IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

UNITED STATES OF AMERICA ex rel. H. Edmund Pigott,	§	
	§	Civil Action No. _____
STATE OF ARKANSAS ex rel. H. Edmund Pigott, Relator,	§	
	§	JURY TRIAL DEMAND
STATE OF CALIFORNIA ex rel. H. Edmund Pigott, Relator,	§	
	§	**FILED IN CAMERA AND UNDER SEAL PURSUANT TO 31 U.S.C. § 3730**
STATE OF COLORADO ex rel. H. Edmund Pigott, Relator,	§	
STATE OF CONNECTICUT ex rel. H. Edmund Pigott, Relator,	§	**DO NOT ENTER INTO PACER**
	§	**DO NOT ENTER INTO CM/ECF**
STATE OF DELAWARE ex rel. H. Edmund Pigott, Relator,	§	**DO NOT PLACE IN PRESS BOX**
DISTRICT OF COLUMBIA ex rel. H. Edmund Pigott, Relator,	§	
STATE OF FLORIDA ex rel. H. Edmund Pigott, Relator,	§	
STATE OF GEORGIA ex rel. H. Edmund Pigott, Relator,	§	
STATE OF HAWAII ex rel. H. Edmund Pigott, Relator,	§	
STATE OF ILLINOIS ex rel. H. Edmund Pigott, Relator,	§	
STATE OF INDIANA ex rel. H. Edmund Pigott, Relator,	§	
STATE OF LOUISIANA ex rel. H. Edmund Pigott, Relator,	§	
STATE OF MASSACHUSETTS ex rel. H. Edmund Pigott, Relator,	§	
STATE OF MICHIGAN ex rel. H.	§	

Edmund Pigott, Relator,	§
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STATE OF MINNESOTA ex rel. H. Edmund Pigott, Relator,	§
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STATE OF MONTANA ex rel. H. Edmund Pigott, Relator,	§
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STATE OF NEVADA ex rel. H. Edmund Pigott, Relator,	§
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STATE OF NEW HAMPSHIRE ex rel. H. Edmund Pigott, Relator,	§
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STATE OF NEW JERSEY ex rel. H. Edmund Pigott, Relator,	§
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STATE OF NEW MEXICO ex rel. H. Edmund Pigott, Relator,	§
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STATE OF NEW YORK ex rel. H. Edmund Pigott, Relator,	§
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STATE OF NORTH CAROLINA ex rel. H. Edmund Pigott, Relator,	§
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STATE OF OKLAHOMA ex rel. H. Edmund Pigott, Relator,	§
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STATE OF RHODE ISLAND ex rel. H. Edmund Pigott, Relator,	§
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STATE OF TENNESSEE ex rel. H. Edmund Pigott, Relator,	§
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STATE OF TEXAS ex rel. H. Edmund Pigott, Relator,	§
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STATE OF VIRGINIA ex rel. H. Edmund Pigott, Relator,	§
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STATE OF WISCONSIN ex rel. H. Edmund Pigott,	§
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Relator,	§
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	§

FILED UNDER SEAL

vs. §
§
FOREST PHARMACEUTICALS, INC., §
§
Defendant. §
§

FALSE CLAIMS ACT COMPLAINT

PRELIMINARY STATEMENT

1. This is an action brought by H. Edmund Pigott ("Relator") to recover damages and civil penalties on behalf of the United States of America and individual states for false and/or fraudulent claims made, used, and caused to be made, used, or presented, by Forest Pharmaceuticals, Inc., ("Forest") in violation of the False Claims Act ("FCA"), 31 U.S.C. § 3729, *et seq.* and comparable state statutes.

2. The central allegation of this Complaint is that the largest antidepressant drug study ever conducted, the STAR*D study[1] funded by the National Institute of Mental Health, was biased in favor of Forest's antidepressant drug Celexa, a fact that the Relator has demonstrated in peer-reviewed journal articles. Relator here alleges upon information and belief that the demonstrated bias in the STAR*D study, which cannot be explained on any other reasonable basis, was the result of kickbacks, bribes and other improper financial inducements paid by Forest to John Rush, M.D., the project's principal investigator, and one or more of the project's other investigators.

3. Relator believes and therefore alleges that conflicts of interest and improper financial arrangements between Forest and Dr. Rush and other investigators not only caused the selection of Forest's drug Celexa to be used as the only antidepressant employed in the first leg of the study, a significant advantage by itself, but also caused falsification and overstatement of the effectiveness of

[1] STAR*D stands for Sequenced Treatment to Relieve Depression.

Celexa in the published reports of the study. The end result was a significant increase in sales of Celexa (and its second-generation version, Lexapro) to patients covered by federal and state healthcare programs.

JURISDICTION AND VENUE

4. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331 and 31 U.S.C. § 3732, the latter of which specifically confers jurisdiction on this Court for actions brought pursuant to 31 U.S.C. §§ 3729 and 3730. Under 31 U.S.C. § 3730(e), there has been no relevant public disclosure of the "allegations or transactions" in this Complaint.

5. This Court has personal jurisdiction over Defendant pursuant to 31 U.S.C. § 3732(a) because Defendant can be found in, resides or transacts, or has transacted business nationally and specifically within the District of Maryland.

6. Venue is proper in this District pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. §§1391(b) and (c) because Defendant has transacted business in the District of Maryland.

7. The causes of action alleged herein are timely brought because of, among other things, efforts by the Defendant to conceal from the United States wrongdoing in connection with the allegations made herein.

PARTIES

8. Relator H. Edmund Pigott, is a Ph.D. psychologist who resides in Clarksville, Maryland. Relator has reported bias in the STAR*D study in at least one scholarly publication, but has not previously reported the allegations made here that kickbacks and other improper financial ties caused the bias in the STAR*D study. If there have been any public disclosures of the particular allegations and transactions set forth in this Complaint, Relator is the original source of those disclosures as he conducted the investigation that revealed the bias in the study, he is the source of allegation that improper financial

arrangements with Forest caused that bias, and he has voluntarily provided the information to the United States Attorney before filing of this Complaint.

9. Defendant Forest is a wholly owned subsidiary of Forest Laboratories, Inc. Defendant Forest has its principal place of business in St. Louis, Missouri. Forest manufactures, distributes, and sells prescription drug products in the United States. Forest Laboratories, Inc. has a license from H. Lundbeck A/S ("Lundbeck"), a Danish company, to promote and sell Celexa in the United States.

ALLEGATIONS

10. The STAR*D study was the largest antidepressant effectiveness study ever conducted. It was funded by the National Institute of Mental Health ("NIMH") at a cost of $35 million. STAR*D enrolled 4,041 depressed patients and provided them with free acute and 12 months of continuing antidepressant care to maximize their likelihood of achieving and maintaining remission.

11. Patients were first prescribed Defendant Forest's antidepressant drug Celexa, a Selective Seratonin Reuptake Inhibitors ("SSRI"), similar to but chemically distinct from Prozac, Zoloft, Paxil and other popular antidepressants that work by preventing the body's reuptake or removal of a naturally-occurring neurotransmitter that is believed to have a positive impact upon mood.

12. Those who failed to get adequate relief from Celexa were provided with up to three additional trials of pharmacologically distinct drug treatments, only one of which was an SSRI (Zoloft) that is sold in competition with Celexa. In contrast though to Zoloft, whose effectiveness was compared in the second leg of the study to two other antidepressants that were not SSRIs, Celexas was not compared to any other antidepressants in the first leg of the study and was identified as being an appropriate "first step" antidepressant for this largest depression study ever conducted. In effect, Forest was provided an opportunity to demonstrate the superiority of its branded SSRI without a side-to-side or sequential comparison of the effectiveness of Celexa to other such as Prozac, Zoloft and Paxil.

13. NIMH initially entered into a contract with the University of Texas' Southwest Medical Center

in September 1999, with John Rush, M.D. serving as the study's principal investigator ("P.I."). The first phase of the contract was to develop an agreed-upon research protocol which was finalized on June 28, 2002.

14. Celexa was recommended by Dr. Rush to be the antidepressant given first to all 4,041 patients, supposedly because in June of 2002, it had the lowest market share of the SSRIs with a depression indication. Because of its lower market share, the research protocol determined that Celexa would facilitate participant recruitment given the lower likelihood of prior exposure. Celexa was also chosen because, supposedly, there would be minimal discontinuation symptoms so that the tolerability of the switch to other pharmacological agents at level 2 would not be confounded by the emergence of significant discontinuation reactions. Finally, the research protocol also suggested that Celexa had minimal risk of drug-drug interactions, thereby reducing the complications due to its use in medically ill participants who are on concomitant medications.

15. Relator believes and therefore alleges that it is questionable that Celexa has a scientifically established superiority over other SSRIs such as Prosac, Zoloft, and Paxil with respect to discontinuation syndrome and drug-to-drug interactions. If Celexa were known to be superior on these grounds, and to be equally effective, then it surely would not have been the least-prescribed SSRI. It seems more likely that Celexa was less popular with doctors because it was less effective or had greater risk of discontinuation syndrome or drug-to-drug interactions.

16. Selecting a drug to be the sole antidepressant used in the first leg of a publicly-funded study on the ground that fewer patients would have been exposed to it because it was not as popular as other SSRIs has the hallmarks of a choice made to increase the drug's market share, not a choice based upon scientific principles.

17. Being selected as the step-1 antidepressant in the STAR*D study was highly advantageous to Defendant for numerous reasons including the fact that with the STAR*D study being the largest and

most prestigious antidepressant study ever conducted, Celexa's selection as the initial drug could be pointed to in Forest's marketing efforts as an indication of the drug's superiority over other SSRIs. Also, because the first leg of the study, for which Celexa was used, did not involve a comparison of Celexa to other SSRIs or any other control condition such as a placebo, there was really no way for Defendant to not benefit as long as the success rates were the same or better than previously documented.

18. Relator believes and therefore alleges that the decision to use Celexa was influenced by kickbacks, bribes and other financial remuneration provided by Forest to Dr. Rush. If NIMH personnel went along with Dr. Rush's choice, then it is likely that they did so because Dr. Rush misrepresented to them the real reasons for his recommendation of Celexa. Relator believes and therefore alleges that any of the other popular SSRIs[2] could have been substituted for Celexa and that the stated grounds for the selection of Celexa were a rationalization of a choice that was dictated more than anything else by financial ties between the principal investigator and Defendant Forest.

19. STAR*D was supposedly designed as a comparative effectiveness study of different treatment options for people with major depression and included 12 pre-specified research outcome measures and a detailed analytic plan for evaluating the effectiveness and cost-efficiency of 11 pharmacologically distinct drug treatments for depressed patients who failed to improve from their first antidepressant.

