2005 in Omnicare's Offering, as set forth in the Certification filed with the Court on April 3, 2006 (Dkt. No. 16).

27. Defendant Omnicare provides pharmaceutical care for elderly individuals in the United States and Canada. The Company operates through two segments, Pharmacy Services and Contract Research Organization Services. Omnicare's securities trades in an efficient market on the New York Stock Exchange ("NYSE") under the symbol OCR.

28. Defendant Gemunder was, at all relevant times, Chief Executive Officer, President and a director of Omnicare. Gemunder directed the Company in selling more than $2.5 billion in Omnicare securities pursuant to the Offering, including the stock offering at issue. Defendant Gemunder prepared and signed the false and misleading Registration Statement and Prospectus, the FY 2004 Form 10-K and all 2005 interim financial reports.

29. Defendant Froesel was, at all relevant times, Chief Financial Officer and Senior Vice President of Omnicare. Froesel assisted the Company in selling more than $2.5 billion in Omnicare securities pursuant to the Offering, including the stock offering at issue. Defendant Froesel prepared and signed the false and misleading Registration Statement and Prospectus, the FY 2004 Form 10-K and all 2005 interim financial reports.

30. Defendant Hodges was, at all relevant times, Secretary and Senior Vice President of Omnicare. Hodges assisted the Company in selling more than $2.5 billion in Omnicare securities pursuant to the Offering, including the stock offering at issue. Defendant Hodges prepared and signed the false and misleading Registration Statement and Prospectus, the FY 2004 Form 10-K and all 2005 interim financial reports.

31. Defendant Hutton was, at all relevant times, Chairman of the Board of Omnicare. Hutton assisted the Company in selling more than $2.5 billion in Omnicare securities pursuant to the Offering, including the stock offering at issue. Defendant Hutton prepared and signed the false and misleading Registration Statement and Prospectus, the FY 2004 Form 10-K and all 2005 interim financial reports.

32. Defendant Laney was, at all relevant times, a director of Omnicare. Laney assisted the Company in selling more than $2.5 billion in Omnicare securities pursuant to the Offering, including the stock offering at issue. Defendant Laney prepared and signed the false and misleading Registration Statement and Prospectus, the FY 2004 Form 10-K and all 2005 interim financial reports.

THE DECEMBER 2005 OFFERING

33. On December 15, 2005, Omnicare completed a public offering of 12.8 million shares of common stock at $59.47 per share, raising more than $765 million in proceeds. The shares were offered through a Prospectus Supplement (to a prospectus dated November 25, 2005), and filed with the SEC on December 14, 2005 on Form 424B5. The Offering was initially registered with the SEC on Form S-3 filed on or about August 17, 2005 (*i.e.*, the registration statement), later amended on November 23, 2005 (S-3/A) as Amendment No. 1.

34. The Registration Statement contained summary consolidated financial information for 2002, 2003 and 2004 as well as for the nine months ended September 30, 2005, and incorporated certain financial statements as follows:

> We have elected to "incorporate by reference" certain information into this prospectus supplement. By incorporating by reference, we can disclose important information to you by referring you to another document we have filed separately with the SEC. The information incorporated by reference is deemed to be part of this prospectus supplement, except for information incorporated by reference that is superseded by information contained in any document we subsequently file with the SEC that is incorporated or deemed to be incorporated by reference in this

prospectus. Likewise, any statement in this prospectus supplement or any document which is incorporated or deemed to be incorporated by reference herein will be deemed to have been modified or superseded to the extent that any statement contained in any document that we subsequently file with the SEC that is incorporated or deemed to be incorporated by reference herein modifies or supersedes that statement. We are incorporating by reference the following documents that we have previously filed with the SEC (other than information in such documents that is deemed not to be filed):

(a) Omnicare, Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2004, filed March 16, 2005 including the portions of our proxy statement and related supplement incorporated by reference therein;[9]

(b) Omnicare, Inc.'s Quarterly Reports on Form 10-Q for the fiscal quarters ended March 31, 2005 and June 30, 2005, filed May 10, 2005 and August 9, 2005, respectively, and Form 10-Q/A for the fiscal quarter ended September 30, 2005, filed November 23, 2005; and

(c) Omnicare, Inc.'s Current Reports on Form 8-K and Form 8-K/A, as applicable, filed March 9, 2005, March 29, 2005, May 20, 2005, July 7, 2005, July 8, 2005, July 14, 2005, August 3, 2005, August 11, 2005, October 13, 2005, November 23, 2005, November 23, 2005, November 23, 2005, and December 9, 2005.

STATUTES OMNICARE VIOLATED

35. Omnicare's kickback arrangements, drug interchange programs and other schemes described herein violated numerous state and federal statutes, including those described below.

The Federal Anti-Kickback Statute

36. The Federal Anti-Kickback Statute, 42 U.S.C. §1320a-7b(b), prohibits any person or entity from soliciting or receiving payment of any kind, "directly or indirectly, overtly or covertly," for arranging for or recommending the purchase of any good, including pharmaceuticals, that will be paid for by federally funded health care programs:

> (2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person –
>
> * * *

[9] The Company's 2004 Form 10-K included summary financial information for the years 2000-2004.

> (B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined no more than $25,000 or imprisoned for not more than five years, or both.

42 U.S.C. §1320a-7b(b)(2).

37. Violation of the Federal Anti-Kickback Statute subjects the violator to exclusion from participation in federal health care programs, including Medicaid and Medicare. 42 U.S.C. §1320a-7(b)(7).[10] Additionally, compliance with federal and state laws, including the Federal Anti-Kickback Statute, is a condition precedent to reimbursement of Medicaid claims under the law of every state, which require Medicaid participants to certify their compliance with state and federal laws and regulations. *See, e.g.*, Fla. Stat. §409.920(2)(a)(5); 305 ILCS 5/8A-3(b), (c); 130 CMR 450.261.

The Nursing Home Reform Act

38. Enacted by Congress in the Omnibus Budget Reconciliation Act of 1987 ("OBRA"), Pub. L. 100-203, The Nursing Home Reform Act reflected Congress' concern about the treatment of elderly nursing home residents, and, particularly, the use of drugs as chemical restraints in nursing homes. In OBRA, Congress mandated that nursing homes protect the rights of each of their residents, including the right "to be free from . . . chemical restraints." 42 U.S.C. §1396r(c)(1)(A)(iii). OBRA required that psychopharmacological drugs only be administered upon a physician's orders and only as part of a written plan of care "designed to eliminate or modify the symptoms for which the drugs are prescribed." *Id.*, §1396r(c)(1)(D). To implement OBRA, the Centers for Medicare & Medicaid issued regulations requiring nursing homes to ensure that residents

[10] Violation can also result in civil monetary penalties and imprisonment of up to five years per violation. 42 U.S.C. §§1320a-7(b)(7), 1320a-7a(a)(7). The civil monetary penalties may be up to $50,000 for each act in violation of the Anti-Kickback Statute and damages of up to three times the amount of the remuneration offered or paid. 42 U.S.C. §1320a-7(b).

were "free from unnecessary drugs."[11] To comply with these requirements, nursing homes arrange for a consultant pharmacist to review the medications of each resident at least once a month. During the course of these reviews, the consultant pharmacists make recommendations – which are ostensibly independent, objective and in the best interest of the patient – to remove, change or add medications to the nursing home residents' drug regimens.

The False Claims Act

39. The False Claims Act, 31 U.S.C. §3729, prohibits anyone from:

(a) knowingly presenting a false claim for payment to Medicaid or Medicare (among other government agencies);

(b) knowingly making, using, or causing to be made or used, a false record or statement material to a false claim; or

(c) conspiring to defraud the Government by getting a false claim allowed or paid.

31 U.S.C. §3729. Liability under the False Claims Act subjects the violator to civil penalties equivalent to three times the amount of damages sustained by the Government plus an additional penalty between $5,000-$10,000.

Medicaid Drug Rebate Statute

40. Under the Medicaid Drug Rebate Statute, 42 U.S.C. §1296r-8, pharmaceutical manufacturers are required to advise Medicaid of the "Best Price" associated with a particular drug and pay rebates to Medicaid that increase as the Best Price decreases. Congress enacted the Medicaid Drug Rebate Statute, 42 U.S.C. §1396r-8, to ensure that the Medicaid program would receive the benefit of the same discounts and prices on drugs that other large public and private

[11] An unnecessary drug is any drug when used: (1) in excessive dose (including duplicate drug therapy); (2) for excessive duration; (3) without adequate monitoring; (4) without adequate indications for its use; (5) in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) any combination of the above.

purchasers enjoyed. *See* H.R. Rep. No. 101-881, at 986 (1990), *reprinted in* 1990 U.S.C.A.A.N. 2017, 2108.

41. In order for a brand name drug to be covered and reimbursed by the Medicaid program, its manufacturer has two primary obligations. First, the manufacturer must report on a quarterly basis to the Secretary of Health and Human Services the drug's "average manufacturer price" and the "best price" offered for that drug. 42 U.S.C. §1396r-8(b)(3)(A). Second, the manufacturer must pay each state a quarterly rebate equal to the total number of drug units (*e.g.*, pills) purchased by the state times the greater of: (1) 15.1% of the drug's average manufacturer price, or (2) the difference between the average manufacturer price and the best price. 42 U.S.C. §1396r-8(c)(1)(A). In other words, a drug manufacturer is required to pay at least a 15.1% rebate to each state on all of its drug sales for Medicaid patients, but the manufacturer is required to pay a higher Medicaid rebate on all of those sales if it offered any single customer, *e.g.*, Omnicare, a total discount exceeding 15.1%.

The Food, Drug and Cosmetic Act

42. The Food, Drug and Cosmetic Act, 21 U.S.C. §301, prohibits drug manufacturers from marketing drugs for indications other than those approved by the U.S. Food and Drug Administration ("FDA"), and the FDA Modernization Act of 1997, which bars drug manufacturers from supplying medical practitioners with off-label information unless such information is specifically solicited by the physician. 21 U.S.C. §260aaa-6. In order to obtain FDA approval for a drug, a manufacturer must provide clinical evaluations of the drug's safety and efficacy for the indicated use. The FDA strictly forbids manufacturers from advertising that a drug is safe and effective for unapproved uses or unapproved patient populations. Such marketing is referred to as "off-label" marketing.

OIG Guidance

43. The Office of the Inspector General for the U.S. Department of Health and Human Services ("OIG") has released numerous alerts, opinions and compliance guidelines addressing potential violations of the Federal Anti-Kickback Statute and concerning Medicaid and Medicare fraud and abuse.

44. In 1991, the OIG issued a final ruling, specifying which type of discounts are protected by the "safe harbor" provisions of the Federal Anti-Kickback Statute. Ex. 18. In its ruling, the OIG noted that the safe harbor provisions do not apply to discounts "intended to encourage a particular buyer to purchase or order a particular good or service payable under Medicare or Medicaid." *Id.* at 43. The guidance continued:

> [W]e are aware of cases where laboratories offer a discount to physicians . . . but do not offer the same discount to the Medicare program. In some of these cases, the discount offered to the physician is explicitly conditioned on the physician's referral of all of his or her laboratory business. ***Such a "discount" does not benefit Medicare, and is therefore inconsistent with the statutory intent for discounts***.

Id.

45. In 1994, the OIG issued a Special Fraud Alert regarding potential violations to the Medicaid and Medicare Federal Anti-Kickback Statute and noted its awareness of a "proliferation of arrangements between those in a position to refer business . . . and those providing items or services for which Medicare or Medicaid pays." Ex. 19 at 3 of 14. The 1994 Special Fraud Alert also discussed "joint ventures," which include "contractual arrangement[s] between two or more parties to cooperate in providing services." *Id.* The OIG explained that some joint ventures violate the Medicare and Medicaid Anti-Kickback Statute and are inherently suspect. The OIG identified these areas in which questionable features of the "suspect joint ventures" may be reflected:

(1) the manner in which investors are selected and retained;

(2) the nature of the business structure of the joint venture; and

(3) the financing and profit distributions.

Id. Indicators of "unlawful activity in suspect joint ventures" include situations where:

(i) investors are chosen because they are in the position to make referrals; and

(ii) the amount of capital invested is "disproportionately small and the returns on investment maybe disproportionately large."

Id. at 4 of 14.

46. The 1994 Special Fraud Alert also discussed prescription drug marketing schemes that violate the Anti-Kickback Statute:

> Traditionally, physicians and pharmacists have been trusted to provide treatments and recommend products in the best interest of the patient. In an era of aggressive drug marketing, however, patients may now be using prescription drugs items, unaware that their physician or pharmacist is being compensated for promoting the selection of a specific product. Prescription drugs supplied under one of these programs are often reimbursed under Medicaid.

Id. at 10 of 14.

47. In the 1994 Special Fraud Alert, the OIG also stated that a payment or gift may generally be considered improper if it:

- Is made to a person in a position to generate business for the paying party;
- Relates to the volume of business generated; and
- Is more than nominal in value and/or exceeds fair market value of any legitimate service rendered to the payer, or is unrelated to any service at all other than referral of patients.

Id. Such payments or gifts in exchange for, or based on prescribing , recommending or switching specific products were expressly prohibited, and would warrant OIG investigation.

48. In a 1999 Advisory Opinion, the OIG expressly provided that a violation of the Federal Anti-Kickback Statute occurs when a medical provider offers steep discounts for a Medicare Part A patient in exchange for referring patients to the medical provider under other Medicare parts

or other federal programs. Such "swapping" arrangements, the OIG concluded, would not be protected by the safe harbor provisions of the Federal Anti-Kickback Statute:

> such price reductions create a risk that a supplier may be offering remuneration in the form of discounts on business for which the purchaser pays the supplier, in exchange for the opportunity to service and bill for higher paying Federal health care program business reimbursed directly by the program to the supplier. In such circumstances, neither Medicare nor Medicaid benefits from the discount; to the contrary, Medicare and Medicaid may, in effect, subsidize the other payer's discounted rates. . . . Accordingly, the discount safe harbor specifically excludes "a reduction in price applicable to one payor but not to Medicare or a State health program." *See* 42 CFR §1001.952(h)(3)(iii).

Ex. 20 at 5.

49. The OIG further explained that "swapping" arrangements are "particularly suspect" under the Federal Anti-Kickback Statute where they provide for:

- discounted prices that are below the supplier's cost, and
- discounted prices that are lower than the prices that the supplier offers to a buyer that (i) generates a volume of business for the supplier that is the same or greater than the volume of Part A business generated by the [skilled nursing facility], but (ii) does not have any potentially available Part B or other Federal health care program business.

Id. at 6.

50. In March 2000, the OIG issued a formal Program Guidance for nursing homes regarding the Federal Anti-Kickback Statute , and again identified such "swapping" arrangements as problematic. Ex. 21. The report provided the following definition:

> "Swapping" occurs when a supplier gives a nursing facility discounts on Medicare Part A items and services in return for the referrals of Medicare Part B business. With swapping, there is a risk that suppliers may offer a [skilled nursing facility] an excessively low price for items or services reimbursed under [prospective payment system] in return for the ability to service and bill nursing facility residents with Part B coverage. See OIG Advisory Opinion 99-2 (February 1999).

Id. at n.75.

OMNICARE'S CONDUCT VIOLATED THE LAW

51. Between 2000 and 2005 prior to the December 2005 Offering, Omnicare engaged in a host of schemes designed to increase the Company's revenue and profit. However, unbeknownst to investors, and contrary to defendants' assertions in the Registration Statement, Omnicare's conduct also violated numerous state and federal laws and regulations and caused substantial harm to Omnicare's LTCF patients, as well as to the healthcare system itself.

52. In the years prior to the Offering, defendants developed and maintained complex drug interchange programs and directed, solicited and negotiated improper kickback arrangements in order to recognize increased revenues and profits. But these material facts were omitted from the Registration Statement, and, as a result, rendered defendants' statements in the Company's 2005 Registration Statement regarding the Company's purported regard for patient safety, drug efficacy and legal compliance false and misleading. Neither did the Registration Statement mention the material facts that Omnicare's own attorneys informed defendants that the Company's conduct likely violated federal laws, nor did it mention that senior management, including defendants negotiated the illegal contacts and directed the wrongdoing. All of these material, undisclosed facts, taken collectively, directly contradict defendants' statements to investors that the Company was in compliance with federal and state law, and offered Omnicare's pharmacy services to improve patient care and thereby render those statements false and misleading.

DEFENDANTS SOLICITED AND RECEIVED KICKBACKS FROM PHARMACEUTICAL MANUFACTURERS PURSUANT TO VARIOUS CONTRACTUAL ARRANGEMENTS IN VIOLATION OF THE FEDERAL ANTI-KICKBACK STATUTE

53. Prior to the December 2005 offering, Omnicare entered into illegal agreements with numerous pharmaceutical manufacturers concerning the promotion and sale of specific drugs. Pursuant to these contracts, Omnicare's goal was to increase sales of the manufacturer's drugs and

the manufacturer's "market share" of a particular drug. Market share refers to Omnicare's purchases of the drug as a percentage of its total purchases of drugs in the same therapeutic category. In return, Omnicare received cash rebates as market share increased. In other words, the pharmaceutical manufacturers paid Omnicare to purchase and/or recommend the manufacturers' drugs over competing products. Omnicare's so-called "therapeutic initiatives" or interchanges, discussed more fully below, were the primary vehicle for implementing these contracts.[12]

54. Omnicare's contracts with drug manufacturers, and the initiatives implemented pursuant thereto, violated the Federal Anti-Kickback Statute and were in direct conflict with detailed OIG guidance admonishing the use of discounts to encourage the purchase of goods and services payable under Medicare and Medicaid.[13] The Federal Anti-Kickback Statute, 42 U.S.C. §1320a-7b(b), prohibits any person or entity from soliciting or receiving payment of any kind, "directly or indirectly, overtly or covertly," for arranging for or recommending the purchase of any good, including pharmaceuticals, that will be paid for by Federally funded health care programs.

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[12] Omnicare took these kickbacks into consideration when evaluating the profitability of its clinical initiatives. Ex. 22 at 3 (June 25, 2003, letter from relator Kammerer's counsel to the FDA and U.S. Department of Health & Human Services ("HHS")). Internal documents reveal that Omnicare played pharmaceutical manufacturers against one another in an effort to obtain the highest rebate or greatest profit in exchange for pushing drugs in a particular therapeutic category. *See* Ex. 10 at JNJ298613 (J&J memorandum dated Sept. 25, 2001 indicating that in a Sept. 24, 2001 phone call with Omnicare executive Dan Maloney ("Maloney"), during which Maloney stated that an insufficient offer by J&J would lead him to seek a contract with Bayer).

[13] The Federal Anti-Kickback Statute arose out of Congressional concern that payoffs made to those who can directly influence health care decisions (such as pharmaceutical consultants in nursing homes) will result in conduct that harms patients and federally funded healthcare programs, such as prescription of goods and services that are medically unnecessary, of poor quality, or even harmful to the vulnerable patient population. To protect patients and the integrity of federal health care programs, including Medicare and Medicaid, the Federal Anti-Kickback Statute strictly prohibits the payment of kickbacks or rebates in exchange for promoting or arranging for the purchase of specific pharmaceuticals, even if the drug recommendation or purchase is medically justifiable.

55. Violation of the Federal Anti-Kickback Statute subjects the violator to exclusion from participation in federal health care programs, including Medicaid and Medicare. 42 U.S.C. §1320a-7(b)(7).[14] Additionally, compliance with federal and state laws, including the Federal Anti-Kickback Statute, is a condition precedent to reimbursement of Medicaid claims under the law of every state, which require Medicaid participants to certify their compliance with state and federal laws and regulations. *See, e.g.*, Fla. Stat. §409.920(2)(a)(5); 305 ILCS 5/8A-3(b), (c); 130 CMR 450.261.

56. In order to promote and increase market share of the pharmaceutical manufacturers' drugs, Omnicare utilized its extensive network of pharmacy consultants who provided on-site services in LTCFs. Omnicare, as the nation's largest provider of pharmacy consulting services to nursing homes, was able to offer services to LTCFs at below-market rates in exchange for their agreement to contract with Omnicare to provide drug procurement, distribution and billing services. Once in the nursing homes, Omnicare used its pharmacy consultants to steer nursing home patients to drugs chosen by Omnicare – drugs that increased the Company's revenue or profit because of the drug's reimbursement rate or the Company's kickback arrangements with manufacturers.

57. The nation's largest pharmaceutical manufacturers recognized the stronghold Omnicare had on the Company's captive LTCF patient base. In order to increase market-share for certain prescription drugs in those LTCFs, pharmaceutical companies incentivized Omnicare to promote and push certain drugs on its patients. Pharmaceutical manufacturers were, in essence, competing with each other to offer Omnicare the best incentives. The incentives were mutually beneficial and considered an investment by the pharmaceutical companies to increase their sales.

[14] Violation can also result in civil monetary penalties and imprisonment of up to five years per violation. 42 U.S.C. §§1320a-7(b)(7), 1320a-7a(a)(7). The civil monetary penalties may be up to $50,000 for each act in violation of the Anti-Kickback Statute and damages of up to three times the amount of the remuneration offered or paid. 42 U.S.C. §1320a-7(b).

Thus, the pharmaceutical manufacturers viewed the rebates and incentives as creating positive returns on investments, and Omnicare took advantage of them.

Omnicare's Illegal Kickback Arrangement with Johnson & Johnson

58. Omnicare's relationship with J&J provides one example of the many illegal kickback arrangements Omnicare had with the nation's pharmaceutical manufacturers. As explained in an internal J&J document, Omnicare's willingness to employ initiatives to promote and steer patients towards specific drugs was "highly motivated based on economics" and "spread (their margin)." Ex. 23 at JNJ284630.

59. Omnicare's pharmacy consultants were so effective at promoting and inducing the sale of targeted pharmaceuticals that it caused one J&J executive to comment, "Incredible: good for us but scary on the power to do this." Ex. 24 (June 21, 2001 e-mail from J&J subsidiaries discussing Omnicare's ability to control and direct sales of J&J's drug Levaquin). Indeed, J&J considered Omnicare's consultants an "Extension of [the J&J] Sales Force." Ex. 25 at JNJ289731.

