UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS
BOSTON DIVISION

THE UNITED STATES OF AMERICA, THE STATE OF CALIFORNIA , THE DISTRICT OF COLUMBIA, THE STATE OF FLORIDA, THE STATE OF HAWAII, THE STATE OF ILLINOIS, THE STATE OF LOUISIANA, THE COMMONWEALTH OF MASSACHUSETTS, THE STATE OF NEVADA, THE STATE OF TENNESSEE, THE STATE OF TEXAS, THE COMMONWEALTH OF VIRGINIA, THE STATE OF GEORGIA, THE STATE OF INDIANA, THE STATE OF MICHIGAN, THE STATE OF NEW HAMPSHIRE, THE STATE OF NEW JERSEY, THE STATE OF NEW MEXICO , THE STATE OF NEW YORK, THE STATE OF OKLAHOMA, THE STATE OF RHODE ISLAND, and THE STATE OF WISCONSIN, ex rel. CHRISTOPHER R. GOBBLE, Plaintiffs, v. FOREST LABORATORIES, INC.; FOREST PHARMACEUTICALS, INC.; Defendants.	**CIVIL ACTION NO. 03-10395 NMG**

FOURTH AMENDMENT TO COMPLAINT BY RESTATEMENT

COMES NOW, CHRISTOPHER R. GOBBLE, Plaintiff in the above-styled action, by and through his counsel of record, Wilbanks & Bridges LLP, Philip S. Marstiller, PC, and Suzanne E. Durrell, and states that this is an action brought on behalf of the United States of America by CHRISTOPHER R. GOBBLE [hereinafter referred to as "Relator"] against FOREST LABORATORIES, INC. [hereinafter referred to as “FLI”], FOREST PHARMACEUTICALS, INC. [hereinafter referred to as “FPI”], [hereinafter sometimes collectively referred to as "Defendants"]

pursuant to the *Qui Tam* provisions of the Federal Civil False Claims Act, 31 U.S.C. §§ 3729-33 ("Federal FCA" or "FCA"), and on behalf of the above named states under their respective State False Claims Acts ("State FCAs") (together referred to herein as "*Qui Tam* Action"). Pursuant to 31 U.S.C. § 3730 (b)(2), and comparable provisions in State FCAs, this action was initially brought in camera and under seal. On behalf of himself, Relator is also bringing an action stemming from his retaliatory firing pursuant to 31 U.S.C. sec. 3730(h).

JURISDICTION AND VENUE

1.

This Court has jurisdiction over this action under the Federal FCA pursuant to 28 U.S.C. § 1331 and 1345, and 31 U.S.C. §§ 3732(a) and 3730, and has supplemental jurisdiction over the State FCA claims pursuant to 28 U.S.C. sec. 1367.

2.

Venue is appropriate as to each Defendant in that one or more of Defendants can be found in, resides in, and/or transacts business in this judicial district. Additionally, acts proscribed by 31 U.S.C. § 3729 have been committed by one or more of the Defendants in this judicial district. Therefore, within the meaning of 28 U.S.C. § 1391(b) and (c) and 31 U.S.C. § 3732(a), venue is proper.

THE PARTIES

3.

Plaintiff Christopher Gobble is a citizen of the United States of America. He is a resident of Glenn Allen, Virginia 23060. He brings this *Qui Tam* action based upon direct and unique information obtained during the period of his employment as a sales representative with Defendant FPI. As characterized by the Federal False Claims Act, Plaintiff will be referred to as "Relator"

hereafter. Christopher Gobble is the original source of all information contained herein and in the Complaint and has provided this information and a "Relator's disclosure statement" to the United States government prior to filing of the Complaint. The United States of America has intervened in this *Qui Tam* action and filed its own Complaint in Intervention, which allegations are adopted by Relator and incorporated herein as if fully set out.

4.

Defendant Forest Laboratories, Inc. is a Delaware corporation with its principal place of business located at 909 Third Avenue, New York, New York 10022, and with its registered agent located at that same address. Defendant Forest Laboratories, Inc. maintains an office in the Commonwealth of Massachusetts and does business in every state within the United States.

5.

Defendant Forest Pharmaceuticals, Inc. is a wholly owned subsidiary of Defendant Forest Laboratories, Inc. and is a Delaware corporation with its principal offices located at 13600 Shoreline Drive, St. Louis, Missouri 63045, and with its registered agent, United States Corporation Company, located at 221 Bolivar Street, Jefferson City, Missouri 65101. Defendant Forest Pharmaceuticals, Inc. is the marketing and sales arm of Defendant Forest Laboratories, Inc.

THE LAW

6.

The Medicare Program, Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq*., (hereinafter "Medicare") is a Health Insurance Program administered by the Government of the United States that is funded by taxpayer revenue. The program is overseen by the United States Department of Health and Human Services through the Centers for Medicare and Medicaid Services ("CMS"). Medicare was designed to be a health insurance program and to provide for

the payment of hospital services, medical services and durable medical equipment to persons over sixty-five (65) years of age and others that qualify under the terms and conditions of the Medicare Program. Payments made under the Medicare Program include payment for certain prescription drugs; among those drugs are the drugs at issue in this case, Celexa and Lexapro. Reimbursement for Medicare claims is made by the United States through CMS which contracts with private insurance carriers to administer and pay claims from the Medicare Trust Fund. 42 U.S.C. § 1395u. In this capacity, the carriers act on behalf of CMS.

7.

The Medicaid Program, Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v (hereafter "Medicaid"), is a Health Insurance Program administered by the Government of the United States and the various individual States and is funded by State and Federal taxpayer revenue. The Medicaid Program is overseen by the United States Department of Health and Human Services through CMS. The States directly pay providers, with the States obtaining the federal share of the payment from accounts which draw on the United States Treasury. 42 C.F.R. §§ 430.0-430.30 (1994). Medicaid was designed to assist participating states in providing medical services, durable medical equipment and prescription drugs to financially needy individuals that qualify for Medicaid; among those drugs are the drugs at issue in this case, Celexa and Lexapro.

8.

The Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS") (now known as "TRICARE"), 10 U.S.C. §§ 1071-1106, provides benefits for health care services furnished by civilian providers, physicians, and suppliers to members of the Uniformed Services and to spouses and children of active duty, retired and deceased members. The program

is administered by the Department of Defense and funded by the Federal Government. CHAMPUS pays for, among other items and services, prescription drugs for its beneficiaries; among those drugs are the drugs at issue in this case, Celexa and Lexapro.

9.

The federal government, through its Departments of Defense and Veterans Affairs, also maintains and operates medical facilities including hospitals, and receives and uses federal funds from prescription drugs for patients treated at such facilities and otherwise; among those drugs are the drugs at issue in this case, Celexa and Lexapro. In addition, under the Public Health Service Act, the Section 340B Drug Pricing Program, and the Veterans Health Care Act of 1992, the federal government directly or indirectly provides funds to certain other federal agencies and to state and local facilities and programs, including to non-profit disproportionate share hospitals ("DSH"). See generally 38 U.S.C. § 8126.

10.

The Federal Employees Health Benefits Program ("FEHBP") provides health care benefits for qualified federal employees and their dependents. It pays for, among other items and services, prescription drugs for its beneficiaries; among those drugs are the drugs at issue in this case, Celexa and Lexapro. (Together these programs described in paragraphs 6-10 shall be referred to as "Federal Health Care Programs" or "Government Health Care Programs").

11.

The Federal FCA, 31 U.S.C. § 3729(a)(1)(A) makes "knowingly" presenting or causing to be presented to the United States any false or fraudulent claim for payment or approval a violation of federal law for which the United States may recover three times the amount of the damages the

government sustains and a civil monetary penalty of between $5,000 and $10,000 per claim ($5,500 and $11,000 for claims made on or after September 29, 1999).

12.

The Federal FCA, 31 U.S.C. § 3729(a)(1)(B) makes "knowingly" making, using, or causing to be used or made a false record or statement material to a false or fraudulent claim paid or approved by the Government a violation of federal law for which the United States may recover three times the amount of the damages the Government sustains and a civil monetary penalty of between $5,000 and $10,000 per claim ($5,500 and $11,000 for claims made on or after September 29, 1999).

13.

The Federal FCA, 31 U.S.C. §. 3729(a)(1)(C) makes any person who conspires to commit a violation of the FCA liable for three times the amount of the damages the Government sustains and a civil monetary penalty of between $5,000 and $10,000 per claim ($5,500 and $11,000 for claims made on or after September 29, 1999).

14.

The Federal FCA, 31 U.S.C. § 3729(a)(1)(G) makes any person who "knowingly" makes, uses or causes to be made or used a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, liable for three times the amount of the damages the Government sustains and a civil monetary penalty of between $5,000 and $10,000 per claim ($5,500 and $11,000 for claims made on or after September 29, 1999).

15.

The Federal FCA defines a "claim" to include any request or demand, whether under contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested. 31 U.S.C. § 3729(b)(2).

16.

The Medicare and Medicaid Patient Protection Act, also known as the Anti-Kickback Act, 42 U.S.C. § 1320a-7b(b) ("AKA"), arose out of congressional concern that the remuneration and gifts given to those who can influence health care decisions corrupts medical decision-making and could result in the provision of goods and services that are more expensive and/or medically unnecessary or even harmful to a vulnerable patient population. To protect the integrity of the federal health care programs, Congress enacted a prohibition against the payment of kickbacks in any form. The AKA was enacted in 1972 "to provide penalties for certain practices which have long been regarded by professional organizations as unethical, as well as unlawful . . . and which contribute appreciably to the cost of the Medicare and Medicaid programs." H.R. Rep. No. 92-231, 92d Cong., 1st Sess. 108 (1971), reprinted in 1972 U.S.C.C.A.N. 4989, 5093.

17.

The AKA, 42 U.S.C. §1320a-7b (b), makes it illegal to offer, receive, or solicit any renumeration, kickback, bribe, or rebate, whether directly or indirectly, overtly or covertly, in cash or in kind, to or from any person in order to induce such person to purchase, lease, or order, or to arrange for or recommend the purchasing, leasing, or ordering of any good, service, or item

for which payment may be made in whole or in part under a Federal Health Care Program. The AKA seeks to prohibit such activities in order to secure proper medical treatment and referrals, and to limit the possibility of a patient having to undergo unnecessary treatments or having to accept specific items or services which are based not on the needs of the patient but on the incentives given to others, thereby limiting the patient's right to choose proper medical care and services.

18.

The AKA was strengthened by amendments in 1977 and 1987 which, *inter alia*, increased the criminal penalties from a misdemeanor to a felony and subjected the perpetrator to exclusion from participation in federal health care programs (42 U.S.C. § 1320a-7(b)(7)), civil monetary penalties of $50,000 per violation (42 U.S.C. § 1320a-7a(a)(7)), and three times the amount of remuneration paid, regardless of whether any part of the remuneration is for a legitimate purpose. 42 U.S.C. § 1320a-7a(a).

19.

Concern about improper drug marketing practices prompted the Inspector General of the Department of Health and Human Services to issue a Special Fraud Alert in 1994 concerning prescription drug marketing practices that violated the AKA. *See* Special Fraud Alert: Prescription Drug Marketing Schemes, 59 Fed. Reg. 65,376 (Dec. 29, 1994); see also Fed. Reg. Dec. 19, 2004. Then, on June 11, 2001, the OIG published a solicitation notice seeking information and recommendations for developing compliance program guidance for the pharmaceutical industry. 66 Fed. Reg. 31,246 (June 11, 2001). The OIG's resulting draft guidance was published for notice and comment in October 2002, see 67 Fed. Reg. 62,057 (October 3, 2002), and in May 2003, the Inspector General of HHS published further guidance

on marketing practices which may constitute kickbacks known as the "OIG Compliance Program Guidance for Pharmaceutical Manufacturers," 68 Fed. Reg. 23731 (May 5, 2003) (the "OIG Guidelines").

20.

Compliance with the AKA is a precondition to participation as a health care provider under a Government Health Care Program, including Medicare and the state Medicaid programs. Moreover, compliance with the AKA is a *condition of payment* for drug claims administered by physicians for which Medicare or Medicaid reimbursement is sought. Reimbursement practices under all Government Health Care Programs closely align with the rules and regulations governing Medicare reimbursement. Each of the Government Health Care Programs requires every provider who seeks payment from the program to promise and ensure compliance with the provisions of the AKA and with other federal laws governing the provision of health care services in the United States. In other words, if a provider tells CMS or its agent that it provided services in violation of the AKA (or another relevant law including off label indications), CMS will not pay the claim.

21.

For example, physicians and hospitals enter into Provider Agreements with CMS in order to establish their eligibility to seek reimbursement from the Medicare Program. As part of that agreement, without which the hospitals and physicians may not seek reimbursement from Federal Health Care Programs, the provider must sign the following certification:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to [me]. The Medicare laws, regulations, and program instructions are available through the [Medicare] contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the

> [provider's] compliance with all applicable conditions of participation in Medicare.

Form CMS-855A; Form CMS-8551 (effective 2001). In addition, the claims themselves as submitted contain a similar certification. See, e.g., Form CMS-1500.

22.

When a provider submits a claim for payment, he or she does so subject to and under the terms of its certification to the United States that the services for which payment is sought were delivered in accordance with federal law, to include without limitation the AKA. In the case of Medicaid, each State's Medicaid Program's applicable certifications also incorporate relevant state law.

23.

To be properly reimbursable by a Government Health Care Program, a prescription drug must also meet certain other requirements involving whether the drug is prescribed for an "on label" versus an "off-label" use or indication. The Federal Food, Drug and Cosmetic Act ("FFDCA"), 21 U.S.C. §§ 301, *et seq.*, prohibits the distribution of new pharmaceutical drugs in interstate commerce unless the Food and Drug Administration ("FDA") has determined that the drug is safe and effective for its intended use. 21 U.S.C. § 355 (a) and (d). An approved drug may be prescribed by doctors for uses other than those approved by the FDA, but manufacturers are prohibited from marketing or promoting the drug for such unapproved or "off-label" uses. 21 U.S.C. § 331(d). If the manufacturer intends to promote the drug for a new unapproved use, an application for the proposed new use must be filed with the FDA (or an exemption therefrom must be obtained) and any promotional materials concerning unapproved uses must meet strict statutory and regulatory requirements. See 21 U.S.C. §§ 360aaa, *et seq*.

24.

Whether a drug is FDA-approved for a particular use determines whether a prescription of the drug is reimbursed under many, if not all, Government Health Insurance Programs, including Medicaid and the programs described above. Reimbursement under Medicaid and these other programs is, in most circumstances, available only for "covered outpatient drugs." 42 U.S.C. §1396b(i)(10). Covered outpatient drugs do not include drugs that are "used for a medical indication which is not a medically accepted indication." *Id.* §1396r-8(k)(3). A medically accepted indication includes a use "which is approved under the Federal Food Drug and Cosmetic Act" or which is included in a specified drug compendia. *Id.* §1396r-8(k)(6). Thus, unless a particular off-label use for a drug is included in one of the identified drug compendia, a prescription for the off-label use of that drug is not eligible for reimbursement under Medicaid. There is a single exception: in certain circumstances Medicaid will reimburse the prescription of certain single-source or multi-source innovator drugs for an "off-label" use where the individual State has determined, *inter alia*, that the drug is essential to the health of beneficiaries. 42 U.S.C. §1396r8(a)(3).

25.

The FFDCA provides criminal penalties for the dissemination of written information to health care providers regarding the safety, effectiveness, or benefit of the use of a drug that is not described in the FDA approved labeling of the drug (i.e. that is "off-label"), if that written information fails to conform to the law's requirements. 21 U.S.C. §§ 331(z), 333(a)(1)-(2), 360aaa. A manufacturer may disseminate information on a new use of a drug only if it meets the specific requirements set forth in 21 U.S.C. § 360aaa.

26.

