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IN THE SUPERIOR COURT OF THE STATE OF ARIZONA
IN AND FOR THE COUNTY OF MARICOPA

STATE OF ARIZONA, *EX REL.* KRIS MAYES, ATTORNEY GENERAL,

Plaintiff,

vs.

OPTUM, INC.;
OPTUMRX, INC.;
OPTUMINSIGHT, INC.;
UNITEDHEALTH GROUP, INC.;
CVS HEALTH CORPORATION;
CVS PHARMACY, INC;
CAREMARK RX, LLC;
CAREMARK PCS HEALTH, LLC;
CAREMARK, LLC;
EVERNORTH HEALTH, INC. (FORMERLY EXPRESS SCRIPTS HOLDING COMPANY);
EXPRESS SCRIPTS, INC.;
EXPRESS SCRIPTS ADMINISTRATORS, LLC;
MEDCO HEALTH SOLUTIONS, INC.;
ESI MAIL PHARMACY SERVICES, INC.;
EXPRESS SCRIPTS PHARMACY, INC.;
ELI LILLY AND COMPANY;
SANOFI-AVENTIS U.S. LLC;
NOVO NORDISK INC.;

Defendants.

Case No.: _____

COMPLAINT AND DEMAND FOR JURY TRIAL

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Plaintiff, the State of Arizona, brings this action against the above-named Defendants and alleges as follows:

I. INTRODUCTION

A. Background

1. The State brings this public enforcement action to protect Arizona consumers from Defendants' unfair or deceptive acts, practices, and omissions in the pricing of diabetes medications.

2. The cost of diabetes medications has skyrocketed over the past 20 years. Over that time, while the average cost of consumer goods and services has risen 1.75-fold, the cost of some diabetes medications has risen more than 10-fold. These price increases are not due to the rising cost of goods, production costs, investment in research and development, or competitive market forces. These price increases have been engineered by Defendants to exponentially increase their profits at the expense of consumers, including payors. It is a multi-billion-dollar industry.

3. Diabetes is widespread. According to the American Diabetes Association, the total estimated cost of diabetes in the United States in 2017 was $327 billion. One in four healthcare dollars is spent caring for people with diabetes.

4. In Arizona alone, diabetes costs about $5.1 billion per year in direct medical expenses.

5. Over 631,000 Arizonans—11% of the adult population—currently have diabetes. A report issued by the Arizona Department of Health Services predicts that, by 2050, there could be almost 12 million people living in Arizona and that almost half of them could have diabetes or prediabetes.

6. Defendants Eli Lilly, Novo Nordisk, and Sanofi (collectively, the "Manufacturer Defendants" or "Manufacturers") manufacture nearly all insulins and other diabetes medications available in the United States. In 2020—as in years past—

the three Manufacturer Defendants controlled 92% (by volume) and 96% (by revenue) of the global market for diabetes drugs.

7. Defendants CVS Caremark, Express Scripts, and OptumRx (collectively, the "PBM Defendants") are pharmacy benefit managers that work in concert with the Manufacturers to dictate the availability and price of the at-issue drugs for most of the U.S. market. For purposes of this Complaint, the "at-issue drugs" or "at-issue medications" include: Apidra, Basaglar, Humalog, Humulin N, Humulin R, Humulin R 500, Humulin 70/30, Lantus, Levemir, Novolin N, Novolin R, Novolin 70/30, Novolog, Ozempic, Soliqua, Toujeo, Tresiba, Trulicity, and Victoza.

8. The PBM Defendants are, at once, (a) the three largest PBMs in the United States (controlling more than 80% of the PBM market); (b) the largest pharmacies in the United States (comprising three of the top five dispensing pharmacies in the United States); and (c) housed within the same corporate enterprises as three of the largest insurance companies in the United States—Aetna (CVS Health), Cigna (Express Scripts), and UnitedHealthcare (OptumRx).

9. For transactions in which the PBM Defendants control the insurer, the PBM, and the pharmacy (*e.g.*, Aetna–Caremark–CVS Pharmacy)—these middlemen capture as much as half of the money spent on each insulin prescription (up from 25% in 2014), even though they contribute nothing to the innovation, development, manufacture, or production of the drugs.

10. The PBMs establish national formulary offerings (i.e., approved drug lists) that, among other things, set the baseline for which diabetes medications are covered and which are not covered for consumers in the United States, including in Arizona.

11. The Manufacturers and PBMs understand that the PBMs' national formularies drive drug utilization. The more accessible a drug is on the PBMs' national formularies, the more that drug will be purchased throughout the United States.

Conversely, the exclusion of a drug from one or more of the PBMs' formularies can render the drug virtually inaccessible for millions of covered persons.

12. Given the PBMs' market power and the crucial role their standard formularies play in the pharmaceutical pricing chain, both Defendant groups understand that the PBM Defendants wield enormous influence over drug prices and purchasing behavior.

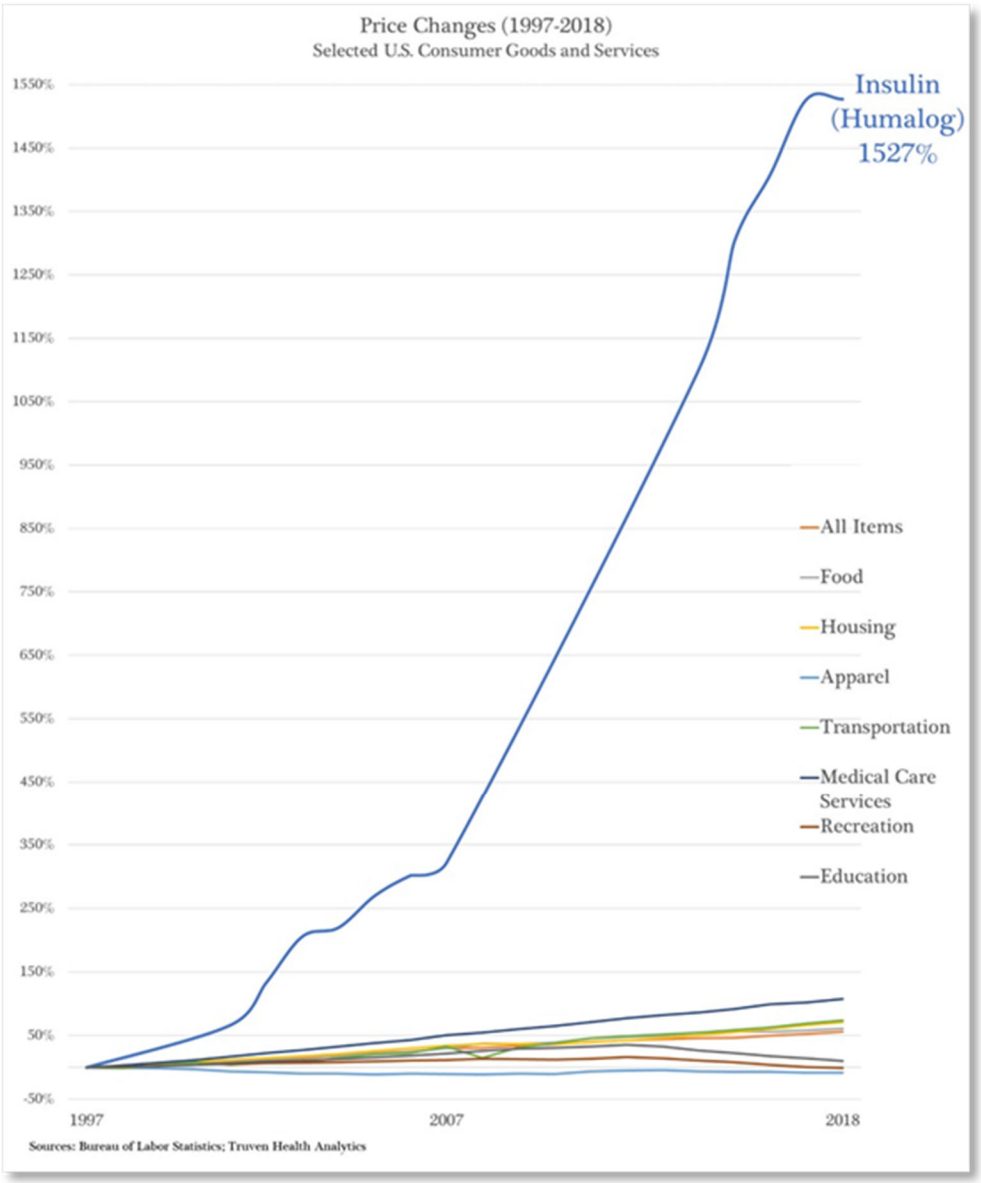
13. The unfair and deceptive conspiracy at the root of this Complaint—the "Insulin Pricing Scheme"—was borne from this mutual understanding.

14. The Manufacturers set the initial list price—i.e., wholesale acquisition cost (WAC)—for their respective insulin medications. Over the last 20 years, list prices have sharply increased in lockstep, even though the cost to produce these drugs has decreased during that period.

15. Insulins, which today cost Manufacturers as little as $2 per vial to produce, and which were priced at $20 per vial in the 1990s, now range in price from $300 to $700.

16. The Manufacturer Defendants have in tandem increased the prices of their insulins up to 1000%, taking the same increase down to the decimal point within a few days of one another and, according to a U.S. Senate Finance Committee investigation, "sometimes mirroring" one another in "days or even hours." Figure 1 reflects the rate at which Defendant Eli Lilly raised the list price of its analog insulin, Humalog, compared to the rate of inflation for other consumer goods and services during the period from 1997-2018.

Figure 1: Price Increase of Insulin (Humalog) vs. Selected Consumer Goods, 1997-2018



17. Today's exorbitant prices are contrary to the intent of insulin's inventors, who sold their original patent rights to the University of Toronto for $1 each, reasoning that "[w]hen the details of the method of preparation are published anyone would be free to prepare the extract, but no one secure a profitable monopoly." One of the inventors, Sir Frederick Banting, MD, stated that "[i]nsulin does not belong to me, it

belongs to the world." But today, in stark contrast to its inventor's noble aims, insulin is the poster child for skyrocketing pharmaceutical prices.

18. Little about these medications has changed over the past 100 years; there has been no significant innovation that would explain the dramatic price increase in insulins.

B. How the Insulin Pricing Scheme Works

19. In the simplest terms, there are three important participants in the insulin medication chain.

a. *Consumers*. Consumers, including health insurance plans, purchase the at-issue insulin medications. Health insurance plans provide cost coverage and reimbursements for medical treatment and care of individuals. These plans often include pharmacy benefits, meaning that the health plan pays a substantial share of the purchase price of its beneficiaries' prescription drugs, including the at-issue diabetes medications. Operators of these plans may be referred to as payors or plan sponsors (or PBM "clients"). The three main types of payors are government/public payors, commercial payors, and private payors.

b. *PBMs.* Payors routinely engage pharmacy benefit managers (PBMs) to manage their prescription benefits, which includes negotiating prices with drug manufacturers and (ostensibly) helping payors manage drug spending. Each PBM maintains a formulary—a list of covered medications. A PBM's power to include or exclude a drug from its formulary theoretically should incentivize manufacturers to lower their list prices. PBMs also contract with pharmacies to dispense medications purchased by the plan's beneficiaries. PBMs

are compensated by retaining a portion of what—again in theory—should be shared savings on the cost of medications.

c. *Manufacturers.* Manufacturers produce the at-issue insulin medications.[1] Each sets a list price for its products. The term "list price" often is used interchangeably with the Wholesale Acquisition Cost (WAC) (defined by federal law as the undiscounted list price for a drug or biologic to wholesalers). The manufacturers self-report list prices to publishing compendiums such as First DataBank, Medi-Span, or Redbook, who then publish those prices.[2]

20. Given the PBMs' purchasing power and their control over formularies that govern the availability of drugs, their involvement should theoretically drive down list prices because drug manufacturers normally compete for inclusion on the standard national formularies. For insulin, however, to gain access to the PBMs' formularies, the Manufacturers artificially *inflate* their list prices and then pay a significant, yet undisclosed, portion of that inflated price back to the PBMs (collectively, the "Manufacturer Payments"). The Manufacturer Payments bear a variety of dubious labels, including rebates, discounts, credits, inflation/price protection fees, and administrative fees. By whatever name, the inflated list prices and resulting Manufacturer Payments are a quid pro quo for inclusion and favorable placement on the PBMs' formularies.

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[1] There are three types of insulin medications. First are *biologics,* which are manufactured insulins derived from living organisms. Second are *biosimilars*, which are "highly similar" copies of biologics. They are similar in concept to "generic" drugs; but in seeking approval, use biologics (rather than drugs) as comparators. Third, the confusingly-named *authorized generics* are not true generics—they are an approved brand-name drug marketed without the brand name on the label. Because the FDA approved the original insulins as drug products rather than biologics, generic competition from biosimilars was effectively precluded until recently, when the FDA recategorized insulin as a biologic.

[2] The related term "Average Wholesale Price" (AWP) is the published price for a drug sold by wholesalers to retailers.

21. Favorable or preferred placement may, for example, involve placing a branded product in a lower cost-sharing tier or relaxing utilization controls (such as prior authorization requirements or quantity limits). Favorable placement of a relatively more expensive drug encourages use of that drug and leads to higher out-of-pocket costs for payors and co-payors.

22. Contracts between PBMs and payors tie the definition of "rebates" to patient drug utilization. But the contracts between PBMs and Manufacturers define "rebates" and other Manufacturer Payments differently, e.g., by calling rebates for formulary placement "administrative fees." Defendants thus profit from the "rebates" and other Manufacturer Payments, which are shielded from payors' contractual audit rights, thereby precluding payors from verifying the components or accuracy of the "rebates" that payors receive.

23. The PBM Defendants' staggering revenues vastly exceed the fair market value of the services they provide—both generally and with respect to the at-issue drugs.

24. The Manufacturers' initial list prices (WAC) for the at-issue drugs are not the result of free-market competition for payors' business. To the contrary, their list prices are the product of collusion between the Manufacturers and the PBMs to facilitate the Insulin Pricing Scheme.[3]

25. The PBM Defendants grant formulary status based on (a) the *highest inflated price* and (b) which diabetes medications generate the largest profits for themselves.

26. The Insulin Pricing Scheme thus creates a "best of both worlds" scenario for Defendants. The Manufacturers buy formulary access and thereby increase their sales and revenues, while the PBM Defendants receive significant, secret Manufacturer Payments based on the Manufacturers' inflated list prices.

[3] In this Complaint, "net price" refers to the amount that the Manufacturers realize for the at-issue drugs, which is roughly the List Price less Manufacturer Payments.

27. The PBM Defendants profit off the Insulin Pricing Scheme in many ways, including: (a) retaining a significant, yet secret, share of the Manufacturer Payments, either directly or through rebate aggregators, (b) using the price produced by the Insulin Pricing Scheme to generate unwarranted profits from pharmacies, and (c) relying on those same artificially inflated list prices to drive up the PBMs' margins and pharmacy-related fees, including those relating to their mail-order pharmacies. In addition, because the PBM Defendants claim that they can extract higher rebates due to their market power, ever-rising list prices increase demand for PBMs' purported negotiation services.

28. As detailed below, although the PBM Defendants represent both publicly and directly to their client payors and the public that they use their market power to drive down prices for diabetes medications, these representations are false and deceptive. Instead, the PBMs intentionally incentivize the Manufacturers to inflate their list prices. The PBMs' "negotiations" with Manufacturers intentionally drive up the price of the at-issue drugs and are directly responsible for the skyrocketing prices of diabetes medications, conferring unearned benefits upon the PBMs and Manufacturers alike.

29. Because the purchase price of every at-issue diabetes medication flows from the artificially inflated list prices generated by Defendants' unfair and deceptive scheme, every consumer (including payors) in the United States that purchases these life-sustaining drugs is directly harmed by the Insulin Pricing Scheme.

30. Consumers of insulin in Arizona, to include both individuals and payors, have been overcharged substantial amounts of money during the relevant period as a direct result of the Insulin Pricing Scheme.

31. A substantial proportion of these overcharges are attributable to the artificially inflated prices of the at-issue drugs, which arose not from transparent or competitive market forces, but from undisclosed, opaque, unfair, and unlawful dealings between the Manufacturer Defendants and the PBM Defendants.

32. This action alleges that Defendants violated Arizona's Consumer Fraud Act by engaging in the Insulin Pricing Scheme. The Insulin Pricing Scheme directly and foreseeably caused, and continues to cause, harm to consumers in Arizona.

33. This action seeks injunctive relief, restitution, disgorgement, civil penalties, attorneys' fees and costs, and all other available relief to address and abate the harm caused by the Insulin Pricing Scheme.

34. The "relevant period" alleged in this action is from 2003 through the present.

II. PARTIES

A. Plaintiff

35. Plaintiff, the State of Arizona, is a body politic created by the Constitution and laws of the State. This action is brought by the State, by and through Kris Mayes, Attorney General of the State of Arizona, in its sovereign capacity, in order to protect the interests of the State and its citizens. Attorney General Mayes is acting pursuant to her authority under A.R.S. § 41-193(A)(2) and A.R.S. § 44-1528 (Attorney General may seek relief under the Arizona Consumer Fraud Act).

36. Plaintiff seeks relief for the harm suffered by consumers in Arizona because of Defendants' unfair or deceptive acts and omissions regarding their illegal Insulin Pricing Scheme.

B. The Manufacturer Defendants

1. Eli Lilly

37. Defendant Eli Lilly and Company ("Eli Lilly") is an Indiana corporation with its principal place of business at Lilly Corporate Center, Indianapolis, Indiana 46285.

38. Eli Lilly has been registered to do business in the State of Arizona since 1980. Eli Lilly may be served through its registered agent: National Registered Agents, Inc., 300 W. Clarendon Ave. #230, Phoenix, Arizona 85013.

39. Eli Lilly holds one active pharmacy license in Arizona.

40. In Arizona and nationally, Eli Lilly manufactures, promotes, and distributes several at-issue diabetes medications, including: Humulin N (first U.S. approval in 1982), Humulin R (first U.S. approval in 1982), Humalog (first U.S. approval in 1996), Trulicity (first U.S. approval in 2014), and Basaglar (first U.S. approval in 2015).

41. Eli Lilly transacts business in Arizona, targeting this market for its products, including the at-issue diabetes medications.

42. Eli Lilly employs sales representatives throughout Arizona to promote and sell Humulin N, Humulin R, Humalog, Trulicity, and Basaglar and it uses wholesalers (McKesson, AmerisourceBergen, and Cardinal Health) to distribute the at-issue products to pharmacies and healthcare professionals within Arizona.