60. According to J&J and its subsidiaries, Omnicare was able to effect dramatic shifts in utilization from one drug to another at its LTCFs, but "in order to have the Omnicare's of the world drive share that high, it must be financially wor[th] their while." Ex. 26 at JNJ284585 (Nov. 17, 2003 e-mail from a National Account Manager at a J&J subsidiary, discussing Omnicare's ability to drive market share based on "lucrative" incentives). The incentives were so lucrative that Omnicare "forecast[ed] customer rebates each quarter." *Id.* All of the rebates Omnicare received from J&J were incentives to Omnicare to advocate use of J&J products.

61. Omnicare's top officers, including defendants Gemunder and Froesel, were intimately involved in negotiations concerning the kickback arrangements, as well as in the implementation of the therapeutic initiatives to increase J&J's market share to earn Omnicare its kickbacks. Exs. 10 at JNJ298613 (on September 18, 2001, defendant Gemunder contacted David Norton, president of

J&J's Janssen division, to say "Omnicare would continue to support Risperdal"); 22 at 4; 27 at JNJ011363 (internal J&J communications and letters from relator Kammerer's counsel to the FDA and HHS department detail the lengths defendants Gemunder and Froesel went to make more money and increased discounts for Omnicare through continued support of J&J's drugs).

62. Omnicare and J&J signed drug supply agreements in 1997 (the "1997 Agreement") and 2000 (the "2000 Agreement") (collectively, "Agreements") that covered the period between April 1, 1997 and March 31, 2004, and established a system where J&J paid Omnicare rebates, or kickbacks, in exchange for Omnicare's promotion of J&J pharmaceuticals (and increasing market share for each drug), in direct violation of the Federal Anti-Kickback Statute. Exs. 11, 13, 28 (Supply Agreements and amendments between Omnicare and J&J, dated March 31, 1997, February 1, 1999 and April 1, 1999, signed by Omnicare Director Maloney).

63. The arrangements Omnicare solicited from J&J also directly contradicted published 1991 OIG guidance, which prohibited the use of discounts to encourage companies like Omnicare to purchase particular drugs payable under Medicare or Medicaid because "[s]uch a 'discount' does not benefit Medicare, and is therefore inconsistent with the statutory intent for discounts. . . ." Ex. 18 at 43. In addition to prohibited discounts, the kickback arrangements also constituted improper compensation and gifts, designed to generate business for J&J, which was expressly prohibited per the OIG's 1994 Special Fraud Alert publication. Ex. 19 at 11.

64. Pursuant to the Agreements, Omnicare promoted specific J&J pharmaceuticals, known as "strategic products" (including J&J's drugs Risperdal, Propulsid, Levaquin, Procit, Duragesic and Ultram), in an effort to increase their market share. Exs. 11 at JNJ001084, 92, 100-03; 13 at JNJ001032, 36-39, 41-42 (identifying specific "Strategic Products," which were the drugs that would earn performance-based rebates). Market share increased when Omnicare's purchases of

J&J-specified drugs increased as a percentage of the Company's total purchases of drugs in the same therapeutic category. Exs. 11 at JNJ001092; 13 at JNJ001032. In turn, J&J paid Omnicare quarterly "market share rebates," which were actually illegal kickbacks, as they were tied directly to the market share Omnicare achieved for a particular strategic drug. Exs. 11 at JNJ001100-03; 13 at JNJ001041-42; *see also* Ex. 19 at 11 (OIG Special Fraud Alert (Dec. 19, 1994) (OIG guidance prohibiting compensation tied to generating market share)). In short, the quarterly rebate was a performance-driven, tiered rebate incentive paid in exchange for Omnicare aggressively pushing and selling J&J drugs in LTCFs.

65. The rebates Omnicare received for increasing the market share of J&J drugs ranged from between 1% and 14% of Omnicare's total purchases of each drug, and increased as the market share for the drug increased. For example, the 2000 Agreement provided for the following tiered rebate incentive schedule:

Product		**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Active Intervention Program Requirements**
DURAGESIC®	Actual Mkt Share Rebate %	55.0% 2.0%	60.0% 4.0%	65.0% 8.0%	70.0% 10.0%		See Below
ACIPHEX™	Actual Mkt Share Rebate %	Transition Period (12 months) 8.0%	<15.0% 0.0%	≥15% to 24% 8.0%	≤25% to 29% 10.0%		See Below
PROPULSID™	Actual Mkt Share Rebate %	Formulary Access 1.5%	20.0% 4.0%	25% 8.0%	30% 10.0%		NONE
LEVAQUIN® TABLETS	Actual Mkt Share Rebate %	Transition Period (6 months) 6.0%	<50% 0.0%	≥50% 15.0%	[redacted]		See Below

Product		**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Active Intervention Program Requirements**
LEVAQUIN® IV	Actual Mkt Share Rebate %	Transition Period (12 months) 5.0%	<50% 0.0%	≥50% to 70% 5.0%	>70% 7.0%	[redacted]	See Below
RISPERDAL®	Actual Mkt Share Rebate %	Transition Period (6 months) 5.0%	<35% 0.0%	35% to 37% 6.0%	>37% to 42% 9.0%	>42% 11.0%	See Below
ULTRAM®	Actual Mkt Share Rebate %	Formulary Access 1.5%	10.0% 3.0%	15.0% 4.0%	20.0% 6.0%	25.0% 8.0%	See Below
PROCRIT®	Actual Mkt Share Rebate %	Formulary Access 2%	[redacted]				See Below

66. In addition to the quarterly market share rebates, Omnicare accepted "performance" rebates from J&J pursuant to the Agreements, which also violated the Federal Anti-Kickback Statute. The 1997 Agreement, for example, included a 1% "Annual Strategic Product Performance Rebate" and the 2000 Agreement included a 2% "Annual Product Performance Incentive." Exs. 11 at JNJ001100; 13 at JNJ001035. Under both provisions, J&J paid Omnicare annual performance rebates for implementing an "Active Intervention Program (AIP)" or "Appropriate Use Program (AUP)" for certain drugs. The performance rebates violated the Federal Anti-Kickback Statute because the AIP and AUP programs from which the rebates were derived were specifically designed to "shift market share" to J&J's strategic drugs, as the Agreements explicitly stated:

> a) "Active Intervention Program" shall mean a program, applied by Manager and accepted by Supplier[15] in writing, which is ***designed to appropriately shift***

[15] "Manager" refers to Omnicare and "Supplier" refers to J&J. Exs. 11 at JNJ001085; 13 at JNJ001028 (footnote added).

> ***market share to Supplier's Product***. Active interventions can include, but are not limited to, disease management initiatives, written correspondence to Participating Providers prescribing or dispensing pharmaceutical products, educating nursing home staff regarding Supplier's Products, ***conducting clinical intervention programs though which consultant pharmacists recommend Supplier's Products when appropriate***.
>
> b) "Appropriate Utilization Program" or "AUP" shall mean a program applied by Manager, and accepted in writing by Supplier, ***designed to cause the appropriate use of Supplier's Product(s)***.

Exs. 11 at JNJ001084, 89; 13 at JNJ001031.

67. Omnicare and J&J jointly developed the AIP/AUP "initiatives," which were intended to increase physicians' prescriptions of a particular drug and, in turn, Omnicare's purchases of J&J drugs. *See, e.g.*, Ex. 11 at JNJ001100; Ex. 13 at JNJ001036. Pursuant to the AIP or AUP, Omnicare and J&J designated certain drugs as "Selected," meaning Omnicare and its pharmacy consultants "favored" those drugs over other brands for certain clinical indications. Ex. 13 at JNJ001043.

68. In order to promote and increase the market share of these Selected drugs, Omnicare personnel "actively participate[d] in educational and promotional programs discussing [the Selected drugs]" and "work[ed] with [J&J] to implement communication effort to inform attending physicians of" a drug's "favored" status. *Id.* Omnicare even developed scripts to enable its pharmacists to more persuasively recommend the J&J products. Ex. 29 at OMNI-MA881954-57 (Aug. 25, 1998 Omnicare memorandum from Mark Lehman, Director of Omnicare's Clinical Services, to Timothy Bien ("Bien") and Omnicare's Regional Vice Presidents and Clinical Directors re: Omnicare's Risperdal Patient Specific Therapeutic Interchange ("Risperdal PTSI"), and strategies and intervention scenarios designed to drive prescriptions of J&J's drug Risperdal). For example, in the August 25, 1998 memorandum, Omnicare included specific language that Omnicare's consultant pharmacists should provide to physicians under specific scenarios, such as: (i) generating new

Risperdal prescriptions for patients not currently on an anti-psychotic; and (ii) switching patients on another anti-psychotic to J&J's drug.

69. Omnicare and J&J met quarterly to discuss the "performance goals" and "progress on the business plan." Ex. 13 at JNJ001036. Then, in 2004, J&J proposed a LTCF contract between J&J and Omnicare, in which J&J offered Omnicare "volume discounts and market share performance rebates," which J&J's compliance team warned would constitute illegal kickbacks. Ex. 30 at JNJ 342990 (May 14, 2004 e-mail between National Account Managers at J&J's subsidiaries). The J&J rebates ultimately proved to be extremely lucrative to Omnicare, with J&J paying Omnicare tens of millions of dollars in market share rebates between 1999 and 2004 pursuant to the 1997 and 2000 Agreements.

70. In addition to the aforementioned "overt" kickbacks, Omnicare also received "covert" kickbacks designed to circumvent anti-kickback law. The kickbacks were generated as a result of Omnicare's and J&J's contractual arrangements, and Omnicare's successful promotion and sale of targeted J&J drugs, but were re-characterized as "data fees" or "grants" to disguise their true purpose, and in an effort to evade required disclosure under Medicaid "Best Price" regulations.

71. The re-characterization was prompted by J&J's concern that the kickbacks would set a new "Best Price" for drugs under the Medicaid Drug Rebate Statute, 42 U.S.C. §1296r-8. Under the Medicaid Drug Rebate Statute, pharmaceutical manufacturers are required to advise Medicaid of the "Best Price" associated with a particular drug and pay rebates to Medicaid that increase as the Best Price decreases.[16] The upfront discounts Omnicare received for purchasing drugs from J&J,

[16] Congress enacted the Medicaid Drug Rebate statute, 42 U.S.C. §1396r-8, to ensure that the Medicaid program would receive the benefit of the same discounts and prices on drugs that other large public and private purchasers enjoyed. *See* H.R. Rep. No. 101-881, at 986 (1990), *reprinted in* 1990 U.S.C.A.A.N. 2017, 2108. Under the Medicaid Drug Rebate Statute, in order for a brand name drug to be covered and reimbursed by the Medicaid program, its manufacturer has two primary

combined with the quarterly rebate incentives Omnicare received, threatened to set a new "Best Price" for the drug such that J&J would have to report the price to the Medicaid program. Accordingly, Omnicare and J&J sought to evade Best Price detection, in violation of the Medicaid Drug Rebate Statute, by impermissibly disguising the kickbacks as "data fees," "grants," and "educational funding."

72. For example, in mid-1999, Omnicare claimed it was entitled to a 1% "annual strategic overlay" of $300,000 from J&J for the period from the second quarter of 1997 to the first quarter of 1998. Ex. 31 at JNJ300995 (May and June, 1999 e-mails in which J&J discusses "Omnicare['s] 1% strategic overlay quagmire" and that J&J has "exhausted all potential solutions to legally pay the rebate"). Such a payment would be illegal, and would have been reportable to Medicaid for Best Price purposes. *Id.* In order to circumvent Medicaid's Best Price reporting requirements, Omnicare's Maloney orally agreed with J&J that Omnicare would receive the $300,000 for "educational funding," rather than as a strategic overlay. Thereafter, in September 1999, J&J cut a $300,000 check to Omnicare to "help[] Omnicare's consultant pharmacists overcome objections from physicians . . . . [E]specially effective in overcoming obstacles pertaining to resistance in prescribing Risperdal." Ex. 32 at JNJ301097; *see also* Ex. 27 at JNJ011362 (September 1999 J&J memorandum discussing how to handle Omnicare's strategic overlay request and J&J's donation of

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obligations. First, the manufacturer must report on a quarterly basis to the Secretary of HHS the drug's "average manufacturer price" and the "best price" offered for that drug. 42 U.S.C. §1396r-8(b)(3)(A). Second, the manufacturer must pay each state a quarterly rebate equal to the total number of drug units (*e.g.*, pills) purchased by the state times the greater of (1) 15.1% of the drug's average manufacturer price, or (2) the difference between the average manufacturer price and the best price. 42 U.S.C. §1396r-8(c)(1)(A). In other words, J&J was required to pay at least a 15.1% rebate to each state on all of its drug sales for Medicaid patients, but J&J would have to pay a higher Medicaid rebate on all of those sales if it offered any single customer, *e.g.*, Omnicare, a total discount that exceeded 15.1%. Under the Medicaid Drug Rebate Statute, 42 U.S.C. §1396r-8, drug manufacturers like J&J are supposed to file quarterly reports showing that Medicaid programs got the same rebates as other big purchasers.

$300,000 to Omnicare for "Supporting programs that help overcome physicians resistance to Risperdal ($300,000)").

73. Internal Omnicare documents also show that in mid-October 1999, Omnicare formally entered into an "Initiative Partnership Agreement" with J&J, pursuant to which Omnicare received $300,000 for "educational assistance in overcoming objections and obstacles pertaining to the Risperdal Initiative." Ex. 33 at OMNI-MA 033998 (October 25, 1999 from J&J to Bien enclosing the so-called Initiative Partnership Agreement to overcome physician objections to Risperdal). In other words, Omnicare received the $300,000 for the express purpose of inducing the Company to recommend that physicians prescribe Risperdal for their elderly LTCF patients. Ex. 34 at JNJ301116 (Oct. 15, 1999 e-mail in which J&J discusses the $300,000 "Omnicare Educational Initiative" and Omnicare's rebate claims).

74. An internal J&J memorandum prepared by J&J's Bruce Cummins dated July 19, 1999 indicated that from 1997 to 1999, J&J had paid Omnicare over $1,000,000 for "educational, pull-through, and social activities." Ex. 35 at JNJ301391. Omnicare's high-level executives directly requested such "educational funding" and specifically noted that the funding was to support initiatives to increase the market share of certain drugs. Ex. 36. For example, in a June 15, 1999 letter, Omnicare's Bien, requested a large donation from J&J to fund Omnicare's Manager's meeting at Amelia Island, Florida. In the June 15, letter, Bien states that the payment will go toward Omnicare's and J&J's "Risperdal Initiative." *Id.* at OMNI-MA778063.

75. In an attempt to evade Medicaid "Best Price" regulations, J&J and Omnicare also entered into a "Consulting and Services Agreement," covering the period between July 1, 2000 and April 1, 2004. Ex. 37. Under the "Consulting and Services Agreement," J&J would appear to pay Omnicare for "data," such as prescriber lists. While this practice was against J&J's internal

corporate policy to "not pay customers for data," J&J nevertheless made an exception to that policy for Omnicare. Ex. 38 at JNJ284524 (internal J&J e-mail dated Oct. 21, 2002 stating J&J Corporate has stated "we will not pay customers for data"); *see also* Ex. 39 (price schedule for data under the Consulting & Services Agreement).

76. Under the Consulting and Services Agreement, J&J and Omnicare agreed that any rebates that would have been received as a result of the promotion and increased market share of J&J drugs would instead be distributed in the form of "data fees," purportedly for Omnicare providing J&J with market share reports for J&J drugs, as well as for data identifying physicians who prescribed competing drugs rather than J&J drugs. Ex. 37. Moreover, J&J internal documents reflect that J&J never actually received the physician information it purportedly paid for. Ex. 40 at JNJ021125 (September 10, 2003, J&J email requesting that employees "scour" their files because it has come to J&J's attention that Healthcare Compliance requires J&J to "demonstrate that we do receive this physician information").

77. An internal memorandum further exposes the illicit nature of the agreement and demonstrates that Omnicare and J&J entered into the agreement solely to circumvent the law:

1. Consulting and Services Agreement

    a. Risperdal Rebates have been pushing towards Best Price.

    b. To avoid Best Price, the Strategic Overlay for Risperdal (2% of sales) had to be eliminated.

    c. In order to balance this, an agreement was established with Omnicare to purchase data, roughly at the cost of the Strategic Overlay for Risperdal.

Ex. 41. In a similar fashion, Omnicare and J&J amended the 2000 Agreement to ensure that Omnicare's "overt" kickbacks would not reduce the current Best Price for a given drug. The amendment stated:

> If at any time during the term of this Agreement the Manager is eligible to receive a discount or rebate, directly or indirectly, for any Product under any contract with Supplier, the combined total of such discount(s) and/or rebate(s) shall be reduced to the extent necessary ***so that it does not create a new Medicaid "best price***" for any Product. In the event the combined total of such discount(s) and or rebate(s) would create a new "best price," a price adjustment shall be made.

Exs. 42 at JNJ002618.

78. In an internal J&J e-mail dated May 17, 2000, J&J employees discussed labeling Omnicare payments as "marketing service fees" that "would be excluded from Medicaid best price calculations." Ex. 43 at JNJ301466. In 2001 and 2003 letters from J&J addressed to Omnicare officer Maloney, Director of Purchasing, J&J enclosed payments to Omnicare pursuant to the "Consulting and Services Agreement." Ex. 44. In the three letters, J&J referred to the payments, nearly $1 million in total, as a "marketing fee." *Id.* at JNJ068428, JNJ072381, JNJ021102. The letters also cautioned Omnicare that "some or all of this amount may be considered a Discount which Omnicare may have an obligation to reflect in any cost report or claim for reimbursement filed with Medicare/Medicaid." *Id.* at JNJ072381.

79. Pursuant to the "Consulting and Services Agreement," Omnicare received $4,650,000 between 3Q00 and 1Q04. Ex. 39.[17] The Consulting and Services Agreement violated the Medicaid Drug Rebate Statute by concealing the true "Best Price" for J&J drugs.

80. Omnicare and J&J also sought to disguise kickbacks paid pursuant to an agreement concerning the J&J drug Sporanox. Omnicare had increased Sporanox's market share enough to justify a rebate of 25%, setting a new "Best Price for the drug," under the statute. In order to avoid

[17] Pursuant to the "consulting" agreement, Omnicare and J&J agreed to mischaracterize the rebates as "data fees" from the fourth quarter of 1998, the first quarter of 1999 and the additional rebates from the two percent Annual Produce Performance Incentive (also referred to as a "strategic overlay" for Risperdal that J&J was required to pay under the 2000 Agreement). The same document also reflects that J&J sent $2.5 million in advance of the regular rebate schedule its 2Q00 rebates in order to assist Omnicare with cash flow issues. *Id.*; Ex. 42 at JNJ002618.

"Best Price" detection, J&J sought to decrease the contractual rebate to 20% and "make up" for the 5% rebate loss "in another way." In a July 22, 2002 e-mail, J&J noted:

> We were looking at the cost impact of the Omnicare Sporanox purchases on Janssen business. Since the 25% rebate on Omnicare Sporanox purchases sets the best price, and the next best price is 20%, the Medicaid cost impact is about $1 million per year (avg $200k per % point) for the additional 5%. It may make sense for us approach Omnicare about reducing the rebate to 20%.
>
> * * *
>
> I would recommend to try to make up the loss of rebates in another way.

Ex. 45 at JNJ347031-32. The same e-mail indicated that after speaking with Omnicare, Omnicare was open to switching the rebate payment, but "did not have a good idea of where to switch the $4,000 payment to." *Id.* at JNJ347032.

81. Omnicare also solicited over $250,000 in "donations" from J&J pursuant to the Company's Re*View "health management" program, which was designed to increase prescriptions and drugs administered to Omnicare's LTCF patients. Ex. 46; *see also* Ex. 47 (Jan. 6, 2000 letter from Omnicare's Bien soliciting $50,000 in "donations" form J&J). Such "donations" were solicited by Omnicare in order to increase the number of prescriptions its LTCF patients were prescribed, thereby driving up the market share of J&J's drugs.[18]

82. The kickback arrangements between Omnicare and J&J were lucrative for both companies. Between 1999 and 2004, Omnicare's annual purchases of J&J drugs nearly tripled to almost $300 million, with annual purchases of Risperdal alone rising to over $100 million. J&J determined that, "for a $3MM investment in rebates with Omnicare, [J&J] gain[s] $9MM in sales, less costs and investments, returns $4.8MM to OMP." Ex. 48 at JNJ351497. In another internal J&J e-mail, J&J bragged about the success of the kickback scheme between Omnicare and J&J, noting

[18] *See also* ¶¶107, 166-171 for additional details regarding Omnicare's so-called Re*View program.

that for every a $1.44 million in "investment in rebates" with Omnicare, J&J gained $9 million in sales. *Id.*

83. In total, Omnicare obtained many millions of dollars in rebates from J&J. During 4Q01, the Company also specifically obtained: an 8% rebate for Duragesic purchases, totaling $2,282,609; a 5% rebate for purchases of Ultram, totaling $326,003; a 14% rebate for Ditropan XL purchases, totaling $866,096; a 2% rebate on Topamax purchases, totaling $98,640; a 7% rebate on Reminyl purchases, totaling $231,897; a 2% rebate on Aciphex purchases, totaling $51,956; and a 2% rebate on Regranex purchases, totaling $50,212. Ex. 1, ¶46.

84. On November 3, 2009, the DOJ announced that it reached a $98 million settlement with Omnicare to resolve the allegations relating to J&J and Omnicare's solicitation of kickbacks from J&J in exchange for Omnicare pushing Risperdal on its patients. In the announcement, Tony West, Assistant Attorney General for the Civil Division of the Department of Justice, stated: "[Omnicare] broke the law to take advantage of our nation's most vulnerable citizens – the elderly and the poor." Ex. 9.

Omnicare's Illegal Kickback Arrangement with Abbott

85. A complaint filed by the United States against Abbott details an extensive kickback scheme between Omnicare and Abbott prior to the Offering.[19] In mid-2000, executives from Omnicare and Abbott met to "structure a program of value" for the two companies. The goal was a mutual commitment that would provide Omnicare with "rewards and business gains beyond those covered by Abbott Divisions' current product agreements." Ex. 5, ¶43.