As set forth below, several states have passed False Claims Act legislation, which in most instances closely tracks the Federal FCA: California False Claims Act, Cal. Gov't Code § 12650 *et seq.*, Delaware False Claims and Reporting Act, Del. Code Ann. Tit. 6, § 1201 *et seq.*, District of Columbia Procurement Reform Amendment Act, D.C. Code § 2-308.13 *et seq.*, Florida False Claims Act, Fla. Stat. § 68.081 *et seq.*, Hawaii False Claims Act, Haw. Rev. Stat. § 661-21 *et seq.*, Illinois Whistleblower Reward and Protection Act, 740 Ill. Comp. Stat. § 175/1 *et seq.*, Louisiana Medical Assistance Programs Integrity Law, 46 La. Rev. Stat. c. 3, sec. 437.1 *et seq*., Massachusetts False Claims Act, Mass. Gen. Laws Ch. 12, § 5A *et seq.*, Nevada False Claims Act, Nev. Rev. Stat. § 357.040 *et seq.*, Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-181 *et seq.*, Texas Medicaid Fraud Prevention Law, Tex. Hum. Res. Code Chapter 32, § 36.002 *et seq.*, Virginia Fraud Against Taxpayers Act, Va. Code Ann. § 8.01-216.1 *et seq.* , Ga. Code Anno. 49-4-168 et. seq.; Indiana, IC 5-11-5.5; Michigan Medicare False Claims Act, MI ST Ch. 400, 400.602 et. seq.; New Hampshire False Claims Act, N.H. RSA §§ 167:61-b et. seq.; New Jersey False Claims Act, Sec. 2A:32C-1 et. seq.; New Mexico "Fraud Against Taxpayers Act," N.M. LEGIS 49 (2004 AND 2007) Chap. 4; New York State False Claims Act, 2007 New York Laws 58, Sec. 39, Article XIII, Sec. 189(a) et seq.; Oklahoma Medicaid False Claims Act, 2007 OK. ALS 137; Rhode Island False Claims Act, Sec. 9-1.1-1 et. seq.; Wisconsin False Claims for Medical Assistance Act, Chapter 20, Subchapter 91, 20.931. These State False Claims Acts apply to the state portion of Medicaid fraud losses caused by false Medicaid claims to the jointly federal-state funded Medicaid program. Each of the statutes listed above contains *qui tam* provisions governing a relator's right to claim a share of the State's recovery.

27.

Many States also have anti-kickback laws similar to the AKA, which apply to medical providers and entities participating in their Medicaid programs. E.g., California, Cal. Welf. & Inst. Code § 14107.2; Delaware, Del. Code. Ann. Tit. 31, § 1005; Florida, Fla. Stat. § 409.920(2)(a)(5); Illinois, 305 Ill. Comp. Stat. 5/8A; Louisiana, La. Rev. Stat. Ann. § 46:438.2; Massachusetts, Mass. Gen. Laws ch. 118E, § 41; Michigan, Mich. Comp. Laws § 400.604; New Hampshire, N.H. Rev. Stat. Ann. § 167.61; New York, N.Y. Soc. Serv. Law § 366-d; and Virginia, Va. Code Ann. § 32.1-315.

28.

Furthermore, the Federal FCA, 31 U.S.C. § 3730(h), provides relief to employees who have been retaliated against in their employment because of lawful acts done by the employee in furtherance of efforts to stop one or more violations of the FCA. Such retaliation may include discharge, demotion, suspension, threats, harassment or any other type of discrimination in the terms and conditions of employment. The employee is entitled to all relief necessary to make that employee whole, including reinstatement, two times back pay, interest on the back pay, and compensation for any special damages, including litigation costs and reasonable attorney's fees.

29.

The Defendants in this case have violated the Federal and State FCAs and the AKA and the FFDCA by engaging in the following alleged conduct from at least 1998 to the present, involving the marketing, selling, prescribing, pricing, and billing of Celexa and Lexapro, which drugs Defendants knew were paid for by Federal Health Care Programs, and which drugs Defendants Forest expected the other Defendants and numerous unnamed other persons around the United States to prescribe and administer to their patients and thereafter illegally bill or cause to be billed to

Federal Health Care Programs. .Defendants' schemes, included, but are not limited to, the following actions, all of which violate the Federal and State FCAs and the AKA:

(a) Conspiring to create unlawful incentives to provide in exchange for patient referral and prescription business;

(b) Conspiring with others to solicit and accept kickbacks in exchange for patient referrals and prescription business;

(c) Paying money and providing gifts to physicians for the purpose of inducing physicians to prescribe medications manufactured and sold by FLI and FPI;

(d) Accepting and receiving money paid from FLI and FPI to physicians in exchange for prescribing medications manufactured and sold by FLI and FPI;

(e) Conspiring to make and use false records and statements to get false claims paid by the Government;

(f) Conspiring to defraud the Government by getting false or fraudulent claims allowed or paid by the Government in furtherance of the object of the conspiracy, which was to promote the sales of drugs by FLI and FPI in exchange for cash payments to the physicians involved;

(g) Knowingly making and using a false record or statement to conceal, avoid or decrease obligations to pay or transmit money or property to the Government;

(h) Conspiracy to pay money to physicians and non-physicians in order to seek assistance from the person(s) receiving the kickbacks and/or gifts in influencing other physicians to prescribe medications manufactured and sold by FPI and FLI;

(i) Conspiracy through kickbacks and gifts to influence physicians to prescribe FLI and FPI produces, even though said products were less effective and more expensive than other competing drugs; and

(j) Illegal off-label marketing of Celexa and Lexapro; and

(k) Retaliating against Relator and other unlawful activities as described herein in this amended Complaint.

FACTS AND ALLEGATIONS

30.

FLI manufactures a drug known as Celexa (citalopram HBr). FPI sells and markets Celexa. Celexa is a prescription antidepressant drug that was first launched in the United States in 1998. Celexa's principal competing drugs are Effexor, Zoloft, Paxil and Prozac (now referred to as fluoxetine, which is the generic version of Prozac).

31.

FLI and its subsidiaries such as FPI have not entered into a national television or print media advertising campaign for Celexa. This is in direct contrast to many, if not all, of the competing antidepressant drug manufacturers. Even though FLI and FPI [hereinafter collectively referred to as "Defendant Forest" where appropriate] do not advertise to consumers for Celexa and its product costs more than other competitors while performing at or below the effectiveness of said competitors, Defendant Forest captured over 10% of this highly competitive market in its first year, making it one of the most prescribed drugs ever for a first year. Medicaid alone spends over $700,000,000 per year on antidepressant medications. Medicaid payments for Celexa alone should exceed $250,000,000 for the period of 1998-2002.

32.

FPI markets and sells Celexa and other FPI drugs in nine (9) regions across the United States. There are seven (7) divisions within each region. There are at least ten (10) sales representatives within each division. Over 1,500 sales representatives (each armed with budgets exceeding $240,000 per year per representative) are trained to aggressively sell FPI products in order to gain market share and revenues.

33.

Celexa went from sales of approximately $92 million in 1999 to sales of over $1 billion in 2002. This increase was due in large part to the illegal incentives provided to physicians in order to induce prescriptions of the Defendant Forest drugs. Physicians with hospital based practices, as well as independent physicians were targeted by FPI for the incentives, gifts and kickbacks set forth hereafter.

34.

Over 6,000,000 patients have been prescribed Celexa in the United States since 1998. It has been heavily prescribed for elderly populations.

35.

The patent protections on Celexa expire in July 2003 (for pediatric medicine) and January 2004 (for other prescriptions). Therefore, there was a push by Defendant Forest from the outset in 1998 to sell as much Celexa as quickly as possible. This emphasis on gaining market share for Celexa was implemented by FPI, although Celexa at low doses is not as beneficial as the competitor drugs. Clinical efficacy trails indicate no response to major depression at 10 mg. and 20 mg. doses. Efficacy is only seen at 40 mg. and it is only slightly better at 60 mg. 40 mg. of Celexa sells at the CVS pharmacies in Richmond for $88.99 for a 30 day supply. Generic Prozac (fluoxetine) at 20 mg.

sells for $63.99 for a 30 day supply. Therefore, Celexa's cost is 28% higher than the cost of flouxetine, which is a leading competitor drug. Similarly, Lexapro is more expensive than equally, if not more effective, competing drugs. Additionally, Celexa has only one indication – depression treatment, while Lexapro which was first approved for the treatment of major depressive disorder in adults in August 2002, was also approved in December 2003, for the treatment of generalized anxiety disorder in adults . Flouxetine has multiple indications for common diseases such as anxiety disorders, social phobia and post traumatic stress disorder. In order to compete, Defendants, among other things, marketed, promoted, caused the prescribing of, and prescribed Celexa and Lexapro for non approved, non indicated uses or purposes including, without limitation, pediatric and adolescent depression and anxiety, obsessive compulsive disorder, post traumatic stress syndrome, adult anxiety, panic disorder, phobia, and premenstrual syndrome.

36.

The same marketing pressures and schemes now exist within Defendant Forest to induce physicians to prescribe Lexapro (escitalopram). Lexapro has patent protection through 2009. Forest will lose more than $1 billion per year in sales if they cannot replace Celexa market losses with Lexapro market gains. Lexapro gained FDA approval and was launched in September 2002. However, prior to said time, FPI asked its sales representatives to push Celexa prescriptions to pave the way for Lexapro sales. Relator was told by his Divisional Manager at a divisional meeting in April, 2002 that it was an "easy switch" for physicians to move patients from Celexa to Lexapro.

37.

Beginning in October, 2001, Relator was employed by FPI as a sales representative for the Virginia, West Virginia, Pennsylvania and Ohio region. Relator was trained by FPI. Training was a three-part process. Phase I was general training in his region with his regional support group. Phase

II was in Commack, New York, where Relator and other sales representatives from across the country came for four (4) weeks for sales training. It was while Relator was in New York that he first learned of many of the strategies used nationwide to increase sales of their products. In the final phase of training, Relator and other sales representatives from around the country were paired with more experienced sales representatives in their respective markets, and they were advised to follow the practices of these representatives. Relator gained first-hand information about the illegal kickbacks and physician inducements directly from the senior sales representative (Stephen Jones) that FPI assigned to Relator and from the FPI Divisional Manager (Jason Richardson). Jason Richardson was Relator's superior and he was also Stephen Jones' brother-in-law.

38.

Relator and the other sales representative trainees were given quarterly budgets to use for entertaining doctors and paying physicians to present speeches, provide preceptorships or conduct studies funded by Defendants. These budget items amount to $240,000 per year, per sales representative.

39.

FPI provided Relator and the other new hires with very large expense budgets to spend on physicians for the purpose of inducing them to prescribe Celexa. Each sales representative received $45,000 per quarter to pay physicians for "speaker programs and educations grants." Additionally, each sales representative received $15,000 per quarter for "discretionary expenses" that was also used to induce the doctors to prescribe Celexa.

40.

While Relator was employed by Defendants, he became familiar with and knowledgeable of various aspects of the business practices of Defendant Forest. He learned that many of the illegal

practices complained of herein were known to, and encouraged by Defendant Forest. The business practices of the FPI sales representatives and managers were in direct conflict with written materials that were ignored. Defendant Forest published "Standards of Business Ethics and Conduct" that purported to object, *inter alia*, to physician inducements, kickbacks or whistleblower retaliation. However, in reality, Relator learned that Defendant Forest was more focused on obtaining greater market share and revenues from Celexa than compliance with federal laws or its own stated policies and procedures. As the patent protection for Celexa was running out, the pressure to sell Celexa increased.

41.

Relator was told by Stephen Jones that he regularly paid unearned speaker fees to Drs. Piedra and Sommers. Stephen Jones said that it was important to keep them excited about FPI so that they would continue to prescribe a high volume of Celexa. He said that it was very important to make sure Dr. Piedra attended the Lexapro speaker training program to be held in Florida.

42.

Stephen Jones also told Relator that other physicians, such as Dr. Prakash G. Ettigi and Saifallah K. Niazi, expected and received bogus fees and gifts from FPI.

43.

During the months from February to May of 2002, sales representative Stephen Jones (who was Relator's mentor for the third phase of his training) repeatedly paid sums of $500 to $1,000 to Drs. Piedra and Sommers, neither of whom performed any services in return for this compensation, except for prescribing Celexa. These payments were ostensibly made either for the doctors speaking at luncheons ("speaker programs") or for the doctors allowing the sales representatives to follow them during treatments to learn more about their practice and procedures ("preceptorships"). At

times, said doctors who accepted these payments neither spoke at luncheons nor allowed the sales representative to be present during their psychiatric practice. Therefore, there was no service of any type given in exchange for the receipt of these funds.

44.

On or about April 23, 2002, and again on May 31, 2002, Relator advised Defendant FPI, through its Divisional Manager Jason Richardson, that these program checks were being paid out by FPI sales representative Stephen Jones, but that no services were being performed to earn the money. Relator stated that he thought such actions constituted illegal kickbacks and physician inducements. Jason Richardson advised Relator that he would look into it, but neither FPI nor Jason Richardson ever took any responsive action, other than to orchestrate the retaliatory firing of Relator. FPI refused to respond to his allegations of misconduct.

45.

With express permission from FPI Divisional Managers, Stephen Jones would use the quarterly budgets for other sales representatives to pay physician incentives and expenses.

46.

Kickbacks for bogus "preceptorships" occurred during Relator's employment with FPI. By way of example, Dr. Sommers was paid $500 for a "preceptorship" on March 1, 2002 that never occurred.

47.

Relator was told by his senior sales representatives that speaker programs and preceptorships were preferred budget expenditures (versus educational grants) because it was easier to prove the marketing value of these expenditures.

48.

Defendant Forest keeps written records of physician prescription choices and patterns to determine how much Celexa is being prescribed. FPI explicitly labels the form used as "Return on Investment".

49.

The "Return on Investment" form is used in part to determine if a doctor prescribes sufficient amounts of other competing companies' antidepressant drugs to justify paying to them kickbacks and regular monetary payments in incremented amounts of approximately $500 to $1000 as inducements to prescribe Celexa instead of competitive drugs. Defendants also keep track of the physicians' prescriptions made after receipt of these monetary payments in order to make sure they are gaining additional prescriptions in exchange for their illegal incentive payments. These forms are labeled "1st Rx Reports".

50.

Relator was told that the system used by Defendant Forest was also designed to reward the doctors who wrote the most prescriptions of Celexa. Defendant Forest, through its sales representatives and managers, targeted the physicians with the highest "decile rating". The decile rating compares the physician's total number of antidepressant prescriptions written year to date against total Celexa prescriptions written year to date. Drs. Piedra, Sommers and Jones all achieved high decile ratings because of the lavish and illegal inducements presented and accepted as set forth herein.

51.

Records are kept specifically to focus and then track the success of Defendants' illegal incentive program nationwide. While Relator was being trained in New York with other sales

representatives from around the U.S., trainees of FPI were advised that they were to provide payments and incentives to doctors who were the top prescribing doctors using the "80/20 method", which meant spending 80% of your resources on the 20% of the doctors who prescribed the most medications in the drug's category (such as Defendant Drs. Piedra and Sommers).

52.

FLI and FPI received an excellent return from their payments to Drs. Piedra and Sommers. Said doctors ranked first and second among the 273 doctors targeted for incentives and tracked by FPI within Relator's territory (based on the number of Celexa prescriptions written) during Relator's employment with FPI. Dr. Jones ranked fourth in Celexa prescriptions among the 273 doctors targeted.

53.

Dr. Jones also solicited "speaker program" payments from Defendant FPI. FPI, through employee Stephen Jones, paid Dr. Jones a speaker program fee although no speaker program was ever performed by her. This payment was made in April, 2002 and was made solely to induce Dr. Jones to prescribe the drug Celexa. Stephen Jones told Relator that Dr. Jones expressly solicited "program money" with no expectation that she would be required to provide any service for the receipt of money from Defendant Forest, other than to prescribe Celexa.

54.

Sales representative Stephen Jones and FPI Divisional Manager Jason Richardson routinely paid for expensive meals and golf outings and equipment, including golf balls and accessories, for the staff and other doctors (including Dr.Sommers), such items being in excess of $100 and being given on a regular monthly basis. These expenditures were made knowingly and willingly to induce physicians to prescribe Celexa.

55.

Additionally, Stephen Jones and Jason Richardson routinely spent money on a non-physician, Glenn Fox. Relator was told that Fox was Manager and a partner of Insight Physicians. Insight is one of the largest psychiatric practices in the Richmond, Virginia area. Relator was told that Fox had influence with the doctors that practiced psychiatry at the offices of Insight and that he could use his position to encourage the physicians to switch their patients to Celexa.

