Purdue Pharma CEO speaks on 'challenging, rewarding' tenure at OxyContin company

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STAMFORD — On June 22, 2017, Dr. Craig Landau was appointed CEO and president of an under-fire Purdue Pharma. The pressure on him and the company has only escalated since then. Landau took the top job amid a nationwide push for accountability for the opioid crisis that has unleashed a storm of litigation and grassroots unrest against the OxyContin maker. Two years on, the controversy shows no signs of abating, but the chief executive — who seldom speaks publicly beyond company-issued statements — said this week that he remains committed to leading the fast-changing firm.

"My first two years as CEO have been exceedingly challenging, but, at the same time, rewarding," Landau said, in an e-mailed response to questions from Hearst Connecticut Media. "As a physician, my top priority has been to identify and pursue opportunities for our company to help address the opioid crisis. Simultaneously, I have been focused on making changes to the business that would allow us to pursue more non-opioid opportunities today and in the longer term." The company declined to make Landau available for an interview. Messages left this week for a spokesperson for the Sackler family members who own Purdue were not returned.

Nationwide legal pressure.

Now 52, Landau took over after previously serving as the president and CEO of Purdue's Canadian business and as the company's chief medical officer. He has worked at Purdue since 1999 and also served 14 years in the U.S. Army.

When he became CEO, Purdue was facing a new wave of local and state lawsuits alleging that fraudulent OxyContin marketing had exacerbated the country's epidemic of opioid abuse. Some 218,000 Americans died from overdoses related to prescription opioids, between 1999 and 2017, according to the U.S. Centers for Disease Control and Prevention.

Two years later, the company is flooded with litigation. Today, 46 states, including Connecticut, are pursuing complaints, in addition to hundreds filed by cities and counties. About 1,800 local governments' lawsuits against Purdue and other opioid makers have been consolidated in a "multidistrict litigation" process in federal court in Cleveland. The first MDL trial is scheduled to start Oct. 21.

The complaints largely focus on accusations that predate Landau's arrival as CEO. Many of them, such as Connecticut's, name as defendants eight Sackler family members who own the company. But some of the lawsuits also implicate Landau. When he was the chief medical officer, Landau helped to develop the company's sales strategy and materials, according to Massachusetts' complaint. Since becoming CEO, he has overseen more than 5,000 visits by Purdue sales representatives to prescribers in the state, the lawsuit also said. Among other allegations, Massachusetts said that Landau drafted goals in 2011 that included supporting the approval of OxyContin for children.

In 2015, the U.S. Food and Drug Administration approved OxyContin for certain pediatric cases, with the new label stipulating that OxyContin should be used only for children 11 or older in severe pain who had already taken an opioid for at least five days. When the FDA made the decision, Purdue said that it would not promote OxyContin for those pediatric uses. Purdue and the Sacklers have denied Massachusetts' allegations, and they have filed motions to dismiss the Massachusetts complaint. Landau declined to comment on the pending lawsuits.

Under his leadership, the company has shown a willingness to settle. In the firm's largest payout of the past 10 years, it reached a $270 million agreement in March with Oklahoma to resolve that state's lawsuit. "The company has been fairly strategic in dealing with the lawsuits; I think they're waiting to see how things turn out with the MDL litigation," said Richard Ausness, a law professor at the University of Kentucky. "I think Landau has done about the best you can expect with the lawsuits, given the circumstances."

A Chapter 11 bankruptcy filing could materialize before the lawsuits are sorted out, according to a number of experts. The company has acknowledged exploring such a scenario in recent months — a move that would ostensibly help contain its liability. "Purdue continues to assess all options, but it is important to note that the company has not made any decisions regarding this matter," Landau said.

Earlier this month, another much-litigated opioid maker, Insys, filed for bankruptcy, days after agreeing to a $225 million settlement of federal criminal and civil cases alleging the company bribed doctors to prescribe its fentanyl-based pain drug.