86. Around June 30, 2000, Omnicare received a payment from Abbott that Omnicare identified as a rebate in the amount of $43,218.64. *Id.*, ¶44. The following month, Omnicare

[19] *United States of America, ex rel. McCoyd v. Abbott Laboratories*, No. 1:07-cv-00081-JPJ-PMS (Dkt. No. 261) (W.D. Va. Dec. 22, 2014). Ex. 5.

executed a "Pharmaceutical Agreement" effective July 1, 2000 through June 30, 2002, which provided that Omnicare would receive quarterly payments from Abbott as remuneration for Omnicare's help increasing the use of Abbott's drug Depakote in the LTCFs it serviced. *Id.*, ¶45. Such remuneration provided in exchange for increased market share violated the Federal Anti-Kickback Statute and directly contradicted publicized OIG guidance prohibiting compensation in exchange for increasing market share. Ex. 19.

87. According to the July 2000 agreement, Omnicare's payments were dependent upon its increasing Depakote use in the LTCFs it serviced by certain threshold amounts compared to the same quarter the previous year, and adjusted yearly based on changes in the number of patients serviced by Omnicare. Thus, Omnicare could receive kickback payments by increasing Depakote use per LTCF patient. Ex. 5, ¶45.

88. For the first six months of the agreement, Omnicare was not entitled to any payments unless it increased the Depakote use by its LTCF patients by at least 12.5% over the previous year. After 2001, the threshold would increase to 15%. However, less than a month after entering the agreement, Omnicare received a $54,237.78 kickback payment from Abbott. *Id.*, ¶¶46-47.

89. On September 8, 2000, Omnicare signed a superseding agreement that added a kickback payment to Omnicare for increasing the use of Depakote ER for its nursing home patients by certain thresholds compared to total Depakote sales. Under this new agreement, if Omnicare increased the use of Depakote ER in its nursing home patients to 10% of the total Depakote use, it was entitled to a kickback of 2% of the total price of its Depakote ER purchases for the quarter. *Id.*, ¶48.

90. The following year, on May 11, 2001, Omnicare sent a letter to Abbott demanding additional kickbacks. *Id.*, ¶50. On June 15, 2001, Omnicare and Abbott retroactively amended the

"rebate agreement" to extend the 12.5% threshold growth requirement from the original December 31, 2000 expiration, to the June 30, 2002 contract ending date. *Id.*, ¶51.

91. On December 20, 2001, Omnicare received more than $175,000 in payments that Omnicare described as Depakote rebates pursuant to the agreement with Abbott. Abbott also paid Omnicare kickbacks of $394,185.42 and $435,744.61 for the first and second quarters of 2002. Omnicare described these payments as "rebates." *Id.*, ¶¶52-53.

92. Although the July 1, 2000 "rebate agreement" expired on June 30, 2002, Omnicare signed an amendment that was effective January 1, 2003, which lowered the threshold increase in Depakote use from 12.5% to 5%, making it even easier for Omnicare to receive "rebates" under the illegal kickback arrangement. *Id.*, ¶54.

93. On March 24, 2003, Omnicare received a $508,544.33 kickback payment from Abbott, which was disguised as a "rebate" for the fourth quarter of 2002, when there had been no rebate agreement in effect. On approximately the following dates, Omnicare received kickback payments from Abbott in the stated amounts that Omnicare disguised as "rebates":

Date	Amount
August 1, 2003	$558,755.33
September 15, 2003	$838,537.75
December 15, 2003	$971,325.00
March 29, 2004	$699,328.45
May 7, 2004	$101,997.41

Id., ¶55.

94. On December 3, 2003, Abbott provided Omnicare with an amended "rebate agreement" effective for Depakote purchased January 1, 2004, through December 31, 2004. The amended agreement included a new two-tiered formula for calculating kickback payments. Under the first tier, Omnicare was entitled to a kickback of 2% of the price of the base utilization (the

amount of Depakote used the previous year) and 20% of the price of the increased use of Depakote by its nursing home patients, but only if Omnicare increased Depakote utilization by at least 2.5% over the previous year. Under the second tier, it could receive a 4% rebate of the base amount used and a 40% rebate on the increased amount used, but only if Omnicare increased the use by at least 5%. *Id.*, ¶56.

95. On approximately the following dates, Omnicare received kickback payments in the stated amounts for Depakote sales, which Omnicare disguised as rebates:

Date	Amount
June 23, 2004	$1,248,291.50
September 30, 2004	$1,318,663.19
December 16, 2004	$1,422,669.18

Id., ¶57.

96. In December 2004, Omnicare executed a new rebate agreement with Abbott, effective the fourth quarter of 2004 through December 31, 2005, and a nearly identical agreement with Omnicare's subsidiary, NeighborCare before it was acquired by Omnicare. The agreements changed the formula for calculating the kickback payments by reducing the importance of increasing the overall use of Depakote, and emphasizing the increase in the market share of Depakote ER compared to all Depakote. *Id.*, ¶58.

97. On approximately the following dates, Omnicare received kickback payments in the stated amounts for Depakote sales, which Omnicare disguised as rebates:

Date	Amount
March 1, 2005	$1,967,240.62
May 16, 2005	$629,306.31
October 27, 2005	$2,115,134.04

Id., ¶59.

98. For the period 2000 through 2005, Omnicare received at least $13 million in rebates from Abbott in connection with Omnicare's promotion of Depakote to its LTCF patients. On March 31, 2006, Omnicare received a $1,601,897.21 "rebate" for Depakote sales from October 1, 2005, through March 31, 2006. Omnicare's rebate agreements with Abbott continued for years and extended beyond the date of the Offering. In 2005, Abbott sought an agreement that would measure Depakote sales against sales of other manufacturers' drugs that competed with Depakote in the control of behaviors in nursing home residents.

99. In addition to "overt" rebates Omnicare received from Abbott under the kickback agreements, Omnicare also solicited and received covert kickbacks from Abbott. For example, as early as 1998, Omnicare received payments from Abbott and recorded payments as "educational grants" and "data" which, as discussed above at ¶¶70-81, would not be reported under Medicaid "Best Price" regulations. In March 1998, Omnicare's Director of Clinical Services, Mark E. Lehman, solicited a substantial educational payment from Abbott. Ex. 5, ¶28.

100. Initially, in March 1998, Lehman requested an "unrestricted educational grant" of $15,000 from Abbott's National Manager for Long Term Care ("LTC Manager"). Ex. 49 (March 18, 1998 solicitation letter from Lehman to Abbott). Abbott's LTC Manager responded to Omnicare's Senior Vice President for Purchasing and Professional Services, Bien, that in order to justify such expenditures, Abbott needed Omnicare to provide data on Depakote utilization in nursing homes serviced by Omnicare. Thus, Omnicare's purported "educational funding" was based on Omnicare providing data to Abbott so Abbott could help Omnicare direct prescriptions to Abbott's drugs. Ex. 5, ¶30.

101. In a follow-up phone call to Omnicare's Maloney, Abbott's LTC Manager offered that Abbott would pay Omnicare $12,500 per year for Depakote sales data, $16,000 to support

Omnicare's Management Meeting, and additional funding of an "assay methodology" for Depakote and K-Tabs (an extended release potassium chloride tablet marketed by Abbott). *Id.* In a handwritten memorandum from Maloney to Bien describing the conversation, Maloney relayed that Abbott's LTC Manager "wants to know will this suffice?" Ex. 50 (June 1998 note from Maloney to Bien documenting Abbott's proposed payments and whether they were sufficient).

102. On June 16, 1998, Maloney again discussed the proposed payments with Abbott. Later that day, Abbott's LTC Manager summarized the discussions, stating that Abbott would pay $12,500 for monthly data for the next calendar year and pay a $15,000 "unrestricted educational grant" to "support the ongoing educational programs." Ex. 5, ¶31. Abbott's LTC Manager concluded by requesting a summary report of all Depakote and Depakene unit and dollar sales by month for 1998, to be followed by a data disk. Ex. 51 at OMNI-MA900638.

103. The agreement between Omnicare and Abbott for the purchase of data from Omnicare continued throughout 2000 and 2001. On March 14, 2001, Omnicare's Maloney sent a letter to Abbott confirming its agreement to purchase sales data. Although Abbott paid $12,500 for data in 2000, the letter stated that "[t]he agreed upon price to continue receiving Depakote and Oxandrin sales data at the pharmacy level will be $32,000 for 2001." Ex. 5, ¶38. Maloney forwarded a copy of the letter to Bien with a handwritten note asking: "What bucket do you want this applied to?" *Id.* After Omnicare confirmed that Abbott would be making the $32,000 payment, Omnicare began taking additional steps to promote Depakote in its LTCFs. On April 2, 2001, for example, Omnicare issued a memorandum informing its Consultant Coordinators that Abbott had commissioned "Behavior Management Wall Charts." *Id.*, ¶39. In the memorandum, Omnicare's Chief Clinical Officer instructed the Coordinators that "[w]hile distributing these reference charts,

the consultant should be reinforcing the appropriate place of Depakote in treating behaviors in long-term care facility with nursing staff and nursing superiors." *Id.*

104. Also, beginning as early as 1999, Omnicare annually solicited covert kickbacks from pharmaceutical manufacturers purportedly to fund an annual management conference on Amelia Island, Florida. As described above, Abbott's LTC Manager asked Omnicare executives if $16,000 for the management conference and various other payments "would suffice." Thereafter, on August 13, 1999, and September 24, 1999, Omnicare received $8,000 kickback checks from Abbott, purportedly for the management conference. *Id.*, ¶66.

105. In February 2000, Omnicare received a $27,000 kickback payment from Abbott. Omnicare and Abbott both attempted to disguise this payment, first as a data purchase payment and, later, as a payment for Omnicare's management conference. *Id.*, ¶67. On February 4, 2000, Abbott issued a purchase order to "Omnicare Management Conference" purportedly for the purchase of "zip level data for sales reporting to LTC [long-term care] salesforce." *Id.* On February 17, 2000, Omnicare issued an invoice billing Abbott $27,000 for this "data." Finally, Omnicare disguised this kickback in its records as a payment to sponsor its management conference on Amelia Island. *Id.*

106. Between 2000 and 2005, Omnicare solicited and received the following kickbacks disguised as payments for its management meetings on Amelia Island:

Date	Amount
August 15, 2000	$9,000
August 15, 2000	$9,000
September 4, 2001	$19,000
June 17, 2002	$19,000
June 20, 2003	$21,000
May 27, 2004	$10,500
July 1, 2004	$10,500
May 17, 2005	$14,500

Date	Amount
May 18, 2005	$10,500

Id., ¶68.

107. Omnicare also received other kickbacks from Abbott. For example, Omnicare solicited and received $50,000 in "donations" from Abbott in 2000 under Omnicare's purported Re*View program, which was an initiative designed to increase drug prescriptions in Omnicare's LTCFs. *Id.*, ¶32; *see also* Ex. 52 (Jan. 6, 2000 Re*View solicitation letter from Bien to Abbott).

108. In July 2000, Bien, Maloney and other Omnicare senior managers were also offered free tickets to the Ladies Professional Golf Association United States Open golf tournament, as well as a round of golf at Kemper Lakes golf course. Ex. 5, ¶69.

109. In 2001 and 2002, Omnicare subsidiary Shore Pharmaceutical Providers received $36,750 and $38,500, respectively, for parties and dinners, including a $12,000 "golf outing" provided by Abbott. *Id.*, ¶70. And, from 1998 through 2004, Omnicare subsidiaries Jacobs Healthcare Systems and Lawrence-Weber Medical received $120,630 from drug manufacturers for education, programs, preceptorships, and a holiday party, including $24,000 from Abbott. *Id.*, ¶71.

110. All of the covert kickback arrangements between Omnicare and Abbott allowed the companies to avoid "Best Price" disclosure under the Medicaid Drug Rebate Statute by improperly disguising discounts Abbott provided to Omnicare tied to the purchase of Abbott's drugs.

Omnicare's Illegal Kickback Arrangement with IVAX

111. In addition to kickback arrangements with branded drug manufacturers like J&J and Abbott, Omnicare also solicited and received illegal kickbacks from generic drug manufacturer, IVAX. Despite Omnicare's own attorneys having apprised defendants of the illegality of the kickback arrangement with IVAX, defendants were undeterred. Over its counsel's objection,

Omnicare negotiated a scheme wherein it would receive nearly $10 million in "bonuses" from IVAX for promoting the manufacturer's generic drugs. Ex. 7.[20]

112. IVAX is a generic drug manufacturer based in Miami, Florida. In 1998 and 1999, Omnicare officers Maloney (Director of Purchasing) and Bien (Senior Vice President, Professional Services and Purchasing) approached IVAX to encourage them to launch the generic forms of drugs whose expiring patents permitted the entry of generic drug alternatives into the market. In an effort to induce IVAX into launching the generic forms, Omnicare's Bien and Maloney advised Kim West, IVAX's Vice President of Sales and Marketing, that in exchange for a multi-million dollar, upfront payment from IVAX, Omnicare would guarantee the purchase of certain generic drugs from IVAX and utilize both their nationwide Disease Management and Therapeutic Interchange Programs to encourage physicians to recommend or switch nursing home patients from other manufacturers' drugs to those manufactured by IVAX (*i.e.*, increase market share for IVAX's generic drugs). The costs of these drugs would then be passed on to the patients' insurers, including Medicaid. *Id.*, ¶¶15-16.

113. According to Omnicare's 8-K filed with the SEC on June 17, 1999, Omnicare faced numerous financial challenges in 1999, due to the "lower-than-anticipated occupancy in many client skilled nursing facilities, particularly relating to Medicare-funded residents, and . . . a significantly diminished acuity level among residents of these facilities." As a result, the prospect of receiving a large upfront payment from IVAX was very attractive to the Company's senior management. Ex. 7, ¶18. By mid-1999, IVAX and Omnicare reached an agreement, pursuant to which IVAX paid Omnicare an $8 million signing bonus and a 5% post-purchase rebate in exchange for Omnicare's commitment to purchase $50 million worth of the generic drugs fluoxetine (Prozac), omeprazole

[20] *United States of America, et al., ex rel. Kammerer v. Omnicare, Inc. and IVAX Pharms., Inc.*, No. 05-cv-11519-RGS (D. Mass. Mar. 4, 2009).

(Prilosec), famotidine (Pepcid), buspirone (Buspar), terazosin (Hytrin), and enalapril (Vasotec), exclusively from IVAX between January 1, 2000 and December 31, 2002. *Id.*, ¶¶17, 22-26, 35.

114. In an effort to complete the agreement, Omnicare sought the advice of their "regular outside counsel for transactional matters involving potential health care fraud and abuse issues" to determine whether the proposed signing bonus from IVAX could be considered a discount that fell under the Federal Anti-Kickback Statute, 42 U.S.C. §l320a-7b(b)(3), or the regulatory safe harbor for discounts, 42 C.F.R. §1001.952(h). *Id.*, ¶19. In a 15-page memorandum dated June 7, 1999, ***the Company's attorney stringently warned Omnicare about the inappropriateness of the contract***, noting that the OIG issued a special fraud alert for payments such as these in 1994. Specifically, its attorney told Omnicare that the contract with IVAX:

> ***carries a heightened risk that a federal or state prosecutor would determine it violates federal or state fraud abuse statutes, specifically the federal anti-kickback statute . . . the proposed arrangement, on its face, has all the characteristics of a kickback. It involves a lump-sum cash payment (the stated "signing bonus") intended as an incentive to win Omnicare's business***.

Id., ¶20 (emphasis added and in original); *see also* Ex. 19 (OIG's 1994 Special Fraud Alert).

115. The following day, during a conference call between the attorney, Omnicare executives and an Omnicare's outside accounting firm, PricewaterhouseCoopers ("PwC"), to determine if Omnicare could recognize the signing bonus from IVAX as revenue before Omnicare actually purchased any drugs, the attorney reiterated "that there was a conflict between the company's desire to book revenue early and . . . any payments by IVAX [needed to] be tied more closely to actual purchases of product." Ex. 7, ¶21.

116. Despite its attorney's warnings, Omnicare continued its negotiations with IVAX. *Id.*, ¶22. After reviewing the most updated contract draft, on July 21, 1999, ***the attorney issued another memo to Omnicare in which he again cautioned that the proposed agreement carried "a significant risk that a federal or state prosecutor would determine it violates federal or state fraud***

and abuse statues, specifically the federal anti-kickback statute." *Id.*, ¶24 (emphasis added and in original). In an effort to avoid any questions regarding the timing of the signing bonus payment, which according to the proposed terms, IVAX was to make more than a year in advance of Omnicare purchasing any drugs, the attorney proposed contractual terms that spread the $8 million into quarterly payments over a three year period, and which did not require Omnicare to purchase products exclusively from IVAX. *Id.*, ¶25.

117. Notwithstanding its attorney's advice, the next draft of the contract IVAX circulated to Omnicare on August 24, 1999, scheduled IVAX to make a significant portion of the $8 million dollar payment ($2.5 million) to Omnicare in August 1999 despite the fact that Omnicare would not be purchasing any products under the agreement until January 1, 2000. *Id.*, ¶26. After reviewing these terms, Omnicare's attorney spoke to IVAX's Associate General Counsel on both August 31 and September 9, 1999 and voiced his concerns about "the fraud and abuse issues raised by the proposed contract" between the two parties. *Id.*, ¶27.

118. On September 13, 1999, Omnicare's attorney then circulated yet ***another*** memo and again attempted to provide Omnicare with guidance regarding its risky contractual terms, stating:

> ***[W]e do not believe Omnicare, nor [IVAX], based upon recent discussions with its Associate General Counsel, would want to be in the position of defending a $2.5 million cash payment as a prepaid rebate which did not cover a rebate period, and the rebate period (for which purchases were required), did not begin until several months after the cash payment was received. As we explained in an earlier memorandum, we believe the OIG could challenge this advance cash payment, for which there is no safe harbor, as a "signing bonus," and/or an interest free loan***.

Id., ¶28.

119. All consultation between Omnicare and its attorney regarding the proposed contract with IVAX then ceased. *Id.*, ¶29.

120. Omnicare's top executives, including defendant Gemunder, were well aware of the legal implications of this type of contract. In fact, Bien had specifically advised Gemunder and

others that the signing bonus had triggered a red flag with the legal department. *Id.*, ¶31. In an effort to obtain a green light, Omnicare then consulted with a ***different*** attorney, but did not tell that attorney about the "signing bonus," and withheld the fact that a portion of the bonus would be received before Omnicare purchased any of IVAX's products. *Id.*, ¶¶32-33. Because this material information was concealed from Omnicare's second attorney, she provided Omnicare with the green light it desperately sought, advising Omnicare that "it is more likely than not that the $8 million [from IVAX] will be viewed as a discount on the purchase of $50 million of products." *Id.*

121. Ultimately, Omnicare and IVAX executed the deal on December 21, 1999, but backdated the contract to April 1, 1999, enabling Omnicare to record revenue over three quarters in 1999. *Id.*, ¶¶34-35. IVAX issued a $2.5 million check to Omnicare on the same day and made an additional $5.5 million in payments to Omnicare during 2000 and 2001. *Id.*, ¶36. Omnicare and IVAX twice extended the time period for Omnicare to purchase the required $50 million in products. *Id.*, ¶¶38-39. On June 30, 2004, Omnicare fulfilled its contractual obligations, having purchased over $50 million in drugs from IVAX, and delivering them to patients in long term care facilities. Omnicare submitted Medicaid reimbursement claims for the IVAX drugs on behalf of the patients who had the relevant insurance coverage. *Id.*, ¶36.

122. On November 3, 2009, the DOJ announced it settled claims against Omnicare and IVAX for a total of $112 million, of which $14 million was paid by IVAX to resolve allegations relating to the kickback scheme between Omnicare and IVAX.[21] The DOJ, just as Omnicare's regular counsel had warned, concluded that "Omnicare solicited, and IVAX paid, $8 million in kickbacks in exchange for Omnicare's agreement to purchase $50 million in drugs from IVAX." Ex. 9.

[21] The remaining $98 million resolved claims against Omnicare regarding the J&J wrongdoing. *See* ¶84.

Omnicare's Illegal Kickback Arrangements with Other Pharmaceutical Companies

123. Omnicare also entered into arrangements with several other large pharmaceutical companies, which entitled Omnicare to illegal kickbacks in exchange for increasing the market share for certain prescription drugs in the period leading up to the Offering.

124. ***Amgen***: A *qui tam* action filed against Amgen and Omnicare details the extensive kickback scheme Omnicare and Amgen entered into in order to promote Amgen's prescription drugs in LTCFs.[22] In 2002, Omnicare's CEO and President, defendant Gemunder, and Omnicare's Seniors Vice President of Business Development, Bien, met with employees at Amgen to discuss how Amgen could compete with J&J regarding sales of erythropoiesis-stimulating agents ("ESA") in order to drive Amgen's sales of its brand drug Aranesp over J&J's competing ESA drug Procrit. Specifically, defendant Gemunder and Bien told Amgen that J&J provided rebates to Omnicare based on the amount of prescriptions Omnicare dispensed for Procrit. At the time, J&J was leading the ESA market in the long term care setting. Defendant Gemunder and Bien made it clear to Amgen that Amgen's rebate deals would have to compete with the rebates being provided to Omnicare by J&J. Ex. 6, ¶70.

125. In 2002, Amgen, at Bien's urging, hired John Thompson as a National Account Manager for Aranesp. Once employed, Thompson devised a comprehensive plan to increase Aranesp usage at Omnicare's LTCFs, based on contract and side agreements that provided Omnicare with a number of financial inducements or kickbacks, including quarterly rebates. These financial incentives from Amgen were provided in exchange for agreements by Omnicare to switch patients already on J&J's Procrit to Aranesp, and to put patients on Aranesp who were not already taking an ESA, thus expanding the market for Aranesp in Omnicare's LTCFs. *Id.*, ¶71.

[22] *See United States of America, ex rel. Kurnik v. Omnicare, Inc.*, No. 11-cv-01464 (D.S.C. June 14, 2011). Ex. 6.

126. The terms of the illegal kickbacks or inducements were memorialized in rebate contracts and other side agreements between Omnicare and Amgen, including comprehensive plans ensuring that LTCF physicians prescribed Aranesp rather than Procrit, and that the pool of patients using Aranesp was expanded to include patients who were not already being treated by an ESA. *Id.*, ¶72.

