



Transcript of Paul Ridker, M.D.

Date: March 29, 2024

Case: Murray & Poole Enterprises, Ltd. -v- Institut de Cardiologie de Montreal

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WORLDWIDE COURT REPORTING & LITIGATION TECHNOLOGY

Transcript of Paul Ridker, M.D.
Conducted on March 29, 2024

1 (1 to 4)

1 UNITED STATES PATENT AND TRADEMARK OFFICE 2 ----- 3 BEFORE THE PATENT TRIAL AND APPEAL BOARD 4 ----- 5 MURRAY & POOLE ENTERPRISES LTD., 6 Petitioner, 7 v. 8 INSTITUT DE CARDIOLOGIE DE MONTREAL, 9 Patent Owner. 10 ----- 11 Case No. IPR2023-01064 12 13 Videotaped Deposition of 14 PAUL RIDKER, M.D. 15 Conducted Virtually 16 Friday, March 29, 2024 17 8:58 a.m. EDT 18 19 20 Job No.: 529936 21 Pages: 1 - 244 22 Reported by: Cassidy Western, RPR	1 A P P E A R A N C E S 2 ON BEHALF OF THE PETITIONER, MURRAY & POOLE 3 ENTERPRISES LTD.: 4 KEVIN LAURENCE, ESQUIRE 5 MATTHEW PHILLIPS, ESQUIRE 6 LAURENCE & PHILLIPS IP LAW 7 1050 Connecticut Avenue, N.W., Suite 500 8 Washington, D.C. 20036 9 (202) 558-6180 10 and 11 JOANNA BROUGHER, ESQUIRE 12 TOM SIEPMANN, Ph.D. 13 ANNA HILLIER, ESQUIRE 14 BIOPHARMA LAW GROUP, PLLC 15 17 Royale Drive 16 Fairport, NY 14450 17 (617) 699-2931 18 19 20 21 22
1 Videotaped Deposition of PAUL RIDKER, M.D., 2 conducted virtually. 3 4 5 6 7 8 Pursuant to notice, before Cassidy Western, 9 RPR, Notary Public in and for the Commonwealth of 10 Pennsylvania. 11 12 13 14 15 16 17 18 19 20 21 22	1 A P P E A R A N C E S (continued) 2 ON BEHALF OF THE PATENT OWNER, INSTITUT DE 3 CARDIOLOGIE DE MONTREAL: 4 MATTHEW T. WILKERSON, ESQUIRE 5 ARENTFOX SCHIFF LLP 6 233 South Wacker Drive, Suite 7100 7 Chicago, IL 60606 8 (312) 258-5500 9 10 ALSO PRESENT: 11 Sue Pybas, A/V Technician 12 Kylan Barry, Videographer 13 14 15 16 17 18 19 20 21 22

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1 E X H I B I T S (continued)	1 THE VIDEOGRAPHER: Here begins media
2 RIDKER DEPOSITION EXHIBIT PAGE	2 number one in the videotaped deposition of
3 Exhibit 8 Clinicaltrials.gov Colchicine 147	3 Dr. Paul Ridker in the matter of Murray & Poole
4 Cardiovascular Outcomes Trial Record	4 Enterprises Ltd. v. Institut de Cardiologie de
5 History Tab	5 Montreal in the United States Patent and Trademark
6 Exhibit 9 COLCOT Clinical Research Protocol, 151	6 Office before the Patent Trial and Appeal Board,
7 Protocol #MHIPS-003	7 Case Number IPR2023-01064.
8 Exhibit 10 United States Patent 154	8 Today's date is March 29th, 2024. The
9 Number 10,206,891	9 time on the video monitor is 8:58 a.m. Eastern
10 Exhibit 11 New England Journal of Medicine, 164	10 Time. The remote videographer today is Kylan
11 "Antiinflammatory Therapy with	11 Barry, representing Planet Depos. All parties of
12 Canakinumab for Atherosclerotic	12 this video deposition are attending remotely.
13 Disease"	13 Would counsel please voice-identify
14 Exhibit 12 2017 European Society of 176	14 themselves and state whom they represent.
15 Cardiology Guidelines for the	15 MR. WILKERSON: Taking the deposition
16 management of acute myocardial	16 today is Matthew Wilkerson of ArentFox Schiff LLP,
17 infarction in patients presenting	17 and I'm on behalf of the Patent Owner, Montreal
18 with ST-segment elevation	18 Heart Institute.
19 Exhibit 13 Clinicaltrials.gov, "Colchicine 183	19 MR. LAURENCE: Kevin Laurence of
20 for Prevention of Vascular	20 Laurence & Phillips IP Law, representing
21 Inflammation in Non-cardio Embolic	21 Murray & Poole.
22 Stroke (CONVINCE)"	22 MS. BROUGHER: Joanna Brougher of
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9 1 BioPharma Law Group, representing Murray & Poole. 2 MS. HILLIER: Anna Hillier of BioPharma 3 Law Group, representing Murray & Poole. 4 MR. PHILLIPS: Matthew Phillips of 5 Laurence & Phillips IP Law, also representing the 6 Petitioner. 7 THE VIDEOGRAPHER: The court reporter 8 today is Cassidy Western, representing Planet 9 Depos. The witness will now be sworn. 10 PAUL RIDKER, M.D., 11 of lawful age, being first duly sworn or affirmed 12 to testify to the truth, the whole truth, and 13 nothing but the truth, was examined and testified 14 as follows: 15 EXAMINATION BY COUNSEL FOR THE PATENT OWNER, 16 INSTITUT DE CARDIOLOGIE DE MONTREAL 17 BY MR. WILKERSON: 18 Q Good morning, Dr. Ridker. As you just 19 heard, my name is Matt Wilkerson, and I represent 20 Montreal Heart Institute in this matter. And 21 before we proceed, are you okay if -- if 22 throughout our deposition today, if that also is	11 1 being litigated by a third-party group. 2 Q And was that litigation in district 3 court? 4 A I know that at some point in the -- so I 5 know that at some point in the process I had to go 6 down to North Carolina to, I believe -- I -- I 7 actually don't remember. It -- it was -- it was a 8 big courtroom. 9 Q Yeah. No problem. 10 Just going to go through some ground 11 rules for the deposition today, and I'm sure 12 you've heard some of these before, but I think 13 it's a good refresher for everyone. 14 So firstly, the court reporter will be 15 taking down everything we say, and it's beneficial 16 for everyone here if we have a clear record. So 17 for each question, we will need a verbal response. 18 Do you understand that? 19 A I do. 20 Q And we'll both try our best not to talk 21 over each other. I know that can be difficult 22 with Zoom. But we'll do our best. So I will wait
10 1 abbreviated to MHI? 2 A Oh, that's fine. 3 Q Okay. Can you please state your full 4 name for the record? 5 A Paul M. Ridker. 6 Q Can you also please state your address 7 for the record? 8 A 1264 Beacon Street, Apartment 6, 9 Brookline, Massachusetts 02446. 10 Q Thank you. 11 Dr. Ridker, have you been deposed 12 before? 13 A Yes. 14 Q And in those previous depositions, have 15 those been in patent matters? 16 A Yes. 17 Q Approximately how many times have you 18 been deposed in a patent matter? 19 A Once. 20 Q Okay. And what was the nature of that 21 have case? 22 A Those were my own patents that were	12 1 until you've given your full answer before asking 2 my next question, and I ask that you do the same, 3 wait until I complete my question to answer. Is 4 that fair? 5 A Sounds like a good idea. 6 Q Okay. And it's also important that you 7 understand all my questions before you answer, so 8 you can certainly ask for clarification if you 9 need it. Okay? 10 A No problem. 11 Q However, if you do answer a question, 12 I'm going to assume that you understood the 13 question. Is that fair? 14 A I understand. 15 Q Okay. And then throughout the day, we 16 can certainly take breaks as you need. And that's 17 fine. Go ahead and ask. Just the only thing 18 there is make sure you're not doing so in the 19 middle of a question and an answer. So if we have 20 a question pending, we'll answer it and then we 21 can go take our -- our 10-minute break or whatever 22 is needed. Okay?

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13 1 A I understand. 2 Q All right. And another -- another item 3 just to cover is -- is interacting with your 4 counsel. You know, they -- they may throughout 5 the day, lodge -- lodge objections to certain 6 questions. However, I just ask that you -- you 7 still need to answer those questions unless 8 counsel advises you not to on the basis of 9 privilege. Do you understand that? 10 A I do. 11 Q Okay. And, Dr. Ridker, you're here to 12 give full and honest testimony today? 13 A I am. 14 Q Are there any reasons you can't give 15 complete and truthful answers such as medications 16 or anything like that? 17 A No. 18 Q Okay. I just want to talk a little bit 19 about what you did to prepare for today. Can you 20 generally tell me, for this deposition, what did 21 you do to -- to prepare yourself? 22 A I've been a -- a research investigator	15 1 Q Okay. And you said you recently 2 reviewed your own declaration? 3 A I did. 4 Q Did you review any other documents to 5 prepare -- prepare for today? 6 A Yes. 7 Q Okay. And was that with counsel? 8 A Some with counsel and some on my own. 9 Q Okay. And what were the documents that 10 you reviewed on your own? 11 A I reread some of the manuscripts that 12 cover these issues so they'd be fresh in my mind. 13 Q And when you refer to "these issues," 14 are you referring to treatment with low-dose 15 colchicine? 16 A Yes. 17 Q And specifically cardiovascular 18 treatment with low-dose colchicine? 19 A Most of the papers that dealt with 20 cardiovascular disease, yes. 21 Q Okay. Did you speak with anyone other 22 than your counsel to prepare for today?
14 1 in this arena for over 35 years, so I know a great 2 deal about the past history of the field and how 3 it evolved. So some of that is just lived 4 experience. And then the process of this 5 deposition, I sat with attorneys to review 6 specific documents. And then most recently, I 7 reviewed my own declaration. And then yesterday 8 met with counsel here to sort of go over basic 9 things. 10 Q Okay. And you said you reviewed 11 specific documents with -- with attorneys. Would 12 that be the attorneys that are on the Zoom call 13 today? 14 A Yes. 15 Q Okay. And approximately how long did 16 you meet with those attorneys? 17 A Yesterday? Five or six hours. 18 Q Okay. And before yesterday in 19 preparation for this deposition? 20 A We had, I think, two phone calls, maybe 21 each lasted an hour and a half. Something like 22 that.	16 1 A No. 2 Q Did you review Dr. Ardehali's 3 declaration to prepare for today? 4 A I did receive that, and I did read it. 5 Q Okay. And did you also review 6 Mr. Cruitt's expert declaration to prepare for 7 today? 8 A That one is not ringing a bell. 9 Q Okay. So I'll -- does that mean you 10 also did not ever meet with Mr. Cruitt? 11 A I'm not sure I know who Mr. Cruitt is. 12 Q Okay. Did you speak with anyone at 13 Murray & Poole to prepare for today? 14 A For today, no. I'm -- other than the 15 counsel that's in -- in the room with me here. 16 Q And then, just generally, just to kind 17 of close the loop, is there anything else you can 18 think of that you did to prepare for your 19 deposition? 20 A No. 21 Q Okay. Stepping back a little bit, and 22 it's probably going back almost -- almost, you

17 1 know, close to a year now, but how did you first 2 become involved in this case? 3 A I'm an investigator in the field of 4 inflammation atherosclerosis. My own research 5 group has been involved in this arena for, as I 6 said, more than 30 years. I -- I think as far as 7 this case is concerned, the initial contact was 8 from -- actually, I don't recall who the initial 9 contact was from. But I know a lot about the 10 arena and it made sense. 11 Q Okay. So before submitting your 12 declaration for this case, someone on behalf of 13 the petitioner contacted you. Is that right? 14 A Can you explain what you mean by that? 15 Q Sure. So sometime before you submitted 16 your declaration in this case, someone on behalf 17 of Murray & Poole, who is also the petitioner in 18 this matter, contacted you seeking -- seeking 19 your -- your work? 20 A Petitioner in this case means who? 21 Q Murray & Poole. 22 A Oh, okay. Yes, I was contacted to see	19 1 Murray & Poole prior to your -- to your retention 2 in this case? 3 A There was another law firm involved 4 earlier on, but that -- I -- I don't know if 5 that's Murray & Poole or not honestly. 6 Q Okay. And I'll -- I'll probably 7 mispronounce this. But are you familiar with a 8 company called Agepha? Agepha? 9 A Yes, I am. 10 Q Okay. And do you have a relationship 11 with that entity? 12 A Yes, I do. I am a consultant for 13 Agepha. 14 Q Okay. And how long have you been a 15 consultant for Agepha? 16 A Probably three or four years. 17 Q Okay. Do you have any knowledge about 18 the relationship between Agepha and 19 Murray & Poole? 20 A I have a vague sense that they're 21 somehow subsidiaries, one of the other, of that 22 sense.
18 1 if I could help in this case. 2 Q And it was by Murray & Poole. There 3 was -- I guess -- here, let me rephrase this. 4 There wasn't some sort of third-party 5 expert contracting agency that put you in contact? 6 A No. 7 Q Okay. Great. 8 A That's what you're asking about. Okay. 9 Q And you -- you're billing Murray & Poole 10 for your work in this case. Correct? 11 A I am. 12 Q Okay. What is your rate that you're 13 billing Murray & Poole? 14 A \$600 an hour. 15 Q Okay. To -- to date, approximately how 16 much have you billed to Murray & Poole for this 17 case? 18 A On this case? 19 Q Yes. 20 A I'm not sure -- I'm not sure I submitted 21 any bill so far. 22 Q Okay. Did you have any relationship to	20 1 Q Okay. And would you consider your -- 2 your consulting role with Agepha to be an advisory 3 role? 4 A Yes. 5 Q Okay. Would you also say you have a 6 teaching role with them? 7 A A teaching role? 8 Q Do you teach other physicians about the 9 use of Agepha products? 10 A In my general academic life, I often 11 teach other physicians about a variety of issues 12 in inflammation biology. That certainly would 13 include colchicine. 14 Q What about as part of a speakers' 15 bureau? 16 A So I'm not part of any formal speakers' 17 bureau, but I have given many lectures, you know, 18 on a regular basis as part of my professional 19 duties for Harvard Medical School, for CME 20 companies, and some of those would not -- I 21 wouldn't be surprised if they were sponsored by 22 many different people. Perhaps including Agepha.