“For Purdue, there are just too many lawsuits,” said Eric Snyder, chairman of the bankruptcy department at Manhattan-based law firm Wilk Auslander. “I don’t think they have enough time and money to defend the lawsuits and keep the business going.”

Under-fire outside the courts

Amid the glut of allegations of wrongdoing, Purdue officials maintain that the company has worked diligently to combat the epidemic of opioid abuse. In the past 20 years, the firm said it has partnered with law enforcement and other government agencies to advance more than 60 initiatives, costing a total of more than $1.5 billion, according to company data. “We are laser-focused on doing what is right to help society address the opioid-addiction crisis — including increasing access to naloxone,” a drug that can reverse opioid overdoses, and “developing more potent and longer-lasting overdose rescue options, funding youth education and more,” Landau said.

But those efforts have hardly quelled the criticism in or out of the courtrooms. Last summer, a number of protests took place outside Purdue’s downtown headquarters. “What I would like (Landau) to focus on — is their role in this epidemic and paying retribution for treatment, prevention and recovery support; and monies to pay for our children’s burials that we weren’t prepared to pay and support for the children left behind,” said Cheryl Juaire, a co-organizer of a demonstration last August and whose 23-year-old son died of a heroin overdose in 2011. “In all of these settlements and lawsuits, I have seen nothing in support of the children left behind” by parents who fatally overdose. Meanwhile, a number of corporate partners have distanced themselves, apparently fretful about the fallout from doing business with the company. The list includes JPMorgan Chase & Co., the country’s largest bank by assets, which had handled cash and bill payments for Purdue.

Major shifts

As the outrage persists over the company’s alleged role in the opioid crisis, Purdue has undergone sweeping organizational changes in the past two years. Last year, it stopped marketing its opioids to medical prescribers and disbanded its sales force. The sales team’s demise resulted in hundreds of layoffs. “While this change was extremely difficult for those affected, ultimately, it was the right thing to do,” Landau said of the end of the opioid marketing. The sales group was dissolved amid medical prescribers’ growing wariness of opioids and increasing competition from generic drugs. OxyContin sales totaled $1.8 billion in 2017, down from $2.8 billion five years earlier, according to data from health care analytics company Symphony Health Solutions.

Purdue is not abandoning opioids — Landau cited Pain Medicine journal data showing that nearly 18 million U.S. patients are taking long-term prescription opioids — but the company is increasingly focusing on other drug types. A new Purdue subsidiary gained the FDA’s approval in March for a drug called Adhansia XR, to treat attention deficit hyperactivity disorder (ADHD). Around the same time, another new Purdue subsidiary secured the FDA’s “orphan drug designation” for expedited reviews of drugs to, respectively, treat rare bile-duct cancer and an extremely rare type of leukemia. Also in March, Purdue announced an FDA fast-track designation for a “nalmefene hydrochloride” injection that would treat known or suspected opioid overdoses. The company said it would not profit from that medication. “Diversifying the product line is a smart thing to do,” said Angela Mattie, a professor in Quinnipiac University’s schools of business and medicine. “But, in trying to improve the reputation of the company, the train has left the station on that one. The public opinion of the company is a cry for accountability and further complicated by the pending legal cases.”

Looking ahead

As he enters his third year, Landau’s agenda will probably continue to be dominated by the litigation until it is resolved by trials or settlements.

Landau’s relationship with the Sacklers is more difficult to discern. In his responses to Hearst Connecticut Media, he did not comment on his interactions with the owners. All of the Sacklers have left the board in the past two years — with the last of them stepping down around the turn of the year. But they still own the company and likely still have the last word on executive personnel decisions.

In the first interview given by one of the Sackler defendants since they were named in the current round of lawsuits, David Sackler — a grandson of Purdue’s late co-founder Raymond Sackler and a former board member — said in a Vanity Fair profile published this week that his family should not be blamed for the opioid catastrophe. He did not mention Landau. At the same time, Landau said that he wants to continue tackling the opioid crisis and developing new Purdue products, focusing on non-opioid pain medications, central-nervous-system treatments and oncological projects. “I’m personally very excited about the prospects for our pipeline, as well as for the company, on the whole, going forward,” Landau said. “Those that work for Purdue are committed to seeing it through, so that, through our medicines, patients in need can receive the benefit they deserve.”