56.

On one occasion, Relator was requested to take Dr. William L. Ferrar on a golf outing. Relator cancelled this event. When FPI Divisional Manager Jason Richardson found out that the golf outing had been cancelled by Relator, he advised Relator to "make it up" to the doctor by purchasing golf apparel or other gifts for the doctors. Relator followed the direction and advice of Jason Richardson.

57.

On or about June 14, 2002, Defendant Jason Richardson advised Relator that he was being fired for purchasing non-medical gifts for doctors. Relator reminded Jason Richardson that it was he that requested that these things be done, and that it was Relator who had questioned the legality of the sales practices of FPI. Relator had complained in April and on or about May 31, 2002 of the illegal practices set forth herein directly to Jason Richardson. It took Defendant Forest approximately two weeks to set Relator up for a retaliatory firing.

58.

After his termination, Relator spoke with Jeff Wolfe, Human Resource Director for Defendant FPI. Wolfe said he would investigate the matters of the termination and the allegations of

improper conduct/illegal kickbacks. Wolfe then turned over the investigation to April Amory, Regional Manager of FPI.

59.

April Amory and her staff did nothing to rectify the illegal actions of FPI or address the retaliatory and wrongful termination of Relator.

60.

April Amory and FPI refused to give any further explanation to the Relator for his discharge. Relator provided documents and proof to Defendant Forest through the FPI Divisional Manager and Regional Manager that substantiated his claims regarding physician gifts, bogus speaker programs, preceptorships and other kickbacks. Despite being armed with this information, FPI ratified the actions of Jason Richardson in terminating Relator for complaining about the illegal actions and kickbacks involving Defendants as set forth herein.

61.

Defendants FLI and FPI had actual and specific knowledge of the ongoing illegal schemes Relator complained of, and said Defendants created opportunities and incentives for its sales representatives to act in this manner. Defendants even awarded bonuses for sales representatives who succeeded in inducing physicians to prescribe FLI's drugs. These inducements and compensation schemes were uniformly used across the country by Defendant Forest.

62.

Stephen Jones was an experienced FPI employee who attended national sales meetings. He participated in previous national sales launches. He told Relator that paying money to physicians in return for Celexa prescriptions was a common practice. These inducements generated Celexa sales. Higher sales positively affected revenue growth and market share which resulted in higher bonuses,

compensation and incentives to FPI sales representatives and managers. Net sales for FLI and FPI have increased dramatically in the last year. This growth is due principally to the sales of Celexa and Lexapro. For the nine months ending December 31, 2002, FLI's antidepressant sales totaled $1,211,776,000 (compared to the prior year's nine month total of $774,666,000).

63.

Through the use of the "1st Rx Reports" and the "Return on Investment" forms, the sales representatives were able to target the physicians that could generate the highest volume of Celexa and Lexapro sales. Using these forms, FLI and FPI could track and identify the doctors which prescribed more of FLI's drugs after receiving illegal payments and other incentives. Accordingly, these schemes increased the profits of FLI and FPI and increased the bonuses of the individual sales representatives and managers at the territory and divisional levels.

64.

FLI and FPI spent little or no money on consumer advertising. However, a tremendous amount of money was handed to sales representatives to spend on gaining national market share and revenues for FLI and FPI. As stated previously, the sales representatives were each given budgets of $240,000 per year for physician entertainment expenses and physician-related programs such as speeches, preceptorships, and/or grants. Because Celexa and Lexapro generate 80% or more of FPI drug sales, the vast majority of the $240,000 per sales representative was spent on shifting physicians to those drugs and away from the competition.

65.

Data from PLI and FPI in 2002-2003 shows that its national sales force exceeds 1,500 representatives. Simple math reveals annual sales budgets exceeding $35,000,000 per year for Celexa and Lexapro ($240,000/year x 1500 sales representatives).

SPECIFIC ACTS OF FEDERAL HEALTH CARE PROGRAM FRAUD COMMITTED BY DEFENDANTS

COUNT ONE

VIOLATIONS OF THE FEDERAL FCA: 31 U.S.C. sec. 3729(a)(1)(A), (B), and (G)

66.

Relator restates and realleges the allegations contained in Paragraphs 1-65 above and the allegations of Count Four below, as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

67.

The Defendants knowingly presented or caused to be presented false or fraudulent claims to Federal Health Care Programs and knowingly made, used or caused to be made or used false statements to get said claims paid by Federal Health Care Programs. Celexa or Lexapro prescriptions would not have been presented but for the illegal incentives made and received by Defendants, and the illegal off-label marketing, promotion and prescribing activities carried out by Defendants. As a result of this illegal scheme, these claims were improper in whole pursuant to 31 U.S.C. § 3729(a)(1)(A)-(B).

68.

These claims were also false or fraudulent and the statements and records were false because they were monetarily excessive, in violation of 31 U.S.C. sec. 3729(a)(1)(A)-(B). Celexa and Lexapro prescriptions cost more than comparative drugs with the same or superior efficacy and neither is a “least costly alternative”.

69.

In particular, these claims were also false or fraudulent and statements and records were false because the costs of FLI's drugs were inflated due to the Defendants FLI and FPI having to cover their illegal expenditures, thereby inflating the cost of the product. As set forth above, the Defendants authorized $240,000 yearly for monies earmarked for physician recruitment which was used for illegal kickbacks and incentives by sales representatives across the United States. This sum was absorbed within the costs of FLI's drugs and redistributed to the various Federal Health Care Programs by the submission of prescriptions and bills resulting in false claims requesting payment.

70.

Another result of said kickbacks and illegal inducements is that Medicare pricing and Medicaid Rebate violations resulted therefrom. The millions of dollars paid each month by FPI and FLI in physician kickbacks and incentives impacted the prices paid by Federal Health Care Programs for Celexa and Lexapro. The Defendants knowingly concealed their actions and they failed to alert the state or federal governments or to pay the correct rebate amounts to Medicaid. It is illegal to pass the costs incurred in paying illegal kickbacks back to any Federal Health Care Program and it is also illegal to falsely report the true cost of a drug. In addition to violating 31 U.S.C. sec. 3729(a)(1)(A)-(B), Defendants' conduct violated 31 U.S.C. sec. 3729(a)(1)(G).

COUNT TWO

CONSPIRACY TO DEFRAUD: FEDERAL FCA, 31 U.S.C. sec. 3729(a)(1)(C)

71.

Relator restates and realleges the allegations contained in Paragraphs 1-70 above and the allegations contained in Count Four below as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

72.

Defendants knowingly conspired to defraud the United States causing increased sales of FLI's drugs through paying and accepting illegal incentives to have Celexa and Lexapro prescribed, and through illegal off-label marketing, in violation of law. Defendants FLI and FPI conspired to violate the AKA by offering illegal bribes, kickbacks and renumerations to physicians and non-physicians that were in a position of authority to cause physicians to prescribe Celexa and Lexapro. Said actions constitute violations of 31 U.S.C. § 3729(a)(1)(C).

73.

Defendants knowingly conspired to violate the FCA by acting together to present or cause false or fraudulent claims to be presented and to make or use false statements which damaged the Federal Health Care Programs. Said claims were improper and should not have been made but for the illegal remunerations which caused the prescriptions of Celexa to be made. Said claims were also illegally excessive in cost due to the illegal kickbacks and actions of the Defendants. Said actions constitute violations of 31 U.S.C. § 3729(a(1)(C).

74.

The Defendants knowingly conspired to conceal their actions and they failed to alert the state or federal governments or to pay the correct rebate amounts to Medicaid. It is illegal to pass the costs incurred in paying illegal kickbacks back to any Federal Health Care Program and it is also illegal to falsely report the true cost of a drug. Said actions constitute violations of 31 U.S.C. § 3729(a)(1)(C).

COUNT THREE

VIOLATIONS OF THE ANTI-KICKBACK ACT ("AKA")

75.

Relator restates and realleges the allegations contained in Paragraphs 1-74 above and the allegations of Count Four below as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

76.

The Defendants have offered, received and solicited illegal bribes, kickbacks and renumerations in violation of the AKA. In order to sell its drugs, Defendants FLI and FPI authorized their employees and agents to spend large sums of money to buy business. These expenditures were made to doctors to influence the doctors to write prescriptions for FPI drugs.

77.

Furthermore, Defendants FLI and FPI created mechanisms by which they could monitor physicians across the country that prescribed competing drugs and offer illegal incentives to manipulate the top prescribers toward Celexa. Thereafter, they would monitor their "financial investments" in physicians via their "Return on Investment" forms to make sure that said doctors continued to prescribe FLI and FPI drugs.

78.

The doctors, such as Drs. Sommers, Piedra and Jones solicited and/or accepted illegal payments and routinely and disproportionately prescribed FLI's drugs, including, but not limited to, Celexa in exchange for said payments. These doctors continued to prescribe Celexa even though it was more expensive than equally, if not more effective, competing drugs. They also were expected

to transition patients from Celexa to Lexapro as Celexa's patent protection was shortening and Lexapro was approaching its launch.

79.

Defendants FPI and FLI were aware of these practices and encouraged and/or recklessly ignored said illegal activities. Relator's complaints made to his Divisional Manager and Regional Director had no impact, other than to cause his retaliatory firing by FPI.

80.

The goal of the AKA in these circumstances is to prevent the prescription of a drug based not on whether or not it is necessary and appropriate, but on whether it is financially beneficial to the doctor prescribing the drug. Because of the Defendants' illegal actions, FLI's drugs have in fact been prescribed in violation of the AKA and the FCA.

COUNT FOUR

RETALIATORY DISCHARGE IN VIOLATION OF THE FEDERAL FCA

31 U.S.C. § 3730 (h)

81.

Relator restates and realleges the allegations contained in Paragraphs 1-80 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

82.

Forest violated 31 U.S.C. § 3730(h) by its retaliatory acts against Mr. Gobble. The facts show that: (1) his conduct was protected under the FCA; (2) Forest knew that he was engaged in such conduct; and (3) Forest discharged or discriminated against him because of his protected conduct. As set forth in detail herein, Forest threatened, harassed, intimidated and otherwise discriminated against Relator directly because of his lawful acts involving a potential

violation(s) of the False Claims Act by Forest. By these actions, Forest violated the False Claims Act, 31 U.S.C., § 3730(h), as set forth below. Forest's conduct as alleged herein was done knowingly, maliciously, oppressively, and with conscious disregard for the rights of Mr. Gobble.

83.

As will be shown hereafter in greater detail, in April -June 2002, Mr. Gobble reported to his Divisional Manager (and others) what he believed to be ongoing illegal practices at Forest. When he complained about illegal kickbacks being paid by Forest to doctors, he was naïve enough to believe that his protestations would be a catalyst for change – not retaliation.

84.

After Mr. Gobble raised concerns about the illegal practices that he observed in the workplace, his life and livelihood were forever changed in a drastic fashion. On or about June 14, 2002, he was summarily fired by the same divisional manager that Mr. Gobble had sought out earlier to complain about unlawful activities he observed while employed by Forest. It is ironic that the very actions that Mr. Gobble protested – illegal kickbacks to doctors and dangerous off-label marketing to adolescents – were marketing efforts that were well known to and orchestrated by Forest.

85.

It is difficult to fully categorize the financial, personal and emotional devastation suffered by Mr. Gobble and his family in the seven years since his termination. During that time, Mr. Gobble has endured the loss of his chosen career, the dissolution of his marriage, the loss of his home, emotional and physical distress and the ability to provide for himself and his family at the previous

levels he achieved while employed by Forest.

86.

As will be set forth with great specificity hereafter, Mr. Gobble's sudden termination was demonstrably the result of unlawful retaliation by his employer for speaking out to his Divisional Manager and other Forest employees about improper physician kickbacks and other improper activities being utilized by Forest such as off-label marketing of depression pharmaceuticals to children and adolescents.

87.

Mr. Gobble was hired by Forest in 2001 as a sales representative. He was 31 years old, married, with a baby in diapers and a four (4) year old. He and his family lived in Richmond, Virginia. He started work in October 2001, with a $45,000/year base salary exclusive of commission. At the age of 31, Mr. Gobble felt that he was perfectly situated as a Forest Sales Representative to meet his personal and financial goals.

88.

While Relator was employed by Defendant, he became familiar with and knowledgeable of various aspects of the standard business practices of Defendant Forest. He learned that many of the illegal practices described in the preceding and succeeding paragraphs were both known to and encouraged by Defendant Forest.

89.

Many of the business practices of the Forest sales representatives and managers were in direct conflict with Forest's written materials. Defendant Forest published "Standards of Business Ethics and Conduct" that purported to object, *inter alia*, to physician inducements, kickbacks or whistleblower retaliation. However, in reality, Mr. Gobble observed that Defendant Forest was

more focused on obtaining greater market share and raising revenues than compliance with federal laws or its own stated policies and procedures.

90.

When Mr. Gobble began to work as a sales representative at Forest, he was made aware of the huge amount of money that Forest made available for physician marketing activities. Like the other 1,500 sales representatives across the country, Mr. Gobble was allocated approximately $60,000.00 per quarter to spend on physician marketing. This meant that the Forest sales representatives had almost a quarter million dollars per year to spend on physician marketing.

91.

Over the first few months of his employment, Mr. Gobble witnessed first-hand that kickbacks were being paid to referring doctors on a frequent basis. He observed his sales trainer and other Forest employees paying kickbacks to doctors who were targeted by Forest in hopes of influencing their prescription patterns. In fact, Forest provided the names of approximately 273 doctors who were targeted for contact by sales representatives armed with the large marketing budgets described above. He observed that money was paid to doctors and others who were in a position to influence the prescription of Forest drugs. Some monies were paid by Forest to physicians for honorariums or preceptorships that never occurred. Other gifts, trips and benefits were provided to doctors where no legitimate work or education was involved.

92.

Mr. Gobble learned how Forest ranked the targeted physicians according to "decile ratings" in order to quantify the number of prescriptions written by the doctors for specific drugs. He was educated as to the purposes for the "Return On Investment" forms and the "RX Reports." Mr. Gobble utilized the "80-20" sales method wherein he was advised to use 80% of his $240,000

physician marketing budget on the top 20% of the prescribing doctors. Part of his job was to contact the doctors who could prescribe the highest volumes of Forest drugs and to keep those high "decile" doctors happy.

93.

In addition to the types of kickbacks and actions referenced above, Mr. Gobble also became aware that Forest was training its sales representatives to encourage physicians to prescribe Celexa (and Lexapro thereafter) for illegal and dangerous "off-label" purposes. More specifically, pediatric psychiatrists, such as Dr. Susan Jones, were targeted by Forest as being psychiatrists most likely to prescribe Celexa and Lexapro to children and adolescents for depression or anxiety. The irresponsible promotion of a drug for an off-label purpose to dispense to children or adolescents is illegal, immoral and dangerous.

94.

Mr. Gobble observed that Forest utilized its "decile" ratings and "Return On Investment" forms to target potential pediatric prescribers of Celexa and Lexapro. Mr. Gobble was made specifically aware of these marketing efforts. Providers of pediatric drugs such as pediatric psychiatrists were targeted and called upon by Forest in order to encourage the prescribing of Celexa and Lexapro to children and adolescents for depression, anxiety and other non-FDA approved uses. There is evidence to suggest that the prescribing of these drugs to children or adolescents can be very harmful and possibly result in suicide, suicidal ideation or other destructive health consequences. The United Kingdom and Canada banned the use of antidepressants in children and adolescents in 2003-2004. In October 2004, after over a year of inquiries and review intense Congressional and media attention, the FDA required the manufacturers of these antidepressants (including Forest) to put tough warnings (i.e. "black box

warnings") on the drugs to alert doctors, parents and patients that the drugs increase risks of suicidal behavior among children and teens.

95.

At national sales meetings, such as the one occurring in Commack, New York in December 2001, Forest provided copies of a European study that implied that Celexa was effective in reducing depression and anxiety in adolescents. The Forest employees were told to use the study in promoting Celexa but to never leave a copy with the targeted psychiatrists. They were given an "800" telephone number to provide to a doctor if he or she had a question about the European adolescents study. Several pediatric psychiatrists were placed on Mr. Gobble's call panel. At that time, Celexa had no indication for adolescents in the United States. This fact did not prevent Forest from targeting pediatric psychiatrists for the off-label marketing of Celexa for adolescents.

