

IN RE : COURT OF COMMON PLEAS
: PHILADELPHIA COUNTY
REGLAN[®]/METOCLOPRAMIDE :
LITIGATION : JANUARY TERM, 2010
: NO. 1997
This Document Relates to All Cases :

CASE MANAGEMENT ORDER NO. 8:
REVISIONS TO CMO NO. 1 (AMENDED MASTER LONG FORM COMPLAINT AND SHORT FORM COMPLAINTS), CONSENT OF DISMISSAL OF PARTIES NOT NAMED AS DEFENDANTS IN SHORT FORM COMPLAINTS, AFFIDAVIT IN LIEU OF RESPONSE TO PLAINTIFFS' INTERROGATORIES AND AUTHORIZATIONS AND PROCEDURE FOR RELEASE OF RECORDS

I. SCOPE OF THIS ORDER

This Case Management Order shall govern all cases that are presently pending or hereafter filed in the Philadelphia Court of Common Pleas which become part of the program of coordinated pretrial proceedings relating to the prescription drug Reglan[®] and/or metoclopramide (the "Reglan[®]/metoclopramide Litigation"). This Order recognizes the fact that Plaintiffs have filed a First Amended Master Long Form Complaint and clarifies the manner in which certain deadlines set forth in Case Management Order ("CMO") No. 1 will be calculated. This Order also clarifies the time and manner in which Parties shall respond to: (1) the First Amended Master Long Form Complaint and/or any subsequent Short Form Complaints in which they are named as Defendants, and (2) the Master First Set of Interrogatories to All Defendants as described in CMO No. 3. This Order also provides for a process by which the dismissal of a party named in a Writ or Complaint but not named in a Short Form Complaint shall be effectuated. The Order sets forth the process for the filing of an affidavit of non-involvement. Finally, the Order supplements Case Management Order No. 3 by providing the Authorizations that must be attached to the Plaintiff Fact Sheet and discusses the procedure for the release of records.

II. PLAINTIFFS' FIRST AMENDED MASTER LONG FORM COMPLAINT

Pursuant to CMO No. 1, Plaintiffs filed a Master Long Form Complaint within thirty (30) days of entry of that order. Plaintiffs did not request service of the Master Long Form Complaint on the Defendants. Subsequently, Plaintiffs have filed a First Amended Master Long Form Complaint. CMO No. 1 and subsequent CMOs provide some deadlines that relate to the date of filing of the original Master Long Form Complaint and others that relate to the date when the original Master Long Form Complaint is served on the Defendants. Those deadlines in prior CMOs that relate to the date of filing of the original Master Long Form Complaint are hereby modified and will now relate to the date when the First Amended Master Long Form Complaint was docketed on April 23, 2010. Deadlines in prior CMOs that relate to the date of service of the original Master Long Form Complaint are hereby modified and will now relate to the date of service of the First Amended Master Long Form Complaint. All references in prior CMOs to the Master Long Form Complaint will hereinafter be understood to relate to the First Amended Master Long Form Complaint.

III. DEFENDANTS' RESPONSES TO THE FIRST AMENDED MASTER LONG FORM COMPLAINT

Parties named as Defendants in the First Amended Master Long Form Complaint shall respond to that pleading by filing and serving either:

- A. Preliminary Objections to the First Amended Master Long Form Complaint; or

B. A brief Master Answer that shall be accepted as constituting a denial of all allegations in the First Amended Master Long Form Complaint and will be deemed an assertion of all applicable defenses thereto. The filing of a Master Answer shall also constitute a denial of all allegations asserted in any and all Short Form Complaints served on a Defendant in this litigation and an assertion of all applicable defenses thereto, regardless of whether a given Short Form Complaint is served before or after the date of a Defendant's Master Answer. That said, the filing of a Master Answer will not waive a Defendant's right, under CMO No. 1, to file Preliminary Objections to a Short Form Complaint.

IV. DEFENDANTS' RESPONSES TO SHORT FORM COMPLAINTS

Parties named as Defendants in Short Form Complaints shall respond to that pleading by filing and serving either:

- A. Preliminary Objections, provided that, in accordance with CMO No. 1, such Preliminary Objections could not be asserted in Preliminary Objections to the First Amended Master Long Form Complaint; or
- B. A notice of appearance that shall constitute a denial of all allegations asserted in the Short Form Complaint and an assertion of all applicable defenses thereto. In accordance with CMO No. 1, if not already completed, a Defendant must file an entry of appearance on an individual case's docket. The reservation of any and all cross claims and the date for formally asserting any such claims that may be asserted on a case by case basis will be discussed in a subsequent CMO.