20. After the protocol for the study was approved, the recruitment and treatment of depressed patients began in 41 clinics associated with various leading universities (e.g., UT, University of Pittsburgh, Harvard, UC San Diego, and Columbia University) and continued through mid-2005. The STAR*D investigators began publishing their main findings in seven articles beginning in January 2006 concluding with their summary article published in November 2006.

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[2] SSRI stands for Selective Seratonin Reuptake Inhibitor.

21. Despite the passage of four years since the publication of STAR*D's major summary article and the publication of over 70 peer-reviewed articles on the STAR*D findings, none of the articles published by the STAR*D authors have reported the outcomes for any of the 12 pre-specified measures nor reported any findings in a manner consistent with the study's analytic plan as presented in STAR*D's research protocol, including not discussing the main purpose of the study which was to evaluate the cost-effectiveness of the various antidepressant treatments.

22. In contrast to STAR*D's report of positive findings supporting the effectiveness of antidepressants, Relator, with others, in 2010 published a paper attached as Appendix A documenting that only 108 of STAR*D's 4,041 patients (2.7%) had an acute-care remission and neither relapsed nor dropped out during the 12 months of continuing care that followed. This paper also documented how STAR*D changed its research outcome measures and analyses resulting in an inflation of STAR*D's reported acute-care remission rates.

23. Relator has also determined, through an examination of the STAR*D protocols and reported data, that the remission rate for Celexa was inflated by 44.9%. That and related findings will soon be published in the article attached as Appendix B.

24. Ten of the STAR*D authors, including Dr. Rush, have disclosed in journal articles that they have received unspecified sums of money from Forest. In the summer of 2008, about the time that U.S. Senator Grassley identified failures on Dr. Rush's part to fully disclose conflicts of interest related to NIH grants he received, Dr. Rush left the University of Texas, moved to Singapore and was removed as the PI for STAR*D.

25. Relator has concluded, and therefore alleges, that the only reasonable explanation for the false and biased reporting of the study results is that Dr. Rush received significant financial remuneration from Forest which Forest paid to him for the purpose of influencing his actions.

THE LAW

26. The federal Anti-Kickback statute ("AKS") makes it a felony punishable by imprisonment of up to five years and a fine of up to $25,000 to "offer or pay remuneration (including any kickback, bribe, or rebate)" to any person to "induce such person . . . to . . . *recommend* purchasing, leasing, or ordering any good, facility, service or item for which payment may be made in whole or in part under a Federal health care program . . . ." 42 U.S.C. 1320a-7b(b)(2) (emphasis added).

27. The AKS is violated if one purpose of the remuneration is to induce future referrals of business reimbursable under federal health care programs. *United States v. Shaw*, 106 F. Supp. 2d 103,121 (D. Mass. 2000), citing *United States v. Greber*, 760 F.2d 68 (3rd Cir. 1985) and *United States v. Kats*, 871 F.2d 105 (9th Cir. 1989). "The gravamen of Medicare Fraud [under the AKS] is inducement . . . ." Id at 121, citing *United States v. Bay State Ambulance and Hospital Rental Service*, 874 F.2d 20 (1st Cir. 1989).

28. The FCA provides that any person who or entity which knowingly submits, or causes the submission of, a false or fraudulent claim to the United States government for payment or approval, is liable for a civil penalty of up to $11,000 for each such claim, plus three times the amount of the damages sustained by the government. 31 U.S.C. 3729(a)(1)(A). The FCA defines "knowingly" to include acts committed with "actual knowledge," as well as acts committed "in deliberate ignorance" or in "reckless disregard" of their truth or falsity. Liability attaches when a defendant fraudulently seeks, or causes others to seek, payment that is unwarranted from the government, or otherwise retains payments from the government which should have never been paid at all. The FCA allows any person having information about a false or fraudulent claim against the government to bring an action for him or herself and the government, and to share in any recovery.

29. Likewise, section 31 U.S.C. 3729(a)(1)(B) states that any person who knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim is liable to

the United States government. Anyone who conspires to commit a violation under the Federal False Claims Act will also be held liable pursuant to section 31 U.S.C. 3729(a)(1)(C).

30. The false claims acts of the individual states are largely patterned based upon the Federal False Claims Act.

COUNT I

ANTI-KICKBACK VIOLATIONS OF FEDERAL AND STATE FALSE CLAIMS ACTS

31. Relator re-alleges the allegations of paragraphs 1 through 30 of this Complaint as if fully set forth herein.

32. At least one purpose of the remuneration paid to Dr. Rush by Forest was to induce him to recommend use of Celexa as the first-stage antidepressant in the STAR*D study and to recommend through scholarly publications the use of Celexa (and its substitute Lexapro) for treatment of depression by overstating the effectiveness of Celexa in the published reports of the STAR*D study. Forest is therefore guilty of violations of the AKS.

33. Compliance with the AKS is both a condition of participation and a condition of payment under government healthcare programs and is material to the decisions of state and federal programs to reimburse for prescriptions of Celexa and Lexapro. Through violations of the AKS, Forest knowingly caused doctors to prescribe and pharmacies to fill prescriptions for Celexa and Lexapro that it knew would be submitted for reimbursement to state and federal healthcare programs.

34. Forest has therefore caused the submission of false or fraudulent claims for payment or approval in violation of 31 U.S.C. § 3729 (a)(1)(A).

35. The United States has been damaged.

COUNT II

FALSE STATEMENT VIOLATIONS OF FEDERAL AND STATE FALSE CLAIMS ACTS

36. Relator re-alleges and incorporates herein by reference the preceding paragraphs, 1 – 35 of this Complaint as if fully set forth herein.

37. Published reports of the STAR*D study that overstated the effectiveness of Celexa were false reports or statements knowingly made or used by Forest or caused to be made or used by Forest that were material to false or fraudulent claims submitted by pharmacies for the reimbursement of prescriptions for Celexa and Lexapro in violation of 31 U.S.C. §3729(a)(1)(B).

38. The United States has been damaged.

PRAYER FOR RELIEF UNDER THE FEDERAL FALSE CLAIMS ACT

Relator respectfully requests this Court to enter judgment against Defendant, as follows:

(a) That the United States be awarded damages in the amount of three times the damages sustained by them because of the false and fraudulent claims alleged within this Complaint;

(b) That civil penalties of $11,000 be imposed for each and every false claim that Defendant presented to the United States;

(c) That pre- and post-judgment interest be awarded, along with reasonable attorneys' fees, costs, and expenses which the Relator necessarily incurred in bringing and pressing this case;

(d) That Relator be awarded the maximum percentage of any recovery allowed to him pursuant the False Claims Act and its state law counterparts and

(e) That this Court award such other and further relief as it deems proper.

COUNT THREE

VIOLATION OF THE ARKANSAS MEDICAID FRAUD FALSE CLAIMS ACT

39. Relator re-alleges and incorporates the allegations in paragraphs 1 - 38 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of Arkansas. Upon information and belief, Defendant's actions described herein occurred in the State of Arkansas as well.

40. This is a qui tam action brought by Relator and the State of Arkansas to recover treble damages and civil penalties under the Arkansas Medicaid Fraud False Claims Act, A.C.A. §§ 20-77-901 *et seq*.

41. The Arkansas Medicaid Fraud False Claims Act § 20-77-902 provides liability for any person who:

> Knowingly makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under the Arkansas Medicaid program;
>
> At any time knowingly makes or causes to be made any false statement or representation of a material fact for use in determining rights to a benefit or payment;

42. In addition, A.C.A. § 20-77-902(7)(A) prohibits soliciting, accepting, or agreeing to accept any type of remuneration for the following:

Recommending the purchase, lease, or order of any good, facility, service, or item for which payment may be made under the Arkansas Medicaid program.

43. Defendant violated the Arkansas Medicaid Fraud False Claims Act § 20-77-902(1) (2) & (7)(A) by continuously engaging in the fraudulent and illegal conduct described herein.

44. Defendant furthermore violated Arkansas Medicaid Fraud False Claims Act § 20-77-902(1) & (2) and knowingly caused thousands of false claims to be made, used, and presented to Arkansas by their continuous violation of federal and state laws, including A.C.A. § 20-77-902(7)(A) and the AKS, as

described herein.

45. Arkansas, by and through the Arkansas Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

46. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to Arkansas in connection with Defendant's fraudulent and illegal conduct.

47. Had Arkansas known that defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

48. As a result of Defendant's violations of A.C.A. § 20-77-902(1) (2) & (7)(A), the State of Arkansas has been damaged in an amount far in excess of millions of dollars exclusive of interest.

49. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to A.C.A. § 20-77-911(a) on behalf of himself and the State of Arkansas.

50. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of Arkansas in the operation of its Medicaid program.

51. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against defendant:

To the STATE OF ARKANSAS:

Three times the amount of actual damages which the State of Arkansas has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $5,000 and not more than $10,000 for each false claim which defendant caused to be presented to the State of Arkansas;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to A.C.A. § 20-77-911(a) and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this court deems equitable and just.

COUNT FOUR

VIOLATON OF THE CALIFORNIA FALSE CLAIMS ACT

52. Relator re-alleges and incorporates the allegations in paragraphs 1 - 51 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of California. Upon information and belief, Defendant's actions described herein occurred in the State of California as well.

53. This is a qui tam action brought by Relator and the State of California to recover treble damages and civil penalties under the California False Claims Act, Cal. Gov't. Code §§ 12650 *et seq*.

54. Cal. Gov't Code § 12651(a) provides liability for any person who:

Knowingly presents, or causes to be presented, to an officer or employee of the state of any political division thereof, a false claim for payment or approval;

Knowingly makes, uses, or causes to be made or used a false record of statement to get a false claim paid or approved by the state or by any political subdivision;

Conspires to defraud the state or any political subdivision by getting a false claim allowed or paid by the state of by any political subdivision.

Is a beneficiary of an inadvertent submission of a false claim to the state or a political subdivision, subsequently discovers the falsity of the claim, and fails to disclose the false claim to the state or the political subdivision within a reasonable time after discovery of the false claim.

55. In addition, the payment or receipt of bribes or kickbacks is prohibited under Cal. Bus. & Prof. Code §§ 650 & 650.1, and is also specifically prohibited in treatment of medical patients pursuant to Cal. Welf. & Inst. Code § 14107.2.

56. Defendant violated Cal. Gov't Code § 12651(a), Cal Bus. & Prof. Code §§ 650 & 650.1, and Cal. Welf. & Inst. Code § 14107.2 by continuously engaging in the fraudulent and illegal conduct described herein.

57. Defendant furthermore violated Cal. Gov't Code § 12651(a) and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of California by their continuous violation of federal and state laws, including Cal. Bus. & Prof. Code §§ 650, 650.1, Cal. Welf. & Inst. Code § 14107.2, and the AKS, as described herein.