96.

Relator gained first-hand knowledge that numerous Forest representatives (including sales representative Stephen Jones who was Relator's mentor for the third phase of his training) regularly paid unearned speaker fees to doctors who prescribed a high volume of Celexa. He also discovered that doctors were receiving fees from Forest representatives for bogus prescriptions and honorariums as well as other gifts in order to influence and increase prescriptions of Forest's drugs.

97.

In mid to late April, 2002, and again on or about May 31, 2002 and after, Mr. Gobble advised Defendant, through its Divisional Manager Jason Richardson, that money was being paid out by Forest sales representative Stephen Jones to prescribing physicians and others who were in a position to influence prescribing patterns and that no legitimate services were being performed to earn the money. Mr. Gobble stated that he thought such actions were illegal and improper. Jason

Richardson advised Mr. Gobble that he would look into it. Mr. Gobble also relayed his concerns to at least one other Divisional Manager, Jake Beale. However, as discussed hereafter, Relator observed that Forest did not take curative action to address his concerns, other than to orchestrate his retaliatory discharge.

98.

Additionally, Relator personally observed sales representative Stephen Jones and Divisional Manager Jason Richardson routinely pay for expensive meals and golf outings and equipment, including golf balls and accessories, for the staff and doctors of Insight Physicians Group (including Dr. Sommers). Many of the gifts had values in excess of $100 and were given on a regular basis. This was standard procedure at Forest. It is difficult to spend $240,000 per year per Forest representative on doctor marketing without providing lavish gifts and cash payments to doctors. These expenditures were made knowingly and willingly by Forest through the Forest sales representatives to induce physicians to prescribe Celexa and Lexapro.

99.

Mr. Jones and Mr. Richardson also routinely spent money on a non-physician, Glenn Fox. Mr. Gobble was told that Fox was Manager and a partner of Insight Physicians Group. Insight Physician's Group was one of the largest psychiatric practices in the Richmond, Virginia area. Mr. Gobble was told that Fox had influence with the doctors that practiced psychiatry at the offices of Insight Physicians Group and that he could use his management position to encourage the physicians to switch their patients to Celexa.

100.

On one occasion, in May, 2002, Mr. Gobble was requested to take Dr. William L. Ferrar on a golf outing. Relator cancelled this event. When Divisional Manager Jason Richardson found out

that the golf outing had been cancelled by Relator, he advised Relator to "make it up" to the doctor by purchasing golf items as gifts for the doctors (e.g., golf balls, shirts, sunglasses). Relator followed the direction and advice of Jason Richardson. Unbeknownst to Mr. Gobble, by following the specific directive of his manager, he was being set up to be fired. About a week later, Mr. Gobble was to take Dr. Sommers and Glenn Fox golfing, but Dr. Sommers cancelled. Mr. Jones told Relator to keep the date and play with Mr. Fox, i.e. to treat Mr. Fox like a doctor. Relator followed Mr. Jones's advice and then vouchered the event under the name of Dr. Sommers. As detailed below, these two events, in which Relator did nothing more than he was instructed to by Mr. Richardson and Mr. Jones, and what other sales reps and managers did, became the pretext for Forest issuing a written warning to and then firing Mr. Gobble.

101.

Mr. Gobble expressed concern to Forest about the practices referenced above. He was very candid with his co-workers, superiors and with a human resource director for Forest. His disclosure of those illegal practices to Forest constitutes protected activity and he should not be punished or retaliated against for his actions.

102.

An example of his specific protestations about the illegal conduct at Forest occurred in mid-April 2002. Relator became aware that checks were being processed by Forest to pay money to doctors for programs that never occurred. At that time, Relator specifically advised Stephen Jones that the payment of these checks to the doctors was a form of a kickback. He told Mr. Jones that the checks should not be delivered to the physicians. At that time, Mr. Jones stated that the Forest representatives in the other territories conducted business in this fashion. Mr. Jones further stated that Relator was just a junior sales representative and did not know "the way things are done". In

the end, the kickbacks were paid to the doctors.

103.

Later on, Relator informed Jake Beale, another Forest Divisional Manager, that Stephen Jones had paid unearned speaker fees to various doctors including Dr. Piedra. Jake Beale told Relator to discuss this with Jason Richardson, because Mr. Beale was no longer Mr. Jones' manager.

104.

Shortly thereafter, during a car ride between sales visits with Mr. Richardson, Relator again reiterated that checks were being paid out to doctors such as Dr. Piedra where no legitimate services were rendered. Relator expressed his concerns to Mr. Richardson, who was his Division Manager at that time that this conduct was a type of kickback and he believed that it needed to be investigated. Jason Richardson advised Relator that he would "look into it".

105.

During this same car ride, Relator also discussed his call cycle and questioned why he should call on pediatricians and OB/GYN doctors since Celexa did not have any adolescent indications. Mr. Richardson told Relator that doctors could prescribe medications in an off-label fashion. He further advised Relator not to leave behind any of the studies that Forest discussed with its sales representatives dealing with the potential uses of Celexa in adolescents. The fact that Forest encouraged sales representatives to tell doctors about these studies but warned them not to leave the actual studies behind in the doctor's office for the doctor to review was an additional basis for Relator's concern. It was worrisome to Relator that Forest did not want representatives to leave evidence behind with doctors that Celexa could be used in an off-label fashion in children and adolescents that was not FDA-approved.

106.

In addition to the individuals referenced above, in late April through May 2002, Relator had a number of discussions with Forest sales representative Sally Grigsby that centered around improper payments by Forest to physicians. Ms. Grigsby told Relator that Stephen Jones had asked her to fill out bogus forms for Dr. Piedra and Dr. Susan Jones. She actually showed Relator some of the forms that were being used to process bogus payments that reflected Stephen Jones' handwriting. Relator discussed with Ms. Grigsby his feelings that these unearned payments to physicians were illegal kickbacks. He advised her to report what she had seen and heard to her Divisional Manager Jake Beale as he had done. After the conversation that occurred during the ride with Jason Richardson described above, Relator again reiterated his concerns about the illegality of these practices to Jason Richardson on at least one more occasion. He informed Mr. Richardson that Stephen Jones was continuing to pay kickbacks to doctors. It was on this occasion that Mr. Richardson advised Relator to purchase golf balls, etc. for Dr. Ferrar as described above.

107.

Each of these disclosures by Relator described in the preceding paragraphs had the intended effect of making the appropriate employees, manager and supervisors at Forest aware of Mr. Gobble's concerns about the illegal practices described herein. Mr. Gobble made Forest aware of his observations. He reported his first-hand observations of illegal activities involving numerous Forest employees. These actions and reports by Relator constituted protected activity under applicable state and federal laws.

108.

On or about June 11, 2002, Mr. Richardson spoke to Relator about the golf voucher for Dr. Sommers. The next day, Mr. Gobble met with Mr. Richardson who gave him a written

warning for playing golf with a non doctor and expensing the event. Mr. Richardson did so despite Relator telling him that he had been instructed to do so by Mr. Jones and that both Mr. Richardson and Mr. Jones had instructed him to treat Glenn Fox as if he were a doctor. Mr. Gobble expressed his feeling that he was being retaliated against for the objections and concerns he had been raising about Forest's conduct. Nevertheless, Mr. Gobble signed the warning because he felt that under all the circumstances he had no other alternative.

109.

On or about the next day, June 13, 2002, Relator was at a speaker program with Mr. Jones. When the subject of speaker checks came up, Relator reiterated his concerns and objections to Mr. Jones and also told Mr. Jones that he had expressed concerns to their Divisional Manager Mr. Richardson.

110.

On or about the very next day, June 14, 2002, Jason Richardson advised Mr. Gobble that he was being fired for purchasing non-medical gifts for doctors. Mr. Gobble reminded Jason Richardson that it was Mr. Richardson himself that requested that these things be done. Moreover, Mr. Gobble questioned Jason Richardson regarding the legality of these specific Forest standard sales practices (on or about April 23 and on or about May 31, 2002). Mr. Gobble was purportedly fired for the precise conduct that his supervisor authorized and directed (which Mr. Gobble had previously objected to). Worse yet, this conduct was the same conduct that Forest condoned and encouraged all across the county involving tens of millions of dollars and hundreds of Forest employees and physicians. Simply put, Mr. Gobble was told that he was being fired for doing on a miniscule scale what Forest directed to be done on a grand scale all across the United States. In reality, his only offense was not "going along" with the fraudulent schemes orchestrated by Forest.

111.

Forest representatives went to Mr. Gobble's home and removed all company samples and materials and took away his company vehicle. They did all of this as Mr. Gobble was begging them to not fire him. These actions occurred at Mr. Gobble's home while he and his family members watched and sobbed.

112.

Since Mr. Richardson had told Relator that the firing was approved by Regional Director April Amory, Mr. Gobble tried to call her, but was unable to reach her. He left her a voicemail about the situation and Forest's conduct. Unable to reach Ms. Amory, Mr. Gobble then called and spoke to Jeff Wolfe, Forest Vice President of Human Resources, and explained the entire situation including Forest's kickback activity. Mr. Wolfe assured Mr. Gobble that there would be a full investigation and that any decision about his employment would not be final until then.

113.

Subsequently, Mr. Wolfe turned the investigation over to April Amory, and Relator provided Forest with further with facts regarding the kickbacks. Relator then learned that apparently the investigation had been turned over to Mr. Jones' then current Divisional Manager, Kevin Pauly. Shortly thereafter, in July 2002, Mr. Wolfe informed Mr. Gobble that the firing would stand and was final.

114.

In obvious retaliation for Mr. Gobble's repeated objections to the illegal activities of Forest, Regional Manager April Amory, Vice President Jeff Wolfe and others did nothing to rectify Forest's illegal actions or reverse the retaliatory and wrongful termination of Mr. Gobble's employment. Forest refused to give any further explanation to Mr. Gobble for his discharge. He was allegedly

fired for spending at his Divisional Manager's insistence, just over $100 on gifts for one or more physicians. The real reason for his discharge and temporal relationship between the timing of his complaints and his discharge are clear and obvious.

115.

In addition to his verbal protestations, Mr. Gobble provided documents and proof to Defendant Forest through the Divisional Manager and Regional Manager that substantiated his claims regarding illegal physician gifts, bogus speaker programs and preceptorships and the other kickbacks. Despite being armed with this information, Forest ratified the actions of Jason Richardson and upheld the termination of Mr. Gobble because he protested the systemic and well-orchestrated illegal marketing schemes at Forest.

116.

Prior to protesting the conduct at issue, Relator received a favorable performance review and a 17% raise during his short tenure with Forest. Then, within a matter of months after he reported to management that he had observed illegal practices at Forest, he was fired and stripped of his job, car and company benefits. His life would never be the same.

117.

After he was fired, Relator was forced to take any job available to try to keep working to support his family. His attempts to obtain another job in the pharmaceutical industry were unsuccessful. At times, he worked several jobs simultaneously. This often required that he work days, evenings or weekends. There were times when he had to take jobs that were "commission only" without any guaranteed income. Many weeks he worked an eighty (80) hour week and put wear and tear on his automobile without earning a dime. When he did find salaried work, he received far less compensation than he made years earlier at Forest.

118.

The stress from his termination ultimately took its toll on both his marriage and his health. Relator has experienced emotional and physical problems. He has been treated for anxiety attacks since the date of his discharge by Forest.

119.

In summary, Mr. Gobble started working for Forest in October 2001; by mid-April 2002, after having attended Forest national training, he had brought what he believed was illegal conduct to the attention of Forest. He continued to raise his concerns thereafter into at least June, 2002. He was given a written warning on about June 12, 2002, and then fired on or about June 14, 2002. He fully and thoroughly informed Forest that he believed that illegal kickbacks and physician inducements were being paid to influence prescriptions. He had deep concerns that Forest should not be marketing its depression drugs to children or adolescents. He expressed these concerns to his superiors and his co-workers. The real reason he was disciplined and then fired was for engaging in activity that is protected under state and federal law. As a result of these facts, Mr. Gobble is entitled to recover any and all appropriate damages available under the FCA and 31 U.S.C. § 3730(h).

COUNT FIVE

VIOLATIONS OF THE CALIFORNIA FCA

Cal. Gov't Code § 12651(a)(1)

120.

Relator restates and realleges the allegations contained in Paragraphs 1-119 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

121.

The California False Claims Act, Cal. Gov't Code § 12651(a)(1), specifically provides, in part:

> (a) Any person who commits any of the following acts shall be liable to the state . . . for three times the amount of damages which the state . . . sustains because of the act of that person. A person who commits any of the following acts shall also be liable to the state . . . for the costs of a civil action brought to recover any of those penalties or damages, and may be liable to the state . . . for a civil penalty of up to ten thousand ($10,000) for each false claim:
>
> (1) Knowingly presents or causes to be presented to an officer or employee of the state . . . a false claim for payment or approval.

122.

Defendants knowingly presented or caused to be presented to the California Medicaid program false and fraudulent claims for payment and approval, claims which failed to disclose the material violations of the AKA and other laws, in violation of Cal. Gov't Code § 12651(a)(1).

123.

The State of California paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in California, because of these acts by the Defendants.

COUNT SIX

VIOLATIONS OF THE CALIFORNIA FCA

Cal. Gov't Code § 12651(a)(2)

124.

Relator restates and realleges the allegations contained in Paragraphs 1-123 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

125.

The California False Claims Act, Cal. Gov't Code § 12651(a)(2), specifically provides:

> (a) Any person who commits any of the following acts shall be liable to the state . . . for three times the amount of damages which the state . . . sustains because of the act of that person. A person who commits any of the following acts shall also be liable to the state . . . for the costs of a civil action brought to recover any of those penalties or damages, and may be liable to the state . . . for a civil penalty of up to ten thousand ($10,000) for each false claim:
>
> . . .
>
> (2) Knowingly makes, uses, or causes to be made or used a false record or statement to get a false claim paid or approved by the state . . . .

126.

Defendants knowingly made, used and/or caused to be made or used false records and statements to get false and fraudulent claims paid and approved by the California Medicaid program, in violation of Cal. Gov't Code § 12651(a)(2).

127.

The State of California paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in California, because of these acts by the Defendants.

COUNT SEVEN

VIOLATIONS OF THE CALIFORNIA FCA

Cal. Gov't Code § 12651(a)(3)

128.

Relator restates and realleges the allegations contained in Paragraphs 1-127 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

129.

The California False Claims Act, Cal. Gov't Code § 12651(a)(3), specifically provides:

> (a) Any person who commits any of the following acts shall be liable to the state . . . for three times the amount of damages which the state . . . sustains because of the act of that person. A person who commits any of the following acts shall also be liable to the state . . . for the costs of a civil action brought to recover any of those penalties or damages, and may be liable to the state . . . for a civil penalty of up to ten thousand ($10,000) for each false claim:
> . . .
>
> (3) Conspires to defraud the state . . . by getting a false claim allowed or paid by the state . . .

130.

Defendants conspired to defraud the State of California by getting false and fraudulent claims allowed and paid, in violation of Cal. Gov't Code § 12651(a)(3).

131.

The State of California paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in California, because of these acts by the Defendants.

COUNT EIGHT

VIOLATIONS OF THE CALIFORNIA FCA

Cal. Gov't Code § 12651(a)(7)

132.

Relator restates and realleges the allegations contained in Paragraphs 1-131 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

133.

The California False Claims Act, Cal. Gov't Code § 12651(a)(7), specifically provides:

> (a) Any person who commits any of the following acts shall be liable to the state . . . for three times the amount of damages which the state . . . sustains because of the act of that

> person. A person who commits any of the following acts shall also be liable to the state . . . for the costs of a civil action brought to recover any of those penalties or damages, and may be liable to the state . . . for a civil penalty of up to ten thousand ($10,000) for each false claim:
>
> . . .
>
> (7) Knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state . . . .

134.

Defendants knowingly made, used or caused to be made or used a false record or statement to conceal their actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid, in violation of Cal. Gov't Code § 12651(a)(7).

135.

The State of California paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in California, because of these acts by the Defendants.