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21 1 That wouldn't surprise me. 2 Q Do you receive compensation from Agepha 3 for your consulting services? 4 A I do. 5 Q Approximately how much have you received 6 from Agepha? 7 A I -- I receive \$25,000 a year as a 8 regular -- yep. 9 Q Okay. And so that would be \$25,000 a 10 year for each of the last, I think you said three 11 to four years. Is that right? 12 A That sounds right, yeah. 13 Q Okay. And is that work that you do for 14 Agepha to support the marketing of LoDoCo? 15 A Well, they actually, as far as I know, 16 are only now beginning the marketing of LoDoCo. 17 For the -- most of the relationship, it was trying 18 to understand the science for them, what the 19 opportunities might be, things of that nature. 20 Q Okay. Have you received any research 21 funding from Agepha? 22 A No.	23 1 Q Okay. And are you holding yourself out 2 to be an expert in anything other than cardiology? 3 A I'm an expert in raising Golden 4 Retrievers, but I'm not sure that's relevant here. 5 Q When it comes to Golden Retrievers, it's 6 always relevant. 7 But we'll -- we'll just -- we'll just 8 kind of walk through a few of them and make sure 9 we -- we're on the same page. 10 So you're not a chemist. Right? 11 A Correct. 12 Q And you're not holding yourself out 13 as -- as an expert in chemistry? 14 A Correct. 15 Q Okay. And you're not holding yourself 16 out as an economist? 17 A Correct. 18 Q Okay. You're not holding yourself out 19 as an expert in statistics? 20 A I actually do have statistical training. 21 I have a master's degree in public health. And 22 I'm an epidemiologist by training, so I have a
22 1 Q Okay. Do you own any stock in Agepha? 2 A No, but I do have an -- a very minor 3 equity position in another subsidiary of theirs. 4 Q And what subsidiary is that? 5 A It's called Upton. 6 Q Okay. And was that equity share granted 7 to you by Upton or by Agepha? 8 A I'm not sure. I -- I mean, to me, 9 they're -- I believe they're related entities, so. 10 Q Okay. So let's just talk a little bit 11 about -- about you, and you mentioned a couple 12 times your experiences in cardiology. And you're 13 holding yourself out to be an expert in this case? 14 A For legal -- I mean, yes, I guess. I 15 mean -- 16 Q Okay. And do you consider yourself an 17 expert in cardiology? 18 A I am a practicing cardiologist. 19 Q Are you -- are you holding yourself out 20 to be an expert in cardiology for this case? 21 A I -- I have knowledge of cardiovascular 22 medicine, yes.	24 1 pretty good understanding of statistics. It would 2 not be at a level of a Ph.D. statistician, but I 3 think for clinical researchers, my knowledge is -- 4 is actually quite sophisticated. 5 Q Okay. I appreciate that. Do you -- do 6 you consider yourself, for the purposes of this 7 case, an expert in statistics? 8 A I don't know what the legal definition 9 of "expert" is. Again, I write a lot of 10 manuscripts that have major statistical issues in 11 them, and I rely on Ph.D. biostatisticians and 12 professors of biostatistics to help me do that. I 13 do think compared to most people who are in my 14 research arena, I would be considered relatively 15 sophisticated. 16 Q Okay. Your declaration in this case 17 effectively includes your -- your opinions. Is 18 that right? 19 A Yes. 20 Q Okay. And you're giving those opinions 21 to those involved in this case, including the 22 Patent Trial and Appeal Board as an expert. Is

25 1 that right? 2 A Yes. 3 Q And in that analysis, are you 4 considering yourself as an expert in statistics? 5 A To answer your question once again, I 6 think that I'm not a Ph.D. in biostatistics, but I 7 think I'm quite sophisticated for clinical 8 researchers in this arena. I certainly have a 9 master's level training in this field. 10 Q I guess I can -- I can tweak that a 11 little bit. Does -- does your experience in 12 statistics, were you implementing that in your 13 analysis for this case? 14 A Can you restate that? 15 Q Yeah. Are any of your opinions for this 16 case dependent upon your experience in statistics? 17 A My opinions in this case are based on my 18 knowledge of how research is done, and that 19 includes, among many things, statistical analyses. 20 Q Okay. And you're not a pharmaceutical 21 formulator. Is that right? 22 A Correct.	27 1 I'm not sure that's what you're asking. 2 Q No, that's -- that's fine. That's more 3 than a reasonable answer. 4 And I think we'll agree here you're not 5 holding yourself as an expert in patent law. Is 6 that right? 7 A Correct. 8 Q Okay. Do you consider yourself an 9 expert in FDA approval? 10 A I have presented clinical trial data to 11 the FDA. Sometimes of clinical trials I myself 12 have run and conducted. I have served on FDA 13 advisory panels over the years, and I have served 14 as experts to people going to the FDA. So I 15 certainly know a reasonable amount about how the 16 FDA works, yes. 17 Q Okay. But you're not an expert in FDA 18 regulatory law. Right? 19 A I -- correct. I do not have 20 expertise -- 21 Q Okay. 22 A -- in FDA regulatory law.
26 1 Q Okay. And you've never made 2 pharmaceutical formulation? 3 A Correct. 4 Q All right. Have you ever selected 5 excipients that are used in a pharmaceutical 6 formulation? 7 A I'm not even sure I know what an 8 excipient is. 9 Q Okay. Have you ever selected a lead 10 compound in connection with development of a drug? 11 A Can you -- can you define what 12 "selection" means? 13 Q Sure. Have you ever chosen which 14 compound to use as the active ingredient in 15 developing a drug? 16 A I'm not sure whether you're asking about 17 a chemistry development or a clinical trial 18 development. I work in the latter sphere, so I do 19 design and run many clinical trials looking at 20 medications, and in that context, I -- I do -- I 21 often select the -- the medication I'm interested 22 in.	28 1 Q Have you ever been a principal 2 investigator on a trial that resulted in an 3 FDA-approved drug? 4 A Yes. 5 Q And what drug is that? 6 A Easiest one to talk about is a drug 7 called Rosuvastatin. It's a lipid-lowering drug 8 that was made by AstraZeneca. I was the principal 9 investigator of a nearly 18,000-patient randomized 10 double-blind, placebo-controlled trial of -- of 11 that drug. 12 Q Okay. And you said the easiest one to 13 talk about. Is that right? 14 A Yes. 15 Q Okay. So does that mean there are other 16 drugs that you were the principal investigator 17 that received FDA approval? 18 A No. The reason I said that is that I 19 have presented other drugs to the FDA. The one 20 I -- the one I was thinking of was a drug called 21 canakinumab, which is an anti-inflammatory drug. 22 But for a variety of commercial reasons, that drug

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29 1 is being used in oncology rather than cardiology 2 at this point. 3 Q Okay. Do you consider yourself an 4 expert in clinical trials? 5 A Yes. 6 Q Okay. Let's go ahead, and you can take 7 from the binder what is marked as Tab 1. 8 MR. WILKERSON: And also the court 9 reporter can mark Tab 1, the Ridker declaration, 10 as Ridker Exhibit 1. 11 (RIDKER Exhibit 1 was marked for 12 identification and is attached to the transcript.) 13 Q And let me know when you have that 14 document ready. 15 A Give me one second. 16 Q Yeah. 17 A I've got to rearrange the table here a 18 little bit. 19 Q No problem. 20 A Okay. I have what looks like a copy of 21 my declaration in front of me. 22 Q Okay. That's my -- my very next	31 1 prepared back in June of 2022. 2 Q Okay. Do you have any updates to this 3 version of your CV? 4 A Yes. 5 Q And generally speaking, what would those 6 updates be? 7 A It would be more publications as they 8 accrue. And I see this is actually my old home 9 address. We moved about a year ago. I think 10 mostly it would be new publications and things 11 like that. 12 Q Okay. Are any of the new publications 13 since this CV for low-dose colchicine in the 14 treatment of the different version of "CV," 15 cardiovascular events? 16 A I'm sorry. Can you restate that? 17 Q Yeah. Are any of the new papers since 18 you published this regarding low-dose colchicine 19 for the treatment and prevention of CV events? 20 A Since 2022, yeah, they probably are. 21 Q Okay. Do you know what those references 22 are?
30 1 question. 2 Do you recognize this document? 3 A Yes. 4 Q Yeah. And what is it? 5 A It's a copy of my declaration in this 6 case. 7 Q Okay. Great. 8 Let's turn towards the back of this 9 document to page 136. 10 A Okay. 11 Q And are you at page 136? 12 A Yes. Yes. 13 Q Okay. And -- 14 A Just one second. 15 Q Yeah. 16 A Can I take the clip off this thing? 17 Okay. One second. I'm going to rearrange a 18 second time here. A little more room. 19 Okay. We're good. 20 Q Okay. And is this an accurate copy of 21 your CV? 22 A It looks to be a copy of my CV that --	32 1 A One is a review article written in the 2 journal American College of Cardiology that came 3 out sometime this past year. There's a paper 4 about safety of low-dose colchicine, which 5 actually I don't think is technically published 6 yet. It's coming out relatively soon. And I 7 probably have written some commentary-type, 8 editorial-type things. Those are the ones that 9 come to mind right away. 10 Q Okay. Dr. Ridker, what year did you 11 become board certified in internal medicine? 12 A I'd have to go look it up. It's a long 13 time ago. 14 Let's see. Looks like 1988. 15 Q Okay. And what year did you become 16 board certified in cardiology? 17 A Looks like 1991. 18 Q Okay. And is it fair to say that your 19 opinions in this case are based on your education, 20 training, background, and experience? 21 A Yeah. 22 Q Okay. And then you also considered

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33 1 certain materials that you cited in your 2 declaration as well. Is that right? 3 A Yes. 4 Q Okay. And you already mentioned you 5 currently are employed at Harvard Medical School 6 and Brigham and Women's Hospital. Is that right? 7 A Yes. I have the distinct honor of 8 -serving as the Eugene Braunwald professor of 9 medicine at the Harvard Medical School, and I run 10 the Center for Cardiovascular Disease Prevention 11 at the Harvard-affiliated Brigham and Women's 12 Hospital. 13 Q Do you currently treat patients? 14 A I currently read echocardiograms for the 15 hospital as my current patient care 16 responsibilities. I had a cardiology clinic for 17 some 30 years, which I stopped doing a few years 18 ago. 19 Q Okay. When you had your cardiology 20 clinic, approximately how many patients did you 21 treat, say, per month? 22 A I had clinic one day a week, so, you	35 1 days, which is, you know, almost 40 years ago, 2 I've read echocardiograms for the hospital. I 3 continue to do that. 4 Early in my career, I had a great deal 5 more clinical responsibilities, even in the middle 6 part of my career when I had the outpatient clinic 7 that I was referring to. But early in my career, 8 I did lots of clinical work for various purposes. 9 Q And then I guess just to close the loop 10 on that, throughout your career, you've 11 transitioned from having a lot of clinical work to 12 now less clinical work than you did in the middle 13 and early parts of your career? 14 A Oh, absolutely. Thank goodness. 15 Q Okay. And across your -- your career, 16 have the type of patients changed at all? 17 A Yeah, I guess they have. Early -- early 18 in my career, when I was a young staff 19 cardiologist, you saw everything that came in. As 20 my own research career developed in the area of 21 atherosclerosis, I would see more patients with 22 atherosclerotic disease as an issue, and there are
34 1 know, I'm just guessing 10 to 15 patients on a 2 day, something like that. 3 Q Okay. And all those patients had some 4 form of cardiovascular disease? 5 A Well, a general cardiologist sees a wide 6 range of different kinds of cardiovascular issues. 7 Sometimes, patients also use you as their general 8 internist. But in general, it's a cardiology 9 clinic. 10 Q Okay. And then based on your previous 11 answer, would you agree with me that the amount of 12 patients that you see has changed over the course 13 of your career? 14 A The amount? What do you mean by that? 15 Q Well, before, you said that now for the 16 last couple years -- 17 A Oh, okay. 18 Q You read -- you read echocardiograms. 19 Right? 20 A So I am -- in addition to being a 21 cardiologist, I have a subspecialty training in 22 echocardiography. So ever since my fellowship	36 1 some lipid-related diseases that fit in that 2 window. 3 As commonly happens over time, 4 particularly if you're a subspecialist, you tend 5 to see a smaller, narrower window of patients over 6 time, and that's a pretty natural occurrence. 7 Q Okay. And -- and you mentioned this, 8 but you also work as a researcher. Is that right? 9 A Yes. Yes. 10 Q And is a majority of your professional 11 time spent on research? 12 A Yes, it is. 13 Q Okay. And throughout your career, do 14 you have a particular area of focus for your 15 research? 16 A Yeah. My children think I'm quite 17 boring because I really studied one question 18 fundamentally for 35 to 40 years, which is what is 19 the fundamental role of inflammation in this 20 process of atherosclerosis. It's pretty much been 21 focused probably 80 percent of the time on that. 22 Q When you think about that 80 percent of