58. The State of California, by and through the California Medi-Cal program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

59. Compliance with applicable Medicare, Medicaid, Medi-Cal, and the various other federal and state laws cited herein was implied, and upon information and belief, also an express condition of payment of claims submitted to the State of California in connection with Defendant's fraudulent and illegal conduct.

60. Had the State of California known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

61. As a result of Defendant's continuous violations of Cal. Gov't Code § 12651(a), the State of California has been damaged in an amount far in excess of millions of dollars exclusive of interest.

62. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to Cal. Gov't Code § 12652(c) on behalf of himself and the State of California.

63. This Court is requested to accept supplemental jurisdiction over this related state claim as it is predicated upon the same exact facts as the federal claim and merely asserts separate damages to the State of California in the operation of its Medicaid program.

64. WHERFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF CALIFORNIA:

Three times the amount of actual damages which the State of California has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of up to $10,000 for each false claim which Defendant presented or caused to be presented to the State of California;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to Cal. Gov't Code § 12652 and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT FIVE

VIOLATION OF THE COLORADO MEDICAID FALSE CLAIMS ACT

65. Relator re-alleges and incorporates the allegations in paragraphs 1 - 64 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of Colorado. Upon information and belief, Defendant's actions described herein occurred in Colorado as well.

66. This is a qui tam action brought by Relator and the State of Colorado to recover treble damages and civil penalties under the Colorado Act, Co. St. §§ 25.5-4-304 to 25.5-4-310 *et seq*.

67. Co. St. § 25.5-4-305 provides liability in relevant part, to any person who:

> (a) Knowingly presents, or causes to be presented, to an officer or employee of the state a false or fraudulent claim for payment or approval;
>
> (b) Knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim;
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> ***
>
> (f) Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state in connection with the "Colorado Medical Assistance Act," or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state in connection with the "Colorado Medical Assistance Act;"
>
> (g) Conspires to commit a violation of paragraphs (a) to (f) of this subsection (1).

68. Defendant violated Co. St. § 25.5-4-305 by continuously engaging in the fraudulent and illegal conduct described herein.

69. Defendant furthermore violated Co. St. § 25.5-4-305 and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of Colorado by its continuous violation of federal and state laws, including the AKS, as described herein.

70. The State of Colorado, by and through the Colorado Medicaid Program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

71. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Colorado in connection with Defendant's fraudulent and illegal conduct.

72. Had Colorado known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

73. As a result of Defendant's continuous violations of Co. St. §§ 25.5-4-304 to 25.5-4-310 *et seq.*, the State of Colorado has been damaged in an amount far in excess of millions of dollars exclusive of interest.

74. Defendant did not, within thirty days after they first obtained information as to such violations, furnish such information to officials of the State responsible for investigating false claims violations, did not otherwise fully cooperate with any investigation of the violations, and have not otherwise furnished information to the State regarding the claims for reimbursement at issue.

75. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to Co. St. § 25.5-4-306 on behalf of himself and the State of Colorado.

76. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of Colorado in the operation of its Medicaid program.

77. WHERFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF COLORADO:

Three times the amount of actual damages which the State of Colorado has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of up to $10,000 for each false claim which Defendant presented or caused to be presented to the State of Colorado;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to Co. St. § 25.5-4-305 and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT SIX

VIOLATION OF THE CONNECTICUT FALSE CLAIMS ACT

78. Relator re-alleges and incorporates the allegations in paragraphs 1 - 77 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of Connecticut. Upon information and belief, Defendant's actions described herein occurred in Connecticut as well.

79. This is a qui tam action brought by Relator and the State of Connecticut to recover treble damages and civil penalties under the Connecticut False Claims Act, C.G.S.A. §§ 17b-301 *et seq.*

80. C.G.S.A. § 17b-301a provides for liability for any persons who:

> (1) Knowingly present, or cause to be presented, to an officer or employee of the state a false or fraudulent claim for payment or approval under a medical assistance program administered by the Department of Social Services;

> (2) Knowingly make, use or cause to be made or used, a false record or statement to secure the payment or approval by the state of a false or fraudulent claim under a medical assistance program administered by the Department of Social Services;
>
> (3) Conspire to defraud the state by securing the allowance or payment of a false or fraudulent claim under a medical assistance program administered by the Department of Social Services;
>
> ***
>
> (7) Knowingly make, use or cause to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the state under a medical assistance program administered by the Department of Social Services.

81. Defendant violated C.G.S.A. § 17b-301a by continuously engaging in the fraudulent and illegal conduct described herein.

82. Defendant furthermore violated C.G.S.A. § 17b-301a and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of Connecticut in continuous violation of federal and state laws, including the AKS, as described herein.

83. The State of Connecticut, by and through the Connecticut Medicaid Program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

84. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Connecticut in connection with Defendant's fraudulent and illegal conduct.

85. Had Connecticut known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

86. As a result of Defendant's violations of C.G.S.A. § 17b-301, the State of Connecticut has been damaged in an amount far in excess of millions of dollars exclusive of interest.

87. Defendant did not, within thirty days after they first obtained information as to such violations, furnish such information to officials of the State responsible for investigating false claims violations, did not otherwise fully cooperate with any investigation of the violations, and have not otherwise furnished information to the State regarding the claims for reimbursement at issue.

88. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to C.G.S.A. § 17b-301 on behalf of himself and the State of Connecticut.

89. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of Connecticut in the operation of its Medicaid program.

90. WHERFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF CONNECTICUT:

Three times the amount of actual damages which the State of Connecticut has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of up to $10,000 for each false claim which Defendant presented or caused to be presented to the State of Connecticut;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to C.G.S.A. 17b-301b and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT SEVEN

VIOLATION OF THE DELAWARE FALSE CLAIMS ACT

91. Relator re-alleges and incorporates the allegations in paragraphs 1 - 90 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of Delaware. Upon information and belief, Forest's actions described herein occurred in Delaware as well.

92. This is a qui tam action brought by Relator and the State of Delaware to recover treble damages and civil penalties under the Delaware Medicaid False Claims Act, 6 Del. C. §§ 1201 *et seq*.

93. 6 Del. C. § 1201 provides liability for any person who:

> Knowingly presents, or causes to be presented, directly or indirectly, to an officer or employee of the Government a false or fraudulent claim for payment or approval;
>
> Knowingly makes, uses or causes to be made or used, directly or indirectly, a false record or statement to get a false or fraudulent claim paid or approved;
>
> Conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;
>
> Knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, increase or decrease an obligation to pay or transmit money or property to or from the Government.

94. Further, 31 Del. C. § 1005 provides that:

It shall be unlawful for any person to offer or pay any remuneration (including any kickback, bribe or rebate) directly or indirectly, in cash or in kind to induce any other person . . . [t]o purchase, lease, order or arrange for or recommend purchasing, leasing or ordering any property, facility, service, or item of medical care or medical assistance for which payment may be made in whole or in part under any

public assistance program.

95. Defendant violated 6 Del. C. § 1201 & 31 Del. C. § 1005 by continuously engaging in the fraudulent and illegal conduct described herein

96. Defendant furthermore violated 6 Del. C. § 1201 and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of Delaware by their continuous violation of federal and state laws, including 31 Del. C. § 1005 and the AKS, as described herein.

97. The State of Delaware, by and through the Delaware Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

98. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Delaware in connection with Defendant's fraudulent and illegal conduct.

99. Had the State of Delaware known that Defendant was violating the federal and state laws cited herein, it wound not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

100. As a result of Defendant continuing violations of 6 Del C. § 1201(a), the State of Delaware has been damaged in an amount far in excess of millions of dollars exclusive of interest.

101. Defendant did not, within 30 days after they first obtained information as to such violations, furnish such information to officials of the State responsible for investigating false claims violations, did not otherwise fully cooperate with any investigation of the violations, and have not otherwise furnished information to the State regarding the claims for reimbursement at issue.

102. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to 6 Del. C. § 1203(b) on behalf of himself and the State of Delaware.

103. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of Delaware in the operation of its Medicaid program.

104. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties against Defendant:

To the STATE OF DELAWARE:

Three times the amount of actual damages which the State of Delaware has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty on not less than $5,500 and not more than $11,000 for each false claim which Defendant caused to be presented to the State of Delaware;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to 6 Del C. § 1205, and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT EIGHT

VIOLATION OF THE DISTRICT OF COLUMBIA PROCUREMENT REFORM AMENDMENT ACT

105. Relator re-alleges and incorporates the allegations in paragraphs 1 - 104 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the District of Columbia. Upon information and belief, Defendant's actions described herein occurred in the District of Columbia as well.

106. This is a qui tam action brought by Relator and the District of Columbia to recover treble damages and civil penalties under the District of Columbia Procurement Reform Amendment Act, D.C. §§ 2-308.13 *et seq*.

107. D.C. Code § 2-30814(a) provides liability for any person who:

> Knowingly presents, or causes to be presented, to an officer or employee of the District a false claim for payment or approval;
>
> Knowingly makes, uses or causes to be made or used, a false record or statement to get a false claim paid or approved by the District;
>
> Conspires to defraud the District by getting a false claim allowed or paid by the District;
>
> Is the beneficiary of an inadvertent submission of a false claim to the District, subsequently discovers the falsity of the claim, and fails to disclose the false claim to the District.

108. In addition, D.C. Code §§ 4-802(c) & 2-30814(a) prohibits soliciting, accepting, or agreeing to accept any type of remuneration for the following:

> Referring a recipient to a particular provider of any item or service or for which payment may be made under the District of Columbia Medicaid program;
>
> Recommending the purchase, lease, or order of any good, facility, service, or item for which payment may be made under the District of Columbia Medicaid Program.

109. Defendant violated D.C. Code §§ 2-30814(a), 4-802(c), & 2-30814(a) by continuously engaging in the fraudulent and illegal conduct described herein.

110. Defendant furthermore violated D. C. Code § 2-30814(a) and knowingly caused thousands of false claims to be made, used, and presented to the District of Columbia by their continuing violation of federal and state laws, including D. C. Code §§ 4-802(c) & 2-30814(a) and the AKS, as described herein.

111. The District of Columbia, by and through the District of Columbia Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

112. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the District of Columbia is connection with Defendant's fraudulent and illegal conduct.

113. Had the District of Columbia known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

114. As a result of Defendant violations of D.C. Code § 2-308.14(a), the District of Columbia has been damaged in an amount far in excess of millions of dollars exclusive of interest.

115. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to D.C. Code § 2-308.15(b) on behalf of himself and the District of Columbia.

116. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the District of Columbia in the operation of its Medicaid program.

117. WHEREFORE, Relator respectfully request this Court to award the following damages to the following parties and against Defendant:

To the DISTRICT OF COLUMBIA:

Three times the amount of actual damages which the District of Columbia has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $5,000 and not more than $10,000 for each false claim which Defendant caused to be presented to the District of Columbia;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to D. C. Code § 2-308.15(f) and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this court deems equitable and just.