COUNT NINE

VIOLATIONS OF THE DELAWARE FALSE CLAIMS AND REPORTING ACT

Del. Code Ann. Tit. 6, § 1201(a)(1)

136.

Relator restates and realleges the allegations contained in Paragraphs 1-135 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

137.

The Delaware False Claims and Reporting Act, Del. Code Ann. tit. 6, § 1201(a)(1), specifically provides, in part, that any person who:

> (a)(1) Knowingly presents, or causes to be presented, directly or indirectly, to an officer or employee of the Government a false or fraudulent claim for payment or approval;
>
> . . .
>
> shall be liable to the Government for a civil penalty of not less than $5,500 and not more than $11,000 for each act constituting a violation of this section, plus 3 times the amount of actual damages which the Government sustains because of the act of that person.

138.

Defendants knowingly presented or caused to be presented, directly and indirectly, to the Delaware Medicaid program false and fraudulent claims for payment and approval, claims which failed to disclose the material violations of the AKA and other laws, in violation of Del. Code Ann. tit. 6, § 1201(a)(1).

139.

The State of Delaware paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Delaware, because of these acts by the Defendants.

COUNT TEN

VIOLATIONS OF THE DELAWARE FALSE CLAIMS AND REPORTING ACT

Del. Code Ann. Tit. 6, § 1201(a)(2)

140.

Relator restates and realleges the allegations contained in Paragraphs 1-139 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

141.

The Delaware False Claims and Reporting Act, Del. Code Ann. tit. 6, § 1201(a)(2),

specifically provides, in part, that any person who:

> (a)(2) Knowingly makes, uses or causes to be made or used, directly or indirectly, a false record or statement to get a false or fraudulent claim paid or approved;
>
> . . .
>
> shall be liable to the Government for a civil penalty of not less than $5,500 and not more than $11,000 for each act constituting a violation of this section, plus 3 times the amount of actual damages which the Government sustains because of the act of that person.

142.

Defendants knowingly made, used and caused to be made and used, directly and indirectly, false records and statements to get false and fraudulent claims paid and approved by the State of Delaware, in violation of Del. Code Ann. tit. 6, § 1201(a)(2).

143.

The State of Delaware paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Delaware, because of these acts by the Defendants.

COUNT ELEVEN

VIOLATIONS OF THE DELAWARE FALSE CLAIMS AND REPORTING ACT

Del. Code Ann. Tit. 6, § 1201(a)(3)

144.

Relator restates and realleges the allegations contained in Paragraphs 1-143 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

145.

The Delaware False Claims and Reporting Act, Del. Code Ann. tit. 6, § 1201(a)(3), specifically provides, in part, that any person who:

> (a)(3) Conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;
>
> . . .
>
> shall be liable to the Government for a civil penalty of not less than $5,500 and not more than $11,000 for each act constituting a violation of this section, plus 3 times the amount of actual damages which the Government sustains because of the act of that person.

146.

Defendants conspired to defraud the State of Delaware by getting false and fraudulent claims allowed and paid, in violation of Del. Code Ann. tit. 6, § 1201(a)(3).

147.

The State of Delaware paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Delaware, because of these acts by the Defendants.

COUNT TWELVE

VIOLATIONS OF THE DELAWARE FALSE CLAIMS AND REPORTING ACT

Del. Code Ann. Tit. 6, § 1201(a)(7)

148.

Relator restates and realleges the allegations contained in Paragraphs 1-147 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

149.

The Delaware False Claims and Reporting Act, Del. Code Ann. tit. 6, § 1201(a)(7), specifically provides, in part, that any person who:

> (a)(7) Knowingly makes, uses or causes to be made or used a false record or statement to conceal, avoid, increase, or decrease an obligation to pay or transmit money to or from the government;
>
> . . .

> shall be liable to the Government for a civil penalty of not less than $5,500 and not more than $11,000 for each act constituting a violation of this section, plus 3 times the amount of actual damages which the Government sustains because of the act of that person.

150.

Defendants knowingly made, used or caused to be made or used a false record or statement to conceal their actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid, in violation of Del. Code Ann. tit. 6, § 1201(a)(7).

151.

The State of Delaware paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Delaware, because of these acts by the Defendants.

COUNT THIRTEEN

VIOLATIONS OF THE DISTRICT OF COLUMBIA PROCUREMENT REFORM AMENDMENT ACT

D.C. Code § 2-308.14(a)(1)

152.

Relator restates and realleges the allegations contained in Paragraphs 1-151 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

153.

The District of Columbia Procurement Reform Amendment Act, D.C. Code § 2-308.14(a)(1), specifically provides, in part:

> (a) Any person who commits any of the following acts shall be liable to the District for 3 times the amount of damages which the District sustains because of the act of that person. A person who commits any of the following acts shall also be liable to the District for

> the costs of a civil action brought to recover penalties or damages, and may be liable to the District for a civil penalty of not less than $5,000, and not more than $10,000, for each false claim for which the person:
>
> (1) Knowingly presents, or causes to be presented, to an officer or employee of the District a false claim for payment or approval.

154.

Defendants knowingly caused to be presented to the District of Columbia Medicaid program false and fraudulent claims for payment and approval, claims which failed to disclose the material violations of the AKA and other laws, in violation of D.C. Code § 2-308.14(a)(1).

155.

The District of Columbia paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in the District of Columbia, because of these acts by the Defendants.

COUNT FOURTEEN

VIOLATIONS OF THE DISTRICT OF THE COLUMBIA PROCUREMENT REFORM AMENDMENT ACT

D.C. Code § 2-308.14(a)(2)

156.

Relator restates and realleges the allegations contained in Paragraphs 1-155 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

157.

The District of Columbia Procurement Reform Amendment Act, D.C. Code § 2-308.14(a)(2), specifically provides, in part:

> (a) Any person who commits any of the following acts shall be liable to the District for 3 times the amount of damages which the District sustains because of the act of that person. A person who commits any of the following acts shall also be liable to the District for

> the costs of a civil action brought to recover penalties or damages, and may be liable to the District for a civil penalty of not less than $5,000, and not more than $10,000, for each false claim for which the person:
>
> . . .
>
> (2) Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false claim paid or approved by the District;

158.

Defendants knowingly made, used and caused to be made and used, directly and indirectly, false records and statements to get false and fraudulent claims paid and approved by the District of Columbia, in violation of D.C. Code § 2-308.14(a)(2).

159.

The District of Columbia paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in the District of Columbia, because of these acts by the Defendants.

COUNT FIFTEEN

VIOLATIONS OF THE DISTRICT OF THE COLUMBIA PROCUREMENT REFORM AMENDMENT ACT

D.C. Code § 2-308.14(a)(3)

160.

Relator restates and realleges the allegations contained in Paragraphs 1-159 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

161.

The District of Columbia Procurement Reform Amendment Act, D.C. Code § 2-308.14(a)(3), specifically provides:

> (a) Any person who commits any of the following acts shall be liable to the District for 3

> times the amount of damages which the District sustains because of the act of that person. A person who commits any of the following acts shall also be liable to the District for the costs of a civil action brought to recover penalties or damages, and may be liable to the District for a civil penalty of not less than $5,000, and not more than $10,000, for each false claim for which the person:
> . . .
>
> (3) Conspires to defraud the District by getting a false claim allowed or paid by the District;

162.

Defendants conspired to defraud the District of Columbia by getting false and fraudulent claims allowed and paid, in violation of D.C. Code § 2-308.14(a)(3).

163.

The District of Columbia paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in the District of Columbia, because of these acts by the Defendants.

COUNT SIXTEEN

VIOLATIONS OF THE DISTRICT OF COLUMBIA PROCUREMENT REFORM AMENDMENT ACT

D.C. Code § 2-308.14(a)(7)

164.

Relator restates and realleges the allegations contained in Paragraphs 1-163 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

165.

The District of Columbia Procurement Reform Amendment Act, D.C. Code § 2-308.14(a)(1), specifically provides, in part:

> (a) Any person who commits any of the following acts shall be liable to the District for 3 times the amount of damages which the District sustains because of the act of that person.

> A person who commits any of the following acts shall also be liable to the District for the costs of a civil action brought to recover penalties or damages, and may be liable to the District for a civil penalty of not less than $5,000, and not more than $10,000, for each false claim for which the person:
>
> (7) Knowingly makes, uses or causes to be made or used a false record or statement to conceal, avoid, increase, or decrease an obligation to pay or transmit money to or from the government;

166.

Defendants knowingly made, used or caused to be made or used a false record or statement to conceal their actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid, in violation of D.C. Code § 2-308.14(a)(7).

167.

The District of Columbia paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in the District of Columbia, because of these acts by the Defendants.

COUNT SEVENTEEN

VIOLATIONS OF THE FLORIDA FCA

Fla. Stat. § 68.082(2)(a)

168.

Relator restates and realleges the allegations contained in Paragraphs 1-167 above as if each were stated herein in their entirety and said allegations are incorporated by reference.

169.

The Florida False Claims Act, Fla. Stat. § 68.082(2)(a), specifically provides, in part, that any person who:

> (a) Knowingly presents or causes to be presented to an officer or employee of an agency a false claim for payment or approval;
> . . .
>
> is liable to the state for a civil penalty of not less than $5,000 and not more than $10,000 and for treble the amount of damages the agency sustains because of the act or omission of that person.

170.

Defendants knowingly presented or caused to be presented to the Florida Medicaid program false claims for payment and approval, claims which failed to disclose the material violations of the AKA and other laws, in violation of Fla. Stat. § 68.082(2)(a).

171.

The State of Florida paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Florida, because of these acts by the Defendants.

COUNT EIGHTEEN

VIOLATIONS OF THE FLORIDA FCA

Fla. Stat. § 60.082(2)(b)

172.

Relator restates and realleges the allegations contained in Paragraphs 1-171 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

173.

The Florida False Claims Act, Fla. Stat. § 68.082(2)(b), specifically provides, in part, that any person who:

> (b) Knowingly makes, uses, or causes to be made or used a false record or statement to get a false or fraudulent claim paid or approved by an agency;
>
> . . .

> is liable to the state for a civil penalty of not less than $5,000 and not more than $10,000 and for treble the amount of damages the agency sustains because of the act or omission of that person.

174.

Defendants knowingly made, used and caused to be made and used, false records and statements to get false and fraudulent claims paid and approved by an agency of the State of Florida, in violation of Fla. Stat. § 68.082(2)(b).

175.

The State of Florida paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Florida, because of these acts by the Defendants.

COUNT NINETEEN

VIOLATIONS OF THE FLORIDA FCA

Fla. Stat. § 68.082(2)(c)

176.

Relator restates and realleges the allegations contained in Paragraphs 1-175 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

177.

The Florida False Claims Act, Fla. Stat. § 68.082(2)(c), specifically provides, in part, that any person who:

> (c) Conspires to submit a false claim to an agency or to deceive an agency for the purpose of getting a false or fraudulent claim allowed or paid;
>
> . . .
>
> is liable to the state for a civil penalty of not less than $5,000 and not more than $10,000 and for treble the amount of damages the agency sustains because of the act or omission of that person.

178.

Defendants conspired to submit a false claim to Government Health Care Programs and to deceive Federal/Government Health Care Programs for the purpose of getting false and fraudulent claims allowed and paid, in violation of Fla. Stat. § 680.82(2)(c).

179.

The State of Florida paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Florida, because of these acts by the Defendants.

COUNT TWENTY

VIOLATIONS OF THE FLORIDA FCA

Fla. Stat. § 68.082(2)(g)

180.

Relator restates and realleges the allegations contained in Paragraphs 1-179 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

181.

The Florida False Claims Act, Fla. Stat. § 68.082(2)(g), specifically provides, in part, that any person who:

> (g) Knowingly makes, uses or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to an agency
>
> . . .
>
> is liable to the state for a civil penalty of not less than $5,000 and not more than $10,000 and for treble the amount of damages the agency sustains because of the act or omission of that person.

182.

Defendants knowingly made, used or caused to be made or used a false record or statement to conceal their actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid, in violation of Fla. Stat. § 680.82(2)(g).

183.

The State of Florida paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Florida, because of these acts by the Defendants.

COUNT TWENTY-ONE

VIOLATIONS OF THE HAWAII FCA

Haw. Rev. Stat. § 661-21(a)(1)

184.

Relator restates and realleges the allegations contained in Paragraphs 1-183 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

185.

The Hawaii False Claims Act, Haw. Rev. Stat. § 661-21(a)(1), specifically provides, in part, that any person who:

> (1) Knowingly presents, or causes to be presented, to an officer or employee of the State a false or fraudulent claim for payment or approval;
>
> . . .
>
> shall be liable to the State for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages that the State sustains due to the act of that person.

186.

Defendants knowingly presented or caused to be presented to the Hawaii Medicaid program false and fraudulent claims for payment and approval, claims which failed to disclose the material violations of the AKA and other laws, in violation of Haw. Rev. Stat. § 661-21(a)(1).

187.

The State of Hawaii paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Hawaii, because of these acts by the Defendants.

COUNT TWENTY-TWO

VIOLATIONS OF THE HAWAII FCA

Haw. Rev. Stat. § 661-21(a)(2)

188.

Relator restates and realleges the allegations contained in Paragraphs 1-187 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

189.

The Hawaii False Claims Act, Haw. Rev. Stat. § 661-21(a)(2), specifically provides, in part, that any person who:

> (2) Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the State;
>
> . . .
>
> shall be liable to the State for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages that the State sustains due to the act of that person.

190.

Defendants knowingly made, used and caused to be made, used, and caused to be made

and used, false records and statements to get false and fraudulent claims paid and approved by the State of Hawaii, in violation of Haw. Rev. Stat. § 661-21(a)(2).

191.

The State of Hawaii paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Hawaii, because of these acts by the Defendants.

COUNT TWENTY-THREE

VIOLATIONS OF THE HAWAII FCA

Haw. Rev. Stat. § 661-21(a)(3)

192.

Relator restates and realleges the allegations contained in Paragraphs 1-191 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

193.

The Hawaii False Claims Act, Haw. Rev. Stat. § 661-21(a)(3), specifically provides, in part, that any person who:

> (3) Conspires to defraud the State by getting a false or fraudulent claim allowed or paid.
>
> . . .
>
> shall be liable to the State for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages that the State sustains due to the act of that person.

194.

Defendants conspired to defraud the State of Hawaii by getting false and fraudulent claims allowed and paid, in violation of Haw. Rev. Stat. § 661-21(a)(3).

195.

The State of Hawaii paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Hawaii, because of these acts by the Defendants.

COUNT TWENTY-FOUR

VIOLATIONS OF THE HAWAII FCA

Haw. Rev. Stat. § 661-21(a)(7)

196.

Relator restates and realleges the allegations contained in Paragraphs 1-195 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

197.

The Hawaii False Claims Act, Haw. Rev. Stat. § 661-21(a)(7), specifically provides, in part, that any person who:

> (3) Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state.
>
> . . .
>
> shall be liable to the State for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages that the State sustains due to the act of that person.

198.

Defendants knowingly made, used or caused to be made or used a false record or statement to conceal their actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid, in violation of Haw. Rev. Stat. § 661-21(a)(7).

199.

The State of Hawaii paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Hawaii, because of these acts by the Defendants.

COUNT TWENTY-FIVE

VIOLATIONS OF THE ILLINOIS WHISTLEBLOWER REWARD AND PROTECTION ACT

740 Ill. Comp. Stat. § 175/3 (a)(1)

200.

Relator restates and realleges the allegations contained in Paragraphs 1-199 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

201.

The Illinois Whistleblower Reward and Protection Act, 740 Ill. Comp. Stat. § 175/3(a)(1), specifically provides, in part, that any person who:

> (1) knowingly presents, or causes to be presented, to an officer or employee of the State or member of the Guard a false or fraudulent claim for payment or approval;
>
> . . .
>
> is liable to the State for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the State sustains because of the act of that person.

202.

Defendants knowingly caused to be presented to the Illinois Medicaid program false and fraudulent claims for payment and approval, claims which failed to disclose the material violations of the AKA and other laws, in violation of 740 Ill. Comp. Stat. § 175/3(a)(1).

203.

The State of Illinois paid said claims and has sustained damages, to the extent of its

portion of Medicaid losses from Medicaid claims filed in Illinois, because of these acts by the Defendants.