127. By 2003, Omnicare had entered into rebate contracts with Amgen, which provided rebates to Omnicare based on the volume or market share of Aranesp prescribed by physicians at Omnicare's LTCFs. Without any clinical justification for switching patients already treated by Procrit and/or without proper regard for the drugs' different indications, Omnicare was incentivized to ensure that LTCF patients were prescribed Aranesp over Procrit, even if that meant switching a patient already stabilized on Procrit to Aranesp. The rebate contracts and other inducements paid by Amgen to increase Aranesp sales also incentivized Omnicare and Amgen to prescribe Aranesp to patients whose kidney stage and anemia symptoms were outside the drug's indication. *Id.*, ¶77.

128. In August 2003, Bien worked with Karen Daniels, Amgen Director of Corporate Accounts, to construct the framework for an Omnicare rebate contract. On September 2, 2003, Omnicare management met with Amgen to discuss rebate contracts and build continuing partnerships. Upper level managers from Amgen and Omnicare approved of, participated in, and negotiated the rebate contracts between Amgen and Omnicare. Executives from Omnicare who had knowledge of and participated in the scheme included defendant Gemunder, who oversaw all major corporate decisions including contracting; Bien, Omnicare Senior Vice President of Professional Services and Purchasing, Omnicare's key decision maker and negotiator for all of Omnicare's rebate contracting, therapeutic interchange and anemia protocol programs; Maloney, Omnicare Director of Purchasing, who had a key role in Omnicare's rebate contracting, but deferred to Bien on all major

decisions; and Gary Erwin, Omnicare's Vice President of Clinical, who headed Omnicare's effort to design purported educational programs encouraging its consultant pharmacists to switch from Procrit to Aranesp. *Id.*, ¶81.

129. At a September 2003 meeting, Amgen presented Maloney and Bien with a contract proposal. At that meeting, Omnicare agreed to an October 1, 2003 start date, for the contract and to begin converting patients from Procrit to Aranesp at LTC facilities serviced by Omnicare. These economically driven schemes were never disclosed to patients whose drug regimens were changed. *Id.*, ¶82.

130. On October 1, 2003, a "Long Term Pharmacy Agreement" providing rebates to Omnicare took effect. Under the contract, Omnicare was eligible to earn a rebate based on the amount of Aranesp it purchased. To calculate Omnicare's total rebate, Amgen multiplied the amount of Aranesp purchased by an agreed upon "sliding scale" of percentage discounts. For example, the Omnicare/Amgen contract specified that if Omnicare purchased $9,900,000 or more of Aranesp from October 1, 2005, to December 31, 2005, Omnicare would earn a 3% rebate (*i.e.*, the rebates started at $297,000.00); however, if Omnicare purchased $13,400,000 or more of Aranesp, Omnicare would receive a 23% rebate (*i.e.*, the rebates started at $3,082,000.00). Amgen's contracts also granted Omnicare a rebate on Aranesp's market share in the ESA market (*i.e.*, as compared to Procrit) as an additional incentive for Omnicare to convert patients from Procrit to Aranesp. *Id.*, ¶83.

131. The terms of the rebate contracts were often amended and adjusted to keep pace with rebates and other illegal inducements being offered by J&J on Procrit and its other drugs. Some of J&J's rebate contracts also required Omnicare to purchase a particular "market share" or percentage of Procrit versus other ESAs in order for Omnicare to receive a financial incentive. For this reason,

Omnicare told Amgen that its purchases of Aranesp could not exceed 50% of the entire ESA "market" within Omnicare. *Id.*, ¶87.

132. Upper level managers from Omnicare and Amgen worked together to implement and perpetuate the scheme and met many times concerning rebates from 2002 through the date of the Offering. A relator in the *qui tam* action against Amgen estimates that Omnicare received nearly ***$20,000,000 in total rebates from 2003 through the date of the Offering***. Based on Amgen's sales data, the following yearly rebates were paid to Omnicare, exclusive of other inducements paid to Omnicare, such as funds used to promote the therapeutic interchange programs, protocols and speaker events: 2003 (11% discount) – $1.155 million; 2004 (20% discount) – $6.4 million; and 2005 (23% discount) – $11.5 million. *Id.*, ¶¶88-89.

133. Omnicare and Amgen also developed a similar therapeutic interchange programs for Aranesp from 2003 to 2005. Initially, in 2003, Omnicare instituted a therapeutic interchange "pilot program" requiring switching patients from Procrit to Aranesp. *Id.*, ¶116.

134. In July 2005, Amgen helped Omnicare's Barbara J. Zariwutz, Chief Clinical Officer, prepare a letter sent to all Omnicare pharmacists and regional clinical directors reinforcing the "therapeutic interchange" from Procrit to Aranesp. Some nursing homes serviced by Omnicare complained that the therapeutic interchange or switch from Procrit to Aranesp was not financially beneficial to them, especially for patients receiving less than 10,000 units of Procrit. In those situations, the switch to an equivalent amount of Aranesp cost the nursing home more per patient. In 2005, yielding to the pressure of the nursing homes, Omnicare agreed to strike a deal with Amgen on a limited therapeutic interchange program, which provided for switching patients from Procrit to Aranesp only for patients already taking 10,000 units or more of Procrit. *Id.*, ¶¶118-119.

135. Amgen and Omnicare ultimately paid approximately $30 million to resolve claims brought by the DOJ concerning their illegal kickback arrangement. Exs. 53-54.

136. ***AstraZeneca Pharmaceuticals***: In April 2000, Omnicare entered into an agreement with AstraZeneca Pharmaceuticals ("AstraZeneca") intended to increase the market share of certain AstraZeneca drugs. The agreement was described as "highly confidential," and provided for Omnicare to receive rebates of up to 13% depending on the market share Omnicare achieved for the drug Seroquel®. Pursuant to the agreement, Omnicare received a 2% rebate for achieving market share greater than 5%, a 5% rebate for market share greater than 10%, and a 13% rebate for market share greater than 40%. In addition, Omnicare received a 1% rebate in exchange for positioning Seroquel as the "Preferred First Line Atypical Anti-Psychotic." Omnicare and AstraZeneca entered into similar agreements regarding other drugs, such as Zestril and Nolvadex, during other calendar quarters. In 4Q01, these contractual rebates amounted to $2,985,985 for Seroquel, $9,794,130 for Zestril, and $419,657 for Nolvadex. Ex. 1, ¶43.

137. ***Bayer Corporation***: In 4Q01, Bayer Corporation ("Bayer") paid Omnicare rebates totaling $1,576,116 for increasing market share and providing other preferential treatment for Bayer drug Adalat CC. Omnicare had other agreements with Bayer to increase market share of Bayer drugs, including an agreement in 1999 whereby Bayer agreed to and did pay Omnicare a 4% rebate for market share between 2% and 5%; 8% rebate for market share between 5.1% and 10%; and a 27% rebate for market share of 30.1% or higher for the drug Baycol. *Id.*, ¶44.

138. ***Eli Lilly & Co.***: Omnicare and Eli Lilly & Co. ("Eli Lilly") entered into an agreement involving the drug Zyprexa, whereby Omnicare agreed to grant preferential treatment to Zyprexa over competing drugs, and Eli Lilly paid Omnicare a 9.5% rebate totaling $9,874,262 in

exchange for increasing Zyprexa's market share. Omnicare and Eli Lilly entered into similar arrangements for Zyprexa and other drugs during other calendar quarters. *Id.*, ¶45.

139. ***Merck & Co., Inc.***: In 1999, Merck & Co., Inc. ("Merck") entered into an agreement to pay Omnicare rebates ranging from 5% to 28% of its purchases of Prinivil, Vasotec, Prinzide, Mevacor, Zocor, Tim-XE, Cozaar, Hyzaar and Fosamax, in exchange for Omnicare's increasing the market share of the aforementioned drugs and promising not to engage in any programs or initiatives that would divert sales of these drugs. In exchange for increasing the market share of these drugs, Merck paid Omnicare a quarterly check for the total sum of rebates owed. Omnicare entered into similar agreements with Merck in other years as well. *Id.*, ¶47.

140. ***Novartis***: During 4Q01 and in other quarters, Omnicare accepted rebates from Novartis for granting preferential treatment to Novartis drugs, Miacalcin, Exelon, Clozaril and Trileptal. In exchange for increasing the market share of these drugs, Omnicare received an 8% rebate on Miacalcin purchases for a total of $1,068,955; a 15% rebate on Exelon for a total of $1,509,117; a 13% rebate on Clozaril for a total of $1,035,489; and a 1.1% rebate on Trileptal for a total of $38,142. *Id.*, ¶48.

141. ***Novo Nordisk***: In 4Q01, Omnicare received concealed discounts from Novo Nordisk totaling $6,284,874, in exchange for Omnicare's granting preferential treatment for certain drugs manufactured by Novo Nordisk. Specifically, Omnicare received a 53.2% rebate amounting to $2,223,211 for purchases of Novolin N®;$2,113,554 for purchases of Novolin 70/30®; and $1,948,109 for purchases of Novolin R1®. *Id.*, ¶49.

142. ***Pharmacia***: Omnicare entered into contracts with Pharmacia whereby Omnicare received rebates for increasing the market share of, and granting preferential treatment to, certain Pharmacia drugs. For example, in 4Q01, Pharmacia received the following rebates for pushing

market share to Pharmacia drugs: 15%, or $4,074,093, on purchases of Celebrex; 12%, or $838,171, on purchases of Ambien®; 13%, or $826,022, on purchases of Detrol®; 6%, or $292,892, on purchases of Xalatan®; 4%, or $92,598, on purchases of Mirapex®; 2%, or $36,588, on purchases of Zyvox®; and 11%, or $244,587, on purchases of Fragmin®. *Id.*, ¶50.

OMNICARE ENGAGED IN ILLEGAL OFF-LABEL MARKETING AND DRUG SWITCHING SCHEMES TO EFFECTUATE ITS ILLEGAL KICKBACK SCHEMES AND GENERATE ADDITIONAL REVENUE

143. Omnicare and the nation's largest drug manufacturers took advantage of Omnicare's ability to improperly push certain drugs on the Company's LTCF patients. In an effort to increase market share and generate profits for specific prescription drugs so that the Company could receive millions of dollars in illegal kickbacks previously described, Omnicare deliberately directed the prescriptions of certain drugs, or forms of drugs, for its LTCF patients. First, Omnicare directed and promoted off-label use of drugs to its vulnerable LTCF patients in violation of FDA regulations, and in complete disregard for the safety of its elderly patients. Second, Omnicare also engaged in extensive drug switching schemes whereby it directed the switching of one dose of a drug to another through the Company's so-called "therapeutic interchanges," in order to submit larger reimbursement claims to federal and state Medicare and Medicaid programs. These drug interchange programs allowed consultant pharmacists to review patient charts and make switches to prescriptions without having to first consult with the physician. Ex. 55 at JNJ 351940. Omnicare's off-label and drug switching schemes were intended to generate additional income for the Company, without regard to its patients' safety and well-being in order to effectuate the numerous kickback schemes defendants negotiated.

Omnicare Solicited and Encouraged Off-Label Use of Drugs Prescribed for Its LTCF Patients

144. In order to obtain FDA approval for a drug, a manufacturer must provide clinical evaluations of the drug's safety and efficacy for the indicated use and the indicated patient base. The FDA strictly forbids manufacturers from advertising that a drug is safe and effective for unapproved uses or unapproved patient populations. Such marketing is referred to as "off-label" marketing. Omnicare's interchange initiatives not only violated the Federal Anti-Kickback Statute as discussed above, but they also assisted pharmaceutical manufacturers in violating federal regulations concerning off-label marketing, including the Food, Drug, and Cosmetic Act, 21 U.S.C. §301, which prohibits drug manufacturers from marketing drugs for indications other than those approved by the FDA, and the FDA Modernization Act of 1997, which bars drug manufacturers from supplying medical practitioners with off-label information unless such information is specifically solicited by the physician. 21 U.S.C. §260aaa-6. Off-label use of pharmaceuticals subjects a patient to drugs that have not been determined safe and effective to treat their conditions.

145. Omnicare encouraged and engaged in the off-label promotion of several drugs prior to the Offering. Omnicare's blatant off-label promotion was particularly alarming with regard to two drugs, Risperdal and Depakote, which were not FDA-approved for Omnicare's elderly LTCF patients. As to Risperdal, J&J obtained FDA approval for Risperdal ***only*** to treat schizophrenia. Further, the FDA specifically ***rejected*** the drug for the treatment of dementia in elderly patients. Similarly, Depakote, a drug manufactured by Abbott, had never been approved as safe and effective in treating agitation and aggression in elderly patients, and accordingly, neither drug should have been prescribed to Omnicare's elderly patients.

146. These FDA denials notwithstanding, Omnicare and the pharmaceutical manufacturers developed initiatives pursuant to their illegal kickback arrangements to push Risperdal and Depakote

on Omnicare's elderly patients with dementia, without regard to the safety or efficacy of the drugs on Omnicare's geriatric patients. As predicted by the FDA denial of Risperdal to treat the elderly, Omnicare's off-label promotion of Risperdal was linked to increased incidence of cerebrovascular adverse events, including stroke and even death. And dangerous health issues, such as hepatotoxicity (drug-induced liver damage), had not yet been evaluated in geriatric patients undergoing Depakote therapy, and thus, the drug could not yet be considered safe for Omnicare's elderly patients. Nevertheless, in order to effectuate the kickback arrangements Omnicare had with J&J and Abbott, these drugs were prescribed to Omnicare's elderly and vulnerable patients.

The Johnson & Johnson Risperdal Initiative

147. J&J and Omnicare use the term "intervention" to refer to the process in which Omnicare's pharmacists and consultant pharmacists switched LTCF patients from one drug to another. During much of the 1999 through 2004 time period, Omnicare's primary intervention with J&J was to drive prescriptions of Risperdal, J&J's atypical antipsychotic drug that was used as a chemical restraint. As documented in a February 14, 2001 letter, from Bien at Omnicare to Bruce Cummins at J&J, Risperdal and its market share were enormously important to both Omnicare and J&J. As evidenced in the 2001 letter, Omnicare spent hundreds of millions of dollars on J&J drugs in 2001 and worked hard to increase its market share. As Bien wrote, Omnicare was "SELLING MORE HIGH PRICED DRUGS (read Risperdal here) FOR THE PHARMACEUTICAL INDUSTRY!!" Ex. 56 at OMNI-MA040770.

148. Risperdal is an atypical antipsychotic medication that, at the time of the Offering, had only been approved by the FDA for the treatment of schizophrenia. Risperdal has never been approved to treat patients with dementia and dementia-related behavioral issues. Moreover, the drug was shown to increase the risk of stroke and other cerebrovascular attacks in such patients, even resulting in fatalities among dementia patients. *See* Ex. 57 (April 16, 2003 "Dear Healthcare

Professional" letter from J&J's Janssen Division warning of the Cerebrovascular adverse events caused by Risperdal in elderly patients with dementia).

149. Regardless, because only 1% of the elderly population has schizophrenia, Omnicare and J&J implemented an initiative to promote Risperdal sales to patients suffering from ***other*** indications, including dementia, endangering LTCF patients and violating FDA regulations. Pursuant to the 1997 and 2000 drug Supply Agreements between Omnicare and J&J (*see* ¶¶62-69), beginning in 1997, Omnicare and its directors initiated an aggressive campaign known as the "Risperdal Initiative," in which Omnicare directed its Regional Clinical Directors and Consultant Coordinators to push Risperdal on patients in nursing homes. Exs. 12, 36.

150. In order to implement the Risperdal Initiative, Omnicare distributed to all of its pharmacists around the country a so-called Patient Specific Therapeutic Interchange Protocol for Risperdal (the "Risperdal PSTI"). Exs. 12, 29. Omnicare provided its pharmacists with suggested oral statements and written comments to use to encourage physicians to prescribe Risperdal, sometimes regardless of whether a given patient was already stabilized on another antipsychotic.

151. The Risperdal PSTIs drafted to support the initiative were specifically revised to add "much more emphasis on geriatric behavior use and decreased the emphasis on schizophrenia." Ex. 12 at OMNI-MA035232. This protocol sought to justify Omnicare's use of Risperdal to promote and sell the drug to patients with behavioral disturbances associated with dementia – an indication for which Risperdal was not approved – in order to generate as many Risperdal prescriptions as possible and increase the drug's market share. *Id.*

152. Omnicare was incentivized to increase Risperdal's market share because the Company could receive rebates up to 11% for driving the drug's market share above 42%. Lisa

Welford, Omnicare's Director of Clinical Operations, stressed to J&J that Risperdal was Omnicare's "primary intervention." Ex. 58 at JNJ291258.

153. According to an internal Omnicare memorandum from Omnicare's Chief Clinical Officer, as part of its Risperdal Initiative, Omnicare engaged in a "Risperdal Fax Campaign" whereby the Company identified LTCF patients taking conventional antipsychotic drugs and faxed, mailed, or telephoned the patient's physician to recommend a switch to Risperdal therapy. Ex. 59 at OMNI-MA766303. According to the memo, the "interchange" was successful and a "significant number of physicians agreed to the conversion." *Id.* For those physicians who did not automatically convert their patients to Risperdal, Omnicare urged:

> There must continue to be ongoing communication between consultant pharmacists and those physicians who agreed to re-evaluate. Consultants should . . . be armed with the appropriate clinical information. . . . It is imperative that each and every resident on a conventional antipsychotic be re-evaluated for appropriate conversion to an atypical antipsychotic, with Risperdal being the more cost effective GPCG "preferred" alternative.

Id. at OMNI-MA766303-04. Omnicare further directed its pharmacy consultants to continue to evaluate patients who had not been included in the fax campaign for conversion to Risperdal. *Id.*

154. Omnicare further implemented the Risperdal Initiative by issuing Physician Authorization Letters, or "PALs," which requested that the physician pre-authorize pharmacists to substitute Risperdal over a competitor drug when the pharmacist received the prescription. Ex. 60 (Omnicare's Physician Authorization Template). For example, Omnicare pharmacies Jacobs Healthcare and Lawrence Weber, collectively serving almost 30,000 beds, began sending PALs to generate pre-authorized approval of Risperdal in May 2001. Ex. 61 at JNJ289772. Thus, Omnicare was able to direct physicians toward prescribing drugs like Risperdal for off-label use.

155. Omnicare continued its Risperdal initiative throughout the time of the Offering, in blatant disregard for known FDA regulations, and without concern for its patients' safety and well-being.

The Abbott Depakote Initiative

156. In a complaint against Abbott, the DOJ alleged strikingly similar claims for off-label marketing and kickbacks as those alleged in the J&J action above. Ex. 5. In 1997, Abbott developed a Strategic Marketing Plan to promote the use of its drug Depakote to control agitation and aggression in nursing home residents with dementia, ***a use that FDA had never approved as safe and effective***. Abbott recognized Omnicare had the ability to influence treatment plans in elderly patients through formulary control, while simultaneously increasing the market share of Abbott's drugs. So, much like J&J's Risperdal Initiative, Abbott contracted with Omnicare to increase the prescription of Depakote for off-label uses, despite not yet obtaining FDA approval of the drug for elderly dementia patients, through the so-called "Depakote Initiative."

157. In the Strategic Marketing Plan, Abbott acknowledged that off-label uses for Depakote could "add substantial commercial value to the brand," and therefore focused on dementia as a possible profit-generator for its drugs. Ex. 62 at 3. Abbott's goal was to forge relationships with LTCF providers like Omnicare by "providing unrestricted educational grants to the [LTCF] providers in support of initiatives." *Id.* at 6. All of this was motivated by the desire to obtain increased market share for Abbott's drugs.

158. Despite understanding that "[g]enerically available drugs represent an affordable option," and that "***[s]afety concerns, specifically hepatotoxicity [drug-induced liver damage], are issues which have not been addressed adequately with the [LTCF] audience***," Abbott would only make money if LTCFs instead pushed its higher-priced, less safe brand drugs like Depakote on elderly patients. *Id.* at 7-8.

159. Beginning as early as 1998, and continuing through the date of the Offering, Omnicare and Abbott entered into arrangements under which Omnicare would receive millions of dollars in various kickbacks, described more fully at ¶¶85-110, in exchange for Omnicare actively promoting Depakote's off-label use and other various interchange programs. Ex. 5 , ¶28.

160. In exchange for Abbott's kickback payments, Omnicare's corporate management directed Omnicare's pharmacists to promote Depakote to control the behavior of elderly nursing home residents suffering from dementia. In 2002, Omnicare's Director of Clinical Services, Mark E. Lehman, informed Abbott that Omnicare's clinical priorities were "[b]ehavior management in dementia" with a focus "on the treatment of aggression and the use of Depakote." *Id.*, ¶74.

161. On September 26, 2002, Omnicare executives met with Abbott to discuss Omnicare's Depakote purchases in 2002. Abbott encouraged Omnicare to "focus[ ] on identifying new residents that could benefit from the addition of Depakote." Abbott suggested that Omnicare: give Depakote preference in Omnicare's treatment plans; regularly meet with consulting pharmacists about the Depakote Initiative; provide Abbott with physician-level utilization data for generic valproic acid and antipsychotic drugs to permit physician targeting; and, target patients with behavioral disturbances. *Id.*, ¶75.

162. In September 2002, Omnicare and Abbott confirmed that Omnicare would make increasing Depakote sales in Omnicare's LTCFs a top priority. In that regard, Omnicare was focused on implementing four methods for increasing Depakote prescriptions at its LTCFs:

(a) converting patients from generic prescriptions to Abbott's Depakote;

(b) identifying new nursing home residents with behavioral disturbances not exhibiting psychotic features and recommending Depakote as a first-line treatment for them;

(c) using Depakote to augment nursing home residents being treated with an antipsychotic, converting nursing home residents taking benzodiazepines to Depakote; and

(d) increasing the Depakote dosage in nursing home residents taking Depakote but still exhibiting behavioral disturbances.

Id., ¶76.