COUNT NINE

VIOLATION OF THE FLORIDA FALSE CLAIMS ACT

118. Relator re-alleges and incorporates the allegations in paragraphs 1 - 117 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of Florida. Upon information and belief, Defendant's actions described herein occurred in the State of Florida as well.

119. This is a qui tam action brought by Relator and the State of Florida to recover treble damages and civil penalties under the Florida False Claims Act, West's F.S.A. §§ 68.081 *et seq*.

120. West's F.S.A. § 68.082 provides liability for any person who:

Knowingly presents or causes to be presented to an officer or employee of an agency a false claim for payment or approval;

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

Conspires to submit a false claim to an agency or to deceive an agency for the purpose of getting a false or fraudulent claim allowed or paid.

121. Defendant violated West's F.S.A. § 68.082 by continuously engaging in the fraudulent and illegal conduct described herein.

122. Defendant furthermore violated West's F.S.A. § 68.082 and knowingly caused thousands of false claims to be made, used, and presented to the State of Florida by their continuous violation of federal and state laws, including the AKS, as described herein.

123. The State of Florida, by and through the State of Florida Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

124. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Florida in connection with Defendant's fraudulent and illegal conduct.

125. Had the State of Florida known that defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

126. As a result of Defendant's violations of West's F.S.A. § 68.082, the State of Florida has been damaged in an amount far in excess of millions of dollars exclusive of interest.

127. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to West's F.S.A. § 68.083(2) on behalf of himself and the State of Florida.

128. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of Florida in the operation of its Medicaid program.

129. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF FLORIDA:

Three times the amount of actual damages which the State of Florida has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $5,000 and not more than $10,000 for each false claim which Defendant caused to be presented to the State of Florida;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to West's F.S.A. § 68.085 and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this court deems equitable and just.

COUNT TEN

VIOLATION OF THE GEORGIA STATE FALSE MEDICAID CLAIMS ACT

130. Relator re-alleges and incorporates the allegations in paragraphs 1 - 129 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of Georgia. Upon information and belief, Defendant's actions described herein occurred in Georgia as well.

131. This is a qui tam action brought by Relator and the State of Georgia to recover treble damages and civil penalties under the Georgia State False Medicaid Claims Act, Ga. Code Ann. §§ 49-4-168 *et seq*.

132. Ga. Code Ann. §§ 49-4-168.1 *et seq*. provides liability for any person who:

> Knowingly presents or causes to be presented to the Georgia Medicaid program a false or fraudulent claim for payment or approval;
>
> Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Georgia Medicaid program;
>
> Conspires to defraud the Georgia Medicaid program by getting a false or fraudulent claim allowed or paid;
>
> Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay, repay or transmit money or property to the State of Georgia.

133. Defendant violated Ga. Code Ann. § 49-4-168.1 by continuously engaging in the fraudulent and illegal conduct described herein.

134. Defendant furthermore violated Ga. Code Ann. § 49-4-168.1 and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of Georgia by its continuous violation of federal and state laws, including the AKS, as described herein.

135. The State of Georgia, by and through the Georgia Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

136. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Georgia in connection with Defendant's fraudulent and illegal conduct.

137. Had the State of Georgia known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with Defendant's fraudulent and illegal conduct.

138. As a result of Defendant's violations of Ga. Code Ann. § 49-4-168.1, the State of Georgia has been damaged in an amount far in excess of millions of dollars exclusive of interest.

139. Defendant did not, within 30 days after first obtaining information as to such violations, furnish such information to officials of the State responsible for investigating false claims violations, did not otherwise fully cooperate with any investigation of the violations, and have not otherwise furnished information to the State regarding the claims for reimbursement at issue.

140. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to Ga. Code Ann. § 49-4-168.2(b) on behalf of himself and the State of Georgia.

141. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of Georgia in the operation of its Medicaid program.

142. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties against Defendant:

To the STATE OF GEORGIA:

Three times the amount of actual damages which the State of Georgia has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty on not less than $5,500 and not more than $11,000 for each false claim which Defendant caused to be presented to the State of Georgia;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to Ga. Code Ann. § 49-4-168.2(i), and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT ELEVEN

VIOLATION OF THE HAWAII FALSE CLAIMS ACT

143. Relator re-alleges and incorporates the allegations in paragraphs 1 - 142 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of Hawaii. Upon information and belief, Defendant's actions described herein occurred in Hawaii as well.

144. This is a qui tam action brought by Relator and the State of Hawaii to recover treble damages and civil penalties under the Hawaii False Claims Act, Haw. Rev. Stat. §§ 661.21 *et seq.*

145. Haw. Rev. Stat. § 661-21(a) provides liability for any person who:

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

Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state;

Conspires to defraud the state by getting a false or fraudulent claim allowed or paid;

Is a beneficiary of an inadvertent submission of a false claim to the State, who subsequently discovers the falsity of the claim, and fails to disclose the false claim to the State within a reasonable time after discovery of the false claim.

146. Defendant violated Haw. Rev. Stat. § 661-21(a) by continuously engaging in the fraudulent and illegal conduct described herein.

147. Defendant furthermore violated Haw. Rev. Stat. § 661.21(a) and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of Hawaii by their continuous violation of federal and state laws, including the AKS, as described herein.

148. The State of Hawaii, by and through the Hawaii Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

149. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Hawaii in connection with Defendant's fraudulent and illegal conduct.

150. Had the State of Hawaii known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

151. As a result of Defendant's violations of Haw. Rev. Stat. § 661-21(a), the State of Hawaii has been damaged in an amount far in excess of millions of dollars exclusive of interest.

152. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to Haw. Rev. Stat. § 661-25(a) on behalf of himself and the State of Hawaii.

153. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of Hawaii in the operation of its Medicaid program.

154. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF HAWAII:

Three times the amount of actual damages which the State of Hawaii has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $5,000 and not more than $10,000 for each false claim which Defendant caused to be presented to the State of Hawaii;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to Haw. Rev. Stat. § 661-27 and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT TWELVE

VIOLATION OF THE ILLINOIS WHISTLEBLOWER REWARD AND PROTECTION ACT

155. Relator re-alleges and incorporates the allegations in paragraphs 1 - 154 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of Illinois. Upon information and belief, Defendant's actions described herein occurred in Illinois as well.

156. This is a qui tam action brought by Relator and the State of Illinois to recover treble damages and civil penalties under the Illinois Whistleblower Reward and Protection Act, 740 ILCS 175 *et seq.*

157. 740 ILCS 175/3(a) provides liability for any person who:

Knowingly presents, or causes to be presented, to an officer or employee of the State of a member of the Guard a false or fraudulent claim for payment or approval;

Knowingly makes, uses, of causes to be made or used, a false record or statement to get a

false or fraudulent claim paid or approved by the State;

Conspires to defraud the State by getting a false or fraudulent claim allowed or paid.

158. In addition, 305 ILCS 5/8A-3(b) of the Illinois Public Aid Code (Vendor Fraud and Kickbacks) prohibits the solicitation or receipt of any remuneration, including any kickback, bribe or rebate, directly or indirectly, overtly or covertly, in cash or in kind in return for furnishing any item of service for which payment may be made in whole or in part under the Illinois Medicaid program.

159. Defendant violated 740 ILCS 175/3(a) & 305 ILCS 5/8A-3(b) by continuously engaging in the fraudulent and illegal conduct described herein.

160. Defendant furthermore violated 740 ILCS 175/3(a) and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of by its continuous violation of federal and state laws, including 305 ILCS 5/8A-3(b) and the AKS, as described herein.

161. The State of Illinois, by and through the Illinois Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

162. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Illinois in connection with Defendant's fraudulent and illegal conduct.

163. Had the State of Illinois known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

164. As a result of Defendant's violations of 740 ILCS 175/3(a), the State of Illinois has been damaged in an amount far in excess of millions of dollars exclusive of interest.

165. Relator is a private person with direct and independent knowledge of the allegation in this Complaint, who has brought this action pursuant to 740 ILCS 175/3(b) on behalf of himself and the State of Illinois.

166. This court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of Illinois in the operation of its Medicaid program.

167. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF ILLINOIS:

Three times the amount of actual damages which the State of Illinois has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $5,000 and not more than $10,000 for each false claim which Defendant caused to be presented to the State of Illinois;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to 740 ILCS/4(d) and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT THIRTEEN

VIOLATION OF THE INDIANA FALSE CLAIMS AND WHISTLEBLOWER PROTECTION ACT

168. Relator re-alleges and incorporates the allegations in paragraphs 1 - 167 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of Indiana. Upon information and belief, Defendant's actions described herein occurred in Indiana as well.

169. This is a qui tam action brought by Relator and the State of Indiana to recover treble damages and civil penalties under the Indiana False Claims and Whistleblower Protection Act, IC 5-11-5.5 *et seq.*

170. IC 5-11-5.5-2 provides liability for any person who:

> (1) Presents a false claim to the state for payment or approval;
>
> (2) Makes or uses a false record or statement to obtain payment or approval of a false claim from the state;
>
> (3) With intent to defraud the state, delivers less money or property to the state than the amount recorded on the certificate or receipt the person receives from the state;
>
> (4) With intent to defraud the state, authorizes issuance of a receipt without knowing that the information on the receipt is true;
>
> (5) Receives public property as a pledge of an obligation on a debt from an employee who is not lawfully authorized to sell or pledge the property;
>
> (6) Makes or uses a false record or statement to avoid an obligation to pay or transmit property to the state;
>
> (7) Conspires with another person to perform an act described in subdivisions (1) through (6);
>
> (8) Causes or induces another person to perform an act described in subdivisions (1) through (6).

171. In addition, IC 12-15-24-1 & IC 12-15-24-2 prohibits the provision of a kickback or bribe in connection with the furnishing of items or services or the making or receipt of the payment under the Indiana Medicaid program.

172. Defendant violated IC 5-11-5.5-2, IC 12-15-24-1 & IC 12-15-24-2 by continuously engaging in the fraudulent and illegal conduct described herein.

173. Defendant furthermore violated IC 5-11-5.5-2 and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of Indiana their continuous violation of federal and state laws, including IC 12-15-24-1 & IC 12-15-24-2, and the AKS, as described herein.

174. The State of Indiana, by and through the Indiana Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

175. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein is an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Indiana in connection with Defendant's fraudulent and illegal conduct.

176. Had the State of Indiana known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

177. As a result of Defendant's violations of IC 5-11-5.5-2, the State of Indiana has been damaged in an amount far in excess of millions of dollars exclusive of interest.

178. Relator is a private person with direct and independent knowledge of the allegation in this Complaint, who has brought this action pursuant to IC 5-11-5.5-4 on behalf of himself and the State of Indiana.