43. Eli Lilly also directs advertising and informational materials to Arizona physicians and potential users of Eli Lilly's products.

44. At all relevant times, in furtherance of the Insulin Pricing Scheme, Eli Lilly published its prices for the at-issue diabetes medications throughout Arizona with the express knowledge that payment and reimbursement by consumers, including payors like Plaintiff, would be based on those artificially inflated list prices.

45. During the relevant period, Arizona consumers purchased Eli Lilly's at-issue drugs at prices based on artificially inflated list prices generated by the Insulin Pricing Scheme.

46. All of the Eli Lilly diabetes medications related to the at-issue transactions were paid for and/or reimbursed in Arizona based on the specific inflated prices Eli Lilly caused to be published in Arizona in furtherance of the Insulin Pricing Scheme.

2. Sanofi

47. Defendant Sanofi-Aventis U.S. LLC ("Sanofi") is a Delaware limited liability company with its principal place of business at 55 Corporate Drive, Bridgewater, New Jersey 08807.

48. Sanofi has been registered to business in Arizona since 2006. Sanofi may be served through its registered agent: Corporation Service Company, 8825 N. 23rd Ave., Suite 100, Phoenix, Arizona 85021.

49. Sanofi holds one active pharmacy license in Arizona.

50. Sanofi manufactures, promotes, and distributes pharmaceutical drugs both in Arizona and nationally, including several at-issue diabetes medications, including: Lantus (first U.S. approval in 2000), Apidra (first U.S. approval in April 2004), Toujeo (first U.S. marketing authorization in February 2015), and Soliqua (first U.S. approval in November 2016).

51. Sanofi transacts business in Arizona, targeting this market for its products, including the at-issue diabetes medications.

52. Sanofi employs sales representatives throughout Arizona to promote and sell Lantus, Toujeo, Apidra, and Soliqua, and it uses wholesalers to distribute the at-issue products to pharmacies and healthcare professionals within Arizona.

53. Sanofi also directs advertising and informational materials to Arizona physicians and potential users of Sanofi's products for the specific purpose of selling the at-issue drugs in Arizona and profiting from the Insulin Pricing Scheme.

54. At all relevant times, in furtherance of the Insulin Pricing Scheme, Sanofi published prices of its at-issue diabetes medications throughout Arizona for the purpose of payment and reimbursement by consumers, including payors.

55. During the relevant period, consumers in Arizona, including payors like the State, purchased Sanofi's at-issue drugs at prices based on artificially inflated list

prices that Sanofi caused to be published in Arizona in furtherance of the Insulin Pricing Scheme.

3. Novo Nordisk

56. Defendant Novo Nordisk Inc. ("Novo Nordisk") is a Delaware corporation with its principal place of business at 800 Scudders Mill Road, Plainsboro, New Jersey 08536.

57. Novo Nordisk holds one active pharmacy license in Arizona.

58. Novo Nordisk manufactures, promotes, and distributes pharmaceutical drugs both in Arizona and nationally, including: Novolin R (first U.S. approval in 1991), Novolin N (first U.S. approval in 1991), Novolog (first U.S. approval in June 2002), Levemir (first U.S. approval in June 2005), Victoza (first U.S. approval in January 2010), Tresiba (first U.S. approval in 2015), and Ozempic (first U.S. approval in 2017).

59. Novo Nordisk transacts business in Arizona, targeting this market for its products, including the at-issue diabetes medications.

60. Novo Nordisk employs sales representatives throughout Arizona to promote and sell Novolin R, Novolin N, Novolog, Levemir, Tresiba, Victoza, and Ozempic, and it uses wholesalers to distribute the at-issue products to pharmacies and healthcare professionals within Arizona.

61. Novo Nordisk also directs advertising and informational materials to Arizona physicians and potential users of Novo Nordisk's products.

62. At all times relevant hereto, in furtherance of the Insulin Pricing Scheme, Novo Nordisk published its prices of its at-issue diabetes medications throughout Arizona for the purpose of payment and reimbursement by consumers, including payors.

63. During the relevant period, Arizona consumers, including payors, purchased Novo Nordisk's at-issue diabetes medications at prices based on artificially inflated list prices that Novo Nordisk caused to be published in Arizona in furtherance of the Insulin Pricing Scheme.

64. As set forth above, Eli Lilly, Sanofi, and Novo Nordisk are referred to collectively as the "Manufacturer Defendants" or the "Manufacturers."

C. PBM Defendants

1. CVS Caremark

65. Defendant CVS Health Corporation ("CVS Health") is a Delaware corporation with its principal place of business at One CVS Drive, Woonsocket, Rhode Island 02895.

66. CVS Health transacts business and has locations throughout the United States and Arizona.

67. CVS Health—through its executives and employees, including its CEO, Chief Medical Officer, Executive Vice Presidents, Senior Executives in Trade Finance, Senior Vice Presidents, and Chief Communication Officers—is directly involved in creating and implementing the company policies that inform its PBM services and formulary construction, including with respect to the at-issue drugs involved in the Insulin Pricing Scheme.

68. CVS Health's conduct had a direct effect in Arizona and damaged consumers in the State who purchase insulin.

69. On a regular basis, CVS Health executives and employees communicate with and direct its subsidiaries related to the at-issue PBM services and formulary activities.

70. In each annual report for at least the last decade, CVS Health (or its predecessor) has repeatedly and explicitly stated that CVS Health itself:

a. designs pharmacy benefit plans that minimize the costs to the client while prioritizing the welfare and safety of the clients' members;

b. negotiates with pharmaceutical companies to obtain discounted acquisition costs for many of the products on CVS Health's drug lists,

and these negotiated discounts enable CVS Health to offer reduced costs to clients; and

c. uses an independent panel of doctors, pharmacists, and other medical experts, referred to as its Pharmacy and Therapeutics Committee, to select drugs that meet the highest standards of safety and efficacy for inclusion on its drug lists.

71. CVS Health publicly represents that it lowers the cost of the at-issue drugs.

72. A 2017 CVS Health report stated that "*CVS Health* pharmacy benefit management (PBM) strategies reduced trend for commercial clients to 1.9 percent per member per year the lowest in five years. Despite manufacturer price increases of near 10 percent, *CVS Health* kept drug price growth at a minimal 0.2 percent."

73. In November 2018, CVS Health acquired Aetna for $69 billion and became the first combination of a major health insurer, PBM, and mail-order and retail pharmacy chain. As a result, CVS Health controls the health plan/insurer, the PBM, and the pharmacies used by approximately 40 million Aetna members in the United States and in Arizona. CVS Health controls the entire drug pricing chain for these 40 million Americans.

74. CVS Health is the immediate or indirect parent of many pharmacy subsidiaries that own and operate hundreds of pharmacies throughout Arizona—including CVS Pharmacy, Inc., which is registered to do business in the state—that dispensed and received payment for the at-issue diabetes medications throughout the relevant period. According to CVS Health's 2022 Form 10-K filed with the U.S. Securities and Exchange Commission, the company "maintains a national network of approximately 66,000 retail pharmacies, consisting of approximately 40,000 chain pharmacies (which include CVS Pharmacy locations) and approximately 26,000 independent pharmacies, in the United States."

75. Defendant CVS Pharmacy, Inc. ("CVS Pharmacy") is a Rhode Island corporation whose principal place of business is at the same location as CVS Health.

76. CVS Pharmacy—a wholly owned subsidiary of CVS Health—has been registered to do business in the State of Arizona since 2001. It may be served through its registered agent: CT Corporation System, 3800 North Central Ave., Suite 460, Phoenix, AZ 85012.

77. CVS Pharmacy is the immediate or indirect parent of many pharmacy subsidiaries that own and operate hundreds of pharmacies throughout Arizona, and it is directly involved in these pharmacies' policies for dispensing and payment related to the at-issue diabetes medications.

78. CVS Pharmacy is also the immediate and direct parent of Defendant Caremark Rx, LLC.

79. CVS Pharmacy holds numerous pharmacy licenses in Arizona.

80. During the relevant period, CVS Pharmacy provided retail pharmacy services in Arizona that gave rise to and implemented the Insulin Pricing Scheme, which damaged consumers, including payors like Plaintiff.

81. Defendant Caremark Rx, LLC is a Delaware limited liability company and an immediate or indirect parent of many subsidiaries, including pharmacy benefit management and mail-order subsidiaries that engaged in the activities in Arizona that gave rise to this action.

82. Caremark Rx, LLC is a subsidiary of Defendant CVS Pharmacy, which is a wholly owned subsidiary of Defendant CVS Health, and its principal place of business is at the same location as CVS Pharmacy and CVS Health.

83. During the relevant period, Caremark Rx, LLC provided PBM and mail-order pharmacy services in Arizona that gave rise to and implemented the Insulin Pricing Scheme and damaged payors in Arizona and the public.

84. Defendant Caremark LLC is a California limited liability company whose principal place of business is at the same location as CVS Health.

85. Caremark, LLC is a subsidiary of Caremark Rx, LLC, which is a subsidiary of Defendant CVS Pharmacy, which is a wholly owned subsidiary of Defendant CVS Health.

86. Caremark, LLC has been registered to do business in Arizona since 2009. Caremark, LLC may be served through its registered agent: CT Corporation System, 3800 North Central Ave., Suite 460, Phoenix, Arizona 85012.

87. Caremark, LLC (d/b/a CVS/Specialty or CarelonRX Specialty Pharmacy) holds six active pharmacy licenses in Arizona.

88. During the relevant period, Caremark, LLC provided PBM and mail-order pharmacy services in Arizona that gave rise to and implemented the Insulin Pricing Scheme, which damaged payors in Arizona and the public.

89. Defendant CaremarkPCS Health, LLC ("CaremarkPCS Health") is a Delaware limited liability company whose principal place of business is at the same location as CVS Health.

90. CaremarkPCS Health is a subsidiary of CaremarkPCS, LLC, which is a subsidiary of Caremark Rx, LLC, which is a subsidiary of Defendant CVS Pharmacy, which is a wholly owned subsidiary of Defendant CVS Health.

91. CaremarkPCS Health has been registered to do business in Arizona since 2009. CaremarkPCS Health may be served through its registered agent: CT Corporation System, 3800 North Central Ave., Suite 460, Phoenix, Arizona 85012.

92. CaremarkPCS Health, doing business as CVS Caremark, provides pharmacy benefit management services.

93. During the relevant period, CaremarkPCS Health provided PBM services in the State of Arizona, which gave rise to and implemented the Insulin Pricing Scheme, which damaged payors in Arizona and the public.

94. Defendants CaremarkPCS Health and Caremark, LLC are agents and/or alter egos of Caremark Rx, LLC, CVS Pharmacy, and CVS Health.

95. As a result of numerous interlocking directorships and shared executives, Caremark Rx, LLC, CVS Pharmacy, and CVS Health are directly involved in the conduct and control of CaremarkPCS Health and Caremark, LLC's operations, management, and business decisions related to the at-issue formulary construction, Manufacturer Payments, and mail-order and retail pharmacy services to the ultimate detriment of consumers, including payors.

96. Defendants CVS Health, CVS Pharmacy, Caremark Rx, LLC, Caremark, LLC, and CaremarkPCS Health, including all predecessor and successor entities, are referred to collectively as "CVS Caremark."

97. CVS Caremark is named as a Defendant in its capacities as a PBM and as a mail-order pharmacy.

98. In its capacity as a PBM, CVS Caremark coordinated with Novo Nordisk, Eli Lilly, and Sanofi regarding the price of the at-issue diabetes medications, as well as for the placement of these firms' diabetes medications on CVS Caremark's formularies.

99. At all relevant times, CVS Caremark offered pharmacy benefit services nationwide and to Arizona payors, and derived substantial revenue therefrom, and, in doing so, (a) made misrepresentations or omissions while concealing the Insulin Pricing Scheme, and (b) used the artificially inflated prices generated by the Insulin Pricing Scheme.

100. At all relevant times, CVS Caremark offered PBM services nationwide and maintained standard formularies that were used nationwide, including in Arizona. Those formularies included diabetes medications, including those at issue in this action, and CVS Caremark participated in pricing the at-issue drugs based off the list prices it knew to be artificially inflated.

101. In its capacity as a mail-order pharmacy, CVS Caremark received payments from Arizona payors for, and set the out-of-pocket price paid for, the at-issue drugs based on the artificially inflated prices produced by the Insulin Pricing Scheme and, as a result, damaged those payors.

102. CVS Caremark purchased drugs directly from manufacturers for dispensing through its pharmacy network.

103. During the relevant period, CVS Caremark dispensed the at-issue medications nationwide through its mail-order pharmacies and derived substantial revenue from these activities in Arizona.

104. Further, in its capacity as a retail pharmacy, CVS Caremark knowingly profited from the artificially inflated list prices produced by the Insulin Pricing Scheme by pocketing the spread between the acquisition cost for the at-issue drugs (an amount well below the list price generated by the Insulin Pricing Scheme) and the amounts it received from payors (which amounts were based on the artificially inflated list prices and, in many cases, were set by CVS Caremark in its capacity as a PBM).

105. During the relevant period, CVS Caremark provided mail-order and retail pharmacy services nationwide and within the State of Arizona and employed prices based on the artificially inflated list prices generated by the Insulin Pricing Scheme.

106. At all relevant times, CVS Caremark dispensed the at-issue medications nationwide and within the State of Arizona through its mail-order and retail pharmacies and it derived substantial revenue from these activities in Arizona.

107. At all relevant times, CVS Caremark had express agreements with Novo Nordisk, Sanofi, and Eli Lilly related to the Manufacturer Payments paid by the Manufacturer Defendants to CVS Caremark, as well as agreements related to the Manufacturers' at-issue drugs sold through CVS Caremark's mail-order pharmacies.

2. Express Scripts

108. Defendant Evernorth Health, Inc. ("Evernorth"), formerly known as Express Scripts Holding Company, is a Delaware corporation with its principal place of business at One Express Way, St. Louis, Missouri 63121.

109. Evernorth, through its executives and employees, including its CEO and Vice Presidents, is directly involved in shaping the company policies that inform its PBM services and formulary construction, including with respect to the at-issue drugs, related to the Insulin Pricing Scheme.

110. Evernorth's conduct had a direct effect in Arizona.

111. On a regular basis, Evernorth executives and employees communicate with and direct Evernorth's subsidiaries related to the at-issue PBM services and formulary activities.

112. Evernorth is the immediate or indirect parent of pharmacy and PBM subsidiaries that operate throughout Arizona, who engaged in the activities that gave rise to this action.

113. In 2018, Evernorth merged with Cigna in a $67 billion deal to consolidate their businesses as a major health insurer, PBM, and mail-order pharmacy. As a result, the Evernorth corporate enterprise controls the health plan/insurer, the PBM, and the mail-order pharmacies used by approximately 15 million Cigna members in the United States, including in Arizona. Evernorth controls the entire drug pricing chain for these 15 million Americans.

114. Evernorth's annual reports over the past several years have repeatedly and explicitly:

a. Acknowledged that it is directly involved in the company's PBM services, stating "[Evernorth is] the largest stand-alone PBM company in the United States."

b. Stated that Evernorth controls costs, including for example, that it: "provid[es] products and solutions that focus on improving patient outcomes and assist in controlling costs; evaluat[es] drugs for efficacy, value and price to assist clients in selecting a cost-effective formulary; [and] offer[s] cost-effective home delivery pharmacy and specialty services that result in cost savings for plan sponsors and better care for members."

115. Defendant Express Scripts, Inc. is a Delaware corporation and is a wholly owned subsidiary of Defendant Evernorth. Express Scripts, Inc.'s principal place of business is at the same location as Evernorth.

116. Express Scripts, Inc. has been registered to do business in Arizona since 1993 and may be served through its registered agent: CT Corporation System, 3800 North Central Ave., Suite 460, Phoenix, Arizona 85012.

117. Express Scripts, Inc. is the immediate or indirect parent of pharmacy and PBM subsidiaries that operate throughout Arizona and that engaged in the conduct that gave rise to this action.

118. During the relevant period, Express Scripts Inc. was directly involved in PBM and mail-order pharmacy services that gave rise to and implemented the Insulin Pricing Scheme, which damaged payors in Arizona and the public.

119. Defendant Express Scripts Administrators, LLC, doing business as Express Scripts and formerly known as Medco Health, LLC, is a Delaware limited liability company and is a wholly owned subsidiary of Evernorth. Its principal place of business is at One Express Way, St. Louis, Missouri 63121—the same location as Evernorth.

120. Express Scripts Administrators, LLC is registered to do business in Arizona and may be served through its registered agent: CT Corporation System, 3800 North Central Ave., Suite 460, Phoenix, Arizona 85012.

121. During the relevant period, Express Scripts Administrators, LLC provided the PBM services in Arizona that gave rise to and implemented the Insulin Pricing Scheme that damaged payors and the public.

122. Defendant Medco Health Solutions, Inc. ("Medco") is a Delaware Corporation whose principal place of business is at the same location as Evernorth.

123. Medco has been registered to do business in Arizona since 2002. Medco may be served through its registered agent: CT Corporation System, 3800 North Central Ave., Suite 460, Phoenix, Arizona 85012.

124. In 2012, Express Scripts acquired Medco for $29 billion.

125. Before the merger, Express Scripts and Medco were two of the largest PBMs in the United States and in Arizona.

126. Before the merger, Medco provided the at-issue PBM and mail-order services, including in Arizona, which gave rise to and implemented the Insulin Pricing Scheme, which damaged payors in Arizona and the public.

127. Following the merger, all of Medco's PBM and mail-order pharmacy functions were combined into Express Scripts. The combined company (Medco and Express Scripts) continued under the name Express Scripts with all of Medco's payor customers becoming Express Scripts' customers. The combined company covered over 155 million lives at the time of the merger.

128. At the time of the merger, on December 6, 2011, in his testimony before the Senate Judiciary Committee, David Snow, then-CEO of Medco, publicly represented that "the merger of Medco and Express Scripts will result in immediate savings to our clients and, ultimately, to consumers. This is because our combined entity will achieve even greater purchasing volume discounts [i.e., Manufacturer Payments] from drug manufacturers and other suppliers."

129. At the same time, the then-CEO of Express Scripts, George Paz, provided written testimony to the Senate Judiciary Committee's Subcommittee on Antitrust,

Competition Policy and Consumer Rights, stating: "A combined Express Scripts and Medco will be well-positioned to protect American families from the rising cost of prescription medicines." First on Mr. Paz's list of "benefits of this merger" was "[g]enerating greater cost savings for patients and plan sponsors."