V. TIME TO RESPOND TO THE FIRST AMENDED MASTER LONG FORM COMPLAINT

A party named as a Defendant in the First Amended Master Long Form Complaint shall serve its response to the First Amended Master Long Form Complaint (as described in Section III, *supra*), only if it has been properly served with both a copy of the First Amended Master Long Form Complaint and at least one Short Form Complaint in which it is named a Defendant in an individual case. The Defendant's deadline to file such a response to the First Amended Master Long Form Complaint shall be the later of:

- A. 20 days after the first available day on which the Defendant has been served with both the First Amended Master Long Form Complaint and a Short Form Complaint; or
- B. 20 days after the date of execution of this Order.

VI. TIME TO RESPOND TO SHORT FORM COMPLAINTS

A. A party who has been named as a Defendant in both the First Amended Master Long Form Complaint and a Short Form Complaint shall serve its response to that Short Form Complaint in an individual case (as described in Section IV, *supra*), twenty (20) days after the later of:

- 1. The first available date on which it has been served with both the First Amended Master Long Form Complaint and the Short Form Complaint for the particular case; or

2. The date of execution of this Order.

B. A party who is not named as a Defendant in the First Amended Master Long Form Complaint but is named as a Defendant in a Short Form Complaint in an individual case shall serve its response to that Short Form Complaint within twenty (20) days of:

1. Service of the Short Form Complaint; or
2. The date of execution of this Order,

whichever is later, provided that, for purposes of notice and due process, the party is also served with a copy of the First Amended Master Long Form Complaint. Similarly, a party who is not named as a Defendant in the First Amended Master Long Form Complaint, but only in a Short Form Complaint, shall also serve a response to the First Amended Master Long Form Complaint (as described in Section III, *supra*) under the same deadlines described in this section.

C. For avoidance of doubt, Plaintiffs' Liaison Counsel need only serve the First Amended Master Long Form Complaint once on each party named as a Defendant in the Reglan[®]/metoclopramide Litigation.

VII. CONSENT OF DISMISSAL OF PARTIES NOT NAMED AS DEFENDANTS IN SHORT FORM COMPLAINTS

A. Within ten (10) days after filing a Short Form Complaint, or other subsequent pleading such as an Amended Short Form Complaint, naming fewer than all Defendants named in any associated Complaint or Writ of Summons, the subject Plaintiff shall file a praecipe of discontinuance without prejudice as to all Defendants not named in the subsequent pleading. With respect to all Short Form Complaints filed before this Order is executed, the ten (10) days shall run from the date of execution of the Order, rather

than from the filing date of the Short Form Complaint. All Defendants named in the associated Complaint or Writ of Summons are deemed to consent to such discontinuance without prejudice as to all Defendants in the action not named in a subsequent pleading. That said, all remaining Defendants reserve their right to seek contribution.

B. In the event that a Plaintiff fails to file the praecipe of discontinuance as contemplated by paragraph A, any other party to the case may send a letter to Plaintiff's counsel, with a copy to all parties, requesting that the praecipe of discontinuance be filed. Absent written objection served on all parties to the case by Plaintiff within ten (10) days of service of the letter, any Defendant may file the praecipe of discontinuance, to which all parties will be deemed to have consented.

VIII. AFFIDAVIT IN LIEU OF RESPONSE TO PLAINTIFFS' INTERROGATORIES

In lieu of responding to Master First Set of Interrogatories, a Defendant may serve an Affidavit attesting to the fact that neither the named defendant nor any current or former corporate subsidiary of the defendant manufactured, sold, distributed or marketed Reglan[®]/metoclopramide at any time. Upon service of the affidavit, the attesting defendant's discovery obligations are suspended. If Plaintiffs believe that there is a good faith basis for requiring the attesting defendant to respond to said interrogatories, the parties agree to meet and confer. If they are unable to resolve the issue, the dispute will be submitted to Discovery Master Bock who may require defendant to respond to the interrogatories or may fashion such other relief as he may deem appropriate. Nothing in this Paragraph shall constitute a waiver by Plaintiffs of any of their rights with respect to the attesting defendant.