179. This court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of Indiana in the operation of its Medicaid program.

180. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF INDIANA:

Three times the amount of actual damages which the State of Indiana has sustained as a result of Defendant's fraudulent and illegal conduct;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to IC 5-11-5.5-6 and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT FOURTEEN

VIOLATION OF THE LOUISIANA MEDICAL ASSISTANCE PROGRAMS INTEGRITY LAW

181. Relator re-alleges and incorporates the allegations in paragraphs 1 - 180 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of Louisiana. Upon information and belief, Defendant's actions described herein occurred in Louisiana as well.

182. This is a qui tam action brought by Relator and the State of Louisiana to recover treble damages and civil penalties under the Louisiana medical Assistance Programs Integrity Law, La Rev. Stat. Ann §§ 437.1 *et seq*.

183. La. Rev. Stat. Ann. § 438.3 provides:

No person shall knowingly present or cause to be presented a false or fraudulent claim;

> No person shall knowingly engage in misrepresentation to obtain, or attempt to obtain, payment from medical assistance programs funds;
>
> No person shall conspire to defraud, or attempt to defraud, the medical assistance programs through misrepresentation or by obtaining, or attempting to obtain, payment for a false or fraudulent claim;

184. In addition, La. Rev. Stat. Ann.§ 438.2(A) prohibits the solicitation, receipt, offering or payment of any financial inducements, including kickbacks, bribes, rebates, etc., directly or indirectly, overtly or covertly, in cash or in kind, for furnishing health care goods or services paid for in whole or in part by the Louisiana medical assistance programs.

185. Defendant violated La. Rev. Stat. Ann. §§ 438.3 & 438.2(A) by continuously engaging in the fraudulent and illegal conduct described herein.

186. Defendant furthermore violated La. Rev. Stat. Ann. § 438.3 and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of Louisiana by their continuous violation of federal and state laws, including La. Rev. Stat. Ann. § 438.2(A) and the AKS, as described herein.

187. The State of Louisiana, by and through the Louisiana Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

188. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Louisiana in connection with Defendant's fraudulent and illegal conduct.

189. Had the State of Louisiana known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

190. As a result of Defendant's violations of La. Rev. Stat. Ann. § 438.3, the State of Louisiana has been damaged in an amount far in excess of millions of dollars exclusive of interest.

191. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to La. Rev. Stat. Ann. § 439.1(A) on behalf of himself and the State of Louisiana.

192. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of Louisiana in the operation of its Medicaid program.

193. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF LOUISIANA:

Three times the amount of actual damages which the State of Louisiana has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $5,000 and not more than $10,000 for each false claim which Defendant caused to be presented to the State of Louisiana;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to La. Rev. Stat. § 439.4(A) and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award or reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT FIFTEEN

VIOLATION OF THE MASSACHUSETTS FALSE CLAIMS ACT

194. Relator re-alleges and incorporates the allegations in paragraphs 1 – 193 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the Commonwealth of Massachusetts. Defendant's actions described herein occurred in Massachusetts as well.

195. This is a qui tam action brought by Relator and State of Massachusetts for treble damages and penalties under Massachusetts False Claims Act, Mass. Gen. Laws Ann. Chap 12 §§ 5(A) *et seq.*

196. Mass. Gen. Laws Ann. Chap 12 § 5B provides liability for any person who:

> Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
>
> Knowingly makes, uses, or causes to be made or used, a false record or statement to obtain payment or approval of a claim by the commonwealth or any political subdivision thereof;
>
> Conspires to defraud the commonwealth or any political subdivision thereof through the allowance or payment of a fraudulent claim;
>
> Is a beneficiary of an inadvertent submission of a false claim to the common wealth or political subdivision thereof, subsequently discovers the falsity of the claim, and fails to disclose the false claim to the commonwealth or political subdivision within a reason able time after discovery of the false claim.

197. In addition, Mass. Gen. Laws Ann. Chap. 118E § 41 prohibits the solicitation, receipt or offering of any remuneration, including any bribe ore rebate, directly or indirectly, overtly or covertly, in cash or in kind in return for furnishing any good, service, or item for which payment may be made in whole or in part under the Massachusetts Medicaid program.

198. Defendant violated Mass. Gen. Laws Ann. Chap. 118E § 41 & Mass. Gen. Laws Ann. Chap. 12 § 5B by continuously engaging in the fraudulent and illegal conduct described herein.

199. Defendant furthermore violated Mass. Gen. Laws Ann. Chap 12 § 5B and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of Massachusetts by their continuous violation of federal and state laws, including Mass. Gen. Laws Ann. Chap. 118E § 41 and the AKS, as described herein.

200. The State of Massachusetts, by and through the Massachusetts Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

201. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Massachusetts in connection with Forest's fraudulent and illegal conduct.

202. Had the State of Massachusetts known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

203. As a result of Defendant's violations of Mass. Gen. Laws Ann. Chap. 12 § 5B, the State of Massachusetts has been damaged in an amount far in excess of millions of dollars exclusive of interest.

204. Relator is a private person with direct and independent knowledge of the allegations in this Compliant, who has brought this action pursuant to Mass. Gen. Laws Ann Chap. 12 § 5(c)(2) on behalf of himself and the State of Massachusetts.

205. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon that exact same facts as the federal claim, and merely asserts separate damage to the State of Massachusetts in the operation of its Medicaid program.

206. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF MASSACHUSETTS:

Three times the amount of actual damages which that State of Massachusetts has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $5,000 and not more than $10,000 for each false claim which Defendant caused to be presented to the State of Massachusetts;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to Mass. Gen. Laws Ann. Chap. 12 § 5F and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT SIXTEEN

VIOLATION OF THE MICHIGAN MEDICAID FALSE CLAIM ACT

207. Relator re-alleges and incorporates the allegations in paragraphs 1 - 206 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in Michigan. Upon information and belief, Defendant's actions described herein occurred in Michigan as well.

208. This is a qui tam action brought by Relator and State of Michigan for treble damages and penalties under Michigan Medicaid False Claim Act, M.C.L.A. 400.601 *et seq*.

209. M.C.L.A. 400.607 provides liability for any person who, among other things:

> Causes to be made or presented to an employee or officer of this state a claim under the social welfare act, Act No. 280 of the Public Acts of 1939, as amended, being sections 400.1 to 400.121 of the Michigan Compiled Laws, upon or against the state, knowing the claim to be false;
>
> Presents or causes to be made or presented a claim under the social welfare act, Act No. 280 of the Public Acts of 1939, which he or she knows falsely represents that the goods or services for which the claim is made were medically necessary in accordance with professionally accepted standards.

210. In addition, M.C.L.A. 400.604 prohibits the solicitation, receipt, or offering of a kickback or bribe in connection with the furnishing of goods or services for which payment is or may be made in whole or in part pursuant to the Michigan Medicaid program.

211. Defendant violated M.C.L.A. 400.607 & 400.604 by continuously engaging in the fraudulent and illegal conduct described herein.

212. Defendant furthermore violated M.C.L.A. 400.607 and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of Michigan by their continuous violation of federal and state laws, including M.C.L.A. 400.604 and the AKS, as described herein.

213. The State of Michigan, by and through the Michigan Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

214. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Michigan in connection with Defendant's fraudulent and illegal conduct.

215. Had the State of Michigan known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

216. As a result of Forest's violations of M.C.L.A. 400.607, the State of Michigan has been damaged in an amount far in excess of millions of dollars exclusive of interest.

217. Relator is a private person with direct and independent knowledge of the allegations in this Compliant, who has brought this action pursuant to M.C.L.A. 400.610a on behalf of himself and the State of Michigan.

218. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon that exact same facts as the federal claim, and merely asserts separate damage to the State of Michigan in the operation of its Medicaid program.

219. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF MICHIGAN:

All damages to which the State of Michigan is entitled pursuant to M.C.L.A. 400.612;

Civil penalties for each false claim which Defendant caused to be presented to the State of Michigan;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to M.C.L.A. 400.610a(9) and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT SEVENTEEN

VIOLATION OF THE MINNESOTA FALSE CLAIMS ACT

220. Relator re-alleges and incorporates the allegations in paragraphs 1 - 219 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in Minnesota. Upon information and belief, Defendant's actions described herein occurred in Minnesota as well.

221. This is a qui tam action brought by Relator and State of Minnesota for treble damages and penalties under Montana False Claims Act, M.S.A. §§ 15C.02 *et seq*.

222. M.S.A. § 15C.02a provides liability for any person who:

> (1) knowingly presents, or causes to be presented, to an officer or employee of the state or a political subdivision a false or fraudulent claim for payment or approval;
>
> (2) knowingly makes or uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state or a political subdivision;
> (3) knowingly conspires to either present a false or fraudulent claim to the state or a political subdivision for payment or approval or makes, uses, or causes to be made or used a false record or statement to obtain payment or approval of a false or fraudulent claim;
>
> (4) has possession, custody, or control of public property or money used, or to be used, by the state or a political subdivision and knowingly delivers or causes to be delivered to the state or a political subdivision less money or property than the amount for which the person receives a receipt;
>
> (5) is authorized to prepare or deliver a receipt for money or property used, or to be used, by the state or a political subdivision and knowingly prepares or delivers a receipt that falsely represents the money or property;
>
> (6) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state or a political subdivision who lawfully may not sell or pledge the property;
>
> (7) knowingly makes or uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state or a political subdivision.

223. Defendant violated M.S.A. § 15C.02a by continuously engaging in the fraudulent and illegal conduct described herein.

224. Defendant furthermore violated M.S.A. § 15C.02a and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of Minnesota by their continuous violation of federal and state laws, including the AKS, as described herein.

225. The State of Minnesota, by and through the Minnesota Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

226. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Minnesota in connection with Defendant's fraudulent and illegal conduct.

227. Defendant did not, within 30 days after first obtaining information as to such violations, furnish such information to officials of the State responsible for investigating false claims violations, did not otherwise fully cooperate with any investigation of the violations, and have not otherwise furnished information to the State regarding the claims for reimbursement at issue.

228. Had the State of Minnesota known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

229. As a result of Defendant's violations of M.S.A. § 15C.02a, the State of Minnesota has been damaged in an amount far in excess of millions of dollars exclusive of interest.

230. Relator is a private person with direct and independent knowledge of the allegations in this Compliant, who has brought this action pursuant to M.S.A. § 15C.02a on behalf of himself and the State of Minnesota.

231. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon that exact same facts as the federal claim, and merely asserts separate damage to the State of Minnesota in the operation of its Medicaid program.

232. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF MINNESOTA:

All damages to which the State of Minnesota is entitled pursuant to M.S.A. §§ 15C.02 *et seq.*;

Civil penalties for each false claim which Defendant caused to be presented to the State of Minnesota;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to M.S.A. § 15C.02a and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT EIGHTEEN

VIOLATION OF THE MONTANA FALSE CLAIMS ACT

233. Relator re-alleges and incorporates the allegations in paragraphs 1 - 233 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a

nationwide, continuous practice of Defendant. Forest conducts business in Montana. Upon information and belief, Defendant's actions described herein occurred in Montana as well.

