IN THE SUPREME COURT OF THE STATE OF NEVADA

STATE OF NEVADA; NEVADA DEPARTMENT OF CORRECTIONS; JAMES DZURENDA, Director of the Nevada Department of Corrections, in his official capacity; IHSAN AZZAM, Ph.D., M.D., Chief Medical Officer of the State of Nevada, in his official capacity; and JOHN DOE, Attending Physician at Planned Execution of Scott Raymond Dozier in his official capacity,

Petitioners,

v.

THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNT OF CLARK; AND THE HONORABLE ELIZABETH GONZALEZ, DISTRICT COURT JUDGE ,

Respondents.

and

ALVOGEN, INC.; and HIKMA PHARMACEUTICALS USA INC.,

Real Parties in Interest.

Supreme Court Case No: 76485

District Court No: A-18-777312-B

SANDOZ INC.'S MOTION FOR LEAVE PURSUANT TO NRAP 29 TO PARTICIPATE AS AMICUS CURIAE IN SUPPORT OF REAL PARTIES' IN INTEREST

POINTS AND AUTHORITIES

Nevada Rule of Appellate Procedure 29 provides, in part, that non-governmental parties' desiring to participate as *amicus curiae* before this Court "may file a brief only by leave of court granted on motion or at the court's request or if accompanied by written consent of all parties." NRAP 29(a). Sandoz Inc. ("Sandoz"), a manufacturer of one of the drugs to be used in the State of Nevada's execution protocol for Scott Dozier, had filed a Motion to Intervene in the district court proceedings that was set to be heard on shortened time on August 9, 2018. This Court issued a temporary stay of proceedings on August 8, 2018, which prevented the lower court from considering Sandoz's intervention motion.

As part of its Motion to Intervene, Sandoz explained in detail why it has a protectible interest in the district court proceedings and why it was not adequately represented by Real Parties in Interest, Alvogen, Inc. and Hikma Pharmaceuticals USA, Inc. The foregoing factors are similar to those for a party seeking leave pursuant to NRAP 29. *See* NRAP 29(c) (requiring moving party to show its interest and why an amicus brief is desirable). Accordingly, Sandoz hereby incorporates the arguments contained in its Motion to Intervene as though fully set forth, and has attached a true and correct copy of its intervention motion as Exhibit A hereto.

Sandoz desires to participate in this matter as *amicus curiae* in support of the Real Parties in Interest. A true and correct copy of Sandoz's proposed brief in

support of Real Parties in Interest's Opposition to the State's Motion to Stay Proceedings is attached hereto as Exhibit B.

CONCLUSION

Sandoz respectfully requests that its motion for leave to participate as *amicus curiae* in these proceedings be granted.

DATED this 13th day of August, 2018.

CAMPBELL & WILLIAMS

By /s/ *J. Colby Williams*

J. COLBY WILLIAMS, ESQ.
Nevada Bar No. 5549
jcw@cwlawlv.com
PHILIP R. ERWIN, ESQ.
Nevada Bar No. 11563
pre@cwlawlv.com
700 South Seventh Street
Las Vegas, NV 89101
Telephone: 702.382.5222

Attorneys for *Amicus Curiae Sandoz Inc.*

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of CAMPBELL & WILLIAMS, and that on this 13th day of August, 2018, I caused to be served via the Court's e-filing/e-service system and by email a true and correct copy of the above and foregoing **Sandoz Inc.'s Motion for Leave Pursuant to NRAP 29 to Participate as Amicus Curiae in Support of Real Parties in Interest** to the following:

Jordan T. Smith
Assistant Solicitor General
555 East Washington Avenue, #3900
Las Vegas, Nevada 89101
JSmith@ag.nv.gov

Attorneys for the State of Nevada

James J. Pisanelli, Esq., Bar No. 4027
JJP@pisanellibice.com
Todd L. Bice, Esq., Bar No. 4534
TLB@pisanellibice.com
Debra L. Spinelli, Esq., Bar No. 9695
DLS@pisanellibice.com
PISANELLI BICE PLLC
400 South 7th Street, Suite 300
Las Vegas, Nevada 89101
Telephone: 702.214.2100

Kenneth G. Schuler, Esq.
(pro hac vice pending)
kenneth.schuler@lw.com
Michael J. Faris, Esq.
(pro hac vice pending)
michael.faris@lw.com
Alex Grabowski, Esq.

(pro hac vice pending)
alex.grabowski@lw.com
LATHAM & WATKINS LLP
330 North Wabash Avenue, Suite 2800
Chicago, IL 60611
Telephone: 312.876.7659

Angela Walker, Esq.
(pro hac vice pending)
angela.walker@lw.com
LATHAM & WATKINS LLP
555 Eleventh Street, NW, Suite 1000
Washington, DC 20004-1304
Telephone: 202.637.3321

Attorneys for Alvogen, Inc.

E. Leif Reid, Esq.
Josh M. Reid, Esq.
Kristen L. Martini, Esq.
LEWIS ROCA ROTHGERBER CHRISTIE LLP
3993 Howard Hughes Parkway, Suite600
Las Vegas, NV 89169-5996

Attorneys for Hikma Pharmaceuticals

SERVED VIA HAND-DELIVERY

The Honorable Elizabeth Gonzalez
Eighth Judicial District Court, Dept. XI
Regional Justice Center
200 Lewis Avenue
Las Vegas, Nevada 89155

/s/ J. Colby Williams
An employee of Campbell & Williams

EXHIBIT A

MINV

J. Colby Williams, Esq. (5549)
jcw@cwlawlv.com
Philip R. Erwin, Esq. (11563)
pre@cwlawlv.com
CAMPBELL & WILLIAMS
700 South Seventh Street
Las Vegas, NV 89101
Telephone: 702.382.5222

Noël B. Ix, Esq. (*pro hac vice to be submitted*)
ixn@pepperlaw.com
PEPPER HAMILTON LLP
301 Carnegie Center, Suite 400
Princeton, NJ 08540
Telephone: 609.452.0808

Andrew Kantra, Esq. (*pro hac vice to be submitted*)
kantraa@pepperlaw.com
PEPPER HAMILTON LLP
3000 Two Logan Square
Eighteenth and Arch Streets
Philadelphia, PA 19103
Telephone: 215.981.4000
Attorneys for Intervenor

DISTRICT COURT

CLARK COUNTY, NEVADA

ALVOGEN, INC.,

Plaintiff,

v.

STATE OF NEVADA; NEVADA DEPARTMENT OF CORRECTION; JAMES DZURENDA, Director of the Nevada Department of Correction, in his official capacity; IHSAN AZZAM, Ph.D., M.D., Chief Medical Officer of the State of Nevada, in his official capacity; and JOHN DOE, Attending Physician at Planned Execution of Scott Raymond Dozier, in his official capacity;

Defendants.

Case No. A-18-777312-B
Dept. No. XI

SANDOZ INC.'S MOTION TO INTERVENE AND ORDER SHORTENING TIME

Date of Hearing:
Time of Hearing:

AND ALL RELATED CLAIMS

Intervenor Sandoz Inc. ("Sandoz"), through its undersigned counsel, moves to intervene in this action as a matter of right pursuant to Nevada Rule of Civil Procedure 24(a) or, in the alternative, for permissive intervention under Nevada Rule of Civil Procedure 24(b). This motion is based on Eighth Judicial Court Rules 2.20 and 2.26. the following Memorandum of Points and Authorities, and the exhibits attached hereto, including the proposed Complaint in Intervention attached as Exhibit A.

DATED this 3rd day of August, 2018.

CAMPBELL & WILLIAMS

By: ***/s/ J. Colby Williams***

J. Colby Williams, Esq. (5549)
Philip R. Erwin, Esq. (11563)
700 South Seventh Street
Las Vegas, NV 89101

PEPPER HAMILTON LLP

Noël B. Ix, Esquire (*pro hac vice to be submitted*)
301 Carnegie Center, Suite 400
Princeton, NJ 08540

Andrew Kantra, Esquire (*pro hac vice to be submitted*)
3000 Two Logan Square
Eighteenth and Arch Streets
Philadelphia, PA 19103

Attorneys for Intervenor

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

DECLARATION OF J. COLBY WILLIAMS, ESQ.
IN SUPPORT OF APPLICATION FOR ORDER SHORTENING TIME

I, J. Colby Williams, Esq., hereby declare as follows:

1. I am admitted to practice law in the State of Nevada and the courts of Clark County.

2. I am counsel of record for Sandoz in the above-referenced action and submit this Declaration in support of Sandoz's Motion to Intervene and to Shorten Time ("Motion").

3. I have personal knowledge of the facts stated herein, except those stated upon information and belief, which I believe to be true. I am competent to testify to the facts stated herein.

4. As set forth in the motion, and as alleged in the proposed Complaint in Intervention, attached hereto as Exhibit A, on July 10, 2018, Plaintiff Alvogen, Inc. ("Alvogen") commenced this action through the filing of its Complaint for Emergency Injunctive Relief and Return of Illegally-Obtained Property, its *Ex Parte* Application for Temporary Restraining Order and Motion for Order Shortening Time, and its *Ex Parte* Motion for Order Shortening Time.

5. Alvogen's action seeks to enjoin Defendants from using Alvogen's products, including Midazolam, as part of their execution protocol.

6. I am informed and believe that on or about July 7, 2018, Sandoz learned that Defendant Nevada Department of Correction ("NDOC") had purchased Sandoz's Cisatracurium Besylate Injection (Sandoz's Cisatracurium) from Cardinal Health, a wholesaler, in December 2017 and intended to use it as part of the State's lethal injection protocol for the execution of Scott Dozier on July 11, 2018.

7. On July 10, 2018, Sandoz sent a letter to the State objecting to the use of its products, including, Cisatracurium in connection with capital punishment and requesting the return of all such products. Sandoz has not received a response to this letter.

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

8. This Court heard argument on Alvogen's *Ex Parte* Application for Temporary Restraining Order on July 11, 2018. Sandoz was represented at that hearing by the undersigned counsel, and submitted its July 10, 2018 letter as an exhibit. This Court issued the Temporary Restraining Order ("TRO") at the close of the hearing, restraining and enjoining the State of Nevada from using or disposing of the Alvogen's Midazolam pending further order. The TRO will remain pending the completion of the preliminary injunction hearing. The Court scheduled a "status check" for September 10, 2018, which is to include a status report on discovery.

9. The State of Nevada has postponed the execution of Mr. Dozier until further notice.

10. On July 25, 2018, Hikma filed a motion to intervene in this action to assert claims similar to Alvogen, but with respect to Fentanyl, another drug in the State's execution protocol that Hikma manufactures. This Court granted Hikma's motion to intervene on July 31, 2018.

11. As discussed in detail in its Motion, Sandoz has a protected and sufficient interest in this litigation's subject matter, particularly its interest in preventing the misuse of its products. Without intervention, Sandoz's ability to protect its interests will be impaired. Neither Alvogen nor Hikma can adequately protect Sandoz's interest as their claims pertain only to Midazolam and Fentanyl respectively.

12. Sandoz's Motion is also timely. Sandoz has expeditiously filed this Motion after learning that the NDOC was in possession of its Cisatracurium. The existing parties to this action will not suffer any prejudice as a result of Sandoz's intervention. Sandoz does not seek to move any deadlines or otherwise delay this action, but instead intends to join Alvogen's motion for preliminary injunction, but with respect to Sandoz's Cisatracurium, and to participate in discovery that has just commenced. Moreover, Sandoz's claims arise from the same factual basis as the claims of Alvogen and Hikma, and are based on largely the same legal issues and theories of liability.

13. Additionally, the TRO only relates to Midazolam. The State of Nevada is not presently enjoined from using Sandoz's Cisatracurium in its lethal injection protocol to execute Mr.

Dozier. Thus, there is an imminent risk that the State will misuse Sandoz's products thereby causing irreparable harm to Sandoz. Accordingly, Sandoz seeks resolution of its Motion on shortened time to mitigate this risk and promote efficiency, thereby conserving the resources of the parties and this Court.

14. Good cause thus exists to shorten the time for decision and to hold a hearing on the Motion as soon as practicable.

I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct.

DATED this 3rd day of August, 2018.

/s/ ***J. Colby Williams***
J. Colby Williams, Esq.

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

ORDER SHORTENING TIME

TO: ALL PARTIES AND THEIR ATTORNEY OF RECORD

IT IS HEREBY ORDERED that the time for hearing on Sandoz, Inc.'s Motion to Intervene is hereby shortened and shall be heard on the 9 day of Aug, 2018, at 9, p.m./a.m., in Department XI in the above-entitled court, or alternatively, as soon thereafter as counsel may be heard.

DATED this __ day of August, 2018.

DISTRICT COURT JUDGE

CAMPBELL & WILLIAMS

By: ***/s/ J. Colby Williams***
J. Colby Williams, Esq.,
700 South Seventh Street
Las Vegas, NV 89101

PEPPER HAMILTON LLP

Noël B. Ix, Esquire (*pro hac vice to be submitted*)
301 Carnegie Center, Suite 400
Princeton, NJ 08540

Andrew Kantra, Esquire (*pro hac vice to be submitted*)
3000 Two Logan Square
Eighteenth and Arch Streets
Philadelphia, PA 19103

Attorneys for Intervenor

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Sandoz is a global leader in generic pharmaceuticals, with the stated mission to discover new ways to improve and extend people's lives. Defendants in this action seek to misuse one of Sandoz's products, Cisatracurium, for the exact opposite purpose: to carry out the lethal injection of NDOC inmate Scott Dozier. The use of Sandoz's products in this unauthorized manner will cause substantial reputational and other harm to Sandoz, and compromise Sandoz's longstanding efforts to ensure its products are not used in connection with capital punishment.

Cisatracurium is one of three drugs, along with Midazolam and Fentanyl, that make up the State of Nevada's current execution protocol. The manufacturer of Midazolam, Alvogen, initially commenced this action against Defendants on July 10, 2018, alleging various statutory and common law claims and seeking an injunction enjoining Defendants from using Alvogen's products to perform executions. Hikma, a manufacturer of Fentanyl, moved to intervene in this action on July 25, 2018, after learning Defendants intended to use its Fentanyl in Mr. Dozier's execution. That motion was granted just days ago.

The claims Sandoz seeks to pursue here are in effect no different than those of Alvogen and Hikma. All three companies have long-standing, publicly-stated opposition to the misuse of their products in capital punishment. They are, therefore, concerned that Defendants' unauthorized and wrongful use of their drugs as part of the State of Nevada's execution protocol will work a significant and irreparable harm to their reputations and cause substantial injury resulting from, among other things, damage to business and investor relationships and damage to goodwill.

Sandoz's claims arise from the same factual basis as the claims of Alvogen and Hikma, and are based on largely the same legal issues and theories of liability. That said, there is no question that Sandoz's unique interests are not adequately represented by the other drug manufacturers. As a practical matter, the injunctive relief requested by Alvogen and Hikma will apply only to their

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

respective drugs. Even if they prevail, the Court is presently unable to grant relief that would prevent Defendants from using Sandoz's Cisatracurium for lethal injection, exposing Sandoz to significant and irreparable harm should its drugs be used in Mr. Dozier's execution. Indeed, media coverage of this matter demonstrates what's at stake; a recent New York Times article reported that the use of Sandoz's Cisatracurium "would have prevented Mr. Dozier from writhing on the gurney or showing any outward signs of pain, even as he suffered an agonizing death" and that critics "argued that the paralytic could potentially mask the suffering involved in a botched execution." Richard A. Oppel Jr., *Nevada Execution Is Blocked After Drugmaker Sues*, N.Y. TIMES, July 11, 2018 (available at https://www.nytimes.com/2018/07/11/us/dozier-execution-fentanyl.html) (last visited August 2, 2018). This description stands in stark contrast to Sandoz's fundamental objective to provide therapeutic and life-saving treatments to patients in need.

For these reasons, Sandoz has timely filed the instant motion and is thus entitled to intervention under Nevada Rule of Civil Procedure 24(a). The parties will suffer no prejudice as a result of Sandoz's intervention. Hikma's similar motion was granted earlier this week; discovery has not yet occurred; and there is no other basis to deny Sandoz its right to protect its interests in this litigation. Additionally, even if Sandoz was not entitled as a matter of right to intervene, permissive intervention is appropriate under Nevada Rule of Civil Procedure 24(b) as Sandoz's claims and Alvogen's claims share common questions of law and fact. Either way, Sandoz should have the opportunity to protect its interests and ensure that its products are not being misused in an unapproved manner that is entirely at odds with the company's mission.

II. RELEVANT FACTUAL AND PROCEDURAL BACKGROUND

For years Sandoz has been steadfast that it does not support the use of any of its drugs for off-label use in connection with lethal injection. For example, in early 2011 Sandoz took steps to prevent the sale of sodium thiopental in the United States due to the drug's then-frequent use in lethal injection cocktails and made public statements reaffirming its position that it did not support

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

the sale of its products for the non-approved use of capital punishment. *See* Exhibit A, Sandoz Inc.'s Complaint in Intervention, at Exhibit 3.

In 2013, Sandoz implemented restrictions on the distribution of Rocuronium Bromide to prevent its use in capital punishment, including amending agreements with distributors to prohibit its sale to U.S. prison hospitals. *See* Exhibit A at Exhibit 4. Since then, Sandoz has made clear to its customers, and to the public at large, that its drugs are only to be used to save and sustain the lives of patients for whom they are needed. Consistent with this position, Sandoz did not respond to a request for proposal issued by the State of Nevada in September 2016 to supply drugs required for lethal injection.[1] *See* Alvogen Compl. for Emergency Injunctive Relief & Return of Illegally-Obtained Prop. at Ex. 1. In 2017, Sandoz also implemented restrictions on the distribution of Anectine to prevent its use in capital punishment. *See* Exhibit A at Exhibit 5. Sandoz reaffirmed its position in an *amicus curiae* brief, which referred to direct communications with Departments of Corrections and government officials in death penalty states, and described its right to enforce its contractual rights and minimize its exposure to reputational, fiscal, and legal risks associated with the use of its drugs in capital punishment. *See* Exhibit A at Exhibit 7. Indeed, in March 2017, the Judiciary Committee of the Nevada Assembly noted that Sandoz was among twenty-one (21) pharmaceutical manufacturers or distributors that opposed the misuse of medications in executions. *See* Exhibit A at Exhibit 6.

In August 2017, Sandoz became aware that the State created a new execution protocol including Sandoz's Cisatracurium. This was the first time any State had included Cisatracurium in a lethal injection protocol, and no State has yet used Cisatracurium in carrying out an execution.

[1] Sandoz is not the only pharmaceutical company that has taken affirmative action to exercise its rights to not sell their products for use in lethal injection. More than 20 American and European pharmaceutical companies have taken action to prevent their products from being used for lethal injection. *See* Exhibit A.

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

This means that the State's proposed novel misuse of the drug in executions is experimental and without precedent establishing that it can be administered without causing unconstitutional suffering. Also in August, Sandoz learned that the NDOC had at that point not purchased any Sandoz-manufactured drugs, including Cisatracurium, for use in executions.[2] Nevertheless, beginning in November 2017 Sandoz began to add distribution restrictions for Cisatracurium to its customer agreements as they came up for renewal that were designed, in part, to prevent customers from selling Sandoz's Cisatracurium products to state and federal prisons. At that point, Sandoz had no reason to believe that NDOC had acquired any Sandoz-made Cisatracurium for use in executions, and Sandoz was taking active measures to ensure that this would remain the case.

It was only on or about July 7, 2018, as a result of a court order in litigation initiated by the American Civil Liberties Union of Nevada against the NDOC, that Sandoz learned the NDOC had purchased Sandoz's Cisatracurium from Cardinal Health in December 2017, and intended to use it in Mr. Dozier's execution just days later. *See* Exhibit A at Exhibit 8. In December 2017, Sandoz had reason to believe that Cardinal Health was well aware that Sandoz did not want its products distributed to corrections facilities for use in lethal injection protocols. Prior contracts with Cardinal Health pertaining to other Sandoz products explicitly restricted sales to correctional facilities. As it turned out, however, the NDOC acquired Sandoz's Cisatracurium from Cardinal Health just as Sandoz was instituting express preventative controls to prevent this from happening. By Defendants' design, Sandoz had no way to detect that NDOC had purchased its Cisatracurium for the non-approved use of lethal injection. Notably, the billing and shipping addresses listed on the invoice for the NDOC's purchase of Sandoz's Cisatracurium were those of the NDOC administrative building in Las Vegas. Mr. Dozier's execution, however, was to take place over 200

[2] The NDOC had instead purchased Cisatracurium from another manufacturer, Fresinius Kabi, in May 2017.

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

miles away at Ely State Prison. The only conclusion is that Defendants purposely circumvented Sandoz's expressed policies against the use of its drugs for capital punishment. Indeed, the NDOC has acknowledged that it has attempted to maintain the secrecy of and/or conceal their acquisition and possession of execution protocol drugs because of a concern that information as to "where a State obtains execution drugs" may be used "to persuade the manufacturer and others to cease selling that drug for execution purposes." *American Civil Liberties Union of Nev. Found. v. State,* Case No. 18-OC-00163, Order granting in part Emergency Pet. Issuing Writ of Mandamus, at 4 (Nev. Dist. Ct. July 6, 2018).

Consequently, Sandoz sent a letter on July 10, 2018 to Governor Brian Sandoval, Attorney General Adam Laxalt, and NDOC Director James Dzurenda "strongly object[ing] to the misuse of any of [its] medicines for purposes of lethal injection." Exhibit A at Exhibit 2. Sandoz explained that:

> Our products are developed, manufactured and distributed to help save and improve people's lives. Their use in connection with executions, many of which have gone horribly wrong in recent years, is fundamentally contrary to this purpose.

Id. Sandoz was unequivocal that it would not allow the State's use of its Cisatracurium in connection with lethal injection, and demanded the return of its products:

> We write to communicate in the clearest possible terms that Sandoz objects to the misuse of Sandoz Cisatracurium or any other Sandoz product in the administration of capital punishment. We request the NDOC immediately return the Sandoz Cisatracurium that it purchased from Cardinal Health along with any other Sandoz products that Nevada may have obtained for use in lethal injection executions in exchange for a full refund.

Id. Sandoz has not received any response.

The same day Sandoz sent its letter, it learned that Alvogen filed the instant litigation and requested a TRO in connection with Midazolam. Given that Sandoz's interests were directly implicated by the litigation, counsel for Sandoz attended the July 11, 2018 hearing on Alvogen's TRO application to make a formal objection to the use of Cisatracurium for the non-approved use

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

of lethal objection. *See* Transcript from July 11, 2018 Emergency Hearing (hereafter, "Hrg. Tr.") at 30:14-31:16. Sandoz also submitted its July 10, 2018 letter as an exhibit to the Court. *Id.* The Court issued the TRO at the close of the hearing, restraining and enjoining the State from using Alvogen's Midazolam pending the outcome of the preliminary injunction hearing. Importantly, the TRO is specifically limited to Midazolam.

Hikma, the maker of the third drug in the State's execution protocol, Fentanyl, also informed the NDOC that it objects to the use of its products for lethal injection. Like Sandoz, Hikma demanded NDOC immediately return all of its products intended for use in executions, but received no response. Accordingly, on July 25, 2018, Hikma moved to intervene in this litigation to protect against the misuse of its drugs and concomitant reputational harm. This Court granted Hikma's motion on July 31, 2018.

Sandoz is similarly entitled to intervene here. Sandoz's products, like Alvogen and Hikma, have been obtained by the NDOC for a non-approved purpose in circumvention of Sandoz's longstanding and public objection to the use of its products for capital punishment. As this Court has recognized, a company like Sandoz has the "right to decide not to do business with someone, including the government, especially if there's a fear of misuse of their product." Hrg. Tr. at 73:19-22. Absent intervention, Sandoz will not be able to adequately protect this right and will remain exposed to immediate and irreparable reputational harm.

III. ARGUMENT

A. Sandoz Should Be Permitted to Intervene as a Matter of Right.

Under Nevada Rule of Civil Procedure 24(a), Sandoz must be permitted to intervene in this action as a matter of right if it can establish the following four elements:

1) it has a sufficient interest in the litigation's subject matter;

2) it could suffer an impairment of its ability to protect that interest if it does not intervene;

3) its interest is no adequately represented by existing parties; and

4) its application is timely.

American Home Assur. Co. v. Eighth Judicial Dist. Ct., 122 Nev. 1229, 1238, 147 P.3d 1120, 1126 (2006). Rule 24 traditionally receives liberal construction in favor of applicants for intervention, and the practical and equitable considerations that guide the Court's analysis all favor Sandoz here. *See Donnelly v. Glickman*, 159 F.3d 405, 409 (9th Cir. 1998).

1. Sandoz Has a Sufficient Interest in This Litigation's Subject Matter.

The first element requires Sandoz to establish a sufficient interest in this litigation's subject matter. Also referred to as a "significantly protectable interest," the Ninth Circuit has explained in analyzing the analogous federal rule that "[i]t is generally enough that the interest [asserted] is protectable under some law, and that there is a relationship between the legally protected interest and the claims at issue." *Sierra Club v. United States EPA*, 995 F.2d 1478, 1484 (9th Cir. 1993). Accordingly, Sandoz need only show that "the resolution of the plaintiff's claims actually will affect [it]." *Donnelly*, 159 F.3d at 410.

Sandoz has multiple interests implicated in this action. First, Sandoz seeks to assert its right to refuse business with those that would misuse its products. There is a long-recognized right to "'freely [] exercise [one's] own independent discretion as to parties with whom he will deal.'" *Image Tech. Servs. v. Eastman Kodak Co.*, 125 F.3d 1195, 1211 (9th Cir. 2007) (quoting *Aspen Highlands Skiing Corp. v. Aspen Skiing Co*., 738 F.2d 1509, 1517-23 (10th Cir. 1984)); *see also United States v. Colgate & Co*., 250 U.S. 300, 307 (1919). This Court has already explained that this litigation involves a company's "right to decide not to do business with someone" out of a "fear of misuse of [its] product." Hrg. Tr. at 73:19-22. That is the exact interest Sandoz seeks to advance here.

Second, Sandoz has an interest in the protection of its reputation and goodwill. In granting its application for a TRO, this Court determined that Alvogen would "suffer irreparable harm to its

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

reputation as a company that produces life-enhancing and life-saving drugs if Defendants are allowed to misuse its product." TRO at 1. The same would hold true for Sandoz.

Further, there is no question that there is a relationship between Sandoz's legally protected interests and the claims at issue. Sandoz, like Alvogen and Hikma, seeks injunctive relief to bar the misuse of its drugs in connection with capital punishment, and to prevent the reputational harm that would ensue if the State were permitted to follow through with its intended protocol in Mr. Dozier's execution. Accordingly, Sandoz satisfies the first element of the Rule 24(a) analysis.

2. Sandoz Will Not Be Able to Protect Its Interest if It Is Not Permitted to Intervene.

Sandoz can also establish that its ability to protect its interest will be impaired if it is not permitted to intervene as a matter of right. As a general rule, if a movant would "be substantially affected in a practical sense by the determination made in an action, he should . . . be entitled to intervene." *Citizens for Balanced Use v. Mont. Wilderness Ass'n*, 647 F.3d 893, 898 (9th Cir. 2011) (quoting Fed. R. Civ. P. 24 advisory committee's note). Thus, if the movant has a significant protectable interest, there should be "little difficulty concluding that the disposition of th[e] case may, as a practical matter, affect it." *California ex rel. Lockyer v. United States*, 450 F.3d 436, 442 (9th Cir. 2006).

Sandoz currently sits in a no-win situation absent its permitted intervention in this litigation. Even were Alvogen to ultimately prevail on its claims, any permanent injunctive relief would be granted only with respect to Alvogen's products. The State would still be able to use Sandoz's Cisatracurium to carry out lethal injection over Sandoz's objections, harming the company's reputation and business goodwill. On the other hand, should Defendants prevail on Alvogen's claims, Sandoz would be left fighting an uphill battle on a very short timeframe to prevent the use of its products by the State in an unintended and unapproved manner.

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

Sandoz cannot afford to be relegated to the sideline given the rapid and aggressive nature of this litigation, and its interests will be impaired if forced to file its own action to seek similar relief sought in this litigation. For instance, absent intervention Sandoz will not be able to participate in the discovery process in this matter, likely restricting its ability to prosecute any later independent action. Accordingly, like Hikma, Sandoz should be granted intervention as a matter of right to protect its interests in the outcome of this litigation.

3. Sandoz's Interests Are Not Adequately Represented by Existing Parties.

It is indisputable that Sandoz's interests are not adequately represented by the existing parties in this litigation. The "Ninth Circuit [has] explained that '[t]he burden on proposed intervenors in showing inadequate representation is minimal, and would be satisfied if they could demonstrate that representation of their interests 'may be' inadequate.'" *Hairr v. First Judicial Dist. Court*, 368 P.3d 1198, 1201 (2016) (quoting *Arakaki v. Cayetano*, 324 F.3d 1078, 1086 (9th Cir. 2003)).

Neither Alvogen nor Hikma can adequately represent Sandoz's interests in this litigation. Both companies seek relief only with respect to their products; the resolution of their claims will not have any impact on how the State uses Sandoz's drugs. Neither Alvogen nor Hikma has any reason (or standing) to represent Sandoz's interests in this matter. Accordingly, Sandoz's presence would "add some necessary element to the proceedings which would not be covered by the parties in the suit," *Blake v. Pallan*, 554 F.2d 947, 955 (9th Cir. 1977), which weighs heavily in favor of granting intervention.

4. Sandoz's Motion for Intervention is Timely.

Finally, Sandoz's motion for intervention is timely. "The most important question to be resolved in the determination of the timeliness of an application for intervention is not the length of the delay by the intervenor but the extent of prejudice to the rights of existing parties resulting

from the delay." *Dangberg Holdings Nev., L.L.C. v. Douglas County*, 115 Nev. 129, 141, 978 P.2d 311, 318 (1999).

The parties will not suffer any prejudice from any perceived delay in Sandoz's filing of the instant motion. The parties were on notice of Sandoz's interest in this lawsuit as a result of its participation in the July 11th hearing, which took place just one day after Alvogen filed suit. Moreover, Sandoz understands that the parties have only recently commenced written discovery in the case, further mitigating any prejudice that Sandoz's intervention may arguably cause. But perhaps the best indication that Sandoz's intervention will not prejudice the parties is that Hikma was just permitted to intervene as a matter of right on July 31st. There is no reason why Sandoz's intervention would cause prejudice, but Hikma's would not.

Additionally, Sandoz can hardly be said to have delayed seeking intervention. Sandoz only learned that the NDOC had purchased its Cisatracurium on or about July 7, 2018. On July 10, 2018, Sandoz sent its letter to Defendants objecting to the use of its Cisatracurium for lethal injection and requesting the return of its products. And, again, Sandoz was present at the July 11th hearing, providing notice to the parties that it believed its interests were implicated in this litigation and apprising the parties and the Court of its objection to the use of its Cisatracurium in the State's execution protocol. Nothing about Sandoz's conduct has been dilatory.

Defendants have argued that Sandoz has slept on its rights and should have pursued its interests in earlier habeas corpus litigation brought on behalf of Mr. Dozier. *See* Hrg. Tr. at 29:7-30:8. However, that litigation concerned whether the general use of Cisatracurium as part of the execution protocol constituted cruel and unusual punishment. *See Nevada Dep't of Corr. v. Eighth Judicial Dist. Court*, 417 P.3d 117, 2018 Nev. Unpub. LEXIS 396 (2018). For several reasons, that litigation has no bearing as to whether Sandoz's claims and motion are timely. *First*, as the Nevada Supreme Court determined, not even Mr. Dozier could challenge the use of Cisatracurium as part of the execution protocol within his post-conviction proceeding; in fact, he could only do so in an

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

action pursuant to 42 U.S.C. § 1983. *See id.* at *5. The suggestion that Sandoz, a nonparty, should have or could have asserted a challenge to the general use of Cisatracurium within Mr. Dozier's proceedings, where "confusion reigned," *id.*, is without merit. *Second*, Mr. Dozier's habeas corpus proceedings concluded on May 10, 2018. At that time, Sandoz had no indication that the NDOC was in in possession of any of Sandoz's Cisatracurium and, in fact, believed the contrary.[3] *Third*, the updated version of the execution protocol released by the NDOC during the pendency of Mr. Dozier's habeas proceedings included Fentanyl in addition to Cisatracurium. Hikma's intervention motion has nevertheless been deemed timely here.[4]

In short, Sandoz has acted expeditiously with respect to the claims it seeks to assert in this action. Although the current parties will suffer no prejudice through Sandoz's intervention, Sandoz will be severely prejudiced if this matter proceeds without its significant interests being adequately represented. Accordingly, Sandoz is entitled to intervention as a matter of right and its motion should be granted.

B. Sandoz Is Alternatively Entitled to Permissive Intervention

Although Sandoz is entitled to intervene as a matter of right, the Court can alternatively grant Sandoz permissive intervention. Nevada Rule of Civil Procedure 24(b) provides that a party may be permitted to intervene upon timely application "when an applicant's claim or defense and

[3] Indeed, while Sandoz had no knowledge that Nevada had possession of its product, Nevada was keenly aware, but did not serve notice on Sandoz, to allow participation in the habeas corpus proceeding.

[4] At the July 11, 2018 hearing, counsel for Defendants suggested that the claims Sandoz seeks to assert here are barred by the equitable doctrine of laches. The doctrine is inapplicable here. In Nevada, "[l]aches is more than a party delaying the enforcement of his rights; it is delay that works a disadvantage to another." *State v. Rosenthal*, 107 Nev. 772, 778, 819 P.2d 1296 (1991). Further, "[a]s a result of such delay, the condition of the party asserting laches becomes drastically altered, whereby he cannot be restored to his former state." *Id.* For the same reasons Defendants cannot establish prejudice as a result of Sandoz's intervention, Defendants also cannot meet their burden to establish laches.

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

the main action have a question of law or fact in common." NRCP 24(b). The Court should consider "whether the intervention will unduly delay or prejudice the adjudication of the rights of the original parties." *Id.*

Sandoz's claims here are similar, and indeed intertwined, with those asserted by both Alvogen and Hikma. The companies' respective claims clearly share a common factual basis and pose nearly identical questions of law. There is no tenable argument that Sandoz's intervention in this action will unduly delay or prejudice the rights of the original parties. Sandoz is not suggesting that any deadlines should be pushed back, or that the litigation should otherwise be delayed to accommodate Sandoz's entry. Hikma was permitted to intervene just days ago. Thus, there are no factors counseling against the Court's use of its discretion to permit Sandoz to intervene pursuant to NRCP 24(b).

IV. CONCLUSION

Sandoz must be allowed to intervene to protect its legally recognized interests, which are not currently represented by any party. Otherwise, Sandoz will be severely prejudiced and exposed to significant reputational harm and other injury. For the foregoing reasons, therefore, Sandoz respectfully requests that the Court grant intervention as a matter of right under NRCP 24(a) or, in the alternative, permit Sandoz to intervene under NRCP 24(b).

DATED this 3rd day of August, 2018.

CAMPBELL & WILLIAMS

By: ***/s/ J. Colby Williams***

J. Colby Williams, Esq. (5549)
Philip R. Erwin, Esq. (11563)
700 South Seventh Street
Las Vegas, NV 89101

PEPPER HAMILTON LLP

Noël B. Ix, Esquire (*pro hac vice to be submitted*)
301 Carnegie Center, Suite 400
Princeton, NJ 08540

Andrew Kantra, Esquire (*pro hac vice to be submitted*)
3000 Two Logan Square
Eighteenth and Arch Streets
Philadelphia, PA 19103

Attorneys for Intervenor

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that I am an employee of Campbell & Williams, and that on this 3rd day of August, 2018 I caused the foregoing document entitled **SANDOZ, INC.'S MOTION TO INTERVENE AND ORDER SHORTENING TIME** to be served upon those persons designated by the parties in the E-Service Master List for the above-referenced matter in the Eighth Judicial District Court eFiling System in accordance with the mandatory electronic service requirements of Administrative Order 14-2 and the Nevada Electronic Filing and Conversion Rules.

/s/ ***John Y. Chong***
An employee of Campbell & Williams

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

EXHIBIT A

J. Colby Williams, Esq. (5549)
jcw@cwlawlv.com
Philip R. Erwin, Esq. (11563)
pre@cwlawlv.com
CAMPBELL & WILLIAMS
700 South Seventh Street
Las Vegas, NV 89101
Telephone: 702.382.5222

Noël B. Ix, Esq. (*pro hac vice to be submitted*)
ixn@pepperlaw.com
PEPPER HAMILTON LLP
301 Carnegie Center, Suite 400
Princeton, NJ 08540
Telephone: 609.452.0808

Andrew Kantra, Esq. (*pro hac vice to be submitted*)
kantraa@pepperlaw.com
PEPPER HAMILTON LLP
3000 Two Logan Square
Eighteenth and Arch Streets
Philadelphia, PA 19103
Telephone: 215.981.4000
Attorneys for Intervenor

DISTRICT COURT

CLARK COUNTY, NEVADA

ALVOGEN, INC., Plaintiff, v. STATE OF NEVADA; NEVADA DEPARTMENT OF CORRECTION; JAMES DZURENDA, Director of the Nevada Department of Correction, in his official capacity; IHSAN AZZAM, Ph.D., M.D., Chief Medical Officer of the State of Nevada, in his official capacity; and JOHN DOE, Attending Physician at Planned Execution of Scott Raymond Dozier, in his official capacity; Defendants.	Case No. A-18-777312-B Dept. No. XI **SANDOZ INC.'S COMPLAINT IN INTERVENTION**
AND ALL RELATED CLAIMS	

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

COMES NOW Intervenor Sandoz Inc. ("Sandoz"), through its counsel and for its Complaint in Intervention alleges and complains against Defendants as follows:

PARTIES, JURISDICTION AND VENUE

1. Intervenor Sandoz is a Colorado corporation with its principal place of business located at 100 College Road West, Princeton, New Jersey. Sandoz is an indirect subsidiary of Novartis AG ("Novartis"), which trades on the SIX Swiss Exchange under the ticker symbol NOVN and whose American Depository Shares are publicly traded on the New York Stock Exchange under the ticker symbol NVS.

2. Upon information and belief, Plaintiff Alvogen, Inc. ("Alvogen") is a Delaware corporation with its principal place of business located at 10 Bloomfield Avenue, Pine Brook, New Jersey.

3. Upon information and belief, Intervenor Hikma Pharmaceuticals USA Inc. ("Hikma") is a Delaware corporation with its principal place of business located at 246 Industrial Way West, Eatontown, New Jersey.

4. Defendant State of Nevada ("Nevada") is the sovereign government of Nevada.

5. Defendant Nevada Department of Corrections ("NDOC"), led by its Director James Dzurenda, is a Nevada state governmental entity, with offices in Nevada, including at 3955 West Russell Road, Las Vegas, Nevada, 89118.

6. Defendant Dr. Ihsan Azzam, Ph.D, M.D. serves as the Nevada State Chief Medical Officer at the Nevada Department of Health and Human Services, Division of Public and Behavioral Health, with Offices in Nevada, including in Las Vegas.

7. Defendant John Doe I is an individual who will serve as the attending physician at the planned execution of inmate Scott Raymond Dozier. To the extent that there are multiple individuals who will serve as attending physicians at the planned execution, they are named herein as John Doe II, John Doe III, *et seq.*

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

8. Jurisdiction over Defendants is appropriate in this Court as each of them is an entity or agent of the State of Nevada, conducting business in Nevada. Venue in this Court is appropriate, including pursuant to NRS 13.020, as material events giving rise to this action, including the Defendants' illegitimate acquisition of Sandoz's drug Cisatracurium ("Sandoz's Cisatracurium" or "Sandoz Cisatracurium"), occurred in Clark County, Nevada.

INTRODUCTION

9. Nearly one-hundred years ago, the United States Supreme Court made it very clear that a manufacturer of a product has the right to not sell its products to certain individuals or entities, and that there is a "long recognized right of a trader or manufacturer engaged in an entirely private business, freely to exercise his own independent discretion as to parties with whom he will deal." *See United States v. Colgate & Co*., 250 U.S. 300, 307 (1919). This right, commonly referred to as the "*Colgate* doctrine," continues to be recognized and applied by the Court. *See Pacific Bell Tele. Co. v. Linkline Commc'ns, Inc.*, 555 U.S. 438, 448 (2009).

10. Sandoz has repeatedly expressed its position from 2011 to the present against the use of any of its products in lethal injection and has implemented controls to prevent its products from being misused in connection with capital punishment.

11. Upon learning that some states, including the State of Nevada, were considering new medicines to use in their lethal injection protocols, Sandoz exercised its rights and took action to prevent its medicines from being used in a way that is inconsistent with the U.S. Food and Drug Administration's ("FDA") approved therapeutic and medical uses for its products and counter to Sandoz's values as an organization, the interests of its customers, and the financial interests of Sandoz and its shareholders.

12. Sandoz is not the only pharmaceutical company that has taken affirmative action to exercise its rights to not sell their products for use in lethal injection. More than 20 American and European pharmaceutical companies have taken action to prevent their products from being used

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

for lethal injection. *See* Exhibit "1," Pfizer Blocks the Use of Its Drugs in Executions, THE NEW YORK TIMES, May 13, 2016; *see also* http://lethalinjectioninfo.org/industry-statements/. Similar to other pharmaceutical companies, Sandoz has an important interest in protecting its business reputation and meeting its fiduciary duties to its shareholders. Experts have commented, for example, that a pharmaceutical company's involvement with lethal injection may open the company to liability, including the loss of large institutional investors and litigation from their shareholders. Ex. 1. Sandoz has taken multiple proactive actions to protect its rights and values, and also to protect its business and investor and prospective investor relations.

13. In July 2018, Defendants revealed their plans to utilize a Sandoz product they illegitimately obtained to execute Scott Raymond Dozier by lethal injection. That product is Cisatracurium Besylate Injection.

14. Upon learning of Defendants' plans, Sandoz promptly objected to the use of its Cisatracuriam (or any of its products) in Mr. Dozier's execution or any capital punishment, and further demanded the immediate return of all Sandoz Cisatracurium that it had purchased, along with any other Sandoz products that Nevada may have obtained for use in lethal injection executions. *See* Exhibit "2," Letter from Sandoz to NDOC, Attorney General Adam Laxalt, and Governor Brian Sandoval dated July 10, 2018.

15. Defendants have not responded to the Sandoz letter or returned the Sandoz Cisatracurium illegitimately acquired for use as part of their lethal injection protocol for Scott Raymond Dozier.

16. NDOC has acknowledged that they have attempted to maintain the secrecy of and/or conceal their acquisition and possession of Sandoz's Cisatracurium because of a concern that information as to "where a State obtains execution drugs" may be used "to persuade the manufacturer and others to cease selling that drug for execution purposes." *American Civil*

Liberties Union of Nev. Found. v. State, Case No. 18-OC-00163, Order Granting in part Emergency Pet. Issuing Writ of Mandamus, at 4 (Nev. Dist. Ct. July 6, 2018).

17. Defendants' acquisition of Sandoz's Cisatracurium to use in a lethal injection protocol (over the specific objections of Sandoz) violates Sandoz's rights and the law. If Defendants are allowed to continue to circumvent the law, and Sandoz's recognized right to use its own business judgment to determine how its products may be sold and used, and use Sandoz's product for lethal injection, Defendants' actions will result in immediate and irreparable harm to Sandoz, damage to Sandoz's hard-earned business reputation, and financial injury to Sandoz and its shareholders.

GENERAL ALLEGATIONS

I. SANDOZ'S MANUFACTURE AND APPROVED DISTRIBUTION OF CISATRACURIUM AND POSITION ON RESTRICTED USE OF ITS PRODUCTS FOR CAPITAL PUNISHMENT.

18. Sandoz, a division of Novartis, is a leading generic pharmaceutical company focused on discovering new ways to improve and extend people's lives. Sandoz contributes to society's ability to support growing healthcare needs by pioneering novel approaches to help people around the world access high-quality medicine.

19. Among its products in the United States, Sandoz manufactures and distributes Cisatracurium Besylate Injection (Abbreviated New Drug Application number 200154).

20. Upon information and belief, five other manufacturers produce Cisatracurium Besylate in the United States.

21. Sandoz's Cisatracurium is a nondepolarizing skeletal muscle relaxant for intravenous administration approved by the FDA for inpatients and outpatients as an adjunct to general anesthesia, to facilitate tracheal intubation, and to provide skeletal muscle relaxation during surgery or mechanical ventilation in the ICU.

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 South Seventh Street, Las Vegas, Nevada 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

22. To maintain Sandoz's reputation for producing safe, high-quality products, Sandoz is committed to going beyond mere compliance with the law and strives to uphold the highest ethical standards.

23. In an attempt to ensure that its products are used responsibly, Sandoz has placed controls on the purchase and use of certain of its products that states have publicly identified may be used in connection with lethal injection. Such controls include internal policies and procedures, and contracts with its customers to restrict the supply of Sandoz products for the distribution and use in lethal injection protocols.

24. Sandoz has refused the direct sale of its products to Departments of Correction for use in capital punishment, and works directly with its distribution partners to add restrictions for unintended use to its distribution contracts.

25. In early 2011, Sandoz made public statements reaffirming its position and restrictions on sales of its products to third party distributors, stating "Sandoz and Novartis support only the authorized use of injectable thiopental, which is primarily indicated for the induction of anesthesia, and do not support the sale of this or **any product** for use in non-approved treatments." *See* Exhibit "3," Novartis Moves to Stop Execution Drug Reaching U.S., REUTERS HEALTH NEWS, February 10, 2011 (emphasis added).

26. In 2013, Sandoz implemented restrictions on the distribution of Rocuronium Bromide to prevent its use in capital punishment, including amending agreements with distributors to prohibit its sale to United States prison hospitals. *See* Exhibit "4," Amendment to Cardinal Health Generic Wholesale Service Agreement dated December 10, 2013.

27. Consistent with this position, Sandoz did not respond to a request for proposal issued by the State of Nevada in September 2016 to supply drugs required for lethal injection.

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

28. In 2017, Sandoz also implemented restrictions on the distribution of Anectine to prevent its use in capital punishment. *See* Exhibit "5," Controlled Distribution Program Amendment to Generic Wholesale Service Agreement.

29. Sandoz's objection to the use of its products in capital punishment is even noted in the minutes of the March 29, 2017 Judiciary Committee of the Nevada Assembly, with Sandoz included among the twenty-one (21) companies that have made statements opposing the misuse of medications in executions. *See* Exhibit "6," March 29, 2017 Minutes of Nevada Assembly Judiciary Committee.

30. In 2017, Sandoz reaffirmed its position in an *amicus curiae* brief, which refers to direct communications with Departments of Corrections and government officials in death penalty states, and describes its right to enforce its contractual rights and minimize associated reputational, fiscal, and legal risks by ensuring that its medicines not be diverted for use in capital punishment. *See* Exhibit "7," *Amicus Curiae* Brief in Support of Relator on Behalf of Fresenius Kabi USA, LLC and Sandoz Inc., *State of Ohio ex rel. Hogan Lovells US LLP and Elizabeth Och v. Ohio Dep't of Rehab. & Correction*, No. 2016-1776 (S. Ct. Ohio), *available at* http://lethalinjectioninfo.org/wp-content/uploads/2018/02/2017_07_10_PRIV-Amicus-Curiae-Brief-in-Ohio-Sandoz-and-Fresenius-Kabi.pdf.

31. More recently, after learning that Cisatracurium had been added to at least one execution protocol, Sandoz began implementing controls to restrict distribution and usage of its Cisatracurium for capital punishment.

II. DEFENDANTS ADD CISATRACURIUM TO THE STATE'S LETHAL INJECTION PROTOCOL, THE FIRST STATE TO DO SO.

32. Upon information and belief, NDOC, like other death-penalty states, was well-aware of certain drug manufacturers' restrictions on the use of their drugs in executions. According to the Las Vegas Review-Journal, as reported on October 7, 2016, NDOC sent out 247 requests for

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

proposals on September 2, 2016, to manufacturers for the purchase of the drugs that it intended to use in lethal injections after the stockpile of at least one of the drugs in its possession expired. (Nevada's last execution occurred in 2006.) Not one response was received. Because no pharmaceutical companies bid to supply the drugs for lethal injection, Nevada prison officials were on the record as stating that "the State will have to explore its options to carry out executions." *See* Alvogen Compl. for Emergency Injunctive Relief & Return of Illegally- Obtained Prop. at Ex. 1.

33. Other states in which the death penalty is implemented have also attempted to locate alternative compounds for their lethal injection protocols as a result of drug manufacturers' opposition to having their medicines used in executions. Upon information and belief, some states started to experiment with mixtures of drugs that were never intended for this purpose.

34. In August 2017, Sandoz became aware that Nevada created a new execution protocol that included Cisatracurium, which has never been used in an execution. Also in August, Sandoz learned that the NDOC had not at that point purchased any Sandoz-manufactured drugs, including Cisatracurium, for use in executions.[1]

35. Nonetheless, beginning in November 2017, Sandoz began to add distribution restrictions for Cisatracurium to its customer agreements covering this product as they came up for renewal that were designed, in part, to prevent customers from selling Sandoz's Cisatracurium to state and federal prisons.

36. On or about July 7, 2018, Sandoz learned that the NDOC revealed it had purchased Sandoz's Cisatracurium from Cardinal Health in December 2017, and intended to use it in Mr. Dozier's execution. Unbeknownst to Sandoz, NDOC had acquired Sandoz's Cisatracurium just as Sandoz was instituting controls to prevent this from happening.

[1] The NDOC had instead purchased Cisatracurium from another manufacturer, Fresinius Kabi, in May 2017.

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

37. No state has ever carried out a lethal injection using Cisatracurium. This means that the State's proposed novel misuse of the drug in executions is experimental and without precedent establishing that it can be administered without causing unconstitutional suffering.

38. On July 10, 2018, Sandoz wrote a letter to the State making clear its position against misuse of its product for capital punishment:

> We strongly object to the misuse of any of our medicines for purposes of lethal injection. Our products are developed, manufactured and distributed to help save and improve people's lives. Their use in connection with executions, many of which have gone horribly wrong in recent years, is fundamentally contrary to this purpose.
>
> …
>
> We write to communicate in the clearest possible terms that Sandoz objects to the misuse of Sandoz Cisatracurium or any other Sandoz product in the administration of capital punishment.

See Ex. 2.

39. The same day that Sandoz sent its letter, it learned that Alvogen filed the instant litigation and requested a Temporary Restraining Order in connection with Midazolam. Counsel for Sandoz attended the July 11, 2018 hearing on Alvogen's TRO application, to make a formal objection to the use of Cisatracurium for the non-approved use of lethal injection. *See* Hrg. Tr. at 30:14-31:16.

40. This Court heard argument on Alvogen's ex parte application for a TRO on July 11, 2018. This Court issued a Temporary Restraining Order the same day, prohibiting and enjoining Defendants from using Alvogen's Midazolam in capital punishment until further order of the Court.

41. On July 30, 2018, this Court granted the motion to intervene by Hikma, as manufacturer of the third drug proposed for use in the lethal injection execution of Scott Raymond Dozier.

III. DEFENDANTS WRONGFULLY OBTAINED SANDOZ'S CISATRACURIUM FOR DEFENDANTS' INTENTIONAL AND UNAPPROVED USE IN SCOTT RAYMOND DOZIER'S EXECUTION.

42. In litigation initiated by the American Civil Liberties Union of Nevada, the court ordered NDOC to disclose the lethal injection procedures it planned to implement in Scott Raymond

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

Dozier's execution.. *See American Civil Liberties Union of Nev. Found.* v. *State,* Case No. 18 OC 00163 1B, Order Granting in part Emergency Pet. Issuing Writ of Mandamus (Nev. Dist. Ct. July 6, 2018). Sandoz obtained copies of those documents, which included a list of the drugs to be included in the lethal injection protocol along with the invoices related to NDOC's purchase of those specific drugs. These invoices identified Sandoz's Cisatracurium. *See* Exhibit "8," Nevada Execution Manual & Invoices for Drugs Purchased.

43. The invoice for Sandoz's Cisatracurium was from one of Sandoz's wholesale distributors, Cardinal Health, and documented an order placed on December 14, 2017 to be billed and shipped to the Nevada Department of Correction Center Pharmacy, located at the NDOC's administrative building in Las Vegas—not to the Ely State Prison, which is where Nevada's executions take place and is located over 200 miles away from its Las Vegas building. *See id.*

44. In December 2017, Sandoz had reason to believe Cardinal Health understood that Sandoz objected to the use of its products in lethal injection protocols. Prior contracts with Cardinal Health pertaining to other Sandoz products explicitly restricted sales to correctional facilities. Sandoz and Cardinal Health entered into negotiations regarding a formal amendment to their Generic Wholesale Service Agreement to memorialize the terms on which Cardinal Health would restrict such sales. The final agreement was executed in May 2018. *See* Exhibit "9," May 15, 2018 Amendment to Cardinal Health Generic Wholesale Service Agreement.

45. NDOC acquired Sandoz's Cisatracurium from Cardinal Health, aware that Sandoz strongly objected to and prohibited the use of all of its products in executions, as being contrary to FDA-approved therapeutic and medical uses, and Sandoz's intention of manufacturing products for the health and well-being of patients in need, and values as a Company. *See* Exhibit "10," Cisatracurium Package Insert.

46. Despite Sandoz's repeated and steadfast public positions against usage of its drugs for lethal injection, Defendants circumvented Sandoz's policy by purchasing Sandoz's

Cisatracurium through an unsuspecting intermediary and without disclosing to said intermediary that they planned to use the Cistracurium for an execution. Defendants were thus able to obtain Sandoz's Cisatracurium in a manner that they would not have been able to accomplish had they disclosed that they planned to use Sandoz's Cisatracurium for an execution.

47. Upon information and belief, NDOC also failed to follow the State's purchasing procedures when it acquired Sandoz's Cisatracurium. Instead of using the Nevada Purchasing Division's contract with Minnesota Multi-State Contracting for Pharmacy (MMCAP), which was mandatory for all state agencies, NDOC purchased Sandoz's Cisatracurium off-contract through Cardinal Health at the higher list price. *See* NRS 333.435.

48. Defendants use of Sandoz's Cisatracurium in the lethal injection protocol for Scott Raymond Dozier is for a purpose for which it is neither allowed nor intended to be used. While Sandoz takes no position on the death penalty sentence imposed on Scott Raymond Dozier, Sandoz's products were manufactured to promote the health and well-being of patients in need—not in state-facilitated executions.

49. Upon confirming that Defendants intended to use Sandoz's Cisatracurium in the scheduled lethal injection of Scott Raymond Dozier on July 11, 2018, Sandoz sent a letter on July 10, 2018, stating its belief that NDOC is in possession of Sandoz's Cisatracurium, and that it may be used in the pending execution, additionally stating:

> To ensure our products are not purchased for this purpose, Sandoz has imposed a system of strict distribution controls designed to prohibit the sale of its medicines to correctional facilities or otherwise for the use in connection with lethal injection executions. These controls align with prevailing industry standards in the pharmaceutical sector and reflect our company's strict policy on ensuring the appropriate use of our medicines.

See Ex. 2.

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

50. Sandoz demanded that NDOC immediately return all of Sandoz's Cisatracurium, and other products, intended for use in executions, in exchange for a full refund for such use would represent a serious misuse of life-saving medicines. *Id.*

51. Defendants have not responded to Sandoz's letter.

IV. DEFENDANTS CONTINUED MISUSE OF SANDOZ'S CISATRACURIUM IN EXECUTIONS, INCLUDING THAT OF SCOTT RAYMOND DOZIER, WILL CAUSE SANDOZ TO SUFFER IMMEDIATE AND IRREPARABLE INJURY.

52. Since NDOC's declaration of its new and untested lethal injection protocol to be used in the execution of Scott Raymond Dozier, including the novel use of Cisatracurium in the execution, NDOC's protocol has been widely criticized.

53. The severe criticism communicated by the American public, medical and legal professionals, and scholars alike, leads to Sandoz as the manufacturer of the first-time use of this drug in this divisive execution. As more fully set forth herein, Defendants' actions have caused, and will continue to cause, unless preliminarily and permanently enjoined, substantial and irreparable injury to Sandoz including, but not limited to, reputational injury arising out of (i) association with the manufacture of drugs used for executions, (ii) the corresponding damage to business and investor and prospective investor relationships, (iii) damage to goodwill, and (iv) other irreparable harm to be proven at trial.

COUNT I: REPLEVIN

54. Sandoz incorporates the preceding paragraphs as though fully set forth herein.

55. Upon information and belief, Defendants sought to circumvent Sandoz's controls by issuing purchase orders for Sandoz's Cisatracurium with an unsuspecting distributor, Cardinal Health. Based on those purchase orders, Cardinal Health shipped to Defendants a total of 20 vials of 2mg/ml 10X5ML Cisatracurium. *See* Ex. 8.

56. As set forth above, Defendants knew or should have known that the distributor was not permitted, allowed, or authorized to sell Sandoz's Cisatracurium to NDOC and the other

Defendants, let alone for the purpose of an execution. Indeed, Sandoz had made clear in its public statements and company policies that it does not support the use of any of its drugs for off-label use in connection with lethal injection.

57. On information and belief, NDOC wrongfully took possession of Sandoz's Cisatracurium by tacitly misrepresenting that it would be used for a legitimate medical purpose.

58. In light of its clear and unambiguous communications and restrictions regarding the sale of its Cisatracurium, Sandoz is the rightful owner of Cisatracurium and has a present and immediate right of possession to said property.

59. Given Sandoz's consistent public statements and policies, recognized and acknowledged by the Nevada Assembly Judiciary Committee, Defendants were on actual and/or constructive notice that they could not purchase Sandoz's Cisatracurium directly from Sandoz and that Sandoz's distributors were not authorized to transfer Sandoz's Cisatracurium to Defendants for purposes of utilizing it in an execution. Thus, Defendants had actual and/or constructive notice that they could not in good faith acquire title to Sandoz's Cisatracurium. Hence, Sandoz's Cisatracurium is neither the property of NDOC nor the State of Nevada.

60. Sandoz has a specific interest in Sandoz's Cisatracurium that is in the possession of the NDOC because the NDOC intends to use Sandoz's property for the administration of capital punishment, in violation of Sandoz's policies and agreements between Sandoz and its distributors.

61. In its July 2018 letter, Sandoz specifically stated that it had imposed a system of distribution controls to prohibit the sale of its medicines to correctional facilities or otherwise for use in connection with lethal injection executions and that Defendants should immediately return the Sandoz Cisatracurium it purchased from Cardinal Health in exchange for a full refund.

62. In spite of said demand, Defendants have refused to return the Cisatracurium that they illicitly and improperly obtained.

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

63. Sandoz's Cisatracurium is approved by the FDA solely for the following therapeutic uses: as an adjunct to general anesthesia, to facilitate tracheal intubation, and to provide skeletal muscle relaxation during surgery or mechanical ventilation in the ICU. *See* Ex. 10.

64. Defendants have announced plans to utilize Sandoz's Cisatracurium for a purpose for which it is neither indicated nor intended to be used in Defendants' lethal injection protocol. Defendants' proposed use for Sandoz's Cisatracurium clearly runs counter to the FDA-approved indications for this product. While Sandoz takes no position on the death penalty itself, Sandoz's products were developed to save and improve patients' lives and their use in executions is fundamentally contrary to this purpose.

65. Sandoz has a property right in both its Cisatracurium and its right to deal – or refuse to deal – with particular prospective customers with respect to said drug, The Supreme Court of the United States long ago recognized the "right of [a] trader or manufacturer engaged in an entirely private business freely to exercise his own independent discretion as to parties with whom he will deal, and, of course, [to] announce in advance the circumstances under which he will refuse to sell." *United States v. Colgate & Co*., 250 U.S. 300, 307 (1919). Sandoz has exercised those rights both generally in its statements to the public and to prison officials and specifically in communications with Defendants. Thus, as set forth *supra*, Sandoz specifically wrote to the Nevada Department of Corrections (through the Warden at the prison at which the Execution is to take place) and the Nevada Attorney General to specifically warn them that they were customers with whom Sandoz refused to deal – both directly and indirectly – with regard to the acquisition of its Cisatracurium.

66. Defendants' actions are wrongful vis-à-vis Sandoz because, *inter alia*, they are inconsistent with Sandoz's property rights, they do not constitute the appropriate and therapeutic use for the Cisatracurium for a legitimate medical purpose, they are contrary to the therapeutic uses for which the drug can be utilized, and they risk grave harm to Sandoz's reputation and goodwill.

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

67. Because of Defendants' wrongdoing, Sandoz has suffered and continues to suffer injuries, including, but not limited to reputational injury arising out of (i) association with the manufacture of drugs used for executions, (ii) the corresponding damage to business and Investor relationships, (iii) damage to goodwill, and (iv) other irreparable harm to be proven at trial.