IX. AUTHORIZATIONS AND PROCEDURE FOR RELEASE OF RECORDS

In accordance with the timing set forth in Case Management Order No. 3, completed Plaintiff Fact Sheets shall be accompanied by executed copies of the Authorizations that are attached hereto as Exhibit "A." Defendant shall provide via electronic mail to Plaintiffs' individual counsel all completed authorizations for records, and Plaintiffs' individual counsel shall have five (5) business days to object to the use of the authorizations in writing. Authorizations shall not be utilized over objection until resolution by meet & confer or a ruling by the Special Discovery Master.

Prior to providing psychological, psychiatric, mental health, counseling and/or insurance records to Defendants, MCS will notify Plaintiffs' counsel that such records are in the possession of MCS. Plaintiff's counsel shall have thirty (30) days to review and make redactions prior to production to Defendants. On the thirty-first day, absent objection, the records will be made available to all parties. With respect to any redacted materials, Plaintiffs shall identify the record provider and basis for redaction to all parties of record within five (5) days of counsel's direction to redact. Upon objection by defense counsel, Defendants may seek the redacted information through the meet and confer or Special Discovery Master processes.

X. AUTHORIZATIONS AND TAX RECORDS

Tax records will be provided only in cases where a Plaintiff is claiming loss of earnings.

Date: 6/16/10

SO ORDERED



THE HONORABLE SANDRA MAZER MOSS

EXHIBIT A

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip Code: _____

I. General Release.

I hereby authorize _____ to disclose the information set
[Name and address of record source: e.g., Employer

forth in Section IV of this Authorization for the period from _____ to _____.
The released information is required for litigation. I further authorize The MCS Group, Inc., a private record reproduction company, upon presentation of this authorization or a copy thereof, to photocopy such records as are reasonably necessary for the above-state purposes.

II. HIPAA Complaint Authorization for the Release of Medical Records Pursuant to 45 CFR 164.508. I authorize the disclosure of all protected medical information for the purpose of review and evaluation in connection with a legal matter. I expressly request that the designated records custodian of all covered entities under HIPAA disclose full and complete protected medical information: _____

[Name of the Provider: Hospital, Doctor, Insurance Co.]

a.) Person(s) authorized to disclose the information:

b.) Information to be disclosed: I understand that any information disclosed in response to this request will include any information related to AIDS/HIV, sexually transmitted diseases, psychiatric/psychological care, treatment for drug and alcohol abuse and genetic testing unless specifically checked below.

- AIDS/HIV Communicable Disease Information Sexually transmitted disease(s), diagnosis and/or testing
 Psychiatric/Psychological Care Treatment for Drug/ Alcohol Abuse Genetic testing

c.) Person(s) authorized to receive the disclosed information: The MCS Group, Inc. on behalf of: _____
[Name of MCS Client]

I further authorize The MCS Group, Inc., a private record reproduction company, upon presentation of this authorization or a copy thereof, to photocopy such records as are reasonably necessary for the above-state purposes.

d.) Purpose of this request: At my request.

e.) Expiration Date: Unless otherwise revoked, this authorization will expire two years after the date of this authorization or later as indicated here _____.

f.) Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying in writing each Person identified in Section (a). I understand that the revocation is only effective after it is received and logged by such Person. I understand that any disclosure made prior to the revocation under this authorization will not be affected by the revocation.

g.) Subsequent Disclosure: I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

h.) Impact on Medical Treatment: I understand that I do not need to sign this authorization to assure any medical treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer for each Person identified in Section (a).

i.) Redisclosure of Information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information, may not apply to the recipient of the information and therefore may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure.

j.) Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

III. Signature/Certification.

Signature of Person Identified Above or his or her Authorized Representative / Guardian _____

Date _____

By signing this authorization, the Authorized Representative and/or Guardian warrants that he or she has the authority to act on behalf of the person identified above on the basis of: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