234. This is a qui tam action brought by Relator and State of Montana for treble damages and penalties under Montana False Claims Act, MT ST 17-8-401 *et seq*.

235. MT ST 17-8-403 provides liability for any person who:

> Knowingly presenting or causing to be presented to an officer or employee of the governmental entity a false claim for payment or approval;
>
> Knowingly making, using, or causing to be made or used a false record or statement to get a false claim paid or approved by the governmental entity;
>
> Conspiring to defraud the governmental entity by getting a false claim allowed or paid by the governmental entity.

236. In addition, MT ST 45-6-313 prohibits the solicitation, receipt or offering any remuneration, including but not limited to a kickback, bribe, or rebate, other than an amount legally payable under the medical assistance program, for furnishing services or items for which payment may be made under the Montana Medicaid program.

237. Defendant violated MT ST 17-8-403 & MT ST 45-6-313 by continuously engaging in the fraudulent and illegal conduct described herein.

238. Defendant furthermore violated MT ST 17-8-403 and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of Montana by their continuous violation of federal and state laws, including MT ST 45-6-313 and the AKS, as described herein.

239. The State of Montana, by and through the Montana Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

240. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Montana in connection with Defendant's fraudulent and illegal conduct.

241. Had the State of Montana known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

242. As a result of Defendant's violations of MT ST 17-8-403, the State of Montana has been damaged in an amount far in excess of millions of dollars exclusive of interest.

243. Relator is a private person with direct and independent knowledge of the allegations in this Compliant, who has brought this action pursuant to MT ST 17-8-406 on behalf of himself and the State of Montana.

244. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon that exact same facts as the federal claim, and merely asserts separate damage to the State of Montana in the operation of its Medicaid program.

245. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF MONTANA:

Three times the amount of actual damages which that State of Montana has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of $10,000 for each false claim which Defendant caused to be presented to the State of Montana;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to MT ST 17-8-410 and/or any other applicable

provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT NINETEEN

VIOLATION OF THE NEVADA FALSE CLAIMS ACT

246. Relator re-alleges and incorporates the allegations in paragraphs 1 - 245 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Defendant. Forest conducts business in the State of Nevada. As set forth above, Defendant's actions described herein occurred in Nevada as well.

247. This is a qui tam action brought by Relator and the State of Nevada to recover treble damages and civil penalties under the Nevada False Claims Act, N.R.S. §§ 357.010 *et seq*.

248. N.R.S. § 357.040(1) provides liability for any person who:

Knowingly presents or causes to be presented a false claim for payment or approval;

Knowingly makes or uses, or causes to be made or used, a false record or statement to obtain payment or approval of a false claim;

Conspires to defraud by obtaining allowance or payment of a false claim;

Is a beneficiary of an inadvertent submission of a false claim and, after discovering the falsity of the claim, fails to disclose the falsity to the state or political subdivision within a reasonable time.

249. In addition, N.R.S. § 422.560 prohibits the solicitation, acceptance or receipt of anything of value in connection with the provision of medical goods or services for which payment may be made in whole or in part under the Nevada Medicaid program.

250. Defendant violated N.R.S. §§ 357.040(1) & 422.560 by continuously engaging in the fraudulent and illegal conduct described herein.

251. Defendant furthermore violated N.R.S. § 357.040(1) and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of Nevada by their continuous violation of federal and state laws, including N.R.S. § 422.560 and the AKS, as described herein.

252. The State of Nevada, by and through the Nevada Medicaid program and other health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

253. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Nevada in connection with Defendant's fraudulent and illegal conduct.

254. Had the State of Nevada known that Forest were violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

255. As a result of Defendant's violations of N.R.S. § 357.040(1), the State of Nevada has been damaged in an amount far in excess or millions of dollars exclusive of interest.

256. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to N.R.S. § 357.080(1) on behalf of himself and the State of Nevada.

257. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of Nevada in the operation of its Medicaid program.

258. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF NEVADA:

Three times the amount of actual damages which the State of Nevada has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $2,000 and not more than $10,000 for each false claim which Defendant caused to be presented to the State of Nevada;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to N.R.S § 357.210 and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT TWENTY

VIOLATION OF THE NEW HAMPSHIRE FALSE CLAIMS ACT

259. Relator re-alleges and incorporates the allegations in paragraphs 1 - 258 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the New Hampshire. Upon information and belief, Defendant's actions described herein occurred in New Hampshire as well.

260. This is a qui tam action brought by Relator and State of New Hampshire for treble damages and penalties under New Hampshire False Claims Act, N.H. Rev. Stat. §§ 167:61-b *et seq*.

261. N.H. Rev. Stat. § 167:61-b provides liability for any person who:

> Knowingly presents, or causes to be presented, to an officer or employee of the department, a false or fraudulent claim for payment or approval;
>
> Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the department;
>
> Conspires to defraud the department by getting a false or fraudulent claim allowed or paid.

262. Defendant violated N.H. Rev. Stat. § 167:61-b by continuously engaging in the fraudulent and illegal conduct described herein.

263. Defendant furthermore violated N.H. Rev. Stat. § 167:61-b and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of New Hampshire their continuous violation of federal and state laws, including the AKS, as described herein.

264. The State of New Hampshire, by and through the New Hampshire Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

265. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of New Hampshire in connection with Defendant fraudulent and illegal conduct.

266. Had the State of New Hampshire known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

267. As a result of Defendant's violations of N.H. Rev. Stat. § 167:61-b, the State of New Hampshire has been damaged in an amount far in excess of millions of dollars exclusive of interest.

268. Relator is a private person with direct and independent knowledge of the allegations in this Compliant, who has brought this action pursuant to N.H. Rev. Stat. § 167:61-c on behalf of himself and the State of New Hampshire.

269. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon that exact same facts as the federal claim, and merely asserts separate damage to the State of New Hampshire in the operation of its Medicaid program.

270. WHEREFORE, Relator respectfully request this Court to award the following damages to the following parties and against Defendant:

To the STATE OF NEW HAMPSHIRE:

Three times the amount of actual damages which that State of New Hampshire has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $5,000 and not more than $10,000 for each false claim which Defendant caused to be presented to the State of New Hampshire;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to N.H. Rev. Stat. § 167:61-e and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT TWENTY-ONE

VIOLATION OF THE NEW JERSEY FALSE CLAIMS ACT

271. Relator re-alleges and incorporates the allegations in paragraphs 1 - 270 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a

nationwide, continuous practice of Defendant. Forest conduct business in New Jersey. Upon information and belief, Forest's actions described herein occurred in New Jersey as well.

272. This is a qui tam action brought by Relator and State of New Jersey for treble damages and penalties under New Jersey False Claims Act, N.J.S.A. 2A:32C-1 *et seq*.

273. N.J.S.A. 2A:32C-3 provides liability for any person who:

> Knowingly presents or causes to be presented to an employee, officer or agent of the State, or to any contractor, grantee, or other recipient of State funds, a false or fraudulent claim for payment or approval;
>
> Knowingly makes, uses, or causes to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the State;
>
> Conspires to defraud the State by getting a false or fraudulent claim allowed or paid by the State.

274. In addition, N.J.S.A. 30:4D-17 prohibits solicitation, offers, or receipt of any kickback, rebate, or bribe in connection with the furnishing of items or services for which payment is or may be made in whole or in part under the New Jersey Medicaid program, or the furnishing of items or services whose cost is or may be reported in whole or in part in order to obtain benefits or payments under New Jersey Medicaid.

275. Defendant violated N.J.S.A. 2A:32C-3 & N.J.S.A. 30:4D-17 by continuously engaging in the fraudulent and illegal conduct described herein.

276. Defendant furthermore violated N.J.S.A. 2A:32C-3 and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of New Jersey by their continuous violation of federal and state laws, including N.J.S.A. 2A:32C-3 and the AKS, as described herein.

277. The State of New Jersey, by and through the New Jersey Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

278. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of New Jersey in connection with Defendant's fraudulent and illegal conduct.

279. Had the State of New Jersey known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

280. As a result of Defendant's violations of N.J.S.A. 2A:32C-3, the State of New Jersey has been damaged in an amount far in excess of millions of dollars exclusive of interest.

281. Relator is a private person with direct and independent knowledge of the allegations in this Compliant, who has brought this action pursuant to N.J.S.A. 2A:32C-5 on behalf of himself and the State of New Jersey.

282. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon that exact same facts as the federal claim, and merely asserts separate damage to the State of New Jersey in the operation of its Medicaid program.

283. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF NEW JERSEY:

Three times the amount of actual damages which that State of New Jersey has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $5,000 and not more than $10,000 for each false claim which Defendant caused to be presented to the State of New Jersey;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to N.J.S.A. 2A:32C-7and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT TWENTY-TWO

VIOLATION OF THE NEW MEXICO MEDICAID FALSE CLAIMS ACT AND THE FRAUD AGAINST TAXPAYERS ACT

284. Relator re-alleges and incorporates the allegations in paragraphs 1 - 283 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of New Mexico. Upon information and belief, Forest's actions described herein occurred in the State of New Mexico as well.

285. This is a qui tam action brought by Relator and the State of New Mexico to recover treble damages and civil penalties under the New Mexico Medicaid False Claims Act, N. M. S. A. 1978, § 27-14-1 *et seq.* and the New Mexico Fraud Against Taxpayers Act, N. M. S. A. 1978, § 44-9-1 *et seq.*

286. N. M. S. A. 1978, § 27-14-4 provides liability for any person who:

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

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

Conspires to defraud the state by getting a claim allowed or paid under the Medicaid program knowing that such claim is false or fraudulent.

287. N.M.S.A. 1978, § 44-9-3 provides liability for any person who:

Knowingly presents, or causes to be presented, to an employee, officer or agent of the state or to a contractor, grantee or other recipient of state funds a false or fraudulent claim for payment or approval;

Knowingly makes or uses, or causes to be made or used, a false, misleading or fraudulent record or statement to obtain or support the approval of or the payment on a false or fraudulent claim;

Conspires to defraud the state by obtaining approval or payment on a false or fraudulent claim;

Conspires to make, use or cause to be made or used, a false, misleading or fraudulent record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the state.

288. Defendant violated N. M. S. A. 1978, §§ 27-14-4 & 44-9-3 by continuously engaging in the fraudulent and illegal conduct described herein.

289. Defendant furthermore violated N. M. S. A. 1978, §§ 27-14-4 & 44-9-3 and knowingly caused thousands of false claims to be made, used, and presented to the State of New Mexico by their continuous violation of federal and state laws, including the AKS, as described herein.