130. Defendant ESI Mail Pharmacy Service, Inc. is a Delaware corporation and is a wholly owned subsidiary of Defendant Evernorth. ESI Mail Pharmacy Service, Inc.'s principal place of business is at the same location as Evernorth.

131. ESI Mail Pharmacy Service, Inc. has been registered to do business in Arizona since 2000 and may be served through its registered agent: CT Corporation System, 3800 North Central Ave., Suite 460, Phoenix, Arizona 85012.

132. ESI Mail Pharmacy Service, Inc. holds five active pharmacy licenses in Arizona.

133. During the relevant period, ESI Mail Pharmacy Services provided the mail-order pharmacy services in Arizona discussed in this Complaint, which gave rise to and implemented the Insulin Pricing Scheme, which damaged payors and the public.

134. Defendant Express Scripts Pharmacy, Inc. is a Delaware corporation and is a wholly owned subsidiary of Defendant Evernorth. Express Scripts Pharmacy, Inc.'s principal place of business is at the same location as Evernorth.

135. Express Scripts Pharmacy, Inc. has been registered to do business in Arizona since 2021 and may be served through its registered agent: CT Corporation System, 3800 North Central Ave., Suite 460, Phoenix, Arizona 85012.

136. Express Scripts Pharmacy, Inc. holds six active pharmacy licenses in Arizona.

137. During the relevant period, Express Scripts Pharmacy, Inc. provided the mail-order pharmacy services in Arizona that gave rise to and implemented the Insulin Pricing Scheme, which damaged payors and the public.

138. As a result of numerous interlocking directorships and shared executives, Evernorth (f/k/a Express Scripts Holding Company, Inc.) and Express Scripts, Inc. control Express Scripts Administrators, LLC, ESI Mail Pharmacy Service, Inc., Medco Health Solutions, Inc., and Express Scripts Pharmacy, Inc.'s operations, management, and business decisions related to the at-issue formulary construction, negotiations, and mail-order pharmacy services.

139. Defendants Evernorth Health, Inc., Express Scripts, Inc., Express Scripts Administrators, LLC, ESI Mail Pharmacy Service, Inc., Medco Health Solutions, Inc., and Express Scripts Pharmacy, Inc., including all predecessor and successor entities, are referred to collectively as "Express Scripts."

140. Express Scripts is named as a Defendant in its capacities as a PBM and mail-order pharmacy.

141. In its capacity as a PBM, Express Scripts coordinates with Novo Nordisk, Eli Lilly, and Sanofi regarding the price of the at-issue diabetes medications, as well as for the placement of these Manufacturers' diabetes medications on Express Scripts' formularies.

142. Express Scripts transacts business throughout the United States and Arizona.

143. At all relevant times, Express Scripts derived substantial revenue from providing retail and mail-order pharmacy benefits in Arizona using prices based on the artificially inflated list prices for the at-issue drugs.

144. At all relevant times, and contrary to its express representations, Express Scripts knowingly insisted that its payor clients use the artificially inflated list prices produced by the Insulin Pricing Scheme as the basis for reimbursement of the at-issue drugs.

145. At all relevant times, Express Scripts concealed its critical role in generating those artificially inflated list prices.

146. In its capacity as a mail-order pharmacy, Express Scripts received payments from Arizona payors for, and set the out-of-pocket price paid for, the at-issue drugs based on the artificially inflated prices produced by the Insulin Pricing Scheme.

147. At all relevant times, Express Scripts offered pharmacy benefit management services nationwide and maintained standard formularies that are used nationwide, including in Arizona. During the relevant period, those formularies included drugs produced by the Manufacturer Defendants, including the at-issue diabetes medications.

148. Express Scripts purchases drugs directly from manufacturers for dispensing through its pharmacy network.

149. During the relevant period, Express Scripts dispensed the at-issue medications nationwide through its mail-order pharmacies and derived substantial revenue from these activities in Arizona.

150. At all relevant times, Express Scripts had express agreements with Defendants Novo Nordisk, Sanofi, and Eli Lilly related to the Manufacturer Payments paid by the Manufacturer Defendants to Express Scripts, as well as agreements related to the Manufacturers' at-issue drugs sold through Express Scripts' pharmacies.

3. OptumRx

151. Defendant UnitedHealth Group, Inc. is a corporation organized under the laws of Delaware with its principal place of business at 9900 Bren Road East, Minnetonka, Minnesota 55343.

152. UnitedHealth Group, Inc. offers a spectrum of products and services, including health insurance plans through its wholly owned subsidiaries and prescription drugs, through its PBM, OptumRx.

153. Over one-third of UnitedHealth Group's total revenue is attributable to OptumRx, which operates a network of more than 67,000 pharmacies.

154. UnitedHealth Group, through its executives and employees, is directly involved in the company policies that shape its PBM services and formulary construction, including with respect to the at-issue drugs and related to the Insulin Pricing Scheme.

155. UnitedHealth Group's Sustainability Report states that "OptumRx works directly with pharmaceutical manufacturers to secure discounts that lower the overall cost of medications and create tailored formularies – or drug lists – to ensure people get the right medications. [UnitedHealth Group] then negotiate[s] with pharmacies to lower costs at the point of sale . . . [UnitedHealth Group] also operate[s] [mail order pharmacies] . . . . [UnitedHealth Group] work[s] directly with drug wholesalers and distributors to ensure consistency of the brand and generic drug supply, and a reliance on that drug supply."

156. In addition to being a PBM and a mail-order pharmacy, UnitedHealth Group owns and controls a major health insurance company, UnitedHealthcare. As a result, UnitedHealth Group controls the health plan/insurer, the PBM, and the mail-order pharmacies used by more than 26 million UnitedHealthcare members in the United States, including in Arizona. UnitedHealth Group controls the entire drug pricing chain for these 26 million Americans.

157. UnitedHealth Group states in its annual reports that UnitedHealth Group "uses Optum's capabilities to help coordinate patient care, improve affordability of medical care, analyze cost trends, manage pharmacy benefits, work with care providers more effectively and create a simpler consumer experience."

158. Defendant Optum, Inc. is a Delaware corporation with its principal place of business in Eden Prairie, Minnesota. Optum, Inc. is a health services company managing subsidiaries that administer pharmacy benefits, including Defendant OptumRx, Inc.

159. Optum, Inc. is directly involved, through its executives and employees, in the company policies that inform its PBM services and formulary construction, including with respect to the at-issue drugs and related to the Insulin Pricing Scheme, which had a direct effect in Arizona and damaged payors.

160. Defendant OptumRx, Inc. is a California corporation with its principal place of business at 2300 Main Street, Irvine, California 92614.

161. OptumRx, Inc. operates as a subsidiary of OptumRx Holdings, LLC, which in turn operates as a subsidiary of Defendant Optum, Inc.

162. OptumRx, Inc. has been registered to do business in Arizona since 2008 and may be served through its registered agent: CT Corporation System, 3800 North Central Ave., Suite 460, Phoenix, Arizona 85012.

163. OptumRx, Inc. holds five active pharmacy licenses in Arizona.

164. During the relevant period, OptumRx, Inc. provided the PBM and mail-order pharmacy services in Arizona that gave rise to and implemented the Insulin Pricing Scheme, which damaged payors, including Plaintiff, and the public.

165. Defendant OptumInsight, Inc. ("OptumInsight") is a Delaware corporation with its principal place of business in Eden Prairie, Minnesota.

166. OptumInsight, Inc. has been registered to do business in Arizona since 1997 and may be served through its registered agent: CT Corporation System, 3800 North Central Ave., Suite 460, Phoenix, Arizona 85012.

167. OptumInsight is an integral part of the Insulin Pricing Scheme and, during the relevant period, coordinated directly with the Manufacturer Defendants in furtherance of the conspiracy. OptumInsight analyzed data and other information from the Manufacturer Defendants to advise the other Defendants about the profitability of the Insulin Pricing Scheme to the benefit of all Defendants.

168. As a result of numerous interlocking directorships and shared executives, UnitedHealth Group, OptumRx Holdings, LLC and Optum, Inc. are directly involved in

the conduct of and control OptumInsight's and OptumRx's operations, management, and business decisions related to the at-issue formulary construction, negotiations, and mail-order pharmacy services to the ultimate detriment of consumers, including payors.

169. Defendants UnitedHealth Group, Inc., OptumRx, Inc., OptumInsight, and Optum, Inc., including all predecessor and successor entities, are collectively referred to as "OptumRx."

170. OptumRx is named as a Defendant in its capacities as a PBM and mail-order pharmacy.

171. OptumRx is a pharmacy benefit manager and, as such, coordinates with Novo Nordisk, Eli Lilly, and Sanofi regarding the price of the at-issue diabetes medications, as well as for the placement of these Manufacturers' diabetes medications on OptumRx's drug formularies.

172. OptumRx provides pharmacy care services to more than 65 million people in the nation through a network of more than 67,000 retail pharmacies and multiple delivery facilities. It is one of UnitedHealth Group Inc.'s "four reportable segments" (along with UnitedHealthcare, Optum Health, and OptumInsight).

173. At all relevant times, OptumRx derived substantial revenue from providing pharmacy benefits in Arizona.

174. At all relevant times, OptumRx offered pharmacy benefit management services nationwide and maintained standard formularies that are used nationwide, including in Arizona. Those formularies included diabetes medications, including those at issue in this action. OptumRx purchased drugs directly from manufacturers for dispensing through its pharmacy network.

175. At all relevant times, OptumRx concealed its critical role in generating the artificially inflated list prices.

176. In its capacity as a mail-order pharmacy with a contracted network of retail pharmacies, OptumRx received payments from payors for, and set the out-of-pocket

price paid for, the at-issue drugs based on the artificially inflated prices produced by the Insulin Pricing Scheme and, as a result, damaged payors and the public.

177. At all relevant times, OptumRx dispensed the at-issue medications nationwide and in Arizona through its mail-order and retail pharmacies and derived substantial revenue from these activities in Arizona.

178. OptumRx purchases drugs produced by the Manufacturer Defendants, including the at-issue diabetes medications, for dispensing through its mail-order pharmacies and network of retail pharmacies.

179. At all relevant times, OptumRx had express agreements with Novo Nordisk, Sanofi, and Eli Lilly related to the Manufacturer Payments paid by the Manufacturer Defendants to OptumRx, as well as agreements related to the Manufacturers' at-issue drugs sold through OptumRx pharmacies.

180. As set forth above, CVS Caremark, OptumRx, and Express Scripts are referred to collectively as the "PBM Defendants."

III. JURISDICTION AND VENUE

181. Jurisdiction is appropriate in this Court pursuant to A.R.S. § 12-123. The amount in controversy exceeds the jurisdictional minimum. Both the nature of this case and the damages sought in this case qualify for Discovery Tier 3 pursuant to Rule 26.2(c)(3) of the Arizona Rules of Civil Procedure.

182. This Court has personal jurisdiction over each Defendant. Each Defendant: (a) transacts business and/or is admitted to conduct business within Arizona; (2) maintains substantial contacts in Arizona, and (3) committed violations of Arizona statutes in whole or part within the State of Arizona. This action arises out of and relates to each Defendant's contacts with this forum.

183. The Insulin Pricing Scheme has been directed at, and has had the foreseeable and intended effect of, harming consumers residing in, located in, or doing

business in Arizona. At-issue transactions occurred in the State of Arizona and/or involved Arizona residents.

184. Each Defendant purposefully availed itself of the privilege of doing business within this state, and each derived substantial financial gain from doing so. These continuous, systematic, and case-related business contacts—including the tortious acts described herein—are such that each Defendant should reasonably have anticipated being brought into this Court.

185. Each Defendant submitted itself to jurisdiction through, among other things, pervasive marketing; encouraging the use of its services; and its purposeful cultivation of profitable relationships in the State of Arizona.

186. In short, each Defendant has systematically served the Arizona market relating to the Insulin Pricing Scheme and has harmed consumers in Arizona such that there is a strong relationship among Defendants, this forum, and the litigation.

187. Venue is appropriate pursuant to A.R.S. § 12-401 as Maricopa County is the seat of the State government and the Office of the Attorney General.

IV. ADDITIONAL FACTUAL ALLEGATIONS

A. Diabetes and Insulin Therapy

1. The Diabetes Epidemic

188. Diabetes occurs when a person's blood glucose is too high. In people without diabetes, the pancreas secretes the hormone insulin, which controls the rate at which food is converted to blood glucose. When insulin is lacking or when cells stop responding to insulin, however, blood sugar stays in the bloodstream. Over time, this can cause serious health problems, including heart disease, blindness, and kidney disease.

189. There are two basic types of diabetes—Type 1 and Type 2. Roughly 90-95% of diabetics are Type 2, which develops when a person does not produce enough insulin or has become resistant to the insulin they produce. Although Type 2 patients can

initially be treated with tablets, most patients eventually must switch to insulin injections.

190. Diabetes has been on the rise for decades. In 1958, only 1.6 million Americans had diabetes. By the turn of the century, however, that number had grown to over ten million. Fourteen years later, that number had tripled. Today, more than 37 million Americans—approximately 11% of the country—live with the disease.

2. Insulin: A Century-Old Drug

191. Even though diabetes is the eighth leading cause of death in the United States, it is a treatable disease and has been for almost a century. Patients who follow a prescribed treatment plan consistently avoid severe health complications associated with the disease.

192. In 1922, Frederick Banting and Charles Best, while working at the University of Toronto, pioneered a technique for removing insulin from an animal pancreas that could then be used to treat diabetes. Banting and Best obtained a patent and then sold their patent rights to the University of Toronto for $1 (equivalent to $18 today), reasoning that "[w]hen the details of the method of preparation are published anyone would be free to prepare the extract, but no one could secure a profitable monopoly."[4] One of the inventors, Sir Frederick Banting, MD, stated that "[i]nsulin does not belong to me, it belongs to the world."[5]

193. After purchasing the patent, the University of Toronto contracted with Defendants Eli Lilly and Novo Nordisk to scale its production. Under this arrangement, Eli Lilly and Novo Nordisk were allowed to apply for patents on variations to the manufacturing process.

194. The earliest insulin was derived from animals and, until the 1980s, was the only treatment for diabetes. While effective, animal-derived insulin created the risk

[4] Michael Bliss, *The Discovery of Insulin* (2013).
[5] *Id*.

of allergic reaction. This risk was reduced in 1982 when synthetic insulin—known as human insulin because it mimics the insulin humans make—was developed by Eli Lilly. Compared to animal-derived insulin, human insulin is also cheaper to mass-produce. Eli Lilly marketed this insulin as Humulin. The development of human insulin benefited heavily from government and non-profit funding through the National Institutes of Health and the American Cancer Society.

195. In the mid-1990s, Eli Lilly introduced the first analog insulin—a laboratory-grown and genetically altered insulin. These altered forms of human insulin are called "analogs" because they are analogous to the human body's natural pattern of insulin release and more quickly lower blood sugar. Eli Lilly released this analog in 1996 under the brand name Humalog at a cost of $21 per vial (equivalent to $40 in 2022).

196. Other rapid-acting analogs include Novo Nordisk's Novolog and Sanofi's Apidra, which have similar profiles. Rapid-acting insulins are used in combination with longer-acting insulins, such as Sanofi's Lantus and Novo Nordisk's Levemir.

197. The Manufacturer Defendants introduced these rapid-acting and long-acting analog insulins between 1996 and 2007.

198. In 2015, Sanofi introduced Toujeo, another long-acting insulin similar to Lantus. Toujeo, however, is highly concentrated, reducing injection volume as compared to Lantus.

199. In December 2015, Eli Lilly introduced Basaglar—a long-acting insulin that is biologically similar to Sanofi's Lantus.

200. Most insulin presently used in the United States is analog insulin and not human insulin. In 2000, 96% of insulin users used human insulin versus 19% using analog insulin. By 2010, the ratio had switched; only 15% of patients used human insulin while 92% used analog insulin. In 2017, for example, less than 10% of the units of insulin dispensed under Medicare Part D were human insulins.

201. Eli Lilly, Novo Nordisk and Sanofi still make nearly all of the insulin sold in the United States. The market therefore remains concentrated.

202. In 2021, the U.S. House of Representatives Committee on Oversight and Reform issued a report following its investigation into drug pricing ("Drug Pricing Investigation").[6] It expressly included inquiry into the Manufacturer Defendants' insulin pricing strategies[7] and concluded: "Every company in the Committee's investigation engaged in one or more strategies to suppress competition from generics or biosimilars, and keep prices high."[8]

3. Current Insulin Landscape

203. While insulin today is generally safer and more convenient to use than when originally developed in 1922, there is a lack of evidence showing that the overall efficacy of insulin has significantly improved over the last 20 years.

204. Moreover, all of the at-issue insulins in this case have either been available in the same form since the late 1990s or early 2000s or are biologically equivalent to insulins that were available then.

205. Production costs have decreased in recent years. A September 2018 study in BMJ Global Health calculated that, based on production costs, a reasonable and profitable price for a *one-year supply* of human insulin is between $48 and $71 per person and between $78 and $133 for analog insulin. Another recent study found that the Manufacturers could be profitable charging as little as $2 per vial.[9]

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[6] *Drug Pricing Investigation: Majority Staff Report*, Committee on Oversight and Reform U.S. House of Representatives December 2021, available at https://oversightdemocrats.house.gov/sites/democrats.oversight.house.gov/files/DRUG%20PRICING%20REPORT%20WITH%20APPENDIX%20v3.pdf (last visited Nov. 17, 2023).

[7] *Id.* at PDF 4, n.5.

[8] *Id.* at PDF 13.

[9] Gotham D, Barber MJ, Hill A. *Production costs and potential prices for biosimilars of human insulin and insulin analogues*. BMJ Global Health https://gh.bmj.com/content/3/5/e000850 (last visited Nov. 17, 2023).

206. Yet, in 2016, diabetics spent an average of $5,705 for insulin. According to a 2020 RAND report, the 2018 list price per vial across all forms of insulin was just $14.40 in Japan, $12.00 in Canada, $11.00 in Germany, $9.08 in France, $7.52 in the United Kingdom, and less than $7.00 in Australia. In the United States it was $98.70.

207. While R&D costs often contribute significantly to the price of a drug, the initial basic insulin research—original drug discovery and patient trials—occurred 100 years ago and those costs have long since been recouped.

4. Insulin Adjuncts: Type 2 Medications

208. Over the past decade, the Manufacturer Defendants released several non-insulin medications to help control insulin levels, to include Novo Nordisk's Victoza, Eli Lilly's Trulicity, Sanofi's Soliqua, and Novo Nordisk's Ozempic. Each can be used in conjunction with insulins to control diabetes.