163. To standardize and facilitate Omnicare's promotion of Depakote, Omnicare developed model comments that consulting pharmacists in its LTCFs could import into the recommendations they sent to prescribing physicians. For example, the model comments:

(a) Advocated the use of Depakote to control behaviors in LTCFs:

> "[T]his resident was identified as having recurrent behavioral symptoms affecting others. . . . The non-medication behavioral interventions being utilized for this resident have not been fully successful at eliminating these adverse behaviors.
>
> Please consider initiating Depakote at 250 mg QHS in an attempt to control resident's behaviors. . . ."

(b) Encouraged doctors to prescribe higher doses of Depakote:

> "Depakote was initiated at 125 mg BID to control behaviors and behavioral symptoms persist. Average target doses of Depakote needed to control behaviors are 500 mg – 1000 mg daily.
>
> Please consider further titration to Depakote ER 500 mg QHS. . . ."

(c) Encouraged doctors to add Depakote when a resident's drug regimen already included a different antipsychotic drug:

> Current medication regimen includes * (an antipsychotic). Despite the use of antipsychotic therapy, resident continues to display behavioral symptoms.
>
> Please consider initiating Depakote 125 mg BID. Further titration in therapy *(i.e.*, Depakote 250 BID) can then be based upon clinical response. . . .

Id., ¶78.

164. Often, the model comments and recommendations directly resulted in the administration of Depakote to Omnicare's LTCF patients, and resulted in false claims being submitted to Medicare and Medicaid in the years preceding the Offering. Thus, not only was

Omnicare violating Medicare and Medicaid law, but also prescribing unsafe drugs to its vulnerable patients, exposing them to tremendous health issues, including drug-induced liver damage.

Omnicare Directed the Improper Interchange of Prescription Drugs

165. In addition to the blatant off-label use initiatives described above, between 2000 and 2005, Omnicare engaged in an extensive campaign to increase revenue and profit by implementing other "therapeutic initiatives," which were essentially marketing programs designed to switch LTCF patients' current prescriptions to higher-profit drugs. Omnicare's practices were motivated by the Company's internal assessments of a particular drug's profitability as well as its contractual arrangements with pharmaceutical manufacturers, including illegal kickback arrangements. Large drug manufacturers knew that Omnicare's willingness to employ initiatives to promote and steer patients towards specific drugs was "highly motivated based on economics and 'spread' (their margin)." Ex. 23 at JNJ284630. According to J&J, Omnicare was able to effect dramatic shifts in utilization from one drug to another, but "in order to have the Omnicare's of the world drive share that high, it must be financially wor[th] their while." Ex. 26 at JNJ284585.

166. One of Omnicare's extensive therapeutic interchange programs was the Company's "Re*View" program. During the early 2000s, Omnicare ventured to raise money from numerous drug manufacturers under the so-called "Re*View" program. The program was ostensibly created to develop "health management" programs (*i.e.*, therapeutic initiatives) that would identify nursing home patients for whom additional drugs could be prescribed. In a January 6, 2000 letter to Bruce Cummins at J&J, Omnicare's Bien solicited $50,000 from J&J pursuant to Omnicare's Re*View program. Ex. 47. On January 6, 2000, Bien also solicited Abbott for a payment described as "an educational grant in the amount of $50,000" to support Omnicare's "Re*View" program. Ex. 52.

167. But the Re*View program was merely a façade established by Omnicare for soliciting kickbacks under the guise of educational programs designed to promote prescriptions drugs to

Omnicare's LTCF patients, while at the same time increasing the market share for those drugs. It was understood internally at Omnicare that the Re*View program was actually established in order to push extra drugs on Omnicare's vulnerable patients to increase profit.

168. For example, in early 2001, Omnicare invited over a dozen pharmaceutical manufacturers, including Abbott, to a meeting that Omnicare referred to internally as "Industry Day." During Industry Day, Omnicare presented materials about the Re*View program and other opportunities for manufacturers to provide remuneration to Omnicare. The presentation included a solicitation for an additional $50,000 payment from Abbott to support the "Re*View program." Ex. 5, ¶35.

169. Following Industry Day, Omnicare maintained an internal score sheet to track each pharmaceutical manufacturer's willingness to pay kickbacks to Omnicare in various forms under Omnicare's Re*View program, including increased discounts for drug purchases, contracts for sample packaging, "good faith discussion of microchip projects," "good faith discussion on contract research for [Omnicare]," and commitment to "'Review' grant request." Ex. 63. Omnicare's Bien received reports about the status of the rebate solicitations.

170. In a April 3, 2001 memorandum from Omnicare's Senior Vice President of Professional Services and Purchasing Bien to defendant Gemunder, the two refer to the Re*View program as the "one extra script per patient (Re*View) program," and tout having raised nearly $1,000,000 from pharmaceutical manufacturers to support the "one extra script" initiative for Omnicare's elderly patients. Ex. 64. In all, a least 18 pharmaceutical companies donated funds to Omnicare's Re*View program in 2000, including $251,000 from J&J alone. Ex. 46.

171. In the April 3, 2001 memorandum, Bien noted that with an additional $1.1 million he expected to be raised in 2001 through the Re*View therapeutic interchange program, Omnicare

would have more than $2 million in its "war chest." Ex. 46. The Re*View program demonstrates that Omnicare deliberately solicited funds from manufacturers solely to increase the prescriptions it could push on its LTCF patients to generate revenue.

172. Statements made by confidential witnesses and former employees who blew the whistle on Omnicare detail the Company's other profit-driven drug-substitution initiatives that took place prior to the Offering. Those witnesses describe how Omnicare made ongoing assessments of drugs' profitabilities and, in order to convince physicians to prescribe the most profitable drugs, prepared false clinical assessments indicating that the most profitable drug was also, conveniently, the cheapest and most efficacious. Omnicare would then implement therapeutic interchanges to drive sales of higher-profit drugs, and even directed its employees to switch patients' drug prescriptions without physician authorization.

173. David Kammerer ("Kammerer"), the former Director of Medicaid Reimbursement at Omnicare until 2002 who worked directly with Omnicare's top management, explained that Omnicare made ongoing assessments of the profitability of drugs prescribed to LTCF patients and implemented clinical initiatives designed specifically to push patients from lower-profit to higher-profit drugs. As part of Kammerer's regular job responsibilities, he developed models to determine which drug (*e.g.*, Ranitidine, Axid, Pepcid/Famotidine) and which form of the particular drug (tablet or capsule) was the most profitable for each state in which Omnicare operated. Ex. 22 at 4-5.[23] Utilizing this information, Kammerer generated profit forecasts that were based on "how much Omnicare market share could be moved from one drug (or drug form) to another drug (or drug

[23] Kammerer prepared the models using Omnicare's "dead net" acquisition cost for each drug, which was highly confidential and only available to a select few at Omnicare, including defendant Gemunder, executive Bien, Chief Operating Officer ("COO") Patrick Keefe ("Keefe"), and a few people in the purchasing department. These highly confidential "dead net" costs were never shared with the government, other third parties or with Omnicare pharmacies. *Id.* at 5.

form)." *Id.* at 5. Kammerer developed company-wide and regional forecasts for a specific drug-switching initiative. *Id.* at 4-5. According to Kammerer, if the drug switch would increase Omnicare's profitability, then management, including defendant Gemunder, would approve the initiative and direct its Regional Vice Presidents, Regional Clinical Directors, Operations Managers and Consultant Coordinators to make the switch. Exs. 1, ¶41; 22 at 3-5.

174. Kammerer, working directly with Omnicare's top management, was responsible for evaluating and increasing the profitability of Omnicare's clinical initiatives and monitoring pharmacies' compliance with those initiatives. *Id.* Kammerer met up to ten times daily with Bien, a direct report to defendant Gemunder, to discuss profits derived from clinical initiatives as well as pharmacies' compliance with Omnicare initiatives. *Id.* Kammerer also discussed Omnicare's profits and clinical initiatives with defendants Gemunder and Froesel, as well as COO Keefe, who, along with Bien, Kammerer considered to be the top four officers at Omnicare. *Id.* Occasionally, defendant Gemunder even contacted Kammerer at home to discuss these matters. *Id.* It was Bien's responsibility to approve or disapprove clinical initiatives, and defendant Gemunder sometimes participated in the approval process as well. *Id.*

175. CW1, a former Executive Assistant at Omnicare's Midwest Regional Headquarters in Missouri between 1998 and 2005, stated that Omnicare employed these therapeutic interchanges designed to boost Company revenue at least once or twice per quarter. According to CW1, Froesel held conference calls with all of Omnicare's Regional CFOs ("RCFO") and their delegates (the operations and clinical heads and certain financial support persons on the Regional staff), including CW1, during which Froesel advised the call participants that either the whole Company, a particular region or a particular subsidiary pharmacy, required a revenue boost to make its monthly or quarterly revenue and/or earnings numbers. During these calls, Froesel identified the financial shortfall and

then directed the regional or subsidiary pharmacies to employ a "health management initiative," *i.e.*, take steps to gain the required extra revenue by substituting higher priced drugs for the lower priced drugs currently prescribed to patients. CW1 had access to his/her Region's financial information because CW1 attended monthly managers meetings discussing Regional financials, was responsible for assembling the monthly financial statements prepared by Omnicare's pharmacies in the Midwest Region, and compiled financial presentations for the Corporate Office. CW1 stated that the Region always had difficulty meeting earnings numbers and "never had any breathing room."

176. According to CW1, in order to justify the drug-switching initiative, CFO Froesel directed Omnicare's RCFOs to create "clinical case studies" to support the proposition that the target drug was more effective and/or more cost effective than the competing drug currently being prescribed. The RCFOs then conferred with the Regional Clinical Director to "put the clinical spin" on the drugs identified for substitution, with the goal that the "clinical program would bring the desired price and revenue increase."

177. In the Midwest Region, the RCFO was Douglas Pepper and the Regional Clinical Director was Joseph Gruber. In addition to Pepper and CW1, Mark Price and Steve McConnell of the regional operations team participated in the calls with Froesel. According to CW1, after Froesel's call, Pepper and Price would discuss operations aspects of the drug substitution initiative and then confer with Gruber to "put the clinical spin on it." CW1 worked closely with Gruber when developing the clinical justification for the initiative.

178. CW1 explained that in order to develop the "clinical spin," the Regional Clinical Officers (Gruber in the Midwest Region) met with the Corporate Clinical Officers, including Lisa Welford, Corporate Director for Clinical Operations, who led these drug-substitution efforts, and

Barbara Zarnowitz, Corporate Chief Clinical Officer. Both Welford and Zarnowitz were in charge of developing clinical programs. *See* Ex. 55 at JNJ351935, 37.

179. Once the program, or initiative, had been developed, the Regional Clinical Officers conferred with their assistants, such as CW1, who were responsible for searching Omnicare's patient database to identify and locate target patients and compile data about each patient's attending/prescribing physician, the LTCF in which they reside and the patient's family and medical information. Gruber would contact CW1 to compile this information. After the data was compiled, Omnicare prepared and sent "therapeutic interchange letters" to the patient's physician, LTCF, and/or family members, recommending the target-drug and asserting that it was in the patient's best interest to make the switch.

180. According to CW1, the tone and content of the letters was often adapted to the recipient. For instance, a letter to family might state, "grandma would only have to take one pill instead of two," while the letters to the LTCF would focus on cost savings, and those to physicians might focus on the efficacy of the drug, with the intent of making it easy for the doctor to say yes to the substitution.[24] Kammerer corroborated this information, stating that Omnicare would advise its pharmacists and physicians that, for example, drug A had the same or even better efficacy than drug B, but drug A would save the payor money and decrease Omnicare's costs, when in fact this was not true. Ex. 1, ¶¶56, 59. Omnicare created these clinical case studies and therapeutic interchange letters for the sole purpose of obtaining higher profit margins and were not accompanied by any independent or valid clinical support for the recommendation. According to CW1, physicians had a high volume of patients and did not have time to perform analyses of different drugs themselves.

[24] CW1 stated that at the time of CW1's departure, Omnicare was in the process of developing a single letter that could be mass produced electronically by filling in certain information concerning the specific patient, drug class and particular drug. CW1 was involved directly with the project to create this single form letter.

181. According to Kammerer and CW1, therapeutic interchange letters were often utilized in conjunction with authorization forms that would make it easy for the physician to approve the drug-change simply by checking a box or line. Such communications were called Physician Authorization Letters, or "PALs," requesting that the physician authorize the Omnicare pharmacy to make the recommended drug switch. Ex. 60 (Physician Authorization Letter template). The PALs, too, would misrepresent the efficacy and/or cost benefits of the target drug. Ex. 1, ¶57. Bernard Lisitza, a licensed pharmacist and supervisor in charge of several pharmacists at Omnicare's Jacobs HealthCare between 1992 and 2001, personally investigated the statements made in PALs concerning the cost benefits of drugs and determined that, contrary to those statements, the cost of the proposed drug or dosage switch resulted in greater cost to the payor than did the initial prescription. Ex. 3, ¶¶34-35. CW1 said that, once prepared, the letters were sent out by "blast fax," *i.e.*, a bulk faxing sent to all addressees. At times, Omnicare would even implement the drug switch without physician authorization. Ex. 1, ¶57.

182. Omnicare engaged in these drug switching practices for numerous drugs, including Ranitidine, Celexa, Fluoxetine and Buspirone. Ex. 22 at 9-10. CW1 verified that it was Omnicare's top management in the Corporate Office that was responsible for negotiating contracts with pharmaceutical manufacturers.

183. ***The Ranitidine Initiative***: According to CW1, Kammerer and Lisitza, Omnicare took on a major drug-switching initiative with respect to the drug Ranitidine – the generic form of the antacid Zantac and the second-most prescribed drug to LTCF patients. Kammerer, who was responsible for evaluating the profitability of specific initiatives, developed financial spread sheets that demonstrated whether Omnicare's profitability could be increased by switching the form of patients' Ranitidine prescriptions, *i.e.*, from tablets to capsules. Upon determining that switching

patients from Ranitidine tablets to capsules would yield greater revenue, Omnicare management approved the drug-switching initiative and directed the appropriate personnel to make the switch. Ex. 22 at 5-6. As early as 2000, Omnicare took advantage of the discrepancy in reimbursement rates by systematically instructing its clerical staff to alter physician orders for Ranitidine from tablets to capsules. Ex. 3, ¶¶5, 25.

184. According to Lisitza, Omnicare's initiative to switch patients' Ranitidine prescriptions from tablet to capsule form, resulted in receipt of two to four times the revenue (more than $10 million in 2000-2001 alone) than the Company was entitled to receive from Ranitidine sales. *Id.*, ¶¶2-5, 30, 55. The price differential stems from the fact that there is a maximum reimbursement price, known as the "Federal Upper Limit,"[25] associated with the frequently prescribed tablet. *Id.* The capsules have no corresponding Federal Upper Limit because they are rarely prescribed and are generally only required for individuals who are intubated and require medication dissolved in a solution to be administered through a nasal tube.[26] *Id.*, ¶¶22-23.

185. According to Lisitza, in order to effect the drug form switch, Omnicare reconfigured its computers to make it virtually impossible for data entry clerks to enter any prescription orders for Ranitidine tablets. *Id.*, ¶¶24-27. Upon receiving tablet prescriptions, Omnicare's data entry clerical personnel simply could not process the orders. *Id.* Omnicare would then instruct its clerical personnel to physically alter the prescriptions to make it appear that physicians had prescribed capsules instead of tablets and then enter the false prescription information, requesting capsules instead of tablets, into the order entry system. *Id.*

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[25] The Federal Upper Limit was set by the Health Care Financing Administration, now known as the Center for Medicare & Medicaid Services.

[26] Ranitidine capsules and tablets are not considered the same medication under federal and state law. A pharmacy cannot unilaterally switch between one form of Ranitidine and another without a physician's express order.

186. The altered order (from tablets to capsules) was also entered on the patients' Physician Order Sheets, which were required to be verified by physicians on a monthly basis pursuant to state regulations. *Id.* The verifying physicians, however, failed to notice the change from tablet to capsule and would sign off on the Physician Order Sheets, appearing to approve the change. *Id.*

187. According to Kammerer, the Ranitidine tablet-to-capsule switch was also effected through the use of PALs. Occasionally, the PALs just stated that the form of the prescription would be switched unless the physician actively intervened to stop Omnicare pharmacists from doing so. Ex. 22 at 8-9. Furthermore, when market conditions changed, making the tablet more profitable than the capsule, Omnicare would send a directive to its pharmacies to revert to the initial prescription, or "turn off the PAL." *Id.* at 8. Significantly, according to Kammerer, in most cases, the periodic switches from Ranitidine tablets to Ranitidine capsules were done ***without a new physician prescription authorizing the change***. *Id.* at 6.

188. CW1 indicated that during her tenure with the Company, the government began investigating the Ranitidine drug-switching practices at one of the pharmacies in the Midwest Region, prompted by the justifications for the interchange that appeared in the interchange letters. According to CW1, Omnicare's top management viewed the Ranitidine investigation as "big trouble," and an issue that the Corporate Office and Regional Operations were "tight lipped" about.

189. ***The Levaquin Initiative***: Another one of Omnicare's "primary interventions" was the "Levaquin Initiative," designed to promote the J&J drug and increase its market share with respect to its number one competitor, Cipro. Ex. 58. Cipro, a Bayer Pharmaceutical drug, had long been the drug of choice in the antibiotic therapeutic category, with over 70% market share. Through the Levaquin Initiative, whereby Omnicare and its pharmacy consultants actively favored Levaquin over

Cipro and other brand named drugs in the same category, Omnicare was able to increase the market share for Levaquin from 19.2% in 4Q98 to 66.4% in 2Q01, reducing Cipro from approximately 80% to 28% market share over the same timeframe. Ex. 10. By October 2001, Levaquin surpassed Cipro, reaching over 71% market share. *Id.* To achieve these results, Omnicare sent PALs, or therapeutic interchange letters, to physicians asking for their approval to switch patients to Levaquin. Exs. 61, 65; *see also* Ex. 60 (Omnicare's Risperdal Physician Authorization Letter Template). When physicians did not respond, Omnicare pharmacists called physicians, upon receipt of a prescription for Cipro, and requested the conversion to Levaquin. *Id.*[27]

190. An internal Omnicare memorandum dated June 26, 2000 reiterates the importance of Omnicare's PALs. In the memorandum from Mark Lehman, Director of Clinical Services that was to be sent to all of Omnicare's Regional Vice Presidents, Operations Managers, and Regional Clinical Directors, with orders that the memorandum be distributed to all Omnicare Pharmacists, Lehman state that "As operations managers, ***you must make sure that the physician authorization letter (PAL) process is strictly enforced in all pharmacies, and that a zero-tolerance mentality be implemented for letter eligible prescriptions slip through due to staffing concerns or other confounding variables***." Ex. 67 at OMNI-MA 883376.

191. The success of Omnicare's drug interchange programs was unprecedented, generating greater market share for the pharmaceutical manufacturers and generous kickbacks for the Company. In a PowerPoint presentation in 2000, J&J commended Omnicare for the success of both the Risperdal and Levaquin Initiatives:

[27] Omnicare's initiatives were not limited to Risperdal and Levaquin alone. Its contractual arrangements with J&J specified that the Company would receive kickbacks for promoting other drugs as well. Exs. 11, 13. Omnicare's initiatives to promote these drugs were successful as well. For example, J&J commended Omnicare for its success in shifting market share to other drugs, such as Ultram, noting that Omnicare had "been able to switch . . . prescriptions to Ultram." Ex. 66.

1999 Accomplishments

- Completed "Risperdal Re-ignition Program" – Generating over a 50% market share.

* * *

- Developed Programs for Consultant Pharmacists in Dealing with Obstacles and Overcoming Resistance in Physician Prescribing Habits toward Risperdal.

* * *

- Levaquin over 50% Market Share.

Ex. 68 at OMP004128, 31-32.

192. In another e-mail, J&J again lauded the Company's efforts and success: "Omnicare is the example of what Johnson & Johnson believes to be the gold standard of Pharmacy Providers" based on its stellar performance increasing "Risperdal market share in an extremely competitive market." Ex. 66. An undated internal memorandum summarizes the success of Omnicare's and J&J's undisclosed, profit-driven relationship:

> During 1997, The Johnson & Johnson Long Term Care Business Group along with Johnson and Johnson Health Care Systems signed a performance based contract with Omnicare, Inc. The contract provided for a performance driven tiered rebate to be implemented for Johnson & Johnson strategic brand pharmaceutical products including Ultram, Duragesic, Propulsid, Procrit, Risperdal, Levaquin, and Floxin.
>
> Currently, Omnicare is running two initiatives for products produced at Janssen and Ortho-McNeil. Risperdal has generated an all time market share high of 55.5% throughout the 1st quarter of 2000. This market share represents Omnicare's ability in persuading physicians to write Risperdal in the areas of Behavioral Disturbances associated with Dementia.
>
> Omnicare also has an initiative under way for the antibiotic Levaquin for Urinary Tract Infections and Community Acquired Pneumonia. At the end of the first quarter, Levaquin reached an all time high market share of 67.02%. Once again, demonstrating Omnicare's ability to persuade physicians to write the most efficacious medication based on clinical evidence.

> The partnership has grown beyond product interventions. Omnicare's Clinical Research Organizations have been involved with past clinical studies and offers potential in a geriatric specific environment for products such as Reminyl.
>
> Janssen and Omnicare have also piloted an e-commerce initiative that would demonstrate ***Omnicare's abilities in persuading physicians to write medications in a less structured assisted care living environment***. There are also meetings currently underway that would look at a partnership approach in the European sector, in addressing the same type of product interventions with Janssen Cilag in England.
>
> ***Omnicare, Inc. has demonstrated its ability to partner in a true sense of the word and has generated well over 100 million dollars of Johnson & Johnson pharmaceuticals annually***.

Ex. 69.

193. Omnicare and its pharmacy consultants had unbelievable power to influence patients' drug prescriptions. As J&J observed in an internal memorandum from 2003:

> Omnicare has over 900 consultant pharmacists who review patient charts monthly and make recommendations based on the formulary and Omnicare programs for physicians. ***Pharmacists' recommendations are accepted more than 80% of the time***. Consultant pharmacists actively meet with physicians or correspond with them through the mail to obtain approval to make appropriate medication switches for all their applicable nursing home patients. . . . Omnicare consultant pharmacists receive monthly "report cards" showing them their success in obtaining goals for therapeutic programs.

Ex. 55 at JNJ351928.