COUNT TWENTY-SIX

VIOLATIONS OF THE ILLINOIS WHISTLEBLOWER REWARD AND PROTECTION ACT

740 Ill. Comp. Stat. § 175/3(a)(2)

204.

Relator restates and realleges the allegations contained in Paragraphs 1-203 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

205.

The Illinois Whistleblower Reward and Protection Act, 740 Ill. Comp. Stat. § 175/3(a)(2), specifically provides, in part, that any person who:

> (2) knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the State;
>
> . . .
>
> is liable to the State for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the State sustains because of the act of that person.

206.

Defendants knowingly made, used and caused to be made and used, false records and statements to get false and fraudulent claims paid and approved by the State of Illinois, in violation of 740 Ill. Comp. Stat. § 175/3(a)(2).

207.

The State of Illinois paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Illinois, because of these acts by the

Defendants.

COUNT TWENTY-SEVEN

VIOLATIONS OF THE ILLINOIS WHISTLEBLOWER REWARD AND PROTECTION ACT

740 Ill. Comp. Stat. § 175/3(a)(3)

208.

Relator restates and realleges the allegations contained in Paragraphs 1-207 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

209.

The Illinois Whistleblower Reward and Protection Act, 740 Ill. Comp. Stat. § 175/3(a)(3), specifically provides, in part, that any person who:

> (3) conspires to defraud the State by getting a false or fraudulent claim allowed or paid;
>
> . . .
>
> is liable to the State for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the State sustains because of the act of that person.

210.

Defendants conspired to defraud the State of Illinois by getting false and fraudulent claims allowed and paid, in violation of 740 Ill. Comp. Stat. § 175/3(a)(3).

211.

The State of Illinois paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Illinois, because of these acts by the Defendants.

COUNT TWENTY-EIGHT

VIOLATIONS OF THE ILLINOIS WHISTLEBLOWER REWARD AND PROTECTION ACT

740 Ill. Comp. Stat. § 175/3(a)(7)

212.

Relator restates and realleges the allegations contained in Paragraphs 1-211 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

213.

The Illinois Whistleblower Reward and Protection Act, 740 Ill. Comp. Stat. § 175/3(a)(7), specifically provides, in part, that any person who:

> (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the State
>
> . . .
>
> is liable to the State for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the State sustains because of the act of that person.

214.

Defendants knowingly made, used or caused to be made or used a false record or statement to conceal their actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid, in violation of 740 Ill. Comp. Stat. § 175/3(a)(7).

215.

The State of Illinois paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Illinois, because of these acts by the Defendants.

COUNT TWENTY-NINE

VIOLATIONS OF THE LOUISIANA FALSE CLAIMS ACT/MEDICAL ASSISTANCE PROGRAMS INTEGRITY LAW

46 La. Rev. Stat. c. 3 § 438.3A

216.

Relator restates and realleges the allegations contained in Paragraphs 1-215 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

217.

The Louisiana False Claims Act/Medical Assistance Programs Integrity Law ("Louisiana FCA"), 46 La. Rev. Stat. c. 3 § 438.3A, specifically provides, in part, that: "No person shall knowingly present or cause to be presented a false or fraudulent claim".

218.

Defendants knowingly presented or caused to be presented to the Louisiana Medicaid program false and fraudulent claims for payment and approval, claims which failed to disclose the material violations of the AKA and other laws, in violation of 46 La. Rev. Stat. c. 3 § 438.3A.

219.

The State of Louisiana paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Louisiana, because of these acts by the Defendants.

COUNT THIRTY

VIOLATIONS OF THE LOUISIANA FALSE CLAIMS ACT/MEDICAL ASSISTANCE PROGRAMS INTEGRITY LAW

46 La. Rev. Stat. c. 3 § 438.3B

220.

Relator restates and realleges the allegations contained in Paragraphs 1-219 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

221.

The Louisiana False Claims Act, 46 La. Rev. Stat. c. 3 § 438.3B, specifically provides, in part, that:

> No person shall knowingly engage in misrepresentation to obtain, or attempt to obtain, payment from medical assistance programs funds;

222.

Defendants knowingly engaged in misrepresentation and made, used and caused to be made and used, false records and statements to obtain or attempt to obtain payment from or get false and fraudulent claims paid and approved by the State of Illinois, in violation of 46 La. Rev. Stat. c. 3 § 438.3B.

223.

The State of Louisiana paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Louisiana, because of these acts by the Defendants.

COUNT THIRTY-ONE

VIOLATIONS OF THE LOUISIANA FALSE CLAIMS ACT/MEDICAL ASSISTANCE PROGRAMS INTEGRITY LAW

46 La. Rev. Stat. c. 3 § 438.3C

224.

Relator restates and realleges the allegations contained in Paragraphs 1-223 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

225.

The Louisiana False Claims Act, 46 La. Rev. Stat. c. 3 § 438.3C, specifically provides, in part, that:

> No person shall conspire to defraud, or attempt to defraud, the medical assistance programs through misrepresentation or by obtaining, or attempting to obtain, payment for a false or fraudulent claim.

226.

Defendants conspired to defraud the State of Louisiana by getting false and fraudulent claims allowed and paid, in violation of 46 La. Rev. Stat. c. 3 § 438.3C.

227.

The State of Louisiana paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Louisiana, because of these acts by the Defendants.

COUNT THIRTY-TWO

VIOLATIONS OF THE LOUISIANA FALSE CLAIMS ACT/MEDICAL ASSISTANCE PROGRAMS INTEGRITY LAW

46 La. Rev. Stat. c. 3 § 438.2A(1)

228.

Relator restates and realleges the allegations contained in Paragraphs 1-227 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

229.

Louisiana False Claims Act, 46 La. Rev. Stat. c. 3 § 438.2A(1), specifically provides that:

> No person shall solicit, receive, offer or pay any remuneration, including but not limited to kickbacks, bribes, rebates, or … payments, directly or indirectly, overtly or covertly, in cash or in kind, for the following . ..
>
> (1) In return for referring an individual to a health care provider, …for the furnishing or arranging to furnish any good, supply, or service for which payment may be made, in whole or in part, under the medical assistance programs.

230.

Defendants solicited, received, offered and/or paid remuneration, including but not limited to kickbacks, bribes, and gifts, directly or indirectly, overtly or covertly, in cash or in kind, in return for prescribing or arranging the prescribing of drugs which are paid for by the Louisiana Medicaid program, in violation of 46 La. Rev. Stat. c. 3 § 438.2A(1).

231.

The State of Louisiana paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Louisiana, because of these acts by the Defendants.

COUNT THIRTY-THREE

VIOLATIONS OF THE MASSACHUSETTS FCA

Mass. Gen. Laws Ch. 12, § 5B(1)

232.

Relator restates and realleges the allegations contained in Paragraphs 1-231 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

233.

The Massachusetts False Claims Act, Mass. Gen. Laws Ch. 12, § 5B(1), specifically provides, in part, that any person who:

> (1) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
>
> . . .
>
> shall be liable to the commonwealth or political subdivision for a civil penalty of not less than $5,000 and not more than $10,000 per violation, plus three times the amount of damages, including consequential damages, that the commonwealth or political subdivision sustains because of the act of that person.

234.

Defendants knowingly presented or caused to be presented to the Massachusetts Medicaid program false and fraudulent claims for payment and approval, claims which failed to disclose the material violations of the AKA and other laws, in violation of Mass. Gen. Laws Ch. 12, § 5B(1).

235.

The Commonwealth of Massachusetts paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Massachusetts, because of these acts by the Defendants.

COUNT THIRTY-FOUR

VIOLATIONS OF THE MASSACHUSETTS FCA

Mass. Gen. Laws Ch. 12, § 5B(2)

236.

Relator restates and realleges the allegations contained in Paragraphs 1-235 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

237.

The Massachusetts False Claims Act, Mass. Gen. Laws Ch. 12, § 5B(2), specifically provides, in part, that any person who:

> (2) knowingly makes, uses, or causes to be made or used, a false record or statement to obtain payment or approval of a claim by the commonwealth or any political subdivision thereof;
>
> . . .
>
> shall be liable to the commonwealth or political subdivision for a civil penalty of not less than $5,000 and not more than $10,000 per violation, plus three times the amount of damages, including consequential damages, that the commonwealth or political subdivision sustains because of the act of that person.

238.

Defendants knowingly made, used and caused to be made and used, false records and statements to obtain payment and approval of claim by the Commonwealth of Massachusetts, in violation of Mass. Gen. Laws Ch. 12, § 5B(2).

239.

The Commonwealth of Massachusetts paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Massachusetts, because of these acts by the Defendants.

COUNT THIRTY-FIVE

VIOLATIONS OF THE MASSACHUSETTS FCA

Mass. Gen. Laws Ch. 12, § 5B(3)

240.

Relator restates and realleges the allegations contained in Paragraphs 1-239 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

241.

The Massachusetts False Claims Act, Mass. Gen. Laws Ch. 12, § 5B(3), specifically provides, in part, that any person who:

> (3) conspires to defraud the commonwealth or any political subdivision thereof through the allowance or payment of a fraudulent claim;
>
> . . .
>
> shall be liable to the commonwealth or political subdivision for a civil penalty of not less than $5,000 and not more than $10,000 per violation, plus three times the amount of damages, including consequential damages, that the commonwealth or political subdivision sustains because of the act of that person.

242.

Defendants conspired to defraud the Commonwealth of Massachusetts through the allowance and payment of fraudulent claims in violation of Mass. Gen. Laws Ch. 12, § 5B(3).

243.

The Commonwealth of Massachusetts paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Massachusetts, because of these acts by the Defendants.

COUNT THIRTY-SIX

VIOLATIONS OF THE MASSACHUSETTS FCA

Mass. Gen. Laws Ch. 12, § 5B(8)

244.

Relator restates and realleges the allegations contained in Paragraphs 1-243 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

245.

The Massachusetts False Claims Act, Mass. Gen. Laws Ch. 12, § 5B(8), specifically provides, in part, that any person who:

> (8) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or to transmit money or property to the commonwealth;
>
> . . .
>
> shall be liable to the commonwealth or political subdivision for a civil penalty of not less than $5,000 and not more than $10,000 per violation, plus three times the amount of damages, including consequential damages, that the commonwealth or political subdivision sustains because of the act of that person.

246.

Defendants knowingly made, used or caused to be made or used a false record or statement to conceal their actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid, in violation of Mass. Gen. Laws Ch. 12, § 5B(8).

247.

The Commonwealth of Massachusetts paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Massachusetts, because of these acts by the Defendants.

COUNT THIRTY-SEVEN

VIOLATIONS OF THE NEVADA FCA

Nev. Rev. Stat. § 357.040(1)(a)

248.

Relator restates and realleges the allegations contained in Paragraphs 1-247 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

249.

The Nevada False Claims Act, Nev. Rev. Stat. § 357.040(1)(a), specifically provides, in part, that a person who:

> With or without specific intent to defraud, does any of the following listed acts is liable to the state or a political subdivision, whichever is affected, for three times the amount of damages sustained by the state or political subdivision because of the act of that person, for the costs of a civil action brought to recover those damages and for a civil penalty of not less than $2,000 or more than $10,000 for each act:
>
> (a) Knowingly presents or causes to be presented a false claim for payment or approval.

250.

Defendants knowingly presented or caused to be presented to the Nevada Medicaid program false claims for payment and approval, claims which failed to disclose the material violations of the AKA and other laws, in violation of Nev. Rev. Stat. § 357.040(1)(a).

251.

The State of Nevada paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Nevada, because of these acts by the Defendants.

COUNT THIRTY-EIGHT

VIOLATIONS OF THE NEVADA FCA

Nev. Rev. Stat. § 357.040(1)(b)

252.

Relator restates and realleges the allegations contained in Paragraphs 1-251 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

253.

The Nevada False Claims Act, Nev. Rev. Stat. § 357.040(1)(b), specifically provides, in part, that a person who:

> With or without specific intent to defraud, does any of the following listed acts is liable to the state or a political subdivision, whichever is affected, for three times the amount of damages sustained by the state or political subdivision because of the act of that person, for the costs of a civil action brought to recover those damages and for a civil penalty of not less than $2,000 or more than $10,000 for each act:
>
> . . .
>
> (b) Knowingly makes or uses, or causes to be made or used, a false record or statement to obtain payment or approval of a false claim.

254.

Defendants knowingly made, used and caused to be made and used, false records and statements to obtain payment and approval of false claims, in violation of Nev. Rev. Stat. § 357.040(1)(b).

255.

The State of Nevada paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Nevada, because of these acts by the Defendants.

COUNT THIRTY-NINE

VIOLATIONS OF THE NEVADA FCA

Nev. Rev. Stat. 357.040(1)(c)

256.

Relator restates and realleges the allegations contained in Paragraphs 1-255 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

257.

The Nevada False Claims Act, Nev. Rev. Stat. § 357.040(1)(c), specifically provides, in part, that a person who:

> With or without specific intent to defraud, does any of the following listed acts is liable to the state or a political subdivision, whichever is affected, for three times the amount of damages sustained by the state or political subdivision because of the act of that person, for the costs of a civil action brought to recover those damages and for a civil penalty of not less than $2,000 or more than $10,000 for each act:
>
> . . .
>
> (c) Conspires to defraud by obtaining allowance or payment of a false claim.

258.

Defendants conspired to defraud the Commonwealth of Massachusetts by obtaining allowance and payment of false claims, in violation of Nev. Rev. Stat. 357.040(1)(c).

259.

The State of Nevada paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Nevada, because of these acts by the Defendants.

COUNT FORTY

VIOLATIONS OF THE NEVADA FCA

Nev. Rev. Stat. 357.040(1)(g)

260.

Relator restates and realleges the allegations contained in Paragraphs 1-259 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

261.

The Nevada False Claims Act, Nev. Rev. Stat. § 357.040(1)(g), specifically provides, in part, that a person who:

> With or without specific intent to defraud, does any of the following listed acts is liable to the state or a political subdivision, whichever is affected, for three times the amount of damages sustained by the state or political subdivision because of the act of that person, for the costs of a civil action brought to recover those damages and for a civil penalty of not less than $2,000 or more than $10,000 for each act:
> . . .
>
> (g) knowingly makes or uses, or causes to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the state….

262.

Defendants knowingly made, used or caused to be made or used a false record or statement to conceal their actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid, in violation of Nev. Rev. Stat. 357.040(1)(g).

263.

The State of Nevada paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Nevada, because of these acts by the Defendants.

COUNT FORTY-ONE

VIOLATIONS OF THE TENNESSEE MEDICAID FCA

Tenn. Code Ann. § 71-5-182(a)(1)(A)

264.

Relator restates and realleges the allegations contained in Paragraphs 1-263 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

265.

The Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-182(a)(1)(A), specifically provides, in part, that any person who:

> (A) Presents, or causes to be presented, to the state a claim for payment under the Medicaid program knowing such claim is false or fraudulent;
>
> . . .
>
> is liable to the state for a civil penalty of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), plus three (3) times the amount of damages which the state sustains because of the act of that person.

266.

Defendants knowingly presented or caused to be presented to the Tennessee Medicaid program claims for payment under the Medicaid program knowing such claims were false and fraudulent, claims which failed to disclose the material violations of the AKA and other laws, in violation of Tenn. Code Ann. § 71-5-182(a)(1)(A).

267.

The State of Tennessee paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Tennessee, because of these acts by the Defendants.

COUNT FORTY-TWO

VIOLATIONS OF THE TENNESSEE MEDICAID FCA

Tenn. Code Ann. § 71-5-182(a)(1)(B)

268.

Relator restates and realleges the allegations contained in Paragraphs 1-267 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

269.

The Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-182(a)(1)(B), specifically provides, in part, that any person who:

> (B) Makes, uses, or causes to made or used, a record or statement to get a false or fraudulent claim under the Medicaid program paid for or approved by the state knowing such record or statement is false;
>
> . . .
>
> is liable to the state for a civil penalty of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), plus three (3) times the amount of damages which the state sustains because of the act of that person.

270.