290. The State of New Mexico, by and through the State of New Mexico Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

291. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of New Mexico in connection with W Defendant fraudulent and illegal conduct.

292. Had the State of New Mexico known that Forest were violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

293. As a result of Defendant's continuous violations of N. M. S. A. 1978, §§ 27-14-4 & 44-9-3, the State of New Mexico has been damaged in an amount far in excess of millions of dollars exclusive of interest.

294. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to N. M. S. A. 1978, §§ 27-14-7 & 44-9-5 on behalf of himself and the State of New Mexico.

295. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of New Mexico in the operation of its Medicaid program.

296. WHEREFORE, Relator respectfully request this Court to award the following damages to the following parties and against Defendant:

To the STATE OF NEW MEXICO:

Three times the amount of actual damages which the State of New Mexico has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $5,000 and not more than $10,000 for each false claim which Defendant caused to be presented to the State of New Mexico;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to N. M. S. A. 1978, §§ 27-14-9 & 44-9-7 and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this court deems equitable and just.

COUNT TWENTY-THREE

VIOLATION OF THE NEW YORK FALSE CLAIMS ACT

297. Relator re-alleges and incorporates the allegations in paragraphs 1 - 296 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Defendant. Forest conducts business in the New York. As set forth above, Defendant's actions described herein occurred in New York as well.

298. This is a qui tam action brought by Relator and State of New York for treble damages and penalties under New York False Claims Act, McKinney's State Finance Law § 187 *et seq.*

299. McKinney's State Finance Law § 189 provides liability for any person who:

> Knowingly presents, or causes to be presented, to any employee, officer or agent of the state or a local government, a false or fraudulent claim for payment or approval;
>
> Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state or a local government;
>
> Conspires to defraud the state or a local government by getting a false or fraudulent claim allowed or paid.

300. Defendant violated McKinney's State Finance Law § 189 continuously engaging in the fraudulent and illegal conduct described herein.

301. Defendant furthermore violated McKinney's State Finance Law § 189 and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of New York by their continuous violation of federal and state laws, including the AKS, as described herein.

302. The State of New York, by and through the New York Medicaid program and other state health care programs, and unaware of Defendant fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

303. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment

of claims submitted to the State of New York in connection with Defendant's fraudulent and illegal conduct.

304. Had the State of New York known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

305. As a result of Defendant's violations of McKinney's State Finance Law § 189, the State of New York has been damaged in an amount far in excess of millions of dollars exclusive of interest.

306. Relator is a private person with direct and independent knowledge of the allegations in this Compliant, who has brought this action pursuant to McKinney's State Finance Law § 190(2) on behalf of himself and the State of New York.

307. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon that exact same facts as the federal claim, and merely asserts separate damage to the State of New York in the operation of its Medicaid program.

308. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Forest:

To the STATE OF NEW YORK:

Three times the amount of actual damages which that State of New York has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $6,000 and not more than $12,000 for each false claim which Defendant caused to be presented to the State of New York;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to McKinney's State Finance Law § 190(6) and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT TWENTY-FOUR

VIOLATION OF THE NORTH CAROLINA FALSE CLAIMS ACT

309. Relator re-alleges and incorporates the allegations in paragraphs 1 - 308 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of North Carolina. Upon information and belief, Defendant's actions described herein occurred in the State of North Carolina as well.

310. This is a qui tam action brought by Relator and the State of North Carolina to recover treble damages and civil penalties under the North Carolina False Claims Act, NC ST §§ 1-605 *et seq*.

311. NC ST § 1-607(a) provides liability in relevant part, for any person who:

> (1) Knowingly presents or causes to be presented a false or fraudulent claim for payment or approval;
>
> (2) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
>
> (3) Conspires to commit a violation of subdivision (1), (2), (4), (5), (6), or (7) of this section;
>
> ***
>
> (7) Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the State, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the State.

312. Defendant violated NC ST § 1-607(a) by continuously engaging in the fraudulent and illegal conduct described herein.

313. Defendant furthermore violated NC ST § 1-607(a) and knowingly caused thousands of false claims to be made, used, and presented to the State of North Carolina by their continuous violation of federal and state laws, including NC ST § 1-607(a) and the AKS, as described herein.

314. The State of North Carolina, by and through the State of North Carolina Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

315. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of North Carolina in connection with Defendant's fraudulent and illegal conduct.

316. Had the State of North Carolina known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

317. As a result of Defendant's violations of NC ST § 1-607(a), the State of North Carolina has been damaged in an amount far in excess of millions of dollars exclusive of interest.

318. Defendant did not, within 30 days after they first obtained information as to such violations, furnish such information to officials of the State responsible for investigating false claims violations, did not otherwise fully cooperate with any investigation of the violations, and have not otherwise furnished information to the State regarding the claims for reimbursement at issue.

319. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to NC ST § 1-607(a) on behalf of himself and the State of North Carolina.

320. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of North Carolina in the operation of its Medicaid program.

321. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF NORTH CAROLINA:

Three times the amount of actual damages which the State of North Carolina has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $5,000 and not more than $11,000 for each false claim which Defendant caused to be presented to the State of North Carolina;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant NC ST § 1-610 and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this court deems equitable and just.

COUNT TWENTY-FIVE

VIOLATION OF THE OKLAHOMA MEDICAID FALSE CLAIMS ACT

322. Relator re-alleges and incorporates the allegations in paragraphs 1-321 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of Oklahoma. Upon information and belief, Defendant actions described herein occurred in the State of Oklahoma as well.

323. This is a qui tam action brought by Relator and the State of Oklahoma to recover treble damages and civil penalties under the Oklahoma Medicaid False Claims Act, 63 Okl. St. Ann. § 5053 *et seq.*

324. 63 Okl. St. Ann. § 5053.1 provides liability for any person who:

> Knowingly presents, or causes to be presented, to an officer or employee of the State of Oklahoma, a false or fraudulent claim for payment or approval;
>
> Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state;
>
> Conspires to defraud the state by getting a false or fraudulent claim allowed or paid.

325. In addition, 56 Okl. St. Ann. § 1005 prohibits solicitation or acceptance of a benefit, pecuniary benefit, or kickback in connection with goods or services paid or claimed by a provider to be payable by the Oklahoma Medicaid Program.

326. Defendant violated 63 Okl. St. Ann. § 5053.1 & 56 Okl. St. Ann. § 1005 by continuously engaging in the fraudulent and illegal conduct described herein.

327. Defendant furthermore violated 63 Okl. St. Ann. § 5053.1 and knowingly caused thousands of false claims to be made, used, and presented to the State of Oklahoma by their continuous violation of federal and state laws, including 56 Okl. St. Ann. § 1005 and the AKS, as described herein.

328. The State of Oklahoma, by and through the State of Oklahoma Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

329. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Oklahoma in connection with Defendant's fraudulent and illegal conduct.

330. Had the State of Oklahoma known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

331. As a result of Defendant's violations of 63 Okl. St. Ann. § 5053.1, the State of Oklahoma has been damaged in an amount far in excess of millions of dollars exclusive of interest.

332. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to 63 Okl. St. Ann. § 5053.2(B) on behalf of himself and the State of Oklahoma.

333. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of Oklahoma in the operation of its Medicaid program.

334. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF OKLAHOMA:

Three times the amount of actual damages which the State of Oklahoma has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $5,000 and not more than $10,000 for each false claim which Defendant caused to be presented to the State of Oklahoma;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant 63 Okl. St. Ann. § 5053.4 and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this court deems equitable and just.

COUNT TWENTY-SIX

VIOLATION OF THE RHODE ISLAND FALSE CLAIMS ACT

335. Relator re-alleges and incorporates the allegations in paragraphs 1 - 334 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of Rhode Island. Upon information and belief, Defendant's actions described herein occurred in the State of Rhode Island as well.

336. This is a qui tam action brought by Relator and the State of Rhode Island to recover treble damages and civil penalties under the Rhode Island False Claims Act, Gen. Laws 1956, §§ 9-1.1-1 *et seq*.

337. Gen. Laws 1956, § 9-1.1-3 provides liability for any person who:

> Knowingly presents, or causes to be presented, to an officer or employee of the state or a member of the guard a false or fraudulent claim for payment or approval;
>
> Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state;
>
> Conspires to defraud the state by getting a false or fraudulent claim allowed or paid.

338. In addition, Gen. Laws 1956, § 40-8.2-3 prohibits the solicitation, receipt, offer, or payment of any remuneration, including any kickback, bribe, or rebate, directly or indirectly, in cash or in kind, to induce referrals from or to any person in return for furnishing of services or merchandise or in return for referring an individual to a person for the furnishing of any services or merchandise for which payment may be made, in whole or in part, under the Rhode Island Medicaid program.

339. Defendant violated Gen. Laws 1956, §§ 9-1.1-3 & 40-8.2-3 by continuously engaging in the fraudulent and illegal conduct described herein.

340. Defendant furthermore violated Gen. Laws 1956, § 9-1.1-3 and knowingly caused thousands of false claims to be made, used, and presented to the State of Rhode Island by their continuous violation of federal and state laws, including Gen. Laws 1956, § 40-8.2-3 and the AKS, as described herein.

341. The State of Rhode Island, by and through the State of Rhode Island Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

342. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Rhode Island in connection with Defendant's fraudulent and illegal conduct.

343. Had the State of Rhode Island known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

344. As a result of Defendant's violations of Gen. Laws 1956, § 9-1.1-3, the State of Rhode Island has been damaged in an amount far in excess of millions of dollars exclusive of interest.

345. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to Gen. Laws 1956, § 9-1.1-4(b) on behalf of himself and the State of Rhode Island.

346. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of Rhode Island in the operation of its Medicaid program.

347. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF RHODE ISLAND:

Three times the amount of actual damages which the State of Rhode Island has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $5,000 and not more than $10,000 for each false claim which Defendant caused to be presented to the State of Rhode Island;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant Gen. Laws 1956, § 9-1.1-4(d) and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this court deems equitable and just.

COUNT TWENTY-SEVEN

VIOLATION OF THE TENNESSEE FALSE CLAIMS ACT

348. Relator re-alleges and incorporates the allegations in paragraphs 1 - 347 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of Tennessee. Upon information and belief, Defendant's actions described herein occurred in Tennessee as well.

349. This is a qui tam action brought by Relator and the State of Tennessee to recover treble damages and civil penalties under the Tennessee Medicaid False Claims Act, Tenn. Code Ann. §§ 71-5-181 *et seq*.

350. Section 71-5-182(a)(1) provides liability for any person who:

Presents, or causes to be presented to the state, a claim for payment under the Medicaid program knowing such claim is false or fraudulent;

> Makes or uses, or causes to be made or used, a record or statement to get a false or fraudulent claim under the Medicaid program paid for a approved by the state knowing such record or statement is false;
>
> Conspires to defraud the State by getting a claim allowed or paid under the Medicaid program knowing such claim is false or fraudulent.