COUNT II: CONVERSION

68. Sandoz incorporates the preceding paragraphs as though fully set forth herein.

69. NDOC has undertaken a distinct act of dominion wrongfully exerted over Sandoz's personal property, Sandoz's Cisatracurium, in denial of, or inconsistent with its title or rights therein, or in derogation, exclusion, or defiance of such title or rights.

70. NDOC has dominion over Sandoz's Cisatracurium because NDOC is currently in possession of Sandoz's Cisatracurium.

71. Given Sandoz's unambiguous position and its public statements regarding its corporate policies, recognized and acknowledged by the Nevada Assembly Judiciary Committee, Defendants were on actual and/or constructive notice that they could not purchase Sandoz's Cisatracurium directly from Sandoz and that Sandoz's distributors were not authorized to transfer Sandoz's Cisatracurium to Defendants for purposes of utilizing it in an execution. Thus, Defendants had actual and/or constructive notice that they could not in good faith acquire title to Sandoz's Cisatracurium.

72. Sandoz has true right or title to Sandoz's Cisatracurium because, *inter alia,* they were sold without authorization, in direct contravention of Sandoz's stated policy of not selling its Cisatracurium, or any of its products, directly to Departments of Correction and other entities, and not allowing its distributors to sell Sandoz's Cisatracurium to customers for use in lethal injections, and in violation of Sandoz's fundamental property right to refuse to sell to Defendants (either directly or indirectly), and because Defendants illicitly obtained possession of said product.

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

73. NDOC's dominion is wrongfully exerted because NDOC knew or should have known of Sandoz's policy of not selling any of its products to Departments of Correction for use in carrying out lethal injections.

74. Defendants thereafter sought to circumvent Sandoz's policy by purchasing Sandoz's Cisatracurium through an unsuspecting intermediary and without disclosing to said intermediary the fact that they sought to obtain Sandoz's Cisatracurium for purposes of a non-therapeutic use *(i.e.,* an execution). Defendants were thus able to obtain Sandoz's Cisatracurium in a manner that they would not have been able to accomplish had they disclosed the contents of said letter and/or their intended non-therapeutic use of Sandoz's Cisatracurium to the intermediary.

75. Defendants received additional actual or constructive notice of Sandoz's policies when Sandoz notified Defendants directly through Sandoz's July 2018 Letter, that none of Sandoz's products could be used for lethal objection, and that it had controls in place to prevent Departments of Correction from using Sandoz products for capital punishment or sales to customers. Defendants were aware that their possession of Sandoz's Cisatracurium was unlawful. In its July 2018 Letter, Sandoz specifically demanded that Defendants immediately return to Sandoz its Cisatracurium intended for use in executions, and any other products which have been obtained for that purpose in exchange for a full refund.

76. In spite of said demand, Defendants have refused to return Sandoz's Cisatracurium that they improperly obtained.

77. Defendants have announced plans to utilize Sandoz's Cisatracurium for a purpose for which it is neither indicated nor intended to be used in Defendants' lethal injection protocol. Defendants' proposed use of Sandoz's Cisatracurium clearly runs counter to the FDA-approved indications for this product. While Sandoz takes no position on the death penalty itself, Sandoz's products were developed to save and improve patients' lives and their use in executions is fundamentally contrary to this purpose.

CAMPBELL & WILLIAMS
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700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

78. Sandoz has a property right in both its Cisatracurium and its right to deal – or refuse to deal – with particular prospective customers with respect to said drug. The Supreme Court of the United States long ago recognized the "right of [a] trader or manufacturer engaged in an entirely private business freely to exercise his own independent discretion as to parties with whom he will deal, and, of course, [to] announce in advance the circumstances under which he will refuse sell." *United States v. Colgate & Co.*, 250 U.S. 300, 307 (1919). Sandoz had exercised those rights both generally in its statements to the public and to prison officials and specifically in communications with Defendants. Thus, as set forth *supra*, Sandoz specifically wrote to NDOC and the Attorney General to specifically warn them that they were customers with whom Sandoz refused to deal – both directly and indirectly – with regard to the acquisition of Sandoz's Cisatracurium.

79. Defendants' actions are wrongful vis-à-vis Sandoz because, *inter alia*, they are inconsistent with Sandoz's property rights insofar as Defendants obtained Sandoz's products by defrauding Sandoz's distributor, they do not constitute the appropriate and therapeutic use for the Cisatracurium, they are contrary to the therapeutic uses for which the drug can be utilized, and they risk grave harm to Sandoz's reputation and goodwill.

80. Because of Defendants' wrongdoing, Sandoz has suffered and continues to suffer injuries, including, but not limited to reputational injury arising out of (i) association with the manufacture of drugs used for executions, (ii) the corresponding damage to business and investor relationships, (iii) damage to goodwill, and (iv) other irreparable harm to be proven at trial.

COUNT III: FALSE PRETENSES

81. Sandoz incorporates the preceding paragraphs as though fully set forth herein.

82. As set forth above, Defendants knew or should have known that the distributor was not permitted, allowed, or authorized to sell Sandoz's Cisatracurium to NDOC and the remaining Defendants, let alone for the purpose of an execution. Indeed, Sandoz had made clear in its public

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

statements and company policies that it does not support the use of any of its drugs for off-label use in connection with lethal injection.

83. Despite this awareness, Defendants intentionally defrauded Sandoz's distributor by, on information and belief, concealing the fact that Defendants intended to use Sandoz's Cisatracurium for purposes of an execution. In failing to disclose their intent to use Sandoz's Cisatracurium for purposes of an execution and proceeding to order the Cisatracurium, Defendants omitted relevant information and implicitly made the false representation that they had legitimate therapeutic rationale to purchase Sandoz's Cisatracurium.

84. Sandoz's distributor justifiably relied on the false pretense(s) because they had no reason to suspect that Defendants were not authorized to purchase Cisatracurium or that the Cisatracurium would not be used for a legitimate medical purpose.

85. Defendants were thus able to illicitly and through subterfuge obtain Sandoz's Cisatracurium by defrauding the intermediary, and in doing so, causing grave reputational harm to Sandoz.

86. Defendants have announced plans to utilize Sandoz's Cisatracurium for a purpose for which it is neither indicated nor intended to be used in Defendants' lethal injection protocol. Defendants' proposed use for Sandoz's Cisatracurium clearly runs counter to the FDA-approved indications for this product. While Sandoz takes no position on the death penalty itself, Sandoz's products were developed to save and improve patients' lives and their use in executions is fundamentally contrary to this purpose.

87. Defendants' actions are wrongful vis-à-vis Sandoz because, inter alia, they are inconsistent with Sandoz's property rights insofar as Defendants obtained Sandoz's products by defrauding Sandoz's distributor, they do not constitute the appropriate and therapeutic use for the Cisatracurium, they are contrary to the therapeutic uses for which the drug can be utilized, and they risk grave harm to Sandoz's reputation and goodwill.

88. Because of Defendants' wrongdoing, Sandoz has suffered and continues to suffer injuries, including, but not limited to reputational injury arising out of (i) association with the manufacture of drugs used for executions, (ii) the corresponding damage to business and investor relationships, (iii) damage to goodwill, and (iv) other irreparable harm to be proven at trial.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for relief as follows:

1. For a preliminary and permanent injunction precluding the use of any Sandoz drug, including Sandoz's Cisatracurium, in carrying out any capital punishment and further ordering NDOC to return immediately all Cisatracurium to Sandoz, as well as requiring an impoundment of all Cisatracurium possessed by Defendants pending a hearing on its status;

2. For declaratory relief as requested herein;

3. For an award of attorneys' fees and costs of suit as allowed by law; and

4. For such other and further relief as this Court deems appropriate under the circumstances,

DATED this ___ day of August, 2018

CAMPBELL & WILLIAMS

By: _____

J. Colby Williams, Esq. (5549)
Philip R. Erwin, Esq. (11563)
700 South Seventh Street
Las Vegas, NV 89101

PEPPER HAMILTON LLP

Noël B. Ix, Esquire (*pro hac vice to be submitted*)
301 Carnegie Center, Suite 400
Princeton, NJ 08540

Andrew Kantra, Esquire (*pro hac vice to be submitted*)
3000 Two Logan Square
Eighteenth and Arch Streets
Philadelphia, PA 19103
Attorneys for Intervenor

CAMPBELL & WILLIAMS
ATTORNEYS AT LAW
700 SOUTH SEVENTH STREET, LAS VEGAS, NEVADA 89101
Phone: 702.382.5222 • Fax: 702.382.0540
www.campbellandwilliams.com

EXHIBIT 1

The New York Times

Pfizer Blocks the Use of Its Drugs in Executions

By Erik Eckholm

May 13, 2016

The pharmaceutical giant Pfizer announced on Friday that it had imposed sweeping controls on the distribution of its products to ensure that none are used in lethal injections, a step that closes off the last remaining open-market source of drugs used in executions.

More than 20 American and European drug companies have already adopted such restrictions, citing either moral or business reasons. Nonetheless, the decision from one of the world's leading pharmaceutical manufacturers is seen as a milestone.

"With Pfizer's announcement, all F.D.A.-approved manufacturers of any potential execution drug have now blocked their sale for this purpose," said Maya Foa, who tracks drug companies for Reprieve, a London-based human rights advocacy group. "Executing states must now go underground if they want to get hold of medicines for use in lethal injection."

The obstacles to lethal injection have grown in the last five years as manufacturers, seeking to avoid association with executions, have barred the sale of their products to corrections agencies. Experiments with new drugs, a series of botched executions and covert efforts to obtain lethal chemicals have mired many states in court challenges.

The mounting difficulty in obtaining lethal drugs has already caused states to furtively scramble for supplies.

Some states have used straw buyers or tried to import drugs from abroad that are not approved by the Food and Drug Administration, only to see them seized by federal agents. Some have covertly bought supplies from loosely regulated compounding pharmacies while others, including Arizona, Oklahoma and Ohio, have delayed executions for months or longer because of drug shortages or legal issues tied to injection procedures.

A few states have adopted the electric chair, firing squad or gas chamber as an alternative if lethal drugs are not available. Since Utah chooses to have a death penalty, "we have to have a means of carrying it out," said State Representative Paul Ray as he argued last year for authorization of the firing squad.

Lawyers for condemned inmates have challenged the efforts of corrections officials to conceal how the drugs are obtained, saying this makes it impossible to know if they meet quality standards or might cause undue suffering.

"States are shrouding in secrecy aspects of what should be the most transparent government activity," said Ty Alper, associate director of the death penalty clinic at the University of California, Berkeley, School of Law.

Before Missouri put a prisoner to death on Wednesday, for example, it refused to say in court whether the lethal barbiturate it used, pentobarbital, was produced by a compounding pharmacy or a licensed manufacturer. Akorn, the only approved company making that drug, has tried to prevent its use in executions.

Pfizer's decision follows its acquisition last year of Hospira, a company that has made seven drugs used in executions including barbiturates, sedatives and agents that can cause paralysis or heart failure. Hospira had long tried to prevent diversion of its products to state prisons but had not succeeded; its products were used in a prolonged, apparently agonizing execution in Ohio in 2014, and are stockpiled by Arkansas, according to documents obtained by reporters.

Because these drugs are also distributed for normal medical use, there is no way to determine what share of the agents used in recent executions were produced by Hospira, or more recently, Pfizer.

Campaigns against the death penalty, and Europe's strong prohibitions on the export of execution drugs, have raised the stakes for pharmaceutical companies. But many, including Pfizer, say medical principles and business concerns have guided their policies.

"Pfizer makes its products to enhance and save the lives of the patients we serve," the company said in Friday's statement, and "strongly objects to the use of its products as lethal injections for capital punishment."

Pfizer said it would restrict the sale to selected wholesalers of seven products that could be used in executions. The distributors must certify that they will not resell the drugs to corrections departments and will be closely monitored.

David B. Muhlhausen, an expert on criminal justice at the Heritage Foundation, accused Pfizer and other drug companies of "caving in to special interest groups." He said that while the companies have a right to choose how their products are used, their efforts to curb sales for executions "are not actually in the public interest" because research shows, he believes, that the death penalty has a deterrent effect on crime.

Pressure on the drug companies has not only come from human rights groups. Trustees of the New York State pension fund, which is a major shareholder in Pfizer and many other producers, have used the threat of shareholder resolutions to push two other companies to impose controls and praised Pfizer for its new policy.

"A company in the business of healing people is putting its reputation at risk when it supplies drugs for executions," Thomas P. DiNapoli, the state comptroller, said in an email. "The company is also risking association with botched executions, which opens it to legal and financial damage."

Less than a decade ago, lethal injection was generally portrayed as a simple, humane way to put condemned prisoners to death. Virtually all executions used the same three-drug combination: sodium thiopental, a barbiturate, to render the inmate unconscious, followed by a paralytic and a heart-stopping drug.

In 2009, technical production problems, not the efforts of death-penalty opponents, forced the only federally approved factory that made sodium thiopental to close. That, plus more stringent export controls in Europe, set off a cascade of events that have bedeviled state corrections agencies ever since.

Many states have experimented with new drug combinations, sometimes with disastrous results, such as the prolonged execution of Joseph R. Wood III in Arizona in 2014, using the sedative midazolam. The state's executions are delayed as court challenges continue.

Under a new glaring spotlight, deficiencies in execution procedures and medical management have also been exposed. After winning a Supreme Court case last year for the right to execute Richard E. Glossip and others using midazolam, Oklahoma had to impose a stay only hours before Mr. Glossip's scheduled execution in September. Officials discovered they had obtained the wrong drug, and imposed a moratorium as a grand jury conducts an investigation.

A majority of the 32 states with the death penalty have imposed secrecy around their drug sources, saying that suppliers would face severe reprisals or even violence from death penalty opponents. In a court hearing this week, a Texas official argued that disclosing the identity of its pentobarbital source "creates a substantial threat of physical harm."

But others, noting the evidence that states are making covert drug purchases, see a different motive. "The secrecy is not designed to protect the manufacturers, it is designed to keep the manufacturers in the dark about misuse of their products," said Robert Dunham, executive director of the Death Penalty Information Center, a research group in Washington.

Georgia, Missouri and Texas have obtained pentobarbital from compounding pharmacies, which operate without normal F.D.A. oversight and are intended to help patients meet needs for otherwise unavailable medications.

But other states say they have been unable to find such suppliers.

Texas, too, is apparently hedging its bets. Last fall, shipments of sodium thiopental, ordered by Texas and Arizona from an unapproved source in India, were seized in airports by federal officials.

For a host of legal and political reasons as well as the scarcity of injection drugs, the number of executions has declined, to just 28 in 2015, compared with a recent peak of 98 in 1999, according to the Death Penalty Information Center.

A version of this article appears in print on May 13, 2016, on Page A1 of the New York edition with the headline: Pfizer Prohibits Use of Its Drugs for Executions

EXHIBIT 2

SANDOZ A Novartis Division

Sandoz Inc.
100 College Road West
Princeton, NJ 08540 USA
www.us.sandoz.com

Phone +1-609-627-8500

July 10, 2018

URGENT
VIA EMAIL & UPS

Governor Brian Sandoval
State Capitol Building
101 N. Carson Street
Carson City, NV 89701
Fax: 775-684-5670
C/O Chief of Staff, Mike Wilden; Special Assistant to the Governor, Christina Davis, (Email: cmdavis@gov.nv.gov)

Attorney General Adam Laxalt
Office of the Attorney General
100 North Carson Street
Carson City, NV 89701
Communications Director: Monica Moazez
Office of the Attorney General
Grant Sawyer Building
555 E. Washington Avenue, Suite 3900
Las Vegas, NJ 89010

Director James Dzurenda
Nevada Department of Corrections
3955 W. Russell Road
Las Vegas, NV 89118-2316
C/O Cynthia Keller, Assistant (Email: ckeller@doc.nv.gov)

Dear Governor Sandoval, Attorney General Laxalt, and Director Dzurenda:

It has been brought to our attention that in December of 2017, the State of Nevada Department of Corrections (NDOC) acquired quantities of the drug Cisatracurium from Cardinal Health, with the intention of using this product in a lethal injection execution scheduled for July 11, 2018.

Sandoz Inc. is an FDA-approved manufacturer of Cisatracurium for the US market. Sandoz, a division of Novartis, is a global leader in generic, biosimilar and other value added medicines which we develop, manufacture and distribute with the intention of saving and improving people's lives. We strongly object to the misuse of any of our medicines for purposes of lethal injection. Our products are developed, manufactured and distributed to help save and improve people's lives. Their use in connection with executions, many of which have gone horribly wrong in recent years, is fundamentally contrary to this purpose.

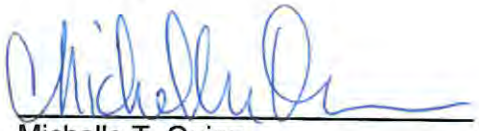
To ensure our products are not purchased for this purpose, Sandoz has imposed a system of strict distribution controls designed to prohibit the sale of its medicines to correctional facilities or otherwise for use in connection with lethal injection executions. These controls align with prevailing industry standards in the pharmaceutical sector and reflect our company's strict policy on ensuring the appropriate use of our medicines.

We write to communicate in the clearest possible terms that Sandoz objects to the misuse of Sandoz Cisatracurium or any other Sandoz product in the administration of capital punishment. We request the NDOC immediately return the Sandoz Cisatracurium that it purchased from Cardinal Health along with any other Sandoz products that Nevada may have obtained for use in lethal injection executions in exchange for a full refund.

Given the gravity and urgency of this matter, we respectfully request a reply to this letter no later than the close of business on July 11, 2018. We specifically do not waive and hereby reserve all of our rights to take necessary legal action to ensure the proper use of our medicines.

We look forward to receiving your response.

Sincerely,



Michelle T. Quinn
Vice President, General Counsel, North America
Sandoz Inc.

Cc: Carol Lynch
President, Sandoz US, Head, North America
Kate Kulesher Jarecke
Director State Government Affairs

EXHIBIT 3

HEALTH NEWS FEBRUARY 10, 2011 / 1:27 PM / 7 YEARS AGO

Novartis moves to stop execution drug reaching U.S.

Katie Reid

3 MIN READ

ZURICH (Reuters) - Novartis and its Sandoz unit, maker of a generic version of an anesthetic used in lethal injections in the United States, have taken steps to try to stop the drug ending up in the United States.

People walk past the logo of Swiss drugmaker Novartis at the company's plant in Basel January 28, 2009.
REUTERS/Arnd Wiegmann

"Sandoz has also advised all of its subsidiaries with locally approved marketing authorizations for sodium thiopental to not sell the product to distributors or third parties that may be selling it into the U.S.," Novartis and Sandoz said in a statement.

Last month, U.S. specialty medicines maker Hospira Inc said it was halting its production of sodium thiopental as it did not want it to be used in executions.

Hospira said it was planning to shift production to its plant in Liscate, Italy, but the Italian parliament will only allow the drug to be made there if Hospira can guarantee that it will not be used in capital punishment.

Italy is a member of the European Union, which has banned the death penalty and criticized the United States for allowing it.

"Sandoz and Novartis support only the authorized use of injectable thiopental, which is primarily indicated for the induction of anesthesia, and do not support the sale of this or any product for use in non-approved treatments," Novartis and Sandoz said in a statement.

Sandoz makes injectable thiopental under contract for a third party located in the UK, which sells it directly to Archimedes Pharma.

The British group is responsible for the product's marketing and commercial supply under its respective UK marketing authorization, Novartis and Sandoz said in the statement.

Novartis and Sandoz also said Sandoz does not market the drug in the United States or ship or sell directly to any third party selling this product into the United States.

Archimedes has never exported the product directly into the United States, Deborah Saw, a spokeswoman for the group said.

It sells the drug to a distributor, which then sells it to hospital pharmacies, primarily in Britain's National Health Service, and also to other wholesalers. Archimedes does not have information on specific end-purchasers or users of its products, she said.

Sandoz and Novartis also said Sandoz was not aware of, and not able to monitor or control, the supply chain beyond its own direct customers, as it was not responsible or involved in the marketing and commercial activities of third parties.

Last November, activists sued the British government to stop the export of the drug used in capital punishment in the United States, but Business Secretary Vince Cable said he would not issue a ban because the drug can be used for legitimate purposes.

Sodium thiopental, a sedative legally required for U.S. lethal injections, is in short supply in the United States, and at least one U.S. state has already turned to Britain to fill the gap.

Our Standards: *The Thomson Reuters Trust Principles.*

FILE PHOTO: The headquarters of the European Medicines Agency (EMA), is seen in London, Britain, April 25, 2017. REUTERS/Hannah McKay/File Photo

The alarm over valsartan was first raised in July, prompting a global recall of affected pills. The EMA believes the problem likely dates back to changes in manufacturing processes at Zhejiang Huahai Pharmaceutical in 2012.

In an update on its investigation issued on Thursday, the European drugs watchdog said its one-in-5,000 risk assessment was based on patients taking the highest valsartan dose every day for seven years.

NDMA, or N-nitrosodimethylamine, is classified as a probable human carcinogen. Based on results from laboratory tests, it may cause cancer with long-term use.

Reporting by Ben Hirschler; Editing by Susan Fenton

Our Standards: *The Thomson Reuters Trust Principles.*

HEALTH NEWS AUGUST 2, 2018 / 8:22 AM / UPDATED 7 HOURS AGO

Celtaxsys cystic fibrosis drug reduces key symptom in mid-stage study

Tamara Mathias

2 MIN READ

(Reuters) - Privately held Celtaxsys Inc said on Thursday a mid-stage trial testing its experimental cystic fibrosis treatment was successful in reducing a key symptom of the genetic lung disease, but did not improve lung function.

There are few treatment options for the 70,000 cystic fibrosis patients worldwide, who rarely live beyond 40 and possess a defective gene that leads to the build-up of thick mucus which clogs the lungs and other organs, often triggering inflammation.

The company is considering private financing, a public offering and possible financial support from the Cystic Fibrosis Foundation ahead of a late-stage study set for the second half of 2019, Chief Executive Officer Greg Duncan told Reuters.

The drug, acebilustat, reduced pulmonary exacerbations, or an acute worsening of symptoms, by 34 percent in patients with a mild form of the disease, which represent an estimated three-quarters of the total affected population, Celtaxsys said.

However, after 48 weeks, patients on the anti-inflammation treatment did not show a difference in lung function versus those on placebo.

A regulatory approval is contingent on proving the treatment's effectiveness in either reducing pulmonary exacerbations or improving lung function and the next trial is likely to focus on the former, the Atlanta-based biotech company said.

The Cystic Fibrosis Foundation contributed $8 million to Celtaxsys' mid-stage study, which tested two doses of the once-a-day oral medicine in 200 patients.

Currently, Vertex Pharmaceuticals Inc is considered the leader in developing treatments for cystic fibrosis and has three approved drugs on the market.

Reporting by Tamara Mathias in Bengaluru; Editing by Bernard Orr

Our Standards: *The Thomson Reuters Trust Principles.*

EXHIBIT 4

SANDOZ

AMENDMENT TO CARDINAL HEALTH GENERICE WHOLESALE SERVICE AGREEMENT

This amendment ("Amendment") to the July 1, 2006, Cardinal Health Generic Wholesale Service Agreement ("GWSA"), and any other existing amendments and addenda thereto (collectively, the "Agreement") is entered into and made effective on December 10, 2013 ("Effective Date"), by and between Cardinal Health (as defined below in the signature block), 7000 Cardinal Place, Dublin, OH 43017 ("Customer" or "Cardinal"), and Sandoz Inc., 506 Carnegie Center, Suite 400, Princeton, NJ 08540 ("SI") on behalf of itself and Eon Labs, Inc., and Fougera Pharmaceuticals Inc.

WHEREAS, SI offers the product Rocuronium Bromide for sale to Customer;

WHEREAS, SI desires to amend this GWSA to require certain restrictions, as set forth below, on the sale and distribution of the product Rocuronium Bromide;

NOW THEREFORE, for and in consideration of the mutual covenants and agreements contained herein, the parties agree to be legally bound as follows:

1. Customer acknowledges and agrees that as of the Effective Date, Customer shall not offer for sale or distribute Rocuronium Bromide, listed in Table A below, to the United State prison hospitals, which includes all state and federal prisons.

Table A

NDC	Product	Size	U/M
781322092	ROCURONIUM BR IJ 100MG/10ML 10	10	VL
781322095	ROCURONIUM BR IJ 50MG/5ML 10X5	10	VL

1. **Counterparts:** This Amendment may be executed in any number of counterparts, each of which shall be deemed to be an original, and all of which together shall be deemed to be one and the same instrument

2. **Entire Agreement; Amendment:** This Amendment incorporates all terms, conditions, rights and obligations set forth in the Agreement. Capitalized terms used herein and not otherwise defined shall have the meaning assigned to them in the Agreement and, except as modified hereby, all terms and conditions of the Agreement shall remain in full force and effect. For the sake of clarity, in the event of a conflict between a term contained in this Amendment and a term contained in the Agreement, the term contained in this Amendment shall prevail.

IN WITNESS WHEREOF the parties have caused this Amendment, its Exhibits, Attachments and Schedules, to be executed by their duly authorized officers or representatives.

SANDOZ INC

By: _____
Name: Dave Picard
Title: VP, US Generics Operating Unit
Date: 12/20/2013

CARDINAL HEALTH**

By: _____
Name: CEMG COUNSEL
Title: SVP, SOURCING
Date: 12/19/13

*Please sign and return two original copies of this Amendment to Sandoz Inc., Attention: Contract and Pricing Department, 506 Carnegie Center, Suite 400, and Princeton, NJ 08540. Upon countersignature, a fully executed copy will be returned.

**The term "Cardinal Health" or "Cardinal" will include the following affiliated operating companies: Cardinal Health 113, Inc.; Cardinal Health 110, Inc.; Cardinal Health 100, Inc.; Cardinal Health 104, LP.; Cardinal Health 107, Inc.; Cardinal Health 3, Inc.; and any other subsidiary of Cardinal Health, Inc., an Ohio corporation ("CHI"), as may be designated by CHI.

EXHIBIT 5

EXECUTION VERSION

CONTROLLED DISTRIBUTION PROGRAM

AMENDMENT TO

GENERIC WHOLESALE SERVICE AGREEMENT

This Controlled Distribution Program Amendment ("**Amendment**") to the Generic Wholesale Service Agreement by and between Sandoz Inc. ("**Supplier**") and Cardinal Health* ("**Cardinal Health**") dated July 1, 2006 as amended (referenced internally by Supplier as Contract #22745 for convenience only) (the "**Agreement**") is made effective as of August 28, 2017 ("**Amendment Effective Date**"). Supplier and Cardinal Health may be hereinafter referred to collectively as the "**Parties**" and individually as a "**Party**".

RECITALS

WHEREAS, Cardinal and Supplier are Parties to the Agreement;

WHEREAS, the Parties desire to amend the Agreement as provided in this Amendment;

NOW, THEREFORE, in consideration of the foregoing recitals and the mutual covenants and agreements contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are mutually acknowledged, the Parties agree to be legally bound as follows:

1. The Amendment to the Agreement by and between Supplier and Cardinal Health with the Effective Date of December 10, 2013 related to the sale and distribution of Rocuronium Bromide is hereby deleted from the Agreement in its entirety.

2. The Amendment to the Agreement by and between Supplier and Cardinal Health with the Effective Date of March 1, 2014 related to the sale and distribution of Rocuronium Bromide is hereby deleted from the Agreement in its entirety.

3. The following paragraph is hereby added to the end of Section 1 of the Agreement, creating a new Section 1.a. as follows:

"1.a. Controlled Distribution Products. Cardinal Health acknowledges and agrees that as of the Amendment Effective Date; Cardinal Health shall not sell, offer to sell or distribute the Rocuronium Bromide or Anectine Products listed in Exhibit 1, attached hereto ("**Controlled Distribution Products**") to: 1) any United States prison hospital, which shall include all State and Federal Prisons in the U.S. (and its commonwealths, territories, possessions, and military bases) (collectively "**U.S. Prison Hospital**"), 2) to any of its customers, affiliates or any other third party that is acquiring Rocuronium Bromide or Anectine Products for use for further distribution in any U.S. Prison Hospital or 3) to any retailer, wholesaler or distributor, in each case unless such customer is an Eligible Customer approved in advance in writing by Sandoz as set forth herein. Cardinal Health shall only be permitted to sell, offer to sell or distribute Rocuronium Bromide or Anectine Products to Eligible Customers (defined below)."

4. The following paragraph is hereby added to the end of Section 1 of the Agreement, creating a new Section 1.b. as follows:

"1.b.i. Eligible Customers. For purposes of this Agreement, Eligible Customers means customers of Cardinal Health that Supplier has determined in its sole discretion are eligible to purchase Controlled Distribution Products pursuant to the terms of this Agreement ("**Eligible Customers**"). The initial Eligible Customer list shall be added to this Agreement as Exhibit 3. The Eligible Customer list may be amended from time to time pursuant to Section 1.b.ii. below.

1.b.ii. Amendments to Eligible Customer List. In the event Cardinal Health receives a request from one of its customers for inclusion on the Eligible Customer list, Cardinal Health will communicate this request to Supplier via email. Supplier shall within 10 days confirm, via email, whether the customer will be approved

for inclusion as an Eligible Customer and will update the Eligible Customer list to reflect such change. Supplier may, at its sole discretion, remove an Eligible Customer from the Eligible Customer list at any time by notifying Cardinal Health via email."

5. The following paragraph is hereby added to the end of Section 1 of the Agreement, creating a new Section 1.c. as follows:

"Cardinal Health agrees to provide Controlled Distribution Program Services as described in Exhibit 2, Controlled Distribution Program Schedule attached hereto in exchange for the Controlled Distribution Program Service Fees described in Exhibit 2."

6. Supplier shall make the Controlled Distribution Products listed in Exhibit 1 attached hereto available for purchase by Cardinal Health in accordance with the terms of this Agreement.

7. ***No Other Changes.*** Except as specifically set forth in this Amendment, the Agreement will continue in full force and effect without change.

8. ***Interpretation.*** To the extent there are any inconsistencies between the provisions of this Amendment and the provisions of the Agreement, the provisions of this Amendment will control. Capitalized terms not otherwise defined herein shall have the same meaning given those terms in the Agreement, it being the intent of the Parties that the Agreement and this Amendment will be applied and construed as a single instrument. The Agreement, as modified by this Amendment, constitutes the entire agreement between Supplier and Cardinal regarding the subject matter of this Amendment and supersedes all prior or contemporaneous writings and understandings between the Parties regarding the same.

9. ***Authorized Signatories.*** All signatories to this Amendment represent that they are authorized by their respective companies to execute and deliver this Amendment on behalf of their respective companies, and to bind such companies to the terms herein.

Sandoz Inc.

By: Robert Spina

Print Name:

Title: VP Pricing & Contracts

Address of Supplier:
100 College Road West
Princeton, New Jersey 08540

Cardinal Health*

By:

Print Name: Melissa Laber

Title: SVP, Global Sourcing

Address of Cardinal Health:
Attention: SVP – Generic Sourcing
7000 Cardinal Health Place
Dublin, Ohio 43017

*The term "Cardinal" or "Cardinal Health" means Cardinal Health 3, LLC; Cardinal Health 104 LP; Cardinal Health 107, Inc.; Cardinal Health 110, LLC; Cardinal Health 112, LLC; Cardinal Health 411, Inc.; Cardinal Health PR 120, Inc.; Parmed Pharmaceuticals, Inc., Kinray, Inc. Dik Drug Company, LLC and any other affiliate of Cardinal Health, Inc., an Ohio corporation ("CHI"), as may be designated by CHI.

EXHIBIT 1

Controlled Distribution Products

NDC	Product	Size	U/M
781322092	ROCURONIUM BR IJ 100MG/10ML 10	10	VL
781322095	ROCURONIUM BR IJ 50MG/5ML 10X5	10	VL
781341195	ANECTINE (Succinylcholine) 200MG/10ML 10LIVI US	10	VL

EXHIBIT 2

CONTROLLED DISTRIBUTION PROGRAM SCHEDULE

1. Services. In consideration for the Service Fees described in this Controlled Distribution Program Schedule, Cardinal Health will provide the following services (collectively, the "**Controlled Distribution Program Services**"):

a) on a weekly basis submit to Supplier a list of its customers including customer class of trade designation as determined by Cardinal Health, DEA, address, and full customer name that Cardinal Health requests to add to the Eligible Customer list
b) order blocking/ restriction of sales to Ineligible Customers
c) customer facing communication outlining customer eligibility
d) monthly auditing of Eligible Customers and Ineligible Customers
e) restrict sales of Controlled Distribution Products to all U.S. Prison Hospitals, any retailer, wholesaler or distributor.

2. Supplier Obligations. In order to ensure that Cardinal Health is performing the Controlled Distribution Program Services as agreed by the Parties, Supplier agrees to:

a) on a weekly basis, review list of customers that Cardinal Health has identified as eligible to purchase Controlled Distribution Products and determine in its sole discretion which of such customers shall be deemed Eligible Customers
b) provide customer facing communication outlining Controlled Distribution Product distribution process to Sandoz contracted customers serviced through Cardinal Health
c) communicate Controlled Distribution Product additions and/or deletions
d) provide Supplier contact information to address customer specific classification inquiries
e) provide timely response to inquiries regarding Eligibility

3. Products subject to the Controlled Distribution Program Services. Cardinal Health will perform the Controlled Distribution Program Services with respect to the following Controlled Distribution Products:

a) ROCURONIUM BR IJ 100MG/10ML 10
b) ROCURONIUM BR IJ 50MG/5ML 10X5
c) ANECTINE (Succinylcholine) 200MG/10ML 10LIVI US

4. Service Fees. In consideration for the Controlled Distribution Program Services, Supplier will pay Cardinal Health a service fee as follows (the "**Controlled Distribution Program Service Fees**"):

a) Controlled Distribution Program Service Fee
Cardinal Health will be entitled to a Controlled Distribution Program Service Fee of 1.5% on the Net Sales of Controlled Distribution Products under this Agreement. The Controlled Distribution Program Service Fee will not exceed $100,000 during any calendar year.

5. Definitions.

a) "**Ineligible Customers**" means those customers that not eligible to purchase Controlled Distribution Products.

b) "**Net Sales**" means the total number of net units of Controlled Distribution Product sold by Cardinal Health multiplied by the Supplier contract cost (or WAC if sold other than pursuant to a contract cost) at the time of each sale. The total number of net units will include all units sold by Cardinal Health less units returned from Cardinal Health customers (including recalls), customary sales

discounts, product specific rebates and credits actually allowed by Supplier (excluding third party returns). The "time of each sale" means the date on which the Controlled Distribution Product is shipped from Cardinal Health to the customer. Net Sales shall be determined utilizing Supplier's chargeback and tracking systems. Payment of the Controlled Distribution Program Service Fee shall be 45 days after the end of the applicable calendar quarter.

EXHIBIT 3

ELIGIBLE CUSTOMERS

(See Attached)

EXHIBIT 3
ELIGIBLE CUSTOMERS

IDN Name	DEA #	Restricted Use Signature Date	Wholesaler	Address	City	ST	Est Vial Usage (annual)
BJC Health -Alton Memorial Hospital	AA9761322	7/17/2017	Cardinal	One Memorial Drive	St. Louis	MO	15,325
CH Allied Services, dba Boone Hospital Center	BB1599971	7/17/2017	Cardinal	1600 East Broadway	Columbia	MO	
Christian Hospital Northeast – Northwest	AC6583872	7/17/2017	Cardinal	11133 Dunn Road	Louis	MO	
Barnes-Jewish Hospital	BB4745785	7/17/2017	Cardinal	216 S. Kingshighway	Louis	MO	
Parkland Health Center–Bonne Terre	BP3541554	7/17/2017	Cardinal	7245 Raider Road	Bonne Terre	MO	
Barnes-Jewish St. Peters Hospital, Inc.	BS4747664	7/17/2017	Cardinal	10 Hospital Drive	Peters	MO	
Parkland Health Center-Farmington	BF3428996	7/17/2017	Cardinal	1101 West Liberty	Farmington	MO	
Missouri Baptist Hospital of Sullivan, dba Missouri Baptist	BM1186053	7/17/2017	Cardinal	751 Sappington Bridge Road P.O. Box 190	Sullivan	MO	
Barnes-Jewish West County Hospital	BB2062305	7/17/2017	Cardinal	12634 Olive Blvd.	Louis	MO	
Parkland Health - Weber Road	FP5286023	7/17/2017	Cardinal	1212 Weber Road	Farmington	MO	
Missouri Baptist Medical Center	AM3965982	7/17/2017	Cardinal	3015 N. Ballas Road	Louis	MO	
St. Louis Children's Hospital	AS3835571	7/17/2017	Cardinal	One Children's Place	Louis	MO	
Progress West HealthCare Center, dba Progress West Hos	FP0051818	7/17/2017	Cardinal	Two Progress Point	O'Fallon	MO	
Protestant Memorial Medical Center, Inc, dba		7/17/2017	Cardinal	4500 Memorial Drive	Belleville	IL	
Memorial East		7/17/2017	Cardinal	1404 Cross Street	Shiloh	IL	
Childrens Hospital LA	RC0276495	7/20/2017	Cardinal	5650 Sunset Blvd	Los Angeles	CA	1925
Connecticut Children's Medical Center	AN1580489	7/21/2017	Cardinal	282 Washington Street	Hartford	CT	450
Excela Health		7/21/2017	Cardinal		Greensburg	PA	5950
SUNY Upstate Medical University	AS0552489	7/21/2017	Cardinal	750 East Adams Street	Syracuse	NY	3475
The Mount Sinai Medical Center	AM9707805	7/21/2017	Cardinal	1 GUSTAVE L. LEVY PL BOX 1211	New York	NY	39875
UCHealth - Medical Center of the Rockies	FM0091392	7/21/2017	Cardinal	2500 Rocky Mountain Ave	Loveland	CO	11300
UCHealth - Poudre Valley Hospital	BP4078603	7/21/2017	Cardinal	1024 S Lemay Ave	Fort Collins	CO	
UCHealth - Longs Peak Hopsital	FL6873954	7/21/2017	Cardinal	1750 E Ken Pratt Blvd	Longmont	CO	
Upstate University Hospital at Community General	FU2889319	7/22/2017	Cardinal	4900 Broad Road	Syracuse	NY	
The Mount Sinai Hospital	BT6411487	7/22/2017	Cardinal	25-10 30th Ave	Long Island City	NY	
Beth Israel Medical Center Inc, DBA Mount Sinai Beth Israe	AB1876296	7/23/2017	Cardinal	First Avenue at 16th Street	New York	NY	
Beth Israel Medical Center, DBA Beth Israel West	FB2035360	7/24/2017	Cardinal	325 West 15th Street	New York	NY	
Boulder Foothills Community Hospital	BB8389555	7/24/2017	Cardinal	4747 Arapahoe Ave	Boulder	CO	2700
Indiana University Health - West Hospital	BC8874655	7/24/2017	Cardinal	1111 Ronald Reagan Pkwy	Avon	IN	16629
Indiana University Health - Bedford Hospital	AE2715944	7/24/2017	Cardinal	2900 16th Street	Bedford	IN	
Indiana University Health - Bloomington Hospital	AB2687284	7/24/2017	Cardinal	601 W. 2nd Street	Bloomington	IN	
Indiana University Health - Oncology Bloomington	FI5682352	7/24/2017	Cardinal	1000 West 1st Street	Bloomington	IN	
Indiana University Health - North Hospital	BC9421443	7/24/2017	Cardinal	11700 N. Meridian Street	Carmel	IN	
Indiana University Health - Central Indiana Cancer Center	BG1303990	7/24/2017	Cardinal	11725 North Illinois Street	Carmel	IN	
Indiana University Health - Saxony Hospital	FI2888115	7/24/2017	Cardinal	13100 E. 136th Street, Suite 1000	Fishers	IN	
Indiana University Health - Central Indiana Cancer Center	AL9663320	7/24/2017	Cardinal	10212 Lantern Drive	Fishers	IN	
Indiana University Health - Blackford Hospital	BB7808580	7/24/2017	Cardinal	410 Pilgrim Blvd	Hartford City	IN	
Indiana University Health - University Medical Center	BC5175561	7/24/2017	Cardinal	550 University Blvd	Indianapolis	IN	
Indiana University Health - Methodist Hospital	BC5175535	7/24/2017	Cardinal	1701 N. Senate Blvd	Indianapolis	IN	
Indiana University Health - Riley Children's Hospital	BC5175511	7/24/2017	Cardinal	705 Riley Hospital Drive	Indianapolis	IN	
Rehabilitation Hospital of Indiana	BR3014090	7/24/2017	Cardinal	4141 Shore Drive	Indianapolis	IN	
Indiana University Health - Arnett Cancer Center	FC2306721	7/24/2017	Cardinal	420 North 26th Street	Lafayette	IN	
Indiana University Health - Arnett	FC1113618	7/24/2017	Cardinal	5165 McCarty Lane	Lafayette	IN	
Indiana University Health - Morgan Hospital	FI5116682	7/24/2017	Cardinal	2209 John R Wooden Drive	Martinsville	IN	
Indiana University Health - White Meml Hospital	FI2576481	7/24/2017	Cardinal	720 S. 6th Street	Monticello	IN	
Indiana University Health - Ball Meml Hosp Inc	AB2645464	7/24/2017	Cardinal	2401 W. University Ave	Muncie	IN	
Indiana University Health - Ball Meml CC at Forest Ridge N	FI5438571	7/24/2017	Cardinal	2200 Forest Ridge Parkway	New Castle	IN	
Indiana University Health - Tipton Hospital	FT1196511	7/24/2017	Cardinal	1000 S. Main Street	Tipton	IN	
Indiana University Health - Ball CC at Jay County Hospital	FI5438987	7/24/2017	Cardinal	500 West Votaw Street	Portland	IN	
Indiana University Health - Arnett Health Horizon Oncolog	FC2306707	7/24/2017	Cardinal	1345 Unity Place	Lafayette	IN	
Indiana University Health - Paoli	BB6659001	7/24/2017	Cardinal	642 W. Hospital Road	Paoli	IN	
Indiana University Health - Indiana Cancer Center East	BA3B76438	7/24/2017	Cardinal	6845 Rama Drive	Indianapolis	IN	
Northwell Health - Forest Hills Hospital	AH0772548	7/24/2017	Cardinal	102-01 66th Road	Forest Hills	NY	68275
Franklin Hospital	AF5712509	7/24/2017	Cardinal	900 Franklin Ave	Valley Stream	NY	
Glen Cove Hospital	AC0783767	7/24/2017	Cardinal	101 St. Andrew's Lane	Glen Cove	NY	
Hillside Hospital/LIJMC	AL5146584	7/24/2017	Cardinal	75-79 263rd St	Glen Oaks	NY	
Huntington Hospital Association	AH0768296	7/24/2017	Cardinal	270 Park Avenue	Huntington	NY	
Lenox Hill Hospital	AL4088604	7/24/2017	Cardinal	100 East 77th St	New York	NY	
Lenox Hill Hospital	FL1071276	7/24/2017	Cardinal	210 East 64th St	New York	NY	
Lenox Hill Hospital Center for Comp Care	FN4611352	7/24/2017	Cardinal	30 Seventh Avenue	New York	NY	
LI Jewish/Schneider	FS4063183	7/24/2017	Cardinal	269-01 76th Ave	New Hyde Park	NY	
LI Jewish Medical Center	AL4849622	7/24/2017	Cardinal	270-05 76th Ave	New Hyde Park	NY	
Northern Westchester	AN1797692	7/24/2017	Cardinal	400 East Main St	Mount Kisco	NY	
NSU Hospital at Manhasset	AN0768917	7/24/2017	Cardinal	300 Community Drive	Manhasset	NY	
NSU Hospital at Plainview	BN4665723	7/24/2017	Cardinal	888 Old Country Road	Plainview	NY	
NSU Hospital at Syosset	BN5716545	7/24/2017	Cardinal	221 Jericho Turnpike	Syosset	NY	
Peconic Bay	BC9945570	7/24/2017	Cardinal	1300 Roanoke Ave	Riverhead	NY	
Phelps Memorial	AP1856423	7/24/2017	Cardinal	701 North Broadway, Rt 9 at Rt 117	Sleepy Hollow	NY	
South Oaks	BW6497487	7/24/2017	Cardinal	400 Sunrise Highway	Amityville	NY	
Southside Hospital RT9-42	AS0779441	7/24/2017	Cardinal	301 E. Main Street	Bayshore	NY	
Staten Island University Hospital North	AT8512966	7/24/2017	Cardinal	475 Seaview Ave	Staten Island	NY	
Staten Island University Hospital South	AR1858692	7/24/2017	Cardinal	375 Seguine Ave	Staten Island	NY	
Stamford Hospital	AS2383278	7/24/2017	Cardinal	190 WEST BROAD STREET	Stamford	NY	1425
Strong Memorial Hospital	AU4158033	7/24/2017	Cardinal	601 Elmwood Avenue	Rochester	NY	23075
Highland Hospital	AH3279432	7/24/2017	Cardinal	1000 South Avenue	Rochester	NY	
Thompson Health	AF4442163	7/24/2017	Cardinal	350 Parrish Street	Canandaigua	NY	
Wyoming County Community Health System	AW6814126	7/24/2017	Cardinal	400 North Main Street	Warsaw	NY	
Yampa Valley Medical Center	AR0844969	7/24/2017	Cardinal	1024 CENTRAL PARK DRIVE	Steamboat Springs	CO	550
Beth Israel Medical Center, Phillips AMB Care Center	BB4708915	7/25/2017	Cardinal	10 Union Square East	New York	NY	
Noyes Hospital		7/25/2017	Cardinal		Dansville	NY	200
RWJ Barnabas Health - St. Barnabas Medical Center	AS2593778	7/25/2017	Cardinal	95 Old Short Hills Road	West Orange	NJ	32050
Community Medical Center	AC1544659	7/25/2017	Cardinal	99 Highway 37 West	Toms River	NJ	
Monmouth Medical Center South Campus	AP3480249	7/25/2017	Cardinal	600 River Avenue	Lakewood	NJ	
Monmouth Medical Center	AC0663319	7/25/2017	Cardinal	300 Second Ave	Long Branch	NJ	
Clara Mass Medical Center	AC0663319	7/25/2017	Cardinal	1 Clara Mass Drive	Belleville	NJ	
Newark Beth Israel Medical Center	AN1534292	7/25/2017	Cardinal	201 Lyons Ave at Osborne Terrace	Newark	NJ	
Jersey City Medical Center	AM4184115	7/25/2017	Cardinal	355 Grand Street	Jersey City	NJ	
Robert Wood Johnson University Hospital	BR0611738	7/25/2017	Cardinal	One Robert Wood Johnson Place	New Brunswick	NJ	
Robert Wood Johnson University Hospital Hamilton	AH4698241	7/25/2017	Cardinal	One Hamilton Health Place	Hamilton	NJ	
Robert Wood Johnson Somerset Medical Center	FR4522822	7/25/2017	Cardinal	110 Rehill Ave	Somerville	NJ	
Robert Wood Johnson Rahway Hospital	AR3479638	7/25/2017	Cardinal	865 Stone Street	Rahway	NJ	

EXHIBIT 3
ELIGIBLE CUSTOMERS

Children's Specialized Hospital	FC0567377	7/25/2017	Cardinal	200 Somerset Street	New Brunswick	NJ	
Barnabas Health Behavioral Health Center	BS3935507	7/25/2017	Cardinal	1691 State Highway #9	Toms River	NJ	
Qualitas Pharmacy Services	BL6510110	7/25/2017	Cardinal	603 Montrose Ave	South Plainfield	NJ	
St. Lukes Cornwall		7/25/2017	Cardinal		Buffalo	NY	1775
Summa Barberton Hospital	FB0673815	7/25/2017	Cardinal	115 Fifth Street NE	Barberton	OH	1525
Summa Akron City Hospital	FA2999017	7/25/2017	Cardinal	525 East Market Street	Akron	OH	
Beth Israel Medical Center, DBA Mount Sinai Brooklyn	AK0778792	7/26/2017	Cardinal	3201 Kings Highway	Brooklyn	NY	
Alice Hyde Medical Center	AH3520269	7/26/2017	Cardinal	113 Park Street	Malone	NY	200
Good Samaritan Hospital	BH4534041	7/26/2017	Cardinal	616 S. WITMER ST	Los Angeles	CA	1625
Harbor UCLA Medical Center		7/26/2017	Cardinal		Torrance	CA	2800
Los Angeles County Medical Center		7/26/2017	Cardinal	1100 N Mission Road	Los Angeles	CA	2525
Methodist Hospital	AM0287309	7/26/2017	Cardinal	300 HUNTINGTON DRIVE	Arcadia	CA	1850
Olive View UCLA Medical Center		7/26/2017	Cardinal		Sylmar	CA	3350
Rancho Los Amigos Rehab Center		7/26/2017	Cardinal		Downey	CA	175
NY Eye & Ear Infirmary, DBA NYEEI of Mount Sinai	AT1859658	7/27/2017	Cardinal	310 E. 14th Street	New York	NY	
Finger Lakes Health - Geneva General	AG0552617	7/27/2017	Cardinal	196 North Street	Geneva	NY	1175
Finger Lakes Health - Soldiers and Sailors Memorial Hospit	AS0514009	7/27/2017	Cardinal	418 North Main Street	Penn Yan	NY	
Harrington Healthcare	AH4691285	7/27/2017	Cardinal	100 South Street	Southbridge	MA	200
Kettering Health Network - Kettering Memorial Hospital	AC2822890	7/27/2017	Cardinal	3535 Southern Blvd.	Kettering	OH	10275
Sycamore Hospital	AK8995524	7/27/2017	Cardinal	4000 Miamisburg-Centerville Rd	Miamisburg	OH	
Grandview Hospital	AG2820579	7/27/2017	Cardinal	405 W. Grand Ave.	Dayton	OH	
Southview Hospital & Family Health Center	AS2141187	7/27/2017	Cardinal	1997 Miamisburg-Centerville Rd.	Miamisburg	OH	
Greene Memorial Hospital	AG2818966	7/27/2017	Cardinal	1141 North Monroe Drive	Xenia	OH	
Fort Hamilton Hospital	AF2802583	7/27/2017	Cardinal	630 Eaton Avenue	Hamilton	OH	
Soin Medical Center	FS2805290	7/27/2017	Cardinal	3535 Pentagon Blvd.	Beavercreek	OH	
Marshall Medical Center	AM2105701	7/27/2017	Cardinal	1100 Marshall Way	Placerville	CA	1125
St. Luke's Roosevelt Hospital Center, DBA Mount Sinai We	AS9148277	7/28/2017	Cardinal	1000 Tenth Avenue	New York	NY	
Boca Raton Regional Medical Center	AB0210788	7/28/2017	Cardinal	800 Meadows Road	Boca Raton	FL	7225
Norton Hospital	AN3011791	7/28/2017	Cardinal	200 E. Chestnut St.	Louisville	KY	31800
Norton Children's Hospital	FN0075021	7/28/2017	Cardinal	231 E. Chestnut St.	Louisville	KY	
Norton Audubon Hospital	BA5991864	7/28/2017	Cardinal	1 Audubon Plaza Dr.	Louisville	KY	
Norton Brownsboro Hospital	FN1392721	7/28/2017	Cardinal	4950 Norton Healthcare Blvd	Louisville	KY	
Norton St. Matthews Hospital	BA5995076	7/28/2017	Cardinal	4001 Dutchmans Lane	Louisville	KY	
Ochsner Clinic Foundation/Ochsner Medical Center	AO3399424	7/28/2017	Cardinal	1514 Jefferson Hwy	New Orleans	LA	27775
Ochsner Baptist	FO4101111	7/28/2017	Cardinal	2700 Napoleon Ave	New Orleans	LA	
Ochsner Kenner	FO0047337	7/28/2017	Cardinal	180 W. Esplanade Ave	Kenner	LA	
Ochsner Baton Rouge	BS9525645	7/28/2017	Cardinal	17000 Medical Center Drive	Baton Rouge	LA	
Ochsner North Shore	FO2071544	7/28/2017	Cardinal	100 Medical Center Dr.	Slidell	LA	
Ochsner West Bank	FO1311953	7/28/2017	Cardinal	2500 Belle Chasse Hwy	Gretna	LA	
Ochsner St Anne	BO9865455	7/28/2017	Cardinal	4608 Highway 1	Raceland	LA	
Leonard J Chabert Medical Center	FS4348961	7/28/2017	Cardinal	1978 Industrial Blvd	Houma	LA	
St Charles Parish Hospital	AT3406659	7/28/2017	Cardinal	1057 Paul Maillard Rd	Luling	LA	
Hancock Medical Center	AH5196399	7/28/2017	Cardinal	149 Drinkwater Blvd	Bay St Louis	MS	
Pine Creek Medical	BP9119543	7/28/2017	Cardinal	9032 Harry Hines Blvd	Dallas	TX	2125
Rice Memorial Hospital	AR3634765	7/28/2017	Cardinal	301 Becker Ave SW	Willmar	MN	500
Redwood Area Hospital	AR3622366	7/28/2017	Cardinal	100 Fallwood Rd	Redwood Falls	MN	
Granite Falls Municipal Hospital	AG3650846	7/28/2017	Cardinal	345 10th Ave	Granite Falls	MN	
Swift County Benson Hospital	AS3617264	7/28/2017	Cardinal	1815 Wisconsin Ave	Benson	MN	
Saratoga Hospital	AS3515814	7/28/2017	Cardinal	211 Church Street	Saratoga Springs	NY	150
St. Lukes Hospital of Duluth	AS3642368	7/28/2017	Cardinal	915 E. 1st Street	Duluth	MN	775
Lake View Hospital	AL3650505	7/28/2017	Cardinal	325 11th Ave.	Two Harbors	MN	
St. Luke's Roosevelt Hospital Center, DBA Mount Sinai St. L	AT9120469	7/29/2017	Cardinal	1111 Amsterdam Avenue	New York	NY	
Arnot Ogden Medical Center	AA0552415	7/31/2017	Cardinal	600 Roe Ave	Elmira	NY	2250
Ira Davenport Memorial Hospital	AT0488951	7/31/2017	Cardinal	7571 State Route 54	Bath	NY	
Saint Josephs Hospital	AS0552580	7/31/2017	Cardinal	555 Saint Josephs Boulevard	Elmira	NY	
Maricopa Medical Center	AE3307875	7/31/2017	Cardinal	2601 E ROOSEVELT ST	Phoenix	AZ	1250
Northern Arizona Healthcare - Flagstaff Medical Center W	BF1069804	7/31/2017	Cardinal	1215 N Beaver St	Flagstaff	AZ	47
Verde Valley Medical Center	AM1276209	7/31/2017	Cardinal	269 S Candy Lane	Cottonwood	AZ	
Beaufort Memorial	AB1482330	8/1/2017	Cardinal	955 Ribaut Rd	Beaufort	SC	
Flagler Hospital- St. Augustine	AF0132275	8/1/2017	Cardinal	400 Health Park Boulevard	Augustine	FL	
McLeod Health Cheraw	BC5258668	8/1/2017	Cardinal	711 Chesterfield Hwy	Cheraw	SC	
McLeod Health Clarendon	AC0334932	8/1/2017	Cardinal	10 Ex Hospital St., PO Box 550	Manning	SC	
McLeod Health Darlington	AW0334564	8/1/2017	Cardinal	701 Cashua Ferry Rd	Darlington	SC	
McLeod Dillon	BM5700554	8/1/2017	Cardinal	301 East Jackson St	Dillon	SC	
McLeod Loris	FM3021134	8/1/2017	Cardinal	3655 Mitchell St	Loris	SC	
McLeod Regional Medical Center	AM4726622	8/1/2017	Cardinal	555 East Cheves St	Florence	SC	
McLeod Seacoast	FM3021122	8/1/2017	Cardinal	4000 Highway 9 East	Little River	SC	
Tidelands Georgetown Hospital System	AG0339033	8/1/2017	Cardinal	606 Black River Road	Georgetown	SC	
Tidelands Waccamaw Community Hospital	BW7998593	8/1/2017	Cardinal	4070 Hwy 17 Bypass South	Murrells Inlet	SC	
ThedaCare Regional Medical Center--Neenah	AT3929784	8/1/2017	Cardinal	130 2nd St.	Neenah	WI	2850
ThedaCare Regional Medical Center-Wild Rose	AW4173720	8/1/2017	Cardinal	601 Grove Ave.	Wild Rose	WI	
ThedaCare Medical Center-New London	AC3539636	8/1/2017	Cardinal	1405 Mill St.	New London	WI	
ThedaCare Medical Center-Shawano	AS3571343	8/1/2017	Cardinal	100 County Road B	Shawano	WI	
ThedaCare Medical Center-Waupaca	AT4050922	8/1/2017	Cardinal	800 Riverside Dr.	Waupaca	WI	
ThedaCare Regional Medical Center-Appleton	AA3910470	8/1/2017	Cardinal	1818 N. Meade St.	Appleton	WI	
ThedaCare Medical Center-Berlin	AB4470415	8/1/2017	Cardinal	225 Memorial Dr.	Berlin	WI	
Buchanan County Health Center		8/2/2017	Cardinal		Independence	IA	100
DeKalb Health	AD2706743	8/2/2017	Cardinal	1316 EAST SEVENTH STREET	Auburn	IN	575
Floyd County Memorial Hospital		8/2/2017	Cardinal		Charles City	IA	125
Jones Memorial Hospital	BJ3424481	8/2/2017	Cardinal	191 N MAIN ST	Wellsville	NY	500
Kingsbrook Jewish Medical Center	AK3430406	8/2/2017	Cardinal	585 Shenectady Ave	Brooklyn	NY	1025
Niagara Falls Medical Center	AN0564056	8/2/2017	Cardinal	621 10 Street	Niagara Falls	NY	925
St. Vincent Medical Center	BS7751755	8/2/2017	Cardinal	2131 W Third Street	Los Angeles	CA	2725
Tri City Medical Center	AT1053925	8/2/2017	Cardinal	4002 Vista Way	Oceanside	CA	325
Auburn Community Hospital	AA0533162	8/3/2017	Cardinal	17 Lansing Street	Auburn	NY	175
Greater Hudson Valley Health System - Orange Regional M	BA8057146	8/3/2017	Cardinal	707 East Main Street	Middletown	NY	6850
Greater Hudson Valley Health System - Catskill Regional M	AC3514405	8/3/2017	Cardinal	68 Harris Bushville Road	Harris	NY	