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37 1 the time, does that also include, you know, 2 authoring papers, book chapters, et cetera? 3 A Yes. 4 Q Okay. And then looking at your CV, 5 you've also had experience working on editorial 6 boards. Is that right? 7 A Yes. 8 Q Okay. And that includes being on the 9 editorial board for the European Heart Journal 10 from 2006 to 2011? 11 A Yes. 12 Q Okay. And would you say that you're 13 knowledgeable about the procedures for submission 14 and publication with the European Heart Journal? 15 A With most journals, I would say it's 16 relatively similar. Yeah. 17 Q Okay. And you've also been a named 18 author on approximately 1,000 articles throughout 19 your career. Is that right? 20 A Sounds right. 21 Q Okay. And on some of those articles, 22 you're the first-named author. Is that right?	39 1 term, but do you have an understanding of what the 2 corresponding author's role is? 3 A Yes. 4 Q Okay. What is that understanding? 5 A Well, again, in my research unit, the 6 corresponding author is either the first -- 7 typically either the first author or the senior 8 author, the last author. It literally is the 9 person who's filling out the forms at the journal, 10 who's doing the correspondence with the journal, 11 who is, you know, running around getting the 12 signatures from the co-authors and the conflict of 13 interest forms, and all that sort of thing. And 14 it's the author that, you know, if people want to 15 correspond with, it's usually your email that's 16 listed. 17 Q Are you aware of any requirements that 18 the corresponding author be either the first or 19 last-named author? 20 A I don't think it's required, no. 21 Q Okay. 22 MR. WILKERSON: Can we go to Tab 18,
38 1 A Yes. 2 Q And then on others, you're obviously 3 not. Is that right? 4 A Yes. On others, I'm -- 5 Q Yeah. 6 A -- last author, and sometimes I'm the 7 middle author, yes. 8 Q And in some of those articles, you're 9 designated as the corresponding author. Is that 10 right? 11 A Probably. I'd have to go look. But 12 usually in our -- in the way we do things is that 13 the senior author in our system is you're 14 typically the corresponding author. I don't -- I 15 don't think -- I -- I could look, but I doubt -- I 16 doubt I'm listed as a corresponding author; I'm 17 probably a middle author. 18 Q Would you say you're knowledgeable about 19 the typical submission and publication process for 20 articles in the cardiology space? 21 A Yes. 22 Q And we already kind of mentioned this	40 1 1-8? And if that could be marked as Ridker 2 Exhibit 2. 3 (RIDKER Exhibit 2 was marked for 4 identification and is attached to the transcript.) 5 THE WITNESS: Matt, can I put my -- 6 the -- the -- this -- my -- this -- my thing away? 7 I have limited space here, so can I -- 8 BY MR. WILKERSON: 9 Q Yeah, set your declaration to the side. 10 Generally, that one we will be referring to 11 multiple times throughout today, so I don't know 12 if you want to put it too far away. 13 A All right. 14 MR. LAURENCE: Was it Tab 18? 15 MR. WILKERSON: Yeah, Tab 18. And we'll 16 be marking this as Ridker Exhibit 2. The European 17 Heart Journal's instructions to authors. 18 Q And whenever you have -- do you have 19 that document, Dr. Ridker? 20 A Yes. It's right in front of me. 21 Q Okay. And do you recognize this 22 document at all?

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41 1 A I might have read something similar to 2 it in other journals, or this journal. But I 3 don't recognize this one, per se, no. But. 4 Q Okay. Do you see at the top there's 5 kind of a title General Instructions, European 6 Heart Journal, Oxford Academic? 7 A Yes. 8 Q Do you see that? 9 A Yes. 10 Q Okay. 11 A Yes. 12 Q And then at the bottom of the page, do 13 you see the footer with the URL? 14 THE WITNESS: This is what he means? 15 Yes. 16 BY MR. WILKERSON: 17 Q And do you see the "eurheartj" in the 18 URL? 19 A Can you show me on the screen where I'm 20 supposed to look? 21 Q Yeah, certainly. In the URL in the 22 footer, we've got kind of the -- the leader then	43 1 Q Okay. Turn to page 5, and we're going 2 to be looking at the bottom of the page here. Do 3 you see kind of the header that says "Instructions 4 for the corresponding author"? 5 A Okay. My page 5 is different than 6 your -- oh, wait a minute. Hang on. Again, show 7 me with your little cursor where I'm supposed to 8 go to. 9 Q Yeah, "Instructions for the" -- 10 A Oh, yes. 11 Q -- "corresponding" -- 12 A I see it. 13 Q -- "author" -- 14 A Yes, I now see it. 15 Q Okay. And then do you see there's four 16 bullets below that? 17 A Yes. 18 Q That continue onto page 6, I suppose 19 is -- is the fair way to describe it. Do you see 20 those four bullets? 21 A Yes. 22 Q Okay. And do you see the second bullet
42 1 academic.oup.com -- 2 A Yeah. 3 Q -- slash, and then it says e-u-r as 4 in -- and then h-e-a-r-t-j. Do you see that? 5 A I do. 6 Q Okay. And do you -- would you 7 understand that to mean "European Heart Journal"? 8 A If you say so, yeah. I mean. 9 Q That's fair. 10 And then if you go up to the top of this 11 page, do you see "About the Journal"? 12 A Yes. 13 Q And that's referring to the European 14 Heart Journal. Right? 15 A Yes. 16 Q Okay. And that's the journal that you 17 served on the editorial board for? 18 A I have served on the editorial board of 19 several journals including this one, yes. 20 Q Okay. And have you ever been published 21 in the European Heart Journal? 22 A Yes.	44 1 there? 2 A Yes. 3 Q And that doesn't say include the first 4 author's last name, does it? 5 A I'm sorry. Can -- can you -- 6 MR. LAURENCE: Form. 7 THE WITNESS: Can you help me out here? 8 BY MR. WILKERSON: 9 Q Certainly. Why don't you just read that 10 second bullet that begins "When the form"? 11 A Can you put your cursor on it please? 12 Oh, I'm on the wrong page. I apologize. 13 When the form is uploaded to editorial 14 manager, include the author's last name in the 15 document title of the form. 16 Q Okay. And that doesn't tell you to 17 include the first-named author's last name in the 18 document title. Is that right? 19 A That seems to be silent on what author 20 is entered, yes. 21 Q Okay. And then if you can turn to 22 page 16. If we go towards the bottom, the last

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45 1 paragraph says "Co-authorship Verification." 2 A I see that. 3 Q Okay. And do you see again that there 4 is responsibilities for the corresponding author 5 described here? 6 A I'm reading it now. 7 The corresponding author is responsible 8 for providing the full list of co-authors on the 9 manuscript. The co-authors will receive an email 10 asking them to verify their contribution to the 11 manuscript. The corresponding author is 12 responsible for ensuring that this step is 13 completed. 14 Q And so those are responsibilities for 15 the corresponding author. Right? 16 A That's what it says. 17 Q Okay. That doesn't describe 18 responsibilities for any of the other named 19 authors, does it? 20 A Well, actually, it does. 21 Q Fair enough. "The co-authors will 22 receive an email asking them to verify their	47 1 the list, the way I'm reading it. 2 Q And -- and -- and perhaps we're talking 3 past each other, but that's -- that's exactly what 4 I'm asking. Who's responsible for providing the 5 full list of co-authors on the manuscript? 6 A Right. No, I'm simply saying there's a 7 big difference between providing a list and 8 actually deciding on a list. That's what I'm 9 trying to get at. 10 Q That's fine. But just so we're clear, 11 you agree that corresponding author is responsible 12 for providing the full list of the co-authors of 13 the manuscript? 14 A This is about correspondence with the 15 journal, so this is simply the person who 16 transmits a list. 17 Q And that person, just so we can make 18 sure we're clear for the record, is the 19 corresponding author. Right? 20 A Yes. 21 Q Okay. And you were differentiating from 22 who actually is an author or determined to be an
46 1 contribution to the manuscript." 2 Who is responsible for ensuring this is 3 completed? 4 MR. LAURENCE: Objection to form. 5 BY MR. WILKERSON: 6 Q Who is responsible for ensuring that the 7 contributions of each co-author is completed? 8 A It says that's the responsibility of 9 the -- it says co--- corresponding author. 10 Q Okay. And who is responsible for, in 11 the first instance, identifying the full list of 12 co-authors on the manuscript? 13 A I'm still trying to understand what 14 you're asking me. 15 Q Sure. So if you look at the first 16 sentence, my question is who is responsible for 17 providing the full list of the co-authors on the 18 manuscript? 19 A I think it says pretty clearly that the 20 provision of the list comes from that person. It 21 doesn't necessarily means it is that person who 22 decided on that list. It's just the provision of	48 1 author versus who is responsible for providing the 2 list of those authors. Right? 3 A Can you repeat that? 4 Q Sure. You were differentiating in your 5 answer between who is responsible for determining 6 authorship -- 7 A Ah. 8 Q -- and who is responsible for providing 9 the list of authorship. Right? 10 A Yes. But perhaps I can explain that. 11 Q Well, actually, I'll -- I'll do a 12 follow-up question. 13 And, in fact, for determining the 14 guidelines for who is an author, the journal 15 determines that. Right? 16 A There are pretty standard academic 17 definitions of who an author is and how -- how he 18 or she might qualify. Yes. 19 Q And that generally comes from the 20 International Committee of Medical Journal 21 Editors? 22 A Right. But the -- the -- the

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49 1 corresponding author is often a position that is 2 simply a correspondence. That's what I'm trying 3 to say. And in many places, that's honorific as 4 much as anything. 5 Q When you've been a corresponding author, 6 is that because you're the lead researcher on the 7 project? 8 A When I'm the corresponding author, it's 9 because I'm either the first author, in which 10 case, I'm taking care of everything. Sometimes 11 I'm the corresponding author, when I'm the last 12 author for a variety of reasons. It might be a 13 fellow who's the first author. And I -- as I said 14 before, I don't think I'm a corresponding author 15 when I'm a middle author. I'd have to go through 16 my entire CV to check, though. 17 Q Let's go to -- back to your declaration 18 if you can -- 19 A Okay. 20 Q -- which is Exhibit 1. And you can turn 21 to paragraph 70. 22 A Okay. Hang on. Is that -- sorry. I	51 1 sure. 2 And I think we can give mutual 3 forgiveness of the pronunciation of this doctor's 4 name, but there you wrote that the Bouabdallaoui 5 reference was published on August 29th, 2020 in 6 the European Heart Journal. Is that right? 7 A That's what it says. I'd have to see 8 the original article to know the actual 9 publication date, but let's assume that's correct. 10 Q We can look at the article in just a 11 second, but that's what you wrote here in your 12 declaration. Is that right? 13 A It's certainly what is written here. 14 Can I look at the article now to verify it? 15 Q Yeah. I just want to ask one more 16 question first. And that's the same journal we 17 just were looking at some of the -- 18 A Yes. 19 Q -- submission instructions for. Right? 20 A Yes. 21 Q Okay. 22 MR. WILKERSON: And now if we could go
50 1 need a little more space here to open up. Hang 2 on. Let's see. 3 Is that on page 42? 4 Q Are you referring to the document -- 5 A Oh, I'm sorry. 6 Q -- page or the -- the -- 7 A Perhaps -- 8 Q So at the bottom -- 9 A Yeah. 10 Q The bottom -- the bottom left that's in 11 bold -- 12 A Yes. 13 Q -- it is page 42 of 318? 14 A I have that. 15 Q But just above that -- okay. Great. 16 A I have -- I have -- yeah, I have that 17 open. 18 Q Okay. And you're looking at 19 paragraph 70? 20 A Yes. 21 Q Okay. And there, you wrote -- I'll just 22 wait for the computer screen to get there to make	52 1 to Tab 3 and mark that as Ridker Exhibit 3. 2 (RIDKER Exhibit 3 was marked for 3 identification and is attached to the transcript.) 4 THE WITNESS: I have it. 5 BY MR. WILKERSON: 6 Q Okay. Do you recognize this document? 7 A I do. And I'm pleased to say it says 8 published ahead of print on August 29th, 2020. So 9 we're good. 10 Q Okay. And what is this document? 11 A I too have difficulty pronouncing this 12 person's name, so if it's okay with you, I'm going 13 to refer to this as the 2020 European Heart 14 Journal paper out of respect to Nadia who I cannot 15 pronounce her last name. So I apologize for that. 16 But it's a follow-up paper from the 17 COLCOT trial. 18 Q Okay. And then I'm assuming you can 19 already see that this is the list of authors 20 because you've already referred to -- to Dr. Nadia 21 here. Is that right? 22 A Yes, I see a list of authors.

