

**From:** Farina, Thomas P  
**Sent:** Monday, November 24, 2003 1:01 AM  
**To:** DL-Powers\_NIE\_J\_Reps  
**Cc:** Holloway, Mary J; RAINERO, RONALD; White, David M; Obeid-Asad, Nada; Combos, Eileen A; Camacho, Erwin P; Elfstrum, Erik J  
**Subject:** Notes from POA

**Attachments:** POA 1 2004-Notes.doc; POA 1 2004 Playbook.xls; Zyvox Superiority.ppt; POA1 2004 Orthopedic Detail.doc

Highlanders,

Thank you again for an awesome POA. I have never felt more confident in our messaging, strategies, and in the great data that we have to available. I am attaching the Playbook and VERY DETAILED notes from our POA. Please print out both files and put them in your Battlebooks along with my 2004 Vision and the Inner Circle print that I gave you at POA. Take the time to read through the Notes as they will definitely refresh your memory and keep our great sessions at the forefront of your mind.

I am also including the "Is Vanco still the holy grail?" presentation that rolls out our MRSA fund initiative. IHRs, this is a great initiative for you to take ownership of and to really show your District and Regional leadership. The IHRs that are successful with this initiative will lead the region with Zyvox - guaranteed!

Here are our Product Must Do's:

Cox-2 Must Do's

- Utilize Drill Down and High Writers to target high Ibuprofen, Naprosyn, and Vioxx Loyalists with appropriate message! Fish Where The Fish Are! Utilize Cox -2 Game book!
- (Searle, PRO, Powers)
  - Target orthopedic groups for Slappendel Pre/Post Op Protocols.
  - Target Rheumatology vs. Mobic
- Leverage ACR data with VIP Hospitals/Managed Care. Ensure a coordinated effort with MMM's, RMRS, Sales, P&T members.
- Accountability - Team Notes **including IHRs**
- Follow up to Speaker Training Program (ACR data will be presented here).
- Every Vioxx Loyalist gets the Medical Inquiry (Specialty=Pro/Powers/Searle, PC=Alta, Upjohn, Roerig) Place in Team notes when completed.
- Utilize Medical Group Builder (Orthopedic, Rheum, Medicaid, Vioxx Loyalist)
- Within next 2 weeks, discuss ACR findings with every Rheumatologist

Zolofit Must Do's

- Consistent Cluster A Team Message - compare & win
- Access - Every Zolofit Call mention starter pack & Zolofit's preferred MCO status & NY State Medicaid
- Cluster coverage of top 10 decile doctors
- Ask for switches from Paxil to Zolofit
- Accountability - team notes, leave behinds, lunch & learn programs, CCP coordination

Zyvox Must Do's

- Begin each day in the hospital to find new patient starts and switches.
- In the next 2 weeks see every ID, Hospitalist, Pharm-D, Pulm/Crit. Care, Administrator with the Wunderink Superiority Study.

- Discharge Planner Thursdays
- Slam Dunk speakers to meet the obstacles to unrestricted use in our hospitals
- MRSA Fund Initiative - target Pharm D's, Hospital Administrators
- In-service Wound Care DVD to targeted Surgeons, Podiatrists, Wound Care Specialists in the next month.
- IHRs
  - Update Zyvox Hospital map and submit to DM by December 15<sup>th</sup>
  - Update Zyvox website for Key Opinion Leaders
  - Coordinate with CEC to pick 1 account to perform pharmacoeconomic analysis of implementing Zyvox first line for MRSA HAP/VAP

#### VFEND Must Do's

- Establish Vfend's superior survivability by targeting the Drug and not the Bug
- Identify 2 key targets per hospital that can write consistent Vfend
- Use 3<sup>rd</sup> party references to let doctors know where their colleagues are using Vfend
  - VA, Maimonides, Brookdale - all have used Vfend for cryptococcal meningitis
  - Brooklyn Hospital, Brookdale - Vfend for refractory oral candidiasis
  - LICH - unstable patients at risk for fungal infections in the ICU
- Target large HIV ID's with the news of the new esophageal indication and have the medical inquiry letter sent to them during your next hospital day. - focus on break through thrush/esophagitis, re-occurring esophageal candidiasis
- Step-down all ampho patients to oral Vfend
- Speaker Program Responsibilities
  - Use speakers ALL day in the key specialties in your hospitals (e.g. ICU, ID, Hem/Onc, Crit. Care, HIV, Pharm D, etc.)
  - Courtney - contact Ben Lomaestro for January
  - Tim - develop Peter Smith, Pulm-CC for Critical Care talks - test run by 2<sup>nd</sup> week December.
  - Michael Glzman - develop Dr. Kupfer, ID for ID talks - start with journal club
  - Alex - contact Jose Vazquez to do Brooklyn 2 days in January/February.
- Have discussion of Ampho B shortage with key IDs, Critical Care, Surgery, and Pharmacy in next 2 weeks - this continues to be a compelling event
- Coordinate ID fellow coverage and handoff
- Prepare for the Esophageal Candidiasis launch - more speaker development targets
- Medical Inquiries on Esophageal Candidiasis



POA 1



POA 1 2004



Zyvox



POA1 2004

04-Notes.doc (145 K) | Playbook.xls (194 K) | Priority.ppt (120 K) | Orthopedic Detail.do.

Great Selling!!

***"There can be only one."***

***Tom Farina***

Brooklyn District Manager - Powers Rx

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## BROOKLYN HIGHLANDERS NOTES FOR POA 1 -2004

### General Business

#### Contests & Award Update

- Contest & Award Update - no more COE now just VPC Top 10% Region - This year is the "Radisson Seven Seas Caribbean Journey"

#### 2004 Core POA Objectives

- Effective Targeting
- Consistent Messaging
  - Alignment = Achievement
- Optimize Access

#### 2004 Weightings

- All Divisions have 50/50 weighting with Cox-2's
- Product Weightings

	<u>PHR</u>	<u>IHR</u>
Bextra	28	20
Celebrex	27	20
Zoloft	<b>25</b>	
Zyvox	20	
Vfend		

35  
25

I am counting on  
the IHRs to own  
these

#### Inner Circle Presentation (KEEP THIS IN YOUR BATTLEBOOK)

- On average, out of all the reps that call on an office, only ~8 are considered to be in the Inner Circle
- Inner Circle reps do not waste a doctor's time
- Red - Limited Access
- Yellow - Consistent Access
- Green - Full Access - we need to be here as often as possible
- It's all about VALUE

### VISION FOR 2004

In 2004 , the Brooklyn Highlanders will LEAD in the following areas:

1. Winning Attitude - it's contagious
2. Passionate, Fundamental Selling
3. Pull through of existing business opportunities (formulary, pathways, Medicaid, etc.)
4. Access messaging
5. Execution with Urgency (implementation)
6. Resource Utilization - speakers, teleconferences, CME, advocacy meetings, etc.
7. Relationship Selling - providing Value to our customers - making what we do matter to our doctors
8. Mastering the Basics - Asking for the business, Action Selling (posters on wall), using our Detail Binder, use of giveaways, etc.
9. Teamwork - Coordination and Communication

10. Having Fun!



## COX-2 PORTFOLIO

Where do we stand? Analysis, trends, budget

- 50/50 Weighting for all divisions
- 2004 Quota increase of 15% Growth
- Top 25 NSAID Neanderthals
- Top 25 Vioxx Violators

Cox-2 POA Goals

- Coordinated Messaging and Co-detailing of both Cox-2's
- Grow the RETAIL MARKET by increasing NRx over traditional NSAIDs, Acetaminophen, and Vioxx
  - Celebrex - Better efficacy over NSAIDs and acetaminophen
  - Bextra - Better efficacy over Vioxx (Flare efficacy - why? Makarowski)
  - ACR Data
    - Proven safer than an NSAID + PPI (encapsulated endoscopy)
    - Solomon data versus Vioxx
- Grow the HOSPITAL MARKET by
  - Increasing NRx through increased pre/post op protocols
  - Pull through clinic OP prescriptions through coordinated targeting
  - Kick Vioxx off of formulary by leveraging Ray, Whelton, and ACR Data.
  - Get Bextra added to key hospital formularies (Maimo example) for use in the acute, peri-operative setting with the overall goal of getting the patient to remain on Bextra long term.
- Utilize Medical Group Builder (Orthopedic, Rheum, Medicaid, Vioxx Loyalist)

Studies

- Encapsulated endoscopy study - review DVD
  - Capsule can take 50,000 images or 1 image every 2seconds
  - Healthy, young patients with an average age of 33.6yrs
  - Compared Celebrex 200mg QD to naproxen 500mg BID plus omeprazole 20mg
  - 12 fold difference between the 2 groups in terms of lesions
  - Celebrex not statistically different than placebo
  - Secondary endpoint of small bowel mucosal breaks - Celebrex 16% vs. N+PPI 55%
- ACR Vioxx AMI study by Dr. Solomon
- Ray Study
- White & Whelton studies
- Slappendel
- Makarowski
- Goldstein for Bextra GI safety vs. Naproxen for 6.5days
- P.A.C.E.S - Celebrex 200QD vs. Acetaminophen 4g (1000mg QID) in a crossover fashion
  - Patients preferred Celebrex 3x more than Tylenol
  - They preferred it because Celebrex works better. Remember, Tylenol is not an anti-inflammatory.