209. The following is a list of diabetes medications at issue in this lawsuit:

Insulin Type	Action	Name	Company	FDA Approval	Current/Recent List Price
Human	*Rapid-Acting*	Humulin R	Eli Lilly	1982	$178 (vial)
		Humulin R 500	Eli Lilly	1982	$1784 (vial) $689 (pens)
		Novolin R	Novo Nordisk	1991	$165 (vial) $312 (pens)
	Intermediate	Humulin N	Eli Lilly	1982	$178 (vial) $566 (pens)
		Humulin 70/30	Eli Lilly	1989	$178 (vial) $566 (pens)
		Novolin N	Novo Nordisk	1991	$165 (vial) $312 (pens)
		Novolin 70/30	Novo Nordisk	1991	$165 (vial) $312 (pens)
Analog	*Rapid-Acting*	Humalog	Eli Lilly	1996	$342 (vial) $636 (pens)
		Novolog	Novo Nordisk	2000	$347 (vial) $671 (pens)
		Apidra	Sanofi	2004	$341 (vial) $658 (pens)
	Long-Acting	Lantus	Sanofi	2000	$340 (vial) $510 (pens)
		Levemir	Novo Nordisk	2005	$370 (vial) $555 (pens)
		Basaglar (Kwikpen)	Eli Lilly	2015	$392 (pens)
		Toujeo (Solostar)	Sanofi	2015	$466 (pens) $622 (max pens)
		Tresiba	Novo Nordisk	2015	$407 (vial) $610 (pens – 100u) $732 (pens – 200u)
Type 2 Medications		Trulicity	Eli Lilly	2014	$1013 (pens)
		Victoza	Novo Nordisk	2010	$813 (2 pens) $1220 (3 pens)
		Ozempic	Novo Nordisk	2017	$1022 (pens)
		Soliqua	Sanofi	2016	$928 (pens)

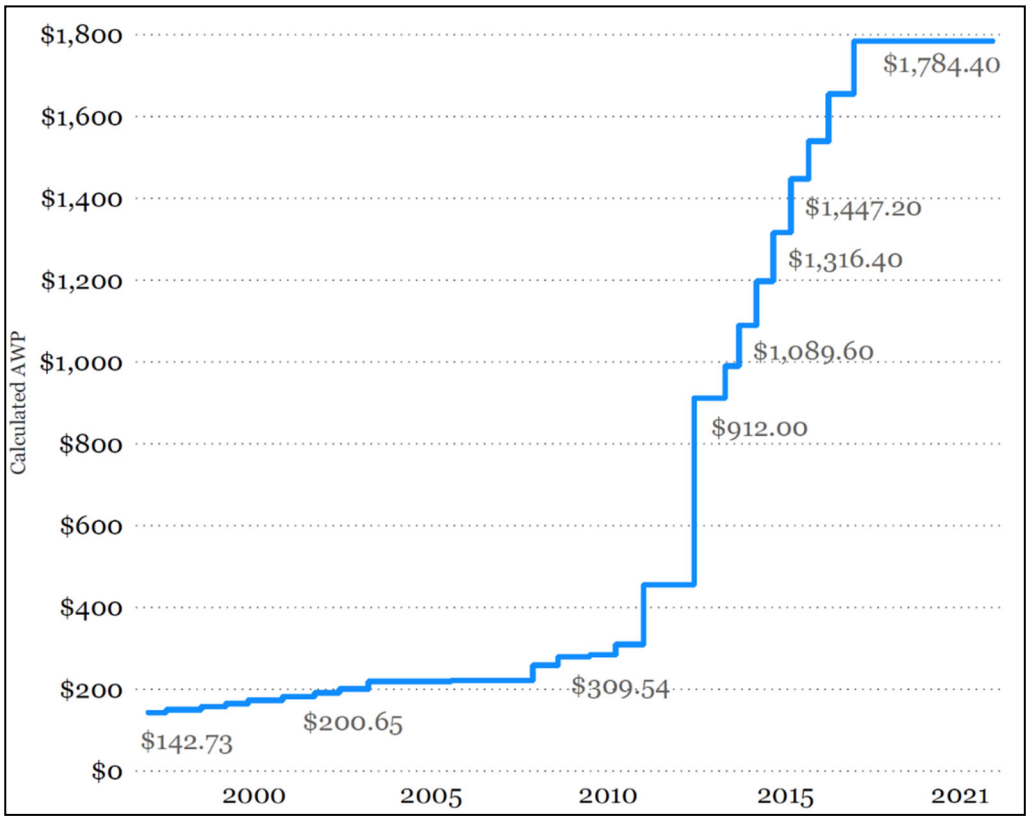
B. The Dramatic Rise in the Prices of Diabetes Medications in the United States

210. Over the past 25 years, the list price of certain insulins has increased in some cases by more than 1000% (10x).

211. According to the U.S. Bureau of Labor Statistics, $165 worth of consumer goods and services in 1997 dollars would, in 2021, have cost $289 (1.75x).

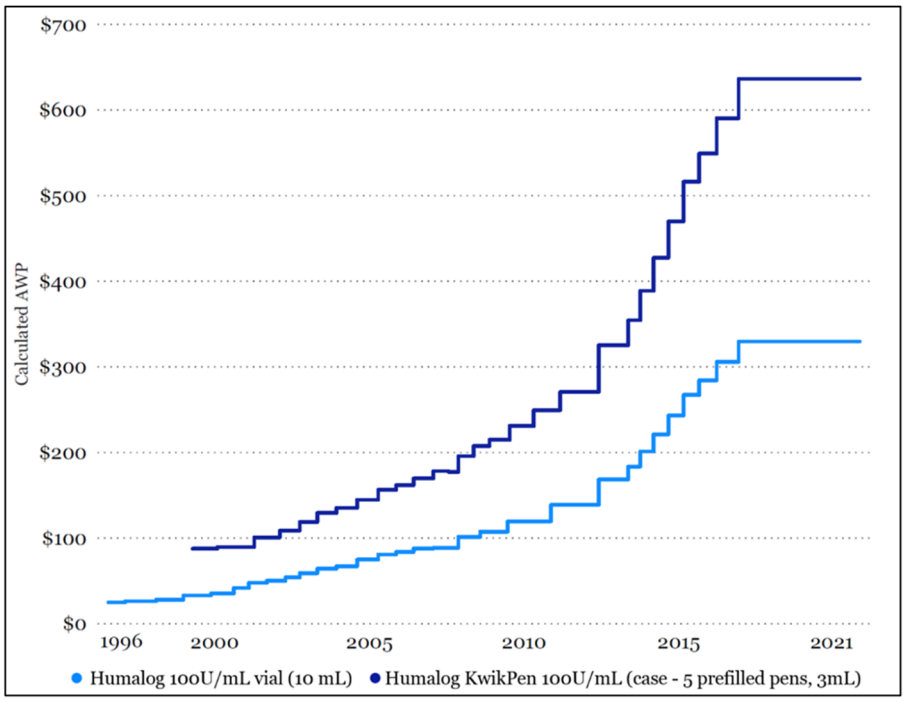
212. Since 1997, Eli Lilly has raised the list price of a vial of Humulin R (500U/mL) from $165 to $1784 in 2021 (10.8x).

Figure 2: Rising list prices of Humulin R (500U/mL) from 1997-2021



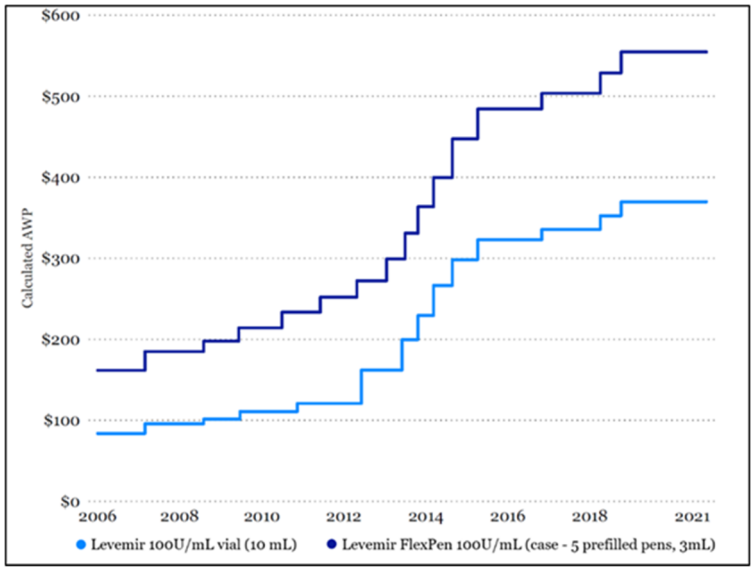
213. Since 1996, Eli Lilly has raised the price for a package of pens of Humalog from under $100 to $636 (6.6x) and from less than $50 per vial to $342 (6.8x).

Figure 3: Rising list prices of Humalog vials and pens from 1996-2021



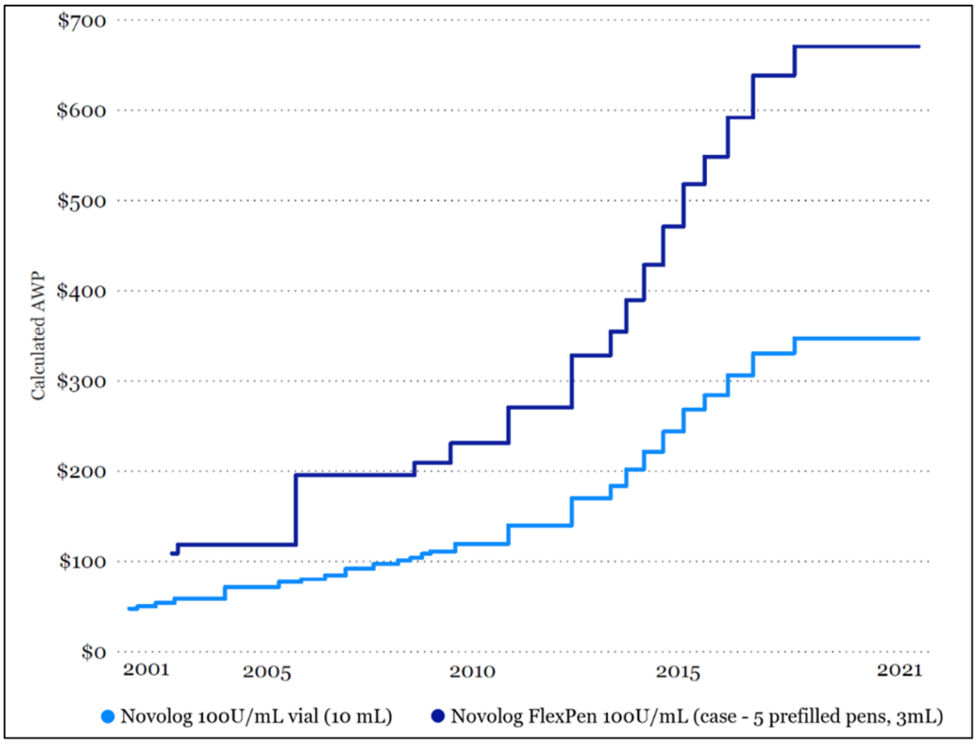
214. From 2006 to 2020, Novo Nordisk raised the price of Levemir from $162 to $555 (3.4x) for pens and from under $100 to $370 per vial (3.7x).

Figure 4: Rising list prices of Levemir from 2006-2021



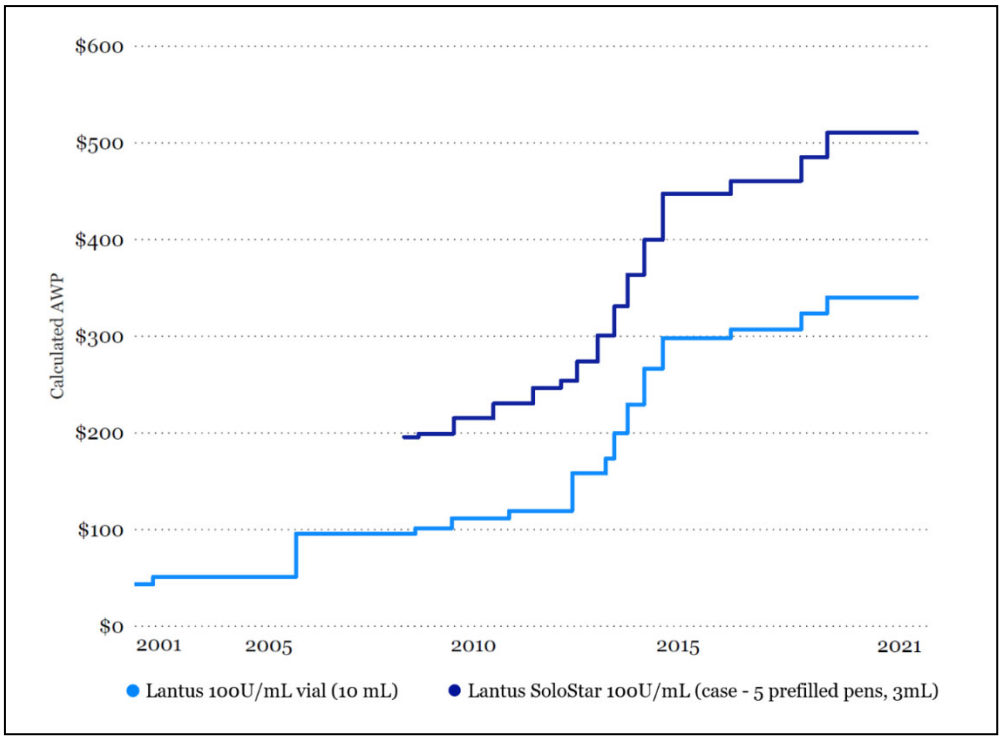
215. From 2002 to 2021, Novo Nordisk raised the list price of Novolog from $108 to $671 (6.2x) for a package of pens and from less than $50 to $347 (6.9x) per vial.

Figure 5: Rising list prices of Novolog vials and pens from 2002-2021



216. Sanofi has kept pace as well. It manufactures a top-selling analog insulin—Lantus—which has been and remains a flagship brand for Sanofi. It has been widely prescribed nationally and within the State of Arizona. Sanofi has raised the list prices for Lantus from less than $200 in 2006, to over $500 in 2020 (2.5x) for a package of pens, and from less than $50 to $340 per vial (6.8x).

Figure 6: Rising list prices of Lantus vials and pens from 2001-2021



217. Driven by these price hikes, payors' and diabetics' spending on these drugs has drastically increased with totals in the tens of billions of dollars.

218. The timing of the price increases reveals that the Manufacturer Defendants have not only dramatically increased prices for the at-issue diabetes treatments, but have done so in lockstep.

219. Between 2009 and 2015, for example, Sanofi and Novo Nordisk raised the list prices of their insulins in tandem 13 times, taking the same price increase down to the decimal point within days of each other (sometimes within a few hours).

220. This practice, in which competitors communicate their intention not to price-compete against one another, is known as "shadow pricing."

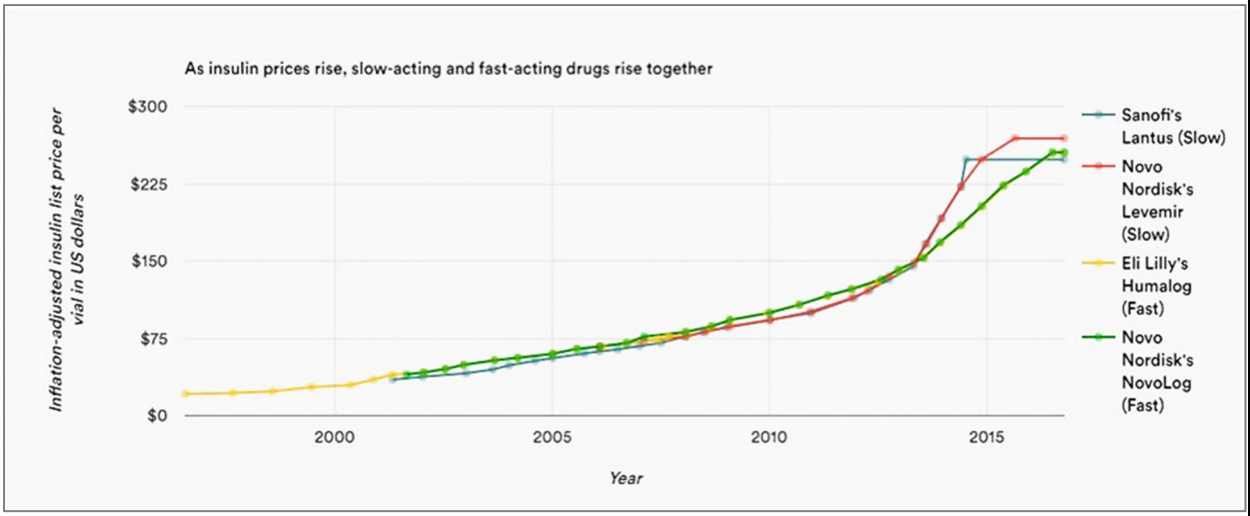
221. In 2016, Novo Nordisk and Sanofi's lockstep increases for the at-issue drugs represented the highest drug price increases in the pharmaceutical industry.

222. Eli Lilly and Novo Nordisk have engaged in the same lockstep behavior with respect to their rapid-acting analog insulins, Humalog and Novolog.

223. Eli Lilly and Novo Nordisk have also engaged in the same lockstep behavior with respect to the human insulins—Eli Lilly's Humulin and Novo Nordisk's Novolin, as well as for their Type-2 drugs Trulicity, Victoza, and Ozempic.

224. The Manufacturer Defendants have exponentially raised the prices of insulin products in near-perfect unison.

Figure 7: Lockstep insulin price increases



225. These lockstep price increases were carefully coordinated to preserve formulary placement for the at-issue medications and to allow greater rebates to the PBMs, and further illustrate the perverse economics of the insulin market, where Manufacturers raise prices to compete.

226. Manufacturers often used a competitor's price increases as a justification for their own increases.

227. Although Sanofi generally led price increases in the long-acting insulin market with its pricing for Lantus, Novo Nordisk often led in the rapid-acting market with NovoLog.

228. The agreements the Manufacturers had with the PBM Defendants deterred competition on lowering price.

229. Following years of rebate and list price increases, the Manufacturers faced increased pressure from patients, payors, and the Federal government to decrease insulin's WAC price. However, internal memoranda and correspondence suggest that the downstream impact of lowering the WAC prices presented hurdles for pharmaceutical companies.