53 1 Q Okay. And do you see -- who is the 2 second-named author? 3 A My colleague, Jean-Claude Tardif. 4 Q Okay. And do you see an asterisk next 5 to Dr. Tardif's name? 6 A I do. 7 Q Okay. And can you scroll to the bottom 8 of the first page? And do you see there's a -- a 9 footer, or a footnote? 10 A Yes. 11 Q Okay. And do you see the first footnote 12 has an asterisk? 13 A Yes. 14 Q Okay. And what does that say? 15 A It says "corresponding author." 16 Q And it's identifying an email. Is that 17 right? 18 A Yes. 19 Q And so this asterisk and the email both 20 correspond to Dr. Tardif? 21 A Yes. 22 Q Okay. In your opinion, would a --	55 1 A If I need to pull the declaration again, 2 but I mean I recall -- I mean. 3 Q I don't think I -- I don't think I'm 4 necessarily disputing what you wrote as your 5 posted definition, I guess I'm just trying to 6 solidify the fact that you provided a POSA 7 definition. Is that right? 8 A Again, if you'd like to take me to that 9 section of my declaration, I can affirm for you. 10 Q Sure. 11 So if you go to page 15 and look at 12 paragraph 18. 13 A Matt, I'm sorry. Is this -- again, when 14 you -- when you say page 15, do you mean the 15 15 bolded in the lower left, or do you mean -- 16 Q Correct. I'm referring to the bolded. 17 A Okay. 18 Q Is that -- is that okay for you? 19 A Yeah, that works fine for me. I have it 20 open now. 21 Q Okay. And do you see that paragraph 22 there?
54 1 actually, let's step back one second. 2 You were provided some -- certain legal 3 standards in -- in forming your opinions for this 4 case. Is that right? 5 MR. LAURENCE: Objection; form, 6 foundation. 7 BY MR. WILKERSON: 8 Q Did counsel provide you with any legal 9 standards in which to frame your analysis for this 10 case? 11 A I'm not really sure what you're asking 12 me. 13 Q Let me rephrase it a little bit. Do you 14 recall the term "person of ordinary skill in the 15 art"? 16 A Yes. 17 Q Okay. And are you okay if we refer that 18 person as a "POSA"? 19 A Sure. 20 Q Okay. And you -- you provided a 21 definition of a POSA in your declaration. Is that 22 right?	56 1 A At the bottom? 2 Q At the bottom. Paragraph 18? 3 A Okay yes. I see the word "POSA," yes. 4 Q Okay. So you -- you were told by 5 counsel that the patents are interpreted from the 6 perspective of a, quote, person of ordinary skill 7 in the art at the time the patent was filed, POSA. 8 Do you see that? 9 A I do. 10 Q And then you said: 11 I provide my opinions on who would 12 qualify to be a POSA for the '063 patent in 13 Section VI.B below. 14 Do you see that? 15 A I do. 16 Q Okay. So now if we flip to page 57 from 17 the bolded, and you look at paragraph 89. 18 A Hang on. 19 MR. WILKERSON: And to the tech, you can 20 use the page numbers I say up in the page tool on 21 the PDF. I'm giving you the PDF pages. So 57. 22 THE WITNESS: I see it.

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57 1 MR. WILKERSON: 57. And go down to 2 paragraph 89. Great. 3 BY MR. WILKERSON: 4 Q Okay. And do you see here you provided 5 a definition of a POSA? Is that right? 6 A Yeah. It looks like I said it should be 7 a skilled cardiologist. Yep. Okay. 8 Q Great. And they would have three to 9 five years of experience. I see that as well. Do 10 you see that? 11 A I do. 12 Q And then you have some other qualifiers 13 regarding that cardiologist, or kind of what the 14 scope of their skills would be. Is that fair? 15 A Yes. They all look like pretty 16 reasonable things to have. 17 Q Okay. Great. 18 So in your opinion, would a POSA 19 understand the words "within about three days of 20 the MI" to include days zero, one, two, and three 21 of the MI? 22 MR. LAURENCE: Objection; foundation.	59 1 This particular time frame has 2 extraordinarily different things going on. The 3 first few hours of an acute myocardial infarction 4 is vastly different than day two and day three. 5 So I'm not sure what you're asking me. 6 BY MR. WILKERSON: 7 Q If you're instructed to initiate a 8 treatment within a certain time period following 9 an MI, would you understand that time period to 10 equal time zero to the upper limit? 11 A No. 12 Q Why not? 13 A Because as I said a second ago, but I'll 14 repeat again. There's vastly different treatments 15 that are involved in the immediate acute care of 16 myocardial infarction versus the stable phase of 17 myocardial infarction, and that spans this 18 three-day window that you are asking me about. So 19 they're vastly different treatment initiatives, 20 vastly different things that we do. 21 Q How quickly can a patient be stabilized? 22 A In modern cardiovascular care,
58 1 THE WITNESS: I'm sorry. What are we -- 2 are you asking -- 3 BY MR. WILKERSON: 4 Q So -- 5 A Are you asking -- are you asking me a 6 numerical question? 7 Q So if -- if a POSA was instructed to 8 initiate a treatment within about three days of an 9 MI -- are you with me so far? 10 A I know what three days are, yes. 11 Q Within three days of an MI. 12 A Do I know -- 13 Q Would a POSA -- 14 A -- what within three days of an MI 15 means? Yes. 16 Q And would a POSA understand that to 17 include days zero, one, two, and three of the MI? 18 MR. LAURENCE: Objection; foundation. 19 THE WITNESS: I'm sorry. Am I supposed 20 to answer the question or not? 21 MR. LAURENCE: Yes. 22 THE WITNESS: Oh, okay.	60 1 remarkably fast. So in my hospital today, and I 2 think this is pretty true of most of the world, 3 many, many myocardial infarction patients are 4 completely stable by day two, and often go home 5 day two, day three is pretty routine. They're 6 stable patients at that point. 7 Q Can an -- can an MI patient be 8 stabilized within one day? 9 A It's certainly possible. 10 Q Do you see it happen? 11 A Yeah. So if -- if we have a patient who 12 comes in immediately after the onset of what 13 typically is crushing chest pain, and if they're 14 lucky enough to live near a major center that has 15 a catheterization laboratory and we can take care 16 of the early parts of this disease phase. So that 17 would be -- and I apologize for the jargon, but 18 it's what we call coronary reperfusion. 19 So my colleagues will do everything they 20 can to open up that coronary artery, and that's an 21 immediate thing that we do in the first -- I mean, 22 as fast as we possibly can do it. And if it's

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61 1 a -- if it's done really fast and the return of 2 oxygen flow to the heart is immediate, they can be 3 stabilized pretty quick. 4 Q And what -- what is pretty quick? 5 A There's tremendous variation here. I'm 6 not -- you know, it's a case-by-case basis. 7 Q Could it be within 12 hours? 8 A It's possible. There's many 9 complications that often occur in those first 6 to 10 12 hours that have to do with platelet function, 11 coagulation, restenosis, technical issues due to 12 the angioplasty, technical issues due to the 13 febrile therapy, if that's what you've given. But 14 they're all focused on this idea of reperfusion, 15 which is what you're really after in the first few 16 hours. 17 Q Could it be within 24 hours? 18 A I'm sorry. Could what be within 19 24 hours? 20 Q Stabilization of the patient. 21 A It's possible. 22 Q So, really, a POSA will understand that	63 1 unstable. 2 So since we very often discharge 3 patients at day two, day three, they are, by 4 definition, stable. So you're correct. They 5 are -- we're talking here today about stable 6 patients. You're absolutely correct. 7 Q Okay. And so as I understand your 8 reason, though, for within three days, excluding 9 day zero was because you'd first stabilize the 10 patient before initiating a treatment. Is that 11 right? 12 A Matt, I don't mean to be disrespectful, 13 but there's no such thing as a day zero. There's 14 a day one, there's a day two, and there's a day 15 three. I don't know what you mean by "day zero." 16 Q Sure. Sure. When I said "day zero," I 17 was referring to the day on which the MI occurs. 18 So we can -- we can call it day one if that's 19 useful for you. I was basically thinking about it 20 as time zero. Right? But if day one is the day 21 at which the patient has the MI. 22 Does that make sense?
62 1 the initiation of a follow-on treatment could be 2 from as soon as stabilization up to whatever the 3 maximum time for initiation is described in a 4 regimen? 5 A Could you repeat that? 6 Q Yes. So I said, really, a POSA would 7 understand that the initiation could be from a 8 stabilization could be from 24 hours -- sorry. 9 Strike that. 10 A POSA would understand that the 11 initiation could start from stabilization, could 12 be 24 hours up to the maximum time for whatever is 13 described in a regimen. 14 And if that doesn't make sense, I'll 15 rephrase. 16 A No, I think I do understand what you're 17 saying. And, actually, you're saying something 18 very important. You're talking about 19 stabilization and stable phase. And that's a very 20 important issue because these patients are, by 21 definition, stable when I send them home from the 22 hospital. I wouldn't send them home if they're	64 1 A Yes. 2 Q Okay. So if that patient is stabilized 3 on day one, right, would a POSA understand that 4 you can initiate treatment on that day one? 5 A Again, Matt, let me try to explain. 6 Because I actually think you do understand and let 7 me just make sure we both understand. 8 You're drawing a very important 9 distinction between an unstable patient and a 10 stable patient, and I fully agree. Stable 11 patients, by definition, are those who we have now 12 handled the acute opening up the artery -- I'm 13 being a little bit general here because we can 14 spend days talking about the details of this. 15 But the general concept, when that 16 patient has an occluded coronary artery, again, 17 exceptions to all the rules here. But as a 18 general rule, a patient comes in with an occluded 19 coronary artery, we initiate a whole series of 20 quite aggressive things to open that artery, to 21 achieve reperfusion, oxygen downstream, as -- 22 trying to save myo- -- as much myocardial tissue

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65 1 as possible. 2 So many, many things have been developed 3 over the years to do that, from chemicals that we 4 can inject as early as sometimes in the ambulance. 5 That's called fibrinolytic therapy. In more 6 modern times, it's opening an artery with a 7 mechanical system as fast as possible. So major 8 hospitals like mine have teams of people available 9 on a 24/7 basis so they can get that done. 10 That's those first four, six, eight 11 hours as -- I mean, again, patients come in. You 12 know, we can't control when a patient comes in. 13 But in a perfect world, if you were -- you know, 14 you're trying to open as fast as possible. 15 The distinction you're drawing is very 16 important, though, because they become stable at 17 some point. And, again, as a responsible 18 physician, we don't send people home, by 19 definition, who are unstable. And it's very 20 common in modern practice that they -- that 21 they're sent home at day two, day two and a half, 22 day three. Tremendous pressure on hospitals, as	67 1 there are just very different goals trying to be 2 achieved in that what may seem to you to be a 3 small -- relatively small window are phenomenally 4 important for the patient's livelihood and whether 5 they're going to live or die. And they're just 6 very, very different periods of time within that 7 window. So that's why I'm answering this way. 8 BY MR. WILKERSON: 9 Q No, I understand. I appreciate that. 10 Within that window, are those 11 differences in therapies that, as you pointed out, 12 are very critical for the patient, are those 13 times, you know, static or are they on a 14 case-by-case basis? 15 A Ultimately, almost everything in 16 medicine is a case-by-case basis. 17 Q So it would not be out of the question 18 for a patient to be brought to the hospital with 19 an MI, and as you pointed out, open up the artery. 20 Is that right? That's kind of the first immediate 21 thing, if I'm following? 22 A That's what we hope to accomplish as
66 1 I'm sure you're aware, to keep costs down and 2 things. And it's perfectly safe to send them home 3 at that point. 4 Q I appreciate that. I -- and -- and I -- 5 I appreciate your comments. I -- I think you're 6 giving me a little more credit on my understanding 7 than I deserve. But I just want to kind of follow 8 up on a couple things there. 9 So I just want to understand, you know, 10 my -- my really baseline here is, first of all, 11 the distinction you're drawing of -- of kind of 12 the acute and stable, and stabilized, right? I 13 guess I'm -- I'm pulling in your previous answer 14 regarding why a POSA would understand that "within 15 about three days of an MI" would exclude certain 16 times. Is that fair? 17 MR. LAURENCE: Objection; form. 18 THE WITNESS: Again, Matt, I -- I'm -- I 19 think we all understand what "three days" means. 20 What I'm trying to say is that therapeutic 21 interventions one does are radically different in 22 that three-day period. And so it's not like --	68 1 rapidly as possible, yes. 2 Q Okay. And then whatever other acute 3 care or therapies are required are -- are within 4 those -- those first hours after arriving at the 5 hospital. Right? 6 A Right. Those acute issues would 7 typically be pain medication, oxygen, 8 anti-coagulate therapy, anti-platelet -- a whole 9 host of -- antiarrhythmic therapy. There's a host 10 of things that have to do with that first 11 absolutely critical few hours where life and 12 death, frankly, is in the cards, and it's one of 13 the modern miracles of cardiology, frankly. 14 Q And then following that treatment, let's 15 say hypothetically 18 hours later, and the patient 16 has responded really well to those initial 17 treatments, the physician then would begin 18 initiating, right, secondary treatments? 19 A Well, I think once a patient has 20 declared himself or herself a patient has had a 21 myocardial infarction, so we're past that now, 22 there's a host of things that any good physician