194. In the same memorandum, J&J observed that Omnicare's "consultant pharmacists are active in having physicians sign therapeutic interchange forms that allow pharmacists to review charts and make switches without having to consult with the physician." *Id.* at JNJ351940. J&J further understood that consultant pharmacists had a "[h]igh degree of impact on product selection" in nursing homes. Ex. 23 at JNJ284630.

195. Omnicare also had extensive therapeutic initiatives in place to direct the prescription of other prescription drugs. For example, similar to the PALs described above, Omnicare developed model comments that consulting pharmacists in its LTCFs could import into the recommendations

they sent to prescribing physicians to direct the prescription of higher profit drugs, such as Abbott's Depakote. For example, the model comments:

(a) Advocated the use of Depakote to control behaviors in LTCFs:

> "[T]his resident was identified as having recurrent behavioral symptoms affecting others. . . . The non-medication behavioral interventions being utilized for this resident have not been fully successful at eliminating these adverse behaviors.
>
> Please consider initiating Depakote at 250 mg QHS in an attempt to control resident's behaviors. . . ."

(b) Encouraged doctors to prescribe higher doses of Depakote:

> "Depakote was initiated at 125 mg BID to control behaviors and behavioral symptoms persist. Average target doses of Depakote needed to control behaviors are 500 mg – 1000 mg daily.
>
> Please consider further titration to Depakote ER 500 mg QHS. . . ."

(c) Encouraged doctors to add Depakote when a resident's drug regimen already included a different antipsychotic drug:

> Current medication regimen includes * (an antipsychotic). Despite the use of antipsychotic therapy, resident continues to display behavioral symptoms.
>
> Please consider initiating Depakote 125 mg BID. Further titration in therapy *(i.e.*, Depakote 250 BID) can then be based upon clinical response. . . .

Ex. 5, ¶78. These model comments provided by Omnicare to physicians directly resulted in the administration of Abbott's drugs over less profitable drugs.

196. Also, in a *qui tam* complaint against Amgen filed by the United States and its relator Kurnik, the United States claims that much like the drug switching described above, Omnicare also solicited and received remuneration from Amgen in the form of purported discounts and rebates in exchange for Omnicare's influencing its LTCFs' selection and utilization of Amgen's drug Aranesp,

and for implementing therapeutic interchange programs intended to identify patients who were taking a competitor drug and to switch those patients to Aranesp.[28]

197. In July 2005, Amgen helped Omnicare's Chief Clinical Officer, Barbara J. Zariwutz, prepare a letter to be sent to all Omnicare pharmacists and regional clinical directors reinforcing the therapeutic interchange from J&J's Procrit to Amgen's Aranesp. Rebates and other inducements paid to Omnicare by Amgen provided a strong incentive for Omnicare and Amgen to expand the number of prescriptions of Amgen's Aranesp drug to patients whose kidney stage and anemia symptoms were outside the drug's indication. Ex. 6, ¶118.

198. Some nursing homes serviced by Omnicare complained that the therapeutic interchange or switch from Procrit to Aranesp was not financially beneficial to them, especially for patients receiving less than 10,000 units of Procrit. In those situations, the switch to an equivalent amount of Aranesp cost the nursing home more per patient. *Id.*, ¶119.

199. Omnicare's pharmacy consultants were so effective at promoting and inducing the sale of targeted pharmaceuticals that it caused one J&J executive to comment, "Incredible: good for us but scary on the power to do this." Ex. 24. Indeed, J&J considered Omnicare's consultants an "Extension of [the J&J] Sales Force." Ex. 25 at JNJ289731.

200. In 2004, Omnicare paid a $1 million fine to the State of Maine for improperly switching patients from generic drug Ranitidine tablets costing $15.10 a month, to Ranitidine capsules costing $82.77 a month instead, in order to improperly increase revenue and reimbursements from state and federal agencies. Ex. 14. In January 2006, Omnicare again announced that it was targeted by federal and state governments for improperly substituting its generic drug prescriptions. *Id.* Specifically, the federal government was investigating Omnicare's

[28] *See United States of America, ex rel. Kurnik v. Omnicare, Inc.*, No. 11-cv-01464 (D.S.C. June 14, 2011). Ex. 6.

practice of switching two 7.5mg Buspirone anti-anxiety tablets for one 15mg tablet; switching Fluoxetine anti-depression tablets for capsules; and switching Ranitidine heartburn capsules for tablets, in order to generate additional revenue. *Id.*

201. In November 2006, Omnicare agreed to pay $49.5 million to settle claims by the United States and 42 states alleging that from 2000-2005 Omnicare aggressively switched patients to different drugs via their therapeutic interchange programs to evade Medicaid reimbursement price limits. In its Semiannual Report to Congress, the OIG reported that Omnicare's "improper [prescription drug] switches cost Medicaid and the Federal Government approximately $26 million more than if the drugs had not been switched."

OMNICARE ALSO *PAID* MILLIONS OF DOLLARS IN ILLEGAL KICKBACKS TO ITS LTCFS IN ORDER TO MAINTAIN PHARMACY SERVICES CONTRACTS WITH THOSE FACILITIES

202. Omnicare also violated the Federal Anti-Kickback Statute by ***paying*** tens of millions of dollars to LTCFs in order to obtain or maintain pharmacy services contracts in those facilities. Exs. 15-16.[29] These contracts for pharmacy services were financially critical to Omnicare, as they provided Omnicare with its primary vehicle for providing pharmacy services to LTCF patients. Several whistleblower actions filed against Omnicare detail the Company's willingness to violate the law in order to secure these contracts.

203. For example, on April 1, 2003, Omnicare entered into a 64-month contract for pharmacy services with one of its LTCF partners, Mariner. Ex. 15, ¶27. Prior to and during 2004, Mariner was one of the largest nursing home chains, operating approximately 252 nursing homes with 32,000 nursing home beds. *Id.*, ¶9. Pursuant to a contract entered into in 2003, Omnicare

[29] *United States of America, ex rel. Resnick v. Omnicare, Inc.*, No. 06-cv-10149-RGS (D. Mass. Mar. 4, 2009); *United States of America and the States of Florida and Illinois, ex rel. Nehls v. Omnicare, Inc.*, No. 07-C-5777 (N.D. Ill. Dec. 21, 2010).

agreed to implement drug-switching programs at its LTCFs with the specific goal of saving Mariner $2.5 million per year. *Id.* During the contract period, Mariner was Omnicare's largest nursing home customer, generating approximately $155 million in revenue and $26 million in profit for Omnicare in 2004 alone. *Id.*, ¶28.

204. On June 29, 2004, 15 months into the contract, Mariner announced that it was being sold to National Senior Care, Inc. *Id.*, ¶29. On November 23, 2004, just prior to closing the acquisition, Mariner sent Omnicare a Termination Notice, stating that the 2003 contract between Mariner and Omnicare would terminate upon close of the acquisition. *Id.*, ¶31.[30] Mariner needed to raise cash to finance the pending transaction with National Senior Care and, therefore, sent Omnicare's Termination Notice in hopes that Omnicare would be willing to pay to prevent a termination of its contract with Mariner. *Id.*, ¶¶30-31.

205. On December 2, 2004, defendants Gemunder and Froesel met with Mariner's agents, who proposed that Mariner withdraw the Termination Notice in exchange for Omnicare's agreement to purchase one of Mariner's business units, MMS, a shell corporation with just two employees and no tangible assets apart from accounts receivable valued at less than $3 million. *Id.*, ¶32. The sole function of MMS was to deliver feeding tube supplies to Mariner nursing homes and bill Medicare for the supplies. *Id.* Mariner's agents made it clear to Omnicare that their objective was to obtain cash to finance the acquisition in exchange for withdrawing the Termination Notice. *Id.*, ¶33.

206. During the December 2004 meeting, defendant Gemunder contacted its regular outside counsel on healthcare regulatory issues to discuss the proposal. *Id.*, ¶34. ***Omnicare's attorneys advised the Company that to condition the Termination Notice withdrawal on Omnicare's agreement to purchase MMS would constitute a violation of the Federal Anti-***

[30] Post-acquisition, Mariner nursing homes was divided between Mariner and a newly created entity called Sava (collectively, "Mariner"). *Id.*, ¶29.

Kickback Statute because Omnicare would effectively be paying Mariner for utilizing Omnicare's pharmacy services. *Id.*

207. On December 4, 2004, Omnicare circulated the terms of the proposed agreement to Mariner which included, *inter alia*, for Omnicare to buy MMS (valued at $3 million) for $50 million, of which, $40 million would be paid at the time of purchase, and the remaining $10 million to be paid six months later. In exchange, Mariner would withdraw of the Termination Notice and amend the existing agreement between Omnicare and Mariner, to ensure that all Mariner nursing homes remained under the 2003 Pharmacy Contract after the larger Mariner acquisition was complete. *Id.*, ¶35.

208. On December 7, 2004, Omnicare's Board of Directors met to consider the proposal. *Id.*, ¶38. An internal Omnicare memorandum explained that Omnicare would be paying an exorbitant sum for a business unit worth very little:

> For the total anticipated consideration to the seller of $50,000,000, plus estimated transaction-related expenses of $285,000, Omnicare will receive tangible assets with an estimated net book value of $2,904,000 [consisting of accounts receivable] and create goodwill and other intangible assets of $47,381,000.

Id. However, one of Omnicare's investment bankers noted that with "3 YEARS LEFT ON [THE] CURRENT DEAL," Omnicare would be giving up "$155MM/REVS [and] $26MM/OP PROFITS" per year if it lost its contract with Mariner. *Id.*, ¶39. The Omnicare board approved the acquisition for $50 million, with $40 million to be paid up front before the deal closed. *Id.*

209. Omnicare exercised its new-found leverage over Mariner by insisting Mariner agree to "material changes" to their existing 2003 Pharmacy Contract and sign a new 15-year pharmacy services contracts that would supersede the existing 2003 agreement (and omitted the 2003 contract's formulary "savings guarantee" of $2.5 million per year, which Omnicare was obligated to

pay Mariner), before Omnicare would pay the $40 million. *Id.*, ¶40. Mariner agreed to all of Omnicare's proposed material changes. *Id.*, ¶41.

210. Because it was illegal for the new pharmacy contracts to be tied to Omnicare's purchase of MMS, Omnicare sought the opinion of its outside counsel in order to minimize the risk of the deal. *Id.*, ¶43. Omnicare's attorney recommended that the closing date of Omnicare's MMS purchase be postponed in order for it not to coincide with the signing of the pharmacy contract. *Id.* In a December 9, 2004 Mariner email, it was noted that "healthcare regulatory lawyers from both sides told us that . . . simultaneous sale of [MMS] could be viewed as consideration for the pharmacy contracts." *Id.*, ¶45.

211. Accordingly, Omnicare's outside counsel conditioned his approval of the simultaneous transactions only if they were independent of each other. *Id.*, ¶49. Omnicare then misrepresented to outside counsel that MMS was not owned by Mariner, which was patently false. *Id.*, ¶¶51-56. Ultimately, Omnicare's outside counsel conditioned his approval of the transactions on receipt of fraudulent, signed certificates attesting to the independence of the acquisition and the pharmacy services contracts. *Id.*, ¶52; *see also id.*, ¶¶57-59.

212. On December 10, 2004, notwithstanding the advice of their outside counsel to maintain independence between the two transactions, Omnicare insisted Mariner sign the 15-year pharmacy contract first and then the parties completed the MMS purchase agreement with Omnicare immediately making $40 million. *Id.*, ¶¶46-47. The $40 million upfront payment allowed the larger Mariner acquisition to also be completed on the same day. *Id.*, ¶48.

213. Separately, in mid-2004, Omnicare acquired Total Pharmacy, a company that provided pharmaceutical products exclusively to nursing homes owned or controlled by Philip Esformes and/or his father Morris ("Esformes-Controlled Nursing Homes"). Ex. 16, ¶¶36-40.

Philip Esformes was a part-owner in Total Pharmacy. *Id.*, ¶¶36-37. Prior to the acquisition, Total Pharmacy maintained one-year contracts with the Esformes-Controlled Nursing Homes. *Id.*, ¶¶43-48. Initially, Omnicare offered to pay $16-$18 million for Total Pharmacy, including $7 million in accounts receivables – effectively a $9-$11 million offer. *Id.*, ¶49. Morris Esformes and the owners of Total Pharmacy (*i.e.*, Tim Dacy with a 51% interest, Philip Esformes with a 40% interest, and Bruce Paler with a 9% interest) were dissatisfied with the $16 million offer. Defendant Gemunder thus negotiated with Morris Esformes to pay Total Pharmacy $25 million and forfeit the $7 million in accounts receivable if the Esformes-Controlled Nursing Homes would extend their pharmacy services contracts from one year to ten years. *Id.*, ¶¶50-54; *see also id.*, ¶¶55-59.

214. The parties agreed to backdate the contracts with the Esformes-Controlled Nursing Homes and Omnicare completed the acquisition of Total Pharmacy in June 2004. As a result, Omnicare paid an additional $16-$23 million in kickbacks to the owners of Total Pharmacy for the sole purpose of securing extended pharmacy services contracts with the nursing homes. Omnicare in substance bought $16 million of its own revenues from those nursing homes, in violation of the Federal Anti-Kickback Statute.

215. In its 10-Q for the quarter-ended June 30, 2013, filed with the SEC on July 24, 2013, Omnicare disclosed that in June 2013, the Company settled whistleblower actions involving allegations relating to the arrangements it made with Total Pharmacy for approximately $20 million.[31]

[31] On August 6, 2013, The Chicago Tribune reported that Philip and Morris Esformes settled kickback claims with the federal government related to Omnicare's purchase of Total Pharmacy for $5 million. Ex. 70.

OMNICARE CHARGED LTCFS DRASTICALLY REDUCED PER DIEM PRICES IN EXCHANGE FOR MEDICAID AND MEDICARE PATIENT REFERRALS IN VIOLATION OF MEDICAID AND MEDICARE LAW

216. In July 1998, the reimbursement methodology for Medicare Part A patients in nursing homes changed. Prior to 1998, nursing homes were reimbursed for the actual cost of Part A patients' prescription drugs. Ex. 17, ¶32.[32] Beginning July 1, 1998, rather than prescription costs being "passed through" to the federal government, the reimbursements were shifted to a prospective payment system in which nursing homes were reimbursed for all medical care and prescription drugs for nursing home patients at a "per diem" fixed sum rate. *Id.*, ¶33. Under the new prospective payment system, nursing homes would pay institutional pharmacies directly for the actual cost of prescribed drugs, but would only be reimbursed at the Part A per diem rate, regardless of how much was actually spent on each patient. *Id.*, ¶35. This incentivized nursing homes to negotiate the lowest possible prices for prescription drugs for a Part A patient, thereby enabling them to pocket the per diem allotment remaining after the purchase of the patient's medications.

217. While this reimbursement restructuring affected Medicare patients, it did not apply to patients covered under Medicaid.[33] Since most patients in nursing home facilities are covered by Medicaid or private insurers,[34] with only a small percentage of patients being covered by Medicare

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[32] *United States of America, the State of California, the State of Colorado, the State of Connecticut, the State of Delaware, the State of Florida, the State of Georgia, the State of Hawaii, the State of Illinois, the State of Indiana, the State of Louisiana, the State of Maryland, the Commonwealth of Massachusetts, the State of Michigan, the State of Minnesota, the State of Montana, the State of Nevada, the State of New Hampshire, the State of New Jersey, the State of New Mexico, the State of New York, the State of North Carolina, the State of Oklahoma, the State of Rhode Island, the State of Tennessee, the State of Texas, the Commonwealth of Virginia, the State of Wisconsin, and the District of Columbia, ex rel. Silver v. Omnicare, Inc.*, No. 1:11-cv-01326-NLH-JS (D.N.J. Sept. 19, 2013) (Dkt. No. 65).

[33] Beginning on January 1, 2006, Medicare Part D took effect and, like Medicaid patients, those under Part D were not subject to the Part A per diem reimbursement rates.

[34] Or by Medicare Part D after January 1, 2006.

Part A, institutional pharmacies realized they could use the unrestricted Medicaid reimbursements to offset losses sustained from the Part A reimbursements. For example, institutional pharmacies such as Omnicare could offer nursing homes a significant discount on their small population of Part A patients' medications in exchange for nursing homes agreeing to provide these ***same drugs*** at substantially higher prices to their large population Medicaid patients.[35] *Id.*, ¶6. This type of kickback, known as "swapping," blatantly violated the Federal Anti-Kickback Statute, and the OIG repeatedly provided guidance and voiced their concerns to providers about such arrangements. *Id.*, ¶58.

218. In a 1999 Advisory Opinion, the OIG expressly provided that a violation of the Federal Anti-Kickback Statute occurs when a medical provider offers steep discounts for a Medicare Part A patient in exchange for referring that patient to the medical provider under other Medicare parts or other federal programs. Such "swapping" arrangements, the OIG concluded, would not be protected by the safe harbor provisions of the Federal Anti-Kickback Statute:

> such price reductions create a risk that a supplier may be offering remuneration in the form of discounts on business for which the purchaser pays the supplier, in exchange for the opportunity to service and bill for higher paying Federal health care program business reimbursed directly by the program to the supplier. In such circumstances, neither Medicare nor Medicaid benefits from the discount; to the contrary, Medicare and Medicaid may, in effect, subsidize the other payer's discounted rates.[36] . . . Accordingly, the discount safe harbor specifically excludes "a reduction in price applicable to one payor but not to Medicare or a State health program." *See* 42 CFR §1001.952(h)(3)(iii).

Ex. 20 at 5.

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[35] From 1999-2005 approximately 45% of Omnicare's annual total sales each year were derived from State Medicaid programs and only approximately 2% of its sales were generated by Medicare patients. Ex. 17, ¶10.

[36] "This is particularly problematic when the contracting payer is a PPS SNF, because Medicare Part B payments essentially may subsidize Part A PPS payments that the government has determined are appropriate and adequate to cover the SNF's costs" (footnote and quote in original).

219. The OIG confirmed that "swapping arrangements are 'particularly suspect' under the Federal Anti-Kickback Statute where they provide for:

- discounted prices that are below the supplier's cost, and
- discounted prices that are lower than the prices that the supplier offers to a buyer that (i) generates a volume of business for the supplier that is the same or greater than the volume of Part A business generated by the [skilled nursing facility], but (ii) does not have any potentially available Part B or other Federal health care program business.

Id. at 6.

220. In March 2000, the OIG issued a formal Program Guidance for nursing homes regarding the Federal Anti-Kickback Statute , and again identified such "swapping" arrangements as problematic. Ex. 21. The report provided the following definition:

> "Swapping" occurs when a supplier gives a nursing facility discounts on Medicare Part A items and services in return for the referrals of Medicare Part B business. With swapping, there is a risk that suppliers may offer a [skilled nursing facility] an excessively low price for items or services reimbursed under [prospective payment system] in return for the ability to service and bill nursing facility residents with Part B coverage. See OIG Advisory Opinion 99-2 (February 1999).

Id. at n.75.

221. Despite the numerous public warnings and extensive guidance issued by the OIG, Omnicare was still quick to adopt prohibited swapping schemes in order to recognize increase revenues. According to Omnicare employee Robert Dries, when the Medicare Part A reimbursement process changed to the perspective payment system, it was a "significant event" for Omnicare, with much of the Company's senior management, including the CEO, CFO and COO, involved in the decisions to offer per diem arrangements to nursing home facilities. Ex. 17, ¶121. In early 1999, Omnicare representatives were observed making overtures to nursing home owners about how "the difference in billing and reimbursement practices with respect to Medicare and Medicaid patients could be used to lower the nursing homes' drug costs," by lowering its charges for Part A patients as

long as it could provide the pharmacy services for the facilities' other patients, including those on Medicaid. *Id.*, ¶90.

222. In July 2005, Omnicare purchased NeighborCare, an institutional pharmacy provider who serviced long term care and skilled nursing facilities. *Id.*, ¶18. In 2003, NeighborCare made a "swapping" agreement with the Montefiore nursing home facility in Beachwood, Ohio to provide a per diem rate of $22.50 for prescription drugs for its Part A Patients. *Id.*, ¶123. By the date of its purchase by Omnicare in 2005, NeighborCare made "swapping" per diem arrangements with 383 nursing facilities (including Montefiore) with an average per diem rate of $14.47. This created an average daily shortfall of $7.99 on each per diem and an annual shortfall of approximately $18.8 million. *Id.*, ¶124.

223. Not only was Omnicare well aware of these per diem arrangements and the resulting shortfalls at the time of the NeighborCare purchase, the Company went on to induce Montefiore with an even more aggressive per diem rate in November 2005 when the parties entered into a new three-year agreement. The terms of this agreement stipulated that Omnicare would pay Montefiore a per diem rate of $21.25, to be reviewed annually, with a new rate being agreed upon between the pharmacy and the nursing home.[37] *Id.*, ¶125. This per diem rate was well below Omnicare's "Usual & Customary" rate, which is what the Company charged "payers in the open market," including Medicaid providers who pay for each drug rather than a flat-rate per diem fee. *Id.*, ¶126.

224. This agreement was clearly commercially unreasonable since in 2006, the first year of the contract, the market-driven, average and customary per diem rate for that year was $36.23 – a full 59% higher than the $21.25 rate Omnicare was actually charging to Montefiore. *Id.*, ¶136. In 2006, Omnicare paid Montefiore $356,489 in total per diems despite the usual and customary rate,

[37] Despite the contract terms to review the per diem rate annually, as of January 2010, the per diem rate remained at $21.25. *Id.*, ¶125.

including the rate charged to Medicaid, for those per diems being $536,672. *Id.* Therefore, Omnicare was inducing Montefiore with illegal kickbacks in the form of significant discounts amounting to $180,183 in 2006. *Id.* These numbers show that Omnicare knowingly and consistently lost money on its Part A business with Montefiore, but recovered that lost profit by significantly benefitting from Montefiore's other government healthcare business. *Id.*, ¶141.

