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| **From:** | Hoegstedt, Johan |
| **Sent:** | Monday, August 18, 2003 5:36 PM |
| **To:** | Campbell, Elaine; Buckanavage, Stephen R; Beamish, Don G; Lewis, Jerry P |
| **Cc:** | Page, Mark; Ross, Tom; Hatzipavlides, Harry; Scott, Mark S (Wilmington); Schwartz, Jack A; Purvis, Joseph; Jackson, Marianne; McCarthy, John A (Sales) |
| **Subject:** | FW: KOL ASSET Presentation.ppt |
| **Attachments:** | KOL ASSET Presentation.ppt |

CBLs and DBLs,

Last week, I had a chance to sit down with Jerry Lewis (AZ Onc. MD) and he shared his thoughts around the business. It was a wonderful chance to pick a very experienced individual's mind on different ways to effectively run an integrated commercial and scientific business. Many of his comments were around PREP activities (which in many ways reinforced many of the very positive experiences we had with core Seroquel faculty events held in HQ a few weeks back), KOL management, and clinical development. Following were some of his main points I heard (of course filtered through my own biases and filters), and please feel forward as you see beneficial to your appropriate team members:

**Advisory boards**: Many of these events seem to be extremely vendor driven. Examples Jerry's suggestions for how AZ can do better in building lasting relationships and a stronger presence could be:

- Dinner events and personal (AZ) welcomes with participants - no matter what low-budget venue is allowed.
- Have a core group of physicians and have the meetings scheduled on a regular basis.
- Rotate the attendance and add maybe 10-20% of the group yearly so that a few KOLs/Physicians are not seen as AZ employees/puppets.
- Have AZ physicians (FMP/Brand Team Physicians...) coordinate and lead more of the discussions vs. using the Med-Ed vendor for facilitation.
- Open up and share our plans, demand confidentiality, and make the participants feel like they are part of the organization for the day(s) and also between the meetings.
- Be open to suggestions by the group to develop complete breakthrough ideas and concepts.

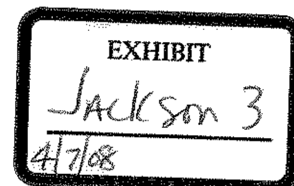
Jerry also mentioned the fact that we should have a set of core AZ brand slides that we consistently refer to and we should get copies of all the slides presented by guest speakers. We may want to coordinate these activities across the brand teams in Oncology where appropriate. I'm not completely up to date on the Advisory board policies (I guess we will all get there over the next few weeks) but it seems like there may be an opportunity to strengthen them even further based on some of Jerry's suggestions. For teams that have not tried the HQ experience - have them connect with Lynn Hagger or Kevin Hamill about the great Seroquel program.

**KOL management**: KOL management is one of the hot topics in the organization today and in some ways is very tied to the topic above and how we treat these people. There are so many initiatives in place to optimize this from many different functional areas. Attached is some draft work that was recently conducted by Medical Affairs. It seems as though each brand team has a slightly different approach and philosophy to the KOL management. The key point to me is that we coordinate these activities and that we have clear accountabilities on the team. The CBL/DBL must make it clear to the team who is responsible for this coordination and make sure that Medical Affairs is a critical player, or likely, leader in this coordination through the DMA.

For Oncology, it seems like we need to have a team sit down and coordinate all the activities currently in place from Champ (with John McCarthy) to Global coordination (by Steve Strand). Tom, maybe you can add this to our Onc franchise project list - attached is a early view from a project that MA are currently conducting with some important steps to consider.

**Clinical development/local clinical trials**. This is not an easy topic. Many of our KOLs are very interested in the IITs, but the real value of these programs could possibly in some cases be challenged, especially since they seem to be very resource intense for AZ's development organization. We must also ask ourselves questions like, "in what areas are we looking for signals vs. what areas are we pursuing for strategic importance" - the answer will clearly direct what approach we are taking. I believe Jerry thinks that we may have better business impact (based on more effective time mgt. and control) if we manage more of these trials internally (and AZ vs. a CRO or cooperative becomes the liaison with the investigator) or as phase IV (or IIIB when appropriate) with cooperatives and partners (again wherever possible AZ



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managed).

We should also look for ways to simplify recording and processes for the investigators (we many times set expectations far beyond FDA requirements) since they add time, costs, and frustrations without significant business value. Jerry also talked about going outside of the current paradigm of our clinical design. In Oncology especially, Jerry mentioned that many products may fail because we use our new agents as the last resort and we, therefore, may test products on the patient population with the lowest possible response rate. Some very effective compound's full potential may therefore never be fully evaluated.

Jerry, thanks for the discussion - please add and correct any key thoughts that I may have missed or misinterpreted.

Love to get your thoughts - not urgent though.

Johan

-----Original Message-----
**From:** Lewis, Jerry P
**Sent:** Friday, August 08, 2003 2:55 PM
**To:** Hoegstedt, Johan
**Subject:** KOL ASSET Presentation.ppt

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resentation.ppt (64.

Johan, thanks for the time today. Here is the summary of Trevor's first committee on KOL Asset Management. I believe it holds the template for management of Global Partners, Institutional alignment, Champs and KOL asset management.

Jerr



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