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IMPORTANT SAFETY INFORMATION

WARNING: ADDICTION, ABUSE AND MISUSE; RISK EVALUATION AND MITIGATION STRATEGY (REMS); LIFE-THREATENING RESPIRATORY DEPRESSION; ACCIDENTAL INGESTION; NEONATAL OPIOID WITHDRAWAL SYNDROME; CYTOCHROME P450 3A4 INTERACTION; and RISKS FROM CONCOMITANT USE WITH BENZODIAZEPINES OR OTHER CNS DEPRESSANTS

Addiction, Abuse, and Misuse
OXYCONTIN® exposes patients and other users to the risks of opioid addiction, abuse, and misuse, which can lead to overdose and death. Assess each patient's risk prior to prescribing OXYCONTIN and monitor all patients regularly for the development of these behaviors and conditions *[see Warnings and Precautions (5.1)]*.

Opioid Analgesic Risk Evaluation and Mitigation Strategy (REMS)
To ensure that the benefits of opioid analgesics outweigh the risks of addiction, abuse, and misuse, the Food and Drug Administration (FDA) has required a Risk Evaluation and Mitigation Strategy (REMS) for these products *[see Warnings and Precautions (5.2)]*.

Life-Threatening Respiratory Depression
Serious, life-threatening, or fatal respiratory depression may occur with use of OXYCONTIN. Monitor for respiratory depression, especially during initiation of OXYCONTIN or following a dose increase. Instruct patients to swallow OXYCONTIN tablets whole; crushing, chewing, or dissolving OXYCONTIN tablets can cause rapid release and absorption of a potentially fatal dose of oxycodone *[see Warnings and Precautions (5.3)]*.

Accidental Ingestion
Accidental ingestion of even one dose of OXYCONTIN, especially by children, can result in a fatal overdose of oxycodone *[see Warnings and Precautions (5.3)]*.

Neonatal Opioid Withdrawal Syndrome
Prolonged use of OXYCONTIN during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening if not recognized and treated, and requires management according to protocols developed by neonatology experts. If opioid use is required for a prolonged period in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available *[see Warnings and Precautions (5.4)]*.

Cytochrome P450 3A4 Interaction
The concomitant use of OXYCONTIN with all cytochrome P450 3A4 inhibitors may result in an increase in oxycodone plasma concentrations, which could increase or prolong adverse drug effects and may cause potentially fatal respiratory depression. In addition, discontinuation of a concomitantly used cytochrome P450 3A4 inducer may result in an increase in oxycodone plasma concentration. Monitor patients receiving OXYCONTIN and any CYP3A4 inhibitor or inducer *[see Warnings and Precautions (5.5), Drug Interactions (7), Clinical Pharmacology (12.3)]*.

Risks From Concomitant Use With Benzodiazepines Or Other CNS Depressants
Concomitant use of opioids with benzodiazepines or other central nervous system (CNS) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death *[see Warnings and Precautions (5.6), Drug Interactions (7)]*.

- **Reserve concomitant prescribing of OXYCONTIN and benzodiazepines or other CNS depressants for use in patients for whom alternative treatment options are inadequate.**
- **Limit dosages and durations to the minimum required.**
- **Follow patients for signs and symptoms of respiratory depression and sedation.**

CONTRAINDICATIONS

OxyContin is contraindicated in patients with:

- Significant respiratory depression
- Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment
- Known or suspected gastrointestinal obstruction, including paralytic ileus
- Hypersensitivity (e.g., anaphylaxis) to oxycodone.