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69 1 would do to ensure that on a long-term basis, that 2 patient is well taken care of and well protected, 3 what we call secondary prevention therapies. 4 Q Can that -- 5 A Yeah. 6 Q Sorry. Didn't mean to interrupt you. 7 Please finish. 8 A No, I was done. 9 Q And those secondary prevention 10 therapies, can those be initiated in the hospital? 11 A Oh, it's a good idea to do so. 12 Q And as you said, the patient is 13 generally, in the modern environment, released 14 from the hospital at two, two and a half, three 15 days. Right? 16 A Yes. And -- and perhaps I should 17 explain why it's a good idea to do so. I mean -- 18 I mean, you know, when a -- when a patient goes 19 home from what has really been a life-changing 20 event in his or her life, we as cardiologists want 21 them on the long-term therapies that we have proof 22 work over the long haul to prevent them from	71 1 A Matt, in all due respect, I think I've 2 answered this several times. I don't understand 3 what you're trying to ask me now. 4 Q If a treatment regimen instructs the 5 physician to initiate within about three days of 6 the MI, what would a POSA understand as to when 7 they can initiate that treatment? 8 A Again, that three-day window is a very 9 heterogeneous period of time from extraordinarily 10 high risk of dying to completely stable. 11 Q Does -- does that mean that that 12 three-day time window doesn't really describe to a 13 POSA when to start? 14 A Again, Matt -- 15 MR. LAURENCE: Objection; form. 16 THE WITNESS: I'm sorry. I'm sorry. 17 BY MR. WILKERSON: 18 Q You can go ahead. 19 A Can you repeat the question? 20 Q Sure. Does that mean that it's your 21 opinion that a POSA wouldn't really understand 22 when within those three days to initiate the
70 1 having a second heart attack or second stroke or a 2 catastrophic death. 3 And we've learned from just a bit of 4 common sense, I suspect, and people that actually 5 study this sort of thing that initiating these 6 therapies that are standard secondary prevention 7 therapies. If I fail to do that at discharge when 8 the patient is stable, as you say, sometime at day 9 two is pretty typical, they might not see their 10 primary care physician for three or four months, 11 they may not see their community cardiologist for 12 quite a while, and I'd hate to have the patient 13 have to wait until then to get a therapy that 14 might save their life. That would be not great 15 care. 16 Q All the context we just went over is 17 very useful. So I want to kind of go back to the 18 first question in this -- in this line of 19 discussion. And that's, in your opinion, what 20 would a POSA understand it to mean if a treatment 21 regimen instructs to initiate treatment within 22 about three days of the MI?	72 1 treatment? 2 A Again, Matt, you're asking an 3 extraordinarily general question which honestly 4 doesn't make sense to me. And I don't -- and, 5 again, I don't mean to be in the slightest 6 disrespectful. The treatment interventions are so 7 radically different between a few hours in and 8 when the patient is stable that it sounds like -- 9 yeah, I mean, they're just different, they're 10 radically different interventions with very 11 different purposes. 12 Q Is there any difference to a POSA if the 13 regimen said within five days of the MI? 14 A I -- I honestly don't really know what 15 you're asking me. 16 Q Okay. I do want to be respectful to 17 you, so we have been going about an hour. If you 18 do want a break, we are at kind of a good pause 19 point. But if you want to keep going, we 20 certainly can keep going. 21 A I'm okay now. Maybe 30 minutes from now 22 might be a good idea. Something like that.

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73 1 Q Okay. Great. 2 Let's keep your -- your declaration up. 3 A Okay. 4 Q And if we go to page 42. And we were 5 there a little bit ago. That paragraph 70. Let 6 me know when you're at that section. 7 A I have it open. 8 Q Okay. And that's the Bouabdallaoui 9 section again -- 10 A Yes. 11 Q -- right? 12 A Again, I'm going to go with European 13 Heart Journal 2020, but thank you. I have it. 14 Yeah. 15 Q Fair enough. 16 If you go to the next page, do you see 17 paragraph 71? 18 A I see that. 19 Q Okay. And it was your opinion that 20 because European Heart Journal 2020 was published 21 on August 29th, 2020, that it's prior art to the 22 claims of the '063 patent. Do you see that?	75 1 A I see that section. 2 Q Okay. And if you -- if you need to look 3 at that section, please do. But you describe 4 several legal standards. But there's no 5 description of what you understand to be an 6 effective filing date. Is that right? 7 A I'm sorry. Do you want me to read this 8 section? 9 Q No. I'm just saying that if you need to 10 review it to answer the question, please do. And 11 I'll restate the question is that you didn't 12 provide any understanding of what an effective 13 filing date is from counsel in here, did you? 14 A I'd have to read it, Matt. I don't -- I 15 mean -- okay, look. So you want me to read 16 Section IV? 17 Q Yeah. Certainly. It's paragraph 17 18 through 21. 19 A 17 is pretty accurate. I'm not an 20 attorney. 21 Okay. 18, we previously reviewed. 22 Okay. I've read through the end of 21,
74 1 A I see it says that, yes. 2 Q Okay. And you had said it's because the 3 '063 patent has an effective filing date of 4 November 13th, 2020. Do you see that? 5 A Yes. 6 MR. WILKERSON: Did you have something, 7 Kevin? 8 MR. LAURENCE: No. 9 MR. WILKERSON: Okay. Sorry. 10 Q And did counsel provide you with any 11 understanding of what an effective filing date is? 12 A I have a vague idea what that -- 13 obviously, I'm not a patent attorney, so. 14 Q Certainly. What is -- what is your 15 vague idea? 16 A In my own patent filings, it's the date 17 that we file the patent. 18 Q Okay. And we saw them earlier, and we 19 can go back to them again, but in your -- in your 20 re- -- declaration at Roman numeral IV, and that 21 begins on page 15, you describe some legal 22 standards?	76 1 and I don't recall your question anymore. But. 2 Q That's fine. I will re-ask it. 3 In this section of your declaration, you 4 didn't provide any definition or understanding of 5 an effective filing date from counsel. Is that 6 right? 7 A Correct, I guess. 8 Q Okay. 9 A Is that what you're asking? 10 Q Yes. And you also don't have any 11 understanding of what constitutes prior art? 12 MR. LAURENCE: Objection; form. 13 THE WITNESS: Well, in my own patent 14 work related to my research, my attorneys have 15 always been very clear to be very, very careful 16 and to ensure that any invention or novel idea we 17 might have is brought to them well in advance of 18 any public disclosure, whether that be in the form 19 of an abstract or a publication or anything of 20 that nature. And my general understanding is that 21 that's an important thing to do to make sure that 22 the attorneys and the lawyers have the information

77 1 prior to general public presentation of such 2 evidence. 3 So I've always thought of prior art as 4 whatever's prior. 5 BY MR. WILKERSON: 6 Q Okay. But you didn't include any 7 definition in your declaration here in the legal 8 standard section? 9 A I'm not a lawyer, Matt. Yeah. 10 Q I -- I understand that. But in this 11 section is -- is things that you were informed 12 by -- by counsel. Right? 13 A Yes. 14 Q Yeah. And that excluded -- we didn't -- 15 you did not include in this section an 16 understanding of the requirements for prior art. 17 Right? 18 MR. LAURENCE: Objection; privileged. 19 THE WITNESS: It -- 20 MR. WILKERSON: Are you instructing him 21 not to answer? 22 MR. LAURENCE: No.	79 1 A Well, again, I'm not an attorney. At 2 one level, the publication date precedes the 3 filing date. So from a common sense perspective, 4 which that may not be a legal perspective, I 5 suppose, but that's a common sense perspective. 6 And the second is that my patent 7 attorneys suggested to me that it might be prior 8 art. 9 Q Okay. So I apologize in advance, but if 10 we turn back down in your report to another 11 location, I want to make sure I have the right 12 spot. 13 Great. If we could turn to page 58. 14 And we'll focus in on paragraph 91. 15 A Okay. I see -- I have page 58 in bold 16 type. 17 Q Yeah. And at the bottom of that page, 18 do you see paragraph 91? 19 A I do. 20 Q Okay. And do you see there you wrote 21 that you were asked to review the November 15th, 22 2019, provisional application as well as the
78 1 MR. WILKERSON: Okay. 2 THE WITNESS: Now I'm -- now I'm 3 confused, guys. What -- what -- what are the 4 different sides you're asking me? You know -- 5 MR. LAURENCE: I do object if you're 6 asking questions about his discussions with 7 counsel. 8 MR. WILKERSON: Not -- not at all. 9 BY MR. WILKERSON: 10 Q I am asking whether or not you included 11 a definition of prior art that you received from 12 counsel in this declaration. 13 A On -- on -- on this page, the answer is 14 no. 15 Q Thank you. All right. 16 So -- but we saw with regards to the 17 European Heart Journal 2020 article that you 18 referred to that as prior art. Right? 19 A Yes. We saw that on previous -- 20 whatever it was in this thing. Yes. 21 Q Yeah. And how did you come to the 22 conclusion that that reference is prior art?	80 1 October 20th, 2020, provisional application? Do 2 you see that? 3 A I see that. 4 Q And the purpose for you doing that 5 was -- as you said here, was: 6 To see if a skilled cardiologist would 7 have understood them to disclose initiating 8 colchicine treatment within about three days of 9 the MI or within four to seven days of the MI. 10 Do you see that? 11 A I see that. 12 Q And then you concluded: 13 In my opinion, neither provisional 14 application discloses initiating colchicine 15 treatment within this period. 16 Is that what you wrote there? 17 A I -- I see -- I see those words, yes. 18 Q Okay. So let me take a step back. 19 We've been talking about your declaration. Did 20 you write this declaration? 21 A This declaration was written by 22 attorneys I met with when we discussed a lot of

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81 1 issues related to inflammation treatment and 2 colchicine. 3 Q And are all the words in this 4 declaration your opinions and not that of your 5 attorneys? 6 A Yeah, I think I can -- yes. I mean, 7 the -- there -- I will -- Matt, I will admit 8 there's a lot of legal jargon here that I don't -- 9 that must make sense to the attorneys in the room. 10 But the -- the big opinions here that are mine are 11 absolutely mine, yes. 12 Q Okay. And that would include this last 13 sentence on paragraph 91: 14 In my opinion, neither provisional 15 application discloses initiating colchicine 16 treatment within this period. 17 Do you see that? 18 A I do see that. It sounds like legal 19 words to me, though. You might want to explain to 20 me what you think they mean. 21 Q Sure. So is it your opinion -- and 22 we'll look at them in -- in just a moment.	83 1 (RIDKER Exhibit 4 was marked for 2 identification and is attached to the transcript.) 3 Q Just let me know when you have this 4 document ready. 5 A Yes, I have that document in front of 6 me. 7 Q Okay. And do you recognize this 8 document? 9 A Looking at it, vaguely. I mean, if I've 10 seen it before, I don't recall looking -- I 11 mean -- I mean, maybe we should review it. 12 Q Yeah, certainly. Can we go -- if you go 13 to the footer on the first page, do you see the 14 footer on the bottom right? It says 15 Murray & Poole Exhibit 1004? 16 A Yes. 17 Q Okay. And does that correspond to the 18 same Exhibit 1004 that you referred to in 19 paragraph 91 of your declaration? 20 A I assume so. 21 Q Okay. And you identified Exhibit 1004 22 as the November 15th, 2019, provisional
82 1 But is it your opinion that the 2 initiating colchicine within about three days of 3 the MI is not disclosed in the provisional 4 applications? 5 A So, again, the notion of disclosure 6 sounds like a very legal thing that the attorneys 7 would have to wrangle with, but if you want -- 8 maybe we should go through those. 9 Q What -- what is -- what is your 10 understanding of "disclosure"? 11 A Well, I have a scientific understanding, 12 which is that when my colleagues and I present 13 data at a meeting or talk about things in that 14 setting or publish a paper, we disclose what our 15 data is. I don't have an opinion on the legal 16 meaning of "disclosure." 17 Q Yeah, certainly. And I'm not seeking a 18 legal opinion. I'm just trying to understand 19 your -- your -- your understanding. 20 So we can turn to Tab 11 in your binder. 21 MR. WILKERSON: And we'll mark this 22 please, Court Reporter, as Ridker Exhibit 4.	84 1 application. Is that right? 2 A Matt, I put my declaration away because 3 it's large and cumbersome. Are you asking me to 4 bring it back out again? 5 Q Only if you need it to confirm. I'm 6 just trying to establish the document we're 7 looking at here. 8 A Matt, I have to admit, if you had asked 9 me what Murray & Poole Exhibit 1004 is, I wouldn't 10 know offhand. I would have to go back and look, 11 right? So I'm sorry about that. But if that's 12 what your question is, then you have to take -- I 13 guess I have to go back. 14 Q Yeah, that's absolutely fine. And so we 15 were at page 58 of your declaration and we were 16 towards the bottom on paragraph 91. 17 A I was asked to review the November 15, 18 2019, provisional application EX1004. This seems 19 to say 1004. Okay. 20 Q Great. Do you understand that to be the 21 same document, then, that you're referring to in 22 your declaration?