EXHIBIT 3
ELIGIBLE CUSTOMERS

Health Alliance Inc	AK3455688	8/3/2017	Cardinal	396 Broadway	Kingston	NY	775
Mary Avenue Campus of Healthalliance Hospital	AB1115713	8/3/2017	Cardinal	105 Mary's Avenue	Kingston	NY	
Iowa City Ambulatory Surgical Center		8/3/2017	Cardinal		Iowa City	IA	400
Kingman Regional Medical Center	AK2435469	8/3/2017	Cardinal	3269 Stockton Hill Rd	Kingman	AZ	1809
Larkin Community Hospitals	FL5986370	8/3/2017	Cardinal	1475 W. 49th Street	Hialeah	FL	1175
Mercer County Community Hospital	AM2080947	8/3/2017	Cardinal	800 W Main St	Coldwater	OH	100
Oneida Hospital	BO4946642	8/3/2017	Cardinal	321 Genesee Street	Oneida	NY	950
The Toledo Hospital, DBA ProMedica Toledo Hospital	AT2867414	8/3/2017	Cardinal	2142 N Cove Blvd	Toledo	OH	9000
Flower Hospital DBA ProMedica Flower Hospital	AF6411231	8/3/2017	Cardinal	5200 Harroun Road	Sylvania	OH	
Bay Park Community Hospital DBA Promedica Bay Park Ho	BB7366481	8/3/2017	Cardinal	2801 Bay Park Dr	Oregon	OH	
Defiance Hospital Inc, DBA ProMedica Defiance Regional H	AD2869052	8/3/2017	Cardinal	1200 Ralson Ave	Defiance	OH	
Emma L Bixby Medical Center, DBA ProMedica Bixby Hosp	BE1454672	8/3/2017	Cardinal	818 Riverside Ave	Adrian	MI	
Herrick Memorial Hospital Inc, DBA ProMedica Herrick Hospital		8/3/2017	Cardinal	500 E. Pottawatamie St	Tecumseh	MI	
Fostoria Hospital Association DBA ProMedica Fostoria Com	BF5016721	8/3/2017	Cardinal	501 Van Buren St	Fostoria	OH	
ProMedica Wildwood Orthopaedic and Spine Hospital	FP3700944	8/3/2017	Cardinal	2901 N Reynolds Rd	Toledo	OH	
Memorial Hospital DBA Promedica Memorial Hospital	AM2872605	8/3/2017	Cardinal	715 S. Taft Ave.	Fremont	OH	
Mercy Memorial Hospital Corp; DBA ProMedica Monroe R	AM2755190	8/3/2017	Cardinal	718 Macomb St	Monroe	MI	
Saint Joseph's Candler Hospital	BC5270931	8/3/2017	Cardinal	5353 Reynolds Street	Savannah	GA	5750
St Joseph's Hospital	BS5270979	8/3/2017	Cardinal	11705 Mercy Blvd	Savannah	GA	
Select Specialty Hospital	BS9415060	8/3/2017	Cardinal	5353 Reynolds Street	Savannah	GA	
Candler Prescription Ctr Corp	FC1794317	8/3/2017	Cardinal	5354 Reynolds Street	Savannah	GA	
Sioux Valley Memorial Hospital	AS4050251	8/3/2017	Cardinal	300 SIOUX VALLEY DRIVE	Cherokee	IA	150
Oswego Hospital	AO3476327	8/4/2017	Cardinal	110 West Sixth Street	Oswego	NY	225
Tidelands Health- Georgetown County Memorial Hospital	AG0339033	8/4/2017	Cardinal	606 Black River Road	Georgetown	SC	2350
Tidelands Health - Waccamaw Community Hospital	BW7998593	8/4/2017	Cardinal	4070 Highway 17 Bypass	Murrells Inlet	SC	
Adventist Health Tehachapi Valley	BT4801038	8/7/2017	Cardinal	115 West E Street	Tehachapi	CA	17950
Glendale Adventist Medical Center	AG0084917	8/7/2017	Cardinal	1509 WILSON TER	GLENDALE	CA	
White Memorial Medical Center	BW1408803	8/7/2017	Cardinal	1720 E CESAR E CHAVEZ AVE	LOS ANGELES	CA	
Castle Medical Center	AC1080869	8/7/2017	Cardinal	640 ULUKAHIKI ST	KAILUA	HI	
Simi Valley Hospital & Health Svcs	AS0074738	8/7/2017	Cardinal	2975 SYCAMORE DR	SIMI VALLEY	CA	
San Joaquin Community Hospital	AS5352567	8/7/2017	Cardinal	2615 CHESTER AVE	BAKERSFIELD	CA	
St Helena Hospital	AS1322762	8/7/2017	Cardinal	10 WOODLAND RD	SAINT HELENA	CA	
Feather River Hospital	BF3384526	8/7/2017	Cardinal	5974 PENTZ RD	PARADISE	CA	
Adventist Medical Center	AP7398426	8/7/2017	Cardinal	10123 SE Market Street	Portland	OR	
Adventist Medical Center	AH1339363	8/7/2017	Cardinal	115 Mall Drive	Hanford	CA	
Ukiah Valley Medical Center	AU9073355	8/7/2017	Cardinal	275 HOSPITAL DR	UKIAH	CA	
Lodi Memorial Hospital	AL2031209	8/7/2017	Cardinal	975 S FAIRMONT AVE	LODI	CA	
Sonora Regional Medical Center	AS1360697	8/7/2017	Cardinal	1000 GREENLEY RD	SONORA	CA	
Tillamook Regional Medical Center	AT1629344	8/7/2017	Cardinal	1000 3RD ST	TILLAMOOK	OR	
Adventist Medical Center - Selma	FA2926939	8/7/2017	Cardinal	1141 ROSE AVE	SELMA	CA	
Adventist Medical Center	FA2922183	8/7/2017	Cardinal	372 W Cypress Ave	Reedley	CA	
Frank R Howard Memorial Hospital Pharma	FF5615503	8/7/2017	Cardinal	1 MARCELA DR	WILLITS	CA	
St Helena Hospital Clearlake	AR2028416	8/7/2017	Cardinal	15630 18TH AVE	CLEARLAKE	CA	
Bellin Health	AB3540766	8/7/2017	Cardinal	744 S Webster Ave	Green Bay	WI	10125
Bellin Health Oconto Hospital and Clinic	FO3350080	8/7/2017	Cardinal	820 Arbutus Ave	Oconto	WI	
BryLin Hospital		8/7/2017	Cardinal		Buffalo	NY	850
Hospital for Special Surgery		8/7/2017	Cardinal		New York	NY	150
Laughlin Memorial Hospital	AL0404119	8/7/2017	Cardinal	1420 Tusculum Boulevard	Greenville	TN	540
Mary Greeley Medical Center		8/7/2017	Cardinal		Ames	IA	150
Ohio State University Wexner Medical Center	7K0AAAL00	8/7/2017	Cardinal	410 W 10th Ave, RM 327	Columbus	OH	2575
Ohio State University Hospital James	7K0AAALFC	8/7/2017	Cardinal	410 W 10th Ave, RM 327	Columbus	OH	
Ohio State University Stefanie Spielman	H1HXF0BF1	8/7/2017	Cardinal	1145 OLENTANGY RIVER RD RM4200	Columbus	OH	
University Hospital East IP Pharm	410910FF0	8/7/2017	Cardinal	181 Taylor Avenue	Columbus	OH	
University Hospital East JC NSS	410910FF3	8/7/2017	Cardinal	181 Taylor Avenue, RM 1431	Columbus	OH	
University Hospital East	410910FF4	8/7/2017	Cardinal	181 Taylor Avenue, RM 1431	Columbus	OH	
Ohio State University Medical Center	J43YRP400	8/7/2017	Cardinal	2050 Kenny Road, Rm 1103	Columbus	OH	
OSUMC Jamieson Crane Sports Med	CGVKF5RF1	8/7/2017	Cardinal	2835 Fred Taylor Drive, Rm 1051	Columbus	OH	
James Cancer Hospital Pharm SVCS	9AKHNDKF1	8/7/2017	Cardinal	300 W. 10th Ave, Rm 233	Columbus	OH	
Ohio State University Medical Center	9AKHNDKF2	8/7/2017	Cardinal	300 W. 10th Ave	Columbus	OH	
Ohio State University Medical Center	C0VKFHN00	8/7/2017	Cardinal	3651 Ridge Mill Drive	Hilliard	OH	
Ohio State University Medical Center	396FT8YF2	8/7/2017	Cardinal	460 W 10th Ave, 8510	Columbus	OH	
Ohio State University Medical Center	396FT8YF1	8/7/2017	Cardinal	460 W 10th Ave, RMD120	Columbus	OH	
Ohio State University	35M83XW00	8/7/2017	Cardinal	915 Olentangy River Road	Columbus	OH	
OSU James Cancer Hospital Outpatient	396FT8YF3	8/7/2017	Cardinal	460 W 10th Ave, Room L012	Columbus	OH	
OSU Carepoint East Infusion	954WX6HF7	8/7/2017	Cardinal	543 Taylor Ave, Suite B125	Columbus	OH	
Ohio State University Outpatient Pharmacy	JDTAP2QF1	8/7/2017	Cardinal	600 Ackerman Road, Suite E-1019	Columbus	OH	
Rome Memorial Hospital	AR4248680	8/7/2017	Cardinal	1500 North James Street	Rome	NY	25
San Antonio Hospital	AS0278134	8/7/2017	Cardinal	999 San Bernardino Road	Upland	CA	2875
Wilson Memorial Hospital	AW2869393	8/7/2017	Cardinal	915 W. Michigan St	Sidney	OH	750
Columbia Memorial Hospital	AC1113101	8/8/2017	Cardinal	71 Prospect Ave	Hudson	NY	1975
Flushing Hospital Medical Center	AF793578	8/8/2017	Cardinal	4500 Parsons Boulevard	Flushing	NY	950
Hancock Regional Hospital	AH2660927	8/8/2017	Cardinal	801 N STATE STREET	Greenfield	IN	2100
Riverside Hospital	AN0633025	8/8/2017	Cardinal	500 J Clyde Morris Blvd	Newport News	VA	1033
Riverside Doctors Hospital of Williamsburg	FR1819347	8/8/2017	Cardinal	1500 Commonwealth Ave	Williamsburg	VA	
Riverside Tappahannock Hospital	BR1922194	8/8/2017	Cardinal	618 Hospital Road	Tappahannock	VA	
Riverside Walter Reed Hospital	AW7631028	8/8/2017	Cardinal	7519 Hospital Drive, Route 17	Gloucester	VA	
Riverside Hospital Inc	FR4202141	8/8/2017	Cardinal	500 J Clyde Morris Blvd	Newport News	VA	
Riverside Doctors Hospital of Williamsburg	FD3757816	8/8/2017	Cardinal	1500 Commonwealth Ave	Williamsburg	VA	
Riverside Shore Memorial Hospital	AN2352936	8/8/2017	Cardinal	9507 Hospital Ave	Nassawadox	VA	
Riverside Behavioral Health Center	AP2403981	8/8/2017	Cardinal	2244 Executive Drive	Hampton	VA	
Rush Memorial Hospital	AR2667886	8/8/2017	Cardinal	1300 N Main	Rushville	IN	175
Sanford Broadway (FKA MeritCare Hospital)	AS3795284	8/8/2017	Cardinal	801 BROADWAY NORTH	Fargo	ND	20900
Sanford Bemidji Medical Center	AB3622710	8/8/2017	Cardinal	1300 Anne St NW	Bemidji	MN	
Sanford Bismarck Medical Center	AB3795272	8/8/2017	Cardinal	300 North 7th Street	Bismarck	ND	
Sanford Medical Center Fargo	FS6683406	8/8/2017	Cardinal	5225 23rd Ave	South Fargo	ND	
Sanford USD Medical Center	AS406893	8/8/2017	Cardinal	1305 West 18th Street	Sioux Falls	SD	
Sanford Worthington Medical Center	AW3654095	8/8/2017	Cardinal	1018 6th Ave	Worthington	MN	

EXHIBIT 3
ELIGIBLE CUSTOMERS

Community Memorial Hospital	AC4069642	8/8/2017	Cardinal	8th & Jackson	Burke	SD	
Douglas County Memorial Hospital	AD4069666	8/8/2017	Cardinal	708 8th Street	Armour	SD	
Jamestown Regional Medical Center	AJ3789584	8/8/2017	Cardinal	2422 20th St SW	Jamestown	ND	
Kittson Memorial Healthcare Center	AK3629601	8/8/2017	Cardinal	1010 S Birch Ave	Hallock	MN	
Mahnomen Health Center	AM3499123	8/8/2017	Cardinal	414 W. Jefferson Ave.	Mahnomen	MN	
McKenzie County Healthcare Systems	AM3791490	8/8/2017	Cardinal	516 North Main Street	Watford City	ND	
Murray County Memorial Hospital	AM3619129	8/8/2017	Cardinal	2042 Juniper Ave.	Slayton	MN	
Northwood Deaconess Health Center	AN3790311	8/8/2017	Cardinal	4 N. Park Street, PO Box 190	Northwood	ND	
Orange City Area Health System	AO4012263	8/8/2017	Cardinal	1000 Lincoln Circle SE	Orange City	IA	
Ortonville Area Health Services	AO3642154	8/8/2017	Cardinal	450 Eastvold Ave	Ortonville	MN	
Perham Health (FKA Perham Memorial Hospital and Home	AM3647609	8/8/2017	Cardinal	1000 Coney St West	Perham	MN	
Pioneer Memorial Hospital & Health Services	AP4075239	8/8/2017	Cardinal	315 N. Washington St.	Viborg	SD	
Riverview Health	AK4487066	8/8/2017	Cardinal	323 S Minnesota St	Crookston	MN	
Sanford Aberdeen Medical Center	FS2940383	8/8/2017	Cardinal	2905 3rd Ave SE	Aberdeen	SD	
Sanford Bagley Medical Center (FKA Clearwater Health Ser	FS4247688	8/8/2017	Cardinal	203 4th St NW	Bagley	MN	
Sanford Canby Medical Center	BS0959176	8/8/2017	Cardinal	112 St. Olaf Ave. South	Canby	MN	
Sanford Canton-Inwood Medical Center	FS1204077	8/8/2017	Cardinal	440 N. Hiawatha Dr.	Canton	SD	
Sanford Chamberlain Medical Center	AM1589297	8/8/2017	Cardinal	800 South Byron Blvd.	Chamberlain	SD	
Sanford Clear Lake Medical Center	BD1209445	8/8/2017	Cardinal	701 3rd Ave. South	Clear Lake	SD	
Sanford Hillsboro Medical Center (FKA Hillsboro Medical C	FS3632545	8/8/2017	Cardinal	12 Third Street SE	Hillsboro	ND	
Sanford Jackson Medical Center	AJ3638496	8/8/2017	Cardinal	1430 N Highway	Jackson	MN	
Sanford Luverne Medical Center	AC3628166	8/8/2017	Cardinal	1600 North Kniss	Luverne	MN	
Sanford Mayville Medical (FKA MeritCare Mayville Union H	AU3791250	8/8/2017	Cardinal	42 6th Ave SE	Mayville	ND	
Sanford Rock Rapids Medical Center	AM4012249	8/8/2017	Cardinal	801 S Greene Street	Rock Rapids	IA	
Sanford Sheldon Medical Center	BN0802581	8/8/2017	Cardinal	118 N 7th Ave	Sheldon	IA	
Sanford Health Thief River Falls Southeast Campus	FM0611978	8/8/2017	Cardinal	1720 Hwy 59 South	Thief River Falls	MN	
Sanford Health Thief River Falls Downtown Campus	FM0561577	8/8/2017	Cardinal	120 Labree Ave. South	Thief River Falls	MN	
Sanford Thief River Falls Medical Center	FS4872962	8/8/2017	Cardinal	8001 Sanford Pkwy	Thief River Falls	MN	
Sanford Tracy Medical Center	AT3625374	8/8/2017	Cardinal	249 Fifth Street East	Tracy	MN	
Sanford Vermillion Medical Center	BS5885085	8/8/2017	Cardinal	1305 West 18th St	Sioux Falls	SD	
Sanford Webster Medical Center	AL3578942	8/8/2017	Cardinal	1401 West First Street	Webster	SD	
Sanford Westbrook Medical Center	AD3640061	8/8/2017	Cardinal	920 Bell Avenue	Westbrook	MN	
Sanford Wheaton Medical Center (FKA Wheaton Commun	FS2658409	8/8/2017	Cardinal	401 12th St. N	Wheaton	MN	
Sidney Health Center	AC1238206	8/8/2017	Cardinal	216 14th Avenue SW	Sidney	MT	
West Holt Memorial Hospital	AW5331234N	8/8/2017	Cardinal	406 W Neely Street	Atkinson	ND	
Windom Area Hospital	AW6825826	8/8/2017	Cardinal	2150 Hospital Drive	Windom	MN	
Winner Regional Healthcare Center	AB4064628	8/8/2017	Cardinal	745 East 8th Street	Winner	SD	
Sanford Fargo Medical Center Warehouse (FKA MeritCare	AS3795284	8/8/2017	Cardinal	501 4th Street	Fargo	ND	
Sanford Health Detroit Lakes Clinic - Same Day Surgery Ce	BL4802826	8/8/2017	Cardinal	1245 Washington Ave	Detroit Lakes	MN	
Sanford South University Surgical Center	BM7670373	8/8/2017	Cardinal	1720 University Drive	South Fargo	ND	
Sanford North (FKA MeritCare Health System)	AS3795284	8/8/2017	Cardinal	720 4th Street N	Fargo	ND	
Sanford Orthopedic Surgery Center (FKA Institute for Spec	BC7040431	8/8/2017	Cardinal	2801 25th Street S, Suite H	Fargo	ND	
Sanford Same Day Surgery Center (FKA MeritCare Same D	BB4191843	8/8/2017	Cardinal	921 8th Ave N	Fargo	ND	
Community Hospital	BC9451989	8/9/2017	Cardinal	2351 G Road	Grand Junction	CO	425
University of California San Diego Health System	AB3311444	8/9/2017	Cardinal	200 West Arbor Drive	San Diego	CA	9875
University of Calliffornia San Diego La Jolla		8/9/2017	Cardinal	9500 Gilman Drive	La Jolla	CA	
Jacobs Medical Center	BT3649350	8/9/2017	Cardinal	9300 Campus Point Drive	La Jolla	CA	
White Plains Hospital	AW1876789	8/9/2017	Cardinal	41 E. Post Road	White Plains	NY	4825
Florida Health Sciences Center- Tampa General	BF5651662	8/10/2017	Cardinal	1 Tampa General Circle	Tampa	FL	25025
Florida Health Sciences Center - Brandon Healthplex	FF6469983	8/10/2017	Cardinal	10740 Palm River Road	Tampa	FL	
Rush Medical Center	BP4026107	8/10/2017	Cardinal	1725 W Harrison St, Suite 418	Chicago	IL	50
Wellmont Health System- Holston Valley Medical Center	BH4946010	8/10/2017	Cardinal	130 W Ravine Rd	Kingsport	TN	5175
Bristol Regional Medical Center	BW4966593	8/10/2017	Cardinal	1 Medical Park Blvd	Bristol	TN	
Lonesome Pine Hospital	BL5208580	8/10/2017	Cardinal	1990 Holton Ave E	Big Stone Gap	VA	
Mountain View Regional Medical Center	FW0405630	8/10/2017	Cardinal	310 Rrd Street NE	Norton	VA	
Hawkins County Memorial Hospital	BW6813807	8/10/2017	Cardinal	851 Locust St	Rogersville	TN	
Hancock County Hospital	BW9153557	8/10/2017	Cardinal	1519 Main Street	Sneedville	TN	
Pushmataha Hospital	AC3352983	8/11/2017	Cardinal	510 E Main Street	Antlers	OK	25
Sharp Memorial Hospital	AL0288856	8/11/2017	Cardinal	7901 Frost Street	San Diego	CA	8811
Sharp Grossmont Hospital	BG2937982	8/11/2017	Cardinal	5555 Grossmont Center Drive	La Mesa	CA	
Sharp Chula Vista Medical Center	BS4005016	8/11/2017	Cardinal	751 Medical Center Drive	Chula Vista	CA	
Sharp Mesa Vista Hospital	BS6028107	8/11/2017	Cardinal	7850 Vista Hill Ave	San Diego	CA	
Sharp Mary Birch Hospital for Women and Newborns	BS5886722	8/11/2017	Cardinal	3003 Health Center Drive	San Diego	CA	
Sharp Coronado Hospital and Healthcare Center	AC0277233	8/11/2017	Cardinal	250 Prospect Place	Coronado	CA	
Sharp Centralized Pharmacy Services	FS5465720	8/11/2017	Cardinal	3558 Ruffin Road, Suite 101	San Diego	CA	
Goshen Hospital	AG6831968	8/14/2017	Cardinal	200 High Park Ave	Goshen	IN	1425
PeaceHealth Southwest Medical Center	BS4803741	8/14/2017	Cardinal	420 NE MOTHER JOSEPH PL	Vancouver	WA	4100
Atlantic Health System - Morristown Medical Center	AM1548479	8/14/2017	Cardinal	100 Madison Avenue	Morristown	NJ	15025
Atlantic Health System - Overlook Medical Center	AO2622187	8/14/2017	Cardinal	99 Beauvoir Avenue	Summit	NJ	4825
Atlantic Health System - Newton Memorial Hospital	FN2797554	8/14/2017	Cardinal	175 High Street	Newton	NJ	800
Atlantic Health System - Chilton Memorial Hospital	AC4844898	8/14/2017	Cardinal	97 West Parkway	Pompton Plains	NJ	1650
Atlantic Health System - Hackettstown Medical Center	AH5403287	8/14/2017	Cardinal	651 Willow Grove Street	Hackettstown	NJ	275
Bronx Lebanon Hospital Center		8/15/2017	Cardinal	1650 Grand Concourse	Bronx	NY	275
Rutland Regional Medical Center	AR1124685	8/15/2017	Cardinal	160 Allen St	Rutland	VT	1325
St Claire Regional Medical Center	AS3003984	8/15/2017	Cardinal	222 Medical Circle	Morehead	KY	1950
NYCHHC/Bellevue	AB4389285	8/15/2017	Cardinal	462 First Avenue	New York	NY	11000
NYCHHC/Coney Island	AC4186587	8/15/2017	Cardinal	2601 Ocean Parkway	Brooklyn	NY	4125
NYCHHC/Kings County	AK4148854	8/15/2017	Cardinal	451 Clarkson Avenue	Brooklyn	NY	3925
NYCHHC/Harlem	AH5560152	8/15/2017	Cardinal	506 Lenox Avenue	New York	NY	5375
NYCHHC/North Central Bronx	AN7166906	8/15/2017	Cardinal	3424 Kossuth Avenue	Bronx	NY	425
NYCHHC/Lincoln	AL4978841	8/15/2017	Cardinal	234 East 149th St	Bronx	NY	7900
NYCHHC/Jacobi	AA5349695	8/15/2017	Cardinal	1400 Pelham Parkway South	Bronx	NY	1675
NYCHHC/Queens	AV3503465	8/15/2017	Cardinal	82-68 164th Street	Jamaica	NY	1750
NYCHHC/Elmhurst	AK3594378	8/15/2017	Cardinal	79-01 Broadway	Elmhurst	NY	5525
NYCHHC/Metropolitan	AC3394618	8/15/2017	Cardinal	1901 First Avenue	New York	NY	2875
NYCHHC/Woodhull	AW9805980	8/15/2017	Cardinal	760 Broadway	Brooklyn	NY	2300
Faxton Saint Lukes Health Care	BF6801559	8/16/2017	Cardinal	1656 Champlin Ave	Utica	NY	85

EXHIBIT 3
ELIGIBLE CUSTOMERS

Saint Elizabeth Medical Center	AS0533302	8/16/2017	Cardinal	2209 Genesee St	Utica	NY	50
Faxton Saint Lukes Health Care	BF6801561	8/16/2017	Cardinal	1676 Sunset Ave	Utica	NY	25
Four Winds of Saratoga	BF1351054	8/16/2017	Cardinal	30 Crescent Ave	Saratoga Springs	NY	450
Natchitoches Regional Medical Center	AN3418010	8/16/2017	Cardinal	501 Keyser Ave	Nachitoches	LA	2310
CHRISTUS Lake Area Medical Center		8/16/2017	Cardinal	4200 Nelson road	Lake Charles	LA	50
St. James Mercy Hospital	AS0564078	8/16/2017	Cardinal	411 Canisteo St.	Hornell	NY	350
Anna Jaques Hospital	AA1935913	8/16/2017	Cardinal	25 Highland Ave	Newburyport	MA	1825
Renown Regional Medical Center	BR0215637	8/16/2017	Cardinal	1155 Mill St	Reno	NV	6575
Renown South Meadows Medical Center	BW6160484	8/16/2017	Cardinal	10101 Double R Blvd	Reno	NV	1650
YAVAPAI REGIONAL MEDICAL CENTER	AY1654486	8/16/2017	Cardinal	1003 WILLOW CREEK RD	Prescott	AZ	450
YAVAPAI REG MED CTR EAST	BY9657808	8/16/2017	Cardinal	7700 E FLORENTINE RD	Prescott	AZ	250
Jefferson Regional Medical Center	AB3219664	8/16/2017	Cardinal	1600 W. 40th Ave	Pine Bluff	AR	1726
Licking Memorial Hospital	AL2828448	8/17/2017	Cardinal	1320 West Main St.	Newark	OH	500
Carson Tahoe Regional Medical Center	BC8579611	8/17/2017	Cardinal	1600 Medical Parkway	Carson City	NV	2100
PROVIDENCE HEALTH & SERVICES	BP4717217	8/18/2017	Cardinal	3725 PROV. PT DR SE	ISSAQUAH	WA	73275
PROVIDENCE HEALTH & SERVICES	FM1807087	8/18/2017	Cardinal	101 NW 12TH AVE SUITE 107	BATTLE GROUND	WA	
PROVIDENCE HEALTH & SERVICES	FP0312075	8/18/2017	Cardinal	12600 BOTHELL EVERETT HWY #140	EVERETT	WA	
SWEDISH MEDICAL CENTER	FS2668549	8/18/2017	Cardinal	751 NE BLAKELY DR	ISSAQUAH	WA	
SWEDISH MEDICAL CENTER	FS3756131	8/18/2017	Cardinal	500 17TH AVE	SEATTLE	WA	
SWEDISH MEDICAL	FS5799943	8/18/2017	Cardinal	37624 SE FURY ST STE 101	SNOQUALMIE	WA	
SWEDISH MEDICAL	FS5800392	8/18/2017	Cardinal	21600 HWY 99 KC BLDG STE290	EDMONDS	WA	
SWEDISH MED CTR CHERRY HILL	FS5799931	8/18/2017	Cardinal	6007 244TH ST SW STE B	MOUNTLAKE TERRAC	WA	
SWEDISH MEDICAL	FS5799955	8/18/2017	Cardinal	520 BOREN AVE N	SEATTLE	WA	
PROVIDENCE HEALTH & SERVICES	FW2818334	8/18/2017	Cardinal	955 SE BASELINE ST	HILLSBORO	OR	
PROVIDENCE HEALTH & SERVICES	FP4915205	8/18/2017	Cardinal	9135 SW BARNES RD EAST PAV 263	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	FP3110260	8/18/2017	Cardinal	18610 NW CORNELL RD SUITE 102	HILLSBORO	OR	
PROVIDENCE HEALTH & SERVICES	FP5208334	8/18/2017	Cardinal	50331A US-93	POLSON	MT	
PROVIDENCE HEALTH & SERVICES	AV6651436	8/18/2017	Cardinal	911 MEALS AVE PO BOX 550	VALDEZ	AK	
YAKIMA VALLEY MEMORIAL HOSPITAL	AY1002055	8/18/2017	Cardinal	2811 TIETON DR	YAKIMA	WA	
PROVIDENCE HEALTH & SERVICES	BP5338391	8/18/2017	Cardinal	1915 E REZANOF DR (BOX)	KODIAK	AK	
PROVIDENCE HEALTH & SERVICES	AT1447538	8/18/2017	Cardinal	1501 BAY AVE	OCEAN PARK	WA	
PROVIDENCE HEALTH & SERVICES	BP1357575	8/18/2017	Cardinal	914 S SCHEUBER RD	CENTRALIA	WA	
PROVIDENCE HEALTH & SERVICES	BM4294524	8/18/2017	Cardinal	3300 PROVIDENCE DR SUITE #101	ANCHORAGE	AK	
PROVIDENCE HEALTH & SERVICES	BN1205839	8/18/2017	Cardinal	26357 MCBEAN PARKWAY	SANTA CLARITA	CA	
PROVIDENCE HEALTH & SERVICES	BM1680645	8/18/2017	Cardinal	982 E COLUMBIA AVE	COLVILLE	WA	
SWEDISH MEDICAL CENTER	FS5854422	8/18/2017	Cardinal	1221 MADISON ST STE 444	SEATTLE	WA	
PROVIDENCE HEALTH & SERVICES	FW0542022	8/18/2017	Cardinal	2830 S GRAND BLVD	SPOKANE	WA	
PROVIDENCE HEALTH & SERVICES	BP8715661	8/18/2017	Cardinal	130 ENTERPRISE DRIVE	PITTSBURGH	PA	
PROVIDENCE HEALTH	FN3729677	8/18/2017	Cardinal	4112 HARBOUR POINTE BLVD SW	MUKILTEO	WA	
PROVIDENCE HEALTH & SERVICES	FK4949725	8/18/2017	Cardinal	7360 W. DESCHUTES AVE	KENNEWICK	WA	
SWEDISH MEDICAL	FS5799804	8/18/2017	Cardinal	4560 KLAHANIE DRIVE SE STE 400	ISSAQUAH	WA	
PACMED CTRS BEACON HILL CLN	FP1869556	8/18/2017	Cardinal	1101 MADISON ST SUITE 400	SEATTLE	WA	
PROVIDENCE HEALTH & SERVICES	FP1239359	8/18/2017	Cardinal	902 N ORANGE ST	MISSOULA	MT	
PROVIDENCE HEALTH & SERVICES	FP1787538	8/18/2017	Cardinal	181 SOUTH BUENA VISTA ST #110	BURBANK	CA	
SWEDISH MEDICAL	FS5799854	8/18/2017	Cardinal	5350 TALLMAN AVE NW STE 303	SEATTLE	WA	
SWEDISH MEDICAL	FS5799830	8/18/2017	Cardinal	18100 NE UNION HILL RD STE 200	REDMOND	WA	
SWEDISH MEDICAL	FS5799866	8/18/2017	Cardinal	22707 SE 29TH ST	SAMMAMISH	WA	
PROVIDENCE HEALTH & SERVICES	FP5850347	8/18/2017	Cardinal	2703 N ONTARIO ST, STE 120&130	BURBANK	CA	
SWEDISH MED CTR CHERRY HILL	FS5799880	8/18/2017	Cardinal	1600 EAST JEFFERSON ST STE 510	SEATTLE	WA	
PROVIDENCE HEALTH & SERVICES	BP6414584	8/18/2017	Cardinal	920 COMPASSION CIRCLE	ANCHORAGE	AK	
PROVIDENCE HEALTH & SERVICES	BP6600539	8/18/2017	Cardinal	9333 S 120TH PL STE 100B	TUKWILA	WA	
PROVIDENCE HEALTH & SERVICES	BS2581002	8/18/2017	Cardinal	6410 NE HALSEY STE 400	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	BS2192425	8/18/2017	Cardinal	6 13TH AVENUE EAST	POLSON	MT	
PROVIDENCE HEALTH & SERVICES	BS3126908	8/18/2017	Cardinal	26357 MCBEAN PARKWAY	SANTA CLARITA	CA	
PROVIDENCE HEALTH & SERVICES	BS3168590	8/18/2017	Cardinal	11333 N. SEPULVEDA BLVD.	MISSION HILLS	CA	
YAKIMA VALLEY MEMORIAL HOSPITAL	BN5967698	8/18/2017	Cardinal	808 N 39TH AVE	YAKIMA	WA	
PROVIDENCE HEALTH & SERVICES	BS3622188	8/18/2017	Cardinal	9333 S 120TH PL STE 100A	TUKWILA	WA	
PROVIDENCE HEALTH & SERVICES	BP6566193	8/18/2017	Cardinal	3333 ENSIGN ROAD NE	OLYMPIA	WA	
PROVIDENCE HEALTH & SERVICES	BS7295252	8/18/2017	Cardinal	1003 PROVIDENCE DR SUITE 110	NEWBERG	OR	
PROVIDENCE HEALTH & SERVICES	BS4145480	8/18/2017	Cardinal	S 711 COWLEY ST	SPOKANE	WA	
PROVIDENCE HEALTH & SERVICES	BO8413952	8/18/2017	Cardinal	5330 NE GLISAN ST, SUITE 200	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	BS7789552	8/18/2017	Cardinal	6410 NE HALSEY STE 400	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	FW0598001	8/18/2017	Cardinal	175 SOUTH COLUMBIA RIVER HWY	SAINT HELENS	OR	
PROVIDENCE HEALTH & SERVICES	BS6989935	8/18/2017	Cardinal	6-13TH AVE E PO BOX 1010	POLSON	MT	
SWEDISH MEDICAL CENTER	FS5990848	8/18/2017	Cardinal	945 HILDEBRAND LANE NE	BAINBRIDGE ISLAND	WA	
PROVIDENCE HEALTH & SERVICES	AS6898906	8/18/2017	Cardinal	401 W POPLAR ST PO BOX 1477	WALLA WALLA	WA	
OLYMPIC MEMORIAL HOSPITAL	AO1005075	8/18/2017	Cardinal	939 CAROLINE ST.	PORT ANGELES	WA	
PROVIDENCE HEALTH & SERVICES	AS1237723	8/18/2017	Cardinal	500 WEST BROADWAY BOX 4587	MISSOULA	MT	
PROVIDENCE HEALTH & SERVICES	AP1006281	8/18/2017	Cardinal	916 PACIFIC AVE/PAC CAMPUS	EVERETT	WA	
PROVIDENCE HEALTH & SERVICES	AP1601536	8/18/2017	Cardinal	1111 CRATER LAKE AVE	MEDFORD	OR	
PROVIDENCE HEALTH & SERVICES	BD1014555	8/18/2017	Cardinal	21311 MADRONA AVE, STE 100-A	TORRANCE	CA	
PROVIDENCE HEALTH & SERVICES	AP1692935	8/18/2017	Cardinal	4805 NE GLISAN ST	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	AR7069087	8/18/2017	Cardinal	23808 MCBEAN PARKWAY	VALENCIA	CA	
PROVIDENCE HEALTH & SERVICES	AS0991338	8/18/2017	Cardinal	101 W EIGHTH AVE PO BOX 2555	SPOKANE	WA	
PROVIDENCE HEALTH & SERVICES	BB1881831	8/18/2017	Cardinal	11333 N. SEPULVEDA BLVD.	MISSION HILLS	CA	
PROVIDENCE HEALTH & SERVICES	BD5974022	8/18/2017	Cardinal	11333 N. SEPULVEDA BLVD.	MISSION HILLS	CA	
PROVIDENCE HEALTH & SERVICES	FO1120500	8/18/2017	Cardinal	41460 HAGGERTY CIRCLE SOUTH	CANTON	MI	
PROVIDENCE HEALTH & SERVICES	BP6348975	8/18/2017	Cardinal	810 12TH STREET	HOOD RIVER	OR	
SWEDISH MEDICAL CENTER	FS4188515	8/18/2017	Cardinal	1221 MADISON ST 3RD FLOOR	SEATTLE	WA	
SWEDISH MEDICAL CENTER	FS2758825	8/18/2017	Cardinal	21642 HIGHWAY 99	EDMONDS	WA	
PROVIDENCE HEALTH & SERVICES	AP1130082	8/18/2017	Cardinal	3200 PROVIDENCE DR	ANCHORAGE	AK	
PROVIDENCE HEALTH & SERVICES	FC6609107	8/18/2017	Cardinal	10930 JOHN W ELLIOTT DR	FRISCO	TX	
PROVIDENCE HEALTH & SERVICES	FP1077684	8/18/2017	Cardinal	18321 CLARK STREET	TARZANA	CA	
SWEDISH MEDICAL	FS5800403	8/18/2017	Cardinal	3400 CALI AVE SW STE200/300	SEATTLE	WA	
SWEDISH MED CTR CHERRY HILL	FS5799676	8/18/2017	Cardinal	21911 76TH AVE WEST STE 110	EDMONDS	WA	
PROVIDENCE HEALTH & SERVICES	BG5890795	8/18/2017	Cardinal	5050 NE HOYT ST SUITE 315	PORTLAND	OR	
PROVIDENCE HEALTH	BA3898282	8/18/2017	Cardinal	12800 BOTHELL-EVERETT STE 160	EVERETT	WA	

EXHIBIT 3
ELIGIBLE CUSTOMERS

PROVIDENCE HEALTH & SERVICES	FP2965828	8/18/2017	Cardinal	1500 DIVISION STREET	OREGON CITY	OR	
PROVIDENCE HEALTH & SERVICES	BB0943135	8/18/2017	Cardinal	1100 GOETHALS DR FLR 1 STE B	RICHLAND	WA	
PROVIDENCE HEALTH & SERVICES	AN1620269	8/18/2017	Cardinal	1001 PROVIDENCE DRIVE	NEWBERG	OR	
PROVIDENCE HEALTH & SERVICES	FW1709279	8/18/2017	Cardinal	400 E 5TH AVE, STE 102	SPOKANE	WA	
PROVIDENCE HEALTH & SERVICES	AC4462521	8/18/2017	Cardinal	10 KRUGER RD BOX 768	PLAINS	MT	
PROVIDENCE HEALTH & SERVICES	BL9662265	8/18/2017	Cardinal	1300 W 7TH STREET	SAN PEDRO	CA	
PROVIDENCE HEALTH & SERVICES	BD8792170	8/18/2017	Cardinal	11333 N SEPULVEDA BLVD	MISSION HILLS	CA	
PROVIDENCE HEALTH & SERVICES	FW0643850	8/18/2017	Cardinal	11983 HAWTHORNE BLVD	HAWTHORNE	CA	
PROVIDENCE HEALTH & SERVICES	AB8052297	8/18/2017	Cardinal	1321 NE 99TH AVE SUITE 100	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	BP0601333	8/18/2017	Cardinal	10150 S E 32ND AVE	MILWAUKIE	OR	
PROVIDENCE HEALTH	AF3260546	8/18/2017	Cardinal	1890 BICKFORD AVE STE 211	SNOHOMISH	WA	
PROVIDENCE HEALTH & SERVICES	AK1005063	8/18/2017	Cardinal	888 SWIFT BLVD	RICHLAND	WA	
PROVIDENCE HEALTH & SERVICES	FW1144562	8/18/2017	Cardinal	6215 SE TUALATIN VALLEY HWY	HILLSBORO	OR	
PROVIDENCE HEALTH & SERVICES	BP3943936	8/18/2017	Cardinal	1321 COLBY AVE.	EVERETT	WA	
PROVIDENCE HEALTH & SERVICES	BP3139806	8/18/2017	Cardinal	2687 PALMER ST SUITE B	MISSOULA	MT	
PROVIDENCE HEALTH & SERVICES	FW0542008	8/18/2017	Cardinal	2702 N ARGONNE RD	MILLWOOD	WA	
PROVIDENCE HEALTH & SERVICES	AS1019000	8/18/2017	Cardinal	413 LILLY ROAD NE	OLYMPIA	WA	
PROVIDENCE HEALTH & SERVICES	AP1431511	8/18/2017	Cardinal	5050 NE HOYT ST STE 142	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	FP3153258	8/18/2017	Cardinal	1321 COLBY AVE C-WING 1ST FL	EVERETT	WA	
PROVIDENCE HEALTH & SERVICES	AM9585658	8/18/2017	Cardinal	9155 SW BARNES RD	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	AC9733418	8/18/2017	Cardinal	401 WEST PENNSYLVANIA	ANACONDA	MT	
SWEDISH MEDICAL	FS5799791	8/18/2017	Cardinal	751 NE BLAKELY DR 5TH FLOOR	ISSAQUAH	WA	
PROVIDENCE HEALTH & SERVICES	AL8258952	8/18/2017	Cardinal	5TH & ADAMS STS	MORTON	WA	
PROVIDENCE HEALTH & SERVICES	AL0278122	8/18/2017	Cardinal	DUMMY-ACCOUNT ONLY	TORRANCE	CA	
PROVIDENCE HEALTH & SERVICES	AH0984965	8/18/2017	Cardinal	5633 NORTH LIDGERWOOD ST	SPOKANE	WA	
SWEDISH MEDICAL	FS5799777	8/18/2017	Cardinal	7210 ROOSEVELT WAY NE	SEATTLE	WA	
PROVIDENCE HEALTH & SERVICES	BG9712729	8/18/2017	Cardinal	1698 EAST MCANDREWS SUITE 400	MEDFORD	OR	
PROVIDENCE HEALTH & SERVICES	BI9716587	8/18/2017	Cardinal	10530 JOHN W ELLIOTT DR STE100	FRISCO	TX	
PROVIDENCE HEALTH & SERVICES	BG6469212	8/18/2017	Cardinal	15640 NW LAIDLAW RD STE 102	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	BH7339117	8/18/2017	Cardinal	870 S. FRONT ST	CENTRAL POINT	OR	
SWEDISH MED CTR CHERRY HILL	FS5799703	8/18/2017	Cardinal	800 5TH AVE STE P100	SEATTLE	WA	
PROVIDENCE HEALTH & SERVICES	AW1632959	8/18/2017	Cardinal	1500 DIVISION STREET	OREGON CITY	OR	
PROVIDENCE HEALTH	BC5635670	8/18/2017	Cardinal	12800 BOTHELL-EVERETT STE 190	EVERETT	WA	
PROVIDENCE HEALTH & SERVICES	BB3840368	8/18/2017	Cardinal	11333 N SEPULVEDA BLVD	MISSION HILLS	CA	
PROVIDENCE HEALTH & SERVICES	AS1096088	8/18/2017	Cardinal	725 S. WAHANNA ROAD	SEASIDE	OR	
PROVIDENCE HEALTH & SERVICES	AP1001851	8/18/2017	Cardinal	101 BOLSTAD ST	LONG BEACH	WA	
PROVIDENCE HEALTH & SERVICES	AP1002330	8/18/2017	Cardinal	101 1ST AVE S PO BOX B	ILWACO	WA	
SWEDISH MEDICAL CENTER	FS0757407	8/18/2017	Cardinal	5300 TALLMAN AVE. NW	SEATTLE	WA	
SWEDISH MEDICAL CENTER	FS0757419	8/18/2017	Cardinal	747 BROADWAY AVE	SEATTLE	WA	
SWEDISH MEDICAL CENTER	FS2212354	8/18/2017	Cardinal	21601 76TH AVE W	EDMONDS	WA	
PROVIDENCE HEALTH & SERVICES	BW1741479	8/18/2017	Cardinal	1200 W FAIRVIEW ST	COLFAX	WA	
SWEDISH MEDICAL CENTER	FS2211237	8/18/2017	Cardinal	7320 216TH SW, SUITE 100	EDMONDS	WA	
PROVIDENCE HEALTH & SERVICES	FS0990487	8/18/2017	Cardinal	520 N PROSPECT AVE STE 103	REDONDO BEACH	CA	
PACMED CTRS BEACON HILL CLN	FP6604880	8/18/2017	Cardinal	1909 234TH ST SE STE 301	BOTHELL	WA	
SWEDISH MEDICAL CENTER	FS2358580	8/18/2017	Cardinal	18100 NE UNION HILL ROAD	REDMOND	WA	
SWEDISH MEDICAL CENTER	FS2656102	8/18/2017	Cardinal	751 NE BLAKELY DR	ISSAQUAH	WA	
PROVIDENCE HEALTH & SERVICES	FP6331336	8/18/2017	Cardinal	413 LILLY ROAD NE	OLYMPIA	WA	
PROVIDENCE HEALTH & SERVICES	BW9710131	8/18/2017	Cardinal	17850 LOWERBOONES FERRY RD	LAKE OSWEGO	OR	
PROVIDENCE HEALTH & SERVICES	BW7586134	8/18/2017	Cardinal	9750 WOODMAN AVE	ARLETA	CA	
SWEDISH MEDICAL CENTER	BW4722307	8/18/2017	Cardinal	7707 SE 27TH ST	MERCER ISLAND	WA	
SWEDISH MEDICAL CENTER	BW5515690	8/18/2017	Cardinal	12405 NE 85TH ST	KIRKLAND	WA	
PROVIDENCE HEALTH & SERVICES	BW7326514	8/18/2017	Cardinal	12335 NE GLISAN STREET	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	BW7147766	8/18/2017	Cardinal	14600 SW MURRAY SCHOLLS DR 201	BEAVERTON	OR	
PROVIDENCE HEALTH & SERVICES	BW7198698	8/18/2017	Cardinal	7280 SW BEAVERTON HILLSDALE HW	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	BT1068560	8/18/2017	Cardinal	201 EAST PARK	ANACONDA	MT	
PROVIDENCE HEALTH & SERVICES	FC5493767	8/18/2017	Cardinal	6348 NE HALSEY ST STE A	PORTLAND	OR	
SWEDISH MEDICAL CENTER	BW7805267	8/18/2017	Cardinal	6300 E LAKE SAMMAMISH PKWY SE	ISSAQUAH	WA	
PROVIDENCE HEALTH & SERVICES	BW3602756	8/18/2017	Cardinal	2105 E WELLESLEY AVE	SPOKANE	WA	
PROVIDENCE HEALTH & SERVICES	BW3602768	8/18/2017	Cardinal	12 E EMPIRE AVE	SPOKANE	WA	
PROVIDENCE HEALTH & SERVICES	BW7860693	8/18/2017	Cardinal	7010 NE CORNELL RD	HILLSBORO	OR	
PROVIDENCE HEALTH & SERVICES	BW3768554	8/18/2017	Cardinal	7905 N DIVISION ST	SPOKANE	WA	
SWEDISH MEDICAL CENTER	BW7874591	8/18/2017	Cardinal	16824 HIGHWAY 99	LYNNWOOD	WA	
PROVIDENCE HEALTH & SERVICES	BW8050849	8/18/2017	Cardinal	1840 PORTLAND RD	NEWBERG	OR	
PROVIDENCE HEALTH & SERVICES	BW8330805	8/18/2017	Cardinal	19975 SW TUALATIN VALLEY HWY	ALOHA	OR	
PROVIDENCE HEALTH & SERVICES	BT7258280	8/18/2017	Cardinal	417 SW 117TH AVE SUITE 200	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	BW8628805	8/18/2017	Cardinal	21065 SW PACIFIC HWY	SHERWOOD	OR	
PROVIDENCE HEALTH & SERVICES	BW4755027	8/18/2017	Cardinal	1708 W NORTHWEST BLVD	SPOKANE	WA	
PROVIDENCE HEALTH & SERVICES	BT8022193	8/18/2017	Cardinal	500 WEST BROADWAY	MISSOULA	MT	
PROVIDENCE HEALTH & SERVICES	BW5234454	8/18/2017	Cardinal	1950 NE BURNSIDE RD	GRESHAM	OR	
PROVIDENCE HEALTH & SERVICES	BW5234548	8/18/2017	Cardinal	3 NE 82ND AVENUE	PORTLAND	OR	
SWEDISH MEDICAL CENTER	BW5321891	8/18/2017	Cardinal	5409 15TH AVENUE NW	SEATTLE	WA	
SWEDISH MEDICAL CENTER	BW5551266	8/18/2017	Cardinal	20725 HIGHWAY 99	LYNNWOOD	WA	
SWEDISH MEDICAL CENTER	BW5716761	8/18/2017	Cardinal	19656 AMBAUM BLVD SW	BURIEN	WA	
PROVIDENCE HEALTH & SERVICES	BW5597298	8/18/2017	Cardinal	22930 S WESTERN AVE	TORRANCE	CA	
PROVIDENCE HEALTH & SERVICES	BW5993349	8/18/2017	Cardinal	2103 W BURNSIDE	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	BW8702145	8/18/2017	Cardinal	12315 N HWY 395	SPOKANE	WA	
PROVIDENCE HEALTH & SERVICES	BW8756047	8/18/2017	Cardinal	4616 NW BETHANY BLVD	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	BW8756061	8/18/2017	Cardinal	13470 NW CORNELL RD	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	BT9711563	8/18/2017	Cardinal	9205 SW BARNES ROAD MMT2890	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	BW6941149	8/18/2017	Cardinal	17010 CHATSWORTH STREET	GRANADA HILLS	CA	
PROVIDENCE HEALTH & SERVICES	BW9530595	8/18/2017	Cardinal	515 MOUNT HOOD ST	THE DALLES	OR	
SWEDISH MEDICAL CENTER	BW6568072	8/18/2017	Cardinal	275 RAINIER AVE S	RENTON	WA	
PROVIDENCE HEALTH & SERVICES	BW3602744	8/18/2017	Cardinal	12312 E SPRAGUE AVE	SPOKANE VALLEY	WA	
PROVIDENCE HEALTH & SERVICES	BW6792255	8/18/2017	Cardinal	13939 SW PACIFIC HWY	TIGARD	OR	
PROVIDENCE HEALTH & SERVICES	BW7686035	8/18/2017	Cardinal	18515 DEVONSHIRE ST	NORTHRIDGE	CA	
PROVIDENCE HEALTH & SERVICES	BW6893300	8/18/2017	Cardinal	15510 E SPRAGUE	SPOKANE VALLEY	WA	
PROVIDENCE HEALTH & SERVICES	BW9565170	8/18/2017	Cardinal	115 N 20TH AVE	CORNELIUS	OR	

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PROVIDENCE HEALTH & SERVICES	AH1070616	8/18/2017	Cardinal	15031 RINALDI ST AO00PH003F00	MISSION HILLS	CA	
SWEDISH MEDICAL CENTER	FW3121338	8/18/2017	Cardinal	1409 11TH AVE	SEATTLE	WA	
PROVIDENCE HEALTH & SERVICES	AS1427815	8/18/2017	Cardinal	1321 NE 99TH AVE SUITE 200	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	BL0250085	8/18/2017	Cardinal	19350 RINALDI STREET	PORTER RANCH	CA	
PROVIDENCE HEALTH & SERVICES	AS1608314	8/18/2017	Cardinal	9205 SW BARNES RD	PORTLAND	OR	
PROVIDENCE HEALTH & SERVICES	AS2187408	8/18/2017	Cardinal	500 E WEBSTER AVE BOX 197	CHEWELAH	WA	
PROVIDENCE HEALTH & SERVICES	FP4122951	8/18/2017	Cardinal	19200 N KELSEY ST	MONROE	WA	
PROVIDENCE HEALTH	BL7166050	8/18/2017	Cardinal	2902 164TH ST SW BLG E1	LYNNWOOD	WA	
PROVIDENCE HEALTH & SERVICES	AS2771853	8/18/2017	Cardinal	110 CENTER ST	MOLALLA	OR	
PROVIDENCE HEALTH & SERVICES	FP3739147	8/18/2017	Cardinal	10807 E MONTGOMERY DR SUITE 8	SPOKANE VALLEY	WA	
PROVIDENCE HEALTH & SERVICES	FP4317764	8/18/2017	Cardinal	301 W POPLAR ST	WALLA WALLA	WA	
PROVIDENCE HEALTH & SERVICES	AS5853622	42965	Cardinal	501 S BUENA VISTA AS21PF025E25	BURBANK	CA	
OLYMPIC MEMORIAL HOSPITAL	FO0137631	42965	Cardinal	844 NORTH 5TH AVE	SEQUIM	WA	
SWEDISH MEDICAL CENTER	FS5990862	42965	Cardinal	1200 112TH AVE NE B100	BELLEVUE	WA	
PROVIDENCE HEALTH & SERVICES	FP4317776	42965	Cardinal	380 CHASE AVENUE	WALLA WALLA	WA	
PROVIDENCE HEALTH & SERVICES	BL9557606	42965	Cardinal	4101 TORRANCE BLVD	TORRANCE	CA	
Covenant Children's Hospital	BM3170610	42965	Cardinal	4015 22nd Pl	Lubbock	TX	
Covenant Hospital - Levelland	BM1598638	42965	Cardinal	1900 College Ave	Levelland	TX	
Covenant Hospital - Plainview	BM3528900	42965	Cardinal	2601 Dimmitt Rd	Plainview	TX	
Covenant Medical Center	BC6300569	42965	Cardinal	3615 19th St	Lubbock	TX	
Covenant Medical Center - Lakeside	BC6300545	42965	Cardinal	4000 24th St	Lubbock	TX	
Covenant Specialty Hospital	FC0138380	42965	Cardinal	3815 20th St	Lubbock	TX	
Joe Arrington Cancer Center	BJ6301030	42965	Cardinal	4101 22nd Pl	Lubbock	TX	
Mission Hospital	BM4323832	42965	Cardinal	27700 Medical Center Rd	Mission Viejo	CA	
Mission Hospital, Laguna Beach	FM1701639	42965	Cardinal	31872 Coast Hwy	Laguna Beach	CA	
Petaluma Valley Hospital	BS5195979	42965	Cardinal	400 N McDowell Blvd	Petaluma	CA	
Queen of the Valley Medical Center	AT2036083	42965	Cardinal	1000 Trancas St	Napa	CA	
Redwood Memorial Hospital	BR4342642	42965	Cardinal	3300 Renner Dr	Fortuna	CA	
Santa Rosa Memorial Hospital	AS2113570	42965	Cardinal	1165 Montgomery Dr	Santa Rosa	CA	
SJHH Wellness Corner Newport Center		42965	Cardinal	600 Newport Center Dr Ste 150	Newport Beach	CA	
SMHDMG AppleBear Cardiology		42965	Cardinal	18031 US Hwy 1	Apple Valley	CA	
SMHDMG AppleBear Spine		42965	Cardinal	18031 US Highway 18 Ste B	Apple Valley	CA	
St Joseph Health St Mary High Desert Group -		42965	Cardinal	12550 Hesperia Rd Ste 100	Victorville	CA	
St Joseph Health St Mary High Desert Group -		42965	Cardinal	12550 Hesperia Rd Ste 100	Victorville	CA	
St Joseph Heritage Healthcare		42965	Cardinal	2501 E Chapman Ave Ste 107	Orange	CA	
St Joseph Heritage Healthcare		42965	Cardinal	505 S Main St	Orange	CA	
St Joseph Hospital General Campus		42965	Cardinal	2200 Harrison	Eureka	CA	
St Joseph Hospital, Eureka	AS1321481	42965	Cardinal	2700 Dolbeer St	Eureka	CA	
St Joseph Hospital, Orange	AS1451070	42965	Cardinal	1100 West Stewart Dr	Orange	CA	
St Jude Medical Center	AS0306628	42965	Cardinal	101 E Valencia Mesa Dr	Fullerton	CA	
St Mary Medical Center	AS1049558	42965	Cardinal	18300 Hwy 18	Apple Valley	CA	
Covenant Home Infusion / Covenant Health Sys	BC6300571	42965	Cardinal	4002 22nd Pl	Lubbock	TX	
Humboldt Home Infusion Program	BH7690515	42965	Cardinal	2612 Harrison Ave	Eureka	CA	
Santa Rosa Memorial Hospital-dba:	FS4442935	42965	Cardinal	3555 Round Barn Cir # 400	Santa Rosa	CA	
St Joseph Health System Home Care Serv		42965	Cardinal	1845 W Orangewood Ave Ste 100	Orange	CA	
Day Kimball Hospital	AD2632049	42965	Cardinal	320 Pomfret St	Putnam	CT	1100
Presence Resurrection Medical Center	AR3860233	42965	Cardinal	7435 W. Talcott Venue	Chicago	IL	1675
Presence Holy Family	BH7665447	42965	Cardinal	100 N River Road	Desplaines	IL	125
Presence St. Francis Hospital	AS3869572	42965	Cardinal	355 Ridge Aveune	Evanston	IL	150
Presence St. Joseph Hospital	BS7424346	42965	Cardinal	2900 N. Lake Shore Dr	Chicago	IL	100
Presence St. Mary & Elizabeth	AM3876414	42965	Cardinal	2233 W. Division	Chicago	IL	1450
Presence St Mary DBA St Elizabeth	BS8618297	42965	Cardinal	1431 N Claremont	Chicago	IL	820
Presence St. Joseph Medical Center	BP5708536	42965	Cardinal	77 N. Airlie St	Elgin	IL	450
Presence Mercy Medical Center	BP5692264	42965	Cardinal	1325 N. Highland Avenue	Aurora	IL	1650
Presence St. Joseph Medical Center	BP5700390	42965	Cardinal	333 N Madison	Joliet	IL	2800
Presence St. Mary's Hospital	BP5692288	42965	Cardinal	500 W. Court St	Kankakee	IL	200
Presence Covenant Medical Center	BP5692276	42965	Cardinal	1400 W Park St	Urbana	IL	125
Presence United Samaritans Medical Center	BP5692240	42965	Cardinal	812 N Logan Ave	Danville	IL	100
University of Vermont Medical Center	BF4323200	42968	Cardinal	111 Colchester Avenue	Burlington	VT	4050
Central Vermont Medical Center, Inc	AC1121285	42968	Cardinal	130 Fisher Road	Berlin	VT	875
Champlain Valley Physicians Hospital	FH4429747	42968	Cardinal	75 Beekman Street	Plattsburgh	NY	3800
Alice Hyde Medical Center	AH3520289	42968	Cardinal	133 Park Street	Malone	NY	725
Porter Medical Center	AP1126067	42968	Cardinal	115 Porter Dr	Middlebury	VT	0
Elizabethtown Community Hospital	AE1115864	42968	Cardinal	75 Park St	Elizabethtown	NY	50
Champlain Valley Physicians Hospital	AC1115886	42968	Cardinal	75 Beekman Street	Plattsburgh	NY	3800
Brookdale Hospital Medical Center	AB0797803	42968	Cardinal	One Brookdale Plaza	Brooklyn	NY	2125
NYPresbyterian Comell	AN1865243	42968	Cardinal	525 East 68th St, NY, NY 10021	New York	NY	1050
NYPresbyterian Columbia	AT1859644	42968	Cardinal	627 W 165th St; NY, NY 10032	New York	NY	1975
NYPresbyterian Allen	BA1455864	42968	Cardinal	627 W 165th St, NY, NY 10032	New York	NY	150
NYPresbyterian Lower Manhattan	FN4215768	42968	Cardinal	525 East 68th St, NY, NY 10021	New York	NY	425
NYPresbyterian of Queens	BT3671131	42968	Cardinal	56-45 Main St, NY, NY 11355	New York	NY	3800
NYPresbyterian Lawrence Hospital	AL1856886	42968	Cardinal	55 Palmer Avenue, Bronxville, NY 10708	Bronxville	NY	2375
NYPresbyterian Methodist	AM3433240	42968	Cardinal	506 5th St, Brooklyn, NY 11215	Brooklyn	NY	2350
NYPresbyterian Hudson Valley Hospital Center	AP1860483	42968	Cardinal	1980 Crompond Road, Cortlandt Manor, NY	Cortlandt Manor	NY	1525
NYPresbyterian/Allen Hospital	BA1455864	42968	Cardinal	5141 Broadway, NY, NY 10034	New York	NY	850
NYPresbyterian/Lower Manhattan	FN4215768	42968	Cardinal	170 William Street, NY, NY 10038	New York	NY	425
Mercy Hospital- Fairfield	AM8090932	42968	Cardinal	300 Mack Road	Fairfield	OH	6325
The Jewish Hospital	FT1958482	42968	Cardinal	4777 E Galbraith Rd	Cincinnati	OH	4125
Mercy Health- West Hospital	FM3905570	42968	Cardinal	3300 Mercy Health Blv	Cincinnati	OH	4000
Mercy Hospital- Anderson	AO2634144	42968	Cardinal	7500 State Rd	Cincinnati	OH	2400
St Elizabeth Health Center	AS2938984	42968	Cardinal	1044 Belmont Ave	Youngstown	OH	2075
Mercy Regional Medical Center	BC5476494	42968	Cardinal	3700 Kolbe Road	Lorain	OH	1225
Mercy Hospital- Clermont	AC6593644	42968	Cardinal	3000 Hospital Dr	Batavia	OH	850
St Joseph Health Center	BS4791047	42968	Cardinal	667 Eastland Ave	Warren	OH	675
St Elizabeth Boardman HC	BS7085182	42968	Cardinal	8401 Market St	Boardman	OH	300
Mercy Allen Hospital	AA2878556	42968	Cardinal	200 West Lorain	Oberlin	OH	150
Marcum & Wallace Memorial	AE3007211	42968	Cardinal	60 Mercy Ct	Irvine	KY	25