THE REGISTRATION STATEMENT CONTAINED FALSE AND MISLEADING STATEMENTS

225. The Registration Statement, which incorporated by reference Omnicare's Annual Report on Form 10-K for the fiscal year ended December 31, 2004, omitted material facts regarding Omnicare's arrangements with pharmaceutical manufacturers and nursing homes, and the pharmaceutical services that Omnicare provided to the patients it served. These material omissions rendered defendants' statements that Omnicare was in compliance with all applicable laws, and that it administered its pharmaceutical services in the best interests of its patients, false and misleading, as the omitted facts show that defendants lacked a reasonable basis for those statements.

Defendants' False and Misleading Statements Regarding Legal Compliance

226. The Registration Statement contained the following false and misleading statements concerning Omnicare's contractual arrangements with pharmaceutical manufacturers:

> Our contractual relationships with pharmaceutical manufacturers can include rebates and other forms of price concessions on the product we purchase. On November 28, 2005 CMS [Centers for Medicare and Medicaid Services] posted to the "Questions and Answers" portion of its website a statement to the effect that it has significant concerns about the continued payment of certain rebates by pharmaceutical manufacturers to long-term care pharmacies with respect to prescriptions dispensed under the new Medicare Part D prescription drug benefit, and that it is examining this issue closely. ***We believe that our contracts with pharmaceutical manufacturers are legally and economically valid arrangements that bring value to the healthcare system and the patients that we serve***. However, there can be no assurance that, if

> these price concessions were no longer provided to us, there would not be a materially adverse effect on our business or results of operations.[38]

227. Omnicare's 2004 Annual Report on Form 10-K (incorporated by reference into the Registration Statement) specifically explained the Company's obligation to comply with the Federal Anti-Kickback Statute and other laws concerning pharmaceutical marketing programs, and then misleadingly assured investors that Omnicare complied with those laws, stating:

> Referral Restrictions. We have to comply with federal and state laws which govern financial and other arrangements between healthcare providers. These laws include the federal anti-kickback statute, which prohibits, among other things, knowingly and willfully soliciting, receiving, offering or paying any remuneration directly or indirectly in return for or to induce the referral of an individual to a person for the furnishing of any item or service for which payment may be made in whole or in part under federal healthcare programs. . . . Violations of these laws may result in fines, imprisonment, denial of payment for services, and exclusion from the federal programs and/or other state-funded programs.
>
> Other provisions in the Social Security Act and in other federal and state laws authorize the imposition of penalties, including criminal and civil fines and exclusions from participation in Medicare, Medicaid and other federal healthcare programs for false claims, improper billing and other offenses.
>
> In addition, a number of states have undertaken enforcement actions against pharmaceutical manufacturers involving pharmaceutical marketing programs, including programs containing incentives to pharmacists to dispense one particular product rather than another. These enforcement actions arose under state consumer protection laws which generally prohibit false advertising, deceptive trade practices, and the like.
>
> ***We believe our contract arrangements with other healthcare providers, our pharmaceutical suppliers and our pharmacy practices are in compliance with applicable federal and state laws. These laws may, however, be interpreted in the future in a manner inconsistent with our interpretation and application.***

228. The Registration Statement also falsely assured investors that:

> We are also subject to federal and state laws that prohibit some types of direct and indirect payments between healthcare providers. These laws, commonly known as

[38] For each of the statements in ¶¶227-228, 230-231, the emphasized text is the statement plaintiffs allege to be false and misleading, with the surrounding, unemphasized, text included merely to provide context.

> the fraud and abuse laws, prohibit payments intended to induce or encourage the referral of patients to, or the recommendation of, a particular provider of items or services. Violation of these laws can result in loss of licensure, civil and criminal penalties and exclusion from the Medicare, Medicare and other federal healthcare programs.
>
> We expend considerable resources in connection with our compliance efforts. ***We believe that we are in compliance in all material respects with state and federal regulation is applicable to our business***.

229. The statements at ¶¶226-228 above regarding Omnicare's legal compliance were rendered false and misleading by the omission of the material facts below, which demonstrate defendants lacked a reasonable basis for those statements:

(a) Defendants solicited and negotiated illegal kickback arrangements with some of the country's largest drug manufacturers and received improper cash incentives in exchange for promoting and increasing the market share for particular drugs, in violation of the Federal Anti-Kickback Statute, including:

(i) From 1999 to 2004, Omnicare received millions of dollars in illegal kickbacks from J&J in the form of various market share and sales rebates for selling J&J's drugs Risperdal, Propulsid, Levaquin, Procit and Duragesic. ¶¶58-84. These rebates violated the Federal Anti-Kickback Statute because they caused Omnicare to advocate the use of J&J's drugs. As a result, Omnicare steered patients towards J&J's drugs based on economics and to increase the Company's profits. Omnicare's top officers, including defendants Gemunder and Froesel, were intimately involved in negotiations concerning the kickback arrangements and the implementation of therapeutic initiatives designed to increase the market share of J&J's drugs. ¶¶61, 173-174. In addition, through the use of these rebates, Omnicare's pharmacists became an extension of the J&J salesforce. ¶¶59, 199. Omnicare's relationship with J&J was extremely profitable for both companies, as Omnicare earned millions of dollars in rebates from 1999 to 2004 and J&J saw

Omnicare's annual purchases of J&J's drugs nearly triple to almost $300 million, with the annual purchases of Risperdal alone rising to over $100 million. ¶82;

(ii) From 2000 to 2005, Omnicare solicited and received over $13 million in illegal rebates from Abbott, which were directly tied to the Company's promotion of Abbott's drug Depakote at Omnicare's LTCFs, solely to increase the market share for that drug in violation of the Federal Anti-Kickback Statute. Under an agreement entered into by the companies, Omnicare received quarterly cash incentives from Abbott as Omnicare increased Depakote prescriptions among the Company's vulnerable elderly patient base, relative to certain threshold amounts agreed upon by the companies. Thereafter, in 2004, Omnicare entered into a separate rebate agreement tied to the Company's promotion of Depakote wherein Omnicare received a flat 2% or 4% kickback for increasing Depakote use by certain threshold amounts, thus incentivizing Omnicare and its pharmacists to push Depakote on the Company's LTCF patients to increase the market share, and push Depakote over other antipsychotic drugs like Risperdal, Seroquel, Zyprexa and Keppra, ¶¶85-110;

(iii) From 1999 to 2004, Omnicare negotiated $8 million in kickbacks ("bonuses") from generic drug manufacturer IVAX in exchange for Omnicare's commitment to purchase $50 million worth of IVAX's generic drugs Fluoxetine (Prozac), Omeprazole (Prilosec), famotidine (Pepcid), buspirone (Buspar), terazosin (Hytrin) and enalapril (Vasotech). ¶¶111-122. The Company entered into the kickback arrangement with IVAX despite (a) stringent warnings and objections from Omnicare's counsel that, according to OIG guidance issued in 1994, this type of an agreement was a clear violation of the Federal Anti-Kickback Statute; and (b) the awareness by Omnicare's top executives, including defendant Gemunder, about the implications of such a deal. ¶¶114-120;

(iv) Beginning in 2002 and continuing through the Offering, Omnicare's senior management, including defendant Gemunder, negotiated and implemented lucrative kickback arrangements with drug manufacturer Amgen in violation of the Federal Anti-Kickback Statute. Omnicare received at least $20 million in kickbacks ("rebates") from Amgen during this timeframe in exchange for switching patients already stabilized on J&J's Procit to Amgen's Aranesp, and prescribing Aranesp to patients who were not currently taking ESAs, thus expanding the market for Aranesp. ¶¶124-135;

(v) Prior to the December 2005 Offering, Omnicare also entered into illegal arrangements with other pharmaceutical manufacturers whereby Omnicare received rebates for achieving sales and market share milestones for increasing the use of these manufacturers' drugs. These other companies included: AstraZeneca Pharmaceuticals, Bayer Corporation, Eli Lily & Co., Merck & Co., Inc., Novartis, Novo Nordisk and Pharmacia. ¶¶136-142; and

(vi) These kickback arrangements violated the Federal Anti-Kickback Statute and directly contradicted the OIG guidance published in 1991 prohibiting the use of discounts such as rebates to encourage companies like Omnicare to purchase particular drugs payable under Medicare and Medicaid. These arrangements also violated the OIG's guidance from 1994, which expressly prohibited the use of special compensation and gifts to generate business for pharmaceutical manufacturers. ¶¶36-37, 43-44, 47, 54-55, 63-64, 86, 114, 118.

(b) Defendants colluded with drug manufacturers to impermissibly disguise kickbacks as "data fees," "educational funding," and "grants" in order to avoid and manipulate the "Best Price" of particular drugs in violation of the Medicaid Drug Rebate Statute and False Claims Act, including:

(i) From 2000 to 2004, in order to evade the Medicaid "Best Price" regulations, J&J and Omnicare entered into a "Consulting and Services Agreement," under which J&J would pay Omnicare for "data" such as prescriber lists and lists of physicians who prescribed competing drugs. ¶¶70-81. Internal J&J documents reflect that J&J never actually received the physician data that it purportedly paid for. ¶76. Internal documents from J&J further demonstrate that J&J and Omnicare specifically amended their Consulting and Services Agreement to avoid violating the Best Price regulations by establishing an agreement "with Omnicare to purchase data, roughly at the cost of the Strategic Overlay for Risperdal." ¶77. In 2001 and 2003, correspondence from J&J addressed to Omnicare included payments pursuant to the Consulting and Services Agreement referred to as marketing fees and cautioned Omnicare that these fees may be considered a discount for Medicare/Medicaid purposes. ¶78. Between 2000 and 2004, Omnicare received $4,650,000 pursuant to the Consulting and Services Agreement, which violated the Medicaid Drug Rebate Statute by concealing the true Best Price for J&J's drugs. ¶79. J&J and Omnicare also sought to disguise kickbacks paid pursuant to an agreement regarding J&J's drug Sporanox. To avoid Best Price detection, J&J and Omnicare agreed to decrease the rebate Omnicare earned to 20% and to make up the other 5% in another way. ¶80; and

(ii) From 2000 and prior to 2005, Omnicare solicited and received hundreds of thousands of dollars in illegal kickbacks, disguised as "educational grants," "data," management conference sponsorship fees and other "donations" and gifts from Abbott in order to evade Best Price regulations in violation of the Medicaid Drug Rebate Statute. The incentives Omnicare received were directly tied to Omnicare's purchase of Depakote and other drugs in an effort to increase market share for those drugs. In order to continue receiving such covert kickbacks

to circumvent the Medicaid Drug Rebate Statute, Omnicare directed its consultant coordinators to reinforce Depakote use in its LTCFs. ¶¶99-110.

(c) Defendants conspired with drug manufacturers, and directed the Company's consultant pharmacists to illegally market and prescribe drugs like Risperdal and Depakote for off-label use in violation of (i) the Federal Anti-Kickback Statute; (ii) the OBRA; and (iii) the Food, Drug, and Cosmetic Act, which strictly forbids off-label marketing, including:

(i) From 1999 to 2004, Omnicare deployed the Risperdal Initiative to promote and increase the market share of J&J's drug Risperdal, which was never approved to treat dementia, in violation of the Federal Anti-Kickback Statute, the Food, Drug and Cosmetic Act and OBRA. Even though patients in LTCFs, for whom Omnicare was responsible, had the right to be free from chemical restraints pursuant to OBRA, to be given drugs that were medically necessary in their best interests and that Risperdal was never approved to treat patients with dementia, Omnicare and J&J entered into the Risperdal Initiative. This initiative was designed to increase Risperdal sales through the off-label prescription of Risperdal and not to improve patient care. ¶¶147-155. Omnicare instructed its pharmacists to add "much more emphasis on geriatric behavior use and decreased the emphasis on schizophrenia" for Risperdal. ¶151. These instructions were designed solely to increase the amount of kickbacks Omnicare received from J&J. Omnicare encouraged its consultant pharmacist to send promotional material to physicians via fax to prescribe Risperdal. ¶153. Omnicare's pharmacy consultants were so effective at convincing physicians to switch to Risperdal, J&J considered them an extension of the J&J sales force (*see* ¶¶59, 199); and

(ii) From 1998 through the date of the Offering, Omnicare deployed a so-called "Depakote Initiative" designed to increase market share for Abbott's Depakote, which had never been approved by the FDA as safe and effective in treating agitation and aggression in elderly

patients, such as those at Omnicare's LTCFs. ¶¶156-164. Omnicare, through its Depakote Initiative, improperly pushed Depakote for off-label use on its elderly patients, exposing its LTCF patients to extreme, adverse medical problems, such as hepatoxicity (drug-induced liver damage), which had yet to be evaluated in elderly patients. Such off-label use violated the Food, Drug and Cosmetics Act and OBRA, which was designed to keep patients "free of unnecessary drugs." To effectuate the various illegal kickback arrangements Omnicare solicited and negotiated with Abbott, and in order to increase market share, Omnicare worked to promote the off-label use of Depakote by (a) converting patients from generic prescriptions to Depakote; (b) recommending Depakote for first time treatment in patients identified as having behavioral disturbances; (c) using Depakote to augment LTCF patients taking other antipsychotics; and (d) increasing dosage in LTCF patients already taking Depakote. ¶¶161-164. In order to increase Depakote prescriptions, including for off-label use, Omnicare developed model comments designed to push Depakote use in LTCF, encouraged doctors to prescribe higher doses of Depakote, and encouraged the prescription of Depakote to supplement LTCFs' patients' other antipsychotic drugs. *Id.*

(d) Omnicare improperly switched patients from one form (or dose) of a drug to another in order to increase profits, and submitted illegal reimbursement claims to federal and state governments in violation of the False Claims Act, including:

(i) Switching patients from generic drug Ranitidine tablets costing $15.10 per month to Ranitidine capsules coasting $82.77 per month instead. In 2004, the State of Maine fined Omnicare $1 million for this illegal drug switching scheme (*see* ¶¶17, 200);

(ii) Switching two 7.5mg Buspirone anti-anxiety tablets for one 15mg tablet; switching Fluoxetine anti-depression tablets for capsules; and switching Ranitidine heartburn capsules for tablets, in order to generate additional revenue. In November 2006, Omnicare agreed to

pay $49.5 million to settle claims by the United States and 42 states alleging that from 2000 through 2005 Omnicare aggressively switched patients to different drugs via their therapeutic interchange programs to evade Medicaid reimbursement price limits. In its Semiannual Report to Congress, the OIG reported that Omnicare's "improper [prescription drug] switches cost Medicaid and the Federal Government approximately $26 million more than if the drugs had not been switched." (*See* ¶¶17, 200-201, 235);

(iii) Switching patients already stabilized on J&J's Procrit to Amgen's Aranesp, in order to obtain lucrative kickbacks from Amgen. Omnicare and Amgen collectively paid approximately $30 million in a settlement with the DOJ to resolve these claims involving switching of patients from Procrit to Aranesp (*see* ¶¶124-135, 196-198);

(iv) Switching LTCF patients from branded drugs to generic drugs, in order to receive $8 million in kickbacks from IVAX for promoting its generic drugs. In exchange, Omnicare agreed to purchase $50 million in IVAX drugs. *See* ¶¶111-122; and

(v) Defendants had no reasonable basis to believe that Omnicare's therapeutic interchange programs were legal or in the best interest of their LTCF patients. It was well established that the Company put such switching schemes in place solely to achieve monthly revenue targets. This practice of substituting higher priced drugs for lower priced drugs currently in use was conducted nationwide at the direction of senior management, including defendant CFO Froesel, who instructed the regional CFO's to achieve required revenue targets through these therapeutic interchange programs.

(e) Defendants conspired with LTCFs to enter into illegal contracts wherein Omnicare paid LTCFs millions of dollars in illegal kickbacks in exchange for Omnicare retaining

pharmacy service contracts at those LTCFs, in violation of the Federal Anti-Kickback Statute, including:

(i) In 2003, Omnicare entered into a multi-year contract with one of its LTCF partners, Mariner, through which Omnicare implemented an extensive drug switching initiative designed to save Mariner $2.5 million, under a "savings guarantee," and to induce Mariner to keep Omnicare as its pharmacy service provider. ¶¶202-212. In 2004, Mariner threatened to terminate the 2003 agreement. In order to salvage the contract with Mariner, in late 2004, defendants Gemunder and Froesel met with Mariner to discuss whether Omnicare would purchase one of Mariner's business units, MMS (valued at $3 million), for $50 million solely for the purpose of enticing Mariner to withdraw its termination notice. During a 2004 meeting, defendants Gemunder and Froesel sought the advice of Omnicare's "regular outside counsel on healthcare regulatory issues" to discuss the proposed acquisition of MMS. Omnicare's counsel concluded that the $50 million transaction violated the Federal Anti-Kickback Statute. Over counsel's objection, Omnicare agreed to acquire MMS anyway. ¶¶206, 210-212. After the deal, Omnicare and Mariner executed a new 15-year pharmacy contract and removed the so-called $2.5 million "savings guarantee" from the new agreement; thereby making the pharmacy services contract much more beneficial to Omnicare. The new agreement violated the Federal Anti-Kickback Statute because the new, favorable pharmacy contracts with Mariner were directly tied to Omnicare's acquisition of MMS. *Id.*

(ii) In 2004, defendant Gemunder negotiated a deal to purchase Total Pharmacy, a pharmaceutical company that provided pharmacy services to Esformes-Controlled Nursing Homes. Under the agreement, defendant Gemunder and Omnicare negotiated to purchase Total Pharmacy for $25 million in exchange for the Esformes-Controlled Nursing Homes extending

the Omnicare/Total Pharmacy services contracts at those nursing homes. Accordingly, Omnicare deliberately overpaid for Total Pharmacy by millions of dollars for the sole purpose of securing pharmacy servicing contracts at Esformes-Controlled Nursing Homes (*see* ¶¶213-215); and

(iii) These kickback arrangements violated the Federal Anti-Kickback Statute and directly contradicted the published OIG 1994 Special Fraud Alert, which expressly provides that suspect joint ventures, like the ventures between Omnicare and Mariner and Total Pharmacy, entered into solely to maintain pharmacy services contracts, violate the Federal Anti-Kickback Statute. In addition, the OIG's 1994 Special Fraud Alert, stated that the Federal Anti-Kickback Statute forbids payments or gifts like those paid to Total Pharmacy and Mariner in exchange for extending contracts (*see* ¶¶45, 47, 210, 214).

(f) Defendants were warned by Omnicare's attorneys – including the Company's "regular outside counsel for transactional matters involving potential health fraud and abuse issues" – that the Company's kickback agreements were illegal, including:

(i) Omnicare's "regular outside counsel for transactional matters involving potential health care fraud and abuse issues" warned Omnicare's senior management – on at least five different occasions and documented in at least three separate memos – that taking an $8 million signing bonus from IVAX in exchange for Omnicare's commitment to purchase $50 million of IVAX's generic versions of Prozac, Prilosec, Pepcid, Buspar, Hybin and Vasotec "has all the characteristics of a kickback" and "carries a heightened risk that a federal or state prosecutor would determine it violates federal or state fraud abuse statutes, specifically the federal antikickback statute." The attorney further warned that "the OIG could challenge this advance cash payment, for which there is not safe harbor, as a 'signing bonus,' and/or an interest free loan." Omnicare ignored its attorney's repeated warnings, and instead sought the advice of a different attorney, but concealed

the "signing bonus" from this new attorney, and withheld the fact that a portion of the signing bonus would be received before Omnicare purchased any of IVAX's products. Without the benefit of this material information, the second attorney signed off on the deal, which IVAX and Omnicare ultimately executed on December 21, 1999. In November 3, 2009, Omnicare and IVAX paid $112 million to settle claims brought by the DOJ that "Omnicare solicited, and IVAX paid $8 million in kickbacks in exchange for Omnicare's agreement to purchase $50 million in drugs from IVAX." *See* ¶¶111-122;

(ii) During a December 2004 meeting, Omnicare's outside counsel on healthcare regulatory issues warned the Company's senior management, including defendant Gemunder, that paying LTCF Mariner $50 million for Mariner's MMS business units, which was valued at less than $3 million, in exchange for Mariner agreeing not to terminate its pharmacy services agreement with Omnicare constituted a violation of the Federal Anti-Kickback Statute, as Omnicare would effectively be paying Mariner for utilizing Omnicare's pharmacy services. Notwithstanding this advice from its attorney, on December 10, 2004, Mariner entered into a 15-year pharmacy contract with Omnicare in exchange for Omnicare's purchase of Mariner's MMS business unit. *See* ¶¶202-212.

(g) Defendants conspired with LTCFs to engage in illegal swapping kickback schemes wherein defendants intentionally offered commercially unreasonable, below fair-market-value prices for prescription drugs to LTCFs for their Medicare Part A patients in exchange for the opportunity to provide the same drugs, at substantially higher, market-driven cost, to the LTCFs' Medicaid and Medicare Part D patients, and charged Medicare and Medicaid programs higher prices than it charged the LTCFs in violation of the Federal Anti-Kickback Statute and False Claims Act. For example:

(i) In July 2005, Omnicare purchased its longtime rival, long term care institutional pharmacy NeighborCare. At the time of purchase, NeighborCare had "swapping arrangements" with 383 LTCFs in which it paid discounted *per diem* rates for prescription drugs for the Medicare Part A patients in exchange for providing pharmacy services to the facilities other patients, including those on Medicaid. At the time of purchase, NeighborCare's average *per diem* rate at the 383 facilities was $14.47, substantially below the actual cost, which created an average shortfall of approximately $18.8 million. For example, NeighborCare had a swapping agreement with LTCF Montefiore under which NeighborCare charged a *per diem* rate of $22.50 for prescription drugs for Montefiore's Part A patients. In November 2005, after Omnicare acquired NeighborCare, in an effort to maintain Montefiore as a LTCF client, Omnicare offered Montefiore a three-year agreement with a *per diem* rate of $21.25, which was much lower than Omnicare's usual and customary *per diem* rate. *See* ¶¶222-224;

(ii) There was no reasonable basis for defendants to believe that Omnicare's contracts with LTCF were legally and economically valid. Defendants knew of NeighborCare's swapping schemes with LTCFs such as Montefiore. In advance of the NeighborCare acquisition, Omnicare conducted the necessary due diligence and should have discovered that NeighborCare suffered an $18 million shortfall between the actual *per diem* costs and what that company was charging LTCFs for Medicare Part A patients. Due diligence would have also revealed that NeighborCare was charging less than the actual costs to maintain its relationships with LTCFs in order to charge full price to other Medicare, Medicaid and private insurance patients. Evidence that senior Omnicare management knew NeighborCare was engaging in swaps includes Omnicare renegotiating the Montefiore contract in November 2005, shortly after NeighborCare was acquired. In order to extend that contract an additional three years and thereby

continue to have access to Montefiore's other patients, senior management agreed to provide even more aggressive *per diem* discounts to Montefiore. *See id.*; and

(iii) Further, there was no reasonable basis to believe that such swapping schemes were either legally or economically valid because the OIG issued specific guidance addressing these arrangements in both its 1999 Advisory Opinion and its 2000 Program Guidance for nursing facilities. Both of these reports clearly state that swapping arrangements such as the one between Omnicare and Montefiore, in which a medical provider offers steep discounts for Medicare Part A patients in exchange for referring other pharmacy patients under another federal program such as Medicaid, are not protected by the safe harbor provisions of the Federal Anti-Kickback Statute. *See* ¶¶48-50, 217, 221.