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85 1 A Yes. 2 Q Okay. And do you see the title of this 3 exhibit, I believe we stamped as Exhibit 4? 4 A I'm sorry. What -- yes, my -- my -- my 5 hard copy next to me looks very much like that. 6 Q Okay. And if we turn to page 2. And if 7 you go to the last paragraph of page 2, let me 8 know when you're there. 9 A I'm there, Matt. But I'm just trying to 10 figure out what I'm looking at here globally 11 first. You're asking me a very specific -- I'm 12 just trying to figure out -- 13 Q That's fine. Take -- take your time. 14 A Matt, I'm just trying to figure out what 15 I'm actually looking at. And maybe it's just my 16 not being an attorney, but, I mean -- 17 Q That's fine. I can give you some 18 background and we can -- 19 A That might help. 20 Q And if you need confirmation, we can 21 refer back to your -- to your declaration. 22 A Okay.	87 1 Q Okay. And so would a POSA understand 2 that this part, the method, involves administering 3 colchicine within five days of the MI to mean 4 initiating the colchicine within from whatever day 5 the patient is stabilized up until day five? 6 MR. LAURENCE: Objection; form. 7 THE WITNESS: Well, again, I -- I think 8 you're actually drawing the most important 9 distinction, Matt, I -- which I think we can both 10 agree on. These are all stable patients. At 11 whatever time this is done, it's stable. So if 12 it's 5 or 10 or 15 or 20, we all -- we acknowledge 13 these patients are stable. 14 BY MR. WILKERSON: 15 Q I guess, from -- from the position of a 16 POSA, when would they understand that initiating 17 colchicine treatment within five days of the MI to 18 include? What's our kind of lower and upper limit 19 of within five days of the MI for initiating 20 colchicine? 21 MR. LAURENCE: Objection; form. 22 THE WITNESS: This is a chronic therapy
86 1 Q So I'll represent to you that this -- 2 Exhibit 4 is a copy of the specification of the 3 November 2019 provisional application, which 4 eventually matured into the '063 patent. So this 5 was the initial filing, which eventually became 6 the '063 patent. 7 A Okay. That's actually very helpful. I 8 appreciate your explaining that. 9 Q Okay. And I specifically want to ask 10 you about page 2 in that last paragraph. 11 And are you there? 12 A I'm -- I'm reading -- it -- it's 13 starting "in some embodiments"? 14 Q Correct. 15 A Okay. Is there a question? 16 Q I can give you the question. 17 And do you see there it says: 18 In some embodiments, the method involves 19 administering colchicine within 5, 10, 15, 20, or 20 25 days of the MI. 21 You see that. Right? 22 A I do.	88 1 used for secondary prevention in stable patients. 2 So I think a POSA would be able to figure out when 3 the patient is stable. And that's going to be 4 when they're stable. 5 As we've already stipulated, again, in 6 modern cardiology practice, very commonly we send 7 patients home as early as day two, and they 8 clearly are stable when they go home. 9 BY MR. WILKERSON: 10 Q So sometime before day two up until day 11 five is what this is telling a POSA. Right? 12 A No. I'm saying when the patient is 13 stable. 14 Q Which includes possibly before day two. 15 Right? 16 A Well, Matt, again, with due respect, I 17 feel like you're trying to generalize an 18 extraordinarily complicated set of 19 life-threatening events going on in the first 20 couple of hours. And what I'm trying to say, and 21 I think every POSA would understand, is, you know, 22 we send patients home when they're stable. And

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89 1 that often occurs within, you know, two or three 2 days. And everything else is variable. 3 Q Okay. That's fine. Let's -- let's get 4 a little -- we can be a little -- slightly more 5 pointed, I suppose. 6 So you agree with me that this 7 provisional application discloses initiating -- 8 sorry, administering colchicine within five days 9 of the MI. You agree that that's said here? 10 A It's -- yes, it says you can administer 11 within five days, and I'm going to presume that 12 means when the patient is stable, as you have 13 stipulated. 14 Q And then -- so I want to go back, then, 15 to that page 58 of your declaration if we can. 16 A Okay. Hang on. 17 THE WITNESS: (Indiscernible.) 18 MR. LAURENCE: Yep. 19 THE WITNESS: All right. Let's see. 20 Okay. 21 BY MR. WILKERSON: 22 Q And I think I know your answer to this,	91 1 perhaps not understanding where you're trying to 2 go. I think I've been pretty clear that when a 3 patient is stable, they can go home. 4 BY MR. WILKERSON: 5 Q I -- I get that part. I'm trying to 6 understand a little bit why it's your opinion that 7 there's no overlap between within about three days 8 of the MI and the phrase "within five days of the 9 MI." 10 A Perhaps because I don't understand why 11 you're asking. 12 Q Well, I'm asking because it -- in your 13 declaration, it's your opinion that the -- the 14 provisional application doesn't teach this within 15 three days. Right? And I'm trying to understand 16 from your perspective why a POSA would read within 17 five days to not overlap with within about three 18 days. 19 A I'm struggling here, Matt. Because I 20 don't think we have a math problem. I think we 21 have a legal problem, and I don't understand the 22 question.
90 1 but we're going to ask it anyway. 2 Is it your opinion that within five days 3 of the MI is different than within about three 4 days of the MI? 5 MR. LAURENCE: Objection; form. 6 THE WITNESS: My opinion here is 7 unchanged. This is about stability. 8 BY MR. WILKERSON: 9 Q And in both instances of initiating 10 within about three days and initiating within 11 about five days, the patient can be stable before 12 or around day two. Right? 13 A Again, pretty common practice to 14 discharge patients home on day two to three. 15 They're clearly stable. I would be in big trouble 16 if I sent someone home unstable. And, obviously, 17 three days is less than five. 18 Q But within five days includes the day 19 two stable patient, the day three stable patient. 20 Right? 21 MR. LAURENCE: Objection; form. 22 THE WITNESS: Matt, once again, I'm	92 1 Q Okay. We can -- we can try to simplify, 2 I suppose. And -- and perhaps your answer of we 3 don't have a math dispute revolves it. 4 I guess my question is simply, in your 5 opinion, does -- does the regimen of initiating 6 treatment within about three days of the MI 7 overlap with initiating treatment within five days 8 of the MI? 9 A And what I think I've said multiple 10 times now is that what this is really all about is 11 when the patient is stable, and when we decide as 12 responsible physicians to put patients on the 13 long-term therapies that we know they need to 14 prevent second heart attacks, second strokes down 15 the road. And that might occur for some patients 16 at day two or three. Other patients, it might 17 occur at day five. 18 It's just about -- it's -- it's this 19 issue that you raised earlier. It's when they're 20 stable is when we initiate these treatments. 21 Q Is it necessary -- and I'm sorry for 22 stepping back. But is it necessary for a patient

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93 1 to be stable to initiate colchicine treatment? 2 A When a patient is unstable, it's not 3 what we're thinking about. We're trying to save 4 that person's life when they're unstable. And 5 I'll repeat again, our goals in the acute, 6 unstable phase are entirely reperfusion. Get that 7 artery open as fast as possible with whatever tool 8 or technique you're lucky enough to have at your 9 disposal, and try to improve myocardial blood flow 10 as fast as you possibly can with the tools at your 11 disposal. 12 Q After the reperfusion, you had talked 13 about some of the drugs that are initiated, like 14 anti-platelets and anticoagulants. Is that right? 15 A Those type of drugs might be initiated 16 then, yes. 17 Q Is the patient considered stable when 18 those drugs are initiated? 19 A Well, the goal of those drugs -- one -- 20 one of the big risks in that very acute phase -- 21 and, actually, it's a risk that can persist -- is 22 that the clot can come back.	95 1 That's not near here, guys. 2 Actually, Matt, I'm getting another kind 3 of semi-urgent text message here. Maybe this -- 4 MR. WILKERSON: Let's take a break. 5 THE WITNESS: -- (indiscernible) -- 6 MR. WILKERSON: Let's take a break. 7 THE WITNESS: Is that okay? Because I 8 need to address this. 9 MR. LAURENCE: Okay. 10 THE VIDEOGRAPHER: We're going -- we're 11 going off the record at 10:28 a.m. 12 (Whereupon, there was a recess in the 13 proceedings.) 14 THE VIDEOGRAPHER: We're going back on 15 the record. The time is 10:40 a.m. 16 BY MR. WILKERSON: 17 Q All right, Dr. Ridker. Welcome back. 18 And I -- I broke my own rule there with 19 having a question pending when we took the break, 20 so I will -- I will kind of reframe and re-ask 21 just so we can tie that up. 22 You were discussing some of the standard
94 1 So let's assume there's a blood clot 2 there. That's a pretty standard presentation. So 3 when we open that artery, it's very common we 4 already will have given the patient anticoagulants 5 as part of the process. We're trying to -- 6 because once that artery's open, the last thing we 7 want to do is close off again. 8 And so drugs that either attack -- and, 9 again, I don't want to get into jargon with you -- 10 either attacks platelet function, or clotting 11 function, are also given in that acute phase. 12 Because that -- again, it's part of what we're 13 trying to achieve early on. 14 Q With those drugs, is there any reason 15 you cannot give colchicine concomitantly at that 16 point? 17 A Sorry. 18 MR. LAURENCE: Sorry. We received an 19 Amber alert. We're all distracted. 20 THE WITNESS: We're all a little 21 distracted here. Can you just give us a break 22 here? One second. Okay. It's in Chicopee, Mass.	96 1 therapy procedures for a typical MI presentation. 2 And as you recall, we were discussing some of the 3 drugs that are initiated after reperfusion. Do 4 you remember that? 5 A Yes. 6 Q Okay. And so my question was, with 7 those drugs that are given after reperfusion, is 8 there any reason that you cannot give colchicine 9 concomitantly at that point? 10 A I suppose, in theory, you could give any 11 drug one wanted to give. The question is, do we 12 have any evidence that it's effective? 13 Remember, we practice what's called 14 evidence-based medicine. We, as physicians, want 15 to minimize the exposure to the adverse effects of 16 drugs. And so to give a -- you know, I could list 17 10,000 different drugs that you could give, I 18 suppose. I wouldn't advise doing so because you'd 19 be exposing patients to the potential hazards of 20 those drugs without any evidence of effectiveness. 21 Q So I guess to -- to understand that, 22 you're effectively saying you wait until the