Celebrex Messaging

**Cox-2 Opener:**

There's compelling new information coming from the latest American College of Rheumatology that is causing physicians to rethink where they use NSAIDs and Cox-2 inhibitors. The first piece of compelling information...

**Opener:** Doctor, there's some compelling new data that is coming out of the American College of Rheumatology that is changing the way that many of your colleagues use traditional NSAIDs. In fact, many are switching their patients from traditional NSAIDs over to Celebrex.

**Promise:** Celebrex will provide superior efficacy and safety that your patients can stay on.

**Facts:**

- Pg. 4 - Patients with ankle sprains that were placed on Celebrex were able to be returned to their normal lives a full day earlier than ibuprofen patients.
- Pg. 4 - When compared to tylenol, patients with OA preferred the superior pain relief that they received with Celebrex 200mg QD versus 4g of acetaminophen.
- Pg. 6 - In this largest ever encapsulated study in healthy young patients, Celebrex 200mg BID was compared to an NSAID + PPI (Naproxen plus omeprazole). This was a randomized, multicenter, placebo-controlled comparison in patients with an average age of 33. Patients were verified to have a clean bill of health using a capsule at the start of the study. At the end of the 2 weeks, even with a PPI, Naproxen had a statistically significant 12 fold increase in small bowel lesions compared to Celebrex. At the end of the study, compared to placebo, Celebrex patients maintained their clean bill of health.

**Trial Close:** What are your thoughts on the findings of this study? How will this affect your use of traditional NSAIDs?

- The real impact that using Celebrex over traditional NSAIDs can have for you and your patients is better overall outcomes. In the largest outcomes study including over 13,000 patients with OA, patients on Celebrex had 45% fewer referrals to specialists and 34 % fewer physician office visits for GI complications as compared to Naprosyn or Diclofenac. Most importantly the Celebrex patients had 75% fewer ICU hospitalizations and 52% fewer GI hospitalizations.

**Patient Benefit:** The benefits to your patients are obvious, more tolerability with less complications.

**Physician Benefit:** The real value to you is that you are able to provide a better drug for your Medicaid patients while maintaining the same \$2.00 copay that they would pay for the older NSAIDs.

Your patients that start on Celebrex will stay on Celebrex as shown in our persistency data. Significantly more patients stayed on Celebrex at 62% compared to ibuprofen and naproxen. As you can see, Celebrex truly provides you with the efficacy and safety that your patients will be able to stay with.

**Close:** Doctor, based upon Celebrex's ability to return your patients earlier to their normal lives, superior safety compared to traditional NSAIDs + PPI's, and favorable Medicaid access, will you use Celebrex before NSAIDs for your patients with pain.

Bextra Messaging

**Cox-2 Opener:**

There's compelling new information coming from the latest American College of Rheumatology that is causing physicians to rethink where they use NSAIDs and Cox-2 inhibitors. The first piece of compelling information...

**Opener:** Doctor, there's some compelling new data that is coming out of the American College of Rheumatology that is changing the way that many of your colleagues use Vioxx. In fact, many of your colleagues are switching their patients from Vioxx to Bextra."

**Promise:** Bextra provides rapid, powerful relief and is the strongest NNA (non-narcotic anti-inflammatory) on the market.

**Facts:**

- Doctor, Bextra should be your Cox-2 of choice because Bextra works faster and better than Vioxx without increasing the risk of Acute MI.
- Visaid Pg. 9 - Bextra is the fastest NSAID on the market as shown in this head to head study that showed that Bextra worked within 26 minutes compared to Anaprox.
- Visaid Pg. 10 - Bextra excels in the tough to treat pain of arthritic flares. In this double-blind, randomized, placebo-controlled trial of osteoarthritis, patients were taken off of their Vioxx, Mobic, or traditional NSAIDs and an arthritic flare was induced. Once the flare was classified as severe, patients were started on Bextra 10mg or placebo. At the end of the study, patients on Bextra received better pain control than their original therapy.
- Pg 294 (Makarowski) - Bextra works well where others fail because Bextra rapidly penetrates the CNS. This means that Bextra works to control pain at the source of the pain and inflammation and prevents central sensitization to pain (much like an opioid). Bextra is the strongest non-narcotic on the market.
- Ray Study: This cohort study in Tennessee Medicaid that was funded by the FDA clearly shows a 70% increase in Acute MI in patients taking Vioxx. Doctor, just last month, Merck presented their own study at the American College of Rheumatology that confirms exactly this. This study was done in Boston at the Brigham and Women's Hospital by Dr. Solomon and was covered by all the major news media including the Wall Street Journal. Now that the information is in the lay press many of your colleagues are stopping their use of Vioxx.
- Visaid Pg. 13 - In contrast, Bextra has shown no increase in cardiovascular risks compared to traditional NSAIDs and does not carry a Package Insert warning on CV risks.

**Trial Close:** Doctor, what are your thoughts on Merck's own data from the ACR? I can have this information sent to you from our Medical Department.

- Pg 11 Dr., now you can see how Bextra can replace Vioxx without concern for Acute MI or replace Non-Narcotic analgesics such as Ultram and Ultracet avoiding patient somnolence as well as the traditional NSAIDs such as Ibuprofen and Naproxen avoiding the dyspepsia and nausea.

**Patient Benefit:** Your patients with severe pain will receive the fastest relief from the strongest NNA on the market. They will return to their normal QOL faster with Bextra.

**Physician Benefit:** You have the peace of mind knowing that you are providing a safer, more effective medication for their pain that will not increase MI's or stroke unlike Vioxx and will not cause the narcotic-like addiction and AE like Ultracet.

**Close:** First Line Therapy over Vioxx and Ultracet.....

Cox-2 Must Do's

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- Utilize Medical Group Builder (Orthopedic, Rheum, Medicaid, Vioxx Loyalist)
- Within next 2 weeks, discuss ACR findings with every Rheumatologist

Resources

- Capsule Study - Medical Inquiry now available - target Top 25 Medicaid NSAID Neanderthals
- ACR Vioxx AMI data - Medical Inquiry now available - Powers/Searle/PRO to cover specialists and Alta/Roerig to cover PCPs with Medical Inquiry letter
- New Cox-2 slides for our speakers
- Highwriters - Medicaid NSAID writers
- Reports - Bubble Report and Customer Drill Down Report

7 Day free coupons for Bextra

## ZOLOFT

Where do we stand? Analysis, trends, budget

- 2004 Quota increase of 12% - \$2.7 Billion in sales
- 10 Most Wanted PCP Paxil Abusers
- Wyeth putting every single rep on Effexor
- Remember, SSRI's DO NOT TREAT SLEEP

POA Goals

- Increase Zolof't's #1 position in NRx market share rank: open gap with PCPs to 2%
- Deliver consistent details to high prescribers - weekly coverage via CCP
- Sustain high MCO/Medicaid formulary access to GROW sales (drill down report, high writers, MGB)
- # 2 after Cox 2

Zolof't Messaging

- **Opener:** Doctor for your patients who presents with mixture of anxiety and depressive symptoms you can count on Zolof't.
- **Promise:** You are guaranteed that Zolof't is proven to work faster, better and longer for the anxious depressed patient with the most indications.
- **Facts:**
  - Zolof't works faster. Regardless of mood disorder, Zolof't works in as little as 1-2 weeks. This is much shorter than the 4 weeks that it takes Paxil to kick in. Your anxiety patients get back to their normal lives faster on Zolof't.
  - I say Zolof't works Better, because in its First of it's kind study from APA (American Psychiatric Association) in 2003 Zolof't shows similar efficacy for first 12 weeks vs. Paxil. But after 3 weeks of taper, statistically more Zolof't patients remained panic attack free. The Zolof't patients also had statistically fewer withdrawal symptoms during the taper. The withdrawal symptoms are similar to the symptoms of anxiety and depression.
  - Zolof't shows better efficacy in terms of drug-to-drug interactions. According to the Journal of Psychiatric Practice, May 2003. p 229. on Table 1. Zolof't showed the least effect on P450 liver enzymes. Just look at the 2D6 inhibition that Paxil shows at 358%!! With Zolof't, you can be confident that you are using the safest SSRI.
  - Zolof't works longer. Long-term treatment of at least 1 year is now recommended by the American Psychiatric Association's Expert Consensus Panel. Zolof't has the longest term data that supports its sustained efficacy. Zolof't should be your first choice to treat the anxious depressed patient young or old.
- **Patient Benefit:** The benefit to your patient is that they will get rapid, long lasting and tolerated relief so they can return to their normal lives.
- **Physician Benefit:** The real value to you is that your patients will be treated right the first time resulting in fewer calls. Zolof't has the most formulary access with Zolof't being on or preferred on 96% of all plans.
- **Trial Close:** What are your thoughts on using Zolof't first line in your anxious depressed patients instead of Paxil?
- **Close:** Remember, Zolof't works faster, better, and longer for your patients that present with both anxiety and depression. Can I count on you to write Zolof't first line for your patients with anxiety and depression?