Defendants made, used and caused to be made and used, records and statements to get false and fraudulent claims under the Medicaid program paid and approved by the State of Tennessee knowing such records and statements were false, in violation of Tenn. Code Ann. § 71-5-182(a)(1)(B).

271.

The State of Tennessee paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Tennessee, because of these acts by the Defendants.

COUNT FORTY-THREE

VIOLATIONS OF THE TENNESSEE MEDICAID FCA

Tenn. Code Ann. § 71-5-182(a)(1)(C)

272.

Relator restates and realleges the allegations contained in Paragraphs 1-271 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

273.

The Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-182(a)(1)(C), specifically provides, in part, that any person who:

> (C) Conspires to defraud the state by getting a claim allowed or paid under the Medicaid program knowing such claim is false or fraudulent;
>
> . . .
>
> is liable to the state for a civil penalty of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), plus three (3) times the amount of damages which the state sustains because of the act of that person.

274.

Defendants conspired to defraud the State of Tennessee by getting claims allowed and paid under the Medicaid program knowing such claims were false and fraudulent, in violation of Tenn. Code Ann. § 71-5-182(a)(1)(C).

275.

The State of Tennessee paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Tennessee, because of these acts by the Defendants.

COUNT FORTY-FOUR

VIOLATIONS OF THE TENNESSEE MEDICAID FCA

Tenn. Code Ann. § 71-5-182(a)(1)(D)

276.

Relator restates and realleges the allegations contained in Paragraphs 1-275 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

277.

The Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-182(a)(1)(D), specifically provides, in part, that any person who:

> (D) Makes, uses, or causes to be made or sued, a record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state, relative to the Medicaid program knowing such record or statement is false;
>
> . . .
>
> is liable to the state for a civil penalty of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), plus three (3) times the amount of damages which the state sustains because of the act of that person.

278.

Defendants knowingly made, used or caused to be made or used a false record or statement to conceal their actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid, in violation of Tenn. Code Ann. § 71-5-182(a)(1)(D).

279.

The State of Tennessee paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Tennessee, because of these acts by the Defendants.

COUNT FORTY-FIVE

VIOLATIONS OF THE TEXAS MEDICAID FRAUD PREVENTION LAW

Tex. Hum. Res. Code Chapter 32, § 36.002(1)(A)

280.

Relator restates and realleges the allegations contained in Paragraphs 1-279 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

281.

The Texas Medicaid Fraud Prevention Law, Tex. Hum. Res. Code § 36.001(1)(A), specifically provides, in part, that a person commits an unlawful act if the person:

> (1) knowingly or intentionally makes or causes to be made a false statement or misrepresentation of a material fact:
>
> (A) on an application for a contract, benefit, or payment under the Medicaid program.

282.

Defendants knowingly and intentionally caused to be made false statements and misrepresentations of material facts on applications for payment under the Texas Medicaid program, claims which failed to disclose the material violations of the AKA and other laws, in violation of Tex. Hum. Res. Code § 36.002(1)(A).

283.

The State of Texas paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Texas, because of these acts by the Defendants.

COUNT FORTY-SIX

VIOLATIONS OF THE TEXAS MEDICAID FRAUD PREVENTION LAW

Tex. Hum. Res. Code Chapter 32, § 36.002(4)(B)

284.

Relator restates and realleges the allegations contained in Paragraphs 1-283 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

285.

The Texas Medicaid Fraud Prevention Law, Tex. Hum. Res. Code § 36.002(4)(B), specifically provides, in part, that a person commits an unlawful act if the person:

> (4) knowingly or intentionally makes, causes to be made, induces, or seeks to induce the making of a false statement or misrepresentation of material fact concerning:
> . . .
>
> (B) Information required to be provided by a federal or state law, rule, regulation, or provider agreement pertaining to the Medicaid program;

286.

Defendants by knowingly and intentionally causing to be made, inducing, and seeking to induce the making of false statements and misrepresentations of material facts concerning information required to be provided by state and federal law, rule, regulation and provider agreements pertaining to the Medicaid program, are in violation of Tex. Hum. Res. Code § 36.002(4)(B).

287.

The State of Texas paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Texas, because of these acts by the Defendants.

COUNT FORTY-SEVEN

VIOLATIONS OF TEXAS MEDICAID FRAUD PREVENTION LAW

Tex. Hum. Res. Code Chapter 32, § 36.002(5)

288.

Relator restates and realleges the allegations contained in Paragraphs 1-287 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

289.

The Texas Medicaid Fraud Prevention Law, Tex. Hum. Res. Code § 36.002(5), specifically provides, in part, that a person commits an unlawful act if the person:

> (8) except as authorized under the Medicaid program, knowingly or intentionally charges, solicits, accepts, or receives, in addition to an amount paid under the Medicaid program, a gift, money, a donation, or other consideration as a condition to the provision of a service or continued service to a Medicaid recipient if the cost of the service to the Medicaid recipient is paid for, in whole or in part, under the Medicaid program . . . .

290.

Defendants knowingly and intentionally paid and received kickbacks, gifts, money, or other consideration as a condition of service to a Medicaid recipient, in violation of Tex. Hum. Res. Code §.36.002(5).

291.

The State of Texas paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Texas, because of these acts by the Defendants.

COUNT FORTY-EIGHT

VIOLATIONS OF TEXAS MEDICAID FRAUD PREVENTION LAW

Tex. Hum. Res. Code Chapter 32, § 36.002(9)

292.

Relator restates and realleges the allegations contained in Paragraphs 1-291 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

293.

The Texas Medicaid Fraud Prevention Law, Tex. Hum. Res. Code § 36.002(9), specifically provides, in part, that a person commits an unlawful act if the person:

> (9) knowingly or intentionally enters into an agreement, combination, or conspiracy to defraud the state by obtaining or aiding another person in obtaining an unauthorized payment or benefit from the Medicaid program . . . .

294.

Defendants knowingly and intentionally conspired to defraud the State of Texas by aiding another person in obtaining an unauthorized payment from the Medicaid program, in violation of Tex. Hum. Res. Code §.36.002(9).

295.

The State of Texas paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Texas, because of these acts by the Defendants.

COUNT FORTY-NINE

VIOLATIONS OF THE VIRGINIA FRAUD AGAINST TAXPAYERS ACT

Va. Code Ann. § 8.01-216.3(A)(1)

296.

Relator restates and realleges the allegations contained in Paragraphs 1-295 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

297.

The Virginia Fraud Against Taxpayers Act, Va. Code Ann. § 8.01-216.3(A)(1), specifically provides, in part, that any person who:

> 1. Knowingly presents, or causes to be presented, to an officer or employee of the Commonwealth a false or fraudulent claim for payment or approval;
> . . .
>
> shall be liable to the Commonwealth for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages sustained by the Commonwealth.

298.

Defendants knowingly presented or caused to be presented, to the Virginia Medicaid program false and fraudulent claims for payment and approval, claims which failed to disclose the material violations of the AKA and other laws, in violation of Va. Code Ann. § 8.01-216.3(A)(1).

299.

The Commonwealth of Virginia paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Virginia, because of these acts by the Defendants.

COUNT FIFTY

VIOLATIONS OF THE VIRGINIA FRAUD AGAINST TAXPAYERS ACT

Va. Code Ann. § 8.01-216.3(A)(2)

300.

Relator restates and realleges the allegations contained in Paragraphs 1-299 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

301.

The Virginia Fraud Against Taxpayers Act, Va. Code Ann. § 8.01-216.3(A)(2), specifically provides, in part, that any person who:

> 2. Knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Commonwealth;
>
> . . .
>
> shall be liable to the Commonwealth for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages sustained by the Commonwealth.

302.

Defendants knowingly made, used and caused to made and used, false records and statements to get false and fraudulent claims paid and approved by the Commonwealth of Virginia, in violation of Va. Code Ann. §.8.01-216.3(A)(2).

303.

The Commonwealth of Virginia paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Virginia, because of these acts by the Defendants.

COUNT FIFTY-ONE

VIOLATIONS OF THE VIRGINIA FRAUD AGAINST TAXPAYERS ACT

Va. Code Ann. § 8.01-216.3(A)(3)

304.

Relator restates and realleges the allegations contained in Paragraphs 1-303 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

305.

The Virginia Fraud Against Taxpayers Act, Va. Code Ann. § 8.01-216.3(A)(3), specifically provides, in part, that any person who:

> 3. Conspires to defraud the Commonwealth by getting a false or fraudulent claim allowed or paid;
>
> . . .
>
> shall be liable to the Commonwealth for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages sustained by the Commonwealth.

306.

Defendants conspired to defraud the Commonwealth of Virginia by getting false and fraudulent claims allowed and paid, in violation of Va. Code Ann.§ 8.01-216.3(A)(3).

307.

The Commonwealth of Virginia paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Virginia, because of these acts by the Defendants.

COUNT FIFTY-TWO

VIOLATIONS OF THE VIRGINIA FRAUD AGAINST TAXPAYERS ACT

Va. Code Ann. § 8.01-216.3(A)(7)

308.

Relator restates and realleges the allegations contained in Paragraphs 1-307 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

309.

The Virginia Fraud Against Taxpayers Act, Va. Code Ann. § 8.01-216.3(A)(7), specifically provides, in part, that any person who:

> 3. knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Commonwealth;
>
> . . .
>
> shall be liable to the Commonwealth for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages sustained by the Commonwealth.

310.

Defendants knowingly made, used or caused to be made or used a false record or statement to conceal their actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid, in violation of Va. Code Ann.§ 8.01-216.3(A)(7).

311.

The Commonwealth of Virginia paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Virginia, because of these acts by the Defendants.

COUNT FIFTY-THREE

VIOLATIONS OF THE GEORGIA STATE FALSE MEDICAID CLAIMS ACT
Article 7B, Chapter 4, Title 49 of the Official Code of Georgia Annotated

312.

Relator restates and realleges the allegations contained in Paragraphs 1-311 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

313.

The Georgia State False Medicaid Claims Act, Official Code of Georgia Annotated, 49-4-168, *et seq*., specifically provides, in part at 49-4-168.1, that:

> (a) Any person who:
>
> (1) Knowingly presents or causes to be presented to the Georgia Medicaid program a false or fraudulent claim for payment or approval;
>
> (2) Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Georgia Medicaid program;
>
> (3) Conspires to defraud the Georgia Medicaid program by getting a false or fraudulent claim allowed or paid;
>
> (4) Has possession, custody, or control of property or money used, or to be used by the Georgia Medicaid program and, intending to defraud the Georgia Medicaid program or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate of receipt; and/or
>
> (7) Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay, repay or transmit money or property to the State of Georgia,
>
> shall be liable to the State of Georgia for a civil penalty of not less than $5,500.00 and not more than $11,000.00 for each false or fraudulent claim, plus three times the amount of damages which the Georgia Medicaid program sustains because of the act of such person.

314.

The Defendants knowingly presented or caused to be presented false or fraudulent claims to Medicaid and the State of Georgia, claims which failed to disclose the material violations of

the law, knowingly made, used or caused to be made or used, false statements to get said claims paid by the Medicaid Program, and conspired to defraud the State of Georgia and its Medicaid Program, all in violation of the Georgia FCA, 49-4-168.1(a)(1)-(3).

315.

Defendants knowingly made, used or caused to be made or used a false record or statement to conceal their actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid, in violation of the Georgia FCA, 49-4-168.1(a)(4) and (7).

316.

In addition, Defendants knowingly presented or caused to be presented to the Medicaid program false and fraudulent claims for payment and approval, and false or fraudulent statements or records, all of which failed to disclose the material violations of the AKA and other laws, and conspired to do so, all in violation of the State FCA.

317.

The State of Georgia paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Georgia, and rebates not paid, because of these acts by the Defendants.

COUNT FIFTY-FOUR

VIOLATIONS OF THE STATE OF INDIANA FALSE CLAIMS AND WHISTLEBLOWER PROTECTION ACT IC 5-11-5.5

318.

Relator restates and realleges the allegations contained in Paragraphs 1-317 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

319.

The Indiana False Claims and Whistleblower Protection Act, IC 5-11-5.5-2(b) (2005), specifically provides, in part, that by certain acts a person commits an unlawful act and shall be liable to the state for civil penalties and three times the amount of damages that the state sustains because of the act if that person [including]:

> (1) presents a false claim to the state for payment or approval;
> (2) makes or uses a false record or statement to obtain payment or approval of a false claims from the state;…
> (6) makes or uses a false record or statement to avoid an obligation to pay or transmit property to the state;
> (7) conspires with another person to perform an act described above; or
> (8) causes or induces another person to perform an act described above.

320.

Defendants knowingly violated these provisions of law by presenting or causing to be presented to the Indiana Medicaid program false and/or fraudulent claims for payment and approval, claims which failed to disclose the material violations of the law; knowingly made, used or caused to be made or used a false record or statement to support such claims and/or to conceal its actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid; and conspired to defraud the state Medicaid program, and caused others

to violate the Indiana Act, all in violation of IC 5-11-5.5-2.

321.

In addition, Defendants knowingly presented or caused to be presented to the Medicaid program false and fraudulent claims for payment and approval, and false or fraudulent statements or records, all of which failed to disclose the material violations of the AKA and other laws, and conspired to do so, all in violation of the State FCA.

322.

The State of Indiana paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Indiana, and rebates not paid, because of these acts by the Defendants.

COUNT FIFTY-FIVE

VIOLATIONS OF THE MICHIGAN MEDICAID FALSE CLAIMS ACT,

MI ST Ch. 400

323.

Relator restates and realleges the allegations contained in Paragraphs 1-322 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

324.

The Michigan Medicaid False Claims Act, MI ST Ch. 400, provides, *inter alia*: as follows:

(1) In § 400.603, that "A person shall not knowingly make or cause to be made a false statement or false representation of a material fact in an application for Medicaid benefits… [or] for use in determining rights to a Medicaid benefit." It further provides that "A person, having knowledge of the occurrence of an event affecting …[the] initial or continued right of any

other person on whose behalf he has applied…shall not conceal or fail to disclose that event with intent to obtain a benefit to which the person or any other person is not entitled or in an amount greater than that to which the person or any other person is entitled."

(2) In § 400.606, that "A person shall not enter into an agreement, combination, or conspiracy to defraud the state by obtaining or aiding another to obtain the payment or allowance of a false claim… ."

(3) In § 400.607, that "A person shall not make or present or cause to be made or presented to an employee or officer [of the state] a claim…upon or against the state, knowing the claim to be false… ." and that " A person shall not make or present or cause to be made or presented a claim …which he or she knows falsely represents that the goods or services for which the claim is made were medically necessary … ."

(4) In § 400.604, that a person is prohibited from soliciting, offering, making or receiving a kickback or bribe or rebate of any kind.

325.

Under § 400.612, "A person who receives a benefit which the person is not entitled to receive by reason of fraud or making a fraudulent statement or knowingly concealing a material fact shall forfeit and pay to the state a civil penalty equal to the full amount received plus triple the amount of damages suffered by the state as a result of the conduct by the person".

326.

Defendants have violated these provisions of the Michigan FCA and caused damage to the State of Michigan which paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Michigan, and rebates not paid, because of these acts by the Defendants.

COUNT FIFTY-SIX

VIOLATIONS OF THE NEW HAMPSHIRE FCA

N.H. RSA §§ 167:61-b *et seq.*

327.

Relator restates and realleges the allegations contained in Paragraphs 1-326 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

328.

The New Hampshire Medicaid False Claims Act, N.H. RSA §§ 167:61-b *et seq.* (2005), specifically provides, in part, that by certain acts a person commits an unlawful act and shall be liable to the state for a civil penalty and three times the amount of damages that the state sustains because of the act if that person:

> (a) presents, or causes to be presented, to the state a claim for payment under the Medicaid program knowing that such claim is false or fraudulent claim;
>
> (b) makes, uses or causes to be made or used a record or statement to get a false or fraudulent claim under the Medicaid program paid for or approved by the state knowing such record or statement is false;
>
> (c) conspires to defraud the state by getting a claim allowed or paid under the Medicaid program knowing that such claim is false or fraudulent; [and/or]
>
> (e) makes, uses, or causes to be made or used a record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the state, relative to the Medicaid program, knowing that such record or statement is false…."

329.