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97 1 patient is stabilized before initiating colchicine 2 because you don't have sufficient evidence to 3 support initiating colchicine with the 4 post-reperfusion anticoagulants and 5 anti-platelets, et cetera. Is that right? 6 A Yes. That -- that -- that is correct. 7 There are multiple ongoing randomized trials 8 addressing whether or not colchicine is or is not 9 effective during that acute phase. We have no 10 answer to that question at all at this point in 11 time. It's an -- it's an ongoing question. 12 Q Okay. 13 MR. WILKERSON: Let's actually pull up 14 the 03 patent itself, which should be tab -- 15 sorry, '063 patent itself, which should be Tab 39. 16 And if we could please mark that as Exhibit -- 17 Ridker Exhibit 5 please. 18 (RIDKER Exhibit 5 was marked for 19 identification and is attached to the transcript.) 20 THE WITNESS: Matt, for what it's worth, 21 I no longer see -- oh, there you go. Okay. Thank 22 you. All right.	99 1 Dr. Tardif? 2 A Yeah. We're -- 3 MR. LAURENCE: Objection -- 4 THE WITNESS: Oh, sorry. 5 MR. LAURENCE: -- form. 6 THE WITNESS: Sorry about that. 7 BY MR. WILKERSON: 8 Q Go ahead. 9 A Yes. Yes. We're colleagues. 10 Q Okay. And do you view Dr. Tardif as a 11 well-respected cardiologist? 12 A Yes. We've worked together on some 13 major projects. 14 Q Okay. If we could go to page 25, so the 15 second-to-last page. And this will be a little 16 bit confusing because of how things were -- were 17 done because we have some unbolded numbers. 18 But on the left-hand column, I want to 19 start with the bolded numbers, so the first number 20 one. Do you see that? 21 A Matt, I'm going to try to follow your 22 cursor. So help me out there.
98 1 BY MR. WILKERSON: 2 Q And do you -- 3 A Yes, I have -- I have that in front of 4 me. 5 Q Okay. And do you recognize this 6 document? 7 A It -- it appears to be the -- one of the 8 patents in -- in this case. 9 Q And that would be U.S. Patent 10 Number 11,400,063? 11 A That's -- yes. 12 Q And are you okay if I refer to that as 13 the '063 patent? 14 A That's fine. 15 Q Okay. On the left column of this cover, 16 do you see the inventor identified? 17 A Yes. 18 Q And that's Jean-Claude Tardif? 19 A Yes. 20 Q Okay. And do you know Dr. Tardif? 21 A I do. 22 Q Do you have any opinions regarding	100 1 Q Do you see that? 2 A Yes. 3 Q Okay. And that is -- is Claim 1. Do 4 you recognize that as Claim 1? 5 A It certainly has a 1 in front of it. 6 Q Okay. And Claim 1 says: 7 A method of treating a patient after 8 having a myocardial infarction, MI, the method 9 comprising initiating administration of colchicine 10 at a daily low dose to the patient within about 11 three days of the MI, wherein the colchicine is 12 administered without pre-loading the patient with 13 a higher dose of colchicine before the 14 administration at the daily low dose, wherein 15 percutaneous coronary intervention was performed 16 for treating the patient's MI. 17 Do you see that? 18 A It's -- it's a mouthful. I do see it. 19 Q Okay. Did I read that correctly? 20 A I believe so. 21 Q Okay. And just a couple questions about 22 this. Would -- would a POSA understand

101 1 percutaneous coronary intervention to be the 2 reperfusion treatment you were describing earlier? 3 A It certainly could be. That would be 4 good for the patient if it was. I guess in a very 5 strict sense, you could have performed the -- 6 so -- so we -- as we talked about earlier, we do 7 want to do a -- some -- getting the oxygen 8 flowing, and that would be one mechanism to do so. 9 In theory, it's also possible that this 10 was done later after the patient was actually 11 stable, because, again, in modern practice, 12 there's a lot of physicians and cardiologists who 13 might actually want to know what the coronary 14 anatomy looks like when the patient is stable for 15 other -- for various other reasons. So. 16 Q Okay. So under your understanding, a 17 POSA could read this and potentially interpret 18 that, in some cases, the PCI is occurring after 19 the patient is stabilized? 20 A Well, again, I -- it -- it just simply 21 says here, wherein percutaneous coronary 22 intervention was performed for treating the	103 1 comprising initiating -- I think that's a compound 2 verb for those of you keeping track. 3 Comprising initiating the administration 4 of colchicine at a daily low dose to the patient 5 within about three days, wherein the colchicine is 6 administered without pre-loading the patient with 7 a higher dose of colchicine before -- before the 8 administration at the daily dose, wherein the 9 patient is at lower risk of a cardiovascular 10 event, relative to a patient not being 11 administered colchicine, and wherein the 12 cardiovascular agent -- sorry. And wherein the 13 cardiovascular event is resuscitated cardiac 14 arrest, stroke, or urgent hospitalization. 15 Matt, I'm going to admit here that I've 16 now read it and have no idea what it's talking 17 about. 18 Q Fair enough. How about a simple 19 question of, does it state anywhere that the 20 patient must be stable? 21 A The -- it says -- it actually says 22 "alter having a myocardial infarction." Let's --
102 1 patient's MI. The way I look at that, it might be 2 in that acute phase, and it might be at -- and if 3 this whole thing says -- is could be at day two to 4 three. I mean, it's not very clear. 5 Q Okay. That's fine. I -- I'm just 6 trying to make sure I understood your description 7 there. 8 Anywhere in this claim that you see, 9 Claim 1, does it require the patient to be stable? 10 A I don't see the word "stable" in there, 11 but it -- that's what we're doing. 12 Q And then if -- if we scroll down a 13 little bit to Claim 8. Do you see Claim 8? 14 A Okay. I see it on your screen. Okay. 15 Q And please take a moment to -- to read 16 Claim 8 if you need, but I'll also give you my 17 question, is, does Claim 8 require waiting until 18 the patient is stable to initiate colchicine? 19 A I'm -- I'm sorry, Matt. I'm going to 20 have to read this. 21 So a method of treating a patient after 22 having a myocardial infarction, the method	104 1 let's -- let's -- let's assume that means "after." 2 At least my version says "alter." Does 3 yours say "alter"? Yours says "alter," too. 4 Q It does. 5 A I don't know what an alter -- 6 Q It does. 7 A I don't know what an alter myocardial 8 infarction is. I have a sense that the care that 9 went into this is pretty sloppy. 10 I don't under- -- I don't understand 11 this paragraph, Matt. I honestly don't. I don't 12 know how to answer your question. I don't even 13 know what this paragraph means. Maybe you can 14 explain it to me. 15 Q Sure. So first of all, you're -- you're 16 correct that -- that there was a correction 17 submitted for this, and "alter" is correctly read 18 as "after." 19 However, this is -- this is effectively 20 reciting a method of treating a patient after 21 having an MI. Right? 22 A Yes, assuming the "alter" is an "after,"

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105 1 yes. 2 Q Yep. And looking at Claim 1, that is 3 how that claim began as well. Correct? 4 A And it's spelled correctly in Claim 1. 5 Q Correct. And then after, we -- there is 6 the steps, the method comprising. Right? 7 A Yes. 8 Q And the first step is initiating the 9 administration of colchicine at a daily low dose 10 to the patient within about three days of the MI. 11 Do you see that? 12 A I do. 13 Q And within that language, it doesn't 14 require that the patient first be stabilized, does 15 it? 16 A All the patients in the COLCOT trial 17 were stable by definition. Because you -- I mean, 18 you -- you told me that. 19 Q That -- that -- that may be. I don't 20 believe that I told you that. I was trying to use 21 your definitions earlier. 22 But -- but my question simply is,	107 1 Q Yep. Please do. 2 A Okay. Do I need to read the preceding 3 stuff or just 27? 4 Q Just Claim 27. 5 A So it's not dependent on anything else? 6 Q Correct. 7 A Okay. A method for reducing the risk of 8 a stroke in a patient after having a myocardial 9 infarction, the method comprising initiating the 10 administration of colchicine at a daily low dose 11 to the patient within about 30 days of a 12 myocardial infarction. 13 Q Okay. So within Claim 27, is 14 there any -- I think I understand where you're 15 coming from, but I just want you to listen to the 16 question a little carefully. 17 Is there any requirement that the 18 colchicine be initiated in a stable patient? 19 MR. LAURENCE: Objection; form. 20 THE WITNESS: So, Matt, since we've 21 stipulated that within three days is a very wide 22 range of things going on, I would sure like to
106 1 though, that in Claim 8, it doesn't have the 2 requirement of stability for the patient, does it? 3 A Again, Matt, I'm obviously not a patent 4 attorney. But in my own patent submissions over 5 the years, the evidence one has is usually what I 6 understand things matter, and these are all stable 7 patients. So I -- I'm, again, not quite sure what 8 you're asking me. I mean -- 9 Q Just simply whether or not Claim 8 10 states the word "stable," "stability," 11 "stabilization." 12 A Is the word there? No. 13 Q Correct. 14 A But all the -- all the patients in the 15 data that this entire patent describes are stable. 16 Q Okay. Can we go over to the right-hand 17 column to Claim 27. 18 A I apologize. I'm very near-sighted. 19 Okay. 27 on your screen. I'm looking 20 at my thing. Again, let me just read it, Matt. 21 Because I've figured out I've got to read these 22 things.	108 1 believe that at 30 days, the patients are pretty 2 darn stable. 3 BY MR. WILKERSON: 4 Q Would you agree that within 30 days 5 includes earlier times than 30 days? 6 A Yes. 7 Q Okay. So that goes all the way back to 8 right after the MI, in theory. And so my question 9 is, is there any requirement in Claim 27 that the 10 patient be stable to initiate the colchicine 11 treatment? 12 A Again, Matt, the reason I'm just 13 struggling with your line of questioning is 14 because this clinical trial enrolled patients on 15 average 12 to 15 days after their myocardial 16 infarction and they're all stable. So parsing 17 these things is -- honestly, doesn't make biologic 18 sense to me. They're all stable patients. 19 Q Okay. Is that required in Claim 27? 20 A I'm sorry. Is -- is what required? 21 Q I'll -- I'll rephrase it. 22 Does Claim 27 state that a patient must

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109 1 be stable to initiate colchicine treatment? 2 A Claim 27 talks about a patient who could 3 be as far out of a myocardial infarction as 4 30 days. 5 Q And they could be as shortly out from a 6 myocardial infarction as one day. Right? 7 A Those patients were not entered into 8 this trial as far as I know. 9 Q In the COLCOT trial, were there no 10 patients that initiated colchicine within three 11 days of MI? 12 MR. LAURENCE: Objection -- 13 THE WITNESS: You asked me within -- 14 MR. LAURENCE: -- foundation. 15 THE WITNESS: Matt, I believe you asked 16 me within one day, and I -- and the answer is I 17 don't know. 18 BY MR. WILKERSON: 19 Q Okay. 20 A And -- 21 Q And -- 22 A And it does not appear to be.	111 1 Q I'm asking whether you know what they 2 do. 3 A Would you like my opinion on what this 4 patent's all about? 5 Q No. I guess just simply, do you know 6 why we have these multiple one-sentence claims 7 separated from the rest of the patent body? 8 MR. LAURENCE: Objection; relevance. 9 THE WITNESS: Again, Matt, I'm not an 10 attorney. I -- I. 11 BY MR. WILKERSON: 12 Q Okay. 13 A I don't -- I don't know why you guys do 14 it this way. No, I don't know. 15 Q That's fine. I just want to get back 16 one last time to Claim 27. 17 Does it state anywhere in Claim 27 that 18 the patient must be stabilized before initiating 19 colchicine? 20 A I -- I believe you've asked and I've 21 answered multiple times. You know, these -- these 22 22 patients are stable by definition.
110 1 Q Okay. And aside from the COLCOT trial, 2 this claim here, does it require the patient to be 3 stable before initiating colchicine? 4 A Again, Matt, I'm sorry to be so 5 redundant for you, and I apologize if it -- but 6 I -- I just don't understand what you're asking 7 me. Because the COLCOT trial, these are stable 8 patients. And I -- I'm under the impression from, 9 even not as an attorney, that the data one has is 10 the data that one has. 11 So I don't -- you know, you're -- 12 Q Do you have any understanding of -- of 13 what the purpose of the patent's claims are? 14 A Can I get in the mind of the person who 15 filed these patents and predict what they were 16 thinking? No. 17 Q I guess that's a fair -- fair answer. 18 We can -- we can correct the -- the wording a 19 little bit. 20 When looking at a patent, what is -- 21 what is the role of the claims? What do they do? 22 A Are you asking me a legal question?	112 1 Q And where in Claim 27 are you relying on 2 that understanding? 3 A Because the patients in the COLCOT trial 4 are stable. And that's the evidence that this 5 patent's based on, so. 6 Q Okay. Okay. Do you recall earlier we 7 were talking about -- 8 MR. WILKERSON: Can you -- Tech, can you 9 scroll back over to the left side of this page so 10 we can look at Claim 1? 11 And is there any chance that we can do a 12 side-by-side with Tab 11? 13 THE TECHNICIAN: Sure. 14 MR. WILKERSON: I think was Exhibit 4. 15 THE TECHNICIAN: Sure. Please stand by. 16 BY MR. WILKERSON: 17 Q And, Dr. Ridker, if you want to get 18 those two documents together, by all means. 19 A I'm sorry. What are we -- 20 Q Yep. So one is the patent and the other 21 is the provisional application. 22 A Okay. I have -- well, I have one in