EXHIBIT 3
ELIGIBLE CUSTOMERS

St Rita's Medical Center	AS7471852	42968	Cardinal	730 W Market	Lima	OH	3950
Mercy St Vincent Med Center	AS2861145	42968	Cardinal	2213 Cherry St	Toledo	OH	2325
Springfield Regional Med Center	AT2827838	42968	Cardinal	100 Medical Center Dr	Springfield	OH	1825
Mercy Health- Tiffin	FM4602861	42968	Cardinal	45 St Lawrence Dr	Tiffin	OH	700
Mercy St Anne	BR5662778	42968	Cardinal	3404 W Sylvania Ave	Toledo	OH	575
Mercy St Charles	AS2868911	42968	Cardinal	2600 Navarre Ave	Oregon	OH	425
Mercy Hospital- Defiance	BM7415195	42968	Cardinal	1404 E 2nd St	Defiance	OH	225
Mercy Memorial Hospital	AS2861147	42968	Cardinal	904 Scioto St	Urbana	OH	125
Institute For Orthopaedic	BW8011520	42968	Cardinal	801 Medical Dr	Lima	OH	
Mercy Emergency Services	FM4228171	42968	Cardinal	12621 Eckel Junction	Perrysburg	OH	
Hutchinson Health Hospital	FH0730754	42968	Cardinal	1095 Highway 15 S.	Hutchinson	MN	750
Beth Israel Deaconess Hospital Milton	AM1926851	42969	Cardinal	199 Reedsdale Road	Milton	MA	1000
Capital Medical Center	BC5392573	42969	Cardinal	3900 Capital Mall Dr SW	Olympia	WA	25
St. Clair's Hospital	AS1685986	42970	Cardinal	1000 Bower Hill Road	Pittsburgh	PA	5775
Community Health Center of Branch County	BC0405086	42970	Cardinal	274 E. Chicago Street	Coldwater	MI	600
Adventist Health System	AF0202147	42970	Cardinal	900 Hope Way	Altamonte Springs	FL	14230
Florida Hospital	AF0202147	42970	Cardinal	601 E. Rollins St	Orlando	Fl	
Florida Hospital Altamonte	AF5412755	42970	Cardinal	601 E. Altamonte Dr.	Altamonte Springs	Fl	
Florida Hospital Apopka	AF6710772	42970	Cardinal	201 N. Park Ave	Apopka	FL	
Florida Hospital Celebration Health	BA5671107	42970	Cardinal	400 Celebration Place	Celebration	FL	
Florida Hospital East Orlando	BA2617922	42970	Cardinal	7727 Lake Underhill Rd.	Orlando	FL	
Florida Hospital Kissimmee	BA3849760	42970	Cardinal	2450 N. Orange Blossom Tr.	Kissimmee	FL	
Winter Park Memorial Hospital	BA6894263	42970	Cardinal	200 N. Lakemont Ave.	Winter Park	FL	
Florida Hospital Central Fill Pharmacy	FA4413693	42970	Cardinal	601 E. Rollins St	Orlando	FL	
Florida Hospital Waterman	BF3373204	42970	Cardinal	1000 Waterman Way	Tavares	FL	
Florida Hospital Deland	BM4210554	42970	Cardinal	701 West Plymouth Ave	Deland	FL	
Florida Hospital, Fish Memorial	BS5847029	42970	Cardinal	1055 Saxon Blvd.	Orange City	FL	
Florida Hospital Flagler	BM1982285	42970	Cardinal	60 Memorial Medical Parkway	Palm Coast	FL	
Florida Hospital Memorial Medical Center	AO1187473	42970	Cardinal	301 Memorial Medical Pky.	Daytona Beach	FL	
FHMMC Oceanside	BM5639136	42970	Cardinal	264 S. Atlantic Ave.	Ormond Beach	FL	
Florida Hospital New Smyrna Beach	FB5001956	42970	Cardinal	401 Palmetto Ave.	New Smyrna Beach	FL	
Florida Hospital Heartland Medical Center, Sebring	BA5558892	42970	Cardinal	4200 Sun 'N Lake Blvd.	Sebring	FL	
Florida Hospital Heartland Medical Ctr Lake Placid	AW1418549	42970	Cardinal	1210 US Highway 27, N.	Lake Placid	FL	
Florida Hospital Wauchula	BW3551937	42970	Cardinal	533 W. Carlton St.	Wauchula	FL	
Florida Hospital Tampa	AU0202159	42970	Cardinal	3100 E. Fletcher Ave.	Tampa	FL	
Florida Hospital Carrollwood	BU3878761	42970	Cardinal	7171 Dale Mabry Hwy.	Tampa	FL	
FH North Pinellas	AT0186987	42970	Cardinal	1395 S. Pinellas Ave.	Tarpon Springs	FL	
Florida Hospital Wesley Chapel	FP3286235	42970	Cardinal	2600 Bruce B. Downs Boulevard	Wesley Chapel	FL	
Florida Hospital Connerton LTAC	FU1178664	42970	Cardinal	9441 Health Center Dr	Land O Lakes	FL	
Florida Hospital Zephyrhills	AE1220839	42970	Cardinal	7050 Gall Blvd.	Zephyrhills	FL	
Shawnee Mission Medical Center	AS4415091	42970	Cardinal	9100 West 74th St.	Shawnee Mission	KS	
Chippewa Valley Hospital	AC9604112	42970	Cardinal	PO Box 224	Durand	WI	
Gordon Hospital	AG9023778	42970	Cardinal	PO Box 12938	Calhoun	GA	
Manchester Memorial Hospital	AM4541581	42970	Cardinal	210 Marie Langdon Dr.	Manchester	KY	
Park Ridge Health	AM3188706	42970	Cardinal	100 Hospital Drive	Hendersonville	NC	
Murray Medical	FM5261474	42970	Cardinal	707 Old Dalton Ellijay Rd	Chatsworth	GA	
Takoma Regional Hospital	AT0404886	42970	Cardinal	401 Takoma Ave.	Greenville	TN	
Central Texas Medical Center	AH3214311	42970	Cardinal	1301 Wonder World Dr.	San Marcos	TX	
Metroplex Hospital	AM7464287	42970	Cardinal	2201 S. Clear Creek Rd.	Killeen	TX	
Rollins-Brook Community Hospital	BR2985440	42970	Cardinal	608 N. Key Ave.	Lampass	TX	
Texas Health Huguley Hospital Fort Worth South	FH3341334	42970	Cardinal	PO Box 6337	Fort Worth	TX	
Washington Adventist Hospital	AW2544307	42970	Cardinal	7600 Carroll Ave	Takoma Park	MD	
Shady Grove Hospital	AS9878899	42970	Cardinal	9901 Medical Center Dr.	Rockville	MD	
Beloit Health System	AB3926144	42970	Cardinal	1969 W. Hart Rd.	Beloit	WI	175
University of Colorado Hospital	BI8615001	42971	Cardinal	12605 E 16th Ave 80045	Aurora	CO	11300
Beloit Health System	AB3926144	42971	Cardinal	1969 W. Hart Rd.	Beloit	WI	175
Sanford Worthington Medical Center	AW3654096	42971	Cardinal	1018 6th Ave.	Worthington	MN	175
Sanford Bemidji Medical Center	AB3622710	42971	Cardinal	1300 Anne St NW	Bemidji	MN	1125
Sanford Kitson Memorial Healthcare Center	AK3629601	42971	Cardinal	1010 S. Birch Ave.	Hallock	MN	25
Sanford Mahnomen Health Center	FM3499123	42971	Cardinal	414 W. Jefferson Ave.	Mahnomen	MN	
Sanford Murray County Memorial Hospital	AM3619129	42971	Cardinal	2042 Juniper Ave.	Slayton	MN	25
Sanford Ortonville Area Health Services	AO3642154	42971	Cardinal	450 Eastvold Ave.	Ortonville	MN	75
Sanford Perham Health.	AM3647609	42971	Cardinal	1000 Coney St W	Perham	MN	50
Sanford Riverview Health	AK4487066	42971	Cardinal	323 S. Minnesota St.	Crookston	MN	300
Sanford Bagley Medical Center	FS4247888	42971	Cardinal	203 4th St. NW	Bagley	MN	75
Sanford Canby Medical Center	BS0956178	42971	Cardinal	112 St. Olaf South	Canby	MN	100
Sanford Jackson Medical Center	AL3639496	42971	Cardinal	1430 N. Highway	Jackson	MN	100
Sanford Luverne Medical Center	AC3628166	42971	Cardinal	1600 North Kniss	Luverne	MN	75
Sanford Thief River Falls Southeast Campus	FM0611978	42971	Cardinal	1720 Hwy 59 South	Thief River Falls	MN	
Sanford Thief River Falls Downtown Campus	FM0561677	42971	Cardinal	120 Labree Ave. South	Thief River Falls	MN	
Sanford Thief River Falls Medical Center	FS4872962	42971	Cardinal	3001 Sanford Pkwy.	Thief River Falls	MN	525
Sanford Tracy Medical Center	AT3625374	42971	Cardinal	249 Fifth St. East	Tracy	MN	
Sanford Westbrook Medical Center	AB3640061	42971	Cardinal	920 Bell Ave.	Westbrook	MN	
Sanford Wheaton Medical Center	FS2658409	42971	Cardinal	401 12th St.	Wheaton	MN	25
Sanford Wisdom Area Hospital	AW6026826	42971	Cardinal	2150 Hospital Dr.	Windom	MN	50
Sanford Health Detroit Lakes	BL4602626	42971	Cardinal	1245 Washington Ave.	Detroit Lakes	MN	175
Stringfellow Memorial	AS0461094	42971	Cardinal	301 E. 18th St.	Anniston	AL	1350
UCSF Medical Center at Parnassus Heights	BU7019626	42971	Cardinal	505 Parnassus Ave	San Francisco	CA	150
UCSF Benioff Children's Hospital - Oakland	AC2023490	42971	Cardinal	747 52nd St	Oakland	CA	1300
Langley Porter Psychiatric Hospital	AV3310404	42971	Cardinal	401 Parnassus Ave	San Francisco	CA	50
UCSF Medical Center at Mount Zion	BU7019614	42971	Cardinal	1600 Divisadero St	San Francisco	CA	50
UCSF Benioff Children's Hospital - Parnassus	BU7019626	42971	Cardinal	505 Parnassus Ave	San Francisco	CA	150
UCSF Medical Center at Mission Bay	FU2144727	42971	Cardinal	1825 4th St	San Francisco	CA	7100
Albany Medical Center	AA1115948	42971	Cardinal	43 New Scotland Avenue	Albany	NY	9100
SSM Healthcare Corporation		42971	Cardinal	12312 Olive Blvd, Suite 500	St. Louis	MO	30300
Dean Medical Center		42971	Cardinal	1808 W Beltline Hwy	Madison	WI	
Dean St Mary's Surgery & Care Center	AH1695395	42971	Cardinal	700 S Park St	Madison	WI	

EXHIBIT 3
ELIGIBLE CUSTOMERS

St. Mary's Dean Joint Venture Surgery Center, Davis	FH2454287	42971	Cardinal	1025 Regent St	Madison	WI	
SSM Health Cardinal Glennon Children's Hospital	BC5180257	42971	Cardinal	1465 S Grand Blvd	Saint Louis	MO	
SSM Health Depaul Hospital - St. Louis	BD4407070	42971	Cardinal	12303 de Paul Dr	Bridgeton	MO	
SSM Health Good Samaritan Hospital - Mt. Vernon	BG4793166	42971	Cardinal	1 Good Samaritan Way	Mount Vernon	IL	
SSM Health Saint Louis University Hospital	FS5514927	42971	Cardinal	3635 Vista Ave	Saint Louis	MO	
SSM Health St Marys Hospital - Audrain	AA3938721	42971	Cardinal	620 E Monroe St	Mexico	MO	
SSM Health St. Clare Hospital - Fenton	FS1293391	42971	Cardinal	1015 Bowles Ave	Fenton	MO	
SSM Health St. Joseph Hospital - Lake St. Louis	BS3514987	42971	Cardinal	100 Medical Plz	Lake Saint Louis	MO	
SSM Health St. Joseph Hospital - St. Charles	BS3544447	42971	Cardinal	300 1st Capitol Dr	Saint Charles	MO	
SSM Health St. Joseph Hospital - Wentzville	FS0699065	42971	Cardinal	500 Medical Dr	Wentzville	MO	
SSM Health St. Mary's Hospital - Centralia	AS3758680	42971	Cardinal	400 N Pleasant Ave	Centralia	IL	
SSM Health St. Mary's Hospital - Jefferson City	BS6653605	42971	Cardinal	100 Saint Marys Plz	Jefferson City	MO	
SSM Health St. Mary's Hospital - St. Louis	BS3516929	42971	Cardinal	6420 Clayton Rd	Saint Louis	MO	
St. Joseph Health Center		42971	Cardinal	300 1st Capitol Dr	Saint Charles	MO	
SSM St. Anthony Hospital	AS2144791	42971	Cardinal	1000 N Lee Ave	Oklahoma City	OK	
SSM Bone and Joint Hospital at St Anthony	FB1196665	42971	Cardinal	1111 N Dewey Ave	Oklahoma City	OK	
SSM St. Anthony Shawnee Hospital	FS3382900	42971	Cardinal	1102 W MacArthur St	Shawnee	OK	
St. Anthony Behavioral Medicine at St. Michael Hospit	BS8106824	42971	Cardinal	2129 SW 59th St	Oklahoma City	OK	
SSM St. Clare Hospital and Health Services	BS6630099	42971	Cardinal	707 14th St	Baraboo	WI	
SSM St. Francis Hospital	AS3884322	42971	Cardinal	2016 S Main St	Maryville	MO	
SSM St. Mary's Hospital	BS6610679	42971	Cardinal	700 S Park St	Madison	WI	
SSM St. Mary's Janesville	FS2686945	42971	Cardinal	3400 E Racine St	Janesville	WI	
St. Anthony Healthplex Mustang	FS4940575	42971	Cardinal	201 S Sara Rd	Mustang	OK	
Clay County Hospital	AC3561572	42971	Cardinal	911 Stacey Burk Dr	Flora	IL	
Hamilton Memorial Hospital District	AH3752119	42971	Cardinal	611 S Marshall Ave	Mc Leansboro	IL	
North Cypress Emergency Room - Fairfield	FN5412654	42971	Cardinal	15103 Mason Rd Ste E	Cypress	TX	
Ozarks Medical Center Employee	BO8059819	42971	Cardinal	18 Pkwy Ctr	West Plains	MO	
Ozarks Medical Center Pharmacy Ozarks Medical Center		42971	Cardinal	1100 N Kentucky Ave	West Plains	MO	
Beaver County Memorial Hospital	AB6754091	42971	Cardinal	212 E 8th St	Beaver	OK	
Bothwell Regional Health Center	AJ3943316	42971	Cardinal	601 E 14th St	Sedalia	MO	
Columbus Community Hospital, Inc	AC3974917	42971	Cardinal	1515 Park Ave	Columbus	WI	
Craig General Hospital	AC9001487	42971	Cardinal	735 N Foreman St	Vinita	OK	
Stoughton Hospital	AS4058562	42971	Cardinal	900 Ridge St	Stoughton	WI	
Doctors Hospital at Renaissance	BD8479239	42971	Cardinal	5501 S McColl Rd	Edinburg	TX	
Edgerton Hospital and Health Services, Inc.	AM3923504	42971	Cardinal	11101 N Sherman Rd	Edgerton	WI	
Epic Medical Center	FE2880206	42971	Cardinal	1 Hospital Dr	Eufaula	OK	
Fairview Regional Medical Center	BF0503006	42971	Cardinal	523 E State Rd	Fairview	OK	
Fulton County Hospital	AF3216757	42971	Cardinal	679 N Main St	Salem	AR	
Hannibal Regional Healthcare System, Inc.	BH5098935	42971	Cardinal	6000 Hospital Dr	Hannibal	MO	
Harper County Community Hospital	AH3353137	42971	Cardinal	1003 Hwy 64 N	Buffalo	OK	
Madison Medical Center	AM3931802	42971	Cardinal	611 W Main St	Fredericktown	MO	
Monroe Clinic Hospital	AS3919670	42971	Cardinal	515 22nd Ave	Monroe	WI	
Newman Memorial Hospital	AN2166002	42971	Cardinal	905 S Main St	Shattuck	OK	
North Cypress Medical Center	FN0094605	42971	Cardinal	21214 Northwest Fwy	Cypress	TX	
North Texas Medical Center	AG2246292	42971	Cardinal	1900 Hospital Blvd	Gainesville	TX	
Okeene Municipal Hospital	AR3353284	42971	Cardinal	207 E F St	Okeene	OK	
Ozarks Medical Center	AW3776551	42971	Cardinal	1100 N Kentucky Ave	West Plains	MO	
Pauls Valley General Hospital	AP2160771	42971	Cardinal	100 Valley Dr	Pauls Valley	OK	
Phelps County Regional Medical Center	AP9733014	42971	Cardinal	1000 W 10th St	Rolla	MO	
Pike County Memorial Hospital	AP3972658	42971	Cardinal	2305 Georgia St	Louisiana	MO	
Pinckneyville Community Hospital	AP3848275	42971	Cardinal	101 N Walnut St	Pinckneyville	IL	
Purcell Municipal Hospital	AP2175138	42971	Cardinal	1500 N Green Ave	Purcell	OK	
Pushmataha Hospital Clinic	AC3352983	42971	Cardinal	510 E Main St	Antlers	OK	
Roger Mills Memorial Hospital	AR2157318	42971	Cardinal	501 S L L Males Ave	Cheyenne	OK	
Upland Hills Health	AM5866734	42971	Cardinal	800 Compassion Way	Dodgeville	WI	
Share Medical Center Alva Hospital Authority	AS2173730	42971	Cardinal	800 Share Dr	Alva	OK	
Southwest Health Center	BS9114315	42971	Cardinal	1400 Eastside Rd	Platteville	WI	
St. Louis Regional Psychiatric Stabilization Center	FS2975413	42971	Cardinal	5355 Delmar Blvd	Saint Louis	MO	
The Children's Center Inc. dba The Children's Center	FT4097487	42971	Cardinal	6800 NW 39th Expy	Bethany	OK	
Washington County Hospital	AW3841601	42971	Cardinal	703 S Grand St	Nashville	IL	
Weatherford Regional Hospital Weatherford Hospital	BW0160686	42971	Cardinal	3701 E Main St	Weatherford	OK	
Monroe Clinic Hospital	AS3919670	42971	Cardinal	515 W. 22nd St.	Monroe	WI	800
Centra Virginia Baptist Hospital	AV2488763	42971	Cardinal	3300 Rivermont Ave	Lynchburg	VA	2625
Lynchburg General Hospital	BL0035328	42971	Cardinal	1901 Tate Springs Rd	Lynchburg	VA	500
Bedford Memorial Hospital	AB0635904	42971	Cardinal	1613 Oakwood St	Bedford	VA	425
Centra Southside Hospital	AS2499198	42971	Cardinal	800 Oak St	Farmville	VA	575
Centra OutPatient Pharmacy	FC3186031	42971	Cardinal	3300 Rivermont Ave	Lynchburg	VA	100
Cullman Regional	AC0459013	42970	Cardinal	1912 AL Hwy 157	Cullman	AL	1650
Decatur County Memorial Hospital	AD2849618	42975	Cardinal	720 N Lincoln St	Greensburg	OH	175

EXHIBIT 6

MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON JUDICIARY

Seventy-Ninth Session
March 29, 2017

The Committee on Judiciary was called to order by Chairman Steve Yeager at 8:06 a.m. on Wednesday, March 29, 2017, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/79th2017.

COMMITTEE MEMBERS PRESENT:

Assemblyman Steve Yeager, Chairman
Assemblyman James Ohrenschall, Vice Chairman
Assemblyman Elliot T. Anderson
Assemblywoman Lesley E. Cohen
Assemblyman Ozzie Fumo
Assemblyman Ira Hansen
Assemblywoman Sandra Jauregui
Assemblywoman Lisa Krasner
Assemblywoman Brittney Miller
Assemblyman Keith Pickard
Assemblyman Tyrone Thompson
Assemblywoman Jill Tolles
Assemblyman Justin Watkins
Assemblyman Jim Wheeler

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator Tick Segerblom, Senate District No. 3
Assemblywoman Dina Neal, Assembly District No. 7

STAFF MEMBERS PRESENT:

Diane C. Thornton, Committee Policy Analyst
Brad Wilkinson, Committee Counsel
Erin McHam, Committee Secretary
Melissa Loomis, Committee Assistant

OTHERS PRESENT:

Cynthia Portaro, Private Citizen, Las Vegas, Nevada
Drew Johnson, Senior Fellow, Taxpayers Protection Alliance
Scott L. Coffee, Attorney, Clark County Public Defender's Office; and representing Nevada Attorneys for Criminal Justice
Michael Pescetta, Private Citizen, Las Vegas, Nevada
Charles "Chuck" Durante, Pastor and Chair, Life Peace and Justice Commission of the Diocese of Reno; and representing Nevada Catholic Conference
Maizie Pusich, Chief Deputy Public Defender, Washoe County Public Defender's Office
Nancy E. Hart, President, Nevada Coalition Against the Death Penalty
Holly Welborn, Policy Director, American Civil Liberties Union of Nevada
Lynn Chapman, State Vice President, Nevada Eagle Forum
Christopher J. Hicks, District Attorney, Washoe County District Attorney's Office; and representing Nevada District Attorneys Association
Steven B. Wolfson, District Attorney, Clark County District Attorney's Office
Christopher J. Lalli, Assistant District Attorney, Clark County District Attorney's Office
Ronald P. Dreher, Government Affairs Director, Peace Officers Research Association of Nevada
Terri Bryson, Chapter Co-Leader, Desert of Hope Chapter, National Organization of Parents of Murdered Children, Inc.
Shalonda Hughes, Private Citizen, Las Vegas, Nevada
Tereza Trejbalova, Private Citizen, Las Vegas, Nevada
Kenneth Cherry, Sr., Private Citizen, Oakland, California
Jennifer Otremba, Private Citizen, Las Vegas, Nevada
Lisa Postorino, Private Citizen, Las Vegas, Nevada
Brett Kandt, Chief Deputy Attorney General, Office of the Attorney General
Tehran Boldon, Private Citizen, Las Vegas, Nevada
Escenthio Marigny, Jr., Student and Climate Justice Organizer, Progressive Leadership Alliance of Nevada
Wendy Stolyarov, Legislative Director, Libertarian Party of Nevada
Donald G.T. Gallimore, Second Vice President, Reno/Sparks Branch, National Association for the Advancement of Colored People
Sarah Collins, representing Nevada Psychological Association
Tamika Shauntee, representing Las Vegas Branch, National Association for the Advancement of Colored People

Chairman Yeager:
[Roll was called and Committee protocol was explained.] We will now formally open the hearing on Assembly Bill 237. Before we get started, I want to give everyone a roadmap on how we are going to move through this meeting today. We have the bill's sponsors at the table. After they are done speaking, I have a list of people who are going to testify in support as part of the presentation. That list contains an additional eight or nine people. We have spoken about making sure the testimony remains brief. At that time, I will take questions from the Committee for the presenters. If you have a question that is directed toward a specific presenter, that would be helpful. If your question is general, I would ask the presenters to designate one person to answer that question. We simply do not have time for everyone to answer every question. I want to make sure we have a complete hearing. I know we could go on for several hours, but we only have about 2.5 hours. After the presenters, I will take supporting testimony, opposition testimony, and neutral if there is anyone.

Assembly Bill 237: Abolishes capital punishment. (BDR 15-544)

Assemblyman James Ohrenschall, Assembly District No. 12:
It is not difficult to understand why we, as a state, have in the past turned to the death penalty as a punishment for the gravest of crimes. Emotionally, the response to the deep injustice of murder can be difficult to separate from the realities of state-sanctioned execution. In the case of the death penalty in Nevada, the reality is complicated and nuanced, but the truth remains—the death penalty is a costly, intrinsically unfair, and ineffective deterrent. Nevada has executed just a dozen inmates since the ban on the death penalty was lifted in 1976 by the Supreme Court of the United States, despite the fact that the state typically houses 80 inmates on death row. Moreover, 11 of those 12 executions were what are called "volunteers." They were inmates who decided to waive any further appeals and be put to death rather than live out their days in prison. The fate of Nevada's current 80-some death row inmates remains, at best, in question. A person sentenced to death in Nevada is more likely to die of natural causes than to be executed, and more than three-quarters of Nevada's death row inmates have been there for more than a decade, while more than half have been on death row for more than two decades. Despite these facts, Clark County, our state's most populous county, has one of the highest per capita rates of pending death penalty cases in the country—more pending cases than San Diego, Los Angeles, and San Francisco combined.

It is not difficult to see that the number of inmates on death row will only increase in coming years, as Nevada is now unable to acquire the lethal chemical cocktail required to perform executions in this state. In fact, just last September the state issued 247 requests for proposals to supply these drugs required for lethal injection and received no bids from any pharmaceutical companies. In fact, the pharmaceutical company Pfizer stated its intent to refrain from providing the drugs going forward, releasing a statement saying that "Pfizer's mission is to apply science and our global resources to improve health and well-being at every stage of life. We strive to set the standard for quality, safety, and value in the discovery, development, and manufacturing of medicines. Pfizer makes its products to enhance and save the lives of the patients we serve. Consistent with these values, Pfizer strongly objects to the use of its products as lethal injections for capital punishment."

The statement (Exhibit C) outlines Pfizer's methods for restricting access to the drugs required for lethal injection, effectively ensuring that wholesalers, distributors, and direct purchasers would be allowed to access the drugs only "under the condition that they will not resell these products to correctional institutions for use in lethal injections," and that "Government purchasing entities must certify that products they purchase or otherwise acquire are used only for medically prescribed patient care and not for any penal purposes."

Beyond the logistics of the state's lack of access to the lethal chemicals used for capital punishment, the reality of the astronomical cost for the state must be considered. In 2014, the Nevada Legislature conducted an audit that documented the high financial costs of continuing to offer capital punishment as a penalty in Nevada. According to this audit, the decision to seek the death penalty adds, on average, about $500,000 to the cost of a case, as opposed to a similar case being prosecuted as life without the possibility of parole. That cost is incurred every time the death penalty is sought, even though fewer than 20 percent of these cases result in a sentence of death. A 2012 University of Nevada, Las Vegas (UNLV) study estimated that the 80 capital cases prosecuted in Clark County would cost $15 million more than if they had been prosecuted without seeking the death penalty.

Chairman Yeager and members of the Committee, I am intimately aware of the fear that many Nevadans have in response to removing the death penalty as a potential deterrent to would-be criminals. In separating emotion from the facts, we must consider the thoughtful research that, time and again, has failed to show any connection between deterrence of violent crime and the death penalty. In 2012, the National Academy of Sciences, after reviewing 30 years of research, found that there was no proof that the death penalty acted as a deterrent, stating that, "research to date on the effect of capital punishment on homicide is not informative on whether capital punishment decreases, increases, or has no effect on homicide rates. Therefore, the committee recommends that these studies not be used to inform deliberations requiring judgments about the effect of the death penalty on homicide. Consequently, claims that research demonstrates that capital punishment decreases or increases the homicide rate by a specified amount or has no effect on the homicide rate should not influence policy judgments about capital punishment." That is from the United States Department of Justice study through its research branch, the National Institute of Justice.

The death penalty's unfairness is also well documented. When Harvard Law School's Fair Punishment Project analyzed the country's 16 counties that imposed the most death sentences from 2007 to 2015, the analysis found that Clark County exhibited the highest levels of prosecutorial misconduct. The Nevada Supreme Court echoed these findings, noting misconduct in 47 percent of Clark County death penalty cases reviewed on appeal since 2006. During the same period, the Project also found that 71 percent of victims in cases that resulted in a death sentence were white, while only 33 percent of murder victims in Las Vegas, the most populous county in our state, were white. In fact, based on exonerations, innocent African Americans are roughly seven times more likely to be

wrongfully convicted of murder than innocent Caucasians. Examinations of reviews of the relationship between race and the death penalty conducted in every major death penalty state found that 96 percent of those reviews showed a pattern of either race-of-victim or race-of-defendant discrimination, or both.

While the emotions often tied to the death sentence are undeniable, the facts remain unavoidable. Beyond the logistical problem of the state's inability to acquire the chemicals required to carry out a death sentence, it is an inescapable truth that the death penalty is unfair, ineffective, and extremely costly to our taxpayers. It is time that the Nevada Legislature recognizes these truths and ends capital punishment in Nevada. Chairman Yeager, with your permission I would like to turn it over to Senator Segerblom. I then have Cynthia Portaro, the mother of Michael Portaro who was murdered in Clark County in 2011. Cynthia would like to testify in support of the bill, as will Drew Johnson from the Taxpayers Protection Alliance.

Senator Tick Segerblom, Senate District No. 3:
I will be brief since Assemblyman Ohrenschall said it all. The reality is that it is important to reconsider this issue every few years because it is a moral issue and an expense issue. From a moral ground, I do not see how we can justify capital punishment. If killing is something that our society condemns, how can we as a society turn around and kill people? As long as we are killing people, others will be killing people. Looking at the financial aspect, it has cost us a fortune and it is ineffective. We had to spend $800,000 to build a death chamber, but we cannot buy the drugs to use the death chamber. It is half a million dollars more every time it is sought. There is no good reason for it other than the psychological factor of wanting to be able to kill somebody. If you realize that you cannot kill anybody at the end of the day, why waste that money, why waste those resources, and why stigmatize our society by saying that as a society we are entitled to kill people. Thank you for raising this issue. I am somebody who believed we would never have legalized marijuana in my lifetime and we did, so hope springs eternal.

Cynthia Portaro, Private Citizen, Las Vegas, Nevada:
This is an emotional topic for me. I am not just here based on emotions; I am very educated in this process. I am also engaged in this bill. I am fully aware of the financial aspects of this, but I am more aware of the devastation that we victims of crime live with day in and day out. Tomorrow marks the six-year anniversary of my son being brutally shot and killed for just a car theft. The guy wanted his car. My son was sitting in a parking lot of a restaurant in Las Vegas right across the street from a very popular hospital. He had his door open. My son's killer's name is Brandon J. Hill. You will hear me use his name. He was convicted of the crime. He was sitting on a bench in front of the restaurant waiting for somebody's car that he could hijack. My son was out selling tickets for a concert in which he was performing. He was a songwriter and performed on stage. He met two women in the parking lot of this restaurant to exchange tickets for money. He had called his partner 15 to 20 minutes prior to that and told him that he would be back to the place they were going to practice by 11 or 11:15 a.m. At that time, he got out of the car, exchanged the tickets and

money, got back in his car, and left his door open. Brandon came up, walked for 11 seconds, and shot my son. It is funny, but I cannot remember if it was four times in the head or six times in the head. I did sit through the trial. I heard the details of the crime that Brandon committed.

Michael was a good kid. He was always good to the underdog. He never accepted bullying in school and he protected kids. His best friend in high school was a quadriplegic whom he cared for on a regular basis. He was a teenager. He did his share of mischievous stuff, but he had a heart of gold. If Brandon had walked up to my son and said, "Hey, I want your car," my son would have given him the keys and said, "Here you go, bro."

My 16-year-old daughter was extremely close to my son. I raised five children in Las Vegas and they all went to the same high school—Faith Lutheran Middle School and High School. I raised my kids to be kind to others. If they would come to me with a situation, I would ask them, "How would that affect so-and-so? Think of their feelings. Think of how that is going to relate to them." That may not be important to this bill, but it is important when you have a family that, in the blink of an eye, is devastated. My daughter took it the hardest. As a mother, you want to protect your children. When you do not have that choice, when that choice is taken from you, you are devastated. We finally got my daughter, as angry as she was, into a good counsellor and in a good place. I took her and some friends up to our mountain condo in Brian Head, Utah. She was killed on an ATV five months later. She rolled it. She was a good driver, but there was some conflict with a car that was coming toward her. She tried to veer off of the road. I was the first one on the scene. After losing my son, we had to deal with Chrissy's death. Both I and my husband, who followed most of the postponements, wanted the death penalty. My family wanted revenge. We were angry.

The stress of having to go through what you go through as a family without your two kids is great. My other three kids were not the same for a long time. It takes a long time. What the state offers us victims of crime is a mere $1,000 toward counselling per family member. You tell me, after six years, how $1,000 is going to cover the heartache that a parent, sibling, family member, or friend feels at the loss of somebody so wonderful. Sitting through postponement after postponement for over four years, finally we came to trial. In the meantime, my husband was diagnosed in October 2012 with a tumor in his sinus cavity. He passed away Thanksgiving Day, 2014. In six years, half of my family has disappeared. Now, as a mother, I am faced with sitting through the trial of my son. Going into that trial, listening to what I listened to, and hearing what I heard not only broke me to pieces, but I was angry and upset.

My son's killer, Brandon, is black. My son is white, with blue eyes and dark brown hair. In the meantime, Trayvon Martin was killed. Everybody knows about that trial because it made national news and President Obama made a big stink about it. It angered me even more to think that a black kid killed a white kid; what is the difference? Blood is blood; red is red. We are all called to be human beings. Why make such a big deal out of that and not about my son? As I started to think about my faith, I started to think we are called to forgive. We are called to be different if you are a faithful person. During the trial, after the closing

arguments, I sat and thought, What if a mother who is devastated by what happened to her son forgave a black kid for killing him. What would that do to society? Would that not show peace and forgiveness? Maybe he has something that he needs to do for the rest of his life. I went to the prosecution and said, "I want to talk about this death penalty thing. I do not want it." They were not happy. He said, "No, we cannot do that. We need to have this. We need life in prison." That is basically what he was telling me was if we got the death penalty he would for sure be in prison for life. I said, "No, I do not want that on my head. I want to be able to sleep at night knowing that a life was saved, not taken." Too many lives are taken because of poor decisions that people make, and I wanted it to end right there. That was my decision—to say, I do not want the death penalty because it does absolutely nothing. I sat before a panel of attorneys at UNLV, and one of the attorneys said, "We want restitution for the family." I got up and said, "Restitution? Is killing somebody going to bring my son back? No, it is not. Nothing is going to bring my son back, but maybe this kid can make a difference in the world." I chose to say no to the death penalty. It does not do anything for me. Some of these murder victims lose their breadwinners. Their kids are losing their father or mother to crime. Where is restitution? Why can we not use some of that money to help these families get back on their feet? I deal with an organization of homeless teens, Project 150, and there are kids who lose their parents and are living on the street. We help take care of them. Why is our state not using some of these funds to take care of these families? That is where I became educated.

When my daughter died, her volleyball teammate had a dream. The only thing in the dream was that my daughter said to her, "Colossians 3:15." I do not know what your faith is; I only know what mine is. This is not about me telling you how to think. When you read this, the scripture is "Let the peace of Christ rule in your hearts, since as members of one body you are called to peace. And be thankful. Let the message of Christ dwell in you richly as you teach and admonish one another, [forgiving one another] with all wisdom." That scripture has carried me through today. I thank you for allowing me to speak from my heart and from my knowledge. We need to make a change in what is happening in our country with the anger that people have; for killing people for no reason; for the horrific crimes that have taken place that I have personally helped parents deal with. It is something that needs to stop.

Chairman Yeager:
Please accept our deepest condolences for your losses, and thank you for being here and sharing with the Committee.

Drew Johnson, Senior Fellow, Taxpayers Protection Alliance:
Chairman Yeager, you are my Assemblyman. I live in Summerlin South, Las Vegas. As much as I appreciate you and the other Democrats having me here to speak, I am not here to talk to you. I am here to talk to the Republicans, my fellow conservatives. I am a senior scholar at the Taxpayers Protection Alliance, a group committed to ensuring that government remains small and responsible and that tax dollars are well-spent and used responsibly. I am also the national director of a group called Protect Internet Freedom. I have columns in the *Daily Caller*, *Newsmax*, and *The Hill*. I founded one of America's most successful free

market think tanks and ran it for about ten years. I also worked at the American Enterprise Institute and the National Taxpayers Union. I say all of that to say I am one of you. I am a conservative, and I have committed my entire life to promoting conservative, free-market, limited government values. For years, I supported the death penalty because I thought it was the "conservative" thing to do. I now understand that capital punishment is against all the values I hold dear as a conservative. I believe the death penalty is the single least-conservative thing that we do as a society.

The most important principle for Republicans and conservatives is the idea that government should be limited in size and scope. Most of the Republicans sitting here today ran on the promise that you would reduce the expense and the expanse of government here in Nevada. When you think about it, we do not trust government to hand out driver's licenses. In this state, we do a terrible job at those sorts of basic things with the weight and mounds of bureaucracy. For some reason we trust the government to kill its own citizens. Not surprisingly, a bloated, inefficient, ineffective state government makes mistakes. Nearly 160 Americans have been released from death row due to wrongful convictions. Others have not been so lucky.

More than 4 percent of the people put to death since America reinstituted the death penalty in the mid-1970s were innocent, according to the *Proceedings of the National Academy of Sciences*, a scientific journal. Even if we lived in a dream world where we were sure we never put an innocent person to death, it still gives government power it should not have: to be able to kill its own citizens. Speakers after me will talk about compassion. Certainly, the preceding speaker spoke about compassion. I want to talk about a different kind of compassion—compassion for taxpayers. Let us be honest—Nevada does not have a death penalty. In almost 40 years, we have put one person to death against his will. As Assemblyman Ohrenschall said before I came up, 11 other people chose to be executed because they would have rather died than spend the rest of their lives in jail. That speaks to the fact that life without parole, functionally death in prison, is in many cases a worse punishment than the death penalty. The state really does not have a death penalty now because there is no way to get the lethal injection drugs. It will probably be years, if ever, before we are able to get the drugs again. The state, for all intents and purposes, does not have a death penalty, but it does have a death penalty prosecution racket that adds half a million dollars to the cost of every death penalty case. The defendant is not even sentenced to death in more than 80 percent of those cases. We are paying half a million dollars a case when usually they are not sentenced to death. Even if they are sentenced to death, they are never actually put to death.

Credible studies indicate that the total price tag to sentence a murderer to death by execution generally runs about ten times higher than sentencing the same person to death in prison when you factor in other costs such as appeals and the additional expense of housing somebody on death row. This particularly affects Clark County, which is literally, per capita, the death penalty capital of the United States. In Clark County, taxpayers including me pay tens of millions of dollars to sentence criminals to death by execution, when they end up dying in prison, just like the inmates who are sentenced to life in prison. As a professional

budgetary economist, I find it irresponsible that the Legislature has not already repealed the death penalty. As a Clark County taxpayer, I am sick and tired of being ripped off, having my money spent for absolutely nothing except a silly dog-and-pony show that allows district attorneys and other officials to say they are being tough on crime, when by prosecuting somebody for the death penalty they get the same outcome as if they had prosecuted them for death in prison. Death in prison is what life without parole is here in Nevada. Since 1995, Nevada has had the strongest life-without-parole laws in America. If you are sentenced to life without parole in Nevada, you spend your life in jail. You never set foot outside of the penitentiary. It is the same as being sentenced to death.

Besides being ridiculously expensive, the death penalty fails at the only thing it is supposed to do, which is deter crime. No credible study shows that the death penalty actually deters crime. Studies have shown that states without the death penalty actually have lower crime rates than states with the death penalty. There is an inverse relationship to having the death penalty in your state. The death penalty does not always provide closure to victims' families. There is no peace or closure. It often prolongs their agony because of the appeals process and the fact that they are never actually put to death. In fact, several families of victims killed in the Boston Marathon bombing objected to death penalty prosecution after speaking with other murder victims' families, who warned about the numerous appeals and often emotionally painful legal process associated with the death penalty.

The Nevada Legislature is unique because every other state that is seriously considering repealing the death penalty actually has Republicans sponsoring or cosponsoring the death penalty bill. This includes GOP lawmakers in Missouri, South Dakota, Wyoming, Nebraska, Utah, Kansas, Kentucky, Montana, Georgia, and New Hampshire. It seems like in many ways you are behind the trend when it comes to supporting death penalty repeal. I encourage you to consider not only cosponsoring this bill, but also voting for its passage, both in this Committee and on the floor. Ultimately, there is nothing that violates conservative, Republican, limited-government principles more than the death penalty. Let us be honest: this year you guys are not going to win many battles. This is one opportunity where you can be involved in passing something that actually does uphold our conservative principles. By abolishing the death penalty, you will save taxpayers money, eliminate the possibility of killing an innocent person, get rid of a completely useless government program, and strip the government of a power it should not have. What could be more conservative than that?

Chairman Yeager:
Members, we are going to hold questions until we finish with the other presenters. Next, we will call up Mr. Coffee and Mr. Pescetta.

Scott L. Coffee, Attorney, Clark County Public Defender's Office; and representing Nevada Attorneys for Criminal Justice:
I have been on the front lines of this for the better part of 20 years. Nevada reinstated the death penalty in 1977 after a Supreme Court decision in 1976. I have been around for half of that time. As a result of that, I have by necessity dug into numbers related to the death penalty. The numbers are staggering, even if you philosophically are in favor of the death

penalty. I understand that all of us may not have the grace of Ms. Portaro and be able to accept what happened as graciously as she did. Some people may feel it necessary to push for the death penalty. Nevada's death penalty is broken; it is broken beyond repair.

Since January 1, 2005, there have been 175 death penalty notices filed in Clark County. If you look at the legislative cost audit, you are talking about a cost of $70 million to put those cases through the system, above and beyond what it would have cost to take those cases to trial as life-without-parole cases. It is a huge amount of money. Even if you believe that the death penalty is some kind of moral imperative necessary for the worst of the worst in the right case, whether you are likely to have the death penalty sought in your case in Nevada has more to do with where the crime occurs than what you have done. How can I say that? I can say that because since 2005, Washoe County has sought capital punishment in only 4 cases compared to the 175 in Clark County. We are filing at 40 times the rate in Clark County that they do in Washoe County, even though the number of murders is about 7 times as much. There were about 200 murders in Washoe County during that period; there were about 1,500 in Clark County. The numbers are extremely out of proportion.

Why is it so expensive? Common sense would tell us that if we execute someone, it should be cheaper. We do not have to pay for "three hots and a cot" for that person. I have heard that pitch before. The ugly secret of this is that we do not execute anybody. Nevada juries have handed back a death sentence 186 times. In 186 times, we have had 12 executions. It is less than 10 percent, and most of those people volunteered. It is a less than 1 percent chance of executing a non-volunteer over a 40-year history. It is getting worse because of the unavailability of drugs about which we have talked. We simply do not have the means of going forward.

There is an argument to be made that sometimes they are simply the worst of the worst and we need a designation. The truth is that Nevada's death penalty at this point is little more than a label—a designer label that has no real purpose—we foot the bill for it time and again. I say that because of the lack of executions. I say that because of the reality. The lack of closure that Mr. Johnson just spoke about is certainly true. There is an argument to be made that there is no price that can be put on justice, and I understand that. Justice is not something we get with Nevada's death penalty.

What the bill does is convert Nevada's death penalty to death by incarceration. You will die because of your conviction. You will never see the light of day. That is what the death penalty in effect is right now—death by incarceration. If you take away the label, the costs go away.

Why is it so expensive? Death is different. The United States Supreme Court said so in 1972 when they struck the death penalty. They said so in 1976 when they brought it back. Our Supreme Court said so 20 years ago when they adopted something called "Nevada Supreme Court Rule 250," which qualifies what I have to do in a capital case to prepare that case. In a normal murder case, my investigation looks at an hour, or perhaps a day, in someone's life. In a capital case, I have to look at their entire life history. That is

expensive. It is eight times more expensive in a pre-trial phase, according to the cost audit, for the defense of a capital case compared to a noncapital case, regardless of whether the death penalty is imposed, regardless of whether the case is negotiated. By the way, 60 percent of those 175 that have filed since 2005 will end up in a negotiation before they go to trial. When they go to trial, only about 1 in 3 is going to result in a death penalty. Then we get to the futility of that when there are no executions.

It is broken. It is getting worse. We have tried to tinker with it and fix it for every session since I have been up here—this is probably my fifth or sixth, and Mr. Thomas Pitaro has done more than that—and the solutions just have not worked. There is no good way to do this. If we replace the death penalty with death by incarceration, which is what the death penalty is, all of these things that control my behavior go away—Supreme Court Rule 250 and Administrative Order ADKT-411. I do indigent defense. I defend people who have no money, and of these 175 death penalty cases, the taxpayers have footed the bill for approximately 170 of them. Almost nobody can afford the money to put on a capital defense; it is just not there. When that piece of paper is filed things trigger. For example, under Supreme Court Rule 250, two attorneys have to be appointed as opposed to one. The hourly rate goes from $100 an hour to $125 an hour. Those costs just continue to generate. If we were getting a bang for our buck it might make sense, but I can think of no bigger waste of Nevada's tax dollars than fighting to put the label of death penalty on the case and spending the money for it when there is no means of doing it and there is no chance that it is going to be carried out. For that reason, we are in support of Assemblyman Ohrenschall's bill.

Michael Pescetta, Private Citizen, Las Vegas, Nevada:
I am a lawyer and practice almost exclusively in death penalty work and review in state and federal court. I am here representing myself and not my employer, the Federal Public Defender, District of Nevada. I am not expressing the views of that office. We have supplied you with some statistics (Exhibit D), which are fairly dry. It begins with a sheet titled "The Death Penalty in Nevada Since 1977." We have compiled these statistics over the years as part of our litigation efforts. Since 1977 when the death penalty was reinstituted here, there have been 186 death sentences imposed and a total number of 160 individuals who were sentenced to death. The total number of reversals, the third line on this sheet, is 88, which is 46.7 percent of those imposed death sentences. The number of individuals who have been removed for legal action, followed by either a new penalty hearing or a negotiation, is 50, which is a little over 30 percent of those cases. Putting aside any of the other contentious issues about the death penalty itself, if this were a government program that was just being offered to this body as a good idea, some members of this Committee would say, "This system has an error rate of 46 percent and a failure rate of over 30 percent. Does that make sense? Is that a system that is worth having, is that a system that is worth continuing to fund, and does it do what it is supposed to do?" I think not.

The fundamental problem is that when the United States Supreme Court in 1972 declared that all death penalty statutes then in existence were unconstitutional, part of their reasoning was that it gave jurors and prosecutors too much power over the entire range of murder cases. Typically at that time, most state systems gave the issues to a jury, a jury decided whether the person was guilty of first-degree murder, and then decided the sentence without any guidance at all. In a memorable phrase, it was said that being sentenced to death was arbitrary in the sense that being struck by lightning was arbitrary. In 1976, the Supreme Court allowed the death penalty to be reinstituted if states had guiding standards for how and to whom it was imposed. In 1977 Nevada adopted a death penalty statute, which depends on what are called "aggravating factors"—statutory circumstances where those factors are going to narrow the number of individuals who are exposed to the death penalty or eligible to be sentenced to death and so reduce the arbitrariness of the system. Beginning in 1977 with the initial death penalty statute, that list of aggravating factors is now 15 with some subparts. It is more difficult to find a first-degree murder that would not be death-eligible than it is to find one that would be.

This list of aggravating factors has done nothing but expand over the years, and it captures the great majority of first-degree murder cases. For example, if you look at the Federal Bureau of Investigation (FBI) statistics on murder in the United States, other than being killed by someone whom you know or someone in your family, the next highest percentage of death of circumstances of first-degree murder is felony murder. That is a murder that happens in the course of committing another felony. Of course, we have a felony murder aggravating factor in Nevada, as do many states. What we are saying is that the narrowing function that the United States Supreme Court was looking for by bringing the death penalty back under these narrower circumstances includes something that captures almost all of the first-degree murder cases. Our experience has shown that it is just too hard—we are human beings and as such all fallible; certainly lawyers, certainly judges, and legislators as well—to create a system that is going to fairly and reliably determine who should live and who should die. Our experience, like all states that have the death penalty, shows that we cannot do it. We can narrow the scope of the arbitrariness somewhat if those aggravating factors are policed, but once it gets to the jury, they have virtually unlimited discretion to say yes or no once death penalty eligibility is established for these aggravating factors. If you looked at the nearly 1,000 people in prison in Nevada for homicide and the 82 who are on death row for first-degree murder, I think you would be hard-put to tell the difference, except in rare cases, between the cases in which the death sentence was imposed and those in which a death sentence was not imposed.

That is really the key to much of my practical objection to the death penalty. People have, in general, a very inaccurate view of what we are doing. We are always told, and I am sure some of the prosecutors who will testify against this bill will emphasize, about the terrible brutality of cases that make the death penalty the only possible sentence. You cannot get the death penalty in Nevada unless you have committed a first-degree murder. There are no nice first-degree murders. Every first-degree murder leaves a brutal scene with horrible autopsy photographs and grieving relatives. Let me make clear that nobody can discount the kind of damage that victims and their family members experience. However, for the approximately

90 percent of people who are in prison for first-degree murder, all of those characteristics are true in those cases too. We have some cases that are very egregious in which a death sentence is imposed, and we have some where it is not. We have some cases that are not, in the universe of first-degree murders, particularly egregious, yet they result in a death sentence. This is where the use of discretion by prosecutors is key. I do think that prosecutors in the main sincerely try to reserve death sentences for the worst of the worst, but they cannot control what jury verdicts are. It is very controversial what the "worst of the worst" means.

Most people would agree that a murder in which two people are killed is worse than a murder in which one person is killed. Most of the people on death row in Nevada have killed one person, but there are people who have killed two or more people who are not on death row and sentenced to life without the possibility of parole. A case arose on the night of the Rodney King verdict where two men decided that under the cover of the confusion it would be a good time for them to deal with a person they thought was a police informant. They went to the suspected informant's house. There were four people in the house, and they killed all four people. There was a child who was not killed. Those two individuals went to trial and were convicted of four first-degree murders. The first one was not sentenced to death by the jury; he was sentenced to life without the possibility of parole. He has four first-degree murder convictions and he is not on death row. The second man went to trial, was convicted of four first-degree murders, and sentenced to death. The distinction between them is illusive in terms of their culpability. It turned out that that conviction and those sentences were reversed by the Nevada Supreme Court and sent back for a retrial. Because of a plea negotiation, that individual was sentenced to four counts of life without the possibility of parole. Take one of the relatively famous cases among lawyers in Clark County: two men go over to see a drug dealer with the intent of robbing him. They end up robbing him, killing him, and killing his wife after raping her. They are tried together and both convicted of two counts of first-degree murder. Each one of them had 12 or 13 aggravating factors relating to those convictions, and the jury sentenced both of them to life without the possibility of parole. Those seem like egregious cases. They did not end up in death.

Take the other end of the spectrum: someone currently on death row. He and another man went to get some drugs from their drug dealer who was a street dealer. The individual on death row was the driver. The passenger had a gun. They get the drugs from the dealer and drive away without paying. The drug dealer gave chase and the passenger leaned out of the window, shot, and killed the drug dealer. The passenger, who actually killed the victim, pled guilty and was given life without parole. He also agreed to testify, but ultimately he did not. The driver, who did not have a gun—and there was never any evidence that anyone had conspired or agreed ahead of time to kill this drug dealer—had an unfortunately substandard lawyer, and he was sentenced to death. In one transaction, we have the actual killer who gets life without, we have the person who did not plan or commit the killing on death row, and the district attorney's office is continuing to litigate that case to keep him on death row. This would strike most people as counterintuitive. The fact is that there is no mechanism in our statute to address that.

Every prosecutor and every district attorney in every county can decide whom he or she wants to charge with the death penalty. The extent of the aggravating circumstances is so broad it is usually possible to find an aggravating circumstance to allege against a defendant who has committed first-degree murder. There we have what we have now, on a slightly smaller scale: a situation in which being sentenced to death is arbitrary in the same way being struck by lighting is arbitrary. It does not diminish or disrespect the suffering that is undergone by victims and their families to say we are not good enough to figure out, in a constitutional way or in a fair and reliable way, that this person should be on death row and this person should not be under those circumstances.

On the deterrence point, there is a lot of statistical evidence that has been put before you. I would ask you to look at the Death Penalty Information Center material (Exhibit E) that is attached to this statistical information. Think of it this way: New York and Texas could hardly be more different. Texas [page 3, (Exhibit E)] has executed over 540 people since the death penalty came back in 1977; that is over a third of all the executions in the country since then. New York has not executed anybody; they had a death penalty very briefly, and it was found unconstitutional. Their homicide rate today is identical. Look at two states that are closer in their characteristics—North and South Dakota. South Dakota has the death penalty and North Dakota does not. North Dakota's homicide rate is 2.8. South Dakota's homicide rate is 3.7. It is 1.1 higher in the state with the death penalty. Finally, on the cost issue, the study that was done by the Legislative Counsel Bureau (LCB) looked only at the costs through the trial and appeal. That does not count postconviction habeas and it does not count federal review in which the Office of the Attorney General conducts the litigation. Litigating these cases is always a moving target because the laws change. There is a case that the United States Supreme Court decided last year that a certain element of death eligibility, outweighing [*Hurst v. Florida*, 577 U.S. __ (2016)] which we have in our state, has to be found beyond a reasonable doubt. No jury in any Nevada case has ever been instructed that they had to find that outweighing element beyond a reasonable doubt. We are going to be functionally litigating that forever—in every one of those 82 cases that are still pending. It takes a long time and it takes a lot of money, but when you get down to it, just in September of last year, the Nevada Supreme Court sent a case back down 23 years after the offense for a hearing on actual innocence. It was hearing not based on DNA, but based on medical evidence that existed at the time of the offense that showed that the child who died actually died of medical conditions, not from being beaten to death as was alleged by her mother's boyfriend. It took 23 years for us to figure that out. It is too hard. That is the basis I submit for supporting this bill. To achieve a fair and just system for choosing who lives and who dies is not something that is within our competence.

Chairman Yeager:
I would let the Committee members know the exhibits that Mr. Pescetta referenced are on the Nevada Electronic Legislative Information System (NELIS). They are very good exhibits in terms of describing the history of the death penalty in the state and looking at it as a country

as a whole. Assemblywoman Dina Neal has just arrived, so we will take her testimony next. I would also invite Father Durante and Ms. Pusich to the table. I think we are doing okay on time, but feel free to truncate your remarks. We do have a number of folks who want to speak in opposition and I want to make sure they have an equal amount of time.

Assemblywoman Dina Neal, Assembly District No. 7:
This issue was near and dear to my family. My dad focused on this issue, and I have at least six boxes on the death penalty in my garage. I am here today as the Regional Chair for the National Black Caucus of State Legislators. I oversee nine states in the region. We put a resolution together about a year ago in support of abolishing the death penalty (Exhibit F). I know you have heard a lot of statistics and I see you have 19 exhibits, so I will simply say I appreciate Assemblyman Ohrenschall for bringing the bill and we support the abolishment of the death penalty.

Charles "Chuck" Durante, Pastor and Chair, Life Peace and Justice Commission of the Diocese of Reno; and representing Nevada Catholic Conference:
I am a native Nevadan, a member of the State Bar Association, and a concerned citizen who has worked on this area of capital punishment for over 20 years. I can remember working with Senator Joe Neal when this type of bill was presented many years ago. As a student of criminal justice, there has always been something in my gut that tells me the death penalty is wrong, but as I have ministered to victims and inmates alike, it has convinced me even more. The horrific violence of murder is never excusable nor should it be diminished. When I have stood outside the then-Nevada State Prison, the site of our past executions, on the nights of several of these terrible events, I have stood with signs for the victims of murder as well as for an end to another killing through capital punishment.

I have witnessed the heartbreak, the tears, and the anger in conversations with family members of murder victims, and I have seen the rancor, anxiety, and hatred that surfaces every time an execution is scheduled or carried out. Some seem almost to take pleasure in an execution as an opportunity for vengeance or self-righteousness. Others wrestle with having participated in such a death, whether as a guard or an administrator or even a reporter. I find it especially poignant that executions have taken place at night: first at midnight and, I think, the last one at 9 p.m. It is as though the state takes this action in cover of darkness.

It is rare that a family member really finds closure with an execution. It is never able to compensate for the seemingly endless number of times the murder is relived in the media and in the lives of family and witnesses throughout the intense investigation and trial of a capital case and each time there is an appeal or a vacated execution date. A much swifter conclusion that does not require the state to participate in a killing is life in prison without the possibility of parole. That closes the book on the legal process much sooner and allows family members to continue grief counseling and other work toward healing without the threat of being brought back into the court or interviewed by yet another reporter.

It always has been the goal of the criminal justice system to preserve the safety of the people and to weigh evidence and render sentences in an objective manner, based on principles and the rule of law. Yet when a case is certified as a capital case, emotions run much higher, and I have seen some of that integral objectivity displaced. The stakes are high in this type of case that falsely presumes perfection. The alternative to that presumption is settling for the possibility of the killing of another innocent person, this time in your name and mine.

As you know and will hear, many of our sister states in the union and democratic countries around the globe have abolished the use of the death penalty as barbaric, ineffective, and wasteful of government resources. As such, it is a bad public policy that violates the basic principle of respect for human life itself. In light of horrible acts of violence, we can become discouraged and desperate to take a stand. We want to be tough on crime, so we lower ourselves to killing someone to punish and to demonstrate that killing is wrong. So long as we can protect society in another way, and we can, it diminishes all of us when we resort to violence. We do not rape a rapist or beat up someone who has beaten up another because it would be inhuman of us. Yet we will justify killing, the taking of life itself. Many religious leaders across many faith traditions, including Pope Francis and numerous popes before him, have spoken strongly against the death penalty. Pope John Paul II put it well when he was in Missouri in 1999. He called for an unconditionally pro-life stance on the death penalty, saying, "A sign of hope is the increasing recognition that the dignity of human life must never be taken away, even in the case of someone who has done great evil." Modern society has better means of protecting itself. I urge you to move for that means today by ending the use of capital punishment in Nevada.

Chairman Yeager:
I would invite the final presenters, Ms. Hart and Ms. Welborn, to the table.

Maizie Pusich, Chief Deputy Public Defender, Washoe County Public Defender's Office:
I have defended capital cases in Washoe County for the past 26 years. The risk of executing an innocent person is too high to maintain the death penalty as a possible punishment in Nevada. I had the extraordinary privilege to represent a woman named Cathy Woods. Cathy was convicted of the 1976 murder of a beautiful young woman named Michelle Mitchell. Cathy was seriously mentally ill and falsely confessed to that crime. It may seem hard to believe that people falsely confess to murder, but hers is not the only case where that has occurred. In many of the cases that have been resolved as DNA exoneration cases nationally, there was a confession from the accused. Cathy was arrested, tried, and convicted twice. Her first case was overturned on appeal. She spent over 30 years in the Nevada State Prison and yet, she was one of the lucky ones. She lived to see her conviction overturned and be released from custody and returned to the loving arms of her family. She was not saved because we had the good sense to realize that she was innocent while she was going before those 24 honest and hardworking jurors. She was saved by luck and science. The lucky part was that the crime occurred in 1976 and we did not have a death penalty then, so she did not have to face that. She is one of the people whose case had sufficient notoriety that if it had been available, I do not think she would have lived to be exonerated. The Washoe County

District Attorney and his Chief Deputy, who are both here today, dismissed the charges against Cathy about a year and a half ago because they realized that the actual killer had been found through subsequent police work. You might think the system worked—it did not. Science and luck saved Cathy. All 24 of those honest, hardworking jurors who found her guilty in two separate trials were wrong. While Cathy served her 30-plus years in prison, the actual killer committed new crimes—kidnapping, rape, escape, and three other murders. Cathy was one of the lucky ones because she lived to see freedom.

Nevada has put two innocents on death row. Roberto Miranda was convicted and sentenced to die in 1982. His defense was assigned to a novice. Although Mr. Miranda named six witnesses who could establish his innocence, the young attorney contacted none of them. Mr. Miranda spent 14 years on Nevada's death row before a different attorney showed a court that his defense at trial had been wholly unprepared. The case against Mr. Miranda was dismissed, and he later sued Clark County, the Public Defender's Office, and the detectives who had investigated, and ultimately received a multimillion-dollar settlement for their errors.

Ronnie Milligan was also tried for murder, convicted, and sentenced to die. Mr. Milligan's conviction was the result of opportunistic codefendants. In 1980, he was honorably discharged from the United States Navy. He drove cross-country with a group of acquaintances. By all accounts, he spent most of that trip drunk. In southern Nevada, the group robbed and killed an elderly woman. Mr. Milligan was once again drunk and remembered nothing. The other three men quickly decided to blame him. With no memory of the killing, he was a sitting duck. The state's star witness, a man named Ramon Houston, faced no charges. Two others in the group were convicted of lower offenses, served their time, and were paroled. Mr. Milligan was sentenced to death because the crime occurred in the course of a robbery. The ability to use robbery to support the death sentence was changed by later court rulings and the sentencing was returned to Humboldt County District Court Judge Richard Wagner. Judge Wagner was a tough, conservative judge. Before being elected judge, he served 16 years as a county prosecutor in rural Nevada. He learned during the new sentencing hearing that the state's star witness, Mr. Houston, actually wrote a letter to a friend during the first trial in which he said Mr. Milligan had not even been present at the killing. Mr. Houston had been found with the victim's purse and had her blood on his clothes—Milligan had none of her belongings or any of her blood on his clothing. During the resentencing, Judge Wagner announced that he had "grave reservations" that Mr. Milligan was guilty at all. He ordered him paroled. After over 30 years on Nevada's death row, Ronnie Milligan was granted parole in 2011.

Woods, Miranda, and Milligan collectively spent over 70 years in prison for crimes they did not commit. Yet, they are among the lucky ones. They lived to see their freedom. Whom have we missed and whom will we miss? We should always think about whom we are sentencing to die and whom we are executing. You have heard that the death penalty reflects all the worst of society's prejudices, but it is worse than merely targeting minorities, the mentally ill, the poor, and the poorly educated. It frequently includes people we ought to be nurturing and caring for.

Terry Dennis was one of the convicted that Nevada executed. Terry was 17 when he lied about his age to join the Vietnam War to escape years of being a victim of incest. He served and then returned to the United States an alcoholic and pot smoker. After his service, he was brought back to New York. As he traveled back to Washington State, he ended up stopped in South Dakota where he was charged with possession of marijuana and ordered to serve a year in prison. He still went home and married his high school sweetheart, and they started a family together. He realized that one of his neighbors was molesting another child, and instead of turning to the authorities, he tried to take matters into his own hands. He suffered another felony conviction and served his time. He lost his relationship and his family. He came to Reno. He was an alcoholic although he was no longer using drugs—a year in the prison in South Dakota was enough. He started hearing voices that told him he should hurt someone. He went to the U.S. Department of Veterans Affairs (VA) where he qualified for services and he asked for help. Years before we had a scandal about scheduling at the VA, he was told to come back in a month. By the time he came back for his appointment, his victim was dead. He had killed a woman who he had befriended in a local bar. He called the police and told them he had done it. He pled guilty against the advice of his attorney—me—and he then went to a capital sentencing hearing where a three-judge panel found that he was someone who should be sentenced to die. He became suicidal when he was young, and he stayed suicidal to the end. Terry was one of our volunteers. He was on a mission to complete suicide for most of his adult life, but when he got to Nevada, it worked. We did not offer him the VA support that he had earned. We did not thank him for his service defending us in an unpopular war. The only time that society actually responded to what Terry wanted was in August 2004, when we killed him in the Nevada execution chamber.