WARNINGS AND PRECAUTIONS

Addiction, Abuse, and Misuse

- OxyContin contains oxycodone, a Schedule II controlled substance. OxyContin exposes users to the risks of opioid addiction, abuse, and misuse. Because extended-release products such as OxyContin deliver the opioid over an extended period of time, there is a greater risk for overdose and death due to the larger amount of oxycodone present.
- Although the risk of addiction in any individual is unknown, it can occur in patients appropriately prescribed OxyContin. Addiction can occur at recommended doses and if the drug is misused or abused.
- Assess each patient's risk for opioid addiction, abuse, or misuse prior to prescribing OxyContin, and monitor all patients receiving OxyContin for the development of these behaviors and conditions. Risks are increased in patients with a personal or family history of substance abuse (including drug or alcohol abuse or addiction) or mental illness (e.g., major depression). The potential for these risks should not, however, prevent the proper management of pain in any given patient. Patients at increased risk may be prescribed opioids such as OxyContin, but use in such patients necessitates intensive counseling about the risks and proper use of OxyContin along with intensive monitoring for signs of addiction, abuse, and misuse.

- Abuse or misuse of OxyContin by crushing, chewing, snorting, or injecting the dissolved product will result in the uncontrolled delivery of oxycodone and can result in overdose and death.
- Opioids are sought by drug abusers and people with addiction disorders and are subject to criminal diversion. Consider these risks when prescribing or dispensing OxyContin. Strategies to reduce these risks include prescribing the drug in the smallest appropriate quantity and advising the patient on the proper disposal of unused drug.

Opioid Analgesic Risk Evaluation and Mitigation Strategy (REMS)

- To ensure that the benefits of opioid analgesics outweigh the risks of addiction, abuse, and misuse, the Food and Drug Administration (FDA) has required a Risk Evaluation and Mitigation Strategy (REMS) for these products. Under the requirements of the REMS, drug companies with approved opioid analgesic products must make REMS-compliant education programs available to healthcare providers. Healthcare providers are strongly encouraged to do all of the following:
- complete a REMS-compliant education program,
- counsel patients and/or their caregivers, with every prescription, on safe use, serious risks, storage, and disposal of these products,
- emphasize to patients and their caregivers the importance of reading the Medication Guide every time it is provided by their pharmacist, and
- consider other tools to improve patient, household, and community safety.
- To obtain further information on the opioid analgesic REMS and for a list of accredited REMS CME/CE, call 1-800-503-0784, or log on to www.opioidanalgesicrems.com. The FDA Blueprint can be found at www.fda.gov/OpioidAnalgesicREMSBlueprint

Life-Threatening Respiratory Depression

- Serious, life-threatening, or fatal respiratory depression has been reported with the use of opioids, even when used as recommended, and if not immediately recognized and treated, may lead to respiratory arrest and death.
- While serious, life-threatening, or fatal respiratory depression can occur at any time during the use of OxyContin, the risk is greatest during the initiation of therapy or following a dosage increase. Closely monitor patients for respiratory depression, especially within the first 24-72 hours of initiating therapy with and following dosage increases of OxyContin.
- To reduce the risk of respiratory depression, proper dosing and titration of OxyContin are essential. Overestimating the OxyContin dosage when converting patients from another opioid product can result in a fatal overdose with the first dose.
- Accidental ingestion of even one dose of OxyContin, especially by children, can result in respiratory depression and death due to an overdose of oxycodone.

Neonatal Opioid Withdrawal Syndrome

- Prolonged use of OxyContin during pregnancy can result in withdrawal in the neonate. Neonatal opioid withdrawal syndrome, unlike opioid withdrawal syndrome in adults, may be life-threatening if not recognized and treated, and requires management according to protocols developed by neonatology experts. Observe newborns for signs of neonatal opioid withdrawal syndrome and manage accordingly. Advise pregnant women using opioids for a prolonged period of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available.