351. Defendant violated Tenn. Code Ann. § 71-5-182(a)(1) from at least 2001 to the present by continuously engaging in the fraudulent and illegal conduct described herein.

352. Defendant furthermore violated Tenn. Code Ann. § 71-5-182(a)(1) and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of Tennessee from at least 2001 to the present by their continuous violation of federal and state laws, including the AKS, as described herein.

353. The State of Tennessee, by and through the Tennessee Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

354. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Tennessee in connection with Defendant's fraudulent and illegal conduct.

355. Had the State of Tennessee known that Defendant violated the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

356. As a result of Defendant's violations of Tenn. Code Ann. § 71-5-182(a)(1), the State of Tennessee has been damaged in an amount far in excess of millions of dollars exclusive of interest.

357. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to Tenn. Code Ann. § 71-5-183(a)(1) on behalf of himself and the State of Tennessee.

358. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of Tennessee in the operation of its Medicaid program.

359. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF TENNESSEE:

Three times the amount of actual damages which the State of Tennessee has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $5,000 and not more than $10,000 for each false claim which Defendant caused to be presented to the State of Tennessee;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed to Tenn. Code Ann. §71-5-183(c) and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this Court deems equitable and just.

COUNT TWENTY-EIGHT

VIOLATION OF THE TEXAS MEDICAID FALSE CLAIMS ACT

360. Relator re-alleges and incorporates the allegations in paragraphs 1 - 359 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of Texas. Defendant's actions described herein occurred in Texas as well.

361. This is a qui tam action brought by Relator and the State of Texas to recover double damages and civil penalties under the Texas False Claims Act, V.T.C.A. Hum. Res. Code § 36.001 *et seq*.

362. V.T.C.A. Hum. Res. Code § 36.002, in relevant part, provides liability for any person who:

> (1) Knowingly makes or causes to be made a false statement or misrepresentation of a material fact to permit a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized;
>
> (2) Knowingly conceals or fails to disclose information that permits a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized;
>
> (3) Knowingly applies for and receives a benefit or payment on behalf of another person under the Medicaid program and converts any part of the benefit or payment to a use other than for the benefit of the person on whose behalf it was received
> (5) Except as authorized under the Medicaid program, knowingly pays, charges, solicits, accepts, or receives, in addition to an amount paid under the Medicaid program, a gift, money, a donation, or other consideration as a condition to the provision of a service or product or the continued provision of a service or product if the cost of the service or product is paid for, in whole or in part, under the Medicaid program;
>
> * * *
> (5) Except as authorized under the Medicaid program, knowingly pays, charges, solicits, accepts, or receives, in addition to an amount paid under the Medicaid program, a gift, money, a donation, or other consideration as a condition to the provision of a service or product or the continued provision of a service or product if the cost of the service or product is paid for, in whole or in part, under the Medicaid program;
>
> * * *
> (9) Knowingly enters into an agreement, combination, or conspiracy to defraud the state by obtaining or aiding another person in obtaining an unauthorized payment or benefit from the Medicaid program or a fiscal agent;

* * *

(12) Knowingly makes, uses, or causes the making or use of a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to this state under the Medicaid program.

363. Defendant violated V.T.C.A. Hum. Res. Code § 36.002, as referenced in part above, by continuously engaging in the fraudulent and illegal conduct described herein.

364. Defendant furthermore violated V.T.C.A. Hum. Res. Code § 36.002 and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State of Texas by their continuous violation of federal and state laws, including, the AKS, as described herein.

365. The State of Texas, by and through the Texas Medicaid program and other state healthcare programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

366. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Texas in connection with Defendant's fraudulent and illegal conduct.

367. Had the State of Texas known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

368. As a result of Defendant;' violations of V.T.C.A. Hum. Res. Code § 36.002, the State of Texas has been damaged in an amount far in excess of millions of dollars exclusive of interest.

369. Defendant did not, within 30 days after they first obtained information as to such violations, furnish such information to officials of the State responsible for investigating false claims violations, did not otherwise fully cooperate with any investigation of the violations, and have not otherwise furnished information to the State regarding the claims for reimbursement at issue.

370. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to V.T.C.A. Hum. Res. Code § 36.101 on behalf of himself and the State of Texas.

371. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of Texas in the operation of its Medicaid program.

372. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF TEXAS:

Damages at two times the value of any payment or monetary or in-kind benefit provided under the Medicaid program, directly or indirectly, as a result of the unlawful acts set forth above, as provided by the Texas Human Resources Code § 36.052(a)(1) & (4);

Civil penalties of $15,000 for each and every unlawful act set forth above that resulted in injury to a person younger than 18 years of age, as provided by the Texas Human Resources Code § 36.052(3)(A);

Pre- and post-judgment interest, Tex. Hum. Res. Code § 36.052(a)(2).

To RELATOR:

The maximum amount allowed pursuant to V.T.C.A. Hum Res. Code § 36.110(a), and/or any other applicable provision of law;

Reimbursement for reasonable expenses and costs which Relator incurred in connection with this action, Tex Hum Res. Code §§ 36.007 & 36.110(c);

Reasonable attorneys' fees which the Relator necessarily incurred in bringing and pressing this case, Tex Hum Res. Code §§ 36.007 & 36.110(c); and

Such further relief as this Court deems equitable and just.

COUNT TWENTY-NINE

VIOLATION OF THE VIRGINIA FRAUD AGAINST TAXPAYERS ACT

373. Relator re-alleges and incorporates the allegations in paragraphs 1 - 372 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the Commonwealth of Virginia. Upon information and belief, Defendant's actions described herein occurred in the Commonwealth of Virginia as well.

374. This is a qui tam action brought by Relator and the Commonwealth of Virginia to recover treble damages and civil penalties under the Virginia Fraud Against Taxpayers Act, Va. Code Ann. §§ 8.01-216.1 *et seq*.

375. Va. Code Ann. § 8.01-216.3 provides liability for any person who:

> Knowingly presents, or causes to be presented, to an officer or employee of the Commonwealth a false or fraudulent claim for payment or approval;
>
> Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Commonwealth;
>
> Conspires to defraud the Commonwealth by getting a false or fraudulent claim allowed or paid.

376. Defendant violated Va. Code Ann. § 8.01-216.3 by continuously engaging in the fraudulent and illegal conduct described herein.

377. Defendant furthermore violated Va. Code Ann. § 8.01-216.3 and knowingly caused thousands of false claims to be made, used, and presented to the Commonwealth of Virginia by their continuous violation of federal and state laws, including the AKS, as described herein.

378. The Commonwealth of Virginia, by and through the Commonwealth of Virginia Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

379. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment

of claims submitted to the Commonwealth of Virginia is connection with Defendant's fraudulent and illegal conduct.

380. Had the Commonwealth of Virginia known that Forest were violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

381. As a result of Defendant's violations of Va. Code Ann. § 8.01-216.3, the Commonwealth of Virginia has been damaged in an amount far in excess of millions of dollars exclusive of interest.

382. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to Va. Code Ann. § 8.01-216.5(A) on behalf of himself and the Commonwealth of Virginia.

383. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the Commonwealth of Virginia in the operation of its Medicaid program.

384. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the COMMONWEALTH OF VIRGINIA:

Three times the amount of actual damages which the Commonwealth of Virginia has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $5,000 and not more than $10,000 for each false claim which Defendant caused to be presented to the Commonwealth of Virginia;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant to Va. Code Ann. § 8.01-216.7 and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this court deems equitable and just.

COUNT THIRTY

VIOLATION OF THE WISCONSIN FALSE CLAIMS FOR MEDICAL ASSISTANCE ACT

385. Relator re-alleges and incorporates the allegations in paragraphs 1 - 384 as if fully set forth herein. Additionally, Relator states that the course of conduct described in this Complaint was a nationwide, continuous practice of Forest. Forest conducts business in the State of Wisconsin. Upon information and belief, Defendant's actions described herein occurred in the State of Wisconsin as well.

386. This is a qui tam action brought by Relator and the State of Wisconsin to recover treble damages and civil penalties under the Wisconsin False Claims for medical Assistance Act, W.S.A. 20.931 *et seq*.

387. W.S.A. 20.931(2) provides liability for any person who:

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

388. In addition, W.S.A. 49.49(2) prohibits solicitation or receipt of any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under any Wisconsin medical assistance program.

389. Defendant violated W.S.A. 20.931(2) & W.S.A. 49.49(2) by continuously engaging in the fraudulent and illegal conduct described herein.

390. Defendant furthermore violated W.S.A. 20.931(2) and knowingly caused thousands of false claims to be made, used, and presented to the State of Wisconsin by their continuous violation of federal and state laws, including W.S.A. 49.49(2) and the AKS, as described herein.

391. The State of Wisconsin, by and through the State of Wisconsin Medicaid program and other state health care programs, and unaware of Defendant's fraudulent and illegal conduct, paid the claims submitted by pharmacists in connection therewith.

392. Compliance with applicable Medicare, Medicaid, and the various other federal and state laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Wisconsin in connection with Defendant's fraudulent and illegal conduct.

393. Had the State of Wisconsin known that Defendant was violating the federal and state laws cited herein, it would not have paid the claims submitted by pharmacists in connection with such fraudulent and illegal conduct.

394. As a result of Defendant violations of W.S.A. 20.931(2), the State of Wisconsin has been damaged in an amount far in excess of millions of dollars exclusive of interest.

395. Relator is a private person with direct and independent knowledge of the allegations in this Complaint, who has brought this action pursuant to W.S.A. 20.931(5) on behalf of himself and the State of Wisconsin.

396. This Court is requested to accept supplemental jurisdiction of this related state claim as it is predicated upon the exact same facts as the federal claim, and merely asserts separate damage to the State of Wisconsin in the operation of its Medicaid program.

397. WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against Defendant:

To the STATE OF WISCONSIN:

Three times the amount of actual damages which the State of Wisconsin has sustained as a result of Defendant's fraudulent and illegal conduct;

A civil penalty of not less than $5,000 and not more than $10,000 for each false claim which Defendant caused to be presented to the State of Wisconsin;

Prejudgment interest; and

All costs incurred in bringing this action.

To RELATOR:

The maximum amount allowed pursuant W.S.A. 20.931(11) and/or any other applicable provision of law;

Reimbursement for reasonable expenses which Relator incurred in connection with this action;

An award of reasonable attorneys' fees and costs; and

Such further relief as this court deems equitable and just.

DEMAND FOR JURY TRIAL

398. Relator hereby demands a jury trial.

Dated: March 17, 2011

UNITED STATES OF AMERICA ex rel.
H. EDMOND PIGOTT

By: **WATERS & KRAUS LLP**

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