## Zoloft Must Do's

- Consistent Cluster A Team Message - compare & win
- Access - Every Zoloft Call mention starter pack & Zoloft's preferred MCO status & NY State Medicaid
- Cluster coverage of top 10 decile doctors
- Ask for switches from Paxil to Zoloft
- Accountability - team notes, leave behinds, lunch & learn programs, CCP coordination

## ZYVOX

### Where do we stand? Analysis, trends, budget

- Ownership - Take a look around the room, "This is it - we either win together or we lose together"
- Are you on the inner circle of your hospital - i.e. Do you know who writes vanco the most? Do you know who your obstacles are to getting Zyvox used/de-restricted/on formulary? Do you have people in your hospital actively looking for MRSA? Do you have people in your hospital actively looking to switch patients off of vanco? Are your ID's, Pulmonologists, Surgeons, Vascular Surgeons, Podiatrists, Hospitalists, Pharm D's calling you? Are they telling you what Cubicin is doing? Etc.
- 2004 Budget - 38% increase to \$305 million
- IHR's 35% & PHR's 25% Zyvox Weighting for 2004

### Zyvox Goals for 2004

- Differentiate Zyvox's superiority over vanco in known or suspected MRSA with efficacy, survivability and cost
- Broaden and Expand Zyvox's usage for HAP, VAP, CSSSI's, and DFI with known or high risk MRSA.
- Minimize/Overcome Restrictions - CEC, Parodi data, targeting Pharm D's, Hospitalist and Administrators
- Leverage superiority data to gain first line usage in the Hospital
- Continue development of Zyvox speakers from Impact program

### Key Points

- Better is hard to Restrict
- Go on the Offensive - Zyvox will save more lives and save your hospital more money.
- DFI - use Zyvox when your worried about MRSA
- Core Message - "Zyvox is the superior therapeutic selection for known or suspected MRSA infections."
- Access - No MCO influence in the hospital

### Cost Analysis

- Zyvox IV 200mg BID = \$126/day
- Zyvox oral 200mg BID = \$94/day

### "Is Vancomycin Still the Holy Grail?" Presentation - MRSA Fund initiative

- Must find out who tracks LOS
- Good targets are Pharm Ds, discharge planners, hospitalists, Chair of Medicine, ICU Directors, etc.

### Detail

- **Opener:** The information that I would like to share with you has transformed the way that the thought leaders/your colleagues treat NP/VAP/DFI due to suspected or known MRSA.
- **Promise:** Zyvox is the Superior agent for your patients with known or suspected MRSA Infections...

- **Facts:** Hot off the press in the November Issue of Chest, Zyvox demonstrated superiority to Vanco with better clinical outcomes and survivability. Superior in NP and VAP!! WHY?
- - As you know, in order for the AB to truly fight the infection, it must penetrate to the site of the infection. For your nosocomial pneumonia patients, Zyvox penetrates the lungs better than any other AB. In fact, Zyvox penetrates the lungs 450% higher than the serum and stays above the MICs for the full 24 hour period. Your patients benefit by the increased chance of a successful outcome.
- **Facts:** Patients with Diabetes and Peripheral Vascular Disease are at higher risk for MRSA. Many of these patients will end up with a Diabetic Foot Infection. Hot off the press in a study done by Dr. Lipsky et al, Zyvox demonstrated statistically significant Clinical Cure Rates vs. comparators in treating infected foot ulcers due to MRSA. And in CSSSIs, Zyvox penetration is 104% versus the serum. This means that you know that with every dose of Zyvox, the patients infection will be treated with maximum amount of Zyvox possible. Again your patients benefit by the increased chance of a successful outcome.
- **Cost/Resistance Spread:** It is hard to restrict Superior! Stevens ( IV exposure file card), Parodi, Tice and CDC.
- Dosing
- **Patient Benefit:** With Zyvox, your patients have the best possible chance of survival from gram positive/MRSA infections.
- **Physician Benefit:** With Zyvox, you can be confident knowing that regardless of whether the gram positive pathogen is susceptible or not, your patient is covered.
- **Trial Close:** What are your thoughts on Zyvox for MRSA? What do you currently use when you suspect MRSA? Do you currently have restrictions on the use of vanco? Zyvox? How do you think your patients could benefit from the superior survivability data that Zyvox has for MRSA NP/ VAP/DFI? Can you think of any patients that you can start or switch to Zyvox today? Do you have any patients on vanco that you can switch over to IV/PO Zyvox?
- **Question for PCP:** Do you ever have occasion to use Vancomycin? If doctor says no, then go right into Zoloff.
- **Close:** What I am asking you to do is to use Zyvox before vancomycin in your MRSA infected patients.

#### Objections

- Zyvox costs too much
  - Keys - SUPERIORITY, Efficacy, LOS/Discharge, Total Hosp cost, QOL, PIN, RSVP
  - Confirm managed care status.
- Cost is the exact reason why you should choose Zyvox first line for MRSA.
  - I could understand your concern if the two drugs were equivalent but Zyvox saves more lives.
  - The most expensive drug is the one that doesn't work. No other drug works better for MRSA than Zyvox.
  - I could understand your concern if the two drugs were equivalent but not when Zyvox clearly will save more lives.
  - Zyvox is proven to reduce LOS in patients with MRSA by 4 days vs. vancomycin (7 vs. 11 days), due to Zyvox's 100% bioavailability of oral step down.
  - 61% of Zyvox were stepped down to oral within 5 days.
  - Twice as many Zyvox patients were discharged within the first week vs. vanco.
  - Respond quicker.

- Home infusion cost of vanco @ \$150/day versus \$94/day for oral Zyvox
- In the hospital, cost of vanco = \$7-\$10/day and IV Zyvox = \$126
- No home IV therapy required.
- So back to your question about cost, Zyvox will reduce total cost to hospital and the patients will benefit because they will be out of the hospital, reduced exposure to nosocomial infection, improved QOL P Road to Recovery.
- Resistance
  - Resistance is the exact reason why you should use Zyvox.
  - Pg. 1481 MRSA resistance to vanco is developing
  - VRE - result of too much pressure on vanco/overuse
  - Unique mechanism of action (PI)
  - 0 cross resistance - requires a 6 step mutation to develop resistance
  - Pg. 1488 - 0 resistance in any clinical trial
  - Pg. 1489 - Use of Zyvox will relieve pressure off of vancomycin
  - Get patients out of the hospital sooner, less exposure for nosocomial infections
  - Take IV line out, less chance of developing catheter-related infection.
  - CDC recommends restricting the use of vanco
- ID Restricted
  - It Is Hard to Restrict Better/Superior
  - MRSA Fund
- The data looks good but I'll reserve Zyvox - have each rep detail in front of room with no proof sources

### Cubicin Workshop

- Each 500mg vial costs \$134/vial
- Dosed at 4mg/kg QD so an average 70kg patient would require 280mg
- They waste the extra amount
- Only have a CSSSI indication
- They failed their pneumonia trial and did not get the indication

### Resources

- Kollef 24 hour teleconference - [www.innovameded.com/register.cfm](http://www.innovameded.com/register.cfm)
- Medical Inquiry Letter - now available for Weigelt CSSSI superiority data
- Awesome little jims and one page detailers - CSSSI, MRSA pneumonia, DFI, pharmacoeconomic
- RSVP slim jims/PIN - order tons
- Speakers
  - Kollef - HAP/VAP - (314)454-8764 or [kollefm@msnotes.wustl.edu](mailto:kollefm@msnotes.wustl.edu) - Alex/Courtney
  - Nasraway - HAP/VAP/CSSSI - (617)636-4630 or [snasraway@tufts-nemc.org](mailto:snasraway@tufts-nemc.org) Nelson/Tanya
  - Rotstein - HAP/VAP - (905)574-3301 or [crotstei@mcmaster.ca](mailto:crotstei@mcmaster.ca) - Courtney
  - Kwon Lee - CSSSI, LTC, DFI, wound care - P.O.C Ann Weaver - (440)632-9185 - Angela/Rob
  - Wunderink - HAP/VAP
  - Weigelt - CSSSI (414)805-8636 (Asst. Amy) - Tim
  - Rob Owen, Pharm D - IV to PO (207)871-6294 or [owensr@mmc.org](mailto:owensr@mmc.org) - Irina/Tanya
  - Andy Shorr - HAP/VAP - [afshorr@mail.dnamail.com](mailto:afshorr@mail.dnamail.com) - Rob
  - Warren Joseph, PDM - DFI - Irina