Risks of Concomitant Use or Discontinuation of Cytochrome P450 3A4 Inhibitors and Inducers

- Concomitant use with a CYP3A4 inhibitor, such as macrolide antibiotics, azole-antifungal agents, and protease inhibitors, particularly when an inhibitor is added after a stable dose of OxyContin is achieved, and discontinuation of a CYP3A4 inducer, such as rifampin, carbamazepine, and phenytoin, may increase plasma concentrations of oxycodone and prolong opioid adverse reactions, which may cause potentially fatal respiratory depression. Monitor patients closely at frequent intervals and consider dosage reduction of OxyContin until stable drug effects are achieved. Concomitant use of OxyContin with CYP3A4 inducers or discontinuation of a CYP3A4 inhibitor could decrease oxycodone plasma concentrations, decrease opioid efficacy or, possibly, lead to a withdrawal syndrome in a patient who had developed physical dependence to oxycodone. Monitor patients closely at frequent intervals and consider increasing the opioid dosage if needed to maintain adequate analgesia or if symptoms of opioid withdrawal occur.

Risks from Concomitant Use with Benzodiazepines or Other CNS Depressants

- Profound sedation, respiratory depression, coma, and death may result from the concomitant use of OxyContin with benzodiazepines or CNS depressants (e.g., non-benzodiazepines sedatives/hypnotics, anxiolytics, tranquilizers, muscle relaxants, general anesthetics, antipsychotics, other opioids, alcohol). Because of these risks, reserve concomitant prescribing of these drugs for use in patients for whom alternative treatment options are inadequate.
- If the decision is made to prescribe a benzodiazepine or other CNS depressant concomitantly with an opioid analgesic, prescribe the lowest effective dosages and minimum durations of concomitant use. In patients already receiving an opioid analgesic, prescribe a lower initial dose of the benzodiazepine or other CNS depressant than indicated in the absence of an opioid, and titrate based on clinical response. If an opioid analgesic is initiated in a patient already taking a benzodiazepine or other CNS depressant, prescribe a lower initial dose of the opioid analgesic, and titrate based on clinical response. Follow patients closely for signs and symptoms of respiratory depression and sedation.

- Advise both patients and caregivers about the risks of respiratory depression and sedation when OxyContin is used with benzodiazepines or other CNS depressants (including alcohol and illicit drugs). Advise patients not to drive or operate heavy machinery until the effects of concomitant use of the benzodiazepine or other CNS depressant have been determined. Screen patients for risk of substance use disorders, including opioid abuse and misuse, and warn them of the risk for overdose and death associated with the use of additional CNS depressants including alcohol and illicit drugs.
- The use of OxyContin in patients with acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment is contraindicated. OxyContin-treated patients with significant chronic obstructive pulmonary disease or cor pulmonale, and those with a substantially decreased respiratory reserve, hypoxia, hypercapnia, or pre-existing respiratory depression are at increased risk of decreased respiratory drive including apnea, even at recommended dosages of OxyContin.

Life-Threatening Respiratory Depression in Patients with Chronic Pulmonary Disease or in Elderly, Cachectic, or Debilitated Patients

- Life-threatening respiratory depression is more likely to occur in elderly, cachectic, or debilitated patients because they may have altered pharmacokinetics or altered clearance compared to younger, healthier patients.
- Monitor such patients closely, particularly when initiating and titrating OxyContin and when OxyContin is given concomitantly with other drugs that depress respiration. Alternatively, consider the use of non-opioid analgesics in these patients.

Adrenal Insufficiency

- Cases of adrenal insufficiency have been reported with opioid use, more often following greater than one month of use. If adrenal insufficiency is suspected, confirm the diagnosis with diagnostic testing as soon as possible. If adrenal insufficiency is diagnosed, treat with physiologic replacement doses of corticosteroids. Wean the patient off of the opioid to allow adrenal function to recover and continue corticosteroid treatment until adrenal function recovers.

Severe Hypotension

- OxyContin may cause severe hypotension including orthostatic hypotension and syncope in ambulatory patients. There is an increased risk in patients whose ability to maintain blood pressure has already been compromised by a reduced blood volume or after concurrent administration of certain CNS depressants drugs (e.g., phenothiazines or general anesthetics). Monitor these patients for signs of hypotension after initiating or titrating the dosage of OxyContin. In patients with circulatory shock, OxyContin may cause vasodilation that can further reduce cardiac output and blood pressure. Avoid the use of OxyContin in patients with circulatory shock.