IV. Information Subject to the General Release.	
☐	Employment: Copies of any and all records including but not limited to all applications for employment, all prior employment verification information, all pre-employment background or health documentation, applications for insurance, insurance forms, all physician or medical reports or records of any kind pertaining to physical examination required for employment, continued employment, or health or disability insurance, all reports or records of job or other injury, attendance records, sick time records, vacation records, payroll records, W-2 forms, salary history, progress records, letters of complaint, layoffs or termination for any and all times, occasions or reasons, pertaining to the Person identified on the front of this Authorization Form.
☐	Social Security Benefits: Any and all records showing all payments and benefits received, and all benefits still available and not used by the Person identified on the front of this Authorization Form, including but not limited to any and all disability benefits, application for benefits, approval or denial of benefits and other social security benefits records regarding the above mentioned individual.
☐	School: Copies of any and all school records, transcripts, attendance records, disciplinary reports, extracurricular activities, and cumulative records regarding the Person identified on the front of this Authorization Form.
☐	Other:
V. Information Subject to the Health Information Release.	
☐	Employment: Copies of any and all records including but not limited to all applications for employment, all prior employment verification information, all pre-employment background or health documentation, applications for insurance, insurance forms, all physician or medical reports or records of any kind pertaining to physical examination required for employment, continued employment, or health or disability insurance, all reports or records of job or other injury, attendance records, sick time records, vacation records, payroll records, W-2 forms, salary history, progress records, letters of complaint, layoffs or termination for any and all times, occasions or reasons, pertaining to the Person identified on the front of this Authorization Form.
☐	Pharmacy: Any and all prescription records kept in the regular course of business including but not limited to prescription prescribed, physicians prescribing medications, medication description, medication side effect print out, frequency medication being taken, billing, insurance and payment records, etc., and any and all records kept in your file regarding the below listed party; from the first date of treatment to the present (pertaining to the Person identified on the front of this Authorization Form).
☐	Medical Insurance: Copies of any and all claim files concerning claims made by the below listed party including but not limited to pay out sheets, medical records, bills and reports of treating and examining physicians, state of claims, correspondence, notes and documents concerning any payments made to medical providers under the provisions of the policy. Insured: (the Person identified on the front of this Authorization Form).
☐	Medical: Copies of any and all medical records, reports, charts, notes, diagrams, documents, papers, correspondence, memoranda, microfilmed document emergency room reports, billing information, x-ray films, MRI films, and/or films or of radiological studies and any and all other records of reports in your possession, custody or control, from the inception of your records to the present pertaining to the Person identified on the front of this Authorization Form.
☐	Other:

The Authorization for Release of Information is subject to the requirements of Case Management Order Nos. 3 and 8 in the matter of *In Re: Reglan®/metoclopramide Litigation*, Philadelphia Court of Common Pleas No. 1001-01997.

**Information to Help You Fill Out the
"1-800-MEDICARE Authorization to Disclose Personal Health Information" Form**

By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in the privacy notice contained in the Medicare & You handbook. You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.

If you want 1-800-MEDICARE to give your personal health information to someone other than you, you need to let Medicare know in writing.

If you are requesting personal health information for a deceased beneficiary, please include a copy of the legal documentation which indicates your authority to make a request for information. (For example: Executor/Executrix papers, next of kin attested by court documents with a court stamp and a judge's signature, a Letter of Testamentary or Administration with a court stamp and judge's signature, or personal representative papers with a court stamp and judge's signature.) Also, please explain your relationship to the beneficiary.

Please use this step by step instruction sheet when completing your "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form. Be sure to complete all sections of the form to ensure timely processing.

1. Print the name of the person with Medicare.

Print the Medicare number exactly as it is shown on the red, white, and blue Medicare card, including any letters (for example, 123456789A).

Print the birthday in month, day, and year (mm/dd/yyyy) of the person with Medicare.

2. This section tells Medicare what personal health information to give out. Please check a box in 2a to indicate how much information Medicare can disclose. If you only want Medicare to give out limited information (for example, Medicare eligibility), also check the box(es) in 2b that apply to the type of information you want Medicare to give out.

3. This section tells Medicare when to start and/or when to stop giving out your personal health information. Check the box that applies and fill in dates, if necessary.

4. Medicare will give your personal health information to the person(s) or organization(s) you fill in here. You may fill in more than one person or organization. If you designate an organization, you must also identify one or more individuals in that organization to whom Medicare may disclose your personal health information.

5. The person with Medicare or personal representative must sign their name, fill in the date, and provide the phone number and address of the person with Medicare.

If you are a personal representative of the person with Medicare, check the box, provide your address and phone number, and attach a copy of the paperwork that shows you can act for that person (for example, Power of Attorney).