Defendants knowingly violated these provisions of law by presenting or causing to be presented to the New Hampshire Medicaid program false and/or fraudulent claims for payment and approval, claims which failed to disclose the material violations of the law; knowingly

made, used or caused to be made or used a false record or statement to support such claims and/or to conceal their actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid; and they conspired to defraud the state Medicaid program, all in violation of N.H,. RSA sec. 167:61-b I. (a)-(c) and (e).

330.

Defendants knowingly presented or caused to be presented to the Medicaid program false and fraudulent claims for payment and approval, and false or fraudulent statements or records, all of which failed to disclose the material violations of the AKA and other laws, and conspired to do so, all in violation of the State FCA.

331.

The State of New Hampshire paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in New Hampshire, and rebates not paid, because of these acts by the Defendants.

COUNT FIFTY-SEVEN

VIOLATIONS OF
THE NEW JERSEY FALSE CLAIMS ACT

332.

Relator restates and realleges the allegations contained in Paragraphs 1-331 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

333.

The New Jersey False Claims Act specifically provides that, under pain of treble damages or a maximum and a sum not less than nor more than the civil penalty under the federal False Claims Act per individual violation, any person who:

> (a) Knowingly presents or causes to be presented to the an employee, officer or agent of the State, or to any contractor, grantee or other recipient of State funds, a false claim for payment or approval;
> (b) Knowingly makes, uses, or causes to be made or used a false record or statement to get a false claim paid or approved by the State;
> (c) Conspires to defraud the State by getting a false claim allowed or paid;
> (d) Has possession, custody, or control of public property or money used, or to be used by the State and, knowingly delivers or causes to be delivered less property than the amount for which the person receives a certificate or receipt…or
> (g) Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the State.

334.

Defendants knowingly violated these provisions of law by presenting or causing to be presented to the New Jersey Medicaid program false and/or fraudulent claims for payment and approval, claims which failed to disclose the material violations of the law; knowingly made, used or caused to be made or used a false record or statement to support such claims and/or to conceal their actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid; and they conspired to defraud the state Medicaid program, all in violation of the New Jersey FCA.

335.

Defendants knowingly presented or caused to be presented to the New Jersey Medicaid program false and fraudulent claims for payment and approval, claims which failed to disclose the material violations of the AKA and other laws, in violation of the NJ FCA 3(a) to (d) and (g).

336.

The State of New Jersey paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in New Jersey, and rebates not paid, because of these acts by the Defendants.

COUNT FIFTY-EIGHT

VIOLATIONS OF THE NEW MEXICO MEDICAID FCA and NEW MEXICO FRAUD AGAINST TAXPAYERS ACT N.M. LEGIS 49 (2004 and 2007) CHAPTER 4

337.

Relator restates and realleges the allegations contained in Paragraph 1-336 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

338.

The New Mexico Medicaid False Claims Act, §27-14-1 to §27-14-15, specifically provides, in part, that by certain acts "a person commits an unlawful act and shall be liable to the state for three times the amount of damages that the state sustains because of the act if that person [including]:

§27-14-4A. presents, or causes to be presented, to the state a claim for payment under the Medicaid program knowing that such claims is false or fraudulent claim;

B. presents, or causes to be presented, to the state a claim for payment under the Medicaid program knowing that the person receiving a Medicaid benefit or payment is not authorized or is not eligible for a benefit under the Medicaid program;

C. makes, uses or causes to be made or used a record or statement to obtain a false or fraudulent claim under the Medicaid program paid for or approved by the state knowing such record or statement is false;

D. conspires to defraud the state by getting a claim allowed or paid under the Medicaid program knowing that such claim is false or fraudulent; [and/or]

E. makes, uses, or causes to be made or used a record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the state, relative to the

Medicaid program, knowing that such record or statement is false…."

339.

Defendants knowingly violated these provisions of law and the similar provisions of the 2007 New Mexico Fraud Against Taxpayers by presenting or causing to be presented to the New Mexico Medicaid program false and/or fraudulent claims for payment and approval, claims which failed to disclose the material violations of the law; knowingly made, used or caused to be made or used a false record or statement to support such claims and/or to conceal its actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid; and conspired to defraud the state Medicaid program, all in violation of the New Mexico Medicaid False Claims Act and the New Mexico Fraud Against Taxpayers Act.

340.

Defendants knowingly presented or caused to be presented to the Medicaid program false and fraudulent claims for payment and approval, and false or fraudulent statements or records, all of which failed to disclose the material violations of the AKA and other laws, and conspired to do so, all in violation of the New Mexico FCA.

341.

The State of New Mexico paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in New Mexico, and rebates not paid, because of these acts by the Defendants.

COUNT FIFTY-NINE

VIOLATIONS OF THE NEW YORK STATE FCA:
2007 NEW YORK LAWS 58, § 39, ARTICLE XIII, §189 (a)

342.

Relator restates and realleges the allegations contained in Paragraphs 1-341 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

343.

The New York FCA, provides in relevant part as follows:

§ 189. Liability for certain acts.

1. Subject to the provisions of subdivision two of this section, any person who:

(a) knowingly presents, or causes to be presented, to any employee, officer or agent of the state or a local government, a false or fraudulent claim for payment or approval;
(b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state or a local government;
(c) conspires to defraud the state or a local government by getting a false or fraudulent claim allowed or paid;
(d) has possession, custody, or control of property or money used, or to be used, by the state or a local government and, intending to defraud the state or a local government or willfully to conceal the property or money, delivers, or causes to be delivered, less property or money than the amount for which the person receives a certificate or receipt;
(e) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the state or a local government and, intending to defraud the state or a local government, makes or delivers the receipt without completely knowing that the information on the receipt is true; or
(g) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state or a local government;

shall be liable: (i) to the state for a civil penalty of not less than six thousand dollars and not more than twelve thousand dollars, plus three times the amount of damages which the state sustains because of the act of that person… .

344.

Defendants knowingly violated these provisions of law by presenting or causing to be presented to the New York Medicaid program false and/or fraudulent claims for payment and approval, claims which failed to disclose the material violations of the law; knowingly made, used or caused to be made or used a false record or statement to support such claims and/or to conceal its actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid, and conspired to defraud the state Medicaid program, all in violation of the New York FCA.

345.

Defendants knowingly presented or caused to be presented to the Medicaid program false and fraudulent claims for payment and approval, and false or fraudulent statements or records, all of which failed to disclose the material violations of the AKA and other laws, and conspired to do so, all in violation of the State FCA.

346.

The State of New York paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in New York, and rebates not paid, because of these acts by the Defendants.

COUNT SIXTY

VIOLATIONS OF THE OKLAHOMA MEDICAID FALSE CLAIMS ACT 2007 OK. ALS 137

347.

Relator restates and realleges the allegations contained in Paragraphs 1-346 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

348.

The Oklahoma Medicaid False Claims Act 2007 OK ALS 137, codified in Title 63, § 5053.1, specifically provides, in part, that:

> (a) Any person who:
>
> (1) Knowingly presents, or causes to be presented, to an officer or employee of the State of Oklahoma, a false or fraudulent claim for payment or approval;
> (2) Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state;
> (3) Conspires to defraud the states by getting a false or fraudulent claim allowed or paid;
> (4) Has possession custody or control of property or money used, or to be used, by the state and, intending to defraud the state or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate of receipt…or
> (7) Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state,
>
> is liable to the State of Oklahoma for a civil penalty of not less than $5,000.00 and not more than $10,000.00 unless a penalty is imposed for the act of that person in violation of this subsection under the federal False Claims Act for the same or a prior action, plus three times the amount of damages which the states sustains because of the act of that person.

349.

Defendants knowingly violated these provisions of law by presenting or causing to be presented to the Oklahoma Medicaid program false and/or fraudulent claims for payment and approval, claims which failed to disclose the material violations of the law; knowingly made, used or caused to be made or used a false record or statement to support such claims and/or to

conceal its actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid; and conspired to defraud the state Medicaid program, all in violation of the Oklahoma FCA.

350.

Defendants knowingly presented or caused to be presented to the Oklahoma Medicaid program false and fraudulent claims for payment and approval, claims which failed to disclose the material violations of the AKA and other laws, in violation of the Oklahoma Medicaid False Claims Act sub-sections (B)(1)-(4) and (7).

351.

The State of Oklahoma paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Oklahoma, and rebates not paid, because of these acts by the Defendants.

COUNT SIXTY-ONE

VIOLATIONS OF THE RHODE ISLAND FALSE CLAIMS ACT

Sec. 9-1.1-1

352.

Relator restates and realleges the allegations contained in Paragraphs 1-351 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

353.

The Rhode Island False Claims Act specifically provides, in part, that:

(a) Any person who:

(1) Knowingly presents, or causes to be presented, to an officer or employee of the state or a member of the guard a false or fraudulent claim for payment or approval;

> (2) Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state;
> (3) Conspires to defraud the state by getting a false or fraudulent claim allowed or paid;
> (4) Has possession custody or control of property or money used, or to be used by the state and, intending to defraud the state or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate of receipt…or
> (7) Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the state,
>
> is liable to the state for a civil penalty of not less than $5,000.00 and not more than $10,000.00, plus three (3) times the amount of damages which the state sustains because of the act of that person. A person violating this subsection (a) shall also be liable to the state for the costs of a civil action brought to recover any such penalty or damages.

354.

Defendants knowingly violated these provisions of law by presenting or causing to be presented to the Rhode Island Medicaid program false and/or fraudulent claims for payment and approval, claims which failed to disclose the material violations of the law; knowingly made, used or caused to be made or used a false record or statement to support such claims and/or to conceal its actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid; and conspired to defraud the state Medicaid program, all in violation of the Rhode Island FCA.

355.

Defendants knowingly presented or caused to be presented to the Medicaid program false and fraudulent claims for payment and approval, and false or fraudulent statements or records, all of which failed to disclose the material violations of the AKA and other laws, and conspired to do so, all in violation of the State FCA.

356.

The State of Rhode Island paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Rhode Island, and rebates not paid, because of these acts by the Defendants.

COUNT SIXTY-TWO

VIOLATIONS OF THE WISCONSIN FALSE CLAIMS FOR MEDICAL ASSISTANCE ACT, CHAPTER 20 SUBCHAPTER 91

357.

Relator restates and realleges the allegations contained in Paragraphs 1-356 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

358.

The Wisconsin False Claims for Medical Assistance Act specifically provides, in relevant part at 20.931(2) that, under pain of treble damages and a maximum of $10,000 per individual violation, any person who:

> (a) Knowingly presents or causes to be presented to any officer, employee or agent of this state a false claim for medical assistance.
> (b) Knowingly makes, uses, or causes to be made or used a false record or statement to obtain approval or payment of a false claim for medical assistance.
> (c) Conspires to defraud this state by obtaining allowance or payment of a false claim for medical assistance, or by knowingly making or using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or to transmit money or property to the Medical Assistance Program.
> (g) Knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid or decrease any obligation to pay or transmit money or property to the Medical Assistance program.

359.

Defendants knowingly violated these provisions of law by presenting or causing to be presented to the Wisconsin Medicaid program false and/or fraudulent claims for payment and approval, claims which failed to disclose the material violations of the law; knowingly made,

used or caused to be made or used a false record or statement to support such claims and/or to conceal its actions and to avoid or decrease an obligation to pay or transmit money to the state, including without limitation, by failing to alert the state government or to pay the correct rebate amounts to Medicaid; and conspired to defraud the state Medicaid program, all in violation of the Wisconsin FCA.

360.

Defendants knowingly presented or caused to be presented to the Medicaid program false and fraudulent claims for payment and approval, and false or fraudulent statements or records, all of which failed to disclose the material violations of the AKA and other laws, and conspired to do so, all in violation of the Wisconsin FCA , 20.931(2)(a)-(c) and (g).

361.

The State of Wisconsin paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from false claims for medical assistance filed in Wisconsin, and rebates not paid, because of these acts by the Defendant.

PRAYERS FOR RELIEF

WHEREFORE, Relator Christopher Gobble, acting on behalf of and in the name of the United States of America and the State Plaintiffs, and on his own behalf, demands and prays that judgment be entered as follows against each Defendant under the Federal FCA and under supplemental State FCA claims as follows:

(a) In favor of the United States against each Defendant, jointly and severally, for treble the amount of damages to Federal Health Care Programs from the marketing, selling, prescribing, pricing and billing of Celexa and Lexapro, plus maximum civil penalties of Eleven Thousand Dollars ($11,000.00) for each false claim;

(b) In favor of the United States against each Defendant, jointly and severally, for disgorgement of the profits earned by Defendants as a result of their illegal scheme;

(c) In favor of the Relator for the maximum amount allowed pursuant to 31 U.S.C. § 3730(d) to include reasonable expenses, attorney fees and costs incurred by Relator;

(d) In favor of Relator against Defendants for all available damages and relief under 31 U.S.C. § 3730(h), including, without limitation, two times back pay plus interest (and prejudgment interest), reinstatement, front pay, and compensation for any special damages and/or exemplary or punitive damages, and litigation costs, and attorneys' fees.

(e) In favor of the Relator for damages available under 31 U.S.C. §3730(h) for wrongful employment termination, to include two times back pay plus interest, compensation for special damages, litigation costs and attorney fees, and punitive damages;

(f) For all costs of the Federal FCA civil action;

(g) In favor of the Relator and the United States for such other and further relief as this Court deems to be just and equitable;

(h) In favor of the Relator and the named State Plaintiffs against Defendants jointly and severally in an amount equal to three times the amount of damages that California, Delaware, District of Columbia, Florida, Hawaii, Illinois, Louisiana, Massachusetts, Nevada, Tennessee, Virginia, Georgia; Indiana; Michigan; New Hampshire; New Jersey; New Mexico; New York; Oklahoma; Rhode Island; and Wisconsin have sustained, respectively, as a result of the Defendants' actions, as well as a civil penalty against the Defendants of a statutory maximum for each violation of each State's FCA.

(i) In favor of the Relator and the Plaintiff State of Texas against each Defendant jointly and severally in an amount equal to two times the amount of damages that Texas has sustained as a result of the Defendants' actions, as well as a civil penalty against the Defendants of a statutory maximum for each violation of Tex. Hum. Res. Code § 36.002;

(j) In favor of the Relator for the maximum amount allowed pursuant to Cal. Gov't Code 12652(g); Del. Code Ann. Tit. 6, § 1205; D.C. Code § 2-308.14(f); Fla. Stat. § 68.085; Haw. Rev. Stat. § 661-27; 740 Ill. Comp. Stat. § 175/4(d); 46 La. Rev. Stat. c. 3, sec. 437.1 et seq., Mass. Gen. Laws Ch. 12, § 5F; Nev. Rev. Stat. §§ 357.210, 357.220, Tenn. Code Ann. § 71-5-183(c); Tex. Hum. Res. Code § 36.110, and Va. Code Ann. § 8.01-216.7; Ga. Code Anno. 49-4-168 et. seq.; Indiana, IC 5-11-5.5; Michigan, MI ST Ch. 400, 400.602 et. seq.; New Hampshire, N.G. RSA §§ 167:61-b et. seq.; New Jersey, Sec. 2A:32C-1 et. seq.; New Mexico, N.M. LEGIS 49 (2004 AND 2007) Chap. 4; New York State, 2007 New York Laws 58, Sec. 39, Article XIII, Sec. 189(a) et seq.; Oklahoma, 2007

OK. ALS 137; Rhode Island, Sec. 9-1.1-1 et. seq.; Wisconsin, Chapter 20, Subchapter 91, 20.931;

(k) In favor of the Relator for all costs and expenses associated with the pendent State claims, including attorney's fees; and

(l) In favor of the State Plaintiffs and the Relator for all such other relief as the Court deems just and proper.

JURY DEMAND

RELATOR DEMANDS A TRIAL BY JURY BE HAD AS TO THE ALLEGATIONS AGAINST EACH DEFENDANT SET FORTH HEREIN.

This 8th day of January, 2010.

Respectfully submitted,

/s/ Suzanne E. Durrell
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CERTIFICATE OF SERVICE

I hereby certify that this document, filed through the ECF system, will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF), and paper copies will be mailed first class mail, postage prepaid to any non registered participants.

January 8, 2010

/s/ Suzanne E. Durrell
Suzanne E. Durrell