### Zyvox Must Do's:

- Begin each day in the hospital to find new patient starts and switches.
- In the next 2 weeks see every ID, Hospitalist, Pharm-D, Pulm/Crit. Care, Administrator with the Wunderink Superiority Study.
- Discharge Planner Thursdays
- MRSA Fund Initiative - target Pharm D's, Hospital Administrators
- Inservice Wound Care DVD to targeted Surgeons, Podiatrists, Wound Care Specialists in the next month.
- IHRs
  - Update Zyvox Hospital map and submit to DM by December 15<sup>th</sup>
  - Update Zyvox website for Key Opinion Leaders
  - Coordinate with CEC to pick 1 account to perform pharmacoeconomic analysis of implementing Zyvox first line for MRSA HAP/VAP

## VFEND

### IHR standings & opportunities

- Vfend Growth of 46% in 2004 or \$120 million in sales
- IHR's 25% Vfend Weighting for 2004
- Esophageal Candidiasis Launch - March 15<sup>th</sup> & 16<sup>th</sup> in Dallas?
- Hospital Sales - we are not getting consistent usage in 99% of our hospitals
- You must sell Vfend EVERY day that you are in your hospitals. You can not afford to miss a single patient.
- IHRs - considering where we are on the GAR with Vfend, your resource utilization is low. This includes "slam dunk" speakers, teleconferences, CME grand rounds, etc. Target your opportunities, obstacles and challenges with the great resources that we have available.

### Vfend Goals for 2004

- Appropriate Targeting - highest Ampho and Abelcet hospitals; find 1-2 doctors that will write regularly
- Establish Vfend's superior Efficacy and Survivability - The Gold Standard - Not the Old Standard
  - Bottom Line - **Vfend saves more lives**
- Focus on the **Drug and not the Bug** - When you would normally consider amphotericin
  - Ampho B shortage continues
  - Nothing else is superior and at the same time better tolerated
- Flexibility in dosing IV to PO without sacrificing efficacy
  - J-tube study and WLF study from POA box to show safety of SBECD
- **Maximize resource utilization**

### Cost Analysis

1. VFEND IV for Injection (single use vial equivalent to 200mg VFEND) = \$85 per vial
2. 70kg patient on 10 Days IV Calculation:
  - Day 1 Load  $6\text{mg/kg} \times 70\text{kg} = 420\text{mg}$  required  $\times 2$  doses = 840mg for Day 1
  - Days 2-10  $4\text{mg/kg} \times 70\text{kg} = 280\text{mg}$  required  $\times 2$  doses = 560mg for each Day  
or a total of 9 days  $\times 560\text{mg/day} = 5040\text{mg}$
  - Total #mg required for 10 days = 5040mg + 840mg = 5880mg Total
  - Total # Vials Required for 10 day = 5880mg / 200mg per vial = 30 vials total (29.4 to be exact)
  - Total cost for one 70kg patient on 10 days IV = 30  $\times$  \$85 = \$2550 or \$255/day for 10 days of IV
  - **ROUNDED OFF IV Cost/day = \$250/day**
- Current Quotas per IHR
  - Alex - \$28,173 for 2<sup>nd</sup> Semester  $\approx$  \$4700/month or **2 patients/month on IV for 10days**
  - Courtney - \$29,716 for 2<sup>nd</sup> Semester  $\approx$  \$5000/month or **2 patients/month on IV for 10days**
  - Tim - \$43,248 for 2<sup>nd</sup> Semester  $\approx$  \$7200/month or **3 patients/month on IV for 10days**
3. **With the 46% quota increase, projected patients per month would be 3-5 patients/month on IV for 10 days**

## Studies

- Voriconazole - Better Chances for Patients with Invasive Mycoses - note Vfend indicated for resistant candidiasis in Europe
- Two case studies of Cerebral Aspergillosis Successfully Treated with Voriconazole - "halo effect"
- Herbrecht study & OLAT

Resources - Resource Navigator to handle objections, Vfend DVD for refresher training

## Esophageal Candidiasis Pre-launch Advocacy Meeting Targeted Doctors

1. Critical Care
  - Peter Smith, MD  
Director of the Medical ICU  
Long Island College Hospital  
92 Aminity Street  
Brooklyn, NY 11201  
(718)558-7291
2. Pharm D
  - Tina Abraham, Pharm D  
NY Methodist Hospital  
506 Sixth Street  
Brooklyn, NY 11215  
(718)780-5629
3. ID
  - Kenneth Roistacher, MD  
Director of Infectious Diseases  
Mary Immaculate Hospital  
88-25 89<sup>th</sup> Avenue  
Jamaica, NY 11432  
(718)558-7291
  - Anand Persaud, MD  
Attending Infectious Diseases  
173-25 Jamaica Avenue  
Jamaica, NY 11432  
(718)657-4000  
Fax(718)657-6000  
[apersaud@pol.net](mailto:apersaud@pol.net)
  - Michael Augenbraun, MD  
Department of Epidemiology  
SUNY Downstate Medical Center  
440 Lennox Road, Box 1187  
Brooklyn, NY 11203  
(718)270-2234

- Edward Chapnick, MD  
Director of Infectious Diseases  
Maimonides Medical Center  
4802 Tenth Avenue  
Brooklyn, NY 11219  
(718)283-7492  
Fax (718)283-7974  
[echapnick@maimonidesmed.org](mailto:echapnick@maimonidesmed.org)
- Alternates: Dr. Andre Brutus, Dr. Cheryl Croney, Dr. Pujol

**Detail** - If you get nothing else across, you must emphatically convince them of Vfend's STATISTICALLY SUPERIOR SURVIVABILITY. Bottom Line - MORE PATIENTS ON VFEND WILL LIVE!!

- **Opener:** Survival Sell sheet - I'd like to share some information with you that has caused many of your ID colleagues to rethink the way that they treat patients at high risk for fungal infections. I'm sure that the one thing that matters the most to you when treating serious fungal infections is SURVIVABILITY.
- **Promise:** Vfend offers superior antifungal efficacy and survivability over both traditional and lipid forms of amphotericin B. Vfend is the New Gold Standard to replace the Old standard.
- **Facts:**
  - 1) Herbrecht study setup
  - 2) Visual Aid pg 16 - statistically superior efficacy to amphotericin B (53% vs 32%)
  - 3) Herbrecht pg 412 - statistical superiority regardless of whether it was documented or probable infection and regardless of patient type.
  - 4) 22% relative survival benefit. Vfend showed statistically superior survivability over ampho B at 71% vs. 58%. More than twice as many patients on amphotericin B died due to mold infections.
  - 5) Visual Aid pg 33 - Flexibility of IV to PO without sacrificing efficacy. This will allow you to discharge patients faster and reduce LOS.
- **Patient Benefit:** Your patients will have the best chance of survival while not having to worry about the adverse events of ampho.
- **Physician Benefit:** The real value to you is that you will confidence knowing that you have given your patients the best possible agent for their survival. At the same time, you will have peace of mind knowing that you did not hurt the patients kidneys. Vfend also allows you the opportunity to reduce LOS and thus reduce overall hospital costs.
- **Trial Close:** Knowing this, what are your thoughts are using Vfend instead of amphotericin or Abelcet?
- **Close:** Do you have any patients that right now that you are considering putting on an AF? Will you put that patient on Vfend 6mg/kg Q12h? Do you any patients right now on amphotericin? Will you switch that patient to oral Vfend?

#### **VFEND Must Do's:**

- Establish Vfend's superior survivability by targeting the Drug and not the Bug
- Identify 2 key targets per hospital that can write consistent Vfend
- Use 3<sup>rd</sup> party references to let doctors know where their colleagues are using Vfend
  - VA, Maimonides, Brookdale - all have used Vfend for cryptococcal meningitis
  - Brooklyn Hospital, Brookdale - Vfend for refractory oral candidiasis
  - LICH - unstable patients at risk for fungal infections in the ICU
- Target large HIV ID's with the news of the new esophageal indication and have the medical inquiry letter sent to them during your next hospital day. - focus on break through thrush/esophagitis, re-occurring esophageal candidiasis
- Stepdown all ampho patients to oral Vfend
- Speaker Program Responsibilities
  - Use speakers ALL day in the key specialties in your hospitals (e.g. ICU, ID, Hem/Onc, Crit. Care, HIV, Pharmc D, etc.)
  - Courtney - contact Ben Lomaestro for January
  - Tim - develop Peter Smith, Pulm-CC for Critical Care talks - test run by 2<sup>nd</sup> week December.