Risks of Use in Patients with Increased Intracranial Pressure, Brain Tumors, Head Injury, or Impaired Consciousness

- In patients who may be susceptible to the intracranial effects of CO2 retention (e.g., those with evidence of increased intracranial pressure or brain tumors), OxyContin may reduce respiratory drive, and the resultant CO2 retention can further increase intracranial pressure. Monitor those patients for signs of sedation and respiratory depression, particularly when initiating therapy with OxyContin. Opioids may obscure the clinical course in a patient with a head injury. Avoid the use of OxyContin in patients with impaired consciousness or coma.

Difficulty in Swallowing and Risk for Obstruction in Patients at Risk for a Small Gastrointestinal Lumen

- There have been post-marketing reports of difficulty swallowing OxyContin tablets. These reports include choking, gagging, regurgitation, and tablets stuck in the throat. Instruct patients not to pre-soak, lick or otherwise wet OxyContin tablets prior to placing in the mouth, and to take one tablet at a time with enough water to ensure complete swallowing immediately after placing in the mouth.
- There have been rare post-marketing reports of cases of intestinal obstruction, and exacerbations of diverticulitis, some of which have required medical intervention to remove the tablet. Patients with underlying GI disorders such as esophageal cancer or colon cancer with a small gastrointestinal lumen are at greater risk of developing these complications. Consider use of an alternative analgesic in patients who have difficulty swallowing and patients at risk for underlying GI disorders resulting in a small gastrointestinal lumen.

Risks of Use in Patients with Gastrointestinal Conditions

- OxyContin is contraindicated in patients with known or suspected gastrointestinal obstruction, including paralytic ileus. The oxycodone in OxyContin may cause spasm of the sphincter of Oddi. Opioids may cause increases in the serum amylase. Monitor patients with biliary tract disease, including acute pancreatitis.

Increased Risk of Seizures in Patients with Seizure Disorders

- The oxycodone in OxyContin may increase the frequency of seizures in patients with seizure disorders, and may increase the risk of seizures occurring in other clinical settings associated with seizures. Monitor patients with a history of seizure disorders for worsened seizure control during OxyContin therapy.

Withdrawal

- Avoid the use of mixed agonist/antagonist (e.g., pentazocine, nalbuphine, and butorphanol) or partial agonist (e.g., buprenorphine) analgesics in patients who are receiving a full opioid agonist analgesic, including OxyContin. In these patients, mixed agonist/antagonist and partial agonist analgesics may reduce the analgesic effect and/or may precipitate withdrawal symptoms. When discontinuing OxyContin, gradually taper the dosage. Do not abruptly discontinue OxyContin.

Risks of Driving and Operating Machinery

- OxyContin may impair the mental or physical abilities needed to perform potentially hazardous activities such as driving a car or operating machinery. Warn patients not to drive or operate dangerous machinery unless they are tolerant to the effects of OxyContin and know how they will react to the medication.

Laboratory Monitoring

- Not every urine drug test for "opioids" or "opiates" detects oxycodone reliably, especially those designed for in-office use. Further, many laboratories will report urine drug concentrations below a specified "cut-off" value as "negative." Therefore, if urine testing for oxycodone is considered in the clinical management of an individual patient, ensure that the sensitivity and specificity of the assay is appropriate, and consider the limitations of the testing used when interpreting results.

ADVERSE REACTIONS

- OxyContin may increase the risk of serious adverse reactions such as those observed with other opioid analgesics, including respiratory depression, apnea, respiratory arrest, circulatory depression, hypotension, or shock.
- The most common adverse reactions (> 5%) reported by adult patients in clinical trials comparing OxyContin with placebo are constipation, nausea, somnolence, dizziness, pruritus, vomiting, headache, dry mouth, asthenia, and sweating.

Please read Full Prescribing Information, including Boxed Warning.