Defendants' False and Misleading Statements Regarding the Company's Provision of Pharmaceutical Services

230. The Registration Statement also contained false and misleading statements regarding Omnicare's therapeutic interchange programs which, unbeknownst to investors, served as a vehicle for defendants to drive sales of high-profit drugs to meet internal revenue and profit goals and/or drive market share for pharmaceutical manufacturers. Omnicare's 2004 Annual Report on Form 10-K (incorporated by reference into the Registration Statement) stated:

> Federal and state regulations mandate that long-term care facilities, in addition to providing a source of pharmaceuticals, ***retain consultant pharmacist services to monitor and report on prescription drug therapy in order to maintain and improve the quality of resident care***. The Omnibus Budget Reconciliation Act ("OBRA") implemented in 1990 sought to further upgrade and standardize care by setting forth more stringent standards relating to planning, monitoring and reporting on the progress of prescription drug therapy, as well as overall drug usage. ***We provide consultant pharmacist services, which help clients comply with the federal and state regulations applicable to nursing homes***. ***The services offered by our consultant pharmacists include:***
>
> - ***monthly drug regimen reviews for each resident in the facility to assess the appropriateness and efficacy of drug therapies, including a review of the resident's current medication usage, monitoring drug reactions to other***

drugs or food, monitoring lab results and recommending alternate therapies, dosing adjustments or discontinuing unnecessary drugs.

- ***assistance to the nursing facility in complying with state and federal regulations as they pertain to drug use.***

231. The incorporated Form 10-K also stated that:

When required and/or specifically requested by the physician or patient, branded drugs are dispensed and generic drugs are substituted in accordance with applicable state and federal laws as requested by the physician or resident. Subject to physician approval and oversight, and in accordance with our pharmaceutical care guidelines, we also provide for patient-specific therapeutic interchange of more efficacious and/or safer drugs for those presently being prescribed.

232. The statements at ¶¶230-231 above that Omnicare provided its pharmaceutical services to maintain and improve the quality of resident care, were false and misleading and omitted material information for the reasons set forth below, including:

(a) Defendants conspired with drug manufacturers, and directed the Company's consultant pharmacists to illegally market and prescribe drugs like Risperdal and Depakote for off-label use in violation of (i) the Federal Anti-Kickback Statute; (ii) the OBRA; and (iii) the Food, Drug, and Cosmetic Act, which strictly forbids off-label marketing and in a manner designed to increase profits and not in the best interests of patients or to improve the quality of patient care, including:

(i) From 1999 to 2004, Omnicare deployed the Risperdal initiative to promote and increase the market share of J&J's drug Risperdal, which was never approved to treat dementia in violation of the Federal Anti-Kickback Statute, the Food, Drug and Cosmetic Act and OBRA. Even though patients in LTCFs, for whom Omnicare was responsible, had the right to be free from chemical restraints pursuant to OBRA and to be given drugs that were medically necessary in their best interests, and even though that Risperdal was never approved to treat patients with dementia, Omnicare and J&J entered into the Risperdal Initiative. This initiative was designed to

increase Risperdal sales through the off-label prescription of Risperdal and not to improve patient care. ¶¶147-155. Omnicare instructed its pharmacists to add "much more emphasis on geriatric behavior use and decreased the emphasis on schizophrenia" for Risperdal. ¶151. These instructions were designed solely to increase the amount of kickbacks Omnicare received from J&J. Omnicare encouraged its consultant pharmacist to send promotional material to physicians via fax to prescribe Risperdal. ¶153. Omnicare's pharmacy consultants were so effective at convincing physicians to switch to Risperdal, J&J considered them an extension of the J&J sales force. *See* ¶¶59, 199;

(ii) From 1998 through the date of the Offering, Omnicare deployed a so-called "Depakote Initiative" designed to increase market share for Abbott's Depakote, which was not approved by the FDA as safe and effective in treating agitation and aggression in elderly patients, such as those at Omnicare's LTCFs. ¶¶156-164. Omnicare, through its Depakote Initiative, improperly pushed Depakote for off-label use on its elderly patients, exposing its LTCF patients to extreme adverse medical problems, such as hepatoxicity (drug-induced liver damage), which had yet to be evaluated in elderly patients. Such off-label use violated the Food, Drug and Cosmetics Act and OBRA, which was designed to keep patients "free of unnecessary drugs." To effectuate the various illegal kickback arrangements Omnicare solicited and negotiated with Abbott and in order to increase market share, Omnicare worked to promote the off-label use of Depakote by (a) converting patients from generic prescriptions to Depakote; (b) recommending Depakote for first time treatment in patients identified as having behavioral disturbances; (c) using Depakote to augment LTCF patients taking other antipsychotics; and (d) increasing dosage in LTCF patients already taking Depakote. ¶¶161-164. In order to increase Depakote prescriptions, including for off-label use, Omnicare developed model comments designed to push Depakote use in LTCF, encouraged doctors

to prescribe higher doses of Depakote, and encouraged the prescription of Depakote to supplement LTCFs patients' other antipsychotic drugs. *See id.*

(b) Omnicare also improperly switched patients from one form of a drug to another in order to increase profits, and not in order to improve the quality of patient care. In addition to submitting illegal reimbursement claims to federal and state governments in violation of the False Claims Act via this switching practice, this conduct also rendered statements in the Prospectus false and misleading and omitted material information because Omnicare:

(i) Switched patients from generic drug Ranitidine tablets costing $15.10 per month to Ranitidine capsules coasting $82.77 per month instead. In 2004, the State of Maine fined Omnicare $1 million for this illegal drug switching scheme (*see* ¶¶17, 200);

(ii) Switched two 7.5mg Buspirone anti-anxiety tablets for one 15mg tablet; switched Fluoxetine anti-depression tablets for capsules; and switched Ranitidine heartburn capsules for tablets, in order to generate additional revenue. In November 2006, Omnicare agreed to pay $49.5 million to settle claims by the United States and 42 states alleging that from 2000 through 2005 Omnicare aggressively switched patients to different drugs via their therapeutic interchange programs to evade Medicaid reimbursement price limits (*see* ¶¶17, 200-201, 235);

(iii) Switched patients already stabilized on J&J's Procrit to Amgen's Aranesp, in order to obtain lucrative kickbacks from Amgen. Omnicare and Amgen collectively paid approximately $30 million in a settlement with the DOJ to resolve these claims involving switching of patients from Procrit to Aranesp (*see* ¶¶124-135, 196-198);

(iv) Switched LTCF patients form branded drugs to generic drugs, in order to receive $8 million in kickbacks from IVAX for promoting its generic drugs (*see* ¶¶111-122); and

(v) Omnicare's improper switching practices were dictated by headquarters, and specifically defendant CFO Froesel, with a complete disregard to the best interest of the Company's LTCFs' elderly patient population, in a concerted effort to ensure that each region was meeting its monthly targets.

POST OFFERING REVELATIONS

233. Since the date of the Offering, Omnicare has been repeatedly targeted by federal and state governments investigating the Company's illegal kickback and drug switching schemes discussed herein. Though Omnicare has settled several of the actions and paid almost $365 million in settlements since the date of the Offering, several government investigations and probes relating to conduct which predates the offering are ongoing.

State and Federal Investigations into Omnicare's Improper Conduct

234. Since January 2006, Omnicare has been the subject of numerous government probes relating to the Company's illegal billing, drug switching and kickback schemes dating back to 1999. Many of the investigations, brought forth by multiple *qui tam* relators, reveal that Omnicare's practices were not only illegal and in violation of state and federal laws, including the False Claims Act and Federal Anti-Kickback Statute, but were also pervasive, ongoing and most certainly not in the best interest of Omnicare's geriatric patients.

235. On January 13, 2006, Omnicare issued a Form 8-K disclosing that the Company had received administrative subpoenas from the Massachusetts United States Attorney's Office, "seeking information arising out of the Company's relationship with certain manufacturers and distributors of pharmaceutical products." The disclosure did not give specific names of the manufacturers involved in the investigation. In the Form 8-K, Omnicare further reported:

> [T]he federal government and a certain states are investigating allegations relating to three generic pharmaceuticals provided by the Company in connection with the

> substitution for capsules for tablets (Ranitidine), tablets for capsules (Fluoxetine) and two 7.5 mg tablets for one 15 mg tablet (Buspirone).

Id.

236. On January 18, 2006, the Ohio Attorney General's Office reported that it conducted a raid of Omnicare's Dublin, Ohio offices on January 11, 2006 "in pursuit of evidence to support suspected acts of Medicaid fraud." Ex. 71. According to the warrant, the state seized, among other things, documents and records related to the sale of medical equipment and billing records for Medicaid and Medicare programs. *Id.*

237. On January 26, 2006, the Michigan Attorney General's office raided Omnicare's Livonia, Michigan offices, as well as Omnicare offices in other unidentified cities. Ex. 72. At the time of the raids, neither the Company nor the Attorney General would disclose details regarding the investigation. *Id.* Despite defendant Gemunder's attempt to reassure the public that the subject of the investigations was "believed to be unique to Michigan," analysts expressed concerns about the "wider implications" of these ongoing probes. Ex. 73.

238. Ultimately, in late 2006, the Michigan Attorney General announced two separate settlements with Omnicare totaling a staggering $102 million. In October 2006, Omnicare agreed to pay $52.5 million, the largest Medicaid Fraud settlement in the State's history, to resolve allegations of improper Medicaid billing practices by the Company's Specialized Pharmacy Services Unit, which was accused of a variety of offenses, including submitting reimbursement charges to Medicaid for patients who were already deceased. Ex. 74. In November 2006, Omnicare agreed to pay $49.5 million to settle claims by the United States and 42 states alleging that from 2000 through 2005, Omnicare aggressively switched patients to different drugs via their therapeutic interchange programs to evade Medicaid reimbursement price limits. Ex. 75. In its Semiannual Report to Congress, the OIG reported that Omnicare's "improper [prescription drug] switches cost Medicaid

and the Federal Government approximately $26 million more than if the drugs had not been switched." Ex. 76.

239. Three years later, on November 3, 2009, as the result of five *qui tam* actions filed between 2002 and 2006 (*see, e.g.*, ¶¶14, 58-84), the Department of Justice announced that Omnicare would pay $98 million "to resolve allegations that Omnicare engaged in kickback schemes with several parties." Ex. 9. Parties involved in Omnicare's kickback schemes included pharmaceutical companies IVAX and J&J and LTCF Mariner. *Id.* Notably, these three companies each paid enormous sums to resolve allegations against them involving their relationships with Omnicare. In November 2013, in one of the largest healthcare fraud settlement in U.S. history, J&J paid more than $2.2 billion to resolve allegations of off-label use and kickback schemes with Omnicare, with criminal fines and forfeitures of $485 million and civil settlements with federal and state governments totaling $1.72 billion. Ex. 77. IVAX paid $14 million to settle its portion of the allegations involving Omnicare at the same time Omnicare settled. Ex. 9. In February 2010, Mariner also paid $14 million to settle its investigation. Ex. 78.

240. In its 10-Q for 2Q13, Omnicare disclosed that it settled another investigation for approximately $20 million. In that case, relators alleged that in 2004, Omnicare purchased Total Pharmacy for a significantly inflated price in order to induce the sellers into long-term contracts between Omnicare and sellers' other LTCFs. In August 2013, the sellers, the Esformes' family, paid $5 million to settle allegations of their involvement in the kickback scheme with Omnicare. Ex. 70.

241. In another set of allegations, stemming from a South Carolina *qui tam* complaint in which the DOJ intervened, Omnicare paid $4.19 million in February 2014 to resolve kickback allegations involving Omnicare and Amgen. Ex. 53. Amgen also settled with the DOJ for its conduct involving Omnicare in April 2013 for $24.9 million. Ex. 54.

242. On June 25, 2014, Omnicare entered into a settlement for participating in a swapping scheme which provided "improper discounts [to Medicare Part A patients] in return for the opportunity to provide medication to Medicare and Medicaid beneficiaries" at certain LTCFs. Ex. 79. The Attorney General for the Justice Department's Civil Division said: "Healthcare providers who seek to profit from providing illegal financial benefits will be held accountable." *Id.* This settlement, totaling $142.72 million, included $124.24 million to settle federal claims and $16.48 million to settle state claims made by California, Colorado, Connecticut, Delaware, the District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Rhode Island, South Dakota, Tennessee, Texas, Virginia, and Wisconsin. Exs. 80-81.

Ongoing Investigations

243. Currently, Omnicare is still involved in numerous ongoing *qui tam* investigations that involve wrongful conduct going back to 2000. The most significant is a case involving Abbott, and concerns allegations that Omnicare received illegal kickbacks to prescribe Abbott's drug Depakote, off-label, to LTCF patients. *See, e.g.*, ¶¶85-110, 156-164. On December 22, 2014, the DOJ, through the Western District of Virginia's U.S. Attorney's office, filed a civil complaint-in-intervention in the two *qui tam* complaints and the State of Kentucky also joined in the action on March 17, 2015. Ex. 5. On May 7, 2012, Abbott pleaded guilty to misbranding and paid a $1.5 billion fine to resolve the investigation, which included criminal fines of $700 million. Ex. 82. The DOJ case, joined by numerous states, against Omnicare is ongoing.

244. As set forth in the charts below, since 2006, Omnicare has paid almost ***$365 million*** to settle claims relating to its wide-spread, ongoing, company-wide strategies and schemes to increase its profits in a manner that was not only illegal, but also antithetical to the best interest of its

elderly patients. In addition to the huge sums the Company has paid out, pharmaceutical manufacturers and LTCFs have also paid dearly for doing business with Omnicare. Since 2009, the companies have paid nearly ***$3.75 billion*** to resolve actions arising out of their arrangements with Omnicare, all of which include wrongdoing that pre-dates the December 2005 Offering.

Settlement Payments Made by Omnicare

Case	Date Settled	Settlement Amount
State of Michigan v. Specialized Pharmacy Services, Inc. and Omnicare, Inc.	10/5/2006	$52.5 million
U.S. et al. ex rel. Bernard Lisitza., v. Omnicare, Inc. , No. 01-cv-7433 (N.D. Ill.) and U.S. ex rel. Kammerer v. Omnicare, Inc., No. 04-cv-2074 (N.D. Ill.)	11/14/2006	$49.5 million
U.S. ex rel. Resnick v. Omnicare, Inc., et al ., No. 06-cv-10149 (D. Mass.); U.S. ex rel. Kammerer v. Omnicare, Inc. et al., No. 05-cv-11518 (D. Mass.); U.S. ex rel. Kammerer v. Omnicare, Inc. and Ivax Pharms., Inc., No. 05-cv-11519 (D. Mass.); U.S. ex rel. Maguire v. Omnicare, Inc., No. 02-cv-11436 (D. Mass.); U.S. ex rel. Lisitza v. TAP Pharmaceutical Products, Inc. and Omnicare, Inc., No. 07-cv-10026 (D. Mass.)	11/3/2009	$98 million
U.S. et al. v. Omnicare, Inc. et al ., No. 07-cv-5777 (N.D. Ill.)	7/11/2013	$20 million
U.S. ex rel. Kurnik v. Omnicare, Inc. , No. 11-cv-01464 (D. So. Carolina)	2/27/2014	$4.19 million
U.S. ex rel. Gale v. Omnicare, Inc. ; 10-CV-00127 (N. D. Ohio); U.S. ex rel. Silver v. Omnicare, Inc., No. 11-cv-01326 (D. NJ)	6/25/2014	$140.72 million
U.S., ex rel. McCoyd v. Abbott Laboratories, et al., No.07-cv-00081 (W.D. VA); U.S., ex rel. Spetter v. Abbott Laboratories, Inc., et al. No. 10-cv-00006 (W.D. VA)	Ongoing	
Total Settlements from 2006-Present		**$364.9 Million**

Settlement Payments Made by Other Companies

Company	Date Settled	Settlement Amount
IVAX	11/3/2009	$14 million
Mariner	2/26/2010	$14 million
Abbott	5/7/2012	$1.5 billion
Amgen	4/16/2013	$24.9 million
Johnson & Johnson	11/4/2013	$2.2 billion
Esformes/Total Pharmacy	8/6/2014	$5 million
Total Third Party Settlements:		**$3.75 billion**

CLASS ACTION ALLEGATIONS

245. Plaintiffs bring this action as a class action pursuant to Fed. R. Civ. P. 23(a) and (b)(3) on behalf of the Class. Excluded from the Class are defendants, the officers and directors of

the Company, at all relevant times, members of their immediate families and their legal representatives, heirs, successors or assigns and any entity in which defendants have or had a controlling interest.

246. The members of the Class are so numerous that joinder of all members is impracticable. Each of the securities were traded on the NYSE. While the exact number of Class members is unknown to plaintiffs at this time and can only be ascertained through appropriate discovery, plaintiffs believe that there are at least thousands of members in the proposed Class for each security. Record owners and other members of the Class may be identified from records maintained by Omnicare or its transfer agent and may be notified of the pendency of this action by mail, using the form of notice similar to that customarily used in securities class actions.

247. Plaintiffs' claims are typical of the claims of the members of the Class as all members of the Class were similarly affected by defendants' wrongful conduct in violation of federal law complained of herein.

248. Plaintiffs will fairly and adequately protect the interests of the members of the Class and have retained counsel competent and experienced in class and securities litigation.

249. Common questions of law and fact exist as to all members of the Class and predominate over any questions solely affecting individual members of the Class. Among the questions of law and fact common to the Class are:

(a) whether the Securities Act was violated by defendants' acts as alleged herein;

(b) whether statements made by defendants to the investing public in the Registration Statement and prospectus misrepresented material facts or omitted material facts necessary not to make the statements misleading about the business, operations and management of Omnicare; and

(c) the extent to which the members of the Class have sustained damages and the proper measure of damages.

250. A class action is superior to all other available methods for the fair and efficient adjudication of this controversy since joinder of all members is impracticable. Furthermore, as the damages suffered by individual Class members may be relatively small, the expense and burden of individual litigation make it impossible for members of the Class to individually redress the wrongs done to them. There will be no difficulty in the management of this action as a class action.

COUNT I

For Violation of §11 of the Securities Act Against All Defendants

251. Plaintiffs repeat and re-allege each of the allegations set forth in the foregoing paragraphs.

252. This claim is brought pursuant to §11 of the Securities Act, 15 U.S.C. §77k, on behalf of the Class, against all defendants. Plaintiffs expressly exclude and disclaim any allegation that could be construed as alleging fraud or intentional or reckless misconduct, as this claim is based solely on theories of strict liability and negligence under the Securities Act.

253. The Registration Statement and Prospectus issued in connection with the December 2005 Offering were false and misleading in that they contained untrue statements of material facts and/or omitted to state material facts necessary to make the statements made therein not misleading, as described above at ¶¶229, 232.

254. Omnicare is the registrant of the December 2005 Offering and filed the Registration Statement and Prospectus used in connection with the Offering. Omnicare is the "issuer" of the common stock sold in the Offering as defined in §11 of the Securities Act. As the issuer, Omnicare is liable for the false statements and omissions contained therein under §11 of the Securities Act.

255. Defendants Gemunder, Froesel, Laney, Hutton and Hodges are responsible for the contents and the dissemination of the Registration Statement, as they each signed the Registration Statement and participated in the preparation and dissemination of the Registration Statement by preparing, reviewing and/or signing the Registration Statement and causing their filing with the SEC.

256. Each of the defendants named in this claim participated in the preparation and dissemination, and signed and/or authorized the signing of the Registration Statement or were sellers of the securities sold in the December 2005 Offering. As a signatory to the Registration Statement, each defendant is liable to plaintiffs and members of the Class for the misstatements and omissions contained within that Registration Statement.

257. Each of the defendants failed to conduct a reasonable investigation of the statements contained in the offering materials and documents incorporated therein by reference and did not possess reasonable grounds for believing that the statements therein where true and not materially misstated. Had these defendants conducted a reasonable investigation, they would have learned that the offering materials contained material misstatements and omissions about Omnicare's compliance with state and federal law and the Company's purported regard for the safety of its patients and efficacy of the prescription drugs administered to its LTCF patients.

258. Omnicare's directors and officers were responsible for the integrity of the due diligence process in their capacity as the ultimate governing body of Omnicare and were at a minimum, knowledgeable about legal compliance and drug interchange issues given their involvement arrangements Omnicare entered into with its pharmaceutical manufacturers and LTCFs, yet failed to reasonably investigate the accuracy of Omnicare's Registration Statement, notwithstanding the presence of red flags.

259. Plaintiffs acquired the securities pursuant and/or traceable to the Registration Statement.

260. Plaintiffs and the Class have sustained damages. At the time of their purchases of the securities, plaintiffs and other members of the Class were without knowledge of the facts concerning the wrongful conduct alleged herein.

PRAYER FOR RELIEF

WHEREFORE, plaintiffs pray for judgment as follows:

A. Declaring this action to be a proper class action pursuant to Fed. R. Civ. P. 23;

B. Awarding plaintiffs and the members of the Class damages, including interest;

C. Awarding plaintiffs reasonable costs and attorneys' fees; and

D. Awarding such equitable/injunctive or other relief as the Court may deem just and proper.

JURY DEMAND

Plaintiffs hereby demand a trial by jury.

DATED: May 29, 2015

s/HENRY ROSEN

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