- Michael Glazman - develop Dr. Kupfer, ID for ID talks - start with journal club
- Alex - contact Jose Vazquez to do Brooklyn 2 days in January/February.
- Have discussion of Amphotericin B shortage with key IDs, Critical Care, Surgery, and Pharmacy in next 2 weeks - this continues to be a compelling event
- Coordinate ID fellow coverage and handoff
- Prepare for the Esophageal Candidiasis launch - more speaker development targets
- Medical Inquiries on Esophageal Candidiasis

COX 2

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1	<i>DISTRICT:</i>
2	<i>PRODUCT:</i>
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4	<i>POA1 2004 Goals</i>
5	<i>COX II</i>
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10	<i>Messaging</i>
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17	<b>CELEBRE</b> ICELECOXIB CAPSULES

COX 2

	B
1	<b>BROOKLYN</b>
2	<b>COX II</b>
3	<b>EFFICACY - SAFETY - ACCESS</b>
4	1) Take business away from NSAIDs & Vioxx - sell both on each call
5	2) Access - Utilize our open status with Medicaid to overcome traditional NSAIDs - \$2.00 copay for Medicaid same for Celebrex
6	3) Capitalize on the information coming out of the ACR (Celebrex capsule study and Solomon poster - Acute MI)
7	4) Get Bextra added to hospital formularies (Maimo example) for use in the acute, peri-operative setting with the overall goal of getting the
8	5) Maintain Celebrex's status on hospital formularies and proactively block VIP contracts
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10	<b>CLUSTER A Core Message:</b> Celebrex provides "Proven strength that your patients can stay with." Bextra provides "Rapid Powerful Relief."
11	<b>Opener:</b> The doctor's compelling new information coming from the latest American College of Rheumatology that is causing physicians to rethink where they use NSAIDs and Cox-2 inhibitors. The first piece of compelling information...  Doctor, there's some compelling new data that is coming out of the American College of Rheumatology that is changing the way that many of your colleagues use Vioxx. In fact, many of your colleagues are switching their patients from Vioxx to Bextra.
12	<b>Promise:</b> Bextra provides rapid, powerful relief and is the strongest NNA (non-narcotic anti-inflammatory) on the market.
13	<b>Facts:</b> Doctor, Bextra should be your Cox-2 of choice because Bextra works faster and better than Vioxx without increasing the risk of Acute MI. - Visaid Pg. 9 - Bextra is the fastest NSAID on the market as shown in this head to head study that showed that Bextra worked within 26 minutes compared to Anaprox. - Visaid Pg. 10 - Bextra excels in the tough to treat pain of arthritic flares. In this double-blind, randomized, placebo-controlled trial of osteoarthritis, patients were taken off of their Vioxx, Mobic, or traditional NSAIDs and an arthritic flare was induced. Once the flare was classified as severe, patients were started on Bextra 10mg or placebo. At the end of the study, patients on Bextra received better pain control than their original therapy. - Pg 294 (Makarowski) - Bextra works well where others fail because <b>Bextra rapidly penetrates the CNS</b> . This means that Bextra works to control pain at the source of the pain and inflammation and <u>prevents central sensitization to pain</u> (much like an opioid). Bextra is the strongest non-narcotic on the market. - Ray Study: This cohort study in Tennessee Medicaid that was funded by the FDA clearly shows a 70% increase in Acute MI in patients taking Vioxx. Presented their own study at the American College of Rheumatology that confirms exactly this. This study was done in Boston at the Brigham and was covered by all the major news media including the Wall Street Journal. Now that the information is in the lay press many of your colleagues are switching their patients from Vioxx to Bextra. - Visaid Pg. 13 - In contrast, Bextra has shown no increase in cardiovascular risks compared to traditional NSAIDs and does not carry a Package Insert warning for increased cardiovascular risks. <b>Trial Close:</b> Doctor, what are your thoughts on Merck's own data from the ACR? I can have this information sent to you from our Medical Department. - Pg 11 Dr. Maimo now you can see how Bextra can replace Vioxx without concern for Acute MI or replace Non-Narcotic analgesics such as Ultram and Tylenol.
14	<b>Patient Benefit:</b> Your patients with severe pain will receive the fastest relief from the strongest NNA on the market. They will return to their normal lives.
15	<b>Physician Benefit:</b> You have the peace of mind knowing that you are providing a safer, more effective medication for their pain that will not increase MI's or stroke unlike Vioxx and will not cause the narcotic-like addiction and AE like Ultracet.
16	<b>Close: First Line Therapy over Vioxx and Ultracet.....</b>
17	<b>CELEBREX:</b> Doctor, there's some compelling new data that is coming out of the American College of Rheumatology that is changing the way many of your colleagues use traditional NSAIDs. In fact, many are switching their patients from traditional NSAIDs over to Celebrex. <b>Key Message:</b> Celebrex will provide superior efficacy and safety that your patients can stay on.

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20	<b>Strategic Musts</b>
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29	<b>Visual Aid Musts</b>
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40	<b>Resources</b>
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46	<b>Power Phrases</b>
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	<b>B</b>		
	<p><b>Facts:</b> Pg. 4 - Patients with ankle sprains that were placed on Celebrex were able to be returned to their normal lives a full day earlier than ibuprofen patients.</p> <p>- Pg. 4 - When compared to tylenol, patients with OA preferred the superior pain relief that they received with Celebrex 200mg QD versus 4g of acetaminophen.</p> <p>- Pg. 6 - In this largest ever encapsulated study in healthy young patients, Celebrex 200mg BID was compared to an NSAID + PPI (Naproxen plus omeprazole). This was a randomized, multicenter, placebo-controlled comparison in patients with an average age of 33. Patients were verified to have a clean bill of health using a capsule at the start of the study. At the end of the 2 weeks, even with a PPI, Naproxen had a statistically significant 12 fold increase in small bowel lesions compared to Celebrex. At the end of the study, compared to placebo, Celebrex patients maintained their clean bill of health.</p> <p><b>Trial Close:</b> What are your thoughts on the findings of this study? How will this affect your use of traditional NSAIDs?</p> <p>- The real impact that using Celebrex over traditional NSAIDs can have for you and your patients is better overall outcomes. In the largest outpatients with OA, patients on Celebrex had 45% fewer referrals to specialists and 34 % fewer physician office visits for GI complications as compared to naproxen. Most importantly the Celebrex patients had 75% fewer ICU hospitalizations and 52% fewer GI hospitalizations. The benefits to your patients are significant. The real value to you is that you are able to provide a better drug for your Medicaid patients while maintaining the same \$2.00 copay.</p> <p>- Your patients that start on Celebrex will stay on Celebrex as shown in our persistency data. Significantly more patients stayed on Celebrex at 6 months compared to naproxen. As you can see, Celebrex truly provides you with the efficacy and safety that your patients will be able to stay with.</p> <p><b>Close:</b> Doctor, based upon Celebrex's ability to return your patients earlier to their normal lives, superior safety compared to traditional NSAIDs.</p>		
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20	Vioxx Violators - Top 25 in each LAT will be sent a Vioxx Acute MI ACR Medical Inquiry (Ortho&Rheum - Powers, PRO; PCP - Upjohn & Alta) - Drive 5% mkt share from Vioxx to Bextra		
21	Dr. Solomon Teleconferences scheduled with local speakers and Vioxx Violators, VIP hospitals		
22	Medicaid NSAID Highwriters targets - focus on Access (\$2.00 copay) - Drive 5% market share from NSAIDs to Celebrex (set LAT baseline)		
23	Expand call cycles to include Celebrex Highwriters for Medicaid, Cash, Express Scripts, Advance PCS - fish where the fish are		
24	Puma - set up Grand Rounds at local hospitals and round tables discussions		
25	Identify and pursue opportunities - pathways, standing orders, formulary successes		
26	Short Term Scripts - 5 days of Celebrex or Bextra cost no more that \$10-\$12 (no more than NSAID) - applies to ER as well		
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29	<b>Bextra</b>	<b>Celebrex - NSAIDs</b>	
30	Onset	Flare Data	ACR Guidelines
31	Makarowski CNS	Ray Study	Visaid Pg. 6 Capsule Study
32	Hypertension/Edema	Dosing	Dosing - \$2 copay
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35	Makarowski	ACR Capsule study & video	
36	Ray	Success visaid	
37	White	ACR Vioxx Acute MI data	
38	Shelton 1 & 2		
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40	Capsule Video		
41	CME Grand Rounds		
42	Cox-2 Clinical Compendium		
43	Cox-2 Hospital Compass		
44	Dr. Puma		
45	Dr. Abraham		
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47	The reason why Bextra works so well where other fail is because Bextra rapidly penetrates the CNS. This means that Bextra works to control pain at the source of the pain and inflammation and prevents central sensitization to pain (much like an opioid). Bextra is the strongest non-		
48	opioid analgesic factor, your patients have a better chance of surviving a GI bleed than they do an Acute MI.		
49	In fact, in EVERY study that we've ever done, Celebrex at it's LOWEST dose of 200mg a day has ALWAYS shown to work at least as well as the MAX dose of every other traditional NSAID.		
50	You just put in a \$10,000 hip and you want a "me too" drug for their pain?		