Sometimes the death penalty is promoted as a sign of respect or compassion to the surviving family of murder victims. I disagree that it shows respect or compassion. My cousin Michael was murdered when he was 28 years old. Executing his killer will not bring him back; it will not bring my family peace. I understand some of the suffering that family survivors go through, but perpetuating the killing will not alleviate any of it.

Several years ago, I was asked to attend an execution. I did not want to be there, but I had a client who had no local family and did not want to be alone. I am grateful that that execution did not go forward while I was there. When I got inside, after I went through security and they decided I was allowed to be there and that I would be safe, one of the things that surprised me was the prison was offering people coffee and cookies. I am sure they were just trying to be polite. I think they were trying to make us comfortable, but I do not ever want to be comfortable with the death penalty and I do not want any of you to be comfortable with the death penalty.

Nancy E. Hart, President, Nevada Coalition Against the Death Penalty:
The Nevada Coalition Against the Death Penalty is a broad-based group of individuals and organizations opposed to capital punishment in our state. We are composed of many different people who support ending our use of the death penalty. There are people of faith who believe that it is wrong for humans to take another life, that taking life is for God to decide. Others are philosophically opposed to the death penalty based on respect for

fundamental human rights, the *Constitution*, or the belief that government does not have the authority to kill its own citizens. We have others who support ending the death penalty because of growing awareness about one or more very troubling issues: that it is racially discriminatory, arbitrary and unfair, extremely costly, runs the risk of executing an innocent person, does not provide true healing for the victim's loved ones, and does not make society safer from violent crime.

Around the country and in Nevada, there is growing support for ending the death penalty. When people learn what is involved in trying to maintain a death penalty system, they understand how broken it is. Here in Nevada, it is tremendously expensive and ineffective, as you have heard. We cannot even carry it out because we lack the drugs to do so. Almost 40 percent of our death row is African American, whereas only 9 percent of the state's population is African American. As you have heard, Clark County has more pending death penalty cases than San Diego, Los Angeles, and San Francisco combined. The needs of victims' family members are largely overlooked.

There have been various efforts to fix our death penalty. In the 15 years since the Coalition was formed, the Legislature has ended executions for people with intellectual disabilities; it ended the death penalty for people who were juveniles at the time of their crime; it ended the use of discriminatory three-judge panels for sentencing; and it authorized a cost audit of the state's death penalty to determine how much we are spending to maintain it. These were important measures that required a lot of advocacy, but they did not fix the many problems. The list of aggravating factors in our statute is still overbroad and unclear. Racial bias remains intractable, and overzealous prosecutors in Clark County continue to file cases at a staggering rate. The bottom line is that Nevada's death penalty is too broken to fix.

There are three recent examples of the breadth of support for ending the death penalty. Virtually all mainstream religious organizations have adopted positions in opposition to the death penalty many years ago, but in October 2015, the National Association of Evangelicals, a stalwart supporter of capital punishment for over 40 years, modified their position to no longer explicitly support the death penalty. This remarkable change was because of growing concerns over the human error in criminal justice, documented wrongful convictions, and a desire among many of their congregations to promote healing instead of retribution.

Just last month, on February 23, 2017, the American Nurses Association took an official position opposing the death penalty for the first time in its organization's history. The organization has objected to nurses participating in the death of prisoners since 1983, but the revised position statement now opposes all capital punishment, not just nurses' involvement.

Just two weeks ago, on March 16, 2017, the head prosecutor for Orlando, Florida, State Attorney Aramis Ayala, announced that she would not be seeking the death penalty in any cases going forward. She said that the death penalty had failed as a deterrent and it did nothing to protect law enforcement officers. She also cited the length of time between sentencing and execution, which often exceeds a decade, and the costs of capital cases. "I am

prohibited from making the severity of sentences the index of my effectiveness," she said in her announcement. "Punishment is most effective when it happens consistently and swiftly. Neither describe the death penalty in this state." Seeking life sentences, she added, would guarantee that "violent offenders will never be released. They will never continue to drain resources from this state with decades of appeals, and we can offer families of the victims more closure and more certainty."

It is very unusual for a prosecutor, especially one from a large metropolitan jurisdiction, to publically state a position against the death penalty. The truth is, Ayala's decision is not unusual. Many district attorneys around the country do not seek death. Of the nation's 2,300 prosecutors, only 27 (barely 1 percent) sentenced a person to death last year. These examples illustrate that professionals and organizations from unexpected sources are increasingly ending their support for the death penalty.

The death penalty in the United States is in decline. There has been a steady and dramatic decline since 1996 in the imposition of new death sentences—from a high of 315 new sentences in 1996 down to only 30 last year, which was a reduction from the previous year. There has been a similar decline in the rate of executions nationwide with only five states carrying out executions last year, 2016, the lowest in over 20 years. Fewer states even have or use the death penalty. In the past decade, eight states have repealed their death penalty laws. Thirty-one states and the federal government still have the death penalty, but 4 of those 31 have governor-imposed moratoria in place. About half of the states in this country have the death penalty and half do not, but that still does not tell the whole story. Contrary to the assumption that the death penalty is widely used in the United States, only a few jurisdictions employ capital punishment extensively. Just 2 percent of the counties in the United States have been responsible for the majority of cases leading to execution since 1976. One of those counties is Clark County. These downward trends in the use of the death penalty reflect communities' growing awareness about the high costs and minimal effectiveness of the death penalty, and serious doubts about aspects such as racial bias and victims' family members' healing.

Going back to the wide support for ending the death penalty, I would like to read from a letter by Jackie Crawford, a former director of the Department of Corrections (NDOC). Ms. Crawford now lives in Utah and was unable to be here today, but she wrote the following:

> This letter is to provide my personal views and experiences concerning the death penalty in Nevada as a career correctional practitioner. I retired from Nevada as corrections director in 2006 after six years in that position and four as warden at Lovelock and of the camps. In my career, I have more than 40 years' experience at all levels with state and local facilities and with court administration and parole/probation agencies in midwest and western states. During those time frames, I served two governors: state of Nevada Governor Kenny Guinn and state of Arizona Governor Bruce Babbitt.

My focus was on safer communities and institutions that emphasized programs, preventions, and rehabilitation of the offender. For many years, I supported the death penalty with the belief that it brought closure to the victims, addressed the severity of the crime, made for a safer work environment for corrections and law enforcement staff, and served as a deterrent to others who might have their criminal behavior tempered knowing the serious consequences of their actions. As a deterrent, I do not believe it has had the impact we all had hoped. Our country has experienced many cultural changes, and what once worked does not seem to have the same impact. Emotionally charged offenses are not deterred much by known consequences.

My experience concerning the death penalty is from a correctional operations view. The death sentence requires some stressful periods for staff who practice and carry out the processes of conducting executions. There is stress during the period with considerable attention focused on the institution and stress on staff that requires some decompression and counselling afterward. My primary concern was the impact on staff. We held debriefings and the department offered counselling for staff members who felt the need to discuss their feelings and emotions about the execution. This was provided on a personal and confidential basis for staff.

Victims are not well served when there is considerable uncertainty about the sentence of death being carried out. Recent history has no inmates executed except for those who wish to stop the appeals process and proceed with execution. Victims in these cases have had emotional times since the inmate can make the decision to have the execution carried out only to back out on the day of the scheduled execution.

There were two instances in the six years while I was director where we prepared to carry out the sentence. In one, the sentence of death by lethal injection was carried out as scheduled. In the second case, the inmate requested it be carried out and then changed his mind on the day of the execution. The victim's family in attendance were shocked, devastated, and felt exploited by the inmate. Over the years, I have observed the pain that victims and their families experienced when they had hoped to find closure. I realize those victims did not find closure when the person was sentenced and especially those who hoped for the offender to be executed. Some, but not many, experienced a little closure; but after losing a loved one, we have to heal ourselves through the love and support of others and through our faith.

Elimination of the death sentence would certainly remove a distasteful task from the already difficult job of managing an inmate population and would leave no doubt about taking the life of an innocent person. But there may also be positive and negative outcomes for communities, law enforcement,

> prosecutors, and sentencing judges as a result of change. All would agree there are those who are a serious risk to society and should never see the outside of a secure correctional facility. If this bill is passes, I am certain that the current laws will assure that the alternative sentence of life without parole has as much certainty as the designation indicates.

[Also submitted by Nancy Hart was a document titled "Death Row Since 1997 Chronological" (Exhibit G).]

Holly Welborn, Policy Director, American Civil Liberties Union of Nevada:
I would like to thank Assemblyman Ohrenschall and Senator Segerblom for bringing this legislation forward. The United States is the only western democracy today that does not view capital punishment as a profound human rights violation and a frightening abuse of government power. Since our founding nearly 100 years ago, the American Civil Liberties Union (ACLU) has made the abolishment of the death penalty a cornerstone of our work. The death penalty denies equal protection of the laws, is cruel and unusual punishment, and removes guarantees of due process of law. The death penalty is so inconsistent with the underlying values of our democratic system—the pursuit of life, liberty, and happiness—that the imposition of the death penalty for any crime is a denial of civil liberties.

Decisions about who lives and who dies are largely dependent upon the financial means of the accused, the skill of their attorneys, their race, and where the crime took place. People of color are far more likely to be executed than white people, especially if the victim of the crime is a white individual. From 1976 to 2015, 1,392 executions occurred in the United States and 995 of them took place in the South. A mere 2 percent of this nation's counties have produced both the majority of all executions imposed since 1976 and of prisoners awaiting execution on death row. The greater likelihood of its imposition upon the poor is demonstrated, among other things, from the obvious fact that the financially able accused of a crime may employ the Cadillac of legal counsel and compensate them fully for the extensive efforts necessary to pursue remedies available to those under penalty of death. The poor, although they too have the right to counsel, cannot afford the same degree of legal defense. Thus, in the case of the death penalty, the punishment does not fit the crime. It is, in fact, a constitutionally prohibited denial of equal protection of the law because it results, regardless of the written provisions of statutes permitting it, in imposition of the death penalty almost exclusively upon society's most disadvantaged members.

Death imposed by the force of the state is the ultimate form of cruel and unusual punishment and thus prohibited by the Eighth Amendment. In an amicus brief filed in *Furman v. Georgia* 408 U.S. 238 (1972)—the case that outlawed the death penalty temporarily—our legal director, Sanford Jay Rosen, wrote, "The death penalty, clearly suspect under the Eighth Amendment, is unnecessary in a society with adequate alternative means of fulfilling the legitimate objectives of the penal law. It is therefore unconstitutional. The death penalty and the necessarily associated experience of death row shocks and devastates the consciences of civilized men. It is therefore unconstitutional." We hold the same position today.

General public abhorrence of the death penalty is revealed by the prohibition and narrow limitation of capital punishment in statutes; the frequent reversal of guilty verdicts for technical errors; a shrinking, geographically isolated number of states permitting it; fewer juries imposing new death sentences; and fewer states carrying out executions previously ordered. The numbers have constitutional significance. The United States Supreme Court has held that uncommon sentencing practices can become so rarely imposed that they are barred by the Eighth Amendment's ban on cruel and unusual punishment. We believe Nevada is so positioned.

The death penalty is an archaic form of punishment and unnecessary in our justice system. We encourage you to support A.B. 237.

Chairman Yeager:
Members, I am going to take some questions. I have questions from a few members so far. If you have a question for a particular presenter, that would be helpful. If not, we will ask that one presenter be designated to answer the question.

Assemblywoman Jauregui:
My question is for Mr. Coffee regarding some of the statistics he gave. You said there was a cost of an extra $500,000. Is this per capital punishment case or for those 186 offenders who were sentenced to death?

Scott Coffee:
Every time a death penalty notice is filed, there are additional costs that come into play. For a case where the death penalty is not sought but a murderer is placed on the row for life without parole, or "death by incarceration," the cost of the case is estimated at $775,000. When the death penalty is sought but not imposed (imposed means by the jury on the front end), the lifetime cost is $1.2 million. Those 175 cases where it was sought have an additional cost of $400,000 or more. When the death penalty is handed down but not imposed, the cost goes up another $100,000 before we get to postconviction costs. You have a cost differential of somewhere around a half million dollars every time a notice of intent to seek death is filed. They are only coming down with a sentence of death in about 15 percent of the cases.

Assemblywoman Jauregui:
Those 186 cases you talked about cost $500,000 more. In addition to those, the other cases sought the death penalty but did not necessarily impose it?

Scott Coffee:
The 186 cases were where a sentence of death was handed down by a jury. In that situation, a person is more likely to die of natural causes or suicide than they are to be executed, even if they volunteer. We have had 16 people who died of suicide or natural causes and only 12 who were executed. Eleven of those were volunteers, so you are ten times more likely to die of natural causes than you are to be involuntarily executed. The 175 are death notices filed in Clark County since January 2005. That is about a quarter of our recent history in

terms of the death penalty. You can multiply that number by whatever it might be, and you can figure we have sought the death penalty 600 to 700 times. That is a reasonable estimate. The costs are imposed every time you file the notice of intent to seek the death penalty because somebody has to investigate it and it is almost always on the county dollar.

Assemblywoman Jauregui:
I did the math for the 186 cases that were sentenced and that is $93 million. I find it hard to believe that we spend $93 million dollars on sentencing people to death and we spend $1,000 each on victims for counselling.

Scott Coffee:
That might be a place to divert some of that money.

Assemblyman Wheeler:
Thank you for allowing me to make a statement to Mr. Johnson. I take great exception at your coming in here and telling the members of this Committee what it means to be a conservative. I have a high Nevada Policy Research Institute (NPRI) rating, one of the highest in the building, and a high American Conservative Union (ACU) rating—one of the highest in the building, as do other people on this panel. If you want to tell me what it means to be a conservative, come to my office; do not come in here and put it on the record. Get your own chops—I have made mine. It takes more than pinching pennies to be a conservative; there is also a social side of that. Thank you, sir, for listening to me.

I have a question for Assemblyman Ohrenschall. Thank you for answering our questions. We have seen a lot of studies that say there is no deterrent value. I looked it up and came up with five or six studies that say exactly the opposite: one from the University of Colorado, Denver says that for every death sentence that is commuted, five more homicides happen. There is another one at 18 murders, another at 3, another at 5, and another at 14. I wondered if you would concede that there are studies on both sides of the issue that show opposite results.

Assemblyman Ohrenschall:
I have not seen those studies, and I do not know how old they are. The studies that I, as well as others presenting, have cited have not shown a deterrent effect in jurisdictions that have capital punishment as opposed to jurisdictions that do not. I am happy to look at any studies you would like to send me. Anecdotally, last year in Clark County we had the highest homicide rate in the history of Clark County, and we have capital punishment on the books. We just spent $800,000 on a new execution chamber at Ely State Prison. That is not a study, but anecdotally I do not see the deterrent effect working in my county. Mr. Coffee might also have more information on that.

Scott Coffee:
There are some studies that show a deterrent effect, but most of those studies are decades old. In the '70s, when the death penalty was brought back pursuant to *Gregg v. Georgia* [428 U.S. 153 (1976)], there were some claims that every capital sentence saved 6 to 8 lives.

That has not proven to be the case. Recent studies have refuted that; our 40-year history since then has refuted that. There was a survey of criminologists—these are not defense attorneys defending capital defendants, but criminologists who work within universities—where about 88 percent concluded that there was no deterrent effect to the death penalty. There is a minority opinion of about 10 percent that there might be deterrent, but to get 88 percent of people to agree on anything is a neat trick.

Assemblyman Wheeler:
I would be happy to send you this article from the *Washington Post*, which quotes from 2001, 2003, 2006, and 2009. That was not decades ago.

Chairman Yeager:
Assemblyman Wheeler, I would invite you to share that study with the rest of the Committee as well. We would likely find it useful.

Assemblyman Wheeler:
It is a news article from the *Washington Post* that quotes these studies—a very "conservative" paper.

Assemblyman Fumo:
Ms. Portaro, I want to tell you that I was in the courthouse when you forgave your son's killer and sat in muted anguish as you spoke the words, "I have been sentenced to a lifetime of grief." You personified the phrase, "To err is human, to forgive divine." My question to you is that you said the district attorney's office was not happy when you went to them and asked them to remove the death penalty. Did you feel pressure in any way to seek vengeance rather than justice? Did you feel pressure from the district attorney to keep pursuing the death penalty rather than life without parole?

Cynthia Portaro:
Fortunately, my prosecuting attorney is a lifelong friend. Our boys grew up together. I know him very well, and he knew me. For him to even have the case was a godsend. He had a personal relationship with my son. When I went to him, he was not happy about it. He said this was not good. My husband's family was not happy with me. That decision that was made was not just mine alone. I went to my children and I told them, "This is what I am thinking; this is what I am feeling." My children agreed with me and said, "Mom, we do not want this." As far as pressure, no, he did not pressure me. I know the process now, and I was able to help make that decision. For me, that brought closure to my family, not vengeance.

Assemblyman Fumo:
Mr. Coffee, I would like to get deeper into the cost. You said it goes from one attorney at $100 per hour to two attorneys at $125 per hour so we are looking at $250 per hour. Can you tell the Committee about the other things involved, not just the investigator, but also the social worker, the neuropsychologist, the psychological tests, and so on?

Scott Coffee:
Death penalty work is the only area that requires a certification for Nevada lawyers. It is governed by Supreme Court Rule 250. There is a panel or group of people that have to be involved in the preparation of a death penalty case. It goes from having one attorney at $100 an hour. Attorney hours are vastly different. It is 400 hours on average to resolve a noncapital case. It takes 1,800 attorney hours on average to resolve a capital case, according to a UNLV cost study conducted by Terance Miethe. Because death is different, because we do not get do-overs in a death case if we make a mistake, there is a heightened level of due process. We talked about life history, but it is literally childhood: I am interviewing fathers, mothers, grandfathers about alcoholism and all kinds of things. The decision whether to impose the death penalty is different than any other decision a jury makes. Every other decision is governed by law and they are given a set of instructions. For the death penalty, it is a moral decision. Each individual juror gets to make a moral determination of whether that person deserves the death penalty. Because of that, what might resonate with a juror might be different in every case. For example, somebody might not like the fact that he was cut from a high school baseball team. I do not know what is going to resonate with a jury. I have to investigate everything—whether it is abuse, alcoholism, or a death in the family. Those numbers go up substantially.

There are certain procedures that are unique to death penalty cases that are not present in any other cases. In a case called *Atkins v. Virginia* [536 U.S. 304 (2002)], the Supreme Court said that you cannot execute the intellectually disabled. That is only an issue in a capital case. The states tried to shut that down and narrow that to some extent, but it has not worked. The Supreme Court issued a decision yesterday in a case called *Moore v. Texas* [581 U.S. __ (2017)] that said the states have to abide by prevailing psychological norms in determining intellectual disability. I have to investigate that any time a person has a poor school record or any time there is a history of poor testing. The determination for intellectual disability includes looking into how they were acting before they were 18 years old—something called "adaptive behavior." Did the onset happen before 18? I have to go back and investigate that. I have to pay a psychologist or psychiatrist to investigate that. That is happening in 40 to 50 percent of the cases coming into our office; we are looking into *Atkins* claims. We are presenting *Atkins* claims in about a third of the cases that come through our office. Generally, the state has to employ an expert. That will run into $10,000, $50,000, or $100,000 by the time we have done all the testing.

You have to look into things like fetal alcohol syndrome. There was a case in the Ninth Circuit Court of Appeals where the attorney did not investigate poisoning of groundwater where the person had grown up and the Ninth Circuit reversed for ineffective assistance of counsel because the counsel did not look into whether there was poisoning from pesticides in the groundwater. The point being: I have to look at everything and if I do not, the case is reversed. It is not as if you can say, "We just will not fund the defense. Let us have a free day of this and put everybody up for it." You cannot do it because if you do, the

cases come back. If you look at the older cases, the reversal rate is much higher than what Mr. Pescetta talked about because not much was done on capital cases 40 years ago. It got better 30 years ago; it was better 20 years ago, and we are getting better now. I expect it will be better in the future, but those costs continue to escalate.

Assemblyman Watkins:
You said the question for a jury as to whether to sentence someone to death is a moral one. What happens in jury selection when somebody says he is morally opposed to the death penalty?

Scott Coffee:
That is part of the unfairness of this whole system. If you are morally opposed to the death penalty, you are removed from the jury venire; you cannot sit on a death penalty jury. What that means is 20 to 30 percent of our panels are flat-out removed because they say they have an objection to the death penalty, so you do not get a cross section. Studies have shown that capital juries are more likely to convict on a case, overall, because of this preselection. The fact is that people who are in favor of the death penalty or consider the death penalty are also more likely to convict. There is a strategic reason from a prosecutor's prospective. I do not think they do these things strategically; I think they have good hearts in the vast majority of cases. There is a strategic reason to "death-qualify" a jury because it increases your likelihood of conviction and you eliminate a good cross section of the population, including devout Catholics and many people of color. It just removes those from the pool.

Assemblyman Pickard:
I find it interesting to see the level of hyperbole in the room today. It brings into stark contrast the schizophrenic approach to how we view life, killing, and the roles of punishment, morality, judgment, forgiveness, and justice, particularly religion and faith in the law, or faith that should be removed entirely from government. I will add to what Assemblyman Wheeler suggested: I reject out of hand some of the premises stated thus far. For instance, the idea that killing more than one person is worse than killing only one—it is killing. I reject the notion that the legislators seated here are irresponsible, whether they be sitting here now or in the past, because the death penalty remains. I reject the idea that the judicial system has a 50-percent failure rate. It sounds to me like the appeals worked; the system works. Not in every case. Are there convictions of innocent people? Yes. I applaud the Innocence Project and others who find those, but they would not make the paper if it were a common occurrence. I think the judicial system, particularly the public defenders and the prosecutors, do a phenomenal job with what they have. It is an imperfect science, but they try as much as they can to use science. I do not disparage them for doing their jobs.

The elephant in the room is the idea that the death penalty goes beyond the idea of deterrence. There is also the idea of a penalty—it is called a "death penalty." We have historically reserved it for the worst and most heinous crimes. Because this is a fundamental social question, I am wondering why are we not putting this to the voters to decide?

Chairman Yeager:
Although that is not the question in front of us today, you may speak to that if you would like. The question for this Committee is the policy of A.B. 237.

Assemblyman Ohrenschall:
Many people have beliefs of faith and moral beliefs about capital punishment. The arguments that I am particularly interested in and I hope the Committee will look at are the proven lack of deterrent affect toward violent crime and the incredible financial burden to our taxpayers without the expected outcomes, where death penalty cases that are sought are, in effect, life without the possibility of parole or "death by incarceration," as one of the witnesses said. Lastly, I would ask the Committee to remember the impossibility of actually implementing an execution. On NELIS there are letters (Exhibit C) posted from the different pharmaceutical companies as to their lack of willingness to provide these chemicals to any state department of corrections. As to how laws are made, our state provides that we can enact legislation either directly through the voters by initiative referendums, but our federal *Constitution* guarantees our constituents a republican form of government, and that is why we are here: to represent our constituents and make these decisions.

Assemblyman Hansen:
I would be willing to support the bill if you add one amendment to it: that you put this on the ballot as a referendum. I did a little homework. In a very liberal state like California, in 2012, they had the issue on the ballot and the people of California overwhelmingly supported keeping the death penalty. In 2014, in Nebraska, the legislature passed an abolition of the death penalty and then it was placed on the ballot. The result was 66 percent of voters were in favor of keeping the death penalty. In spite of the hyperbole, I think people actually do support the death penalty. I would want to have that offered as an amendment. I deeply resent the idea that people who have been victims of murders and therefore want justice are filled with hate and vengeance. It is shocking that some would use that terminology. I do not believe that people who have gone through that should be labeled as horrible, guilty people who have an evil motive. I think what they are trying to do is get justice. Anybody who reads the Fifth Amendment can see it clearly says, "nor be deprived of life, liberty, or property without due process of law." Being deprived of life is capital punishment. We have a due process of law. The argument that this is somehow unconstitutional makes no sense if you actually believe in following the original intent. The real reason we have lost, to some extent, the deterrent value of the death penalty is because liberal, activist judges have used the system for so long now and created so many layers of appeals that it does lose its value. It takes decades for an execution to actually occur. I looked up the Charles Lindbergh case and other cases like that. Within a year after conviction and appeals, the executions occurred. If you look at the numbers in the United States, the death penalty did have a deterrent effect. It did not lose its deterrent effect until we decided to drag it out on appeal for decades. I do not understand why it is so humane if a 21-year-old commits a murder and you keep him in a cage for 70 years. How is that more humane? Why should we say that is the right thing to do, rather than what has been justice for time immemorial in Western societies?

Chairman Yeager:
As this Committee knows, we cannot speak as a legislature on the constitutionality of the death penalty or how it is applied or enacted. We will leave that to our co-equal judicial branch. Assemblyman Hansen, I took the testimony a little differently. I thought the testimony was that leaving someone in prison for life was less humane; that it is more of a punishment than executing him. I could be wrong, but that is how I took the testimony.

Assemblywoman Krasner:
You say that the implementation of the death penalty is a moral judgment. Is it not also a moral judgment when a criminal brutally murders a victim?

Scott Coffee:
I wish it were that simple. The fact of the matter is that I have represented these people for 20 years, and I have yet to meet someone who makes a moral, weighted decision. We assume that these people are acting as rational people, that they make a weighted decision, and that if the death penalty is on the books, then they are not going to commit this crime. That is not how it works. Most of the people who are charged with this are high, they have mental illness, or they have extreme anger problems to the extent that they are out of control. A few planned killers make a moral judgment. Nobody is going to say that it is right. It is wrong and they should be punished. They should be punished by death by incarceration as opposed to the death penalty. The death penalty has failed in Nevada for 40 years. We have tried to fix it for 40 years. We have executed one nonvolunteer out of 186 sentences. With that kind of inefficiency, I do not know how we continue to support it.

Assemblywoman Krasner:
You talk about money and budgets. Are the public defender's offices going to slash their budgets if this bill passes, and is there any evidence of drastic budget cuts in the jurisdictions that have abolished the death penalty?

Scott Coffee:
I do not know. The budgeting is done by the county. I am not the public defender; I simply work in a unit at the public defender's office. If we were not handling these capital cases, I would assume the money could be assigned elsewhere. That is my assumption, but that would be up to a different body, not me.

Assemblywoman Krasner:
Without slashing budgets, where is the real savings?

Scott Coffee:
I did not say that. The money could be allotted to victims' families for counselling or to putting more law enforcement officers on the street; that would certainly be in play if this were cut. Should our budget go down? Yes—our budget should go down if the death penalty is off the books. However, I do not make those decisions.

Chairman Yeager:
We are going to move on to opposition testimony at this point. We have a number of people signed in, so I would ask everyone, to the extent possible, to keep your comments as brief as possible so that everyone has a chance to say something on the record.

Lynn Chapman, State Vice President, Nevada Eagle Forum:
I am also representing my family and myself today. If you look in the Bible to Genesis 9, God gave Noah the first governmental ordinance. He said that if a man willingly takes another man's life, he must give his own in his stead. Murder is always a hate crime. It is based on greed, anger, and jealousy. It is always based on hatred. I heard the word "unfair" and I thought, Yeah, it is unfair that I will never get to see my brother again; I will never get to talk to him. He got to see and know one of his grandchildren, but he did not get to meet the other four grandchildren. My brother was killed by somebody who hated him. It was overwhelming to our family. He was on the way to work one morning. This man hated my brother because this man had done a lot of ugly things to other people. They worked at a logging mill. My brother worked at his job for 40 years as a senior scaler, figuring out board feet in the logs that came into the yard. A log loader is a huge machine that goes up to the logging trucks and takes the logs off of the trucks and brings them into a pile in the yard. This man had the log loader in the employee parking lot, which is against the law. He waited for my brother to come to work. My brother was less than 50 feet away from his parking spot and that man backed the log loader over my brother. That is a horrible way to go.

It does not seem fair at all for my family to have to go through that. There does not seem to be any responsibility or accountability. People always have an excuse for why they do things. I feel like putting them into a cage is almost like time-out. It is terrible what people do to each other.

Thank you, Assemblyman Hansen, for saying what you did. Thank you, Assemblyman Wheeler, for saying what you did. Heck no, I sure do not support this bill. I have forgiven the man that did this to my brother. Luckily, my sister-in-law was smart. They were trying to sweep this whole thing under the rug because it was a small town and a big employer. She did win a wrongful death suit of $1 million. At least somebody got something, but it does not bring back my brother. I am not in favor of doing away with the death penalty; I do not think that is the right way to go. Speaking from the point of view of a victim's family, please hear us. It is an insult.

Chairman Yeager:
Thank you, Ms. Chapman. We are very sorry for your loss. Thank you for being here to share with us this morning.

Christopher J. Hicks, District Attorney, Washoe County District Attorney's Office; and representing Nevada District Attorneys Association:
I speak on behalf of the 15 district attorneys who are not here today. I offer a northern Nevada perspective of A.B. 237. When I am done, I will defer to District Attorney Wolfson to give you the Clark County perspective. I sit here in strong opposition to the bill.

The United States Supreme Court has ruled that the death penalty is constitutional; it is not cruel and unusual punishment. The Nevada Supreme Court has ruled the same. The statutory scheme that this very Legislature has adopted and enacted that allows for prosecutorial pursuit of the death penalty currently restricts it to the very worst crimes so that it cannot be used arbitrarily. Just last session, this very Legislature appropriated $860,000 to create a modern facility where lethal injection could be administered. Polls show that a strong majority of Nevada citizens, my constituents and yours, strongly support the death penalty.

The death penalty is not misused by prosecutors in the state of Nevada. Throughout all of our counties, the decision to seek the death penalty is made sparingly and judiciously. It is reserved for the very worst of the worst. In Washoe County in the last 20 years, my office has prosecuted over 300 murders. In that same time frame, we have sought the death penalty only five times, or 1.7 percent of the time. Those five cases, two of which you will hear about in a moment, present facts that are so horrific, so unthinkable, that they are difficult to hear or even believe.

Much has been referenced of the audit that was done in 2014. The ultimate conclusion it reached is that it costs three times more for a death penalty versus a non-death penalty case. I question the legitimacy of these numbers and I will tell you why. The very first page of the audit offers a forewarning that says, "Much of the information was based on unverifiable estimates provided by various entities." These are not hard numbers; these are estimates. I can represent to you that in the last two death penalty cases that were prosecuted in Washoe County in the last ten years, my office handled those prosecutions. The Washoe County Public Defender's Office handled the defense. In both of those cases our budgets were no greater and no less because of that case. We did not go to the county commissioner and ask for more money; they were simply absorbed by our budgets. Had the cases been life without, it would be the same cost, the same effect. To the appeal process: my office has an appellate division and so does the Washoe County Public Defender's Office. They, too, handle that at no additional cost. What this audit did was it took the time to look at the number of appearances that my office made at different death penalty cases and then added that up to come up with some numbers. The reality is it was just my budget; it is not additional costs.

For the sake of argument, let us accept what the study says, that it is three times more expensive to try a death penalty case than a life-without case. What that means is that in Washoe County, less than 2 percent of the time we spend three times as much money. That is less than 2 percent of the time. In light of the severity of those cases and the depravity exhibited by the accused, such a cost is minimal at best. Simply put, true justice sometimes costs a little more.

You cannot place a price on a victim's life or the justice that they deserve. Victims and their family members cannot be overlooked in debating this bill. In the last ten years, my office has sought and received from the jury the death penalty two times. Those defendants were James Biela and Tamir Hamilton. I am going to offer a brief synopsis of the facts of those

two crimes that will fail to truly encapsulate the horror of these two cases and the horrific impacts they had on the victims' families and our community. Yet, they are so important to consider today because A.B. 237 will not only eliminate our ability to seek the death penalty in these astonishing types of cases in the future, but it will also commute the sentences from those two cases and all others in this state to life in prison, allowing them a life of room, board, health care, and social interaction—simple luxuries that none of these victims ever had. Moreover, it will commute the sentences of verdicts that were given by a jury from our community and relied upon by the victims' family members.

Mr. Biela had three female victims. All were college-age students attacked near the University of Nevada, Reno. He violently raped his first victim on the concrete floor of a parking garage at gunpoint. Using his training in jiu-jitsu, he choked out and kidnapped his second victim, sexually assaulting her numerous times in his truck. Lastly, he abducted 19-year-old Brianna Denison from her friend's house. He raped her and choked her to death with a pair of underwear. He then left her naked, lifeless body discarded like a piece of trash in an empty lot covered by a Christmas tree that someone had disposed of in that lot.

Tamir Hamilton had two victims. Two weeks before his brutal murder of Holly Quick, he randomly attacked and repeatedly raped a 20-year-old who had stopped by her brother's apartment to do some laundry. Hamilton fled when the brother tried to get through the locked apartment door. His second victim, Holly Quick, was only 16. In September 2006, she returned to her mom's residence after attending a local high school football game. She said goodnight to her mom and went to her room to go to bed. The next morning when her mom went into her room to rouse her, thinking that she had overslept, she found Holly. The lower half of her body was naked and hung oddly off of the bed. Her throat was slit so severely that she was nearly decapitated. There was blood everywhere. She had been raped. She had been tortured. She had 40 separate stab injuries to her neck, jaw, and shoulders. Her mom found her.

Family members of both of those victims are here today in opposition of A.B. 237. I would like to recognize them. Lauren Denison, Brianna's aunt, is here on behalf of Brianna Denison's family. Her mother, Bridgette, and her brother would like to have been here as well, but they had a preplanned trip together celebrating what would have been Brianna Denison's twenty-ninth birthday. Holly Quick's father, Thomas Quick, is also present today. Her mother, Patricia Doss, is also here on behalf of Holly's family. The impact of these horrific crimes on these wonderful families is immeasurable. We have a duty to empathize with them. We have a duty to try and understand just how hard it is. We have a duty to support them. These considerations are supremely relevant when proposing a bill that will eliminate the death penalty, and more importantly to them, would commute the very death sentences that were delivered to these monsters to life in prison. They do not wish to provide testimony today; coming here is hard enough for them. I wish to share some small portions of the victim impact statements they made to the very juries who gave the death penalty to their loved ones' murderers. Portions I will share with you

reflect the impact the crimes had on them. I can represent that the remainder of the impact statements, which I will not read today, deeply reflected the character and the magnificent qualities of Brianna and Holly. The first comes from Brianna's aunt, Lauren Denison. These are the statements made to the juries presiding over those murders.

> The reality is that no matter how much we write or how long I could stand up here and speak to you, we would never be able to convey to you the beautiful soul that Brianna was. All of our family members wrote beautiful statements, but I would be up here for days if I read them all. We realize you did not know her or have the opportunity to love her, but we did and we will forever be grateful. The pain and devastation to our family is beyond measure. I just want to thank you guys for finally bringing Brianna some justice. Thanks.

The next came from Robert Zunino, who is Brianna's grandfather.

> Most of you have children or close loved ones. I hope you and everyone in this room never has to go through the experience—the horror, the pain, the sorrow—that my family is going through and has gone through these past two years. Also, hopefully the decision that all of you make today or tomorrow will bring justice and peace to my little Brianna.

This is from Brianna's mother, Bridgette Denison.

> James Biela, I am here before you today as a person who has suffered more tragedy than any mother should ever live with. How you have single-handedly impacted me, my only son, my parents, my brother, and the many others that have been there for me can never be put to words. It is not something that words were ever meant to describe. It sickens me to think that my poor baby girl was alone with you for the last minutes of her life. I will never know what it feels like to see my daughter complete her life's journey.

The next statement I would like to read is the victim impact statement from Tamir Hamilton's case. This was given by Tom Quick, Holly Quick's father.

> When I walked into the police station and gave my name at the front desk, I saw a sad look on the officer's face. On the ride up the elevator, the detective told me that Holly, my daughter, had been murdered. In that moment nothing felt real anymore, like this was all a dream. I no longer felt my legs moving as we went to the questioning room. From the questioning room to the waiting room I cried so much that all I can remember is a pile of tissue and sad faces looking at me. The shock was turning into learning to breathe again. I find myself saying, "Why didn't he just kill her? Why did he have to stab her so many times? Why did he have to rape her?" Then I stop myself and think, What a terrible thing to say about my own daughter. To survive day by day is a fight to temporarily forget about Holly, so that

> I can be around people and not think, Where is my Holly, and start crying again. I want to be able to remember her whenever I want to, not the pictures we have seen here that are stuck in my head, but her smiles. That has been taken away forever. Holly was a big part of me. Now I am a broken man that is looking for the day that I can be with her again in heaven with no one to tear us apart. I do not know what to do now.

Lastly, I want to share with you a portion of the statement made by her mother, Patricia Doss.

> I used to tell Holly when she was small, "Don't say can't, say can," and she would say, "I will try." Now I find myself saying, "I can't." I cannot put into words how this horrible act has impacted my life and so, like her, I say, "I will try." I had so many dreams for her and now I am afraid to dream. I am afraid to sleep. I was asleep while my daughter was too afraid, too terrified to scream out, too terrified to scream for help. I was right there and I did not get a chance to protect my daughter and now I do not get a chance to watch her grow up. I always gave her a kiss goodnight. Where is my kiss now? When she was a baby, I would put a kiss in the palm of her hand before she went to bed and before she went to school. Now I am forced to kiss a stone memorial that is at her grave.

I will tell you after Ms. Doss' victim impact statement, the 911 call she made was played for the jury. I can tell you that is the most chilling and heartbreaking 911 call you will ever hear and never forget.

As President of the Nevada District Attorneys Association and the elected District Attorney for Washoe County, I strongly oppose this bill. It does not take into account the will of the people of Nevada, and it argues for placing a price on justice for victims. In the face of the support of the death penalty in Nevada, the judicious manner in which it is sought and the investments we have made to administer it, what we should be doing here today is taking steps to fix our death penalty system, not simply throwing our hands in the air and walking away. The victims deserve better than that.

Chairman Yeager:
We have to take the bills as presented. I do not think there is anything wrong with the Committee examining the policy behind this bill, but I think your points are well taken and I appreciate your being here.

Steven B. Wolfson, District Attorney, Clark County District Attorney's Office:
In the interest of time, I had a lot to say, but I do not think I am going to be able to get through it all, so I am going to move fast. Mr. Lalli will offer some statistical information. There are six or seven people who have flown into town who are victims' family members. It would be terrible if we did not give them an opportunity.

Chairman Yeager:
We can do that. We do have the reality of a limited amount of time. I can tell the Committee that we have about 45 minutes from this point to get through all the testimony. If you could keep your comments as brief as possible, and we will call folks up afterward. We will have to put some time limits on that, but it is important for everyone to be able to come to the table and at least get their name on the record in either support or opposition.

Steve Wolfson:
I am the Clark County District Attorney (DA), and on behalf of the Clark County District Attorney's Office, we oppose this bill, and I would like to tell you why. It is worth noting that in Clark County the decision to file the notice of intent to seek the death penalty is my decision and mine alone. We have a committee of respected attorneys who meet to determine whether to file this notice. These are earnest, serious, solemn meetings, but at the end of the day, the decision is mine. Before taking office over five years ago, I was a criminal defense attorney for 25 years. During those 25 years, I represented a number of persons charged with murder, including capital murder. I am not a career prosecutor. A lot of people talk about career prosecutors having a narrow vision or narrow view of things. I was a criminal defense lawyer longer than I have been a prosecutor.

Before taking office over five years ago, my predecessor filed the notice of intent to seek the death penalty in an average of 20 cases per year. When I took office, I pledged to reduce that amount because I thought it was the right thing to do. I have done that. In my five years, we have filed the notice of intent in less than 50 percent of the cases of my predecessor. I am not criticizing my predecessor—we are all different and view things differently. In my opinion, a change needed to come to Clark County. That is why we have filed 50 percent fewer death penalty notices in the last five years. Why? I am going to use the phrase that so many people seem to throw around so casually—"the worst of the worst." It applies, but it has meaning too. There is another phrase that I have heard in this industry—"garden variety," the typical type of murder case. I do not like that because, as somebody has already pointed out, no murder is pretty and no murder is just. But there are different kinds of murders and different kinds of people who commit murders. It is not just the event of the crime itself that we base our decision on. It is a variety of factors—a person's background, a person's criminal history, whatever mitigation is presented to us prosecutors—recognizing that we only have a short period under Nevada law to file the notice. We have 30 days after a case reaches the trial court. That is a very short period. We are trying to do something about that. I am on a Supreme Court commission that is looking at changing some of the rules to make it better so that the decision whether to file can be delayed to give the defense lawyers more time to present us with mitigation. That is something that is being discussed by the stakeholders.

The citizens of this state strongly favor the death penalty. A recent poll conducted by the Mellman Group said almost 70 percent of Nevadans favor the death penalty. There are a lot of polls. There are a lot of studies. There are a lot of writings. You can find somebody with a differing opinion and a different poll on almost any subject matter. In Nevada, a recent poll by a recognized pollster found that almost 70 percent of Nevadans support the death penalty.

I work for those people. As an elected official, I have an obligation to ensure that their voice will be heard. If I was presented with polls that showed only 30 percent of Nevadans support the death penalty, I might do something as the Clark County District Attorney because I do have the power to say no. When almost 70 percent of Nevadans still support the death penalty, I have an obligation to seek the death penalty in appropriate cases.

It is not appropriate in most cases, but it is necessary to give the jury the option. District attorneys do not find the death penalty once somebody is convicted of first-degree murder; juries do. We have an excellent defense bar in Clark County. Mr. Coffee, you are one of the finest lawyers in Clark County. He does a great job of representing his client. He has a number of colleagues that do the same thing. At the end of the day, a jury determines whether to impose the death penalty. Usually we seek the death penalty in killings involving children, police officers in the line of duty, where extreme torture or mutilation is involved, or where there are multiple decedents. The criminal justice system relies upon graduated punishment. If the appropriate punishment for a particular murder is life without parole, how do you punish a person who commits multiple murders? How do you punish a person who has committed a murder in another state, is serving life without parole, and because of timing is able to commit another murder? Do we give him another life-without-parole sentence? Our system is based on graduated punishment.

In Clark County, the death penalty is used appropriately. When I am done with my remarks, Mr. Lalli is going to talk about the statistics. So much discussion has occurred today that if we abolish the death penalty, money will be saved. I ask each of you to look closely at that statement. I do not believe we will save money if we abolish the death penalty. If the death penalty is eliminated, the focus will simply shift to life without the possibility of parole. Life without the possibility of parole will become the new death penalty.

Defense attorneys and judges will say a potential sentence of life without the possibility of parole creates a more significant defense obligation than in any other case because now that is the worst. Defense lawyers are going to have to spend the same money, fight the same fight, to avoid the ultimate punishment. We will hear things like, "It is the duty of defense counsel to lead the team in conducting an exhaustive investigation into the life history of the client." We hear that in death penalty cases. We are going to hear the same thing in non-death cases, and we have already heard those same things. We have affidavits from defense lawyers representing noncapital murder clients. "It is the duty of the defense counsel to lead the team in conducting an exhaustive investigation into the life history of the client." It is not going to change. Now life without parole, if you abolish the death penalty, will be the most extreme penalty. "It is incumbent upon the defense to interview all relevant persons and obtain all relevant records and documents that enable the defense to develop and implement an effective defense strategy." We have already heard that in noncapital cases, and I guarantee you we will hear it if you abolish the death penalty and the same costs will exist.

They said we could not obtain lethal drugs. I do not believe that is accurate. The law provides, in *Nevada Revised Statutes* 176.355, that "The Director of the Department of Corrections shall . . . Select the drug or combination of drugs to be used for the execution after consulting with the Chief Medical Officer." I have met the Director of Corrections, Mr. James Dzurenda. I have met personally with the Director and had two conversations with him. He tells me that, should he receive an order of execution, he believes he will be able to find the drug or combination of drugs to carry out an execution. When you hear that the drug is not available, I do not think that is accurate. I would invite you to ask Director Dzurenda yourself.

I have sat here for two hours, and it has been a pleasure. This is a pleasure to come here and speak. Some of you are my friends and I respect all of you, but I heard something that was so insulting. Somebody accused my office and me of a "dog-and-pony show" put on by the DA's office in death penalty cases. I am sorry sir, but that is insulting. I have excellent prosecutors that seek justice for victims. To call it a "dog-and-pony show" is insulting.

Each of us is entitled to our moral opinions on whether we as a society should take another human's life. There are two things going on here. There is the moral angle and the legal angle. We are each entitled to our own moral opinions. I may agree or disagree with some of you, and that is our right. I respect people who disagree with me. Legally, it should remain an option. Most Nevadans want a jury to have the death penalty as an option, and removing it will not save money. As my esteemed colleague Mr. Hicks said, should saving money be the reason to abolish the death penalty? I say no. As Mr. Hicks said, How about reforming a process, both before and after a trial, where a plea of guilty would reduce costs without eliminating a form of justice. In my travels and discussions, most people who complain about the death penalty complain about the fact that it is taking so long and we are not accomplishing it. It is not because we do not return a verdict of death; we are just not getting it done. It takes 10, 15, 20, or 30 years. How about looking at that process? That is what people are complaining about. They are not complaining about the death penalty; they are complaining we are not doing it. How about looking at the process? How about looking at the state appellate process and the federal appellate process? Somebody quoted the Lindbergh Trials, where somebody was executed a year after. I am not suggesting a year. In Clark County, I am part of a panel put together by the Supreme Court justices. Mr. Coffee is on my subcommittee. We are looking at reforms, at getting cases to resolution quicker. That is what people want. They do not want to abolish the death penalty. They want justice quicker, balancing the due process rights of the defendant.

Chairman Yeager:
After Mr. Lalli speaks, I am going to take some questions from the Committee for the prosecutors. I do not think we will have many questions, but there are a few, and then we will take additional testimony.

Christopher J. Lalli, Assistant District Attorney, Clark County District Attorney's Office:
I have been employed at the Clark County Office of the District Attorney for 23 years. I am currently in administration, but for a good part of my career, I was a homicide prosecutor on our Major Violators Unit. This is a very challenging issue for many people, but it is important, particularly for those in the Legislature, to be mindful of actual and true data. For that reason, I want to touch upon a couple of points. One is the recent audit regarding death penalty costs. I would agree with District Attorney Hicks that we ought to use caution in approaching some of the conclusions of that study. I looked at how they determined that prosecution costs in death penalty cases were higher than in non-death penalty cases. Here is what they say, "The in-court costs of prosecuting a death penalty case was higher than for non-death penalty cases. The differences in costs are attributable primarily to the added hearings in the court record for death penalty cases during pretrial." That is on page 22 of the study. They continue, "The cost of prosecuting a death penalty trial is nearly twice the cost of a non-death penalty case. Since the costs were based on actual court time, costs are primarily driven by the length of the trial." That is at page 25 of the study. There are no additional costs realized by the county, who employs all of us prosecutors and defenders in the majority of these cases, by the extension of time of a trial. Those costs simply are not real. Prosecution salaries do not increase based upon the length of time in a courtroom. Staffing levels have not increased based upon more or fewer death filings. The case must be tried irrespective of whether a death notice is filed in the case. The costs of prosecution that are allegedly more in death penalty cases is not accurate. The same could be said for court costs.

I want to give you another example of how that study estimates costs. They assess the cost for pretrial detention of a death penalty defendant. They say it takes longer for death penalty cases so they should look at the costs associated with housing that defendant in local jails pretrial. They assess that figure alone at $157,000. Non-death penalty defendants are detained pretrial as well. It is not a cost unique to a death penalty case. Whether a murderer is detained in a jail pretrial or in prison postconviction, society still bears the cost of incarcerating that individual. The cost is no greater in a death penalty case. Respectfully to that study, these costs are invented.

There was a lot of discussion about deterrence, and Assemblyman Wheeler, you are correct; there are studies going both ways. I have many of them that I can provide to the Committee. I did want to talk about statistics. We have provided the Committee with a document (Exhibit H) titled "Death Penalty Statistics." I want to talk briefly about those as they pertain specifically to our state, to Clark County, and to Nevada's death row. Slide 2 indicates the number of death row inmates separated by race. This is information we did not create but was provided to us by the Department of Corrections (NDOC). I heard a number of speakers in support of this bill suggest that prosecutors target minorities when seeking the death penalty. The facts simply do not bear that out as being accurate. The final slide [slide 4, (Exhibit H)] of this group of charts is entitled "Race of Clark County Death Verdict Defendants 2002-Present." It lists the various percentages as well as the raw numbers of cases in which we have received a death verdict from juries. It is important to consider these

statistics in light of the number of individuals who are actually committing murders in our state and in the country. To do that, I received information from the FBI, the Uniform Crime Report (UCR), numbers that the criminal justice system in every state relies upon heavily. I took the statistics from 2015, which I would suggest is a snapshot similar to other years. In 2015, of the murders that occurred in the United States—there were over 15,000—36.7 percent were committed by African Americans. If you look at the death verdicts in Clark County that involved African-American defendants, that number is 33 percent. We are underrepresenting African Americans in the number of death verdicts returned in Clark County. When you look at the national number of homicides committed by Hispanic individuals, that number is 12.7 percent. These are the FBI numbers. In Clark County, of our verdicts wherein we received a death verdict dating back to 2002, 10 percent of those individuals were Hispanic. Again, that is lower than the statistics showing who has committed murders in our country. Perhaps the most startling figure pertains to white males. The FBI reports that in 2015, of the more than 15,000 murders that occurred in the United States, 30.2 percent of those murders were committed by white males. In Clark County, 52 percent of those individuals wherein a death verdict was received were white males. The suggestion, borne out by the raw numbers, that prosecutors are "targeting minorities" is simply not true.

Chairman Yeager:
Mr. Lalli, I do not think that was the testimony—that prosecutors are targeting minorities. I think the testimony was that they were disproportionately impacted. I want to make sure that is clear because I do not believe anyone said that in his or her testimony.

Christopher Lalli:
With due respect, I wrote it down when I heard it. A speaker did say that, and there was testimony that it is disproportionally given in the cases of minority members. In both of those cases, that assertion is not correct. The other thing we heard was that the death penalty does not undergo a sufficient narrowing under the laws of the state of Nevada. I want to provide you with the raw statistics that we know. There is a pie chart [slide 3, (Exhibit H)] titled "Clark County Death Verdicts 2002-2015." With respect to the number of murders in Clark County, the source was provided by the Clark County Office of the Coroner/Medical Examiner. They have statistics completed through 2015, so I do not have information that is more current. We look at it in terms of the death verdicts returned in Clark County during that time. From 2002 until 2015, there were 2,288 homicides committed in Clark County. During that period, there were 18 death verdicts returned. That is less than 1 percent. It is a fraction of the percentage of the homicides in Clark County. Based on the raw statistics, I would submit there is an absolute narrowing of those who receive the death penalty in Clark County.

One other thing I wanted to mention was cost. I want to address A.B. 237 itself. One of the arguments we hear often from the proponents of the legislation are the cost savings. There may be some; what that is I could not tell you. As I indicated before, I would use extreme caution in approaching that issue. However, just looking at the bill, I would submit that the cost of prosecuting homicide cases could increase. We can look at the number of defense

attorneys that are required to argue a death penalty case in Nevada today; NRS 175.151 provides that in death cases, the court must allow both defense counsel to argue the case to the jury. That is existing law. What this bill would do is amend that statute to require courts to allow both defense counsel to argue the case to a jury in non-death cases. By implication, this bill would require two attorneys to be appointed in every case. I would submit that is going to be an enormous cost to the counties, particularly the rural counties. The bill addresses the number of defense attorneys required to argue a case on appeal. In death penalty cases, the court must allow both defense counsel to argue the case on appeal [NRS 177.235]. Assembly Bill 237 would require the same in non-death penalty cases.

As Mr. Wolfson suggested, life without parole cases that are routinely handled in our justice system will become the new death penalty. I submit that costs of handling those cases would actually increase from their current levels.

Assemblyman Watkins:
I would ask that Mr. Hicks come back up. I want to preface my question by saying this: we elect you to protect us, and you do a wonderful job. I know it is a difficult job where you cannot unsee what you have seen; you cannot unhear what you have heard. I was also elected to ask questions. Some of these questions are going to be difficult, but it is not meant to disrespect your position or the job that you do. I am thankful that you are in the position that you are and doing what you do to keep us all safe.

Regarding the audit that is being quoted, did either or both of your offices have the opportunity to participate in that audit by providing data or input?

Christopher Lalli:
Both of our offices did participate in the study. There is a suggestion to that in the study itself. If you look at page 22 it says that "Although the Clark County and Washoe District Attorneys' Offices did not provide estimated or actual hours on our selected cases," with respect to the time required. We did participate in that audit. We did not and could not provide the type of information that the auditor was looking for. We do not ask our attorneys to keep track of their hourly rates as you would in a private firm where those bills are being passed on. There is no scientific way to estimate the hours spent on particular cases. Moreover, we would still have a responsibility to prosecute the cases that we were questioned about irrespective of whether they were death cases. We did provide information as part of the study. I do not think the study captures the challenges that truly exist.

Assemblyman Watkins:
Was there any information that was in possession of either of your offices that the auditor requested that you did not provide?

Christopher Lalli:
It is my understanding that we provided all of the information that we had to the auditor as best we could.

Christopher Hicks:
I was elected in 2015, so I was not the sitting DA when this occurred. Nevertheless, as far as I understand, we encountered the same hurdles that Mr. Lalli just explained. We gave them any data to which we had access.

Assemblyman Watkins:
Mr. Wolfson, you indicated that the better approach here may be to address the appeals process and the length of time it takes to get through the appeals process before a death sentence could be carried out. It is my understanding that much of our compliance with the law on the appeal process stems from the United States Supreme Court holdings. This body could not have any impact on that. Is there a line in the sand of where we can have an impact as the legislative body for this state versus holdings that came down from the United States Supreme Court that we have no impact over?

Steve Wolfson:
A great deal of the costs that are being talked about are pre-adjudication. Some of these cases take many years to get to trial. In Clark County, we have 330 pending murder cases and 58 capital cases. Of those 330 murder cases, 50 of them are more than 5 years old; 80 of them are more than 3 years old. The point is that so much of the cost is up front. The lawyers have to do their preparation. I think that reforms could be made pre-adjudication to help cut the costs way down but not deprive a defendant of his due process rights.

Assemblyman Watkins:
Would those reforms need to come at the federal level because they are dictated by the United States Supreme Court? Is it something that this body could actually address?

Steve Wolfson:
I am pleased to say that there are four subgroups under the Nevada Supreme Court's Commission on Statewide Rules of Criminal Procedure. One of them is called the Life/Death Committee, and we are spearheading an effort to address these issues on murder cases. On our own, through the Eighth Judicial District Court, we are taking significant steps. I am pleased that we believe we can enact some new rules to get not just death penalty cases but murder cases to resolution. Most of these cases settle without a trial. Why take five or seven years?

Assemblyman Watkins:
According to the data provided in the exhibits we have, the reality is that 13 of the counties in this state effectively have no death penalty. There are no death row inmates and, as far as I can tell, there is nobody even being charged with a crime that pushes them toward the death penalty. We do not have that number. Can you, as the representative for the DA's association for the state, provide the numbers of people who have committed crimes in these rural counties that are death penalty-eligible and whether they are being tried for the purposes of the death penalty?

My last question would be to both of you as well. We have heard some evidence on an unrelated bill about the inadequacy of our jury pools across a cross section of the population of the state of Nevada along either ethnic lines, racial lines, or socioeconomic lines. I wonder if you could address that and whether you believe that inadequacy—or maybe you do not think it is inadequate—has an impact on the likelihood of one person being sentenced to death over another.

Christopher Hicks:
I can only speak to that anecdotally. I have done many jury trials in Washoe County, including death penalty litigation. It has been my experience that the jury pool is reflective of our community. I do not believe that those types of issues exist, at least not that I have seen, and I have not read any studies on that issue.

Steve Wolfson:
I am aware of a bill or two that attempts to address this. I do not believe there are inadequacies at all. We have a system in place where hundreds of potential jurors are summoned into courts. Especially on death penalty cases, it is the norm to use questionnaires. There is a whole process. Sometimes it takes days or weeks to select a jury. There are literally hundreds of people who do represent a cross section of our community. I do not believe there are inadequacies.

Assemblywoman Cohen:
Can you please speak to the services in place for the families of victims? Mr. Hicks, in your role as President of the Nevada District Attorneys Association, if you have information for any of the counties that are not represented here, please provide that as well.

Christopher Hicks:
In regard to victim services?

Assemblywoman Cohen:
Yes.

Christopher Hicks:
Statutorily we can provide a certain amount of money regarding victim services. I have one of our victim advocates from our DA's office in Washoe County here today. She could probably better lay out victim services. I would be happy to have her meet with you afterward if that would be better. We provide victim advocacy from the get-go in all of our cases because we want, first and foremost, to take care of our victims. Excuse me for trying to talk so fast; we have a lot of victims who want to speak today.

Chairman Yeager:
That is fine; I do want to make sure we get to other testimony.

Assemblywoman Miller:
I have a question for Mr. Wolfson and Mr. Lalli. Mr. Wolfson, you mentioned that in a poll, 70 percent of Nevadans favored the death penalty. I would like to know about the poll. You mentioned that it was conducted by a popular pollster. My question is who was the pollster, how many people were polled, what are the demographics of those people—specifically ensuring that they were actually Nevadans—how and what were the questions, and were the facts about the death penalty presented with those questions?

Steve Wolfson:
I actually said "almost 70 percent." In any event, it is approaching 70 percent. This poll was done by the Mellman Group, which my research showed me was a well-respected, well-recognized, often-used polling group. That polling took place between January 12 and January 15, 2017. I have a variety of the statistics broken down. In the interest of time, I did not go through all of those. For example, 66 percent of the voters polled support keeping the death penalty in Nevada; 59 percent said they strongly supported the death penalty. The demographics are divided between Republicans, Independents, Democrats, young and old; and I could go on.

Assemblywoman Miller:
When you say, "almost 70 percent," is that almost 70 percent of 200 people or 2 million people? You are saying "almost 70 percent of Nevadans." I need to hear the number of people who were polled and the demographics of those people.

Chairman Yeager:
In the interest of time, perhaps you could provide the Committee with the information about the poll.

Assemblywoman Miller:
Mr. Lalli, I am looking at the pie charts that were provided. Going back to your concern about the impression that the counties were targeting black defendants: it says, regarding the race of Clark County death verdict defendants, 2002 to present [slide 4, (Exhibit H)], 33 percent were black, with the actual number being seven. However, when I look at the race of current Nevada death row inmates [slide 2], that number for black people increases to 37 percent and increases from 7 black defendants to 30 black defendants. The integrity of numbers is when we are looking at them holistically and quantifiably. At 37 percent we could say that is less than whites, but our Clark County community is around 12 percent black.

Christopher Lalli:
I think your statistical information is correct, but I think it is an error in reasoning to say we are going to compare the people on death row with the population in the state, because not everybody in this state commits murder. We look at the number of murders and the racial makeup of the offenders of those crimes when we talk about statistics. I hope nobody is

getting hung up on the word "targeting," but whether the result is we are putting more minority members on death row than proportionately those who actually commit murders, without any doubt at all, the answer is no, we are not. In fact, we are disproportionately putting white males on death row in Clark County.

Assemblywoman Miller:
How many of the death row offenses, or chargeable offenses, are committed by white men or black men as opposed to how many are resulting in those death row convictions?

Christopher Lalli:
All of the individuals on death row have committed offenses that are punishable by the death penalty. In an answer to your question, that would be 100 percent of them. What we have done is just put all death row inmates in the state into the chart of the race of current Nevada death row inmates [slide 2]. What we have done in Clark County is to look at the trend. What we are doing in the last 5 years, the last 10 years, is more significant than what we did 20 years ago. If you look at the modern trend, I would submit that, based upon the raw numbers, there is not an instance of focusing on racial minority members.

Assemblywoman Miller:
I know we have so much to cover, but I am interested in those raw numbers. It is not an impression of the raw numbers, I am just interested in the raw numbers—crimes versus convictions.

Christopher Lalli:
Maybe I am misunderstanding your question, but the raw numbers of individuals in addition to the percentages are actually included on the diagram [slide 4, (Exhibit H)]. Those numbers consist of 11 white individuals, 7 black individuals, 2 Hispanics and 1 Asian. Those are the raw numbers composing the information on this chart.

Assemblywoman Tolles:
Mr. Wolfson, in regard to the commission that is addressing these issues, when do you anticipate that the report with those recommendations for reforming the process would be made available?

Steve Wolfson:
The commission has been meeting for almost two years. The subcommittees of the commission have been providing reports to the full commission. The subcommittee that is relevant to our discussion is taking action. We have had meetings with the chief justices, the Supreme Court justices, and the judges from the Eighth Judicial District Court to implement some of the things we are talking about. As far as the final and full report, the commission is an ongoing body, so I cannot tell you when a final report will be provided. Unless I am told I cannot, I would be glad to provide you with our subcommittee's report. I am proud of it actually, since I am the chairman of the subcommittee.