6. Send your completed, signed authorization to Medicare at the address shown here on your authorization form.
7. If you change your mind and don't want Medicare to give out your personal health information, write to the address shown under number six on the authorization form and tell Medicare. Your letter will revoke your authorization and Medicare will no longer give out your personal health information (except for the personal health information Medicare has already given out based on your permission).

You should make a copy of your signed authorization for your records before mailing it to Medicare.

1-800-MEDICARE Authorization to Disclose Personal Health Information

Use this form if you want 1-800-MEDICARE to give your personal health information to someone other than you.

1. **Print Name** _____ **Medicare Number** _____ **Date of Birth** _____
(First and last name of the person with Medicare) (Exactly as shown on the Medicare Card) (mm/dd/yyyy)

2. Medicare will only disclose the personal health information you want disclosed.

2A: Check only one box below to tell Medicare the specific personal health information you want disclosed:

- Limited Information (go to question 2b)
 Any Information (go to question 3)

2B: Complete only if you selected "limited information". Check all that apply:

- Information about your Medicare eligibility
 Information about your Medicare claims
 Information about plan enrollment (e.g. drug or MA Plan)
 Information about premium payments
 Other Specific Information (please write below; for example, payment information)
- _____

3. **Check only one box below indicating how long Medicare can use this authorization to disclose your personal health information** (subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):

- Disclose my personal health information indefinitely
 Disclose my personal health information for a specified period only
beginning: (mm/dd/yyyy) _____ and ending: (mm/dd/yyyy) _____
- _____

4. Fill in the name and address of the person(s) or organization(s) to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person(s) for any organization you list below:

1. Name: _____

Address: _____

2. Name: _____

Address: _____

3. Name: _____

Address: _____

5. I authorize 1-800-MEDICARE to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.

Signature

Telephone Number

Date (mm/dd/yyyy)

Print the address of the person with Medicare (Street Address, City, State, and ZIP)

Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the person with Medicare signed above.

Print the Personal Representative's Address (Street Address, City, State, and ZIP)

Telephone Number of Personal Representative: _____

Personal Representative's Relationship to the Beneficiary: _____

6. Send the completed, signed authorization to:

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

7. Note:

You have the right to take back (“revoke”) your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. If you would like to revoke your authorization, send a written request to the address shown above.

Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0930**. The time required to complete this information collection is estimated to average **15 minutes** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Social Security Administration
Consent for Release of Information

Please read these instructions carefully before completing this form.

When to Use This Form **Complete this form only if you want the Social Security Administration to give information or records about you to an individual or group (for example, a doctor, or an insurance company).**

Natural or adoptive parents or a legal guardian, acting on behalf of a minor, who want us to release the minor's:

- **nonmedical** records, should use this form.
- medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F4. You can get this form at any Social Security office.

How to Complete This Form

This consent form must be completed and signed only by:

- the person to whom the information or record applies, or
- the parent or legal guardian of a minor to whom the **nonmedical** information applies, or
- the legal guardian of a legally incompetent adult to whom the information applies.

To complete this form:

- Fill in the name, date of birth, and Social Security Number of the person to whom the information applies.
- Fill in the name and address of the individual or group to which we will send the information.
- Fill in the reason you are requesting the information.
- Check the type(s) of information you want us to release.
- Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.

PAPERWORK REDUCTION ACT: Paperwork Reduction Act Statement: This information collection meets the clearance requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. The office is listed under U. S. Government agencies in your telephone directory or you may call 1-800-772-1213 for the address. You may send comments on our estimate of the time needed to complete the form to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

Social Security Administration
Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number
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I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
_____	_____
_____	_____
_____	_____

I want this information released because:

(There may be a charge for releasing information.)

Please release the following information:

- _____ Social Security Number
- _____ Identifying information (includes date and place of birth, parents' names)
- _____ Monthly Social Security benefit amount
- _____ Monthly Supplemental Security Income payment amount
- _____ Information about benefits/payments I received from _____ to _____
- _____ Information about my Medicare claim/coverage from _____ to _____
(specify) _____
- _____ Medical records
- _____ Record(s) from my file (specify) _____
- _____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature: _____

(Show signatures, names, and addresses of two people if signed by mark.)

Date: _____ Relationship: _____