230. Insulin price increases were driven, in part, by tactics the PBMs employed in the early 2010s. At that time, the PBMs began to aggressively pit manufacturers against each other by implementing formulary exclusions in the insulin therapeutic class, which effectively stopped the Manufacturers from reaching large blocks of patients. This tactic boosted the size of rebates and catalyzed the upward march of WAC prices. The Manufacturers responded to these formulary exclusion threats by raising WAC prices aggressively—increases that often were closely timed with price changes by competitors.

231. Insulin was among the first classes of drugs to face PBM formulary exclusions, and the number of insulins excluded has increased over time. In 2014, Express Scripts and CVS Caremark excluded 6 and 7 insulins, respectively. OptumRx excluded 4 insulins in 2016, its first year with an exclusion list. As of 2022, insulins have faced 193 total plan-years of exclusion across the PBMs since 2014.

232. There also is clear evidence the insulin manufacturers have made price increase decisions due to pressure from the PBMs. Higher list price increases the dollar value of rebates, discounts, and other fees that a manufacturer can offer to a PBM, all of which are based on a percentage of the list price. Internal documents show that insulin manufacturers were sensitive not only to their own bottom lines, but to the bottom line of PBMs that set formularies, without which a manufacturer's product would likely lose significant market share.

233. Exclusions, driven in part by perverse PBM incentives, have had an extensive impact on patients' access to insulin. Lower list-priced insulins have been

available since 2016—including follow-on insulins (Admelog, Basaglar, Lyumjev, Fiasp), "authorized generic" insulins (Lispro, Insulin Aspart), and, more recently, biosimilar insulins. However, PBMs often exclude these insulins from their formularies in favor of products with higher list prices and larger rebates. For example, two of the three PBM Defendants have excluded the two insulin authorized generics from their formularies since 2020, instead favoring the higher list-priced equivalents. Remarkably, this was true even though the list prices for these authorized generic insulins can be half the list price of the brand.

234. In addition to the exclusions of authorized generic insulins, lower list-priced biosimilar insulins have also faced PBM formulary exclusions. The first biosimilar insulin was launched in 2021. Due to prevailing market dynamics, two identical versions of the product were simultaneously introduced—one with a higher list price and large rebates, and one with a lower list price and limited rebates—giving payors the option of which to cover. All three PBMs excluded the lower list-priced version in 2022, instead choosing to include the identical product with the higher list price.[10]

235. Excluding lower list-priced medicines from formularies can substantially increase out-of-pocket costs for patients in plans using deductibles or coinsurance, where cost-sharing is typically determined based on the medicine's full list price.[11] This trend of favoring higher list-priced products has dramatically affected patient affordability and access to insulins.

[10] Adam Fein, *Five takeaways from the big three PBMs' 2022 formulary exclusions* (Jan. 19, 2022), available at https://www.drugchannels.net/2022/01/five-takeaways-from-big-three-pbms-2022.html (last visited Nov. 17, 2023).

[11] Adam Fein, *Express Scripts vs. CVS Health: five lessons from the 2020 formulary exclusions and some thoughts on patient impact* (Jan. 2020), available at https://www.drugchannels.net/2020/01/express-scripts-vs-cvs-health-five.html (last visited Nov. 17, 2023).

236. The PBM Defendants and the Manufacturers are complicit. There has been little, if any, attempt by PBM Defendants to discourage Manufacturers from increasing the list price of their products. Instead, the PBMs used their size and aggressive negotiating tactics, such as the threat of excluding drugs from formularies, to extract even more generous rebates, discounts, and fees from the Manufacturers, who have increased their insulin list prices in lockstep.

237. PBMs thus had every incentive to encourage Manufacturers to raise list prices, since the rebates, discounts, and fees PBMs negotiate are based on a percentage of a drug's list price—and PBMs retain a large portion of what they negotiate. In fact, the Manufacturers have been dissuaded from decreasing list prices for their products, which would have lowered out-of-pocket costs for patients, due to concerns that PBMs and health plans would react negatively.

238. Because of the Manufacturer and PBM Defendants' collusive price increases, diabetes medications have become unaffordable for many diabetics.

C. The Pharmaceutical Payment and Supply Chain

239. The prescription drug industry is comprised of a deliberately opaque network of entities engaged in multiple distribution and payment structures. These entities include manufacturers, wholesalers, PBMs, pharmacies, payors, and patients.

240. Given the complexities of the different parties involved in the pharmaceutical industry, pharmaceuticals are distributed in many ways. Generally speaking, branded prescription drugs, such as the at-issue diabetes medications, often are distributed in one of three ways: (a) from manufacturer to wholesaler (distributor), wholesaler to pharmacy, and pharmacy to patient; (b) from manufacturer to mail-order pharmacy to patient; or (c) from manufacturer to mail-order pharmacy, mail-order pharmacy to self-insured payor, and self-insured payor to patient.

241. The pharmaceutical industry, however, is unique in that the pricing chain is distinct from the distribution chain. The prices for the drugs distributed in the

pharmaceutical chain are different for each participating entity, i.e., different actors pay different prices set by different entities for the same drugs. The unifying factor is that the price that each entity in the pharmaceutical chain pays for a drug is necessarily tied to the price set by the manufacturer.

242. There is no transparency in this pricing system. Typically, there are two kinds of published prices. One is the Wholesale Acquisition Cost (WAC), which is a manufacturer's price for the drug to wholesalers (and excludes any discounts, rebates, or price reductions). The other is Average Wholesale Price (AWP), which is the price wholesalers charge retailers for a drug. Both WAC and AWP, depending on the context, are sometimes colloquially referred to as "list price."[12]

243. AWP is usually calculated by applying a significant mark-up (such as 20%) to the manufacturer's WAC. AWP does not account for discounts available to various payers, nor is it based on actual sales transactions.

244. Publishing compendiums, such as First DataBank, report both the WAC and the AWP.

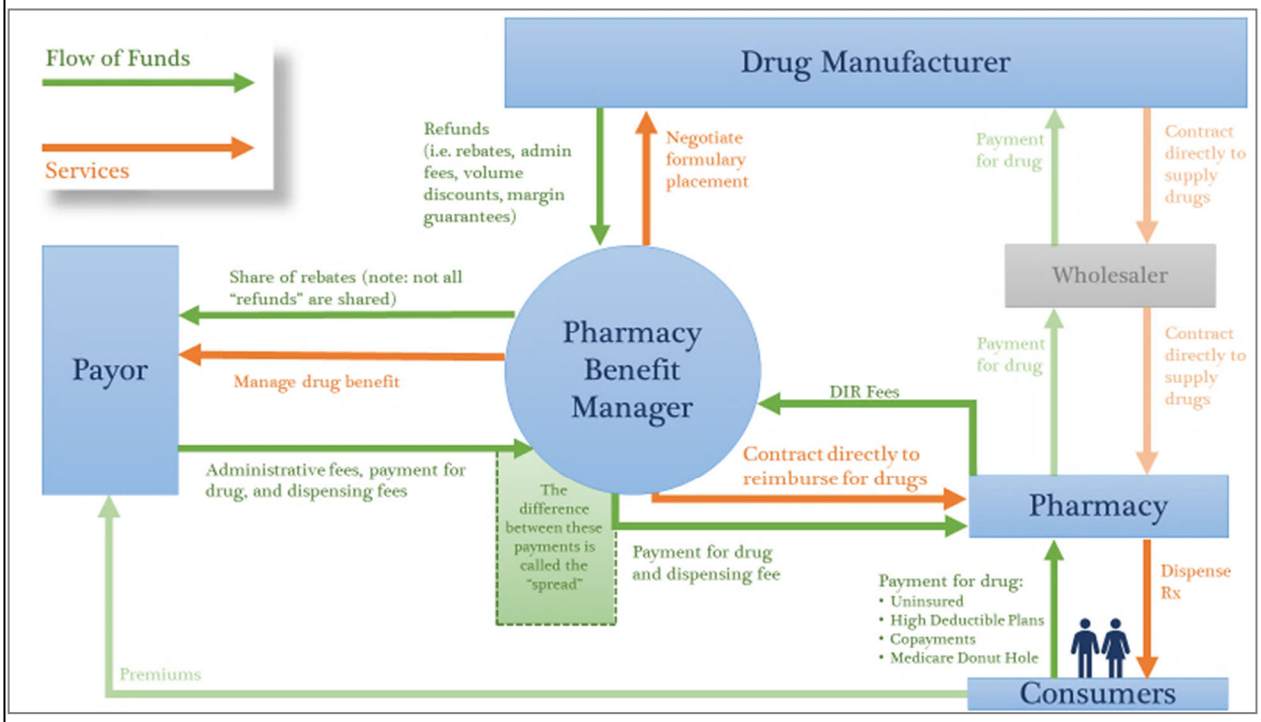
245. As a direct result of the PBMs' conduct, AWP persists as the most commonly and continuously used benchmark price in negotiating reimbursement and payment calculations for both payors and patients.

D. The PBMs' Role in the Pharmaceutical Payment Chain

246. The PBMs are at the center of the convoluted pharmaceutical payment chain.

[12] In general, when this Complaint discusses Defendants' conspiracy to inflate "list prices," Plaintiff is referring to WAC. Because AWP is based on WAC, when a manufacturer raises its WAC, that necessarily results in an increase to the AWP.

Figure 8: Insulin distribution and payment chain



247. PBMs (including the PBM Defendants) develop drug formularies, process claims, create a network of retail pharmacies, set the prices in coordination with the Manufacturers that the payor will pay for prescription drugs, and are paid by the payor to reimburse pharmacies for the drugs used by the payor's beneficiaries.

248. The PBMs also contract with a network of retail pharmacies. Pharmacies agree to dispense drugs to patients and pay fees back to the PBMs. The PBMs reimburse pharmacies for the drugs dispensed.

249. The PBM Defendants also own mail-order and specialty pharmacies, which purchase and take possession of prescription drugs, including those at-issue here, and directly supply those drugs to patients by mail.

250. Often—including for the at-issue drugs—the PBM Defendants purchase drugs directly from the Manufacturers and distribute them directly to the patients.

251. Even where PBM Defendants' mail-order pharmacies purchase drugs from wholesalers, their costs are set by direct contracts with the manufacturers.

252. In addition, and of particular significance here, the PBM Defendants contract with drug manufacturers, including the Manufacturer Defendants. The PBMs extract from the Manufacturers rebates, fees, and other consideration that are paid back to the PBM, including the Manufacturer Payments related to the at-issue drugs.

253. These relationships place PBMs at the center of the flow of pharmaceutical money and allow them to exert tremendous influence over what drugs are available nationwide, on what terms, and at what prices.

254. The PBM Defendants:

a. negotiate the price that payors pay for prescription drugs (based on prices generated by the Insulin Pricing Scheme);

b. separately negotiate a different (and often lower) price that pharmacies in their networks receive for the same drug;

c. set the amount in fees that the pharmacy pays back to the PBM for each drug sold (based on prices generated by the Insulin Pricing Scheme);

d. set the price paid for each drug sold through their mail-order pharmacies (based on prices generated by the Insulin Pricing Scheme); and

e. negotiate the amount that the Manufacturers pay back to the PBM for each drug sold (based on prices generated by the Insulin Pricing Scheme).

255. Yet, for the majority of these transactions, only the PBMs are privy to the amount that any other entity in this supply chain is paying or receiving for the same drugs. This absence of transparency affords Defendants the opportunity to extract billions of dollars from this payment and supply chain without detection.

256. In every interaction that the PBMs have within the pharmaceutical pricing chain, they stand to profit from the prices generated by the Insulin Pricing Scheme.

1. The Rise of the PBMs in the Pharmaceutical Supply Chain

257. In the 1960s, PBMs functioned largely as claims processors. Over time, however, they have taken an ever-expanding role as participants in pharmaceutical pricing and distribution chains.

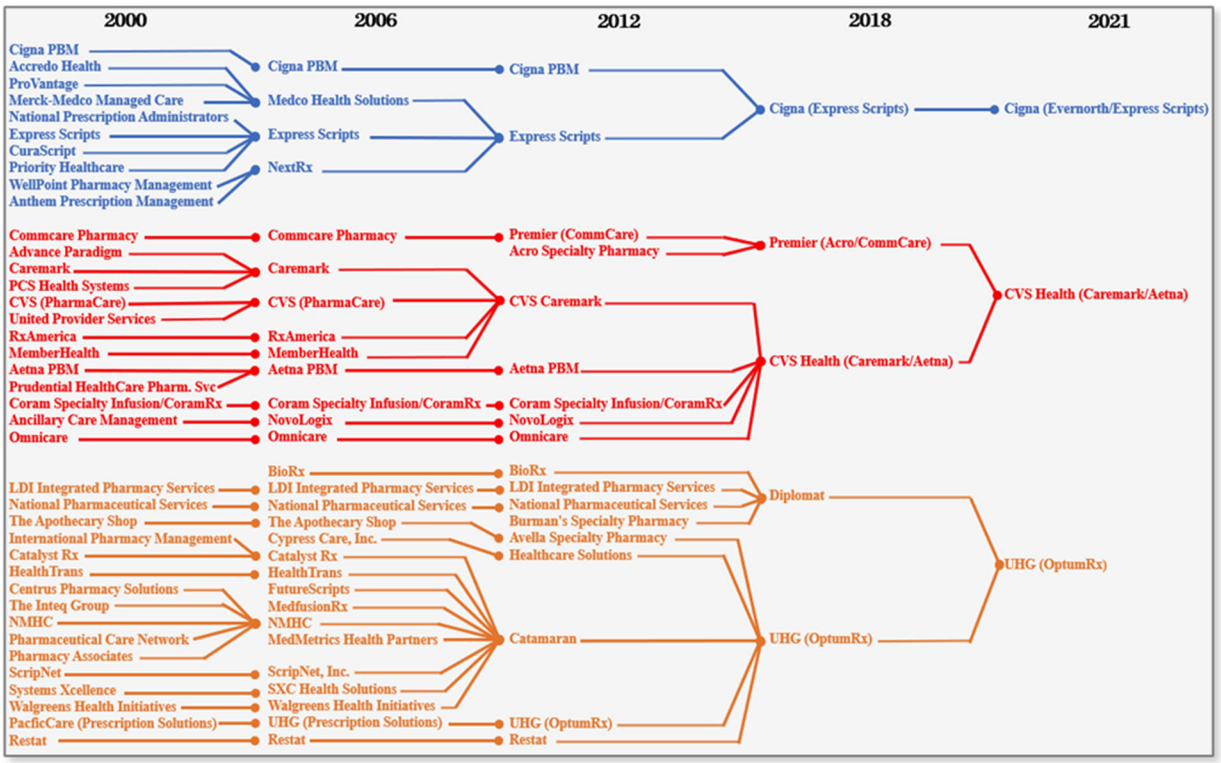
258. One key role PBMs took on was negotiating with drug manufacturers—ostensibly on behalf of payors. In doing so, PBMs affirmatively represented that they were using their leverage to drive down drug prices.

259. In the early 2000s, PBMs started buying pharmacies, thereby creating an additional incentive to collude with manufacturers to keep certain prices high.

260. These perverse incentives still exist today with respect to both retail and mail-order pharmacies housed within the PBMs' corporate families. Further recent consolidation in the industry has given PBMs disproportionate market power.

261. Nearly 40 PBM entities combined into what are now the PBM Defendants, each of which now is affiliated with another significant player in the pharmaceutical chain, e.g., Express Scripts merged with Cigna; CVS bought Caremark (and now also owns Aetna); and UnitedHealth Group acquired OptumRx.

Figure 9: PBM consolidation



262. After merging with or acquiring all of their competitors, and now backed by multi-billion-dollar corporations, the PBM Defendants have taken over the market in the past decade, controlling more than 80% of drug benefits for more than 270 million Americans.

263. Together, the PBM Defendants report more than $300 billion in annual revenue.

264. The PBMs use this market consolidation and the resulting purchasing power as leverage when negotiating with other entities in the pharmaceutical pricing chain.

2. The Insular Nature of the Pharmaceutical Industry

265. The insular nature of the pharmaceutical industry has provided Defendants with ample opportunity for contact and communication with their competitors, as well as with the other PBM and Manufacturer Defendants, so as to plan, agree, and carry out the Insulin Pricing Scheme.

266. For example, each Manufacturer Defendant is a member of the industry-funded Pharmaceutical Research and Manufacturers of America ("PhRMA") and has routinely communicated through PhRMA meetings and platforms in furtherance of the Insulin Pricing Scheme. According to PhRMA's 2019 IRS Form 990, it received more than $515 million in "membership dues." All members are pharmaceutical companies.

267. The PBM Defendants also routinely communicate through direct interaction with their competitors and the Manufacturers at trade associations and industry conferences.

268. Each year during the relevant period, the main PBM trade association, the industry-funded Pharmaceutical Care Management Association ("PCMA"), held several yearly conferences.

269. Every year, high-level representatives and corporate officers from both the PBM and Manufacturer Defendants attend these conferences to meet in person and engage in discussions, including those in furtherance of the Insulin Pricing Scheme.

270. Notably, many of the forums at these conferences are specifically advertised as offering opportunities for private, non-public communications.

271. Key at-issue lockstep price increases occurred immediately after Defendants had convened at PCMA meetings.

272. The PBMs control the PCMA and have weaponized it to further their interests and to conceal the Insulin Pricing Scheme. The PCMA has instituted numerous lawsuits and lobbying campaigns aimed at blocking drug pricing transparency efforts.

E. The Insulin Pricing Scheme

273. The market for the at-issue diabetes medications is unique in that it is highly concentrated with no true generics and few biosimilar options. The drugs and biosimilars have similar efficacy and risk profiles.

274. This affords the PBMs significant leverage that, in theory, could be used to negotiate with the Manufacturer Defendants to drive down list prices for the at-issue drugs through open competition.

275. But the PBMs do not want the prices for diabetes medications to decrease because that would decrease the size of the Manufacturer Payments they receive.

276. The Manufacturer Defendants understand that PBM Defendants make more money as prices increase.

277. The Manufacturer Defendants' pricing strategy, in fact, focuses on the PBMs' profitability.

278. The Manufacturer Defendants also understand that because of the PBMs' market dominance, most payors accept the baseline national formularies offered by the PBMs with respect to the at-issue drugs.

279. The Insulin Pricing Scheme was borne from these understandings. Both sets of Defendants realized that if the Manufacturers artificially inflate their list prices to facilitate large, undisclosed Manufacturer Payments back to the PBMs, both the PBMs and Manufacturers would generate billions of unearned dollars. The plan worked.