Assemblywoman Tolles:
I notice on NELIS that there is a lot of information that has been brought forward that has been posted. I think it would be beneficial to this body as well as the public if I could request a follow-up on that commission report, the audits that were referenced, the poll that was referenced, and some of those studies that were referenced in regard to the deterrent factor. Finally, I would like to take a moment of personal privilege to say thank you, particularly to DA Hicks for speaking on behalf of the victims, for recognizing that the criminals had no objection to imposing the death penalty on their victims. I would like to personally thank your office for prosecuting the man who murdered my family member ten years ago. Forgiveness does not mean the absence of consequences.

Assemblyman Pickard:
My question is for DA Wolfson, given your extensive experience on both sides of this equation. I am wondering about the unintended—or maybe intended—consequences of this bill. In your view, if life without parole is crueler than death, do you believe that this could lead to more defense actions that will then call into question the constitutionality of life without parole under the Eighth Amendment?

Steve Wolfson:
I do not know. So much focus has been on the death penalty, the finality of the death penalty, and whether it is cruel and unusual punishment. I do not think there has been as much focus on the lesser penalty of life without parole. I do not know that death is worse than life without. Juries make decisions based on what should happen to an individual based upon a variety of factors. I cannot predict what the future may have.

Assemblyman Thompson:
I want to talk about prevention. Since we are talking about data so much today, share with us what, if anything, your offices are doing to be proactive around prevention and making those data-driven decisions and strategies in your office. There are a lot of hurting families here today and many who are not here today. What are your offices doing for prevention? The reason I say that is because there is data out there that says that 60 percent of the defendants suffer from mental impairment, 44 percent have intellectual disabilities, nearly 1 in 5 are under the age of 21, racial bias is in the application of the death penalty, so on and so forth. How can your offices see this time and again and not address it prevention-wise?

Steve Wolfson:
I have been the DA for five years. When I took over, I started participating in the Sheriff's Multi-Cultural Advisory Council. I think it started with Sheriff Gillespie and now carried forward with Sheriff Lombardo. We meet once a month. There are 40 or 50 people representing all cultures in that room to talk about what is happening in Clark County. When we had some problems with civil discourse in other communities—Baltimore and the like—Las Vegas was very concerned about what was going to happen in our community. We started meeting ahead of time to talk about what we can do to prevent civil discord. Sheriff Lombardo gets all the credit. We went into the community, met with community representatives, and heard what they had to say. That is one thing that my office participates

in on a regular basis. I have regular meetings with law enforcement to discuss what we can do to combat violent crime. That is what is now on a lot of people's minds: violent crime. We had 158 homicides in Clark County last year—I do not know if it was the record, but it was very close. Violent crime is up. I do not know what to do about it, but I meet with my colleagues, I meet with the sheriff, and I meet with other representatives to discuss getting out into the community. These are social issues, and I cannot answer that question in two minutes.

Assemblyman Thompson:
With all due respect, I hear that you are hearing it and you are talking about it. What are programs that your office, not the sheriff, is doing to combat this? You have profiles of the behaviors of the types of people who are coming in. What is your office doing, not hearing, about it? We all heard today and we hear it all the time: what are we doing, we have to do something about it, we do not want families to be hurting like my colleague and others have shared and will share.

Steve Wolfson:
I have specialty teams in my office. Clark County is a big community. We are the thirteenth largest county in the country. Unlike 20 years ago when we did not have specialized prosecutors, we do now. I have a gang team consisting of four lawyers who target gang violence. I have a gun team with five lawyers who target gun crime. That is what people are most worried about. I am seeking a third grand jury in Clark County so that we can effectively and efficiently prosecute dangerous people. That is one thing I am doing and I am working very hard at it because I think it will have an impact and effect to protect the citizens of Clark County.

Chairman Yeager:
Not to cut you off, but we really have to move on. I will ask you and any other members of the Committee to take those questions offline. For members of the public, here is what we are going to do: we do not have much time and many of you have come here to provide your testimony. The voters do not always make it easy on us here in the Legislature. We have 120 days to get through all of our business. I would first like to invite anyone who would like to give testimony to present it in writing. I do want you to come to the table and at least state your name on the record, your affiliation, and your position on this bill. We do not have time for additional testimony beyond that. Again, I would invite you to submit your written testimony to the Committee. I can assure you that we will read those. Let us start in Carson City, in opposition.

Ronald P. Dreher, Government Affairs Director, Peace Officers Research Association of Nevada:
We are in opposition to A.B. 237. Three of the 83 people on death row are people who I had an input in putting there. I am a retired homicide detective from Reno. There is a lot more to this story that I would be more than happy to share.

Terri Bryson, Chapter Co-Leader, Desert of Hope Chapter, National Organization of Parents of Murdered Children, Inc.
[Additional testimony submitted (Exhibit I).] I am against this bill. I am a mother of a daughter who was murdered. Her name is Cherish Noelle. She was 22; twenty-three years and two weeks into her death. I am also the chapter co-leader of Parents of Murdered Children in Las Vegas, Nevada. Being against this bill is something that I have always felt throughout my life, but now that it has affected me, I want to be able to share that this affects more than just the statistics and the numbers that we are talking about today. There is another side to what we are dealing with here today—that is the victims and the families that are affected—we are convicted for life. We have to live with the ramifications of somebody else's choices against our children. That entire branch of my family tree has been eradicated. I do not have an option. I do not have the privilege of her living out the rest of her life as some of these people who are sitting on death row. I had to pull my surviving daughter off of her dead sister's body. I had to hear the wails of her father still echoing in my mind. I have had to pick my husband off the ground more than once. I, as a chapter leader, hear tales every day. I get the first calls about people who have been affected by this violence. My worst call is saying I need you to talk to a mother who lost her 3-year-old child. If they are calling me it is not an accident; it is not due to illness. I need to have our voices heard. I am coming to you to raise our voice and let you know that there is another side to the statistics. There is something more than the monetary loss and gain. Please hear our cries from the valley of grief. Listen to what we have to say too.

Chairman Yeager:
Thank you for your testimony, ma'am. Feel free to submit your additional testimony in writing if you would like to as well. You can give those to our committee secretary.

Shalonda Hughes, Private Citizen, Las Vegas, Nevada:
I made Kenneth Allen Hardwick a homemade caramel apple pie and kissed him goodbye and I never saw him again until I had to identify his body. He was a son, a brother, an uncle, and a father of four. He was my best friend; he was my fiancé, soon to be my husband. He was going to be the father of my children. I was 30 years old and he was the love of my life. One night, two men did not care what was going on in anyone's world but their own: no regard for kin, his family, friends, loved ones, not me, not you, not anyone. The fact of my case is they took his life for what they thought was money. They followed him. He had a traveling humidor. They killed him over cigars. He lost his life because these criminals were lazy and greedy and it was easy for them. All they got out of it was cigars. This premeditated murder occurred December 5, 2006. It took almost six months before their arrest. I showed up for court every single day. Two preliminary hearings, 24 calendar calls within 32 months, and it finally went to trial March 2010. Our lives were turned upside down. I lived in fear, complete paranoia, wondering if we would ever receive justice. We finally did in April 2010. The criminals convicted of first-degree murder were sentenced to death for the heinous crime they committed. We felt relief 40 months later. We have survived long enough to see another day that our government has enforced rules to protect our lives. Without these rules, our world would be in a chaotic state of nature. Rules and regulations are very important to keeping order within our society.

Yes, the death penalty is the most severe form of punishment sentenced to a person who has been condemned by the law. It is important to me and Ken's family, and all of the innocent victims. It could be you. It is important that we provide retribution to the people who have been victimized in the most atrocious manner. We cannot survive in a society that fails to punish criminals in a way thought to be proportionate to the severity of their crime. If the result of doing something is too extreme, we hope that people will change their behavior. The death penalty provides a justified method of deterrence. It could prevent you from ever having to experience my pain. The death penalty helps us think twice about carrying out intentions of belligerent behavior, and it deters people from committing repulsive acts of crime. The death penalty serves as a reminder that there are severe consequences to our actions.

In conclusion, I want to say that after listening to what everyone was saying on both sides, certainly we need to examine the process and figure out how we fix it. I understand cost is an issue, but I am offended that those people put a value on Ken's life. I am offended. I am not angry; I do not hate; I just want justice. I strongly oppose this bill.

Tereza Trejbalova, Private Citizen, Las Vegas, Nevada:
I am a student of criminal justice and my research area is the death penalty.

Chairman Yeager:
May I ask if you are in opposition or support?

Tereza Trejbalova:
In support.

Chairman Yeager:
Can I ask you to hold off for just a moment? We are still taking opposition testimony.

Kenneth Cherry, Sr., Private Citizen, Oakland, California:
My son was murdered February 21, 2013, on the Las Vegas Strip. He lost his life, and two other people lost their lives too. The way that the murders happened was the two other people burned up in a car. The guy who did it, the animal who did it, escaped and went to Los Angeles. I am sure many of you are familiar with it. Some of the things I have discovered that he said: he was not tripping off the fact that he killed, he murdered, these people—he was trying to get away. The death penalty is definitely needed for people like that. He is not crazy; he is just evil. An example I thought of while I was coming up here is that if we could prosecute the devil and convict him and then he would be sentenced to death, we would kill him. That is one of his protégés.

Chairman Yeager:
I understand your point, but in the interest of time, I need you to keep your comments to this bill.

Kenneth Cherry, Sr.:
I am finished. That is all I want to say. I am opposed to the bill—I came all the way from Oakland, California. I drove all night.

Jennifer Otremba, Private Citizen, Las Vegas, Nevada:
[Read from prepared testimony (Exhibit J).] This is my daughter Alyssa. This picture was taken 48 hours before she was brutally murdered. She was 15 years old and a sophomore in high school. On September 2, 2011, she was walking home from borrowing a textbook from a friend. It was 6:38 when she texted me saying she was walking home and her phone was going to die, but she would be home within a half hour. Exactly 30 minutes later I texted her and there was no response. I called her and there was no answer. I searched for her. I called the police and they were looking for her. It was 24 hours later when her body was found about 300 feet behind our home in the vacant lot. As the details unfolded, I learned that Alyssa was within feet of the pedestrian gate at the end of our street when she was attacked by 19-year-old Javier Righetti. He left his home with a knife because he was bored. He spotted her walking. He proceeded to follow her for a couple of blocks before he attacked her. He drug her into the lot. He sexually assaulted her. He raped her. He tortured her, stabbing her more than 80 times in the head, neck, and body. He carved an "LV" into her thigh because it made him feel "gangster." When you think it cannot get any worse, he came back hours later, he poured gasoline on her, and he burned her body. The coroner had to use dental records to identify her mutilated body. During the autopsy, they found the tip of the knife in her skull. Her remains were too much for us to see; we were told not to see them. There are no words that could adequately describe what this has done to my family. It has been five and a half years. It has been a nightmare. In the midst of all of this we have continued to seek justice. Eight days ago, the man who killed her was sentenced to death. Eight days ago, we finally received justice for her life. It was less than 24 hours later that I got a phone call that there was a bill that was wanting to abolish this. Nothing will bring her back, but there are some people who commit such heinous crimes that they deserve to live on death row and not know when their last days will be coming. I will submit the rest of my testimony.

Chairman Yeager:
Thank you for being here. Please do submit the rest of your testimony.

Lisa Postorino, Private Citizen, Las Vegas, Nevada:
[Additional testimony submitted (Exhibit K).] I am here on behalf of my niece, Alexus Postorino, who was murdered in 2010 by Norman Belcher. Belcher had killed someone prior, just gotten out of prison, and four months later, he killed my niece. I could go on about Alexus, but she was a great kid and very positive. I want you all to understand that if you put somebody in prison for life without parole, it is just another way of life for them; they learn to adapt to that lifestyle. They still have a life, they still go on, and they still interact with others. It is not a punishment. Where is the punishment? A heinous crime is a heinous crime; that is why we had to wait six years to go to trial. That is why we patiently waited through the appeal process. We did everything, and then he gets life without parole? He was just sentenced three months ago, after six years. I waited six years, and he is going to

get a different lifestyle? He cannot see women. What else is the consequence if we just put him without parole? There is no consequence. There has to be punishment. One Assemblywoman said there has to be consequences for actions. I am a Christian; I am not angry, and I forgive everyone, but there has to be punishment for crime or we are going to have more crime.

Brett Kandt, Chief Deputy Attorney General, Office of the Attorney General:
Our office is in strong opposition to this bill, and I will submit written testimony (Exhibit L).

Tehran Boldon, Private Citizen, Las Vegas, Nevada:
I am opposed to this bill. Steve Wolfson and the Las Vegas DA's Office are the finest in the country. The only dog-and-pony show is the one that brings this bill up when my family wants justice.

Chairman Yeager:
Sir, I need you to be respectful to the legislative process. We have not taken any action on this bill; we are simply taking testimony. If you want to make comments on the bill and your position, that is appropriate. We will not stand personal insults to the Committee; we are simply doing the business we were elected to do.

Tehran Boldon:
It does not matter what race the person is who took my brother's life. The jury spoke. They sentenced Ammar Harris, the most worst of the worst of the worst. That is who he is. It is a deterrent. If a police officer is murdered, ambushed by a convict in Henderson, are you going to put a price on that for the family, the taxpayers? There are 82 people on death row. I will pay for one of those and you can take those off the books if price is your concern. What price do you have to put on my brother's life? How dare you try to take away the justice that is granted by the Supreme Court and take my family and these families through this burden. A waste in taxpayer's money is trying to save someone who is the lowest of the low, who has no respect or remorse. I think it is a slap in the face of my family and everybody who has someone on death row. You cannot put a price on the lives lost, my mother's life shortened. My life will be shortened because of this. I cannot function well because of this. But you have the ACLU and all these organizations that spend millions of dollars . . .

Chairman Yeager:
Sir, I need you to be respectful to the process. I take it you are opposed to the bill. I think we have noted that. If you would like to submit additional testimony for the Committee to consider, I would invite you to do that in writing to our committee secretary.

Tehran Boldon:
One more thing I would like to say. I know that when the death penalty is on the table, not too many people who face it want the death penalty. It is a deterrent. It is definitely

a deterrent if someone knows they kill a cop and they will face the death penalty. It is only effective if you use it. It has been 40 years. If you do not use it, how can you qualify whether it is effective or not if nobody has been killed or executed? How can you say it is not a deterrent? Do you get that point?

Chairman Yeager:
I do sir, but this is not the time for witnesses to ask questions. It is time to provide testimony, so I do thank you for your comments and would again invite you to present any additional testimony to the committee secretary.

[Additional testimony in opposition to Assembly Bill 237 was submitted (Exhibit M).]

For now, we are going to come back up to Carson City. I know there were a few others in support. I want to reopen it for support. We are just looking for name, organization, and that you support the bill.

Tereza Trejbalova:
I want to quickly address the deterrence, and I have submitted testimony (Exhibit N) that shows that for the three last states that have abolished the death penalty, Maryland, Connecticut, and Illinois, the murder rates went down since they abolished the death penalty while Nevada is still going up.

Escenthio Marigny, Jr., Student and Climate Justice Organizer, Progressive Leadership Alliance of Nevada:
We are in support of this bill. This is an extremely hard topic. My heart goes out to all of the families who have been impacted by murder personally. As an organization, Progressive Leadership Alliance of Nevada (PLAN) is in support of this bill. It is a major racial and social justice issue and something that we need to take a lot of time to look at.

Wendy Stolyarov, Legislative Director, Libertarian Party of Nevada:
We strongly support this bill. We agree with PLAN—it is a social justice issue and we would like to see this bill passed. [Additional testimony submitted (Exhibit O).]

Donald G.T. Gallimore, Second Vice President, Reno/Sparks Branch, National Association for the Advancement of Colored People:
We in the tristate National Association for the Advancement of Colored People (NAACP) do support this bill. There are a lot of people who are affected by it. I know I am—I have a death row relative. I know how that can affect a family. The forgiveness part of it is a key. If you can forgive, life in prison means that they will not be coming out.

Sarah Collins, representing Nevada Psychological Association:
We are in support.

Tamika Shauntee, representing Las Vegas Branch, National Association for the Advancement of Colored People:
We would like to show our support for A.B. 237. Most of the testimony in support of this bill is in line with the NAACP's stance on the death penalty. Blacks and African Americans are disproportionately sentenced to death at a higher rate.

[All items submitted but not discussed will become part of the record: (Exhibit P), (Exhibit Q), and (Exhibit R).]

Chairman Yeager:
Is there anyone who would like to testify in the neutral position? [There was no one.] I suspected we did not, and those suspicions are confirmed. Assemblyman Ohrenschall, I would invite you to the table at this time to make any concluding remarks. Please remember that we are in a time crunch.

Assemblyman Ohrenschall:
This is a very difficult issue for us all. I appreciate the Committee's time hearing us out. If I could bring justice to the victim's families who were here today, I would. The reality is, notwithstanding what DA Wolfson said, I am not optimistic that we are going to get that chemical cocktail anytime soon. If you look at the statements given by the drug companies (Exhibit C), that further leads me to not be optimistic. Regarding the cost study that was performed by the legislative audit, if anything, due to the minimal participation from some of the prosecutorial offices in the state, the cost of prosecuting a death penalty case versus a life without parole case is underrepresented, not overrepresented. Those are real savings. Those savings could be spent on crime prevention or enforcement, trying to prevent other violent crimes in our state.

The poll that was cited by District Attorney Wolfson was on *The Nevada Independent* website. While I am not familiar with who they called or what percentage were cell phones versus landlines or ages of the people polled, I am aware that that is a political election pollster. This is a policy issue. If we were going to look at polls, I would hope that we look at peer-reviewed studies that actually look at who they call. As I understand it, when polls are conducted where the cost of the death penalty and the lack of availability of the chemicals are factored into the question versus just a straight up or down poll, the results are closer to 50 percent for and against. As in my answer to Assemblyman Pickard's question, we are a representative democracy—a republican form of government—we do not govern by poll. Our constituents sent us here to look at the common sense issues and to make these decisions.

Regarding the argument that life without the possibility of parole would become the new death penalty or become as costly: There was a question to DA Wolfson as to whether there would be Eighth Amendment challenges. Eighteen jurisdictions in our country have life without the possibility of parole now as their maximum penalty. I am not aware of any challenges going through the federal court saying that this is cruel and unusual punishment.

As to any unintended consequences of the bill: there was a point made by Mr. Lalli as to requiring two attorneys in certain life without the possibility of parole cases. That is inadvertent, and I would accept any friendly amendment to remedy that if the Committee is willing to consider processing this measure.

Assemblyman Hansen:
I would object that those two would be given another opportunity to come to the table. If we are short on time, I do not think it is fair to have them come back for a second shot.

Nancy E. Hart:
I would like to say something on behalf of Ms. Portaro if I may. She would like to clarify that she believes that the perpetrator of her son's killing did receive serious consequences for the murder.

Chairman Yeager:
I am going to close the hearing on Assembly Bill 237. I want to thank everyone in the audience for your patience. Please do submit any comments in writing that you were unable to submit here today. At this time, I will open the meeting for public comment. [There was none.]

The meeting is adjourned [at 11:46 a.m.].

RESPECTFULLY SUBMITTED:

_____
Erin McHam
Committee Secretary

APPROVED BY:

_____
Assemblyman Steve Yeager, Chairman

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a document dated March 2017 titled "Company Statements Opposing the Misuse of Medicines in Executions," presented by Assemblyman James Ohrenschall, Assembly District 12, in support of Assembly Bill 237.

Exhibit D is a document titled "The Death Penalty in Nevada Since 1977," dated March 21, 2017, submitted by Nancy E. Hart, President, Nevada Coalition Against the Death Penalty, and presented by Michael Pescetta, private citizen, Las Vegas, in support of Assembly Bill 237.

Exhibit E is a document dated March 20, 2017, titled "Death Penalty Information Center: Facts About the Death Penalty," submitted by Nancy E. Hart, President, Nevada Coalition Against the Death Penalty and presented by Michael Pescetta, private citizen, Las Vegas, in support of Assembly Bill 237.

Exhibit F is a copy of a resolution supporting repeal of the death penalty adopted by the National Black Caucus of State Legislators, presented by Assemblywoman Dina Neal, Assembly District 7, in support of Assembly Bill 237.

Exhibit G is a document titled "Death Row Since 1977 Chronological," dated March 21, 2017, submitted by Nancy E. Hart, President, Nevada Coalition Against the Death Penalty, in support of Assembly Bill 237.

Exhibit H is a copy of a PowerPoint presentation titled "Death Penalty Statistics," presented by Christopher J. Lalli, Assistant District Attorney, Clark County District Attorney's Office, in opposition to Assembly Bill 237.

Exhibit I is written testimony authored and submitted by Terri Bryson, Chapter Co-Leader, Desert of Hope Chapter, National Organization of Parents of Murdered Children, Inc., dated March 29, 2017, in opposition to Assembly Bill 237.

Exhibit J is written testimony in opposition to Assembly Bill 237 presented by Jennifer Otremba, private citizen, Las Vegas.

Exhibit K is written testimony submitted by Lisa Postorino, private citizen, Las Vegas, dated March 29, 2017, in opposition to Assembly Bill 237.

Exhibit L is a letter dated March 31, 2017, to Chairman Yeager and members of the Assembly Committee on Judiciary expressing opposition to Assembly Bill 237, submitted by Brett Kandt, Chief Deputy Attorney General, Office of the Attorney General.

Exhibit M is a collection of letters submitted in opposition to Assembly Bill 237 consisting of the following:

1. A document titled "Arguments Against A.B. 237, Ending Capital Punishment," submitted by Janine Hansen, State President, Nevada Families for Freedom, and representing Nevada Eagle Forum.
2. A letter to Chairman Yeager and members of the Assembly Committee on Judiciary, dated March 29, 2017, from Doug Nulle, private citizen, Las Vegas.

Exhibit N is material in support of Assembly Bill 237, submitted by Tereza Trejbalova, private citizen, Las Vegas, consisting of the following:

1. A letter dated March 28, 2017, to Chairman Yeager and the Assembly Committee on Judiciary authored by Tereza Trejbalova, private citizen, Las Vegas, expressing support for Assembly Bill 237.
2. A document titled "Murder and Non-negligent Manslaughter Rates Comparisons."
3. A document titled "Cost Comparisons of Capital versus Non-Capital Cases."

Exhibit O is written testimony authored and submitted by Wendy Stolyarov, Legislative Director, Libertarian Party of Nevada, in support of Assembly Bill 237.

Exhibit P is a copy of a resolution adopted by the National Hispanic Caucus of State Legislators in support of Assembly Bill 237.

Exhibit Q is a collection of letters in support of Assembly Bill 237 consisting of the following:

1. A letter to Chairman Yeager and members the Assembly Committee on Judiciary dated March 6, 2017, from Chris Giunchigliani, Vice Chair, Clark County Board of County Commissioners.
2. A letter to Chairman Yeager dated March 17, 2017, from Zuzana Trojanova.
3. A letter to Chairman Yeager dated March 27, 2017, from Breanna Boppre, doctoral student in criminology and criminal justice.
4. A letter to Chairman Yeager dated March 27, 2017, from Bridget Kelly.
5. A letter to Chairman Yeager dated March 28, 2017, from Emily J. Salisbury, Ph.D., Associate Professor, University of Nevada, Las Vegas, and Editor, Criminal Justice and Behavior.
6. A letter to Chairman Yeager, dated March 27, 2017, from Miliaikeala S. J. Heen.
7. A letter to Assemblyman Ohrenschall, dated March 28, 2017, from Lisa Rea, President, Restorative Justice International.
8. A copy of an email dated March 28, 2017, from The Reverend Jeffrey Paul, St. Peter's Episcopal Church, to the Assembly Committee on Judiciary.
9. A letter to Chairman Yeager dated March 28, 2017, from Desiree Strohmeyer.
10. A copy of an email dated March 29, 2017, from Reverend Sandy Johnson, Boulder City United Methodist Church, to Chairman Yeager and members of the Assembly Committee on Judiciary.

Exhibit R is material provided by Randolph M. Fiedler, Nevada Attorneys for Criminal Justice, in support of Assembly Bill 237 consisting of the following:

1. A letter dated March 27, 2017, from Randolph M. Fiedler, Nevada Attorneys for Criminal Justice, to the Assembly Committee on Judiciary expressing support for Assembly Bill 237.
2. National Research Council, *Deterrence and the Death Penalty* (2012), Committee on Deterrence and the Death Penalty, Daniel S. Nagin and John V. Pepper, Editors. Committee on Law and Justice, Division of Behavioral and Social Sciences and Education. Washington, D.C.: The National Academies Press.
3. Daniel S. Nagin, *Deterrence in the Twenty-First Century*, 42 Crime & Just. 199 (2013).
4. Marilyn Peterson Armour and Mark S. Umbreit, *Assessing the Impact of the Ultimate Penal Sanction on Homicide Survivors: A Two State Comparison*, 96 Marq. L. Rev. 1 (Fall 2012).
5. Richard C. Dieter, Death Penalty Information Center, *Battle Scars: Military Veterans and the Death Penalty*, Day (2015).
6. Justin D. Levinson, Robert J. Smith, and Danielle M. Young, *Devaluing Death: An Empirical Study of Implicit Racial Bias on Jury Eligible Citizens in Six Death Penalty States*, 89 N.Y.U. L. Rev. 513 (May 2014).

COMPANY STATEMENTS OPPOSING THE MISUSE OF MEDICINES IN EXECUTIONS

March 2017

This document provides a selection of company statements opposing the misuse of medicines in lethal injection executions. The document contains statements from the following 21 firms:

1. Abbott
2. Akorn
3. BD
4. Fresenius Kabi
5. Ganpati Exim
6. Gland Pharma
7. Hikma
8. Hospira
9. Kayem
10. Lundbeck
11. McKesson
12. Mylan
13. Naari
14. Par
15. Pfizer
16. Roche
17. Sagent
18. Sandoz
19. Shrenik Pharma
20. Sun
21. Teva

December 2001: *"Abbott does not support the use of Pentothal in capital punishment. In fact, [we] communicated with departments of corrections in the United States to request that this product not be used in capital punishment procedures."*

March 2015: *"The use of midazolam and/or hydromorphone for lethal injection is clearly contradictory to the FDA approved indications for both products and – as controlled substances – the procurement or use of these products for executions may be in violation of the Controlled Substances Act. Additionally, such use is contrary to Akorn's commitment to promote the health and wellness of human patients.*

"Akorn strongly objects to the use of its products in capital punishment. To align with industry standards and to prevent midazolam and hydromorphone from being used for purposes outside FDA approved indications, Akom will not accept direct orders from departments of correction for any product and we plan to implement additional distribution controls on midazolam and hydromorphone products in the near future.

"To reduce the possibility that Akorn midazolam and hydromorphone vials reach correctional facilities for use outside their labeled indications, these distributors will not sell these products directly to departments of correction or secondary distributors and distributors will use their best efforts in other distribution channels to keep the products out of prison systems".

BD Helping all people live healthy lives

September 2015: *"BD Rx has specifically elected to focus on acute care settings for the use of our products. All of our distributor partners had previously received formal notification on behalf of BD Rx that our products are not intended for use in US prisons including state and federal penitentiaries. BD Rx is committed to ensuring the proper use of our products, to improving injectable drug delivery and helping to manage medication error risk for patients, hospitals, nurses and pharmacists".*

FRESENIUS KABI

August 2012: *"Fresenius Kabi objects to the use of its products in any manner that is not in full accordance with the approved indications. [...] To prevent Propofol from being used for purposes other than its approved indications, Fresenius Kabi does not accept orders for Propofol from any departments of correction in the U.S., nor will we do so, and we have voluntarily instituted tighter distribution controls on all forms of our product."*

GANPATI EXIM PVT. LTD. Pursuing Excellence

2012: *"We at Ganpati Exim are committed to providing access to medicines for the purposes of improving the lives of patients around the world. We are deeply opposed to the use of medicines in killing prisoners and wish to have no part in facilitating capital punishment in the USA or elsewhere. We never indulge in this type of medicines which takes HUMAN LIFE and will never in Future also."*

GLAND PHARMA LIMITED

October 2015: *"Gland makes its products to enhance and save the lives of patients worldwide. Drugs such as Rocuronium bromide are relied upon by doctors and patients as a muscle relaxant during surgery. Gland does not support the use of any of its products for the purpose of capital punishment"*

HIKMA QUALITY

October 2016: *"Hikma aims to improve lives by providing patients with access to high quality, affordable medicines. Our medicines are used thousands of times a day around the world to treat illness and save lives. We strongly object to the use of any of our products in capital punishment as it is inconsistent with our values and mission of improving lives and contrary to the intended label use for the products.*

"In order to safeguard Phenobarbital Sodium, Midazolam Hydrochloride and Hydromorphone Hydrochloride injection products from being used in lethal injection protocols, we have instituted several controls, including specific provisions in our template agreements and additional written assurances from certain purchasers that products will be used for medicinal, patient care not penal purposes."

"We vigorously monitor the distribution of these products and support industry serialization efforts that will help enhance these controls while continuing to promote our values and mission."

Hospira

March 2013: *"Hospira makes its products to enhance and save the lives of the patients we serve, and, therefore, we have always publicly objected to the use of any of our products in capital punishment. […] Hospira has implemented a restricted distribution system under which Hospira and its distributors have ceased the direct sale to U.S. prison hospitals of products, specifically pancuronium bromide, potassium chloride and propofol, that we believe are part of some states' lethal injection protocols."*

KAYEM Pharmaceutical Pvt. Ltd.

April 2011: *"In view of the sensitivity involved with sale of our Thiopental Sodium to various Jails/Prisons in USA and as alleged to be used for the purpose of Lethal Injection, we voluntary declare*

that we as an Indian Pharma Dealer who cherish the Ethos of Hinduism (A believer even in non-livings as the seat of God) refrain ourselves in selling this drug where the purpose is purely for Lethal Injection and its consequent misuse"

August 2011: *"[Lundbeck] is opposed to the use of its products for the purpose of capital punishment. Use of our products to end lives contradicts everything we're in business to do – provide therapies that help improve people's lives. Lundbeck adamantly opposes the distressing misuse of our product in capital punishment. Since learning about the misuse we have vetted a broad range of remedies – many suggested during ongoing dialogue with external experts, government officials, and human rights advocates. After much consideration, we have determined that a restricted distribution system is the most meaningful means through which we can restrict the misuse of Nembutal [pentobarbital]."*

October 2016: *"McKesson has entered into contractual arrangements with some manufacturers and suppliers that restrict the sale of medicines to prison systems and others for lethal injections. McKesson continually monitors developments regarding the use of medicines for lethal injections, and is committed to helping manufacturers and suppliers implement policies in this area".*

October 2015: *"It is important to note that rocuronium bromide is not approved for, labeled for, or marketed for use in lethal injections. Mylan does not distribute this product to prisons, nor does the company condone its product being distributed by any third party for use outside of the approved labeling or applicable standards of care.*

"Recently Mylan received information indicating that a department of corrections in the U.S. purchased Mylan's rocuronium bromide product from a wholesaler for possible use outside of the labeling or applicable standard of care. Mylan takes very seriously the possibility its product may have been diverted for a use that is inconsistent with its approved labeling or applicable standards of care.

"As such, Mylan conducted its own investigation into the matter and took direct action by sending several letters to the department of corrections seeking prompt assurances that it has not purchased any Mylan product for use outside the bounds of its approved therapeutic purpose, approved labeling and applicable standards of care. When Mylan received no response to its inquiries and therefore was unable to ensure appropriate use of its product, Mylan took further action by demanding the return of the Mylan product.

"Mylan is taking steps to prevent similar future issues. Specifically, Mylan is contractually restricting its distributors from distributing Mylan products, including rocuronium bromide, for use in lethal injection or for any other use outside of the approved labeling or applicable standards of care".

November 2011: *[Letter from Naari CEO to Chief Justice Heavican of the Nebraska Supreme Court]: "I am shocked and appalled by this news [of the use of Naari-produced drugs in executions by lethal injection]. Naari did not supply these medicines directly to the Nebraska Department of Correctional Services and is deeply opposed to the use of the medicines in executions."*

May 2014: *"Brevital [methohexital sodium] is a medically important anesthetic that physicians and hospital pharmacies have relied upon for more than 50 years. The state of Indiana's proposed use of Brevital is inconsistent with its medical indications as outlined in its U.S. Food and Drug Administration reviewed and approved product labeling. Brevital is intended to be used as an anesthetic in life-sustaining procedures.*

"As a pharmaceutical company, Par's mission is to help improve the quality of life. The state of Indiana's proposed use is contrary to our mission. Par is working with its distribution partners to establish distribution controls on Brevital to preclude wholesalers from accepting orders from departments of correction."

May 2016: *"Pfizer makes its products to enhance and save the lives of the patients we serve. Consistent with these values, Pfizer strongly objects to the use of its products as lethal injections for capital punishment.*

"Pfizer's obligation is to ensure the availability of our products to patients who rely on them for medically necessary purposes. At the same time, we are enforcing a distribution restriction for specific products that have been part of, or considered by some states for their lethal injection protocols. These products include pancuronium bromide, potassium chloride, propofol, midazolam, hydromorphone, rocuronium bromide and vecuronium bromide.

"Pfizer's distribution restriction limits the sale of these seven products to a select group of wholesalers, distributors, and direct purchasers under the condition that they will not resell these products to correctional institutions for use in lethal injections. Government purchasing entities must certify that products they purchase or otherwise acquire are used only for medically prescribed patient care and not for any penal purposes. Pfizer further requires that these Government purchasers certify that the

product is for "own use" and will not resell or otherwise provide the restricted products to any other party".

January 2015: "*Roche is aware of the use of the benzodiazepine midazolam as part of a drug combination for executions under the death penalty in the U.S. Roche did not supply midazolam for death penalty use and would not knowingly provide any of our medicines for this purpose. We support a worldwide ban on the death penalty."*

March 2014: *"In order to help ensure that patients have access to our products for use in accordance with the products' labels but to ensure our products are not used in capital punishment, Sagent is implementing appropriate distribution controls and other measures. In particular, Sagent will not accept orders from correctional facilities and prison systems for products believed to be part of certain states' lethal injection protocols. Also, each of Sagent's distributors and wholesalers will be asked to make commitments not to sell or distribute any such products to these facilities."*

February 2011: "*Sandoz and Novartis support only the authorized use of injectable thiopental, which is primarily indicated for the induction of anesthesia, and do not support the sale of this or any product for use in non-approved treatments. […]Sandoz has also advised all of its subsidiaries with locally approved marketing authorizations for sodium thiopental to not sell the product to distributors or third parties that may be selling it into the U.S."*

(Shrenik Pharma)

2012: *"We are aware of the use of Thiopental Sodium in killing of prisoners in USA and have often wondered why the US-Govt. does not simply out-law the practice altogether."*

September 2015: *"We currently require our customers to certify that they will prohibit the use and sale of such products to other customers and members that may administer lethal injections or which may sell to facilities that administer lethal injections"*

March 2013: *"[Teva is] limiting the sale and distribution of [propofol] to customers who agree to use best efforts not to sell or distribute to correctional facilities"*

EXHIBIT 7

IN THE SUPREME COURT OF OHIO

STATE OF OHIO, *ex rel.* HOGAN LOVELLS US LLP and ELIZABETH A. OCH 1601 Wewatta Street, Ste. 900 Denver, CO 80202, Relators, v. OHIO DEPARTMENT OF REHABILITATION AND CORRECTION 777 W. Broad Street Columbus, OH 43222, Respondent.	:	Case No. 2016-1776 ORIGINAL ACTION IN MANDAMUS

AMICI CURIAE BRIEF IN SUPPORT OF RELATOR ON BEHALF OF FRESENIUS KABI USA, LLC AND SANDOZ INC.

Marion H. Little, Jr. (0042679)
ZEIGER, TIGGES & LITTLE LLP
3500 Huntington Center
41 South High Street
Columbus, Ohio 43215
(614) 365-9900
(614) 365-7900
little@litohio.com

Counsel for Amici Curiae

John C. Greiner (0005551)*
*Counsel of Record
Darren W. Ford (0086449)
GRAYDON HEAD & RITCHEY LLP
312 Walnut Street, Suite 1800
Cincinnati, OH 45202
Phone: (513) 629-2734
Fax: (513) 651-3836
E-mail: jgreiner@graydon.law
dford@graydon.law

Counsel For Relators
Hogan Lovells US LLP & Elizabeth A. Och

MICHAEL DEWINE (0009181)
Ohio Attorney General

Charles L. Wille (0056444)*
*Counsel of Record
Principal Assistant Attorney General
Criminal Justice Section
150 E. Gay Street, 16th Floor
Columbus, OH 43215
Phone: (614) 728-7055
Fax: (614) 728-9327
charles.wille@ohioattorneygeneral.gov

Sarah E. Pierce (0087799)
Associate Assistant Attorney General
Constitutional Offices Section
30 East Broad Street, 16th Floor
Columbus, OH 43215
Phone: (614) 466-2872
Fax: (614) 728-7592
sarah.pierce@ohioattorneygeneral.gov

Counsel for Respondent Ohio Department of Rehabilitation and Correction

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STATEMENT OF INTEREST OF AMICI CURIAE

Fresenius Kabi USA, LLC and Sandoz Inc. (the Manufacturers), for their *amicus* brief, state:

The Manufacturers submit this *amicus curiae* brief in support of the disclosure of records in response to Relators' public-records request. Fresenius Kabi USA, LLC is a US-based subsidiary of Fresenius Kabi AG based in Germany and part of the Fresenius group of companies. Fresenius Kabi USA[1] is focused on providing drugs for the care of critically and chronically ill patients. It takes its stated mission – "Caring for Life" – very seriously, and, to that end Fresenius Kabi has sought to ensure that its medicines will not be used for lethal injection executions (though it takes no position on capital punishment). Fresenius Kabi manufactures, markets and distributes codes of each of Potassium Chloride, Rocuronium Bromide and Midazolam in the United States.

Sandoz Inc. is a Colorado corporation with corporate offices located at 100 College Road West, Princeton, New Jersey. One drug in its portfolio is Rocuronium Bromide, which is currently marketed in the United States but subject to a restricted distribution system as Sandoz does not support the use of any of its drugs for off-label use in connection with lethal injection.

As the manufacturers of the medicines listed in Ohio's execution protocol, *amici curiae* have an interest in knowing information relating to the drugs that ODRC has purchased for use in executions.

The Manufacturers are among over two dozen U.S. and international pharmaceutical companies which have instituted supply chain controls to prevent the sale of their medicines for

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[1] Fresenius Kabi USA, LLC was known until August 2012 as APP Pharmaceuticals, LLC, when its name was changed. Certain of its drugs still carry labeling and packaging referring to APP Pharmaceuticals. For simplicity, we refer to Fresenius Kabi throughout this brief even where labeling may reflect the name APP.

use in capital punishment, and in doing so, help ensure the availability of these drugs for patient care. *Pfizer Blocks the Use of Its Drugs in Executions*, N.Y. TIMES, May 13, 2016, at A1, *available at* https://www.nytimes.com/2016/05/14/us/pfizer-execution-drugs-lethal-injection.html. The Manufacturers have made their position clear in public, have notified state authorities and departments of correction, and have instituted distribution controls to ensure that the drugs are only used to save and sustain lives of patients for whom they are needed.

The Manufacturers have significant commercial and other interests in ensuring the proper implementation of the controls. The use of the medicines in lethal injections carries with it serious reputational, fiscal, and legal risks for the manufacturers of these medicines. See, for example, the lawsuit brought by the family of Dennis McGuire, executed in Ohio in 2014, against pharmaceutical manufacturer Hospira, which attracted national and international coverage. *Family Sues in Protracted Ohio Execution*, N.Y. T, Jan 25, 2014 at A2, *available at* https://www.nytimes.com/2014/01/26/us/family-sues-in-protracted-ohio-execution.html?mcubz=0.

The Manufacturers have a keen and important interest in knowing whether any department of corrections have obtained their drugs despite and in contravention of their distribution controls and contracts. The Manufacturers have not requested to have records pertaining to them classified as confidential under R.C. 2949.221. To the contrary, the Manufacturers have publicly stated their opposition to the use of their medicines in executions. They have communicated directly with Departments of Corrections and Government officials in executing states affirming their intention to enforce their contractual rights and minimize associated reputational, fiscal, and legal risks by ensuring that their medicines not be diverted for use in capital punishment. As an example, Fresenius Kabi has written to Ohio's Governor

Kasich in September, 2013 and, together with two members of the Ohio Senate, on December, 2014, and, indeed, in December 2014, provided written testimony on HB 663, which was amended and became R.C. 2949.221, in regard to provisions that would have voided any agreements between manufactures and their distributors which seek to ensure that department of corrections cannot purchase drugs for their use in execution.

Any refusal by the state to disclose the manufacturers of its lethal injection drugs directly undermines the Manufacturers' interests, impeding their ability to preserve the integrity of their contracts. Recognizing the Manufacturers' interests, R.C. 2949.221 only extends confidentiality to companies that have affirmatively requested this right. Because the Manufacturers have not requested confidentiality, any records in ODRC's possession pertaining to the Manufacturers do not fall within this exemption and should thus be disclosed. To the extent that these records indicate a violation of manufacturer contracts, release of this information would allow the manufacturers to enforce their contractual rights and take appropriate steps to prevent future diversion of their medicines.

STATEMENT OF THE CASE AND FACTS

The Amici defer to and adopt the Relators' Statement of the Case and Facts.

ARGUMENT

PROPOSITIONS OF LAW

Proposition of Law No. I

Mandamus is the appropriate remedy to compel compliance with R.C. 149.43.

Proposition of Law No. II

A public body may not invoke an exception under R.C. 149.43 without providing evidence that the exception applies.

Proposition of Law No. III

The Court should award Relators their reasonable attorneys' fees under R.C. 149.43(C)(2).

The Amici defer to and adopt the Propositions of Law of Relators.

SUMMARY

For the reasons set forth above, *Amici Curiae* respectfully request that the Court enter judgment on Relators' Petition and issue a writ of mandamus compelling ODRC to comply with its obligations under R.C. 149.43.

Respectfully submitted,

/s/ Marion H. Little, Jr.
Marion H. Little, Jr. (0042679)
ZEIGER, TIGGES & LITTLE LLP
3500 Huntington Center
41 South High Street
Columbus, Ohio 43215
(614) 365-9900
(614) 365-7900
little@litohio.com

Counsel for Amici Curiae

CERTIFICATE OF SERVICE

The undersigned hereby certifies that the foregoing *Amici Curiae* Brief in Support of Relator on Behalf of Fresenius Kabi USA, LLC and Sandoz Inc. was filed on the 10th day of July, 2017 and a copy served via First Class Mail, postage prepaid on the following:

Michael DeWine
Ohio Attorney General
Charles L. Wille, Esq.
Principal Assistant Attorney General
Criminal Justice Section
150 E. Gay Street, 16th Floor
Columbus, OH 43215

Sarah E. Pierce, Esq.
Associate Assistant Attorney General
Constitutional Offices Section
30 East Broad Street, 16th Floor
Columbus, OH 43215

John C. Greiner, Esq.
Darren W. Ford, Esq.
GRAYDON HEAD & RITCHEY LLP
312 Walnut Street, Suite 1800
Cincinnati, OH 45202

/s/ Marion H. Little, Jr.
Marion H. Little, Jr. (0042679)

693732

EXHIBIT 8

NEVADA DEPARTMENT OF CORRECTIONS

EXECUTION MANUAL
EM 103
ACQUISITION AND PREPARATION OF DRUGS FOR LETHAL INJECTION

Effective Date: **06/11/2018**

CONFIDENTIAL IN UN-REDACTED FORMAT: NO

AUTHORITY AND RESPONSIBILITY

The Director and designated Deputy Director will ensure that this manual is accurately revised and published upon order of the Governor prior to a scheduled execution.

103.01 LETHAL INJECTION PROTOCOL

A. Lethal drugs are to be used in the execution. Although the combination of drugs and doses listed below are lethal for most individuals, individual differences do exist. It shall be the responsibility of the Director to consult with the Chief Medical Officer in order to ensure that the selected lethal drug or combination of drugs and their dosages to be used in the execution are sufficient to cause death. The Director shall then select the drug, combination of drugs and dosages to be used for the execution. This information will not be withheld from the inmate or the public.

1. The NDOC Public Information Officer (PIO) will prepare and produce a statement on behalf of the Nevada Department of Corrections.

B. The Director will provide the condemned inmate with written notice of the drug or combination of drugs that will be used for the execution after a final decision has been made and no less than seven (7) calendar days prior to the first day of the week (i.e. Monday), as designated by the district court, that the judgment of death is to be executed.

1. If at any time after written notice of the drug or combination of drugs to be used for the execution has been provided to the condemned inmate, the Director determines that it is necessary to change the Lethal Injection Protocol identified and provided in CEM 110.02, a written notice of the Director's determination, which identifies the necessary changes to the Lethal Injection Protocol and an explanation as to the basis for such changes, will be immediately provided to both the condemned inmate and the condemned inmate's counsel of record.

C. The drug amounts specified below are designed for the execution of persons weighing 500 pounds or less. The drug amounts will be reviewed and revised, as necessary, for a condemned inmate exceeding 500 pounds.

103.02 ACQUIRING LETHAL DRUGS AND EQUIPMENT

A. After the Director makes the final decision as to the drug or combination of drugs that will be used for the scheduled execution, the designated Deputy Director/designated Warden will be responsible for:

1. Confirming that the equipment and materials necessary to properly conduct the execution is on site, immediately available for use and functioning properly.

2. Ensuring all medical equipment, including a backup cardiac monitor is on site, immediately available for use and functioning properly.

3. Ensuring that the drugs identified are acquired, arrive at Ely State Prison (ESP) no later than the day of execution and are properly stored. The drugs shall be stored in a secured locked area that is temperature regulated and monitored to ensure compliance with manufacturer specifications, under the direct control of the designated Warden.

103.03 PREPARATION OF LETHAL DRUGS

A. At the appropriate time, approximately two hours prior to the scheduled execution, the designated Warden shall transfer custody of the drugs to two members of the Security Team who have been selected by the designated Deputy Director as the Drug Administrators. The Drug Administrators will be two individuals who, based upon their years of experience and proven performance within the corrections industry, are uniquely trusted to perform the sensitive and critical tasks of properly preparing the lethal drugs for the execution, and then injecting the lethal drugs into the condemned inmate per these instructions when so ordered.

B. The quantity of the lethal drugs may not be changed without prior approval of the Director.

C. It is the responsibility of the Drug Administrators to prepare the lethal drugs. An Attending Physician or other properly trained and qualified medical professional will observe the Drug Administrators as they prepare the lethal drugs.

1. Both Drug Administrators shall complete detailed written reports describing the preparation and labeling of the lethal drugs.

a. The Drug Administrators shall be responsible for preparing and labeling the assigned syringes in a distinctive manner identifying the specific lethal drug contained in each syringe by (1) lethal drug name, (2) lethal drug amount and (3) assigned number. This information shall be preprinted on a label, with one label affixed to each syringe to ensure a label remains visible.

b. The syringes for each lethal drug by name will then be placed in an individual tray marked for all the syringes of that lethal drug. The labels for each tray and each syringe it contains will be colored to match: red in color for Midazolam, white in color for Fentanyl and blue in color for Cis-atracurium.

c. The drugs and their doses are to be prepared and labeled as follows:

i. Tray-1: Midazolam (labels to be red in color)

		DRUG	CONCENTRATION	SYRINGE	TOTAL
1.	#1-1	Midazolam	5mg/cc	10ml	50mg
2.	#1-2	Midazolam	5mg/cc	10ml	50mg
3.	#1-3	Midazolam	5mg/cc	10ml	50mg
4.	#1-4	Midazolam	5mg/cc	10ml	50mg
5.	#1-5	Midazolam	5mg/cc	10ml	50mg
6.	#1-6	Midazolam	5mg/cc	10ml	50mg
7.	#1-7	Midazolam	5mg/cc	10ml	50mg
8.	#1-8	Midazolam	5mg/cc	10ml	50mg
9.	#1-9	Midazolam	5mg/cc	10ml	50mg
10.	#1-10	Midazolam	5mg/cc	10ml	50mg

11. In the unlikely event that it is deemed necessary (see protocol in EM 110), additional syringes of Midazolam may be ordered by the Director, and then prepared and injected by the Drug Administrators. If ordered, additional syringes will be similarly labeled and numbered next in sequence, for example the next syringe would be numbered #1-11, then #1-12 and so on.

ii. Tray-2: Fentanyl (labels to be white in color)

		DRUG	CONCENTRATION	SYRINGE	TOTAL
1.	#2-1	Fentanyl	50mcg/cc	10ml	500mcg
2.	#2-2	Fentanyl	50mcg/cc	10ml	500mcg
3.	#2-3	Fentanyl	50mcg/cc	10ml	500mcg
4.	#2-4	Fentanyl	50mcg/cc	10ml	500mcg
5.	#2-5	Fentanyl	50mcg/cc	10ml	500mcg
6.	#2-6	Fentanyl	50mcg/cc	10ml	500mcg
7.	#2-7	Fentanyl	50mcg/cc	10ml	500mcg

8.	#2-8	Fentanyl	50mcg/cc	10ml	500mcg
9.	#2-9	Fentanyl	50mcg/cc	10ml	500mcg
10.	#2-10	Fentanyl	50mcg/cc	10ml	500mcg
11.	#2-11	Fentanyl	50mcg/cc	10ml	500mcg
12.	#2-12	Fentanyl	50mcg/cc	10ml	500mcg
13.	#2-13	Fentanyl	50mcg/cc	10ml	500mcg
14.	#2-14	Fentanyl	50mcg/cc	10ml	500mcg
15.	#2-15	Fentanyl	50mcg/cc	10ml	500mcg

16. In the unlikely event that it is deemed necessary (see protocol in EM 110), additional syringes of Fentanyl may be ordered by the Director, and then prepared and injected by the Drug Administrators. If ordered, additional syringes will be similarly labeled and numbered next in sequence, for example the next syringe would be numbered #2-16, then #2-17 and so on.

iii. Tray-3: Cis-atracurium (labels to be blue in color)

		DRUG	CONCENTRATION	SYRINGE	TOTAL
1.	#3-1	Cis-atracurium	2mg/1ml	10ml	20mg
2.	#3-2	Cis-atracurium	2mg/1ml	10ml	20mg
3.	#3-3	Cis-atracurium	2mg/1ml	10ml	20mg
4.	#3-4	Cis-atracurium	2mg/1ml	10ml	20mg
5.	#3-5	Cis-atracurium	2mg/1ml	10ml	20mg
6.	#3-6	Cis-atracurium	2mg/1ml	10ml	20mg
7.	#3-7	Cis-atracurium	2mg/1ml	10ml	20mg
8.	#3-8	Cis-atracurium	2mg/1ml	10ml	20mg
9.	#3-9	Cis-atracurium	2mg/1ml	10ml	20mg
10.	#3-10	Cis-atracurium	2mg/1ml	10ml	20mg

11. In the unlikely event that it is deemed necessary (see protocol in EM 110), additional syringes of Cis-atracurium may be ordered by the Director, and then prepared and injected by the Drug Administrators. If ordered, additional syringes will be similarly labeled and numbered next in

sequence, for example the next syringe would be numbered #3-11, then #3-12 and so on.

2. One Drug Administrator will prepare and label the lethal drug syringes. The second Drug Administrator will observe, verify the preparation, dosage and labeling of each syringe. The second Drug Administrator will then place the syringes in their correct trays for use.

3. The Drug Administrators shall prepare the designated lethal drugs and syringes so that the correct number of syringes are prepared and placed in each correctly labeled tray.

   a. To prepare each syringe for use, the Drug Administrator will draw the appropriate amount of supplied drug solution into each syringe so that the specified dose of each drug is made ready in each syringe.

      i. Midazolam will be used at a concentration of 5 milligrams per milliliter. For this drug, the specified doses to be prepared are 50 milligrams in 10 milliliter syringes. In order to achieve those doses, the Drug Administrator will draw ten (10) milliliters of the supplied solution into each 10 milliliter syringe labeled to contain Midazolam.

      ii. Fentanyl will be used at a concentration of 50 micrograms per milliliter. For this drug, the specified doses to be prepared are 500 micrograms in each 10 milliliter syringe. In order to achieve those doses, the Drug Administrator will draw ten (10) milliliters of the supplied solution into each 10 milliliter syringe labeled to contain Fentanyl.

      iii. Cis-actracurium will be used at a concentration of 2 milligrams per milliliter. For this drug, the specified doses to be prepared are 20 milligrams in each 10 milliliter syringe. In order to achieve those doses, the Drug Administrator will draw ten (10) milliliters of the supplied solution into each 10 milliliter syringe labeled to contain Cis-atracurium.

NO ATTACHMENTS: SEE CEM 112 FOR ALL EXECUTION RELATED FORMS

100187739: 1/000121

0: 1
121/140

NEVADA DEPT OF CORRECTIONS
3955 W. RUSSELL RD-CASA GRANDE
CENTRAL PHARMACY
LAS VEGAS, NV 89118-0000

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
AS2995922	10-31-2019	FEE EXEMPT

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	HOSPITAL/CLINIC	09-20-2016

NEVADA DEPT OF CORRECTIONS
3955 W. RUSSELL RD-CASA GRANDE
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LAS VEGAS, NV 89118-0000

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

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Form DEA-223 (4/07)

NDOC0006

S (623) 478-8500

CARDINAL HEALTH
600 N 83RD AVE
TOLLESON, AZ 85353

PAGE 1 OF 1 ROUTE/STOP 307 / 010

RO

CardinalHealth

DEA RW-0263056 FED ID 68-0158739

CUST. NO.	DATE	ORIGINAL INVOICE
163264	4/02/18	3667966
REG NO.	CUST. DEA NO.	ORDER NO.	CUSTOMER P.O. NUMBER
CA00001	AS2995922	5753613	18XCO0010
	ORDER DATE	CONF. NO.	
	3/30/18	06853	

BILL TO
NV DEPT OF CORRECTION CTR PHCY
CENTRAL PHCY
3955 W RUSSELL RD-CASA GRANDE
LAS VEGAS, NV 89118

SHIP TO
NV DEPT OF CORRECTION CTR PHCY
CENTRAL PHCY
3955 W RUSSELL RD-CASA GRANDE
LAS VEGAS, NV 89118
FORM 222: 18XCO0010

ITEM NUMBER	NDC/UPC	QTY ORDERED	QTY SHIPPED	OMIT	U/M	DESCRIPTION	SIZE	FORM	CLASS	RETAIL PRICE			UNIT PRICE	EXTENSION	NOTE CODE
5095179	17478-0030-05 TOTE# 1	1	1		CT	FENTANYL CIT50MCG/ML 10X5ML C2	10	AM	2				23.24	2324	CT
						PRODUCT ALLOCATION see message(s): 121									
			1			PIECES SHIPPED							SUBTOT	2324	
			1			TOTAL PIECES SHIPPED									
						---------- S U M M A R Y ----------									
						Total RX				23.24					
						NET AMOUNT				23.24					

INVOICE SHIP DATE: 4/01/2018

For SDS Visit: http://www.mycardinalsdspd.com

PLEASE REMIT YOUR PAYMENTS TO FOLLOWING ADDRESS:
CARDINAL HEALTH 110, LLC
C/O BANK OF AMERICA
PO BOX 56412
LOS ANGELES, CA 90074-6412

Messages

121 This product is required by the FDA to be dispensed with a medication guide. To obtain a medication guide for this product, please visit http://www.fda.gov/Drugs/DrugSafety/ucm085729.htm

FOR DELIVERY 4/02/18
DUE DATE 5/02/18

2324

Note Codes:		
T	Taxable	CT Contract
CO	Contract Item Override	SN Special Net
SP	Special Pricing	OV Price Override
		CS Source Contract

Omit Codes:		
C Dropship	4 Not stocked	7 Drug Recall
2 DC Out	5 Mfr Disc	8 New item stock unavail.
3 Mfr Out	6 DC Disc	9 Restricted item
		S Regulatory Review

List Chemical Designations
E - Ephedrine
P - Phenylpropanolamine
S - Pseudoephedrine
L - Other List Chemical

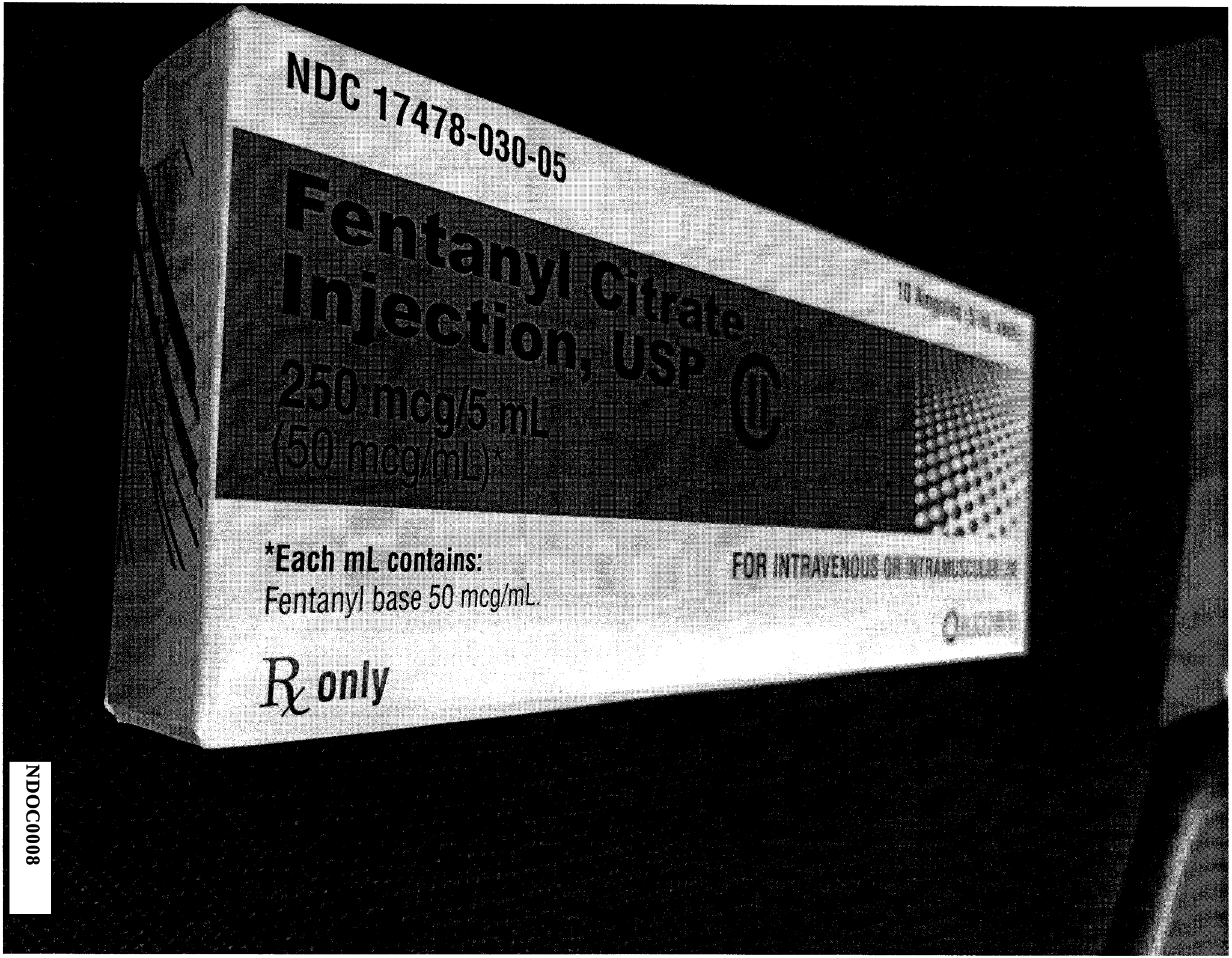
307 / 010

Customer is a final dispenser purchasing for own use and will not redistribute prescription pharmaceuticals into the secondary market.

The prices shown on this invoice are net of discounts provided at the time of purchase. Some of the products listed on this invoice may be subject to additional discounts or rebates. Please refer to your contract or any specific additional discounts or rebates that may apply to these purchases. You may have an obligation pursuant to 42 USC §1320a-7b to report discounts and rebates to Medicare, Medicaid or other governmental health care programs.

Effective January 1, 2015, DSCSA Transaction Data for qualified prescription drugs can be accessed via your usual ordering platform, such as Order Express or Med eCommerce, or at cardinalhealth.com/trace.