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53	<i>Objections</i>
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COX 2

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51	Use Bextra when your patients need a JOLT OF EFFICACY.
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53	Medicaid - Traditional NSAIDs
54	I'm using Celebrex first line. I don't need Bextra.
55	Use a little of everything. They need the business too.
56	VIP hospital
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COX 2

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Bextra Surgical

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2	<i>PRODUCT:</i>
3	<i>POA1 2004 Goals</i>
4	<i>BEXTRA</i>
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8	<i>Messaging</i>
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16	<i>Strategic Musts</i>
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20	<i>Visual Aid Musts</i>
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Bextra Surgical

B	
1	<b>BROOKLYN</b>
2	<b>BEXTRA SURGICAL FOCUS</b>
3	1) Sell Bextra as the replacement to Vioxx and NNAs
4	2) Get Bextra added to pre-op briefing sheets in our Largest Orthopedic offices
5	3) IHRs - Pre-op briefing sheets in anesthesia/OR as well
6	4) Get Bextra added to pre-op briefing sheets in other surgical subspecialties - podiatry, general surgery, plastic surgery, ENT, etc.
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8	<b>Core Message:</b> <b>Surgical Detail - Tell the story – solve the two problems related to increased pre-op pain!</b>
9	Opener: Give me 2 minutes and I will prove to you how I can improve your post op pain control while decreasing your narcotic use!
10	<b>Problem:</b> Pre-op pain relates to post op pain control & morphine use. (I.e. The amount of Post-op pain is related to the degree of Pre-op pain that a patient has. The higher the Pre-op pain, the higher the Post-op pain, the more morphine is used.) - Study demonstrated patients who had moderate to severe pain pre-op used 50% more morphine.
11	<b>Facts:</b> In order to improve pre/post op pain you are going to need to control and solve 2 problems.  1. Patients are taken off traditional NSAIDs 2 weeks prior to surgery in order to avoid bleeding complications. - By taking them off their medication their pain & inflammation return or a FLARE occurs. (Hence pre-op pain due to their arthritis. Solution: - Patients who are on traditional NSAIDs should be switched to Bextra 2 weeks prior to surgery. - There is no worry of bleeding (Leese Bextra/Platelet Study) even at 8 x normal dose. - This is the best agent for arthritic pain and inflammation! Problem Solved.  Any time you have tissue injury (such as surgical incision) Cox 2 is expressed in the CNS (Use Makarowski) - Bextra is the only agent proven to cross the blood brain barrier and thus inhibit Cox 2 in the CNS! - This is why you see narcotic-like efficacy with Bextra in arthritic patients with pain & inflammation. - Due to the fact that Bextra is taking care of pain at its source (CNS), your patients will be have less pain, will use less narcotics and will ambulate quicker!  So doctor, as you can see this is a great multi-modal approach to treating the pain and inflammation in your patients.  You decrease pre-op pain – by controlling their pain and inflammation prior to surgery and you take care of post op pain by inhibiting Cox 2 expression allows you the opportunity to improve your patients post op pain relief while at the same time decreasing narcotic utilization!
12	<b>Patient Benefit:</b> Your patients will experience less pain and will ambulate faster/with less pain.
13	<b>Physician Benefit:</b> You no longer have to rely on narcotics as the cornerstone of pain management. Bextra is so powerful that the patient will need less narcotics and can actually reduce them to a PRN basis.
14	<b>Trial Close/Close:</b> What are your thoughts on this? What does your current office patient pre-op form look like? How can we incorporate Bextra into this? <b>Is there anyone coming in today for their pre-op briefing? When is your next OR day? Can you start all of these patients on Bextra pre-operatively?</b>
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16	Get Bextra added to pre-op briefing sheets in our surgical subspecialty offices (ortho, podiatry, general surgery, ENT, plastic surgery, etc.)
17	IHRs - Pre-op briefing sheets in anesthesia/OR as well (see Maimonides and Kingsbrook examples)
18	Get Bextra added to hospital formularies for peri-operative use
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20	Slappendel pg 146 and 147
21	Flare data
22	Sell with Celebrex Leese but handout Bextra Leese (WLF)
23	Makarowski CNS data
24	Dosing

Bextra Surgical

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26	<i>Key Clinicals</i>
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Bextra Surgical

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26	Slappendel
27	Makarowski
28	Desjardin (not approved for detailing) - great explanation of the importance of CNS penetration of Cox-2 inhibition and Pre-emptive analgesia
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31	Local pre-op instruction sheets in ortho offices and hospital anesthesia departments
32	Orthopedic Surgery video series
33	CME Grand Rounds series
34	Orthopedic slim jim
35	New Promotional Slide Kit
36	Central Sensitization Flash Card
37	Clinical Perspectives in surgery
38	Anatomical Arthritis Model
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40	The reason why Bextra works so well where other fail is because Bextra rapidly penetrates the CNS. This means that Bextra works to control pain at the source of the pain and inflammation and prevents central sensitization to pain (much like an opioid).
41	You just put in a \$10,000 hip and you want a "me too" drug for their pain?
42	<b>Use Bextra when your patients need a JOLT OF EFFICACY.</b>
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44	HMOs/Cost - PA initiative
45	VIP contract - find busiest Ortho and get Bextra/Celebrex available for usage just for this Ortho
46	Most with an Ortho - "You just put in a \$10K hip and you want to use a "me too" drug?"
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Bextra Surgical

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2	<i>PRODUCT:</i>
3	<i>POA1 2004 Goals</i>
4	<i>ZOLOFT</i>
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8	<i>Messaging</i>
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17	<i>Strategic Musts</i>
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25	<i>Visual Aid Musts</i>
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33	<i>Key Clinicals</i>
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PHR ZOLOFT

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1	<b>BROOKLYN</b>
2	<b>ZOLOFT</b>
3	1) Go right after Paxil Generic and switch to Zoloft reach 20% market share.
4	2) Move Zoloft to # 1 in Medicaid Access
5	3) Maintain consistent messaging across all division in the territory
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9	<b>Opener:</b> Doctor for your patients who presents with mixture of anxiety and depressive symptoms you can count on Zoloft.
10	<b>Promise:</b> You are guaranteed that Zoloft is proven to work faster, better and longer for the anxious depressed patient with the most indications.
11	<b>Points:</b> - Zoloft works faster. Regardless of mood disorder, Zoloft works in as little as 1-2 weeks. This is much shorter than the 4 weeks that it takes Paxil to kick in. Your anxiety patients get back to their normal lives faster on Zoloft. - I say Zoloft works Better, because in its First of it's kind study from APA (American Psychiatric Association) in 2003 Zoloft shows similar efficacy for first 12 weeks vs. Paxil. But after 3 weeks of taper, statistically more Zoloft patients remained panic attack free. The Zoloft patients also had statistically fewer withdrawal symptoms during the taper. The withdrawal symptoms are similar to the symptoms of anxiety and depression. - Zoloft shows better efficacy in terms of drug-to-drug interactions. According to the Journal of Psychiatric Practice, May 2003. p 229 on Table 1. Zoloft showed the least effect on P450 liver enzymes. Just look at the 2D6 inhibition that Paxil shows at 358%! With Zoloft, you can be confident that you are using the safest SSR! - Zoloft works longer. Long-term treatment of at least 1 year is now recommended by the American Psychiatric Association's Expert Consensus Panel. Zoloft has the longest term data that supports its sustained efficacy. Zoloft should be your first choice to treat the anxious depressed patient.
12	<b>Patient Benefit:</b> The benefit to your patient is that they will get rapid, long lasting and tolerated relief so they can return to their normal lives.
13	<b>Physician Benefit:</b> The real value to you is that your patients will be treated right the first time resulting in fewer calls. Zoloft has the most formulary access with Zoloft being on or preferred on 96% of all plans.
14	<b>Trial Close:</b> What are your thoughts on using Zoloft first line in your anxious depressed patients instead of Paxil?
15	<b>Close:</b> Remember, Zoloft works faster, better, and longer for your patients that present with both anxiety and depression. Can I count on you to write Zoloft first line for your patients with anxiety and depression?
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17	<b>Consistent Cluster A Team Message w/ compare &amp; win.</b>
18	Access - Every Zoloft Call, mention starter pack and Zoloft's preferred MCO status and Medicaid status.
19	Team Ownership w/ PCPs. Run Paxil Highwriters list for Primary Care Physicians. Incorporate Top 10 Paxil users into call cycle and lead the call with Zoloft. Goal is to drive Zoloft to 20% market share.
20	Target high Medicaid writers and Top 10 decile doctors
21	Accountability - team notes, leave behinds, lunch & learn programs, CCP coordination
22	ASK FOR SWITCHES FROM PAXIL TO ZOLOFT
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25	Visual Aid Page 8. "Zoloft -Proven efficacy across a broad range of indications"
26	Visual Aids page 7. "In the first Double-Blind, Head to Head Trial in Panic Disorders
27	Visual Aid from journal article -Journal of Psychiatric Practice, May 2003. p 229. Table 1
28	Visual Aids Detail Page 9 "Long term treatment is needed to meet guidelines for depression and anxiety disorders
29	Visual Aid page 14 "Convenient, Once-a-day dosing
30	Sell sheet against Paxil " Compare Zoloft and Paxil"
31	Sell sheet against Lexepro " Compare Zoloft and Paxil"
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33	Bandelow (Paxil vs. Zoloft 15 week study)
34	Prescorn ( drug to drug interactions)
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PHR ZOLOFT