280. Over the past several years the Manufacturers have raised prices in unison and have paid correspondingly larger Manufacturer Payments to the PBMs.

281. In exchange for the Manufacturers artificially inflating their prices and paying the PBMs substantial amounts in Manufacturer Payments, the PBM Defendants grant the Manufacturer Defendants' diabetes medications elevated prices and preferred status on their national formularies. During the relevant period, the rebate amounts (as a proportion of the list price) grew year-over-year while list prices themselves increased.

282. Beyond increased rebate demands, the PBM Defendants also have sought and received larger and larger administrative fees from the Manufacturers during the relevant period.

283. Thus—and contrary to their public representations—the PBM Defendants' negotiations and agreements with the Manufacturer Defendants (and the formularies that result from these agreements) have caused and continue to cause precipitous price increases for the at-issue drugs.

284. As a result of the Insulin Pricing Scheme, every payor that pays for and/or reimburses for the at-issue drugs has been overcharged.

285. Moreover, the PBMs use this false price to misrepresent the amount of "savings" they generate for diabetics, payors, and the healthcare system. For example, in January 2016, Express Scripts' president Tim Wentworth stated at the 34th annual JP Morgan Healthcare Conference that Express Scripts "saved our clients more than $3 billion through the Express Scripts National Preferred Formulary."[13] Likewise, in April 2019, CVS Caremark president Derica Rice stated, "Over the last three years . . . CVS Caremark has helped our clients save more than $141 billion by blunting drug price inflation, prioritizing the use of effective, lower-cost drugs and reducing the member's out-of-pocket spend."[14]

286. In making these representations, the PBMs fail to disclose that the amount of "savings" generated is calculated based on the artificially inflated list price, which is not paid by any entity in the pharmaceutical pricing chain and which all Defendants are directly responsible for artificially inflating.

287. The Insulin Pricing Scheme is a coordinated effort between the Manufacturer and PBM Defendants in which each agreed to, and did, participate in, and which created enormous profits for Defendants.

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[13] Surabhi Dangi-Garimella, *PBMs Can Help Bend the Cost Curve: Express Scripts' Tim Wentworth,* AJMC (Jan. 12, 2016), https://www.ajmc.com/view/pbms-can-help-bend-the-cost-curve-express-scripts-tim-wentworth (last visited Nov. 17, 2023).

[14] CVS Health, *CVS Health PBM Solutions Blunted the Impact of Drug Price Inflation, Helped Reduce Member Cost, and Improved Medication Adherence in 2018* (Apr. 11, 2019), https://www.cvshealth.com/news-and-insights/press-releases/cvs-health-pbm-solutions-blunted-the-impact-of-drug-price (last visited Nov. 17, 2023).

288. Rather than using their prodigious bargaining power to lower drug prices as they claim, Defendants used their dominant positions to work together to generate billions of dollars in illicit profits at the expense of payors and diabetics.

F. The Rebate Agreements' Parity Terms Limit Use of Utilization Management Measures

289. The PBMs have historically represented that they work on behalf of their clients to manage the cost of their drug benefits. Their clients in turn have relied on them to design and manage formularies to ensure the safe and cost-effective dispensing of prescription drugs, including the insulin drugs. Toward that end, the PBMs have represented to their clients and the public that they would make formulary decisions and use utilization management ("Utilization Management" or "UM") measures to prefer safe and cost-effective drugs, including insulin drugs. Those representations often were false. In reality, for more than a decade, the PBMs have been working with the Manufacturers toward a common illegitimate purpose of increasing the cost of the at-issue drugs.

290. The PBMs and the Manufacturers used their relationships to further the Insulin Pricing Scheme, including through unfair or deceptive acts or omissions. While the PBM Defendants have represented they would work for their clients and make formulary decisions and implement Utilization Management measures in their interests to make the insulin drugs more affordable, behind closed doors they entered into confidential agreements with the Manufacturers to block UM measures that would have limited dispensing to medically appropriate uses and controlled costs. In exchange for these lucrative agreements, the PBMs provided the Manufacturers with detailed prescribing data which limited implementation of UM measures that would have helped to control the cost of insulin.

291. The PBM Defendants and the Manufacturers regularly discussed and agreed about which, if any, UM measures would be used for particular insulin drugs.

These measures include days' supply quantity and daily dosage limits, NDC blocks (blocking certain insulin drugs from the formularies), prior authorizations (which require additional PBM approval before drug is dispensed) and step edits (which require that a patient try a different preferred drug before being given a non-preferred, often cheaper insulin drug).

292. The PBM Defendants maintain internal committees that determine which drugs are placed on their formularies. These committees are comprised of company personnel. Express Scripts refers to this committee as the Value Assessment Committee; OptumRx refers to this committee as the Formulary Management Committee; and CVS Caremark refers to this Committee as the Formulary Review Committee.

293. In addition, the PBM Defendants have trade relations employees who are responsible for negotiating rebate agreements with drug manufacturers. CVS Caremark and Express Scripts refer to this committee as the Trade Relations Group and OptumRx refers to this committee as the Industry Relations Group.

294. Years ago, the PBM Defendants devised and managed what were known as "open" formularies—formularies that offered varying degrees of plan coverage and benefits for virtually all available FDA-approved drugs. Consequently, with open formularies, drug companies sought to have their drugs placed by PBMs on the formulary that allowed the easiest access to their drugs.

295. Subsequently, however, the PBM Defendants began shifting to "closed" formularies as the default choice for their clients. "Closed" formularies provide tiered benefits, and unlike open formularies, they restrict the overall number of drugs that are entitled to receive any plan prescription drug benefit. For example, while clients traditionally had to opt into closed formularies, by 2014, Express Scripts' national formulary was a closed formulary, and clients had to affirmatively opt out of it.

296. As they have grown and consolidated, the PBM Defendants have increased their control over formulary decisions for the vast majority of patients in the

United States. The PBM Defendants now control formulary decisions for some 245 million Americans.

297. Over at least the last two decades, the Manufacturers have made millions of dollars annually in rebate payments to the PBM Defendants in exchange for placement of their insulin products on the PBMs' formularies. The rebate agreements with the Manufacturers required that the PBMs not implement Utilization Management measures, which would have helped control the cost of insulin drugs.

298. The PBMs have insisted they do not negotiate the prices that the Manufacturers charge for the insulin products.

299. However, the PBMs' control over formulary access has a direct correlation to whether the Manufacturers would be forced to compete on price. For example, throughout their negotiations with the Manufacturers, the PBMs have agreed that, in exchange for rebates, the PBMs would not "disadvantage" the Manufacturers' insulin drugs, i.e., would not place Utilization Management restrictions on their use.

300. The PBM rebate contracts use the term "disadvantaged" any time a Manufacturer's product is subject to PBM Utilization Management measures that negatively affect the reimbursement and/or formulary status of the product as compared to others in its designated competitive product category.

301. Effectively, the use of parity terms has meant that the rebate agreements required the lockstep application of PBM Utilization Management measures, conditioning payment of rebates only if these limitations were applied (if at all) to all other drugs in their formulary's competitive drug category.

302. In exchange for increased rebates, the parties agreed that none of the preferred branded insulin drugs would be disadvantaged and that they all would have the same UM restrictions, if any. These parity and disadvantaged contract terms had the intended effect of ensuring access to the Manufacturers' expensive branded insulins without UM limitations.

303. These parity terms freed the Manufacturers from any need to compete on price, and instead resulted in the lockstep, ever-increasing "shadow pricing" alleged herein.

G. Defendants Blocked Access to Cheaper Biosimilar Insulin Products by Imposing "Fail First" Requirements

304. The Manufacturer Defendants' brand drug rebate agreements with the PBMs also delayed or prevented coverage of biosimilar insulins by requiring step therapy, or a "fail-first" requirement. Such a requirement mandates that a patient must fail first on the reference biologic before becoming eligible for the biosimilar. Such requirements were originally intended to control the costs posed by high-dollar therapies.

305. The agreements between the PBMs and the Manufacturers have required an explicit commitment not to cover biosimilar insulins at all or to do so only in the rarest of circumstances—in effect, to make the brand-name insulins the only one available on their formularies. As a direct result of these exclusive dealing contractual commitments, the biosimilar insulins have not been available on the PBMs' formularies at all, or are designated reimbursable only in "fail first" cases.

306. The "fail first" exception is medically inappropriate and illusory in practice. Most patients do not fail on brand name insulin such that a biosimilar insulin becomes an option under this "fail first" requirement. Moreover, even if a patient did fail on the brand name insulin, a physician would turn to a different drug, not to the biosimilar, which has no clinically meaningful differences from the brand-name insulin.

307. As a result, lower cost, high value biosimilar medicines are frequently not accessible to patients. While it may be appropriate for PBMs to work to negotiate lower prices through the use of their formularies, their preference for highly rebated products has often imposed higher net costs on payors and patients at the pharmacy, and limited patient access to lower cost biosimilar insulins.

308. Even when new biosimilar insulins are launched specifically to benefit patients and the health care system by introducing competition to high-priced drugs, the PBMs remain incentivized to retain revenue through their rebate structure, and thus the savings that these biosimilar entrants should have brought to payors and patients have gone partially or wholly unrealized.

H. The Manufacturers React to Threats of Formulary Exclusion by Raising Rebates Offered to the PBMs

309. Although the PBM Defendants have insisted they had no control over how the Manufacturers price their insulin products, their threats of formulary exclusion illustrate how they used new insulin competitors with lower prices to leverage even higher rebates on the existing insulin drugs.

310. In the face of formulary exclusion threats based on new entrants in the insulin market, the Manufacturers have willingly met the PBM Defendants' demands for increased rebates in order to retain preferred formulary placement and block competitors.

311. For the Manufacturers, the mere threat of exclusion pressured them to offer substantially greater rebates to maintain formulary position. This is because formulary exclusions are likely to cause significant loss of a manufacturer's market share, leading to lower revenue. On the other hand, being the exclusive therapy on a formulary has the opposite effect, incentivizing Manufacturers to offer large discounts to acquire or maintain such status. The use of formulary exclusions has thus led to a market dynamic in which Manufacturers offer ever-higher rebates to avoid exclusion, which has led to higher list prices.

312. While the PBM Defendants have touted that using formulary exclusions in the insulin therapeutic class was a way to drive down costs for their clients, internal correspondence and memoranda show that increased use of formulary exclusions did

exactly the opposite: WAC (list) prices have continued to increase, leading to higher costs for payors and higher prices for patients at the pharmacy counter.

I. Defendants Play Down the Insulin Pricing Scheme and Its Harms

313. On April 10, 2019, the U.S. House of Representatives Committee on Energy and Commerce held a hearing on industry practices titled, "Priced Out of a Lifesaving Drug: Getting Answers on the Rising Cost of Insulin."[15]

314. Representatives from several Defendants testified at the hearing and admitted that the price for insulin had increased exponentially over the past 15 years.

315. None of the testifying Defendants claimed that the significant increase in the price of insulin was related to competitive factors such as increased production costs or improved clinical benefit.

316. The PBM Defendants conceded at the April 2019 Congressional hearing that they grant preferred, or even exclusive, formulary position because of higher Manufacturer Payments paid by the Manufacturer Defendants.

317. While all Defendants acknowledged before Congress their participation in conduct integral to the Insulin Pricing Scheme, none revealed its inner workings or the connection between their coordination and the economic harm that payors and the public were unwittingly suffering. Instead, to obscure the true reason for precipitous price increases, each Defendant group pointed the finger at the other as the more responsible party.

318. The PBM Defendants testified to Congress that the Manufacturer Defendants are solely responsible for their list price increases and that the Manufacturer Payments that the PBMs receive are not correlated to rising insulin prices.

[15] Transcripts available at https://www.congress.gov/event/116th-congress/house-event/109299?s=1&r=3 (last visited Nov. 17, 2023) (hereinafter *Priced Out of a Lifesaving Drug*).

319. This testimony is false. The amount the Manufacturers kick back to the PBM Defendants *is directly correlated* to an increase in list prices. On average, a $1 increase in Manufacturer Payments is associated with a $1.17 increase in list price.

320. Thus, reducing or eliminating Manufacturer Payments would lower prices and reduce out-of-pocket expenditures.

321. Further, in large part because of the increased list prices and related Manufacturer Payments, the PBMs' profit per prescription has grown substantially over the same period that insulin prices have steadily increased.

322. Yet, the Manufacturers urged upon Congress the fiction that the PBMs were solely to blame for insulin prices because of their demands for rebates in exchange for formulary placement. The Manufacturers claimed their hands were tied and sought to conceal their misconduct by suggesting that they have not profited from rising insulin prices.

323. Given the Manufacturers' claims that rebates were the sole reason for rising prices, each was asked directly during the Congressional hearing to guarantee it would decrease list prices if rebates were restricted or eliminated. The spokespersons for Eli Lilly, Novo Nordisk, and Sanofi all said only that they would "consider it."

324. The truth is that, despite their finger-pointing in front of Congress, the Manufacturers and PBMs are both responsible for their concerted efforts in creating and effectuating the Insulin Pricing Scheme.

J. All Defendants Profit from the Insulin Pricing Scheme

325. The Insulin Pricing Scheme affords the Manufacturer Defendants the ability to pay the PBM Defendants secret but significant Manufacturer Payments in exchange for formulary placement, which garners the Manufacturer Defendants greater revenues from sales without decreasing their profit margins. During the relevant period, the PBM Defendants granted national formulary position to each at-issue drug in exchange for large Manufacturer Payments and inflated prices.

326. The Manufacturer Defendants also use the inflated price to earn hundreds of millions of dollars in additional tax breaks by basing their deductions for donated insulins on the inflated list price.

327. Because of the increased list prices, and related Manufacturer Payments, the PBMs' profit per prescription has grown exponentially during the relevant period as well.

328. The PBM Defendants profit from the artificially inflated prices created by the Insulin Pricing Scheme in several ways, including: (a) retaining a significant, yet undisclosed, percentage of the Manufacturers Payments, (b) using the inflated list price to generate profits from pharmacies, and (c) relying on the inflated list price to drive up the PBMs' margins through their own mail-order pharmacies.

1. The PBMs Pocket a Substantial Share of Manufacturers' Secret Payments

329. The first way in which the PBMs profit from the Insulin Pricing Scheme is by keeping a significant portion of the secret Manufacturer Payments.

330. The amount that the Manufacturers pay back to the PBMs has increased over time both in real dollars and as a proportion of the ever-increasing list prices.

331. Historically, contracts between PBMs and payors allowed the PBMs to keep most or all of the rebates they received, rather than forwarding them to the payor.

332. Over time, payors secured contract provisions guaranteeing payment to them of all or some portion of the rebates paid by the Manufacturers to the PBMs. Critically, however, "rebates" are only one aspect of the total secret Manufacturer Payments, particularly as "rebates" are narrowly defined and qualified by vague exceptions in the PBM Defendants' contracts with payors.

333. Indeed, the PBMs and Manufacturers coordinate to determine the contract options made available to payors.

334. Thus, the Manufacturers ultimately played a role in dictating the terms and conditions of the contracts that payors entered into with PBMs. Of course, the payors were not involved in the coordination or the negotiation of the contracts between the PBMs and Manufacturers, and the PBMs disclosed only the fact that such relationships may exist. But the terms of the contracts, the consideration exchanged between the PBMs and Manufacturers, and the means of reaching these determinations all were—and remain—shrouded in secrecy.

335. The PBM and Manufacturer Defendants thus created a "hide-the-ball" system where payors are not privy to rebate negotiations or contracts between the Manufacturers and the PBMs. The consideration exchanged between them (and not shared with payors) is continually labeled and relabeled. As more payors moved to contracts that required PBMs to remit some or all of the manufacturer "rebates" through to the payor, the PBMs renamed the Manufacturer Payments to shield them from scrutiny and from their payment obligations. Payments once called "rebates" were then termed "administrative fees," "volume discounts," "service fees," "inflation fees," or other industry terms designed to obfuscate the substantial sums being secretly exchanged between the PBM Defendants and the Manufacturers.

336. The renamed, and secret, Manufacturer Payments are substantial.

337. These so-called administrative fees typically are based on a percentage of the drug price—as opposed to a flat fee—such that even if the actual "administrative" cost associated with processing two drugs is the same, the "administrative fee" would be correspondingly higher for the higher-priced drug, which again creates (by design) a perverse incentive to give preference to more expensive drugs. Moreover, the PBM Defendants' contracts with payors narrowly define "rebates" by tying them to patient drug utilization. Thus, rebates for formulary placement (which are not tied to patient drug utilization) are characterized as "administrative fees" that are not remitted to payors. Such payments are beyond a payor's contractual audit rights because those rights

are limited to "rebate" payments and these "administrative fees" have been carved out from the definition of "rebates."

338. The opaque nature of these arrangements between the Manufacturers and PBM Defendants also makes it impossible for a given payor to discover, much less assess or confront, conflicts of interest that may affect it or its members.

339. The PBM Defendants also hide the renamed Manufacturer Payments with "rebate aggregators." Rebate aggregators, sometimes referred to as rebate group purchasing organizations ("GPOs"), are entities that negotiate for and collect payments from drug manufacturers, including the Manufacturer Defendants, on behalf of a large group of PBMs (including the PBM Defendants) and different entities that contract for pharmaceutical drugs.

340. These rebate aggregators are often affiliated with or owned by the PBM Defendants, such as Ascent Health Services (Express Scripts), Coalition for Advanced Pharmacy Services and Emisar Pharma Services (OptumRx), and Zinc (CVS Caremark).

341. The PBM Defendants carefully guard the revenue streams from their rebate aggregator activities, concealing them through complex contractual relationships and not reporting them separately in their quarterly SEC filings.

342. Certain rebate-aggregator companies are located offshore, including, for example, in Switzerland (Express Scripts affiliate Ascent Health) and Ireland (Emisar Pharma Services), thereby precluding adequate oversight.

343. Because the PBM Defendants retain and conceal most of the secret Manufacturer Payments that they receive, they are able to make significant profits on the Insulin Pricing Scheme.

344. Even when payor clients receive a portion of the Manufacturer Payments from their PBM, the payors are significantly overcharged, given the extent to which Defendants have deceptively and egregiously inflated the prices of the at-issue drugs.

2. The Insulin Pricing Scheme Allows the PBMs to Profit Off Pharmacies

345. A second way the PBM Defendants profit off the Insulin Pricing Scheme is by using the Manufacturers' inflated price to derive profit from the pharmacies with whom they contract nationwide.