NDOC0007


NDC 17478-030-05
Fentanyl Citrate Injection, USP
250 mcg/5 mL
(50 mcg/mL)*
C II
*Each mL contains:
Fentanyl base 50 mcg/mL.
FOR INTRAVENOUS OR
℞ only

NDOC0008

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CARDINAL HEALTH
600 N 83RD AVE
TOLLESON, AZ 85353

PAGE 1 OF 1 ROUTE/STOP 307 / 010

DV

CardinalHealth

DEA RW-0263056 FED ID 68-0158739

CUST. NO.	DATE	ORIGINAL INVOICE
163264	12/15/17	34-2046
REG NO.	**CUST. DEA NO.**	**ORDER NO.** / **CUSTOMER P.O. NUMBER**
CA0000	AS2995922	5470157
	ORDER DATE	**CONF. NO.**
	12/14/17	09103

BILL TO
NV DEPT OF CORRECTION CTR PHCY
CENTRAL PHCY
3955 W RUSSELL RD-CASA GRANDE
LAS VEGAS, NV 89118

SHIP TO
NV DEPT OF CORRECTION CTR PHCY
CENTRAL PHCY
3955 W RUSSELL RD-CASA GRANDE
LAS VEGAS, NV 89118

ITEM NUMBER	NDC/UPC	QTY ORDERED	QTY SHIPPED	C/S	U/M	DESCRIPTION	SIZE	FORM	C/S	RETAIL PRICE			UNIT PRICE	EXTENSION	NOTE CODE
4729463	00781-3150-95 TOTE# 5	2	2		CT	CISATRACURIUM 2MG/ML10X5ML	10	SD					148.24	296.48	SN
			2			PIECES SHIPPED							SUBTOT	296.48	
			2			TOTAL PIECES SHIPPED									
						---------- S U M M A R Y ----------									
						Total RX				296.48					
						NET AMOUNT				296.48					

INVOICE SHIP DATE: 12/14/2017

For SDS Visit: http://www.mycardinalsdspd.com

PLEASE REMIT YOUR PAYMENTS TO FOLLOWING ADDRESS:
CARDINAL HEALTH 110, LLC
C/O BANK OF AMERICA
PO BOX 56412
LOS ANGELES, CA 90074-6412

Note Codes:		Omit Codes:			List Chemical Designations
T Taxable	CT Contract	C Dropship	4 Not stocked	7 Drug Recall	E - Ephedrine
CO Contract Item Override	SN Special Net	2 DC Out	5 Mfr Disc	8 New item/stock unavail.	P - Phenylpropanolamine
SP Special Pricing	OV Price Override	3 Mfr Out	6 DC Disc	9 Restricted item	S - Pseudoephedrine
	CS Source Contract			S Regulatory Review	L - Other List Chemical

307 / 010

1/14/18
DUE DATE

296.48

Customer is a final dispenser purchasing for own use and will not redistribute prescription pharmaceuticals into the secondary market.

The prices shown on this invoice are net of discounts provided at the time of purchase. Some of the products listed on this invoice may be subject to additional discounts or rebates. Please refer to your contract for any specific additional discounts or rebates that may apply to these purchases. You may have an obligation pursuant to 42 USC §1320a-7b to report discounts and rebates to Medicare, Medicaid or other governmental health care programs.

Effective January 1, 2015, DSCSA Transaction Data for qualified prescription drugs can be accessed via your usual ordering platform, such as Order Express or Med eCommerce, or at cardinalhealth.com/trace.

NDOC0009

10 x 5 mL Single Dose Vials
Sterile, Nonpyrogenic
Cisatracurium Besylate Injection
Rx only
TAMPER
EVIDENT
TAPE
TAMPER
EVIDENT
TAPE
Cisatracurium Besylate Injection
10 x 5 mL Single Dose Vials
Sterile, Nonpyrogenic
Rx only
TAMPER
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CUST. NO.	DATE	ORIGINAL INVOICE 3768806	
163264	5/14/18		
REG NO.	CUST. DEA NO.	ORDER NO.	CUSTOMER P.O. NUMBER
CA00001	AS2995922	5864116	
	ORDER DATE	CONF. NO.	
	5/11/18	07062	

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SHIP TO
NV DEPT OF CORRECTION CTR PHCY
CENTRAL PHCY
3955 W RUSSELL RD-CASA GRANDE
LAS VEGAS, NV 89118

ITEM NUMBER	NDC/UPC	QTY ORDERED	QTY SHIPPED	QTY UNIT	U/M	DESCRIPTION	SIZE	FORM	CLASS	RETAIL PRICE		UNIT PRICE	EXTENSION	NOTE CODE
5392014	47781-0589-91 TOTE# 1	3	3		CT	MIDAZOLAM 5MG/ML 10X10ML C4	10	MD	4			17.18	51.54	CT
			3			PIECES SHIPPED					SUBTOT		51.54	
			3			TOTAL PIECES SHIPPED								
						---------- S U M M A R Y ----------								
						Total RX				51.54				
						NET AMOUNT				51.54				

INVOICE SHIP DATE: 5/13/2018

For SDS Visit: http://www.mycardinalsdspd.com

PLEASE REMIT YOUR PAYMENTS TO FOLLOWING ADDRESS:
CARDINAL HEALTH 110, LLC
C/O BANK OF AMERICA
PO BOX 56412
LOS ANGELES, CA 90074-6412

Note Codes:		
T	Taxable	CT Contract
CO	Contract Item Override	SN Special Net
SP	Special Pricing	OV Price Override
		CS Source Contract

Omit Codes:		
C Dropship	4 Not stocked	7 Drug Recall
2 DC Out	5 Mfr Disc	8 New item:stock unavail.
3 Mfr Out	6 DC Disc	9 Restricted item
		S Regulatory Review

List Chemical Designations
E - Ephedrine
P - Phenylpropanolamine
S - Pseudoephedrine
L - Other List Chemical

307 / 010

6/13/18
DUE DATE

51.54

Customer is a final dispenser purchasing for own use and will not redistribute prescription pharmaceuticals into the secondary market.

The prices shown on this invoice are net of discounts provided at the time of purchase. Some of the products listed on this invoice may be subject to additional discounts or rebates. Please refer to your contract or any specific additional discounts or rebates that may apply to these purchases. You may have an obligation pursuant to 42 USC §1320a-7b to report discounts and rebates to Medicare, Medicaid or other governmental health care programs.

Effective January 1, 2015, DSCSA Transaction Data for qualified prescription drugs can be accessed via your usual ordering platform, such as Order Express or Med eCommerce, or at cardinalhealth.com/trace.

NDOC0011

S (623) 478-8500

CARDINAL HEALTH
600 N 83RD AVE
TOLLESON, AZ 85353

PAGE 1 OF 1 ROUTE/STOP 307 / 010

DV

CardinalHealth

DEA RW-0263056 FED ID 68-0158739

CUST. NO.	DATE	ORIGINAL INVOICE	
163264	5/10/18	3762358	
REG NO.	CUST. DEA NO.	ORDER NO.	CUSTOMER P.O. NUMBER
CA0000	1AS2995922	5858116	
	ORDER DATE	CONF. NO.	
	5/09/18	03654	

BILL TO
NV DEPT OF CORRECTION CTR PHCY
CENTRAL PHCY
3955 W RUSSELL RD-CASA GRANDE
LAS VEGAS, NV 89118

SHIP TO
NV DEPT OF CORRECTION CTR PHCY
CENTRAL PHCY
3955 W RUSSELL RD-CASA GRANDE
LAS VEGAS, NV 89118

ITEM NUMBER	NDC/UPC	QTY ORDERED	QTY SHIPPED	OMIT	UM	DESCRIPTION		SIZE	FORM	CS	RETAIL PRICE			UNIT PRICE	EXTENSION	NOTE CODE
4259263	00054-0176-13	1	1		EA	BUPRENORPHINE 2MG 30 SL	C3	30	TB	3	R			20.92	20.92	CT
	TOTE# 1															
	see message(s): 121															
5392014	47781-0589-91	3	3		CT	MIDAZOLAM 5MG/ML 10X10ML	C4	10	MD	4				17.18	51.54	CT
	TOTE# 1															
			4			PIECES SHIPPED								SUBTOT	72.46	
			4			TOTAL PIECES SHIPPED										
						---------- S U M M A R Y ----------										
						Total RX					72.46					
						NET AMOUNT					72.46					

INVOICE SHIP DATE: 5/09/2018

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C/O BANK OF AMERICA
PO BOX 56412
LOS ANGELES, CA 90074-6412

Messages

121 This product is required by the FDA to be dispensed with a medication guide. To obtain a medication guide for this product, please visit http://www.fda.gov/Drugs/DrugSafety/ucm085729.htm

Note Codes:		
T	Taxable	CT Contract
CO	Contract Item Override	SN Special Net
SP	Special Pricing	OV Price Override
		CS Source Contract

Omit Codes:		
C Dropship	4 Not stocked	7 Drug Recall
2 DC Out	5 Mfr Disc	8 New item:stock unavail.
3 Mfr Out	6 DC Disc	9 Restricted item
		S Regulatory Review

List Chemical Designations:
E - Ephedrine
P - Phenylpropanolamine
S - Pseudoephedrine
L - Other List Chemical

307 / 010

6/09/18
DUE DATE

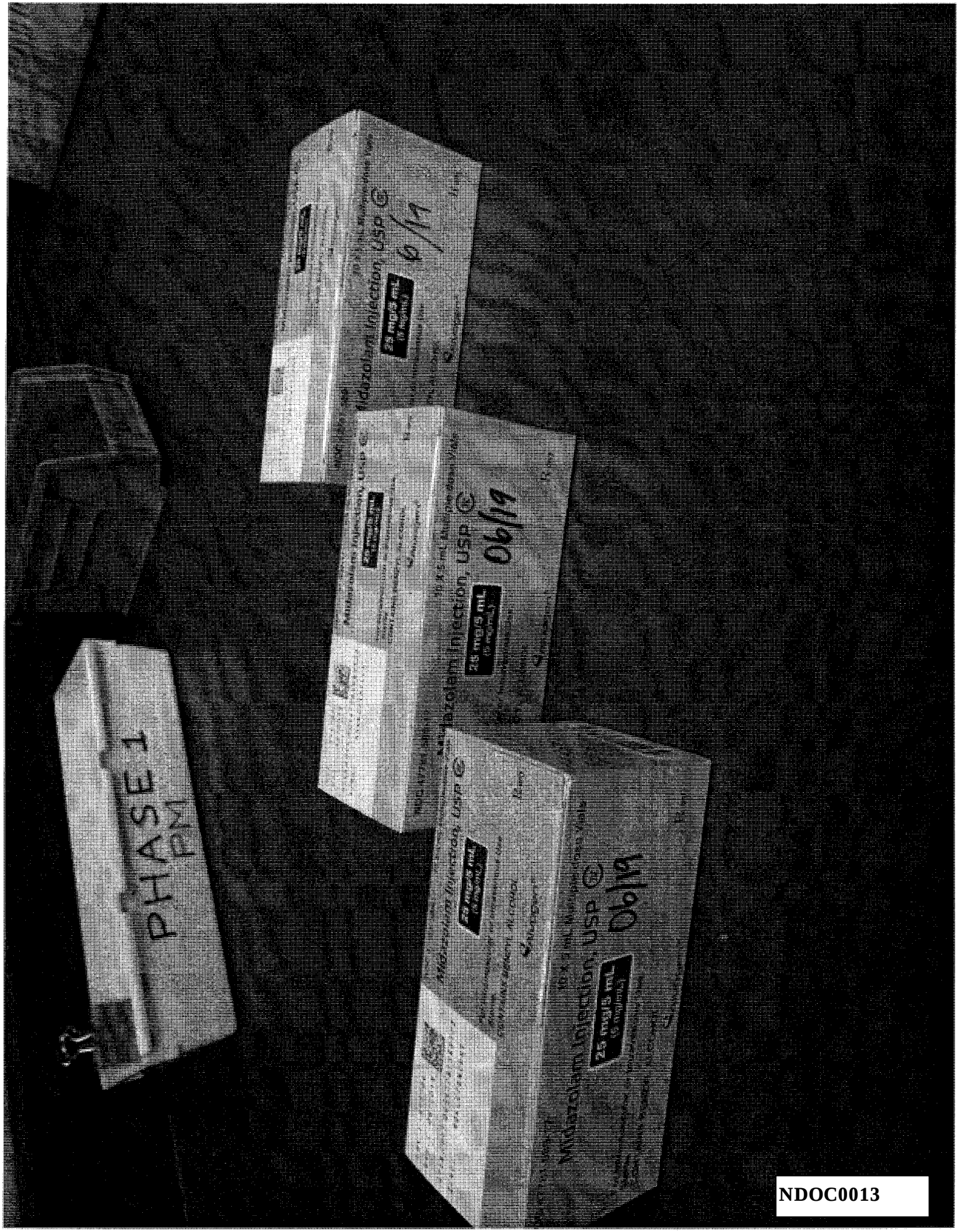
7246

Customer is a final dispenser purchasing for own use and will not redistribute prescription pharmaceuticals into the secondary market.

The prices shown on this invoice are net of discounts provided at the time of purchase. Some of the products listed on this invoice may be subject to additional discounts or rebates. Please refer to your contract for any specific additional discounts or rebates that may apply to these purchases. You may have an obligation pursuant to 42 USC §1320a-7b to report discounts and rebates to Medicare, Medicaid or other governmental health care programs.

Effective January 1, 2015, DSCSA Transaction Data for qualified prescription drugs can be accessed via your usual ordering platform, such as Order Express or Med eCommerce, or at cardinalhealth.com/trace.

NDOC0012


NDOC0013


Midazolam Injection, USP
TAMPER EVIDENT TAPE
Midazolam Injection, USP

NDOC0014

S (623) 478-8500

CARDINAL HEALTH
600 N 83RD AVE
TOLLESON, AZ 85353

 ROUTE/STOP 307 / 010

CardinalHealth

DEA RW-0263056 FED ID 68-0158739

DV

CUST. NO.	DATE	ORIGINAL INVOICE
163264	5/03/18	3745130
REG NO.	CUST. DEA NO.	ORDER NO. / CUSTOMER P.O. NUMBER
CA00001	AS2995922	5839173 / 050218J
	ORDER DATE	CONF. NO.
	5/02/18	03152

BILL TO
NV DEPT OF CORRECTION CTR PHCY
CENTRAL PHCY
3955 W RUSSELL RD-CASA GRANDE
LAS VEGAS, NV 89118

SHIP TO
NV DEPT OF CORRECTION CTR PHCY
CENTRAL PHCY
3955 W RUSSELL RD-CASA GRANDE
LAS VEGAS, NV 89118

ITEM NUMBER	NDC/UPC	QTY ORDERED	QTY SHIPPED	O/S	U/M	DESCRIPTION	SIZE	FORM	CLASS	RETAIL PRICE			UNIT PRICE	EXTENSION	NOTE CODE
3000908	00074-4380-10 TOTE# 14	1	1		CT	NIMBEX 2MG/ML 10X10ML	10ML						258.95	25895	CT
			1			PIECES SHIPPED						SUBTOT		25895	
			1			TOTAL PIECES SHIPPED									
						---------- S U M M A R Y ----------									
						Total RX				258.95					
						NET AMOUNT				258.95					

INVOICE SHIP DATE: 5/02/2018

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C/O BANK OF AMERICA
PO BOX 56412
LOS ANGELES, CA 90074-6412

Note Codes:		
T	Taxable	CT Contract
CO	Contract Item Override	SN Special Net
SP	Special Pricing	OV Price Override
		CS Source Contract

Omit Codes:		
C Dropship	4 Not stocked	7 Drug Recall
2 DC Out	5 Mfr Disc	8 New item:stock unavail.
3 Mfr Out	6 DC Disc	9 Restricted item
		S Regulatory Review

List Chemical Designations
E - Ephedrine
P - Phenylpropanolamine
S - Pseudoephedrine
L - Other List Chemical

307 / 010

6/02/18
DUE DATE

25895

Customer is a final dispenser purchasing for own use and will not redistribute prescription pharmaceuticals into the secondary market.

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NDOC0015

S (623) 478-8500

CardinalHealth

CARDINAL HEALTH
600 N 83RD AVE
TOLLESON, AZ 85353

PAGE 1 OF 1 ROUTE/STOP 307 / 010

DV

DEA RW-0263056 FED ID 68-0158739

CUST. NO.	DATE	ORIGINAL INVOICE
163264	4/10/18	3688754
REG NO.	**CUST. DEA NO.**	**ORDER NO.** / **CUSTOMER P.O. NUMBER**
CA00001	AS2995922	5777644
	ORDER DATE	**CONF. NO.**
	4/09/18	09616

BILL TO
NV DEPT OF CORRECTION CTR PHCY
CENTRAL PHCY
3955 W RUSSELL RD-CASA GRANDE
LAS VEGAS, NV 89118

SHIP TO
NV DEPT OF CORRECTION CTR PHCY
CENTRAL PHCY
3955 W RUSSELL RD-CASA GRANDE
LAS VEGAS, NV 89118

ITEM NUMBER	NDC/UPC	QTY ORDERED	QTY SHIPPED	OUT	U/M	DESCRIPTION	SIZE	FORM	CLASS	RETAIL PRICE		UNIT PRICE	EXTENSION	NOTE CODE
3000908	00074-4380-10 TOTE# 11	1	1		CT	NIMBEX 2MG/ML 10X10ML	10	MD				260.04	26004	CT
			1			PIECES SHIPPED								
			1			TOTAL PIECES SHIPPED						SUBTOT	26004	
						---------- S U M M A R Y ----------								
						Total RX				260.04				
						NET AMOUNT				260.04				

INVOICE SHIP DATE: 4/10/2018

For SDS Visit: http://www.mycardinalsdspd.com

PLEASE REMIT YOUR PAYMENTS TO FOLLOWING ADDRESS:
CARDINAL HEALTH 110, LLC
C/O BANK OF AMERICA
PO BOX 56412
LOS ANGELES, CA 90074-6412

Note Codes:		
T	Taxable	CT Contract
CO	Contract Item Override	SN Special Net
SP	Special Pricing	OV Price Override
		CS Source Contract

Omit Codes:		
C Dropship	4 Not stocked	7 Drug Recall
2 DC Out	5 Mfr Disc	8 New item/stock unavail.
3 Mfr Out	6 DC Disc	9 Restricted item
		S Regulatory Review

List Chemical Designations
E - Ephedrine
P - Phenylpropanolamine
S - Pseudoephedrine
L - Other List Chemical

307 / 010

5/10/18
DUE DATE

26004

Customer is a final dispenser purchasing for own use and will not redistribute prescription pharmaceuticals into the secondary market.

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NDOC0016


Nimbex®
Cisatracurium
Besylate Injection
20 mg/10 mL
(2 mg/mL)
Multiple-dose vial

NDOC0017

S (623) 478-8500

CardinalHealth

CARDINAL HEALTH
600 N 83RD AVE
TOLLESON, AZ 85353

PAGE 1 OF 1 ROUTE/STOP 307 / 010

DV

DEA RW-0263056 FED ID 68-0158739

CUST. NO.	DATE	ORIGINAL INVOICE 3667975	
163264	4/02/18		
REG NO.	CUST. DEA NO.	ORDER NO.	CUSTOMER P.O. NUMBER
CA00001	AS2995922	5753628	
	ORDER DATE	CONF. NO.	
	3/30/18	06864	

BILL TO
NV DEPT OF CORRECTION CTR PHCY
CENTRAL PHCY
3955 W RUSSELL RD-CASA GRANDE
LAS VEGAS, NV 89118

SHIP TO
NV DEPT OF CORRECTION CTR PHCY
CENTRAL PHCY
3955 W RUSSELL RD-CASA GRANDE
LAS VEGAS, NV 89118

ITEM NUMBER	NDC/UPC	QTY ORDERED	QTY SHIPPED	OMIT	U/M	DESCRIPTION	SIZE	FORM	CLASS	RETAIL PRICE		UNIT PRICE	EXTENSION	NOTE CODE
3011335	00074-4378-05 TOTE# 9	1	1		CT	NIMBEX 2MG/ML 10X5ML	10	SD				148.23	14823	CT
			1			PIECES SHIPPED								
			1			TOTAL PIECES SHIPPED						SUBTOT	14823	
						---------- S U M M A R Y ----------								
						Total RX				148.23				
						NET AMOUNT				148.23				

INVOICE SHIP DATE: 4/01/2018

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CARDINAL HEALTH 110, LLC
C/O BANK OF AMERICA
PO BOX 56412
LOS ANGELES, CA 90074-6412

Note Codes:		
T	Taxable	CT Contract
CO	Contract Item Override	SN Special Net
SP	Special Pricing	OV Price Override
		CS Source Contract

Omit Codes:		
C Dropship	4 Not stocked	7 Drug Recall
2 DC Out	5 Mfr Disc	8 New item/stock unaval.
3 Mfr Out	6 DC Disc	9 Restricted item
		S Regulatory Review

List Chemical Designations
E - Ephedrine
P - Phenylpropanolamine
S - Pseudoephedrine
L - Other List Chemical

307 / 010

5/02/18
DUE DATE

14823

Customer is a final dispenser purchasing for own use and will not redistribute prescription pharmaceuticals into the secondary market.

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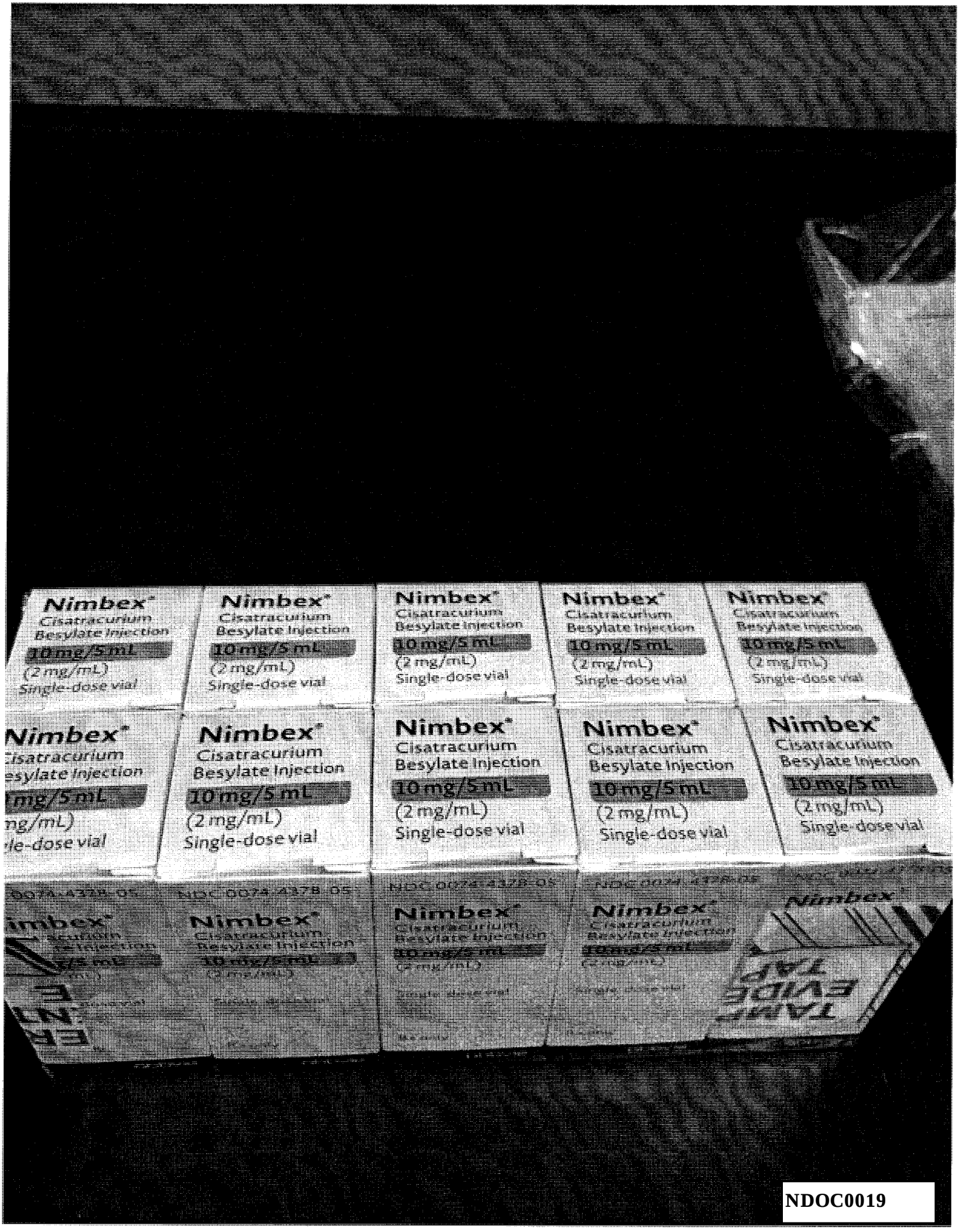
Effective January 1, 2015, DSCSA Transaction Data for qualified prescription drugs can be accessed via your usual ordering platform, such as Order Express or Med eCommerce, or at cardinalhealth.com/trace.

NDOC0018


Nimbex®
Cisatracurium
Besylate Injection
10 mg/5 mL
(2 mg/mL)
Single-dose vial
NDOC 0074-4378-05

NDOC0019

S (623) 478-8500

CardinalHealth

CARDINAL HEALTH
600 N 83RD AVE
TOLLESON, AZ 85353

DEA RW-0263056 FED ID 68-0158739

DV

CUST. NO.	DATE	ORIGINAL INVOICE
163264	5/14/18	3770403
REG NO.	CUST. DEA NO.	ORDER NO. / CUSTOMER P.O. NUMBER
CA00001	AS2995922	5867270
	ORDER DATE	CONF. NO.
	5/13/18	08748

BILL TO
NV DEPT OF CORRECTION CTR PHCY
CENTRAL PHCY
3955 W RUSSELL RD-CASA GRANDE
LAS VEGAS, NV 89118

SHIP TO
NV DEPT OF CORRECTION CTR PHCY
CENTRAL PHCY
3955 W RUSSELL RD-CASA GRANDE
LAS VEGAS, NV 89118

ITEM NUMBER	NDC/UPC	QTY ORDERED	QTY SHIPPED	QTY OUT	U/M	DESCRIPTION	SIZE	FORM	C-CLASS	RETAIL PRICE			UNIT PRICE	EXTENSION	NOTE CODE
5316179	00074-4382-20 TOTE# 11	1	1		CT	NIMBEX 10MG/ML 10X20ML	10	SD					2810.32	281032	CT
			1			PIECES SHIPPED							SUBTOT	281032	
			1			TOTAL PIECES SHIPPED									
						---------- S U M M A R Y ----------									
						Total RX				2810.32					
						NET AMOUNT				2810.32					

INVOICE SHIP DATE: 5/13/2018

For SDS Visit: http://www.mycardinalsdspd.com

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CARDINAL HEALTH 110, LLC
C/O BANK OF AMERICA
PO BOX 56412
LOS ANGELES, CA 90074-6412

Note Codes:		
T	Taxable	CT Contract
CO	Contract Item Override	SN Special Net
SP	Special Pricing	OV Price Override
		CS Source Contract

Omit Codes:		
C Dropship	4 Not stocked	7 Drug Recall
2 DC Out	5 Mfr Disc	8 New item/stock unavail.
3 Mfr Out	6 DC Disc	9 Restricted item
		S Regulatory Review

List Chemical Designations
E - Ephedrine
P - Phenylpropanolamine
S - Pseudoephedrine
L - Other List Chemical

307 / 010

6/13/18
DUE DATE

281032

Customer is a final dispenser purchasing for own use and will not redistribute prescription pharmaceuticals into the secondary market.

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NDOC0020


Nimbex®
Cisatracurium
Besylate Injection
200 mg/20 mL
(10 mg/mL)
Single-dose vial
NDOC0021

EXHIBIT 9

AMENDMENT TO

GENERIC WHOLESALE SERVICE AGREEMENT

This Amendment ("**Amendment**") to the Generic Wholesale Service Agreement by and between Sandoz Inc. ("**Supplier**") and Cardinal Health* ("**Cardinal Health**") dated July 1, 2006 as amended (referenced internally by Supplier as Contract #22745 for convenience only) (the "**Agreement**") is made effective as of May 15, 2018 ("**Amendment Effective Date**"). Supplier and Cardinal Health may be hereinafter referred to collectively as the "**Parties**" and individually as a "**Party**".

RECITALS

WHEREAS, Cardinal and Supplier are Parties to the Agreement;

WEREAS, the Parties entered into the Controlled Distribution Program Amendment dated August 28, 2017;

WHEREAS, the Parties desire to amend the definition of Controlled Distribution Products to add Cisatracurium;

NOW, THEREFORE, in consideration of the foregoing recitals and the mutual covenants and agreements contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are mutually acknowledged, the Parties agree to be legally bound as follows:

1. Section 1.a. of the Agreement is hereby amended and restated to add Cisatracurium to the definition of Controlled Distribution Products as follows:

"1.a. Controlled Distribution Products. Cardinal Health acknowledges and agrees that as of the Amendment Effective Date, Cardinal Health shall not sell, offer to sell or distribute the Rocuronium Bromide, Anectine *or Cisatracurium* Products listed in Exhibit 1, attached hereto ("**Controlled Distribution Products**") to: 1) any United States prison hospital, which shall include all State and Federal Prisons in the U.S. (and its commonwealths, territories, possessions, and military bases) (collectively "**U.S. Prison Hospital**"), 2) to any of its customers, affiliates or any other third party that is acquiring Rocuronium Bromide, Anectine *or Cisatracurium* Products for use for further distribution in any U.S. Prison Hospital or 3) to any retailer, wholesaler or distributor, in each case unless such customer is an Eligible Customer approved in advance in writing by Sandoz as set forth herein. Cardinal Health shall only be permitted to sell, offer to sell or distribute Rocuronium Bromide, Anectine *or Cisatracurium* Products to Eligible Customers (defined below)."

2. Exhibit 1 Controlled Distribution Products is hereby amended by adding the following Cisatracurium Products:

NDC	Product	Size	U/M
781903995	CISATRACURIUM IJ 10MG/ML 10X20	10	VL
781315395	CISATRACURIUM IJ 10MG/ML 10X20	10	VL
781315295	CISATRACURIUM IJ 2MG/ML 10X10M	10	VL
781903895	CISATRACURIUM IJ 2MG/ML 10X10M	10	VL
781903795	CISATRACURIUM IJ 2MG/ML 10X5ML	10	VL
781315095	CISATRACURIUM IJ 2MG/ML 10X5ML	10	VL

3. Exhibit 2 Controlled Distribution Program Schedule, Section 3 Products subject to the Controlled Distribution Program Services is hereby amended to add the following Cisatracurium Products:

CISATRACURIUM IJ 10MG/ML 10X20
CISATRACURIUM IJ 10MG/ML 10X20
CISATRACURIUM IJ 2MG/ML 10X10M
CISATRACURIUM IJ 2MG/ML 10X10M
CISATRACURIUM IJ 2MG/ML 10X5ML
CISATRACURIUM IJ 2MG/ML 10X5ML

4. ***No Other Changes.*** Except as specifically set forth in this Amendment, the Agreement will continue in full force and effect without change.

5. ***Interpretation.*** To the extent there are any inconsistencies between the provisions of this Amendment and the provisions of the Agreement, the provisions of this Amendment will control. Capitalized terms not otherwise defined herein shall have the same meaning given those terms in the Agreement, it being the intent of the Parties that the Agreement and this Amendment will be applied and construed as a single instrument. The Agreement, as modified by this Amendment, constitutes the entire agreement between Supplier and Cardinal regarding the subject matter of this Amendment and supersedes all prior or contemporaneous writings and understandings between the Parties regarding the same.

6. ***Authorized Signatories.*** All signatories to this Amendment represent that they are authorized by their respective companies to execute and deliver this Amendment on behalf of their respective companies, and to bind such companies to the terms herein.

Sandoz Inc.

By: Darren Alkins

Print Name: Darren Alkins

Title: VP, Pricing & Contracts

Address of Supplier:
100 College Road West
Princeton, New Jersey 08540

Cardinal Health*

By:

Print Name: CRAIG COWMAN

Title: EVP GLOBAL SOURCING

Address of Cardinal Health:
Attention: SVP – Generic Sourcing
7000 Cardinal Health Place
Dublin, Ohio 43017

*The term "Cardinal" or "Cardinal Health" means Cardinal Health 3, LLC; Cardinal Health 104 LP; Cardinal Health 107, LLC; Cardinal Health 110, LLC; Cardinal Health 112, LLC; Cardinal Health PR 120, Inc.; The Harvard Drug Group, L.L.C.; and any other affiliate of Cardinal Health, Inc., an Ohio corporation ("CHI"), as may be designated by CHI.

EXHIBIT 10

Date : 30.04.2012

Cisatracurium Besylate Injection

Rx only

SANDOZ

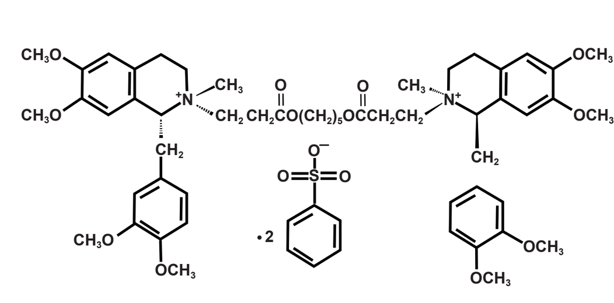
This drug should be administered only by adequately trained individuals familiar with its actions, characteristics, and hazards.

NOT FOR USE IN NEONATES

CONTAINS BENZYL ALCOHOL

DESCRIPTION

Cisatracurium besylate is a nondepolarizing skeletal muscle relaxant for intravenous administration. Compared to other neuromuscular blocking agents, it is intermediate in its onset and duration of action. Cisatracurium besylate is one of 10 isomers of atracurium besylate and constitutes approximately 15% of that mixture. Cisatracurium besylate is [1*R*-[1α, 2α(1'*R**,2'*R**)]]-2,2'-[1,5-pentanediylbis[oxy(3-oxo-3,1-propanediyl)]]bis[1-[(3,4-dimethoxyphenyl) methyl]-1,2,3,4-tetrahydro-6,7-dimethoxy-2-methylisoquinolinium] dibenzenesulfonate. The molecular formula of the cisatracurium parent bis-cation is $C_{53}H_{72}N_2O_{12}$ and the molecular weight is 929.2. The molecular formula of cisatracurium as the besylate salt is $C_{65}H_{82}N_2O_{18}S_2$ and the molecular weight is 1243.50. The structural formula of cisatracurium besylate is:



The log of the partition coefficient of cisatracurium besylate is -2.12 in a 1-octanol/distilled water system at 25°C.

Cisatracurium besylate injection is a sterile, non-pyrogenic aqueous solution provided in 10 mL vials. The pH is adjusted to 3.25 to 3.65 with benzenesulfonic acid. The 10 mL vial contains cisatracurium besylate, equivalent to 2 mg/mL cisatracurium. The 10 mL vial, intended for multiple-dose use, contains 0.9% benzyl alcohol as a preservative.

Cisatracurium besylate slowly loses potency with time at a rate of approximately 5% per year under refrigeration (5°C). Cisatracurium besylate should be refrigerated at 2° to 8°C (36° to 46°F) in the carton to preserve potency. The rate of loss in potency increases to approximately 5% per *month* at 25°C (77°F). Upon removal from refrigeration to room temperature storage conditions (25°C/77°F), use cisatracurium besylate within 21 days, even if rerefrigerated.

CLINICAL PHARMACOLOGY

Cisatracurium besylate binds competitively to cholinergic receptors on the motor end-plate to antagonize the action of acetylcholine, resulting in block of neuromuscular transmission. This action is antagonized by acetylcholinesterase inhibitors such as neostigmine.

Pharmacodynamics

The neuromuscular blocking potency of cisatracurium besylate is approximately threefold that of atracurium besylate. The time to maximum block is up to 2 minutes longer for equipotent doses of cisatracurium besylate compared to atracurium besylate. The clinically effective duration of action and rate of spontaneous recovery from equipotent doses of cisatracurium besylate and atracurium besylate are similar.

The average ED_{95} (dose required to produce 95% suppression of the adductor pollicis muscle twitch response to ulnar nerve stimulation) of cisatracurium is 0.05 mg/kg (range: 0.048 to 0.053) in adults receiving opioid/nitrous oxide/oxygen anesthesia. For comparison, the average ED_{95} for atracurium when also expressed as the parent bis-cation is 0.17 mg/kg under similar anesthetic conditions.

The pharmacodynamics of 2 × ED_{95} to 8 × ED_{95} doses of cisatracurium administered over 5 to 10 seconds during opioid/nitrous oxide/oxygen anesthesia are summarized in **Table 1**. When the dose is doubled, the clinically effective duration of block increases by approximately 25 minutes. Once recovery begins, the rate of recovery is independent of dose.

Isoflurane or enflurane administered with nitrous oxide/oxygen to achieve 1.25 MAC [Minimum Alveolar Concentration] may prolong the clinically effective duration of action of initial and maintenance doses, and decrease the average infusion rate requirement of cisatracurium besylate. The magnitude of these effects may depend on the duration of administration of the volatile agents. Fifteen to 30 minutes of exposure to 1.25 MAC isoflurane or enflurane had minimal effects on the duration of action of initial doses of cisatracurium besylate and therefore, no adjustment to the initial dose should be necessary when cisatracurium besylate is administered shortly after initiation of volatile agents. In long surgical procedures during enflurane or isoflurane anesthesia, less frequent maintenance dosing, lower maintenance doses, or reduced infusion rates of cisatracurium besylate may be necessary. The average infusion rate requirement may be decreased by as much as 30% to 40%.

The onset, duration of action, and recovery profiles of cisatracurium besylate during propofol/oxygen or propofol/nitrous oxide/oxygen anesthesia are similar to those during opioid/nitrous oxide/oxygen anesthesia.

Table 1. Pharmacodynamic Dose Response* of Cisatracurium During Opioid/Nitrous Oxide/Oxygen Anesthesia

Initial Dose of Cisatracurium besylate (mg/kg)	Time to 90% Block (min)	Time to Maximum Block (min)	Time to Spontaneous Recovery: 5% Recovery (min)	25% Recovery† (min)	95% Recovery (min)	$T_4:T_1$ Ratio‡ ≥ 70% (min)	25%-75% Recovery Index (min)
Adults							
0.1 (2 × ED_{95}) (n§= 98)	3.3 (1-8.7)	5 (1.2-17.2)	33 (15-51)	42 (22-63)	64 (25-93)	64 (32-91)	13 (5-30)
0.15‖ (3 × ED_{95}) (n = 39)	2.6 (1-4.4)	3.5 (1.6-6.8)	46 (28-65)	55 (44-74)	76 (60-103)	75 (63-98)	13 (11-16)
0.2 (4 × ED_{95}) (n = 30)	2.4 (1.5-4.5)	2.9 (1.9-5.2)	59 (31-103)	65 (43-103)	81 (53-114)	85 (55-114)	12 (2-30)
0.25 (5 × ED_{95}) (n = 15)	1.6 (0.8-3.3)	2 (1.2-3.7)	70 (58-85)	78 (66-86)	91 (76-109)	97 (82-113)	8 (5-12)
0.4 (8 × ED_{95}) (n = 15)	1.5 (1.3-1.8)	1.9 (1.4-2.3)	83 (37-103)	91 (59-107)	121 (110-134)	126 (115-137)	14 (10-18)
Infants (1-23 mos.)							
0.15** (n = 18-26)	1.5 (0.7-3.2)	2 (1.3-4.3)	36 (28-50)	43 (34-58)	64 (54-84)	59 (49-76)	11.3 (7.3-18.3)
Children (2-12 yr)							
0.08¶ (2 × ED_{95}) (n = 60)	2.2 (1.2-6.8)	3.3 (1.7-9.7)	22 (11-38)	29 (20-46)	52 (37-64)	50 (37-62)	11 (7-15)
0.1 (n = 16)	1.7 (1.3-2.7)	2.8 (1.8-6.7)	21 (13-31)	28 (21-38)	46 (37-58)	44 (36-58)	10 (7-12)
0.15** (n = 23-24)	2.1 (1.3-2.8)	3 (1.5-8)	29 (19-38)	36 (29-46)	55 (45-72)	54 (44-66)	10.6 (8.5-17.7)

* Values shown are medians of means from individual studies. Values in parentheses are ranges of individual patient values.
† Clinically effective duration of block.
‡ Train-of-four ratio.
§ n=the number of patients with Time to Maximum Block data
‖ Propofol anesthesia.
¶ Halothane anesthesia.
** Thiopentone, alfentanil, N_2O/O_2 anesthesia

When administered during the induction of adequate anesthesia using propofol, nitrous oxide/oxygen, and co-induction agents (e.g., fentanyl and midazolam), GOOD or EXCELLENT conditions for tracheal intubation occurred in 96/102 (94%) patients in 1.5 to 2 minutes following 0.15 mg/kg cisatracurium and in 97/110 (88%) patients in 1.5 minutes following 0.2 mg/kg cisatracurium.

In one intubation study during thiopental anesthesia in which fentanyl and midazolam were administered two minutes prior to induction, intubation conditions were assessed at 120 seconds. **Table 2** displays these results in this study of 51 patients.

Table 2. Study of Tracheal Intubation Comparing Two Doses of Cisatracurium (Thiopental Anesthesia)

Intubating Conditions at 120 Seconds	3 × ED_{95} 0.15 mg/kg n = 26	4 × ED_{95} 0.20 mg/kg n = 25
Excellent and Good		
Proportion	23/26	24/25
Percent	88%	96%
95% CI	76,100	88,100
Excellent		
Proportion	8/26	15/26
Percent	31%	60%
Good		
Proportion	15/26	9/25
Percent	58%	36%

While GOOD or EXCELLENT intubation conditions were achieved in the majority of patients in this setting, EXCELLENT intubation conditions were more frequently achieved with the 0.2 mg/kg dose (60%) than the 0.15 mg/kg dose (31%) when intubation was attempted 2 minutes following cisatracurium.

A second study evaluated intubation conditions after 3 and 4 × ED_{95} (0.15 mg/kg and 0.20 mg/kg) following induction with fentanyl and midazolam and either thiopental or propofol anesthesia. This study compared intubation conditions produced by these doses of cisatracurium after 1.5 minutes. **Table 3** displays these results.

Table 3. Study of Tracheal Intubation Comparing Three Doses of Cisatracurium (Thiopental or Propofol Anesthesia)

Intubating Conditions at 90 seconds	3 × ED_{95} 0.15 mg/kg Propofol n = 31	3 × ED_{95} 0.15 mg/kg Thiopental n = 31	4 × ED_{95} 0.20 mg/kg Propofol n = 30	4 × ED_{95} 0.20 mg/kg Thiopental n = 28
Excellent and Good				
Proportion	29/31	28/31	28/30	27/28
Percent	94%	90%	93%	96%
95% CI	85,100	80,100	84,100	90,100
Excellent				
Proportion	18/31	17/31	22/30	16/28
Percent	58%	55%	70%	57%
Good				
Proportion	11/31	11/31	6/30	11/28
Percent	35%	35%	20%	39%

EXCELLENT intubation conditions were more frequently observed with the 0.2 mg/kg dose when intubation was attempted 1.5 minutes following cisatracurium.

A third study in pediatric patients (ages 1 month to 12 years) evaluated intubation conditions at 120 seconds after 0.15 mg/kg cisatracurium besylate following induction with either halothane (with halothane/nitrous oxide/oxygen maintenance) or thiopentone and fentanyl (with thiopentone/fentanyl nitrous oxide/oxygen maintenance). The results are summarized in **Table 4.**

Table 4. Study of Tracheal Intubation for Pediatrics Stratified by Age Group (0.15 mg/kg Cisatracurium Besylate with Halothane or Thiopentone/ Fentanyl Anesthesia)

	Cisatracurium 0.15 mg/kg 1-11 mo. n = 30		Cisatracurium 0.15 mg/kg 1- 4 years n = 31		Cisatracurium 0.15 mg/kg 5-12 years n = 30	
Intubating Conditions at 120 seconds**	Halothane Anesthesia	Thiopentone/ Fentanyl Anesthesia	Halothane Anesthesia	Thiopentone/ Fentanyl Anesthesia	Halothane Anesthesia	Thiopentone/ Fentanyl Anesthesia
Excellent and Good						
Proportion	30/30	30/30	29/30	26/30	29/30	29/30
Percent	100%	100%	97%	87%	97%	97%
Excellent						
Proportion	30/30	25/30	27/30	19/30	22/30	21/30
Percent	100%	83%	90%	63%	73%	70%
Good						
Proportion	0	5/30	2/30	7/30	7/30	8/30
Percent	0%	17%	7%	23%	23%	27%
Poor						
Proportion	0/30	0/30	1/30	4/30	1/30	1/30
Percent	0%	0%	3%	13%	3%	3%

** **Excellent:** Easy passage of the tube without coughing. Vocal cords relaxed and abducted.
Good: Passage of tube with slight coughing and/or bucking. Vocal cords relaxed and abducted.
Poor: Passage of tube with moderate coughing and/or bucking. Vocal cords moderately adducted. Response of patient requires adjustment of ventilation pressure and/or rate.

EXCELLENT or GOOD intubating conditions were produced 120 seconds following 0.15 mg/kg cisatracurium besylate in 88/90 (98%) of patients induced with halothane and in 85/90 (94%) of patients induced with thiopentone and fentanyl. There were no patients for whom intubation was not possible, but there were 7/120 patients ages 1 to 12 years for whom intubating conditions were described as poor.

Repeated administration of maintenance doses or a continuous infusion of cisatracurium besylate for up to 3 hours is not associated with development of tachyphylaxis or cumulative neuromuscular blocking effects. The time needed to recover from successive maintenance doses does not change with the number of doses administered as long as partial recovery is allowed to occur between doses. Maintenance doses can therefore be administered at relatively regular intervals with predictable results. The rate of spontaneous recovery of neuromuscular function after infusion is independent of the duration of infusion and comparable to the rate of recovery following initial doses **(Table 1).**

Long-term infusion (up to 6 days) of cisatracurium besylate during mechanical ventilation in the ICU has been evaluated in two studies. In a randomized, double-blind study using presence of a single twitch during train-of-four (TOF) monitoring to regulate dosage, patients treated with cisatracurium besylate (n = 19) recovered neuromuscular function (T_4:T_1 ratio ≥ 70%) following termination of infusion in approximately 55 minutes (range: 20 to 270) whereas those treated with vecuronium (n = 12) recovered in 178 minutes (range: 40 minutes to 33 hours). In another study comparing cisatracurium besylate and atracurium, patients recovered neuromuscular function in approximately 50 minutes for both cisatracurium besylate (range: 20 to 175; n = 34) and atracurium (range: 35 to 85; n = 15).

The neuromuscular block produced by cisatracurium besylate is readily antagonized by anticholinesterase agents once recovery has started. As with other nondepolarizing neuromuscular blocking agents, the more profound the neuromuscular block at the time of reversal, the longer the time required for recovery of neuromuscular function.

In children (2 to 12 years) cisatracurium has a lower ED_{95} than in adults (0.04 mg/kg, halothane/nitrous oxide/oxygen anesthesia). At 0.1 mg/kg during opioid anesthesia, cisatracurium had a faster onset and shorter duration of action in children than in adults **(Table 1).** Recovery following reversal is faster in children than in adults.

At 0.15 mg/kg during opioid anesthesia, cisatracurium had a faster onset and longer clinically effective duration of action in infants aged 1 to 23 months compared to children aged 2 to 12 years **(Table 1).**

Studies were conducted during both opioid-based and halothane-based anesthesia in children aged 1 to 11 months, 1 to 4 years, and 5 to 12 years. Cisatracurium had a faster onset and longer duration of action in infants 1 to 11 months compared to children 1 to 4 years, who in turn have a faster onset and longer duration of action for cisatracurium compared to children 5 to 12 years.

The mean time to onset of maximum T_1 suppression was generally faster for pediatric patients induced with halothane compared to thiopentone/fentanyl and the clinically effective duration (time to 25% recovery) was longer (by up to 15%) for pediatric patients under halothane anesthesia.

Hemodynamics Profile

The cardiovascular profile of cisatracurium besylate allows it to be administered by rapid bolus at higher multiples of the ED_{95} than atracurium. Cisatracurium besylate has no dose-related effects on mean arterial blood pressure (MAP) or heart rate (HR) following doses ranging from 2 to 8 × ED_{95} (> 0.1 to > 0.4 mg/kg), administered over 5 to 10 seconds, in healthy adult patients (**Figure 1**) or in patients with serious cardiovascular disease **(Figure 2).**

A total of 141 patients undergoing coronary artery bypass grafting (CABG) have been administered cisatracurium besylate in three active controlled clinical trials and have received doses ranging from 2 to 8 × ED_{95}. While the hemodynamic profile was comparable in both the cisatracurium besylate and active control groups, data for doses above 0.3 mg/kg in this population are limited.

Unlike atracurium, cisatracurium besylate, at therapeutic doses of 2 × ED_{95} to 8 × ED_{95} (0.1 to 0.4 mg/kg), administered over 5 to 10 seconds, does not cause dose-related elevations in mean plasma histamine concentration.

Figure 1. Maximum Percent Change from Preinjection in Heart Rate (HR) and Mean Arterial Pressure (MAP) During First 5 Minutes after Initial 4 × ED_{95} to 8 × ED_{95} Doses of Cisatracurium Besylate in Healthy Adult Patients Receiving Opioid/Nitrous Oxide/Oxygen Anesthesia (n = 44)

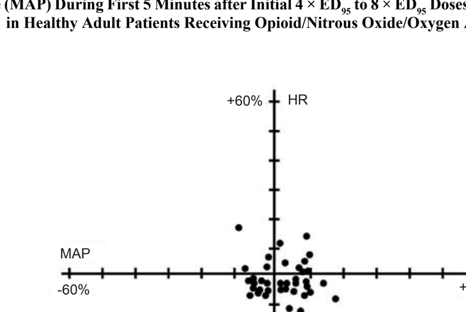
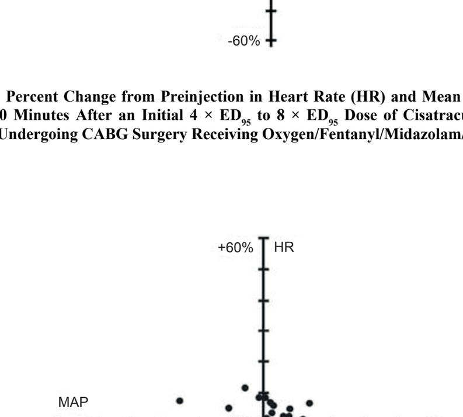


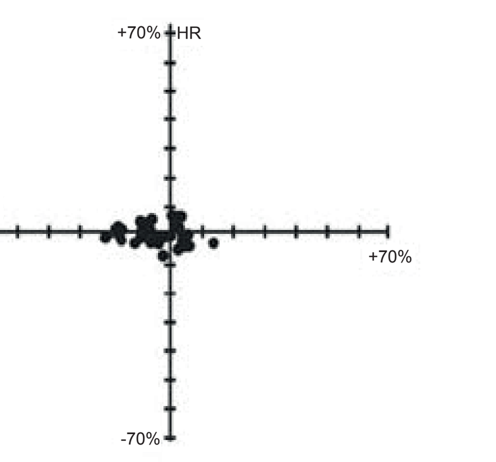
Figure 2. Percent Change from Preinjection in Heart Rate (HR) and Mean Arterial Pressure (MAP) 10 Minutes After an Initial 4 × ED_{95} to 8 × ED_{95} Dose of Cisatracurium Besylate in Patients Undergoing CABG Surgery Receiving Oxygen/Fentanyl/Midazolam/Anesthesia (n = 54)



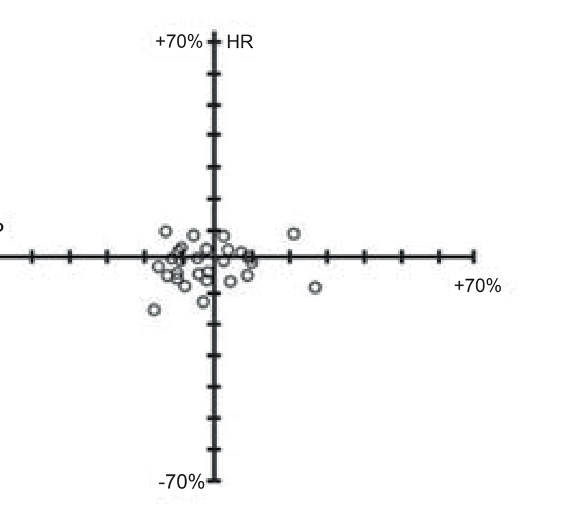
No clinically significant changes in MAP or HR were observed following administration of doses up to 0.1 mg/kg cisatracurium besylate over 5 to 10 seconds in 2- to 12-year-old children receiving either halothane/nitrous oxide/oxygen or opioid/nitrous oxide/oxygen anesthesia. Doses of 0.15 mg/kg cisatracurium besylate administered over 5 seconds were not consistently associated with changes in HR and MAP in pediatric patients aged 1 month to 12 years receiving opioid/nitrous oxide/oxygen or halothane/nitrous oxide/oxygen anesthesia.

Figure 3. Heart Rate and MAP Change at 1 Minute After the Initial Dose, By Age Group Treatment Group: Cisatracurium Besylate 0:3 × ED_{95} Opioid Intubation at 120 Sec.

1-11 Months



1 to 5 Years



5 to 13 Years

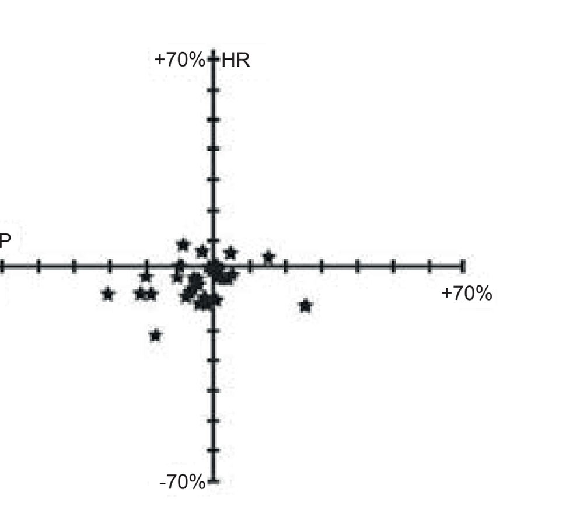
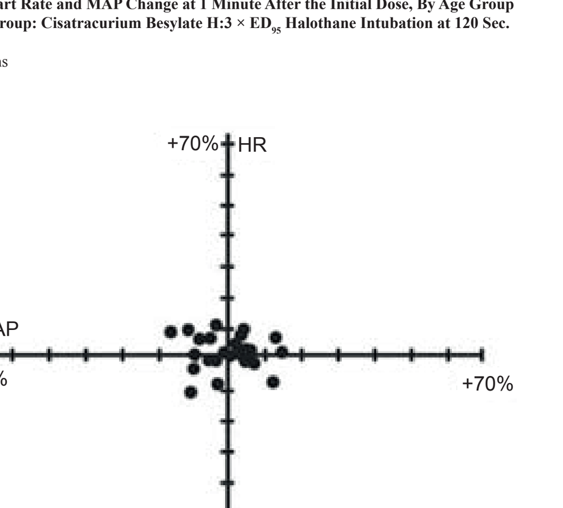
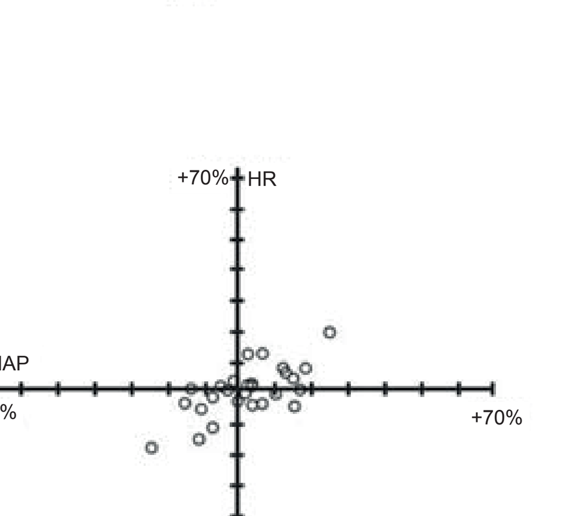


Figure 4. Heart Rate and MAP Change at 1 Minute After the Initial Dose, By Age Group Treatment Group: Cisatracurium Besylate H:3 × ED_{95} Halothane Intubation at 120 Sec.

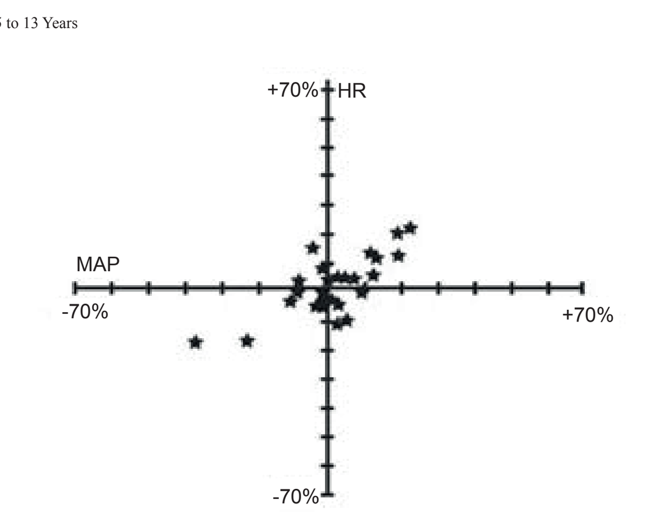
1 to 11 Months



1 to 5 Years



5 to 13 Years



Pharmacokinetics

General

The neuromuscular blocking activity of cisatracurium besylate is due to parent drug. Cisatracurium plasma concentration-time data following IV bolus administration are best described by a two-compartment open model (with elimination from both compartments) with an elimination half-life ($t_{1/2}\beta$) of 22 minutes, a plasma clearance (CL) of 4.57 mL/min/kg, and a volume of distribution at steady state (V_{ss}) of 145 mL/kg. Cisatracurium undergoes organ-independent Hofmann elimination (a chemical process dependent on pH and temperature) to form the monoquaternary acrylate metabolite and laudanosine, neither of which has any neuromuscular blocking activity (see **Pharmacokinetics - *Metabolism*** section). Following administration of radiolabeled cisatracurium, 95% of the dose was recovered in the urine; less than 10% of the dose was excreted as unchanged parent drug. Laudanosine, a metabolite of cisatracurium (and atracurium) has been noted to cause transient hypotension and, in higher doses, cerebral excitatory effects when administered to several animal species. The relationship between CNS excitation and laudanosine concentrations in humans has not been established (see **PRECAUTIONS - Long-Term Use in the Intensive Care Unit).** Because cisatracurium is three times more potent than atracurium and lower doses are required, the corresponding laudanosine concentrations following cisatracurium are one third of those that would be expected following an equipotent dose of atracurium (see **Pharmacokinetics - *Special Populations*** *-Intensive Care Unit Patients*).

Results from population pharmacokinetic/pharmacodynamic (PK/PD) analyses from 241 healthy surgical patients are summarized in **Table 5.**

Table 5. Key Population PK/PD Parameter Estimates for Cisatracurium in Healthy Surgical Patients* Following 0.1 (2 × ED_{95}) to 0.4 mg/kg (8 × ED_{95}) Cisatracurium

Parameter	Estimate†	Magnitude of Interpatient Variability (CV)‡
CL (mL/min/kg)	4.57	16%
V_{ss} (mL/kg)§	145	27%
k_{eo} (min-1)ll	0.0575	61%
EC_{50} (ng/mL)¶	141	52%

* Healthy male non-obese patients 19 - 64 years of age with creatinine clearance values greater than 70 mL/min who received cisatracurium during opioid anesthesia and had venous samples collected.
† The percent standard error of the mean (% SEM) ranged from 3% to 12% indicating good precision for the PK/PD estimates.
‡ Expressed as a coefficient of variation; the % SEM ranged from 20% to 35% indicating adequate precision for the estimates of interpatient variability.
§ V_{ss} is the volume of distribution at steady state estimated using a two-compartment model with elimination from both compartments. V_{ss} is equal to the sum of the volume in the central compartment (V_c) and the volume in the peripheral compartment (V_p); interpatient variability could only be estimated for V_c.
ll Rate constant describing the equilibration between plasma concentrations and neuromuscular block.
¶ Concentration required to produce 50% T_1 suppression; an index of patient Sensitivity.

The magnitude of interpatient variability in CL was low (16%), as expected based on the importance of Hofmann elimination (see **Pharmacokinetics - *Elimination***). The magnitudes of interpatient variability in CL and volume of distribution were low in comparison to those for k_{eo} and EC_{50}. This suggests that any alterations in the time course of cisatracurium-induced block are more likely to be due to variability in the pharmacodynamic parameters than in the pharmacokinetic parameters. Parameter estimates from the population pharmacokinetic analyses were supported by noncompartmental pharmacokinetic analyses on data from healthy patients and from special patient populations.