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38	<i>Resources</i>
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43	<i>Power Phrases</i>
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	<i>Objections</i>
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PHR ZOLOFT

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38	Medicaid - full access SSRI
39	HMO status - most favorable SSRI
40	Hospital formulary - most favorable SSRI
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43	Zoloft has a decade of evidence based data.
44	Zoloft is still the best starting point because it is a classic.
45	Zoloft is a low maintenance drug with proven results
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49	<p>Doctor, what is this the most important reason why you reach for Paxil?</p> <ul style="list-style-type: none"> <li>- I use Paxil because it has many indications.</li> <li>- page 8 detail. Zoloft has as many indications as Paxil and even more on Paxil CR (3).</li> <li>- I use Paxil because it easy to taper off.</li> </ul>
50	Lexapro is the fastest acting SSRI - No data to show Lexapro is safer, or faster acting, or more potent than Celexa or anything else. Remember the issue of "The Medical Letter" on Lexapro states exactly this.
51	Paxil CR - Same effect on 2D6 as Paxil, same withdrawal warning in the PI as in the Paxil PI.

PHR ZOLOFT

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	A
1	<i>DISTRICT:</i>
2	<i>PRODUCT:</i>
3	<i>POA 1 2004 Goals</i>
4	<b>ZYVOX</b>
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	<b>Messaging</b>
8	  <b>ZYVOX</b> linezolid injection tablets, and oral suspension
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16	<b>Strategic Musts</b>
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26	<b>Visual Aid Musts</b>
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ZYVOX

	B
1	<b>BROOKLYN</b>
2	<b>ZYVOX</b>
3	1) Establish Zyvox as the leading choice for the treatment of infections caused by known or suspected MRSA.
4	2) Broaden and Expand usage for NP/VAP/DFI at the expense of Vanco for MRSA.
5	3) Overcome Restrictions and Account Challenges.
6	4) Leverage Superiority Data to gain first line use in the hospital.
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8	<b>Opener:</b> The information that I would like to share with you has transformed the way that the thought leaders/your colleagues treat NP/VAP/DFI due to suspected or known MRSA.
9	<b>Promise:</b> Zyvox is the Superior agent for your patients with known or suspected MRSA Infections...
10	<b>Facts:</b> Hot off the press in the November Issue of Chest, Zyvox demonstrated superiority to Vanco with better clinical outcomes and survivability. Superior in NP and VAP!! WHY? - As you know, in order for the AB to truly fight the infection, it must penetrate to the site of the infection. For your nosocomial pneumonia patients, Zyvox penetrates the lungs better than any other AB. In fact, Zyvox penetrates the lungs 450% higher than the serum and stays above the MICs for the full 24 hour period. Your patients benefit by the increased chance of a successful outcome. <b>Facts:</b> Patients with Diabetes and Peripheral Vascular Disease are at higher risk for MRSA. Many of these patients will end up with a Diabetic Foot Infection. Hot off the press in a study done by Dr. Lipsky et al, Zyvox demonstrated statistically significant Clinical Cure Rates vs. comparators in treating infected foot ulcers due to MRSA. And in CSSSIs, Zyvox penetration is 104% versus the serum. This means that you know that with every dose of Zyvox, the patients infection will be treated with maximum amount of Zyvox possible. Again your patients benefit by the increased chance of a successful outcome.
11	<b>Balance Spread:</b> It is hard to restrict Superior! Stevens ( IV exposure file card), Parodi, Tice and CDC.
12	<b>Benefit:</b> With Zyvox, your patients have the best possible chance of survival from gram positive/MRSA infections.
13	<b>Benefit:</b> With Zyvox, you can be confident knowing that regardless of whether the gram positive pathogen is susceptible or not, your patient is covered.
14	<b>Trial Close:</b> What are your thoughts on Zyvox for MRSA? What do you currently use when you suspect MRSA? Do you currently have restrictions on the use of vanco? Zyvox? How do you think your patients could benefit from the superior survivability data that Zyvox has for MRSA NP/ VAP/DFI? Can you think of any patients that you can start or switch to Zyvox today?
15	<b>Close:</b> What I am asking you to do is to use Zyvox before vancomycin in your MRSA infected patients.
16	Begin each day in the hospital to find new patient starts and switches.
17	In the next 2 weeks see every ID, Hospitalist, Pharm-D, PUD/CC, Administrator with the Wunderink Superiority Study.
18	Send additional MI Requests to Physicians.
19	Maker Tour throughout Territory and District.
20	Wound Care Fund Initiative.
21	Give the Wound Care DVD to targeted Surgeons, Podiatrists, Wound Care Specialists in the next month.
22	- Complete Zyvox Hospital map - SWOT Analysis/ Account Grid for top accounts and submit to DM by December 15th
23	- update Zyvox Website for Key Opinion Leaders and notify DM by December 15th
24	Discharge Planner Thursdays - every week to find new oral Zyvox patients.
25	
26	Wunderink Study - Chest
27	Pneumonia Section / Penetration
28	Risk Factors Highlighted - Diabetes and Peripheral Vascular Skin Disease
29	DFI Section / Penetration
30	Average Page

ZYVOX

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37	<i>Key Clinicals</i>
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43	<i>Resources</i>
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52	<i>Power Phrases</i>
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58	<i>Objections</i>
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ZYVOX

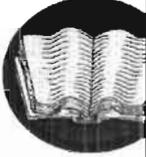
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31	st/Resistance Section:
32	fficacy Flash Cards
33	Stevens, Parodi, Tice
34	CDC
35	Dosing
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37	Wunderink study in CHEST
38	Stevens
39	Parodi - Early Switch and Early Discharge Opportunities in Intravenous Vancomycin Treatment of Suspected Methicillin-Resistant Staphylococcal Species Infections
40	Lipsky DFI Poster - Not for Detailing
41	Tice - Cost Perspectives for Outpatient Antimicrobial Therapy
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43	Medical Inquiry
44	PIN Program / RSVP
45	CDC 12 Step file card, wall charts, tear sheets, CD-ROM (ZV841552, ZV841550, ZV841559, ZV841557)
46	www.Zyvox.com website - doctors can get slides and photos of infection as well as peer reviewed data
47	3 hr CME/ACPE interactive monographs - reps can order for physicians and pharmacists - Diabetic Foot BRC and VAP BRC
48	Kollef 24 hour teleconference - <a href="http://www.innovameded.com/register.cfm">www.innovameded.com/register.cfm</a>
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52	Zyvox is the superior choice for your patients with documented or suspected MRSA...
53	Zyvox can help you say "NO" to vanco
54	Superior/Better is hard to Restrict
55	Zyvox is the only agent proven to be Superior to Vanco
56	The only oral agent approved for MRSA
57	
58	ID Restricted - Hard to Restrict Superior. For any of these objections, get right back to superior survivability.
59	Cost - This may be a concern if the two drugs were equivalent but Zyvox saves more lives.
60	Resistance
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ZYVOX