346. Each PBM Defendant decides which pharmacies are included in the PBM's network and how much it will reimburse these pharmacies for each drug dispensed.

347. The PBMs pocket the spread between the amount that the PBMs are paid by their clients for the at-issue drugs (which are based on the prices generated by the Insulin Pricing Scheme) and the amount the PBM reimburses the pharmacy (which often is less). In other words, the PBMs charge a client payor more for a drug than the PBM pays the pharmacy and pockets the difference.

348. More specifically, the PBM Defendants negotiate with their client payors a reimbursement rate that the client pays the PBM for each prescription drug dispensed by a pharmacy. The PBM Defendants negotiate a separate rate that they pay to pharmacies for each drug dispensed.

349. These rates are tied to AWP. For example, a PBM may purchase an insulin from the pharmacy at a rate of AWP-15%, and the client may reimburse the PBM at a rate of AWP-13%. The PBM pockets the spread (2% of AWP in this example) between the rates.

350. Because the PBM Defendants' revenue from the spread pricing is tied to AWP, the higher the AWP, the greater the amount of money made by the PBMs. In the above example, if the AWP is $100 for a drug, the PBM would make $2 on the spread, but if the AWP is $1000 for the same drug, the PBM would make $20 on the spread from the same sale (AWP-15% = $850; AWP-13% = $870).

351. When a PBM is affiliated with a retail pharmacy, the PBM earns the entire retail margin in addition to the pricing spread described above.

352. The PBM Defendants, therefore, like the Manufacturers, directly benefit from inflated insulin prices.

353. In addition, because the PBM Defendants' client payors pay for thousands of different prescription drugs, the client payors cannot practically keep track of the AWP for each prescription drug on a given formulary or how those prices change over time. The client payors, therefore, are unlikely to independently observe the AWP inflation resulting from the Insulin Pricing Scheme. And the PBM Defendants have no incentive to alert their client payors to increasing AWPs since the PBM Defendants directly profit from those increases.

354. The PBMs often disclose the general concept of spread pricing to payors, but only in vague terms that require no accountability and, because the spread-pricing revenue is not defined as a "rebate" in PBM contracts with payors, it falls outside payors' audit rights.

355. This spread pricing, like the secret Manufacturer Payment negotiation, happens behind closed doors. There is no transparency, no commitment from the PBM Defendants to take into account the cost effectiveness of a drug, and no communication to either the payor or the pharmacy to let them know if they are getting a fair deal.

356. The higher the Manufacturers' list prices, the more money the PBMs make off this spread. At the same time, a beneficiary's out-of-pocket co-pay or deductible cost often is more than if the client had simply paid cash outside of his or her plan. On top of this, the PBM contracts generally allow no rebates to payors where the beneficiary is responsible for 100% of the drug cost, e.g., under his or her deductible.

357. The PBM Defendants also use the Insulin Pricing Scheme to generate additional profits from pharmacies by charging the pharmacies post-purchase fees, including DIR (Direct or Indirect Remuneration) fees, based on the list prices—and again, the higher the list price for each diabetes medication sold, the greater the fees the PBMs generate. They also apply "retrospective" discounts so, for example, a payor's

(and member's co-pay or deductible) cost may be $100, but the price may be discounted post-purchase between the PBM and the (often self-owned) pharmacy to $90, with the spread going to the PBM.

358. So PBM Defendants make money "coming and going." In a pre-PBM world, a competitively priced drug might have a (hypothetical) net cost to a health plan of $50, and that is what it paid. PBMs enter the picture and coordinate with Manufacturers to increase the list price to $150. The PBMs then "negotiate" the inflated price down to $100 and take a $50 rebate, some of which may be forwarded to the payor, whose net cost is less than the inflated list price, but whose real-world cost is considerably more than if the PBMs were not involved.

359. Payors have no access to, and no knowledge of, the intricacies of the dealings between the PBM Defendants and the Manufacturers that are shrouded by vague "disclosures" (which vary in detail, but not in substance, in all three of the PBM Defendants' adhesive contracts). These disclosures could be summed up in a single sentence: "We pass along 'rebates' to client payors, except when we don't."

3. The Insulin Pricing Scheme Increases PBM Mail-Order Profits

360. Another way PBM Defendants profit from the Insulin Pricing Scheme is through their mail-order pharmacies. The higher the price that PBM Defendants can get customers to pay for diabetes medications, the greater the profits PBM Defendants realize through their mail-order pharmacies.

361. Because the PBMs base the prices they charge for the at-issue diabetes medications on the Manufacturers' prices, the more the Manufacturers inflate their prices, the more money the PBMs make.

362. When a PBM has its own mail-order pharmacy, its profits are even greater than when they are dispensed through its retail network pharmacies. When a PBM dispenses prescription drugs through its own mail-order pharmacy, it captures the entire retail margin as increased by the Insulin Pricing Scheme.

363. The PBM Defendants have colluded with the Manufacturers so that the PBMs often know when the Manufacturers are going to raise their prices. The PBMs purchase a significant volume of the at-issue drugs before the price increase goes into effect. Then, after the Manufacturers raise their price, the PBMs charge their mail-order customers based on the increased prices and pocket the difference. The PBMs make significant amounts of money through this arbitrage scheme.

364. The PBM Defendants also charge the Manufacturer Defendants fees related to their mail-order pharmacies, such as pharmacy supplemental discount fees, that are directly tied to the Manufacturers' price. Once again, the higher the price is, the more money the PBMs make on these fees.

K. Defendants' Actions Had the Tendency to Deceive Payors and Patients

365. At no time has either Defendant group disclosed the Insulin Pricing Scheme or that they colluded to artificially inflate list prices.

1. The Manufacturer Defendants' Conduct was Unfair or Deceptive

366. At all times during the relevant period, the Manufacturer Defendants knew that the list prices, net prices, and payors' net costs (purchase prices) did not bear any rational relationship to the actual costs incurred or prices realized by Defendants, did not result from transparent or competitive market forces, and were artificially and arbitrarily inflated for the sole purpose of generating profits for Defendants.

367. The Manufacturer Defendants also knew that payors relied on the artificially inflated list prices generated by the Insulin Pricing Scheme to pay for the at-issue drugs.

368. The Manufacturer and PBM Defendants further knew that payors wanted and expected to pay a price reflecting the lowest fair market value for the drugs (which was not necessarily the same as the lowest price in the market, given that all prices were inflated due to the Insulin Pricing Scheme).

369. Despite this knowledge, the Manufacturer Defendants published list prices generated by the Insulin Pricing Scheme throughout the United States and Arizona through publishing compendia, in various promotional and marketing materials distributed by entities downstream in the drug supply chain, and directly to pharmacies, who then used these prices to set the amount that the pharmacies charged for the at-issue drugs.

370. The Manufacturer Defendants also published these prices to the PBMs, who then used them to charge diabetics and payors for the at-issue drugs.

371. The Manufacturer Defendants knew that their artificially inflated list prices were not remotely related to their cost, their fair market value in a competitive market, or the net price received for the at-issue drugs, but were the product of collusion between the Manufacturer and PBM Defendants. The Manufacturer Defendants, however, did not disclose the collusion that led to the artificially inflated insulin prices.

372. Moreover, to the contrary, the Manufacturer Defendants have publicly represented that the prices of the at-issue drugs are based on each drug's value to the health care system and the need to fund innovation.

2. The PBM Defendants' Conduct Was Unfair or Deceptive

373. The PBM Defendants ensured that the Manufacturer Defendants' artificially inflated list prices harmed diabetics and payors by preferring the highest-priced at-issue drugs for preferred formulary placement and by requiring that their contracts with both pharmacies and with payors include such prices as the basis for payment.

374. The PBM Defendants perpetuate the use of the artificially inflated insulin prices because it allows them to obscure the actual price any entity in the drug pricing chain is paying for the at-issue drugs. This lack of transparency affords Defendants the opportunity to construct and perpetuate the Insulin Pricing Scheme, and to profit therefrom at the expense of payors nationwide.

375. At all times throughout the relevant period, the PBMs have purposefully, consistently and routinely misrepresented that they negotiate with Manufacturer Defendants and construct formularies for the benefit of payors and patients by lowering the price of the at-issue drugs and by promoting the health of diabetics. Representative examples include:

a. CVS Caremark has for the past decade stated in its annual reports that its design and administration of formularies are aimed at reducing the costs and improving the safety, effectiveness and convenience of prescription drugs. CVS Caremark has further stated that it maintains an independent panel of doctors, pharmacists and other medical experts to review and approve the selection of drugs based on safety and efficacy for inclusion on one of Caremark's template formularies and that CVS Caremark's formularies lower the cost of drugs.

b. Express Scripts has consistently represented that it works with clients, manufacturers, pharmacists and physicians to increase efficiency in the drug distribution chain, to manage costs in the pharmacy benefit chain and to improve members' health outcomes. Its annual reports consistently claim that in making formulary recommendations, Express Scripts' Pharmacy & Therapeutics Committee considers the drug's safety and efficacy, without any information on or consideration of the cost of the drug, including any discount or rebate arrangement that Express Scripts negotiates with the Manufacturer, and that Express Scripts fully complies with the P&T Committee's clinical recommendations regarding drugs that must be included or excluded from the formulary based on their assessment of safety and efficacy.

c. OptumRx has stated in its annual reports over the past decade that OptumRx's rebate contracting and formulary management assist customers in achieving a low-cost, high-quality pharmacy benefit. It has consistently claimed that it promotes lower costs by using formulary programs to produce better unit costs, encouraging patients to use drugs that offer improved value and that OptumRx's formularies are selected for health plans based on their safety, cost and effectiveness.[16]

376. In addition to these general misrepresentations, the PBM Defendants have during the relevant period purposefully, consistently, and routinely made misrepresentations about the at-issue diabetes medications. Representative examples include:

a. In a public statement issued in November 2010, CVS Caremark represented that it was focused on diabetes to "help us add value for our PBM clients and improve the health of plan members . . . a PBM client with 50,000 employees whose population has an average prevalence of diabetes could save approximately $3.3 million a year in medical expenditures."[17]

b. In 2010, Andrew Sussman, Chief Medical Officer of CVS Caremark, stated on national television that "CVS is working to develop programs to hold down [diabetes] costs."[18]

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[16] *See, e.g.*, CVS Health Annual Reports (Form 10-K) (FY 2010-2019); OptumRx Annual Reports (Form 10-K) (FY 2010-2019); Express Scripts Annual Reports (Form 10-K) (FY 2010-2017).

[17] Chain Drug Review, *CVS Expands ExtraCare for Diabetes Products* (May 11, 2010), https://www.chaindrugreview.com/cvs-expands-extracare-for-diabetes-products/ (last visited Nov. 17, 2023).

[18] CBS News, Diabetes Epidemic Growing (June 22, 2010, 11:29 AM), https://www.cbsnews.com/news/diabetes-epidemic-growing/ (last visited Nov. 17, 2023).

c. In a public statement issued in November 2012, CVS Caremark represented that formulary decisions related to insulin products "is one way the company helps manage costs for clients."[19]

d. In 2016, Glen Stettin, Senior Vice President and Chief Innovation Officer at Express Scripts, said in an interview with a national publication that "[d]iabetes is wreaking havoc on patients, and it is also a runaway driver of costs for payors . . . [Express Scripts] helps our clients and diabetes patients prevail over cost and care challenges created by this terrible disease."[20] Mr. Stettin also claimed that Express Scripts "broaden[s] insulin options for patients and bend[s] down the cost curve of what is currently the costliest class of traditional prescription drugs."[21]

e. In a 2018 Healthline interview, Mark Merritt, long the President of the PBM trade association, PCMA, misrepresented that: "[Through their formulary construction], PBMs are putting pressure on drug companies to reduce insulin prices."[22]

f. CVS Caremark's Chief Policy and External Affairs Officer claimed in the April 2019 hearings that CVS Caremark "has taken a number

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[19] Jon Kamp & Peter Loftus, *CVS' PBM Business Names Drugs It Plans to Block Next Year*, WSJ (Nov. 8, 2012), https://www.wsj.com/articles/SB10001424127887324439804578107040729812454 (last visited Nov. 17, 2023).

[20] https://www.bizjournals.com/stlouis/news/2016/08/31/express-scripts-launches-program-to-control.html (last visited Nov. 17, 2023).

[21] Angela Mueller, *Express Scripts Launches Program to Control Diabetes Costs,* St. Louis Bus. J. (Aug. 31, 2016), https://drugstorenews.com/pharmacy/express-scripts-implements-latest-diabetes-care-value-program (last visited Nov. 17, 2023).

[22] Dave Muoio, *Insulin Prices: Are PBMs and Insurers Doing Their Part?*, Population Health Learning Network (Dec. 2016), https://www.hmpgloballearningnetwork.com/site/frmc/article/insulin-prices-are-pbms-and-insurers-doing-their-part (last visited Nov. 17, 2023).

of steps to address the impact of insulin price increases. We negotiate the best possible discounts off the manufacturers' price on behalf of employers, unions, government programs, and beneficiaries that we serve."[23]

g. Dr. Sumit Dutta, SVP and Chief Medical Officer of OptumRx, testified before the U.S. Congress in the April 2019 hearing that for "insulin products . . . we negotiate with brand manufacturers to obtain significant discounts off list prices on behalf of our customers."[24]

h. The PBM-funded trade association PCMA's website acknowledges, "the insulin market is consolidated, hindering competition and limiting alternatives, leading to higher list prices on new and existing brand insulins," but then misleadingly claims that "PBMs work hard to drive down costs using formulary management and rebates."[25]

377. The PBM Defendants falsely represent that they negotiate with the Manufacturer Defendants to lower the price of the at-issue diabetes medications not only for *payors*, but also for diabetic *patients*. For example:

a. Express Scripts' code of conduct, effective beginning in 2015, states: "At Express Scripts we're dedicated to keeping our promises to *patients and clients* . . . This commitment defines our culture, and all

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[23] *Priced Out of a Lifesaving Drug* at lines 715-18.

[24] *Id*. at lines 903-06.

[25] PCMA, *PCMA on National Diabetes Month: PBMs Lowering Insulin Costs, Providing Support to Patients* (Nov. 16, 2020), https://www.pcmanet.org/pcma-on-national-diabetes-month-pbms-lowering-insulin-costs-providing-support-to-patients/ (last visited Nov. 17, 2023); Visante, *Insulins: Managing Costs with Increasing Manufacturer Prices* (2020), (last visited Nov. 17, 2023). HYPERLINK "https://www.pcmanet.org/wp-content/uploads/2021/12/PCMA_Visante-Insulins-Prices-and-Costs-.pdf"

our collective efforts are focused on our mission to make the use of prescription drugs safer and more affordable."[26]

b. Amy Bricker—former President of Express Scripts and PCMA board member—testified before Congress in April 2019: "At Express Scripts we negotiate lower drug prices with drug companies on behalf of our clients, *generating savings that are returned to patients* in the form of lower premiums and reduced out-of-pocket costs."[27]

c. Ms. Bricker also testified that "Express Scripts remains committed to . . . *patients* with diabetes and creating affordable access to their medications."[28]

d. OptumRx CEO John Prince testified to the Senate: "We *reduce the costs of prescription drugs* [and] we are leading the way to ensure that *those discounts directly benefit consumers*. . . . OptumRx's pharmacy care services business is *achieving better health outcomes for patients*, *lowering costs* for the system, and *improving the healthcare experience for consumers*. . . . OptumRx negotiates better prices with drug manufacturers *for our customers and for consumers*.[29]

e. In its 2017 Drug Report, CVS Caremark stated that the goal of its pharmacy benefit plans is to ensure "that the cost of a drug is aligned with the value it delivers in terms of *patient* outcomes . . . in 2018,

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[26] Express Scripts, *Code of Conduct*, https://www.express-scripts.com/aboutus/codeconduct/ExpressScriptsCodeOfConduct.pdf (last visited Nov. 17, 2023).

[27] *Priced Out of a Lifesaving Drug* at lines 803-06.

[28] *Id*. at lines 838-40.

[29] Senate Insulin Report—*Hearing Transcript* at 174, available at https://www.finance.senate.gov/imo/media/doc/435631.pdf (last visited Nov. 17, 2023).

we are doing even more to help keep drugs affordable with our new Savings *Patients* Money initiative."[30]

f. The PCMA website touts PBMs as "the only entity in the prescription drug supply and payment chain dedicated to reducing drug costs" and (contradicting the PBM representatives' Congressional testimony), that "when new manufacturers enter the market at a lower list price, PBMs use the competition to drive costs down."[31]

378. Not only have the PBM Defendants intentionally misrepresented that they use their market power to save payors money, they have specifically and falsely disavowed that their conduct drives prices higher.

379. Throughout the relevant period, the PBM Defendants have consistently and repeatedly represented that: (a) their interests are aligned with their payor clients; (b) they work to lower the price of the at-issue drugs and, in doing so, achieve substantial savings for diabetics and payors; and (c) monies they receive from manufacturers and their formulary choices are for the benefit of payors and diabetics.

380. Throughout the relevant period, the PBM Defendants also falsely claimed they are transparent about the Manufacturer Payments and the amounts remitted (or not) to payors. In fact, the PBM Defendants' disclosures of their ties to the Manufacturer Defendants were vague, equivocal, and misleading. Their manner of defining "rebates" in payor contracts is misleading and subject to undefined and indeterminable conditions and exceptions. The PBM Defendants thereby facilitated and obtained secret Manufacturer Payments far above and beyond the amount of "rebates" remitted to payors.

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[30] CVS Health, *2017 Drug Trend Report* (Apr. 5, 2018), https://payorsolutions.cvshealth.com/insights/2017-drug-trend-report (last visited Nov. 17, 2023).

[31] PCMA, *PBMs Reduce Insulin Costs: PBMs are working to improve the lives of patients living with diabetes and their families,* https://www.pcmanet.org/insulin-managing-costs-with-increasing-manufacturer-prices/ (last visited Nov. 17, 2023).

381. The PBM Defendants' internal processes and accounting were and are abstruse and opaque, allowing them to overtly mislead the public and payors.

382. During the relevant period—as seen above—PBM Defendants represented to payors nationwide, including in Arizona, that they constructed formularies and negotiated with the Manufacturer Defendants for the benefit of payors and patients to maximize drug cost savings while promoting the health of diabetics.

383. Throughout the relevant period, the PBMs consistently made similar misrepresentations directly to payors nationwide through bid proposals, member communications, invoices, formulary change notifications, and through extensive direct-to-consumer pull through efforts engaged in with the Manufacturers.