Conventional pharmacokinetic analyses have shown that the pharmacokinetics of cisatracurium are proportional to dose between 0.1 (2 × ED_{95}) and 0.2 (4 × ED_{95}) mg/kg cisatracurium. In addition, population pharmacokinetic analyses revealed no statistically significant effect of initial dose on CL for doses between 0.1 (2 × ED_{95}) and 0.4 (8 × ED_{95}) mg/kg cisatracurium.

Distribution

The volume of distribution of cisatracurium is limited by its large molecular weight and high polarity. The V_{ss} was equal to 145 mL/kg **(Table 4)** in healthy 19- to 64-year-old surgical patients receiving opioid anesthesia. The V_{ss} was 21% larger in similar patients receiving inhalation anesthesia (see **Pharmacokinetics - *Special Populations* -** *Other Patient Factors*).

Protein Binding

The binding of cisatracurium to plasma proteins has not been successfully studied due to its rapid degradation at physiologic pH. Inhibition of degradation requires nonphysiological conditions of temperature and pH which are associated with changes in protein binding.

Metabolism

The degradation of cisatracurium is largely independent of liver metabolism. Results from *in vitro* experiments suggest that cisatracurium undergoes Hofmann elimination (a pH and temperature-dependent chemical process) to form laudanosine (see **PRECAUTIONS - Long-Term Use in the Intensive Care Unit)** and the monoquaternary acrylate metabolite. The monoquaternary acrylate undergoes hydrolysis by non-specific plasma esterases to form the monoquaternary alcohol (MQA) metabolite. The MQA metabolite can also undergo Hofmann elimination but at a much slower rate than cisatracurium. Laudanosine is further metabolized to desmethyl metabolites which are conjugated with glucuronic acid and excreted in the urine.

Organ-independent Hofmann elimination is the predominant pathway for the elimination of cisatracurium. The liver and kidney play a minor role in the elimination of cisatracurium but are primary pathways for the elimination of metabolites. Therefore, the $t_{1/2}\beta$ values of metabolites (including laudanosine) are longer in patients with kidney or liver dysfunction and metabolite concentrations may be higher after long-term administration (see **PRECAUTIONS - Long-Term Use in the Intensive Care Unit**). Most importantly, C_{max} values of laudanosine are significantly lower in healthy surgical patients receiving infusions of cisatracurium besylate than in patients receiving infusions of atracurium (mean ± SD C_{max}: 60 ± 52 and 342 ± 93 ng/mL, respectively).

Elimination

Clearance and Half-life

Mean CL values for cisatracurium ranged from 4.5 to 5.7 mL/min/kg in studies of healthy surgical patients. Compartmental pharmacokinetic modeling suggests that approximately 80% of the CL is accounted for by Hofmann elimination and the remaining 20% by renal and hepatic elimination. These findings are consistent with the low magnitude of interpatient variability in CL (16%) estimated as part of the population PK/PD analyses and with the recovery of parent and metabolites in urine. Following ^{14}C-cisatracurium administration to 6 healthy male patients, 95% of the dose was recovered in the urine (mostly as conjugated metabolites) and 4% in the feces; less than 10% of the dose was excreted as unchanged parent drug in the urine. In 12 healthy surgical patients receiving non-radiolabeled cisatracurium who had Foley catheters placed for surgical management, approximately 15% of the dose was excreted unchanged in the urine.

In studies of healthy surgical patients, mean $t_{1/2}\beta$ values of cisatracurium ranged from 22 to 29 minutes and were consistent with the $t_{1/2}\beta$ of cisatracurium *in vitro* (29 minutes). The mean ± SD $t_{1/2}\beta$ values of laudanosine were 3.1± 0.4 and 3.3 ± 2.1 hours in healthy surgical patients receiving cisatracurium besylate (n = 10) or atracurium (n = 10), respectively. During IV infusions of cisatracurium besylate, peak plasma concentrations (C_{max}) of laudanosine and the MQA metabolite are approximately 6% and 11% of the parent compound, respectively.

Special Populations

Geriatric Patients (≥ 65 years)

The results of conventional pharmacokinetic analysis from a study of 12 healthy elderly patients and 12 healthy young adult patients receiving a single IV dose of 0.1 mg/kg cisatracurium besylate are summarized in **Table 6**. Plasma clearances of cisatracurium were not affected by age; however, the volumes of distribution were slightly larger in elderly patients than in young patients resulting in slightly longer $t_{1/2}\beta$ values for cisatracurium. The rate of equilibration between plasma cisatracurium concentrations and neuromuscular block was slower in elderly patients than in young patients (mean ± SD k_{eo}: 0.071 ± 0.036 and 0.105 ± 0.021 minutes^{-1}, respectively); there was no difference in the patient sensitivity to cisatracurium-induced block, as indicated by EC_{50} values (mean ± SD EC_{50}: 91 ± 22 and 89 ± 23 ng/mL, respectively). These changes were consistent with the 1-minute slower times to maximum block in elderly patients receiving 0.1 mg/kg cisatracurium besylate, when compared to young patients receiving the same dose. The minor differences in PK/PD parameters of cisatracurium between elderly patients and young patients were not associated with clinically significant differences in the recovery profile of cisatracurium besylate.

Table 6. Pharmacokinetic Parameters* of Cisatracurium in Healthy Elderly and Young Adult Patients Following 0.1 mg/kg (2×ED_{95}) Cisatracurium Besylate (Isoflurane/Nitrous Oxide/Oxygen Anesthesia)

Parameter	Healthy Elderly Patients	Healthy Young Adult Patients
Elimination Half-Life ($t_{1/2}\beta$, min)	25.8 ± 3.6†	22.1 ± 2.5
Volume of Distribution at Steady State‡ (mL/kg)	156 ± 17†	133 ± 15
Plasma Clearance (mL/min/kg)	5.7 ± 1	5.3 ± 0.9

* Values presented are mean ± SD.
† P < 0.05 for comparisons between healthy elderly and healthy young adult patients.
‡ Volume of distribution is underestimated because elimination from the peripheral compartment is ignored.

Patients with Hepatic Disease

Table 7 summarizes the conventional pharmacokinetic analysis from a study of cisatracurium besylate in 13 patients with end-stage liver disease undergoing liver transplantation and 11 healthy adult patients undergoing elective surgery. The slightly larger volumes of distribution in liver transplant patients were associated with slightly higher plasma clearances of cisatracurium. The parallel changes in these parameters resulted in no difference in $t_{1/2}\beta$ values. There were no differences in k_{eo} or EC_{50} between patient groups. The times to maximum block were approximately one minute faster in liver transplant patients than in healthy adult patients receiving 0.1 mg/kg cisatracurium besylate. These minor differences in pharmacokinetics were not associated with clinically significant differences in the recovery profile of cisatracurium besylate.

Dimensions: 375 x 480 mm

The $t_{1/2}\beta$ values of metabolites are longer in patients with hepatic disease and concentrations may be higher after long-term administration (see **Pharmacokinetics - *Special Populations*** *- Intensive Care Unit Patients*).

Table 7. Pharmacokinetic Parameters* of Cisatracurium in Healthy Adult Patients and in Patients Undergoing Liver Transplantation Following 0.1 mg/kg (2 × ED_{95}) Cisatracurium (Isoflurane/Nitrous Oxide/Oxygen Anesthesia)

Parameter	Liver Transplant Patients	Healthy Adult Patients
Elimination Half-Life ($t_{1/2}\beta$, min)	24.4 ± 2.9	23.5 ± 3.5
Volume of Distribution at Steady State‡ (mL/kg)	195 ± 38†	161 ± 23
Plasma Clearance (mL/min/kg)	6.6 ± 1.1†	5.7 ± 0.8

* Values presented are mean ± SD.
† P < 0.05 for comparisons between liver transplant patients and healthy adult patients.
‡ Volume of distribution is underestimated because elimination from the peripheral compartment is ignored.

Patients with Renal Dysfunction

Results from a conventional pharmacokinetic study of cisatracurium besylate in 13 healthy adult patients and 15 patients with end-stage renal disease (ESRD) undergoing elective surgery are summarized in **Table 8**. The PK/PD parameters of cisatracurium were similar in healthy adult patients and ESRD patients. The times to 90% block were approximately one minute slower in ESRD patients following 0.1 mg/kg cisatracurium besylate. There were no differences in the durations or rates of recovery of cisatracurium besylate between ESRD and healthy adult patients.

The $t_{1/2}\beta$ values of metabolites are longer in patients with renal failure and concentrations may be higher after long-term administration (see **Pharmacokinetics- *Special Populations*** *- Intensive Care Unit Patients*).

Table 8. Pharmacokinetic Parameters* for Cisatracurium in Healthy Adult Patients and in Patients With End-Stage Renal Disease (ESRD) Receiving 0.1 mg/kg (2 × ED_{95}) Cisatracurium (Opioid/Nitrous Oxide/Oxygen Anesthesia)

Parameter	Healthy Adult Patients	ESRD Patients
Elimination Half-Life ($t_{1/2}\beta$, min)	29.4 ± 4.1	32.3 ± 6.3
Volume of Distribution at Steady State† (mL/kg)	149 ± 35	160 ± 32
Plasma Clearance (mL/min/kg)	4.66 ± 0.86	4.26 ± 0.62

* Values presented are mean ± SD.
† Volume of distribution is underestimated because elimination from the peripheral compartment is ignored.

Population pharmacokinetic analyses revealed that patients with creatinine clearances ≤ 70 mL/min had a slower rate of equilibration between plasma concentrations and neuromuscular block than patients with normal renal function; this change was associated with a slightly slower (~ 40 seconds) predicted time to 90% T_1 suppression in patients with renal dysfunction following 0.1 mg/kg cisatracurium besylate. There was no clinically significant alteration in the recovery profile of cisatracurium besylate in patients with renal dysfunction. The recovery profile of cisatracurium besylate is unchanged in the presence of renal or hepatic failure, which is consistent with predominantly organ-independent elimination.

Intensive Care Unit (ICU) Patients

The pharmacokinetics of cisatracurium, atracurium, and their metabolites were determined in six ICU patients receiving cisatracurium besylate and in six ICU patients receiving atracurium and are presented in **Table 9**. The plasma clearances of cisatracurium and atracurium are similar. The volume of distribution was larger and the $t_{1/2}\beta$ was longer for cisatracurium than for atracurium. The relationships between plasma cisatracurium or atracurium concentrations and neuromuscular block have not been evaluated in ICU patients. The minor differences in pharmacokinetics were not associated with any differences in the recovery profiles of cisatracurium besylate and atracurium in ICU patients.

Table 9. Parameter Estimates* for Cisatracurium, Atracurium, and Metabolites in ICU Patients After Long-Term (24 to 48 Hour) Administration of Cisatracurium or Atracurium Besylate

	Parameter	Cisatracurium (n = 6)	Atracurium (n = 6)
Parent Compound	CL (mL/min/kg)	7.45 ± 1.02	7.49 ± 0.66†
	$t_{1/2}\beta$ (min)	26.8 ± 11.1	16.5 ± 6†
	Vβ (mL/kg)‡	280 ± 103	178 ± 71†
Laudanosine	C_{max} (ng/mL)	707 ± 360	2318 ± 1498
	$t_{1/2}\beta$ (hrs)	6.6 ± 4.1	8.4 ± 7.3
MQA metabolite	C_{max} (ng/mL)	152-181§	943 ± 333ll
	$t_{1/2}\beta$ (min)	26-31§	21-58§

* Presented as mean ± standard deviation.
† n = 5.
‡ Volume of distribution during the terminal elimination phase, an underestimate because elimination from the peripheral compartment is ignored.
§ n = 2, range presented.
ll n = 3.

Plasma metabolite pharmacokinetics are listed in **Table 9.** Limited pharmacokinetic data are available for patients with liver/kidney dysfunction receiving cisatracurium besylate. Data from studies of atracurium demonstrate that renal/hepatic failure in ICU patients produces little to no effect on its pharmacokinetics, but decreases the biotransformation and elimination of the metabolites. Following atracurium, $t_{1/2}\beta$ values for laudanosine were longer in ICU patients with renal failure than in ICU patients with normal renal function (15 and 6 hours, respectively). The $t_{1/2}\beta$ values of laudanosine were 39 ± 14 hours in ICU patients with liver failure receiving atracurium after an unsuccessful liver transplantation and 5 ± 2 hours in similar ICU patients after successful liver transplantation. Therefore, relative to ICU patients with normal renal and hepatic function receiving cisatracurium besylate, metabolite concentrations (plasma and tissues) may be higher in ICU patients with renal or hepatic failure (see **PRECAUTIONS - Long-Term Use in the Intensive Care Unit**). Consistent with the decreased infusion rate requirements for cisatracurium besylate, metabolite concentrations were lower in patients receiving cisatracurium besylate than in patients receiving atracurium besylate.

Pediatric Patients

The population PK/PD of cisatracurium were described in 20 healthy pediatric patients during halothane anesthesia, using the same model developed for healthy adult patients. The CL was higher in healthy pediatric patients (5.89 mL/min/kg) than in healthy adult patients (4.57 mL/min/kg) during opioid anesthesia. The rate of equilibration between plasma concentrations and neuromuscular block, as indicated by k_{eo}, was faster in healthy pediatric patients receiving halothane anesthesia (0.1330 minutes^{-1}) than in healthy adult patients receiving opioid anesthesia (0.0575 minutes^{-1}). The EC_{50} in healthy pediatric patients (125 ng/mL) was similar to the value in healthy adult patients (141 ng/mL) during opioid anesthesia. The minor differences in the PK/PD parameters of cisatracurium were associated with a faster time to onset and a shorter duration of cisatracurium-induced neuromuscular block in pediatric patients.

Other Patient Factors

Population PK/PD analyses revealed that gender and obesity were associated with statistically significant effects on the pharmacokinetics and/or pharmacodynamics of cisatracurium; these factors were not associated with clinically significant alterations in the predicted onset or recovery profile of cisatracurium besylate. The use of inhalation agents was associated with a 21% larger V_{ss}, a 78% larger k_{eo}, and a 15% lower EC_{50} for cisatracurium. These changes resulted in a slightly faster (~ 45 seconds) predicted time to 90% T_1 suppression in patients receiving 0.1 mg/kg cisatracurium during inhalation anesthesia than in patients receiving the same dose of cisatracurium during opioid anesthesia; however, there were no clinically significant differences in the predicted recovery profile of cisatracurium besylate between patient groups.

Individualization of Dosages

DOSES OF CISATRACURIUM BESYLATE SHOULD BE INDIVIDUALIZED AND A PERIPHERAL NERVE STIMULATOR SHOULD BE USED TO MEASURE NEUROMUSCULAR FUNCTION DURING ADMINISTRATION OF CISATRACURIUM BESYLATE IN ORDER TO MONITOR DRUG EFFECT, TO DETERMINE THE NEED FOR ADDITIONAL DOSES, AND TO CONFIRM RECOVERY FROM NEUROMUSCULAR BLOCK.

Based on the known action of cisatracurium besylate and other neuromuscular blocking agents, the following factors should be considered when administering cisatracurium besylate.

Renal and Hepatic Disease

See **PRECAUTIONS** section.

Long-Term Use in the Intensive Care Unit (ICU)

The long-term infusion (up to 6 days) of cisatracurium besylate during mechanical ventilation in the ICU has been evaluated in two studies. Average infusion rates of approximately 3 mcg/kg/min (range: 0.5 to 10.2) were required to achieve adequate neuromuscular block. As with other neuromuscular blocking agents, these data indicate the presence of wide interpatient variability in dosage requirements. In addition, dosage requirements may increase or decrease with time (see **PRECAUTIONS**). Use of cisatracurium besylate in the ICU for longer than 6 days has not been studied.

Drugs or Conditions Causing Potentiation of or Resistance to Neuromuscular Block

Persons with certain pre-existing conditions or receiving certain drugs may require individualization of dosing (see **PRECAUTIONS**).

Burns

Patients with burns have been shown to develop resistance to nondepolarizing neuromuscular blocking agents, and may require individualization of dosing (see **PRECAUTIONS**).

INDICATIONS AND USAGE

Cisatracurium besylate injection is an intermediate-onset/intermediate-duration neuromuscular blocking agent indicated for inpatients and outpatients as an adjunct to general anesthesia, to facilitate tracheal intubation, and to provide skeletal muscle relaxation during surgery or mechanical ventilation in the ICU.

CONTRAINDICATIONS

Cisatracurium besylate injection is contraindicated in patients with known hypersensitivity to the product and its components. The 10 mL multiple-dose vials of cisatracurium besylate injection is contraindicated for use in premature infants because the formulation contains benzyl alcohol. (See **WARNINGS** and **PRECAUTIONS – Pediatric Use**).

WARNINGS

Anaphylaxis

Severe anaphylactic reactions to neuromuscular blocking agents, including cisatracurium besylate injection, have been reported. These reactions have in some cases been life-threatening and fatal. Due to the potential severity of these reactions, the necessary precautions, such as the immediate availability of appropriate emergency treatment, should be taken. Precautions should also be taken in those individuals who have had previous anaphylactic reactions to other neuromuscular blocking agents since cross-reactivity between neuromuscular blocking agents, both depolarizing and non-depolarizing, has been reported in this class of drugs.

Administration

CISATRACURIUM BESYLATE SHOULD BE ADMINISTERED IN CAREFULLY ADJUSTED DOSAGE BY OR UNDER THE SUPERVISION OF EXPERIENCED CLINICIANS WHO ARE FAMILIAR WITH THE DRUG'S ACTIONS AND THE POSSIBLE COMPLICATIONS OF ITS USE. THE DRUG SHOULD NOT BE ADMINISTERED UNLESS PERSONNEL AND FACILITIES FOR RESUSCITATION AND LIFE SUPPORT (TRACHEAL INTUBATION, ARTIFICIAL VENTILATION, OXYGEN THERAPY), AND AN ANTAGONIST OF CISATRACURIUM BESYLATE ARE IMMEDIATELY AVAILABLE. IT IS RECOMMENDED THAT A PERIPHERAL NERVE STIMULATOR BE USED TO MEASURE NEUROMUSCULAR FUNCTION DURING THE ADMINISTRATION OF CISATRACURIUM BESYLATE IN ORDER TO MONITOR DRUG EFFECT, DETERMINE THE NEED FOR ADDITIONAL DOSES, AND CONFIRM RECOVERY FROM NEUROMUSCULAR BLOCK.

CISATRACURIUM BESYLATE HAS NO KNOWN EFFECT ON CONSCIOUSNESS, PAIN THRESHOLD, OR CEREBRATION. TO AVOID DISTRESS TO THE PATIENT, NEUROMUSCULAR BLOCK SHOULD NOT BE INDUCED BEFORE UNCONSCIOUSNESS.

Cisatracurium besylate injection is acidic (pH 3.25 to 3.65) and may not be compatible with alkaline solutions having a pH greater than 8.5 (e.g., barbiturate solutions).

The 10 mL multiple-dose vials of cisatracurium besylate injection contain benzyl alcohol, which is potentially toxic when administered locally to neural tissue. Exposure to excessive amounts of benzyl alcohol has been associated with toxicity (hypotension, metabolic acidosis), particularly in neonates, and an increased incidence of kernicterus, particularly in small preterm infants. There have been rare reports of deaths, primarily in preterm infants, associated with exposure to excessive amounts of benzyl alcohol. The amount of benzyl alcohol from medications is usually considered negligible compared to that received in flush solution containing benzyl alcohol. Administration of high dosages of medications containing this preservative must take into account the total amount of benzyl alcohol administered. The amount of benzyl alcohol at which toxicity may occur is not known. If the patient requires more than the recommended dosages or other medications containing this preservative, the practitioner must consider the daily metabolic load of benzyl alcohol from these combined sources.

PRECAUTIONS

Because of its intermediate onset of action, cisatracurium besylate is not recommended for rapid sequence endotracheal intubation.

Recommended doses of cisatracurium besylate have no clinically significant effects on heart rate; therefore, cisatracurium besylate will not counteract the bradycardia produced by many anesthetic agents or by vagal stimulation.

Neuromuscular blocking agents may have a profound effect in patients with neuromuscular diseases (e.g., myasthenia gravis and the myasthenic syndrome). In these and other conditions in which prolonged neuromuscular block is a possibility (e.g., carcinomatosis), the use of a peripheral nerve stimulator and a dose of not more than 0.02 mg/kg cisatracurium besylate is recommended to assess the level of neuromuscular block and to monitor dosage requirements.

Patients with burns have been shown to develop resistance to nondepolarizing neuromuscular blocking agents, including atracurium. The extent of altered response depends upon the size of the burn and the time elapsed since the burn injury. Cisatracurium besylate has not been studied in patients with burns; however, based on its structural similarity to atracurium, the possibility of increased dosing requirements and shortened duration of action must be considered if cisatracurium besylate is administered to burn patients.

Patients with hemiparesis or paraparesis also may demonstrate resistance to nondepolarizing muscle relaxants in the affected limbs. To avoid inaccurate dosing, neuromuscular monitoring should be performed on a non-paretic limb.

Acid-base and/or serum electrolyte abnormalities may potentiate or antagonize the action of neuromuscular blocking agents. No data are available to support the use of cisatracurium besylate by intramuscular Injection.

Allergic Reactions

Since allergic cross-reactivity has been reported in this class, request information from your patients about previous anaphylactic reactions to other neuromuscular blocking agents. In addition, inform your patients that severe anaphylactic reactions to neuromuscular blocking agents, including cisatracurium besylate have been reported (see **CONTRAINDICATIONS**).

Renal and Hepatic Disease

No clinically significant alterations in the recovery profile were observed in patients with renal dysfunction or in patients with end-stage liver disease following a 0.1 mg/kg dose of cisatracurium. The onset time was approximately 1 minute faster in patients with end-stage liver disease and approximately 1 minute slower in patients with renal dysfunction than in healthy adult control patients.

Malignant Hyperthermia (MH)

In a study of MH-susceptible pigs, cisatracurium besylate (highest dose 2000 mcg/kg equivalent to 3 × ED_{95} in pigs and 40 × ED_{95} in humans) did not trigger MH. Cisatracurium besylate has not been studied in MH-susceptible patients. Because MH can develop in the absence of established triggering agents, the clinician should be prepared to recognize and treat MH in any patient undergoing general anesthesia.

Long-Term Use in the Intensive Care Unit (ICU)

Long-term infusion (up to 6 days) of cisatracurium during mechanical ventilation in the ICU has been safely used in two studies. Dosage requirements may increase or decrease with time (see **CLINICAL PHARMACOLOGY - Individualization of Dosages**).

Little information is available on the plasma levels and clinical consequences of cisatracurium metabolites that may accumulate during days to weeks of cisatracurium administration in ICU patients. Laudanosine, a major, biologically active metabolite of atracurium and cisatracurium without neuromuscular blocking activity, produces transient hypotension and, in higher doses, cerebral excitatory effects (generalized muscle twitching and seizures) when administered to several species of animals. There have been rare spontaneous reports of seizures in ICU patients who have received atracurium or other agents. These patients usually had predisposing causes (such as cranial trauma, cerebral edema, hypoxic encephalopathy, viral encephalitis, uremia). There are insufficient data to determine whether or not laudanosine contributes to seizures in ICU patients. Consistent with the decreased infusion rate requirements for cisatracurium besylate, laudanosine concentrations were lower in patients receiving cisatracurium besylate than in patients receiving atracurium for up to 48 hours (see **Pharmacokinetics-*Special Populations*** *- Intensive Care Unit Patients*).

In a randomized, double-blind study using train-of-four nerve stimulator monitoring to maintain at least one visible twitch, evaluable patients treated with cisatracurium besylate (n = 19) recovered neuromuscular function (T_4:T_1 ratio ≥ 70%) following termination of infusion in approximately 55 minutes (range: 20 to 270) whereas evaluable vecuronium-treated patients (n = 12) recovered in 178 minutes (range: 40 minutes to 33 hours). In another study comparing cisatracurium besylate and atracurium, patients recovered neuromuscular function in approximately 50 minutes for both cisatracurium besylate (range: 20 to 175; n = 34) and atracurium (range: 35 to 85; n = 15).

WHENEVER THE USE OF CISATRACURIUM BESYLATE OR ANY OTHER NEUROMUSCULAR BLOCKING AGENT IN THE ICU IS CONTEMPLATED, IT IS RECOMMENDED THAT NEUROMUSCULAR FUNCTION BE MONITORED DURING ADMINISTRATION WITH A NERVE STIMULATOR. ADDITIONAL DOSES OF CISATRACURIUM BESYLATE OR ANY OTHER NEUROMUSCULAR BLOCKING AGENT SHOULD NOT BE GIVEN BEFORE THERE IS A DEFINITE RESPONSE TO NERVE STIMULATION. IF NO RESPONSE IS ELICITED, INFUSION ADMINISTRATION SHOULD BE DISCONTINUED UNTIL A RESPONSE RETURNS.

The effects of hemofiltration, hemodialysis, and hemoperfusion on plasma levels of cisatracurium besylate and its metabolites are unknown.

Drug Interactions

Cisatracurium besylate has been used safely following varying degrees of recovery from succinylcholine-induced neuromuscular block. Administration of 0.1 mg/kg (2 × ED_{95}) cisatracurium besylate at 10% or 95% recovery following an intubating dose of succinylcholine (1 mg/kg) produced ≥ 95% neuromuscular block. The time to onset of maximum block following cisatracurium besylate is approximately 2 minutes faster with prior administration of succinylcholine. Prior administration of succinylcholine had no effect on the duration of neuromuscular block following initial or maintenance bolus doses of cisatracurium besylate. Infusion requirements of cisatracurium besylate in patients administered succinylcholine prior to infusions of cisatracurium besylate were comparable to or slightly greater than when succinylcholine was not administered.

The use of cisatracurium besylate before succinylcholine to attenuate some of the side effects of succinylcholine has not been studied.

Although not studied systematically in clinical trials, no drug interactions were observed when vecuronium, pancuronium, or atracurium were administered following varying degrees of recovery from single doses or infusions of cisatracurium besylate.

Isoflurane or enflurane administered with nitrous oxide/oxygen to achieve 1.25 MAC [Minimum Alveolar Concentration] may prolong the clinically effective duration of action of initial and maintenance doses of cisatracurium besylate and decrease the required infusion rate of cisatracurium besylate. The magnitude of these effects may depend on the duration of administration of the volatile agents. Fifteen to 30 minutes of exposure to 1.25 MAC isoflurane or enflurane had minimal effects on the duration of action of initial doses of cisatracurium besylate and therefore, no adjustment to the initial dose should be necessary when cisatracurium besylate is administered shortly after initiation of volatile agents. In long surgical procedures during enflurane or isoflurane anesthesia, less frequent maintenance dosing, lower maintenance doses, or reduced infusion rates of cisatracurium besylate may be necessary. The average infusion rate requirement may be decreased by as much as 30% to 40%.

In clinical studies propofol had no effect on the duration of action or dosing requirements for cisatracurium besylate.

Other drugs which may enhance the neuromuscular blocking action of nondepolarizing agents such as cisatracurium besylate include certain antibiotics (e.g., aminoglycosides, tetracyclines, bacitracin, polymyxins, lincomycin, clindamycin, colistin, and sodium colistemethate), magnesium salts, lithium, local anesthetics, procainamide, and quinidine.

Resistance to the neuromuscular blocking action of nondepolarizing neuromuscular blocking agents has been demonstrated in patients chronically administered phenytoin or carbamazepine. While the effects of chronic phenytoin or carbamazepine therapy on the action of cisatracurium besylate are unknown, slightly shorter durations of neuromuscular block may be anticipated and infusion rate requirements may be higher.

Drug/Laboratory Test Interactions

None known.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis and fertility studies have not been performed. Cisatracurium besylate was evaluated in a battery of four short-term mutagenicity tests. It was non-mutagenic in the Ames Salmonella assay, a rat bone marrow cytogenetic assay, and an *in vitro* human lymphocyte cytogenetics assay. As was the case with atracurium, the mouse lymphoma assay was positive both in the presence and absence of exogenous metabolic activation (rat liver S-9). In the absence of S-9, cisatracurium besylate was positive at *in vitro* cisatracurium concentrations of 40 mcg/mL and higher. The highest non-mutagenic concentration (30 mcg/mL) and incubation time (4 hours) resulted in an AUC approximately 120 times that noted in clinical studies and approximately 8.5 times the mean peak clinical concentration noted. In the presence of S-9, cisatracurium besylate was positive at a cisatracurium concentration of 300 mcg/mL but not at lower or higher concentrations.

Pregnancy

Teratogenic Effects

Pregnancy Category B

Teratology testing in nonventilated pregnant rats treated subcutaneously with maximum subparalyzing doses (4 mg/kg daily; equivalent to 8 × the human ED_{95} following a bolus dose of 0.2 mg/kg IV) and in ventilated rats treated intravenously with paralyzing doses of cisatracurium besylate at 0.5 and 1 mg/kg; equivalent to 10 × and 20 × the human ED_{95} dose, respectively, revealed no maternal or fetal toxicity or teratogenic effects. There are no adequate and well-controlled studies of cisatracurium besylate in pregnant women. Because animal studies are not always predictive of human response, cisatracurium besylate should be used during pregnancy only if clearly needed.

Labor and Delivery

The use of cisatracurium besylate during labor, vaginal delivery, or cesarean section has not been studied in humans and it is not known whether cisatracurium besylate administered to the mother has effects on the fetus. Doses of 0.2 or 0.4 mg/kg cisatracurium given to female beagles undergoing cesarean section resulted in negligible levels of cisatracurium in umbilical vessel blood of neonates and no deleterious effects on the puppies. The action of neuromuscular blocking agents may be enhanced by magnesium salts administered for the management of toxemia of pregnancy.

Nursing Mothers

It is not known whether cisatracurium besylate is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised following administration of cisatracurium besylate to a nursing woman.

Pediatric Use

Cisatracurium besylate has not been studied in pediatric patients below the age of 1 month (see **CLINICAL PHARMACOLOGY** and **DOSAGE AND ADMINISTRATION** for clinical experience and recommendations for use in children 1 month to 12 years of age). Intubation of the trachea in patients 1 to 4 years old was facilitated more reliably when cisatracurium besylate was used in combination with Halothane than when opioids and nitrous oxide were used for induction of anesthesia.

The 10 mL multiple-dose vials of cisatracurium besylate injection contain benzyl alcohol as a preservative. Benzyl alcohol, a component of this product, has been associated with serious adverse events and death, particularly in pediatric patients. The "gasping syndrome", (characterized by central nervous system depression, metabolic acidosis, gasping respirations, and high levels of benzyl alcohol and its metabolites found in the blood and urine) has been associated with benzyl alcohol dosages > 99 mg/kg/day in neonates and low-birth-weight neonates. Additional symptoms may include gradual neurological deterioration, seizures, intracranial hemorrhage, hematologic abnormalities, skin breakdown, hepatic and renal failure, hypotension, bradycardia, and cardiovascular collapse. Although normal therapeutic doses of this product deliver amounts of benzyl alcohol that are substantially lower than those reported in association with the "gasping syndrome", the minimum amount of benzyl alcohol at which toxicity may occur is not known. Premature and low-birth-weight infants, as well as patients receiving high dosages, may be more likely to develop toxicity. Practitioners administering this and other medications containing benzyl alcohol should consider the combined daily metabolic load of benzyl alcohol from all sources.

Geriatric Use

Of the total number of subjects in clinical studies of cisatracurium besylate, 57 were 65 and over, 63 were 70 and over, and 15 were 80 and over. The geriatric population included a subset of patients with significant cardiovascular disease (see **CLINICAL PHARMACOLOGY - Hemodynamics Profile and Special Populations** - *Geriatric Patients* subsections). No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between elderly and younger subjects, but greater sensitivity of some older individuals to cisatracurium besylate cannot be ruled out.

Minor differences in the pharmacokinetics of cisatracurium besylate between elderly and young adult patients are not associated with clinically significant differences in the recovery profile of cisatracurium besylate following a single 0.1 mg/kg dose; the time to maximum block is approximately 1 minute slower in elderly patients (see **CLINICAL PHARMACOLOGY -Pharmacokinetics**).

ADVERSE REACTIONS

Observed in Clinical Trials of Surgical Patients

Adverse experiences were uncommon among the 945 surgical patients who received cisatracurium besylate in conjunction with other drugs in US and European clinical studies in the course of a wide variety of procedures in patients receiving opioid, propofol, or inhalation anesthesia. The following adverse experiences were judged by investigators during the clinical trials to have a possible causal relationship to administration of cisatracurium besylate:

Incidence Greater than 1%

None.

Incidence Less than 1%

Cardiovascular

bradycardia (0.4%)
hypotension (0.2%)
flushing (0.2%).

Respiratory

bronchospasm (0.2%).

Dermatological

rash (0.1%).

Observed in Clinical Trials of Intensive Care Unit Patients

Adverse experiences were uncommon among the 68 ICU patients who received cisatracurium besylate in conjunction with other drugs in US and European clinical studies. One patient experienced bronchospasm. In one of the two ICU studies, a randomized and double-blind study of ICU patients using TOF neuromuscular monitoring, there were two reports of prolonged recovery (167 and 270 minutes) among 28 patients administered cisatracurium besylate and 13 reports of prolonged recovery (range: 90 minutes to 33 hours) among 30 patients administered vecuronium.

Observed During Clinical Practice

In addition to adverse events reported from clinical trials, the following events have been identified during post-approval use of cisatracurium besylate in conjunction with one or more anesthetic agents in clinical practice. Because they are reported voluntarily from a population of unknown size, estimates of frequency cannot be made. These events have been chosen for inclusion due to a combination of their seriousness, frequency of reporting, or potential causal connection to cisatracurium besylate.

General

Histamine release, hypersensitivity reactions including anaphylactic or anaphylactoid reactions which in some cases have been life threatening and fatal. Because these reactions were reported voluntarily from a population of uncertain size, it is not possible to reliably estimate their frequency (see **WARNINGS** and **PRECAUTIONS**). There are rare reports of wheezing, laryngospasm, bronchospasm, rash and itching following administration of cisatracurium besylate in children. These reported adverse events were not serious and their etiology could not be established with certainty.

Musculoskeletal

Prolonged neuromuscular block, inadequate neuromuscular block, muscle weakness, and myopathy.

OVERDOSAGE

Overdosage with neuromuscular blocking agents may result in neuromuscular block beyond the time needed for surgery and anesthesia. The primary treatment is maintenance of a patent airway and controlled ventilation until recovery of normal neuromuscular function is assured. Once recovery from neuromuscular block begins, further recovery may be facilitated by administration of an anticholinesterase agent (e.g., neostigmine, edrophonium) in conjunction with an appropriate anticholinergic agent (see Antagonism of Neuromuscular Block below).

Antagonism of Neuromuscular Block

ANTAGONISTS (SUCH AS NEOSTIGMINE AND EDROPHONIUM) SHOULD NOT BE ADMINISTERED WHEN COMPLETE NEUROMUSCULAR BLOCK IS EVIDENT OR SUSPECTED. THE USE OF A PERIPHERAL NERVE STIMULATOR TO EVALUATE RECOVERY AND ANTAGONISM OF NEUROMUSCULAR BLOCK IS RECOMMENDED.

Administration of 0.04 to 0.07 mg/kg neostigmine at approximately 10% recovery from neuromuscular block (range: 0 to 15%) produced 95% recovery of the muscle twitch response and a T_4:T_1 ratio ≥ 70% in an average of 9 to 10 minutes. The times from 25% recovery of the muscle twitch response to a T_4:T_1 ratio ≥ 70% following these doses of neostigmine averaged 7 minutes. The mean 25% to 75% recovery index following reversal was 3 to 4 minutes.

Administration of 1 mg/kg edrophonium at approximately 25% recovery from neuromuscular block (range: 16% to 30%) produced 95% recovery and a T_4:T_1 ratio ≥ 70% in an average of 3 to 5 minutes.

Patients administered antagonists should be evaluated for evidence of adequate clinical recovery (e.g., 5-second head lift and grip strength). Ventilation must be supported until no longer required.

The onset of antagonism may be delayed in the presence of debilitation, cachexia, carcinomatosis, and the concomitant use of certain broad spectrum antibiotics, or anesthetic agents and other drugs which enhance neuromuscular block or separately cause respiratory depression (see **PRECAUTIONS-Drug Interactions**). Under such circumstances the management is the same as that of prolonged neuromuscular block (see **OVERDOSAGE**).

DOSAGE AND ADMINISTRATION

NOTE: CONTAINS BENZYL ALCOHOL (see WARNINGS and PRECAUTIONS – Pediatric Use)

CISATRACURIUM BESYLATE INJECTION SHOULD ONLY BE ADMINISTERED INTRAVENOUSLY.

The dosage information provided below is intended as a guide only. Doses of cisatracurium besylate injection should be individualized (see CLINICAL PHARMACOLOGY-Individualization of Dosages). The use of a peripheral nerve stimulator will permit the most advantageous use of cisatracurium besylate injection, minimize the possibility of overdosage or underdosage, and assist in the evaluation of recovery.

Adults

Initial Doses

One of two intubating doses of cisatracurium besylate injection may be chosen, based on the desired time to tracheal intubation and the anticipated length of surgery. In addition to the dose of neuromuscular blocking agent, the presence of co-induction agents (e.g., fentanyl and midazolam) and the depth of anesthesia are factors that can influence intubation conditions. Doses of 0.15 (3 × ED_{95}) and 0.20 (4 × ED_{95}) mg/kg cisatracurium besylate, as components of a propofol/nitrous oxide/oxygen induction-intubation technique, may produce generally GOOD or EXCELLENT conditions for intubation in 2 and 1.5 minutes, respectively. Similar intubation conditions may be expected when these doses of cisatracurium besylate injection are administered as components of a thiopental/nitrous oxide/oxygen induction-intubation technique. In two intubation studies using thiopental or propofol and midazolam and fentanyl as co-induction agents, EXCELLENT intubation conditions were most frequently achieved with the 0.2 mg/kg compared to 0.15 mg/kg dose of cisatracurium besylate injection. The clinically effective durations of action for 0.15 and 0.20 mg/kg cisatracurium besylate injection during propofol anesthesia are 55 minutes (range: 44 to 74 minutes) and 61 minutes (range: 41 to 81 minutes), respectively. Lower doses may result in a longer time for the development of satisfactory intubation conditions. Doses up to 8 × ED_{95} cisatracurium besylate injection have been safely administered to healthy adult patients and patients with serious cardiovascular disease. These larger doses are associated with longer clinically effective durations of action (see **CLINICAL PHARMACOLOGY**).

Because slower times to onset of complete neuromuscular block were observed in elderly patients and patients with renal dysfunction, extending the interval between administration of cisatracurium besylate injection and the intubation attempt for these patients may be required to achieve adequate intubation conditions.

A dose of 0.03 mg/kg cisatracurium besylate injection is recommended for maintenance of neuromuscular block during prolonged surgical procedures. Maintenance doses of 0.03 mg/kg each sustain neuromuscular block for approximately 20 minutes. Maintenance dosing is generally required 40 to 50 minutes following an initial dose of 0.15 mg/kg cisatracurium besylate injection and 50 to 60 minutes following an initial dose of 0.20 mg/kg cisatracurium besylate injection, but the need for maintenance doses should be determined by clinical criteria. For shorter or longer durations of action, smaller or larger maintenance doses may be administered.

Isoflurane or enflurane administered with nitrous oxide/oxygen to achieve 1.25 MAC (Minimum Alveolar Concentration) may prolong the clinically effective duration of action of initial and maintenance doses. The magnitude of these effects may depend on the duration of administration of the volatile agents. Fifteen to 30 minutes of exposure to 1.25 MAC isoflurane or enflurane had minimal effects on the duration of action of initial doses of cisatracurium besylate injection and therefore, no adjustment to the initial dose should be necessary when cisatracurium besylate injection is administered shortly after initiation of volatile agents. In long surgical procedures during enflurane or isoflurane anesthesia, less frequent maintenance dosing or lower maintenance doses of cisatracurium besylate injection may be necessary. No adjustments to the initial dose of cisatracurium besylate injection are required when used in patients receiving propofol anesthesia.

Children

Initial Doses

The recommended dose of cisatracurium besylate injection for children 2 to 12 years of age is 0.10 to 0.15 mg/kg administered over 5 to 10 seconds during either halothane or opioid anesthesia. When administered during stable opioid/nitrous oxide/oxygen anesthesia, 0.10 mg/kg cisatracurium besylate injection produces maximum neuromuscular block in an average of 2.8 minutes (range: 1.8 to 6.7 minutes) and clinically effective block for 28 minutes (range: 21 to 38 minutes). When administered during stable opioid/nitrous oxide/oxygen anesthesia, 0.15 mg/kg cisatracurium besylate produces maximum neuromuscular block in about 3 minutes (range: 1.5 to 8 minutes) and clinically effective block (time to 25% recovery) for 36 minutes (range: 29 to 46 minutes).

Infants

Initial Doses

The recommended dose of cisatracurium besylate injection for intubation of infants 1 month to 23 months is 0.15 mg/kg administered over 5 to 10 seconds during either halothane or opioid anesthesia. When administered during stable opioid/nitrous oxide/oxygen anesthesia, 0.15 mg/kg cisatracurium besylate produces maximum neuromuscular block in about 2 minutes (range: 1.3 to 3.4 minutes) and clinically effective block (time to 25% recovery) for about 43 minutes (range: 34 to 58 minutes).

Use by Continuous Infusion

Infusion in the Operating Room (OR)

After administration of an initial bolus dose of cisatracurium besylate injection, a diluted solution of cisatracurium besylate can be administered by continuous infusion to adults and children aged 2 or more years for maintenance of neuromuscular block during extended surgical procedures. Infusion of cisatracurium besylate injection should be individualized for each patient. The rate of administration should be adjusted according to the patient's response as determined by peripheral nerve stimulation. Accurate dosing is best achieved using a precision infusion device.

Infusion of cisatracurium besylate injection should be initiated only after early evidence of spontaneous recovery from the initial bolus dose. An initial infusion rate of 3 mcg/kg/min may be required to rapidly counteract the spontaneous recovery of neuromuscular function. Thereafter, a rate of 1 to 2 mcg/kg/min should be adequate to maintain continuous neuromuscular block in the range of 89% to 99% in most pediatric and adult patients under opioid/nitrous oxide/oxygen anesthesia.

Reduction of the infusion rate by up to 30% to 40% should be considered when cisatracurium besylate injection is administered during stable isoflurane or enflurane anesthesia (administered with nitrous oxide/oxygen at the 1.25 MAC level). Greater reductions in the infusion rate of cisatracurium besylate injection may be required with longer durations of administration of isoflurane or enflurane.

The rate of infusion of atracurium required to maintain adequate surgical relaxation in patients undergoing coronary artery bypass surgery with induced hypothermia (25° to 28°C) is approximately half the rate required during normothermia. Based on the structural similarity between cisatracurium besylate injection and atracurium, a similar effect on the infusion rate of cisatracurium besylate injection may be expected.

Spontaneous recovery from neuromuscular block following discontinuation of infusion of cisatracurium besylate injection may be expected to proceed at a rate comparable to that following administration of a single bolus dose.

Infusion in the Intensive Care Unit (ICU)

The principles for infusion of cisatracurium besylate injection in the OR are also applicable to use in the ICU. An infusion rate of approximately 3 mcg/kg/min (range: 0.5 to 10.2 mcg/kg/min) should provide adequate neuromuscular block in adult patients in the ICU. There may be wide interpatient variability in dosage requirements and these may increase or decrease with time (see **PRECAUTIONS *- Long-Term Use in the Intensive Care Unit (ICU)***). Following recovery from neuromuscular block, readministration of a bolus dose may be necessary to quickly re-establish neuromuscular block prior to reinstitution of the infusion.

Infusion Rate Tables

The amount of infusion solution required per minute will depend upon the concentration of cisatracurium besylate in the infusion solution, the desired dose of cisatracurium besylate, and the patient's weight. The contribution of the infusion solution to the fluid requirements of the patient also must be considered. **Tables 10 and 11** provide guidelines for delivery, in mL/hr (equivalent to microdrops/minute when 60 microdrops = 1 mL), of cisatracurium besylate solutions in concentrations of 0.1 mg/mL (10 mg/100 mL) or 0.4 mg/mL (40 mg/100 mL).

Table 10. Infusion Rates of Cisatracurium Besylate for Maintenance of Neuromuscular Block During Opioid/Nitrous Oxide/Oxygen Anesthesia for a Concentration of 0.1 mg/mL

Patient Weight (kg)	Drug Delivery Rate (mcg/kg/min): 1	1.5	2	3	5
	Infusion Delivery Rate (mL/hr)				
10	6	9	12	18	30
45	27	41	54	81	135
70	42	63	84	126	210
100	60	90	120	180	300

Table 11. Infusion Rates of Cisatracurium Besylate for Maintenance of Neuromuscular Block During Opioid/Nitrous Oxide/Oxygen Anesthesia for a Concentration of 0.4 mg/mL

Patient Weight (kg)	Drug Delivery Rate (mcg/kg/min): 1	1.5	2	3	5
	Infusion Delivery Rate (mL/hr)				
10	1.5	2.3	3	4.5	7.5
45	6.8	10.1	13.5	20.3	33.8
70	10.5	15.8	21	31.5	52.5
100	15	22.5	30	45	75

Cisatracurium Besylate Injection Compatibility and Admixtures

Y-site Administration

Cisatracurium besylate injection is acidic (pH = 3.25 to 3.65) and may not be compatible with alkaline solution having a pH greater than 8.5 (e.g., barbiturate solutions).

Studies have shown that cisatracurium besylate injection is compatible with:

- 5% Dextrose injection, USP
- 0.9% Sodium chloride injection, USP
- 5% Dextrose and 0.9% sodium chloride injection, USP
- SUFENTA® (sufentanil citrate) injection, diluted as directed
- ALFENTA® (alfentanil hydrochloride) injection, diluted as directed
- SUBLIMAZE® (fentanyl citrate) injection, diluted as directed
- VERSED® (midazolam hydrochloride) injection, diluted as directed
- Droperidol injection, diluted as directed

Cisatracurium besylate injection is not compatible with DIPRIVAN® (propofol) Injection or TORADOL® (ketorolac) Injection for Y-site administration. Studies of other parenteral products have not been conducted.

Dilution Stability

Cisatracurium besylate injection diluted in 5% Dextrose Injection, USP; 0.9% Sodium Chloride Injection, USP; or 5% Dextrose and 0.9% Sodium Chloride Injection, USP to 0.1 mg/mL may be stored either under refrigeration or at room temperature for 24 hours without significant loss of potency. Dilutions to 0.1 mg/mL or 0.2 mg/mL in 5% Dextrose and Lactated Ringer's Injection may be stored under refrigeration for 24 hours.

Cisatracurium besylate injection should not be diluted in Lactated Ringer's Injection, USP due to chemical instability.

NOTE: Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration whenever solution and container permit. Solutions which are not clear, or contain visible particulates, should not be used. Cisatracurium besylate injection is a colorless to slightly yellow or greenish-yellow solution.

HOW SUPPLIED

Cisatracurium besylate injection, 2 mg cisatracurium per mL, is supplied in the following:

NDC	Container	Size
0781-3152-95	10 mL Multiple-dose Vial	Pack of 10's

NOTE: 10 mL Multiple-dose Vials contain 0.9% w/v benzyl alcohol as a preservative (see **WARNINGS** concerning newborn infants).

Storage

Cisatracurium besylate injection should be refrigerated at 2° to 8°C (36° to 46°F) in the carton to preserve potency. Protect from light. DO NOT FREEZE. Upon removal from refrigeration to room temperature storage conditions (25°C/77°F), use Cisatracurium besylate injection within 21 days even if rerefrigerated.

To report SUSPECTED ADVERSE REACTIONS, contact Sandoz Inc. at 1-800-525-8747 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Manufactured in India by Gland Pharma Limited
for Sandoz Inc., Princeton, NJ 08540

Rev: April 2012

LEA-019405-00

Dimensions: 375 x 480 mm

PRODUCT NAME :	Cisatracurium Besylate Injection		**SUBSTRATE** :	Bible Paper
COUNTRY/CUSTOMER :	US/Sandoz		**DIMENSIONS** :	Open Dimensions: 375 x 480 ± 2 mm folded Dimensions : 92 x 60 ±2 mm
ARTWORK NO. :	LEA-019405-00		**GRAMMAGE** :	40 gsm ±10%
SUPERSEEDS ARTWORK NO.:	NIL		**VARNISHING** :	NA
MODE OF SUPPLY :	Bundles		**PANTONE SHADE NO.** :	P Black

EXHIBIT B

IN THE SUPREME COURT OF THE STATE OF NEVADA

STATE OF NEVADA; NEVADA DEPARTMENT OF CORRECTIONS; JAMES DZURENDA, Director of the Nevada Department of Corrections, in his official capacity; IHSAN AZZAM, Ph.D., M.D., Chief Medical Officer of the State of Nevada, in his official capacity; and JOHN DOE, Attending Physician at Planned Execution of Scott Raymond Dozier in his official capacity, Petitioners, v. THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNT OF CLARK; AND THE HONORABLE ELIZABETH GONZALEZ, DISTRICT COURT JUDGE , Respondents. and ALVOGEN, INC.; and HIKMA PHARMACEUTICALS USA INC., Real Parties in Interest.	Supreme Court Case No: 76485 District Court No: A-18-777312-B

AMICUS CURIAE BRIEF OF SANDOZ INC. IN SUPPORT OF REAL PARTIES IN INTEREST'S OPPOSITION TO PETITIONERS' EMERGENCY MOTION UNDER NRAP 27(E) TO STAY DISTRICT COURT PROCEEDINGS PENDING THIS COURT'S DECISION ON THE PETITION

J. COLBY WILLIAMS, ESQ.
Nevada Bar No. 5549
jcw@cwlawlv.com
PHILIP R. ERWIN, ESQ.
Nevada Bar No. 11563
pre@cwlawlv.com
CAMPBELL & WILLIAMS
700 South Seventh Street
Las Vegas, NV 89101
Telephone: 702.382.5222

Attorneys for *Amicus Curiae Sandoz Inc.*

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STATEMENT OF *AMICUS CURIAE*

Sandoz Inc. ("Sandoz") submits this *amicus curiae* brief in support of Respondents' Opposition to Petitioners' Emergency Motion under NRAP 27(e) to Stay District Court Proceedings Pending This Court's Decision on the Petition. Sandoz is a Colorado corporation with corporate offices located at 100 College Road West, Princeton, New Jersey. Sandoz contributes to society's ability to support growing healthcare needs by pioneering novel approaches to help people around the world access high-quality medicine.

Like Real Parties in Interest Alvogen, Inc. ("Alvogen") and Hikma Pharmaceuticals USA Inc. ("Hikma"), Sandoz has a long-standing, publicly-stated opposition to the misuse of its products in capital punishment. Sandoz strongly objects to the unauthorized and wrongful use of its drugs as part of the State of Nevada's ("the State's") execution protocol. Allowing the State to proceed with its plan to use one of Sandoz's drugs to execute Scott Dozier by lethal injection will work a significant and irreparable harm to its reputation and cause substantial injury resulting from, among other things, damage to business and investor relationships and damage to goodwill.

Sandoz has a unique interest in the outcome of this proceeding because it will impact Sandoz's pending Motion to Intervene in the District Court action. Sandoz only recently learned that the State obtained one of its drugs, a

muscle relaxant known as Cisatracurium, and identified it as one planned for use in the execution of Scott Dozier. Sandoz promptly moved to intervene before Petitioners filed their Emergency Motion with this Court. If a stay is granted, Sandoz, despite being a manufacturer of a drug in the State's lethal injection protocol, would not be a party to the underlying action, even though (i) the outcome could directly affect the usage of its product in Scott Dozier's execution, and (ii) Petitioners have identified the expiration date of Cisatracurium as a primary reason for granting their stay request.

STATEMENT OF THE CASE AND FACTS

Among its products in the United States, Sandoz manufactures and distributes Cisatracurium Besylate Injection (Abbreviated New Drug Application number 200154) ("Sandoz's Cisatracurium"). Cisatracurium is one of three drugs, along with Midazolam and Fentanyl, that make up the State's current execution protocol, which the State plans to use to execute Scott Dozier by lethal injection. The manufacturer of Midazolam, Alvogen, filed this action in Clark County District Court against Petitioners on July 10, 2018, alleging various statutory and common law claims and seeking an injunction enjoining Petitioners from using Alvogen's products to perform executions. Hikma, a manufacturer of Fentanyl, moved to intervene in that action on July 25, 2018, after learning Petitioners intended to use its Fentanyl in Mr. Dozier's execution. That motion was granted

on July 31, 2018, and on August 8, 2018, this Court similarly granted Hikma's motion to appear as a real party in interest in this writ proceeding. (*See* Order Granting Mot. to Appear at 2).

Sandoz's products, like Alvogen's and Hikma's, have been obtained by the Nevada Department of Corrections ("NDOC") for a non-approved purpose in circumvention of Sandoz's longstanding and public objection to the use of its products for capital punishment. The State knew such acquisitions were illegitimate, as evidenced by its efforts to conceal its actions even when faced with public requests for disclosure. It took a lawsuit by the ACLU and an order by First Judicial District Judge Wilson on July 6, 2018 to force the State to disclose the drugs it intended to use in Dozier's execution. (App. Vol. I, 186). With that disclosure, Sandoz was informed of the State's improper purchases and promptly sought relief.

To protect its interests, on August 3, 2018, Sandoz submitted a Motion to Intervene on Order Shortening Time in the District Court action before Judge Elizabeth Gonzalez, asserting many of the same causes of action brought by Alvogen and Hikma, but with respect to its drug, Cisatracurium. *See* Motion for Leave, Exhibit A (Sandoz Inc.'s Motion to Intervene). An argument on Sandoz's motion was scheduled to take place on August 9, 2018, but on August 8, 2018, this Court granted a temporary stay of proceedings in response to the States'

Emergency Motion to Stay Proceedings, preventing the District Court from making a decision on Sandoz's pending motion.

Earlier, the District Court heard extensive arguments on July 11, 2018, and entered a TRO prohibiting the State from using ***Alvogen's Midazolam*** pending further order. (App. Vol. II, 429-31) (emphasis added). The District Court has not yet had the chance to consider any injunctive relief to prohibit the State from using Sandoz's Cisatracurium. The District Court explicitly did not prohibit or stay Dozier's execution: "the determination that I'm making today and the issues that have been presented to the Court are not an issue of a stay of execution. The issue presented here is the plaintiff's right to decide not to do business with someone, including the government, especially if there's a fear of misuse of their product." (App. Vol. II, 414:17-22).

The District Court also refused to treat the TRO as a preliminary injunction, noting the different standard and need to hold an evidentiary hearing. (App. Vol. II, 417:9-12). When the District Court sought to set the preliminary injunction hearing, a hearing in which Sandoz hoped to participate, the State requested that the District Court delay that hearing in favor of discovery. (App. Vol. II, 423:14-18). Indeed, the State demanded "substantial" discovery (App. Vol. II, 417:18-25, 418:15-25), prompting the District Court to allow 120 days of discovery. (App. Vol. II. 419:4-5). While the District Court was willing to hold

the preliminary injunction hearing on an expedited basis (App. Vol. II, 419:24-25), the State opposed doing so, citing its discovery. (App. Vol. II, 421:16-21).

Now the State has reversed course before this Court, asserting that "there is a serious risk that one or more drugs in the State's lethal injection protocol will expire before this Court has the opportunity to issue a decision. If a ruling comes too late, the State may lose its ability to carry out Scott Raymond Dozier's capital sentence – as happened when drugs expired during the prior related writ proceedings." (Mot. to Expedite at 1). The State insists that it needs resolution well before November 30, 2018 because a batch of Cisatracurium would allegedly expire, meaning that "if the Court does not issue a ruling in time to use this November batch, the State will lose its ability to carry out an execution." (Mot. to Expedite at 1).

ARGUMENT

I. Sandoz will be uniquely prejudiced if this Court stays proceedings pending its decision on the State's Petition.

Sandoz submits this brief to highlight the impact that a stay of proceedings would have on its intervention motion pending before the District Court and its corresponding ability to protect its rights.

A stay would effectively prevent Sandoz from intervening in the District Court action, which has direct implications for its interests. Sandoz seeks to assert its right to refuse business with those that would misuse its products.

There is a long-recognized right to "'freely [] exercise [one's] own independent discretion as to parties with whom he will deal.'" *Image Tech. Servs. v. Eastman Kodak Co.*, 125 F.3d 1195, 1211 (9th Cir. 2007) (quoting *Aspen Highlands Skiing Corp. v. Aspen Skiing Co.*, 738 F.2d 1509, 1517-23 (10th Cir. 1984)); *see also United States v. Colgate & Co.*, 250 U.S. 300, 307 (1919). Sandoz also has an interest in the protection of its reputation and goodwill.

Given these significant protectable interests, there should be "little difficulty concluding that the disposition of th[e] case may, as a practical matter, affect [Sandoz]." *California ex rel. Lockyer v. United States*, 450 F.3d 436, 442 (9th Cir. 2006). Unless Sandoz is able to intervene, it will have no voice as a party to this litigation, including the proceedings before this Court. Sandoz's voice is critical to a just and efficient resolution of this matter. Neither Alvogen nor Hikma has any reason (or standing) to represent Sandoz's interests in this matter, and there is no TRO in place with respect to Sandoz's Cisatracurium. Accordingly, Sandoz's presence would "add some necessary element to the proceedings which would not be covered by the parties in the suit." *Blake v. Pallan*, 554 F.2d 947, 955 (9th Cir. 1977).

In fact, Petitioners identify the looming expiration date of Cisatracurium as a primary reason for granting their emergency motion. (*See* Mot. to Expedite at 1-2). Staying all District Court proceedings will prevent Sandoz

from intervening to protect its rights, and is particularly prejudicial given that Cisatracurium is what the State has argued demands immediate court attention. A stay of the District Court proceedings would allow the State to accelerate a decision with regard to Alvogen's and Hikma's claims and the State's ability to carry out an execution, while preventing Sandoz from protecting its rights with respect to its Cisatracurium in the same timeframe.

II. Staying all District Court proceedings would be an inefficient use of judicial resources.

A stay of all District Court proceedings, preventing Sandoz from intervening in the action, also undermines the efficient use of judicial resources to resolve essentially identical claims of all interested parties in one proceeding. *See, e.g.*, *Lockwood v. Langendorf United Bakeries, Inc.*, 324 F.2d 82, 93 (9th Cir. 1963) (acknowledging it is "sensible and efficient judicial administration to permit inclusion in the litigation" of similar questions presented). While Sandoz also has unique interests, Sandoz's claims arise from the same factual basis as the claims of Alvogen and Hikma, and are based on largely the same legal issues and theories of liability. If Sandoz cannot intervene in the District Court action as a result of a stay in proceedings, Sandoz would need to pursue a separate action, which would be judicially inefficient given the substantial overlap in the claims of Sandoz, Alvogen and Hikma.

III. Sandoz joins in Alvogen's Argument and Countermotion.

Amicus defers to and adopts the Argument and Countermotion to Dismiss the Writ Petition in Alvogen's Opposition to Emergency Motion Under NRAP 27(e) to Stay District Court Proceedings Pending This Court's Decision on the Petition.

CONCLUSION

For the reasons set forth above, *amicus curiae*, respectfully requests that the Court deny Petitioners' Emergency Motion.

DATED this 13th day of August, 2018.

Respectfully submitted,

By: */s/ J. Colby Williams*
J. Colby Williams, Esq. (5549)
Philip R. Erwin, Esq. (11563)
700 South Seventh Street
Las Vegas, NV 89101

Attorneys for *Amicus Curiae*
Sandoz Inc.

CERTIFICATE OF COMPLIANCE

I, J. Colby Williams, hereby certify that I have read this *Amicus curiae* brief, and to the best of my knowledge and information, and belief, it is not frivolous or interposed for any improper purpose. I hereby certify that this brief complies with the formatting requirements of NRAP 32(a)(4), the typeface requirements of NRAP 32(a)(5) and the type style requirements of NRAP 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word in size 14 font in double-spaced Times New Roman and contains 2414. I further certify that I have read this brief and that it complies with NRAP 21.

I further certify that this brief complies with all applicable Nevada Rules of Appellate Procedure, in particular NRAP 28(e), which requires every assertion in the brief regarding matters in the record to be supported by a reference to the page of the transcript or appendix where the matter relied on is to be found. I understand that I may be subject to sanctions in the event that the accompanying brief is not in conformity with the requirements of the Nevada Rules of Appellate Procedure.

Dated this 13th day of August, 2018

By: */s/ J. Colby Williams*
J. Colby Williams, Esq. (5549)
CAMPBELL & WILLIAMS