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ZYVOX OBJECTIONS

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1	OBJECTIONS
2	Zyvox costs too much
3	✓ Keys - SUPERIORITY, Efficacy, LOS/Discharge, Total Hosp cost, QOL, PIN, RSVP
4	✓ Confirm managed care status.
5	
6	Cost is the exact reason why you should choose Zyvox first line for MRSA.
7	✓ I could understand your concern if the two drugs were equivalent but Zyvox saves more lives.
8	✓ The most expensive drug is the one that doesn't work. No other drug works better for MRSA
9	✓ Zyvox is proven to reduce LOS in patients with MRSA by 4 days vs. vancomycin (7 vs. 11 days), due to Zyvox's 100% bioavailability of oral step down.
10	✓ 61% of Zyvox were stepped down to oral within 5 days.
11	✓ Twice as many Zyvox patients were discharged within the first week vs. vanco.
12	✓ Respond quicker.
13	✓ Home infusion cost of vanco ≅ \$150/day versus \$94/day for oral Zyvox
14	▪ In the hospital, cost of vanco = \$7-\$10/day and IV Zyvox = \$126
15	✓ No home IV therapy required.
16	✓ So back to your question about cost, Zyvox will reduce total cost to hospital and the patients will benefit because they will be out of the hospital, reduced exposure to nosocomial infection, improved
17	
18	Resistance
19	✓ Resistance is the exact reason why you should use Zyvox.
20	▪ Pg. 1481 MRSA resistance to vanco is developing
21	▪ VRE - result of too much pressure on vanco/overuse
22	▪ Unique mechanism of action (PI)
23	0 cross resistance - requires a 6 step mutation to develop resistance
24	Pg. 1488 - 0 resistance in any clinical trial
25	▪ Pg. 1489 - Use of Zyvox will relieve pressure off of vancomycin
26	▪ Get patients out of the hospital sooner, less exposure for nosocomial infections
27	▪ Take IV line out, less chance of developing catheter-related infection.
28	▪ CDC recommends restricting the use of vanco
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30	ID Restricted
31	✓ It Is Hard to Restrict Better/Superior
32	✓ MRSA Fund
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1	<i>DISTRICT:</i>
2	<i>PRODUCT:</i>
3	<i>POA 1 2004 Goals</i>
4	<i>VFEND</i>
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10	<i>Messaging</i>
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22	<i>Strategic Musts</i>
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35	<i>Visual Aid Musts</i>
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IHR VFEND

B	
1	<b>BROOKLYN</b>
2	<b>VFEND</b>
3	1) Target appropriately - Hospitals and Healthcare providers
4	2) Establish superior efficacy and survivability
5	3) Focus on the competition and not the indication (Focus on the drug and not the bug) - amphotericin products and caspofungin
6	4) Flexibility in dosing IV and oral
7	5) Utilize Vfend Resources
9	
10	<b>Opener:</b> I'm sure that the one thing that matters the most to you when treating serious fungal infections is SURVIVABILITY.
	<b>Promise:</b> Vfend offers superior antifungal efficacy and survivability over both traditional and lipid forms of amphotericin B.
11	
12	<b>Facts:</b> 1) Hebrecht study setup.
13	Visual Aid pg 16 - statistically superior efficacy to amphotericin B (53% vs 32%)
14	Herbrecht pg 412 - statistical superiority regardless of whether it was documented or probable infection and regardless of patient type.
15	4) Vfend showed statistically superior survivability over ampho B at 71% vs. 58%. More than twice as many patients on amphotercin B died due to mold infections.
16	4) Visual Aid pg 33 - Flexibility of IV to PO without sacrificing efficacy. This will allow you to discharge patients faster and reduce LOS.
17	<b>Patient Benefit:</b> Vfend gives your patients best chance of survival.
18	<b>Physician Benefit:</b> The real value to you is that you will know that you are giving them the best chance to survive. At the same time, you have the opportunity to reduce LOS and thus reduce overall hospital costs.
19	<b>Trial Close:</b> Knowing this, what are your thoughts are using Vfend instead of amphotericin?
20	<b>Close:</b> Do you have any patients that right now that you are considering putting on an AF? Will you put that patient on Vfend 6mg/kg Q12h? Do you any patients right now on amphotericin? Will you switch that patient to oral Vfend?
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23	Dr. Boucher teleconference
24	Identifying the patient and utilize pull through to get the patient - <b>just get 1 patient from each HIV doctor right now (REFRACTORY OPPORTUNISTIC INFECTION IN AIDS); PROLONGED NEUTROPENIA (neutropenia &gt; 5 days) in Hem/Onc</b>
25	Each IHR bring in 1 Vfend slam dunk speaker per Quarter - Grand Rounds, 1 on 1's with thought leaders
26	PHR set up Grand Rounds and programs for rest of yr 2002 - speakers like Dr Farber, J. Papadopoulos, Dr Martinez
27	Vfend added to formulary in our biggest accounts - at least ID restricted
28	Position Vfend as effective & tolerable.
29	Recognize where business opportunities exist for Vfend.
30	Update Clinical Pathways - Be sure Vfend is listed as an agent of choice. Revisit any existing Diflucan pathways and add Vfend side.
31	"the mole" - <b>anytime you hear a doctor prescribe ampho, ask for an upgrade to Vfend. Remember is the patient is doing poorly then you can just ask to add Vfend on. If the patient is improving, step down to oral Vfend.</b>
32	Update Clinical Pathways - Be sure Vfend is listed as an agent of choice. Revisit any existing Diflucan pathways and add Vfend side.
33	Increase focus on ID and Hem/Onc
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35	<b>Left Side</b>
36	Cover - Survival
37	Herbrecht study front page
38	Patient demographics Herbrecht pg. 412
39	Flexibility IV to PO - Visaid pg. 33
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IHR VFEND

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43	<i>Key Clinical</i>
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IHR VFEND

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43	Herbrecht
44	Annoum study (WLF) - Voriconazole - Better Chances for Patients with Invasive Mycoses
45	Pfizer (WLF)
46	Isavuconazole vs. Diflucan for Esophageal Candidiasis (NOT APPROVED FOR DETAILING)
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48	
49	Vfend Resource Navigator
50	One thing matters... Survival detail piece
51	Superior Efficacy detail piece
52	Dosing cards
53	HR CD-Rom
54	Oncology Nurses Guide
55	Premium items
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58	Vfend is the Gold Standard and amphotericin is the Old standard.
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64	Vfend is only indicated for IA.
65	SBECD
66	Efficacy
67	Cost
68	Drug-Drug Interactions
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1	<i>DISTRICT:</i>	
2	<i>PRODUCT:</i>	<b>INSERT PRODUCT NAME</b>
3	<i>Launch Goals</i>	
4	<i>VFEND</i>	
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8	<i>Messaging</i>	Opener:
9		Promise:
10		Facts:
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13		Patient Benefit:
14		Physician Benefit:
15		Trial Close:
16		Close:
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18	<i>Strategic Musts</i>	
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29	<i>Visual Aid Musts</i>	
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38	<i>Key Clinical</i>	
39	<i>(Not for Detailing at this time)</i>	
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44	<p><i>Resources</i></p>  <p><i>Power Phrases</i></p> 	
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POA 1, 2004  
ORTHOPEDIC STORY FLOW

Opener: (What is the compelling event)

The information that I would like to share with you has changed the way many of your orthopedic colleagues treat peri-operative pain.

SLAPPENDEL

- Patients undergoing hip replacement surgery. Pre-op pain is directly correlated to post op pain and morphine consumption. Patients that had severe pain before surgery required 50% more morphine post-surgically.
- Goal is to decrease pre-op pain in order to decrease post op pain and narcotic utilization.

↑ Pre-op pain ⇒ ↑ Post-op pain ⇒ ↑ morphine usage

PROBLEM

There are 2 problem with the management of pain in the peri-operative setting:

1. When a patient comes in for their pre-surgical workup, they are taken off NSAID. At this time, every arthritic joint enters a painful flare state and pre-op pain has effectively been increased:
  - Why take off NSAID – worried about bleeding
  - LEESE – No worries about bleeding
  - Great efficacy in severe arthritic flares, efficacy in pain and inflammation with Bextra

∅ NSAID ⇒ add Bextra ⇒ prevents the arthritic flare ⇒ ↓ pre-op pain ⇒ ↓ post-op pain ⇒ reduce morphine usage/consumption

2. As soon as you make an incision, Cox 2 is expressed in the CNS. This starts the cascade of central sensitization of pain.
  - MAKAROWSKI-Bextra is the most effective Cox-2 at crossing the Blood Brain Barrier.
  - Bextra allows you to Pre-empt the central sensitization and to drive down any painful flares.

CLOSE:

Thus by using Bextra instead of an NSAID you can decrease your pre-op pain, have no worries of bleeding, Preempt the central pain cascade get better post op pain scores while decreasing narcotic utilization. Patient is able to ambulate quicker!

What do you think about this approach?

How do you currently manage NSAIDs prior to surgery – or bring out their patient education form. Lets look at how you currently managed NSAIDs prior to surgery... When are you in the OR next? Will you place those patients on Bextra before surgery?

Who else should see this data?

Who at the hospital should we notify?