384. All such representations are false—the Manufacturer and PBM Defendants in fact coordinated to publish the artificially inflated prices and to construct the PBM formularies, causing the price of the at-issue drugs to skyrocket.

385. Defendants knew their representations were false when they made them and coordinated to affirmatively withhold the truth from payors and patients.

386. Defendants concealed the falsity of their representations by closely guarding their pricing negotiations, structures, agreements, sales figures, and the flow of money and other consideration between them.

387. The Defendants have never revealed the full amount of any drug-specific Manufacturer Payments exchanged between them. Despite the claims of transparency, payors, patients, and the public do not know, and cannot learn, of the full extent of the Manufacturer Payments and other agreements between PBMs and the Manufacturer Defendants.

388. The PBM Defendants do not disclose the terms of the agreements they make with the Manufacturers or the Manufacturer Payments they receive. Nor do they disclose the details related to their agreements (formal or otherwise) with pharmacies. All those revenue streams are beyond the scope of the payors' contractual audit rights.

389. Further, although PBMs negotiate drug-specific rebates with Manufacturers, the PBM rebate payments to payor clients and summaries of such payments are in the aggregate, rather than on a drug-by-drug basis. It is impossible for payors to tease out drug-specific rebates, much less the other undisclosed Manufacturer Payments. This allowed the PBM Defendants to hide the large Manufacturer Payments that they receive for the at-issue diabetes medications.

390. The PBM Defendants have gone so far as to sue governmental entities to block the release of details on their pricing agreements with the Manufacturers and pharmacies.

391. Even when audited by payors, the PBM Defendants routinely refuse to disclose their agreements with the Manufacturers and pharmacies by relying on overly broad confidentiality agreements and claims of trade secrets and by erecting other unnecessary roadblocks and restrictions.

392. Beneficiaries of payors' health plans have no choice but to pay prices flowing from the Manufacturers' inflated list prices because beneficiaries need these medications to survive and the Manufacturer Defendants make virtually all diabetes medications available in the United States. The list prices generated by the Defendants' coordinated efforts directly impact out-of-pocket costs at the point of sale.

L. The Insulin Pricing Scheme Has Damaged Patients and Payors

393. Because of Defendants' success in concealing the Insulin Pricing Scheme through acts and omissions, no patient or payor knew, should have known, or could have known during the relevant period that the prices for the at-issue diabetes medications were (and remain) artificially inflated due to the Insulin Pricing Scheme.

394. As a result, patients and payors have unknowingly overpaid for the Manufacturer Defendants' diabetes medications, which would have cost less but for the Insulin Pricing Scheme.

395. In addition, because of the inflated AWPs of insulin caused by the Insulin Pricing Scheme, insured patients had greater out-of-pocket expenses (because their co-pays are tied to AWP). As a result, those patients reached their annual spending caps sooner, such that their payor was obligated to pay more for those individuals' coverage for the remainder of the plan year.

396. In short, the Insulin Pricing Scheme has directly and proximately caused patients and payors to substantially overpay for diabetes medications.

397. Because Defendants continue to generate exorbitant, unfair, and deceptive prices for the at-issue drugs through the Insulin Pricing Scheme, the harm to consumers is ongoing.

M. Fraudulent Concealment

398. Defendants knowingly and fraudulently concealed the facts alleged herein from Plaintiff. Through the acts, omissions, and misrepresentations alleged throughout this Complaint, Defendants fraudulently concealed their unfair and deceptive acts or practices.

399. Defendants purposefully concealed the Insulin Pricing Scheme and their generation of artificially inflated list prices. The Defendants deliberately concealed their behavior and active role in the Insulin Pricing Scheme and other unlawful conduct.

400. Defendants' acts, omissions and misrepresentations were calculated to lull and induce payors and Plaintiff into forbearing legal action or any inquiry that might lead to legal action. Defendants' acts, omissions, and representations were intended to and in fact did prevent Plaintiff, payors, patients, and the public from discovering Plaintiff's claim.

401. Defendants knowingly and fraudulently concealed the facts alleged herein. As alleged herein, Defendants knew of the wrongful acts set forth above, and had information pertinent to their discovery, and concealed them from the public. As a result of Defendants' conduct, Plaintiff did not know, or could not have known through

the exercise of reasonable diligence, of the existence or scope of the Insulin Pricing Scheme or of its cause of action.

402. Defendants continually and secretly engaged in the Insulin Pricing Scheme. Only Defendants and their agents knew or could have known about Defendants' unlawful actions because Defendants made deliberate efforts to conceal their conduct. As a result of the above, Plaintiff was unable to obtain vital information bearing on its claims absent any fault or lack of diligence on its part.

403. As alleged herein, Defendants affirmatively concealed: (a) that the Manufacturers and PBMs coordinated to create the PBM formularies in exchange for money and other consideration; (b) that the list prices were artificially inflated and manipulated; (c) that the list prices and net costs (purchase prices) paid by payors and patients bore no relationship to the fair market value of the drugs themselves or the services rendered by the PBMs in coordinating their pricing; (d) that the at-issue insulin drugs were selected for inclusion or preferred status on the formularies based on higher prices (and greater potential revenues for Defendants) rather than because of cost-effectiveness or because they were beneficial to payors' Beneficiaries; and (e) the exchange of various payments and pricing agreements between the Manufacturers and PBMs.

404. As alleged more fully herein, the PBM Defendants have blocked drug pricing transparency efforts.

405. As alleged more fully herein, the Manufacturer Defendants have testified to Congress that they were not responsible for skyrocketing insulin prices, claiming that they had no control over the pricing, blaming the PBM Defendants for the high prices, and suggesting that they have not profited from astronomical insulin prices.

406. Meanwhile, the PBM Defendants testified to Congress that the Manufacturer Defendants were solely responsible for the list price increases and that the

payments that the PBMs receive from the Manufacturer Defendants are unrelated to rising insulin prices.

407. As alleged herein, PBM Defendants concealed the Insulin Pricing Scheme through vague and manipulable definitions of terms in their contracts, including by hiding the fees that the Manufacturer Defendants paid to the PBM Defendants and which the PBM Defendants retained and did not pass along to payors as Rebates.

408. The PBM Defendants also concealed payments they received from the Manufacturer Defendants through their affiliated rebate aggregators, hiding them in complex contractual relationships—often with other Defendants—and not reporting them on their quarterly SEC filings.

409. Defendants coordinated to affirmatively withhold the truth about the Insulin Pricing Scheme from payors patients, and the public and concealed the falsity of representations made to payors by closely guarding their pricing negotiations, structures, agreements, sales figures, and the flow of money and other consideration between them.

410. Plaintiff did not know, and could not reasonably have discovered, the full extent of agreements between the PBM Defendants and the Manufacturer Defendants or payments the Manufacturer Defendants made to the PBMs because Defendants actively concealed these agreements and payments.

411. Despite the claims of transparency made to payors and to the public, Defendants have never revealed the full amount of drug-specific payments they have exchanged or received. Payors and patients reasonably relied on Defendants' claims of transparency.

412. Defendants intended that their actions and omissions would be relied upon by the public, to include Plaintiff, payors, and patients. Plaintiff did not know, and did not have the means to know, the truth due to Defendants' actions and omissions.

413. Plaintiff, payors, and patients reasonably relied on Defendants' affirmative statements to Congress and the public, and in contracts between PBMs and their clients,

that Defendants were working to lower insulin prices and provide payors with cost savings.

414. The purposes of the statute of limitations are satisfied because Defendants cannot claim any prejudice due to an alleged late filing where Plaintiff filed suit promptly upon discovering the facts essential to its claims, described herein, which Defendants knowingly concealed.

415. In light of the information set forth above, it is clear that Defendants had actual or constructive knowledge that their conduct was deceptive, in that they consciously concealed the schemes set forth herein.

416. Any applicable statutes of limitation therefore have been tolled.

V. CLAIM FOR RELIEF

COUNT ONE
Arizona Consumer Fraud Act
A.R.S. §§ 44-1521 - 1534
(Against All Defendants)

417. Plaintiff re-alleges and incorporates by reference all preceding and succeeding factual allegations.

418. Arizona's Consumer Fraud Act broadly prohibits the "act, use or employment by any person of any deception, deceptive or unfair act or practice, fraud, false pretense, false promise, misrepresentation, or concealment, suppression or omission of any material fact with intent that others rely on such concealment, suppression or omission, in connection with the sale or advertisement of any merchandise whether or not any person has in fact been misled, deceived or damaged thereby" as "unlawful practices." A.R.S. § 44-1522(A).

419. Defendants are "persons" within the meaning of, and subject to, the provisions of the Consumer Fraud Act, A.R.S. § 44-1521(6).

420. Each at-issue drug is an object or good and thus constitutes "merchandise" under the Consumer Fraud Act. A.R.S. § 44-1521(5); *Watts v. Medicis Pharm. Corp*.,

239 Ariz. 19, 28, ¶ 33, 365 P.3d 944, 953 (2016) (prescription drugs are "merchandise" under Arizona's Consumer Fraud Act).

421. The PBM Defendants' pharmacy benefit management services also constitute "merchandise" within the meaning of the Act because they are services. A.R.S. § 44-1521(5).

422. Because Defendants' unlawful practices, as described herein, occurred in the context of Defendants' efforts to sell for consideration the at-issue drugs and/or to sell or solicit pharmacy benefit management services, those practices were committed "in connection with the sale or advertisement" of the at-issue drugs and/or pharmacy benefit management services. A.R.S. § 44-1521 (1), (7).

423. The Arizona Attorney General is authorized by statute to enforce the Consumer Fraud Act whenever the Attorney General "has reasonable cause to believe that a person has engaged in, is engaging in or is about to engage in any" practice which violates the Consumer Fraud Act. A.R.S. § 44–1524. The Attorney General may seek injunctive relief, restitution, and disgorgement. A.R.S. § 44-1528(A)(1)-(3).

424. The Attorney General may also recover a civil penalty of not more than $10,000 per violation, if the violation was willful. A.R.S. § 44-1531(A). A willful violation "occurs when the party committing the violation knew or should have known that his conduct was of the nature prohibited" by the Act. *Id.*(B).

425. The Attorney General is further "entitled to recover costs, which in the discretion of the court may include a sum representing reasonable attorney's fees for the services rendered, for the use of the state." A.R.S. § 44-1534.

426. These remedies are cumulative and "in addition to all other causes of action, remedies and penalties available" to the State. A.R.S. § 44-1533(A).

427. Defendants' misconduct as described throughout this Complaint, collectively and as individuals, constitutes unlawful practices prohibited by the Consumer Fraud Act.

428. Defendants are independently liable for their own misconduct in violation of the Consumer Fraud Act and are liable for their collective efforts in furtherance of the Insulin Pricing Scheme. Using a complex structure of interdependent entities, Defendants confused and misled payors and other consumers about each Defendant's respective role in an attempt to evade liability for their unfair and deceptive scheme as a whole, and for their unfair and deceptive acts and omissions.

429. Defendants' unlawful practices in violation of the Consumer Fraud Act include the creation and implementation of the Insulin Pricing Scheme.

430. Defendants' conduct was unfair or deceptive within the meaning of the Act in that Defendants conspired to artificially inflate the list prices for the at-issue drugs solely to increase their own profits and at the expense of Arizona payors and patients.

431. Defendants' conduct was also unfair or deceptive in that the Manufacturer Defendants misrepresented and actively concealed the true reasons why they set and raised list prices—the truth being that it was to increase revenues and profits and to offer higher prices and larger Manufacturer Payments to the PBMs—all with the PBM Defendants' knowledge, consent, and cooperation.

432. The PBM Defendants' conduct was unfair or deceptive in that they represented to payors and the public that they worked to generate savings with respect to the at-issue drugs and to promote the health of diabetics, when, in fact, the PBMs drove up the prices of the at-issue drugs and damaged payors and patients by demanding ever-increasing Manufacturer Payments that, in turn, increased what otherwise would have been the retail prices for the at-issue drugs.

433. The PBM Defendants' conduct was unfair or deceptive in that they concealed, obfuscated, and laundered Manufacturer Payments through their affiliated entities in order to retain a large and undisclosed proportion of the Manufacturer Payments to the detriment of payors and, ultimately, their beneficiaries.

434. The PBM Defendants engaged in unfair or deceptive acts or practices by intentionally selecting higher-priced diabetes medications for formulary placement and excluding lower priced ones in order to generate larger profits and without regard to the fact that such practices impaired patients' access to more affordable insulin medications.

435. The PBM Defendants committed unfair or deceptive acts or practices by misleading payors as to the true nature or value of their services, in which the PBM Defendants represented that they promoted cost savings for payors and patients when, in fact, the PBM Defendants helped to inflate insulin prices by demanding Manufacturer Payments, which the PBM Defendants knew that the Manufacturer Defendants would largely recoup by raising list prices.

436. The Manufacturer Defendants and PBM Defendants made misrepresentations and material omissions concerning the Insulin Pricing Scheme and its related conduct for the sole purpose of inducing reliance by payors and consumers into purchasing diabetes medications through PBM Defendants.

437. Defendants knew that the representations and omissions described above were false when made—the rebates and formulary positions agreed upon between Defendants did not lower the prices payors or patients in Arizona paid for the at-issue drugs, but rather were primary factors driving the exponential increase in the amount paid for insulin medications in Arizona during the relevant timeframe.

438. Defendants made these false representations and omissions directly to payors and the public through, among other things, oral and written communications, the inclusion of the reported price in their contracts with payors as a determinant of the price for diabetes medications, marketing materials, presentations, publications of the artificially inflated reported price, and in public statements.

439. Defendants misrepresented and omitted facts about the cause of skyrocketing insulin prices. These misrepresentations and omissions were directed at and affected payors and the public in Arizona.

440. Because, among other things, Defendants concealed, suppressed, and omitted facts regarding the pricing of the at-issue drugs, those concealments, suppressions, and omissions were material to sales made to payors and other consumers.

441. Defendants possessed exclusive knowledge regarding the nature of the pricing of diabetes medications and intentionally concealed the foregoing from payors and patients; and made fraudulent, deceptive, or incomplete representations about the pricing of the diabetes medications and the Defendants' role in that pricing, while purposefully concealing, suppressing, and omitting material facts that contradicted those representations.

442. Defendants' actions demonstrate callous disregard for not only the rule of law but also public health, safety, and well-being.

443. As a direct and proximate result of Defendants' fraudulent Insulin Pricing Scheme, payors and consumers in Arizona sustained actual damages, including but not limited to paying excessive and inflated prices for diabetes medications described herein.

444. As a direct and proximate result of the unfair or deceptive acts or practices described herein, Defendants have received, and will continue to receive, income, profits, and other benefits, which they would not have received if they had not engaged in violations of the Arizona Consumer Fraud Act.

445. The State seeks all legal and equitable relief as allowed by law, including, inter alia, injunctive relief for Defendants' violations of the Arizona Consumer Fraud Act, as authorized under § 44-1528(A). Specifically, the State seeks an injunction requiring Defendants to cease the unfair or deceptive acts or practices regarding insulin pricing described herein.

446. The Attorney General has reason to believe, based on the facts alleged herein, that Defendants' unfair and deceptive acts or practices have violated, and will continue to violate, the Arizona Consumer Fraud Act, absent the grant of an injunction.

447. Unless restrained by this Court, Defendants will likely continue to engage in the methods, acts, or practices that are unfair and have a likelihood to deceive, mislead, and confuse the public with respect to insulin pricing and PBM Defendants' services, all in violation of the Arizona Consumer Fraud Act.

448. Defendants' unlawful practices—including their concealments, suppressions, and omissions of material facts—were carried out with the intent that payors and consumers would rely upon them in connection with the sale or advertisement of merchandise.

449. While engaging in the unlawful practices alleged in this Complaint, Defendants have at all times acted "willfully" as defined by A.R.S. § 44-1531: Defendants knew or should have known that their conduct was of the nature prohibited by the Arizona Consumer Fraud Act. This Court, therefore, should impose on Defendants an appropriate civil penalty for each violation of the Arizona Consumer Fraud Act.

450. The acts and practices alleged herein present a continuing harm and affect the public interest.

451. Accordingly, Plaintiff seeks all legal and equitable relief as allowed by law, including, inter alia, restitution, disgorgement, injunctive relief, attorneys' fees and costs of investigation and prosecution of this action, all appropriate civil penalties and fees, and any other relief to which Plaintiff may be entitled.

452. Restitution is appropriate to "[r]estore to any person in interest any moneys . . . which may have been acquired" by Defendants' unlawful practices, which here includes the amounts that Arizona payors and consumers paid to Defendants for the at-issue drugs. A.R.S. § 44-1528(A)(2); A.R.S. § 44-1531.02(B) (state may receive restitution for economic loss resulting from unlawful practices of Consumer Fraud Act).

453. Disgorgement of "any profits, gain, gross receipts or other benefit obtained" by unlawful practices should be "paid to the state for deposition in the

consumer remediation subaccount of the consumer restitution and remediation revolving fund established by § 44-1531.01." A.R.S. § 44-1528(A)(3). Disgorgement here should include Defendants' excess profits that they received from selling the at-issue drugs to Arizona payors and patients at artificially inflated prices.

VI. PRAYER FOR RELIEF

454. WHEREFORE, Plaintiff prays for entry of judgment against the Defendants for all the relief requested herein and to which the Plaintiff may otherwise be entitled, specifically, but without limitation, as follows:

a. That the Court determine that Defendants have violated the Arizona Consumer Fraud Act;

b. Injunctive relief in accordance with the Arizona Consumer Fraud Act (A.R.S. § 44-1531(A)) to the effect that Defendants, their affiliates, successors, transferees, assignees, and the officers, directors, partners, agents, and employees thereof, and all other persons acting or claiming to act on their behalf or in concert with them, be enjoined and restrained from in any manner continuing, maintaining or renewing the conduct, contract, conspiracy or combination alleged herein in violation of Arizona law, or from entering into any other contract, conspiracy or combination having a similar purpose or effect, and from adopting or following any practice, plan, program or device having a similar purpose or effect, or from continuing to collude to artificially inflate list prices;

c. That the Court:

- award restitution, disgorgement, penalties, and all other legal and equitable relief to which Plaintiff and other Arizona consumers may be entitled;

- award Plaintiff pre- and post-judgment interest as provided by law, and that such interest be awarded at the highest legal rate from and after the date of service of the initial Complaint in this action;
- award the State its costs of this action, including its reasonable attorneys' fees; and
- award such other further relief as the case may require and the Court may deem just and proper under the circumstances.

VII. JURY DEMAND

Plaintiff demands trial by jury on all issues so triable.

Dated: _____

Respectfully submitted:

_____

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