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113 1 front of me -- I guess -- actually -- actually, 2 okay. I have -- I have both here. 3 Q Great. 4 MR. WILKERSON: And while the tech is 5 working on that, we can -- oh, awesome. 6 Okay. And, Sue, if you can go down -- 7 stay -- stay the patent where it's at, and on the 8 provisional, if you can go to the bottom of 9 page 2. The last paragraph on page 2. 10 That's great. 11 Q So, Dr. Ridker, you see here we have the 12 language in the patent, within about three days of 13 the MI. Do you see that in claim -- in Claim 1? 14 A I'm sorry. Which patent are you -- I'm 15 sorry. The right-hand side of your screen looks 16 like the file patent as compared to the 17 provisional. Is that right? 18 Q Yeah. So on the right-hand side of the 19 screen -- 20 A Yes. 21 Q -- we have the '063 patent, which is the 22 granted patent that's at issue in this -- in this	115 1 Do you see that? 2 A Yes. 3 Q In your opinion, would a POSA understand 4 that both these initiation time frames of within 5 five days and within three days overlap? 6 MR. LAURENCE: Objection; answered. 7 THE WITNESS: I'm a little confused 8 here, Matt. 9 BY MR. WILKERSON: 10 Q Sure. You have one reference describing 11 a treatment regimen wherein the colchicine is 12 administered within five days of the MI. Right? 13 We have another treatment regimen, another 14 reference, I should say, where the treatment 15 regimen describes the colchicine initiated at 16 about three die -- three days of the MI. Right? 17 A (Indiscernible.) 18 Q My question is -- go ahead. Go ahead. 19 Sorry. 20 A If the one on the left is the 21 provisional one, it looks like they're saying, 22 again, just to read it, that it could be at 5, it
114 1 IPR. 2 A Okay. 3 Q And we're looking at Claim 1 for that. 4 And on the left-hand side is the November 2019 5 provisional application, and we're looking at 6 page 2. The -- the last paragraph there. 7 Do you see that? 8 A Yes, this is the paragraph that we went 9 over before. 10 Q Correct. Awesome. 11 And so we were talking about, earlier, 12 within three days and within five days. Do you 13 remember that? 14 A Yes. 15 Q Okay. So on the right-hand side in 16 Claim 1, we see initiating the colchicine within 17 about three days of the MI. Right? 18 Do you see that? 19 A Yes. 20 Q On the left-hand side, we see in some 21 embodiments the method involves administering 22 colchicine within five days of the MI.	116 1 could be at 10, it could be at 15, it could be at 2 20, it could be at 25. As far as I can tell, 3 they're saying it could be anytime you wanted. I 4 mean, it just -- they're just putting out numbers, 5 right? I mean. 6 And for whatever reason, in the one on 7 the right, they've picked yet a different time. I 8 mean, okay. 9 Q Is the different time within the ranges 10 of the first times? 11 A Again, by definition of math, yes. But 12 from a biologic perspective, that first couple of 13 days is a radically different period of time for 14 what you do. So we're back to where we were 15 before. 16 Q Okay. Okay. 17 MR. WILKERSON: Can we have just Tab 11, 18 which is Exhibit 4, up? 19 Q So that's the provisional application, 20 Dr. Ridker. 21 A Okay. Thank you. 22 MR. WILKERSON: And can you go to the

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117 1 very bottom of this document? 2 Q Do you see at the bottom here, it says 3 "what is claimed," colon? Do you see that? 4 A I see a blank space. 5 Q And this is the end of your Exhibit 1 -- 6 or your Exhibit 1004? 7 A Yes, the front is marked 1004. It looks 8 like -- my page 21 looks like your page 21. Yes. 9 Q Okay. Do you know why you did not also 10 review the filed claims for this application? 11 A I'm -- 12 MR. LAURENCE: Objection. 13 THE WITNESS: I'm confused what you're 14 asking me, Matt. Do I know why I did what? 15 BY MR. WILKERSON: 16 Q Yeah, certainly. So there's additional 17 aspects of this application and that would be the 18 claims. Do you understand that? 19 A I see a blank space. 20 MR. WILKERSON: Let's keep this up and 21 pull up Exhibit 12. 22 THE TECHNICIAN: Do you mean Tab 12?	119 1 Q So Tab 11 and Tab 12. 2 A Matt, I got to apologize. I don't know 3 these tab numbers you're giving me. And what is 4 it you want me to compare this to? 5 Q The provisional application 6 specification that we were just looking at a 7 minute ago. 8 A Oh, okay. 9 Q Also has a header with an attorney 10 docket number. 11 A Give me a second. 12 Q I'm trying to compare that to the 13 document that we just handed you that's also on 14 the screen. 15 A Just give me a second. I got -- I put 16 the -- I got -- so they both say 022001. 17 Q Okay. So do you understand that these 18 refer to the same -- the same application? 19 A I'm assuming that legally, that must be 20 what -- yeah, yes. Yeah. 21 Q Okay. And do you see at the top of this 22 new document, it says "claims"?
118 1 MR. WILKERSON: Sorry, Tab 12. And that 2 will be marked as Exhibit 6. Thank you. 3 (RIDKER Exhibit 6 was marked for 4 identification and is attached to the transcript.) 5 Q Do you see that, Dr. Ridker? Do you 6 have that exhibit? 7 A If you put it up on the screen, I can 8 ver- -- validate that what I have been handed may 9 or may not be what you want me to look at. So why 10 don't we put it up on the screen? 11 MR. WILKERSON: Sue, can I get just that 12 Tab 12 up? We'll make life easier. 13 Q Dr. Ridker, do you see in the -- in the 14 top right corner there's an -- there's "attorney 15 docket number"? 16 A Yes, and it matches the one I have now 17 here in front of me. 18 Q Okay. And if you also look at the -- 19 the specification for the provisional application, 20 does that have the same attorney docket number? 21 A I'm sorry. What am I -- what am I 22 comparing this to now?	120 1 A I see the word "claims," yes. 2 Q Okay. And then do you see claim 3 number 2? 4 A I do. 5 Q Okay. And that also recited 6 administering colchicine within 5, 10, 15, 20, or 7 25 days of the MI. Right? 8 A Yes. I mean, they did a clinical trial 9 where people within 30 days, and they're just 10 putting down all the numbers between 5 and 25. 11 Q I guess my question is a little bit -- 12 so these are the claims that accompany the 13 specification that you relied upon for your 14 declaration. And my question is, why you didn't 15 also consider the claims? 16 A I don't understand, Matt. 17 Q Sure. We can take a step back. 18 Now that we've identified that these 19 share an attorney docket number and that these are 20 the claims for the November 2019 provisional 21 application, did you review this document in -- in 22 forming your opinions for this case?

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121 1 A I think so. I don't recall in great 2 detail, but I think so. 3 Q Okay. And then you're going to -- 4 you're going to really get frustrated with me, so 5 bear with me. 6 If we go to your declaration, the very 7 end, Appendix B. So it's going to begin on 8 page 315. 9 A Okay. 10 Q And this Appendix B is the list of 11 references you relied on for your declaration. 12 Right? 13 A Yes. 14 Q Okay. And you can take -- take time 15 looking at page 315 through -- through 318, and 16 let me know if you see the claims for provisional 17 application from November 15th, 2019, is provided 18 here. 19 A Yes. The third one down is 1 -- 10 -- 20 Q Actually, we -- sorry. And actually, I 21 agree. 1004, and we looked at that. And that 22 actually cut off before the claims. Right?	123 1 reason why you excluded the claims is they weren't 2 provided to you? 3 A Matt, I -- I -- I was asked to read some 4 stuff. I read them. 5 Q Yeah, no. I -- look, I -- I totally 6 understand it. I'm not trying to be sneaky or 7 anything like that. I just have to get a clear 8 record and everything like that, and check my 9 boxes. 10 So I guess my question is just, is the 11 reason why you did not cite to or include the 12 claims for the November 15th, 2019, provisional 13 application because they were not provided to you 14 by counsel? 15 A Matt -- 16 MR. LAURENCE: Objection; relevance. 17 THE WITNESS: Sorry. 18 MR. LAURENCE: Foundation. 19 THE WITNESS: I'm confused. Am I 20 supposed to answer or not? 21 MR. LAURENCE: Yes. 22 THE WITNESS: So I'm -- I don't know
122 1 A Yes. That's the one that has a blank. 2 Q Okay. So I guess I'm trying to 3 understand if you know why you didn't consider the 4 claims as well as Exhibit 1004. 5 A Matt, are you asking me why there's a 6 blank? 7 Q No. I'm asking you why in forming your 8 opinions, you did not choose to include these 9 claims in your exhibit list or consider them to 10 form your opinions? 11 A Again, Matt, with all due respect, that 12 sounds like a very legal question. I mean, 13 there's a blank. It's a blank. What am I 14 supposed to do with that? 15 Q I guess my question could simply be, 16 did -- did you go find these documents yourself, 17 or did counsel provide them for you? 18 A You think I went out and found these? 19 You got to make me laugh. I've got to tell you. 20 Obviously, I did not go out of my way to find 21 these, Matt. 22 Q Okay. So that's -- that's simply the	124 1 what the reason is. 2 BY MR. WILKERSON: 3 Q Okay. 4 A I'm not -- can't get inside of the head 5 of whoever the attorney was either, right? 6 Q I -- I understand that, and I'm not 7 trying to get inside anyone's head other than 8 maybe -- maybe yours a little bit. But -- but no 9 one else's. 10 All right. We can set those aside. 11 A Can you be clear what I can set aside? 12 Because I've got a big pile here. 13 Q Yeah. You can set aside both 14 provisional applications. 15 A Can I set aside this massive thing? The 16 one -- the one that's going to fall apart is 17 the -- 18 Q No, keep the massive thing, 19 unfortunately. 20 A Okay. All right. Hang on. 21 Q If -- 22 THE WITNESS: Okay. These are all back

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125 1 to you? 2 MR. LAURENCE: Yep. 3 THE WITNESS: Okay. Got it. 4 BY MR. WILKERSON: 5 Q Great. We've already talked a little 6 bit about the COLCOT trial. Is that right? 7 A Very briefly. 8 Q Yep. And in your declaration to form 9 your opinions, you rely on a re- -- reference 10 that, for the purposes of today, we'll call the 11 COLCOT protocol? 12 A Well, we're relying on a lot of things, 13 including the main publication of the COLCOT paper 14 in the New England Journal of Medicine. We're 15 looking at the 2020 European Heart Journal paper, 16 we're looking at the protocol, we're looking at 17 dozens and dozens of documents, so I'd -- so yeah. 18 Q Okay. Let's go ahead -- and just to 19 clarify something so we're on the same page. If 20 you go to your declaration -- 21 A Yep. 22 Q -- and you look at page 40.	127 1 slow. 2 So you see the first subsection here is 3 this '891 patent that we've termed "Nidorf." Do 4 you see that? 5 A Yes. 6 Q Okay. Now if you go down to page 42, 7 and we've already looked at this one. And this 8 second subsection -- 9 A Can I just clarify, have -- have we 10 looked at Nidorf? 11 Q We have not looked at it yet. I'm -- 12 A Oh, I thought you said we looked at it. 13 I don't recall looking at it today. Okay. 14 Q Sorry. This subsection number 2, we 15 have looked at. Correct? 16 A Where are you now? Hang on. 17 Q Page 42. And it's the European Heart 18 Journal 2020? 19 A Yes, I still have that paper sitting 20 here on my left. 21 Q Okay. And then if we go down to 22 page 45.
126 1 A Matt, can you give me one small second 2 for something that has nothing to do with this 3 case? I'm getting a text from a -- I want -- I 4 want to make sure it's not a clinical thing. 5 Just -- can I just have one second? Is that all 6 right with you? 7 Q Yeah. 8 A It should not take more than a second. 9 I just want to make sure. 10 Thank you. Appreciate that. Okay. I'm 11 sorry. I'm back. 12 Q Great. Okay. So if we look at this 13 section, you see it says "ground 1 through 4 14 references"? 15 A Yes. 16 Q And then there are subsections with five 17 references following that. First one is Nidorf, 18 Bouabdallaoui, COLCOT protocol, ESC Guidelines, 19 and COLCRYS? 20 A I'm -- I'm sorry, Matt. Where? 21 Q Take -- you can take a minute and 22 I'll -- we can walk through this. Let's take this	128 1 A Okay. 2 Q Subsection 3, that's COLCOT protocol. 3 Right? 4 A I see it listed, yes. 5 Q Okay. And then if we go down to page 47 6 to subsection 4. You'll see it says "ESC 7 Guidelines"? 8 A I see that. 9 Q Okay. And then if we go to page 49 to 10 subsection 5, do you see there it says "COLCRYS"? 11 A I -- I see that section, yes. 12 Q Okay. So do you understand that these 13 are what -- what you've relied on for your 14 opinions as the five allegedly invalidating 15 references? 16 A I don't have a legal opinion on what an 17 invalidating reference is, but I -- I -- I know 18 these are -- are important to this case. 19 Q Okay. Do you understand these as being 20 the references relied upon for grounds 1 through 21 4? 22 A Matt, I -- I -- I am familiar with these

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129 1 references if that's what you're asking me. 2 Q Okay. Let me -- let me ask this a 3 little bit differently. 4 The Tardif 2019 reference is not 5 included in these subsections. Right? 6 A I'm sorry. Tardif 2019 is the New 7 England Journal paper? 8 Q Yes. 9 A The primary report of the COLCOT study, 10 if that -- I mean, I am familiar with it, yes. 11 Q Okay. But that -- that's not one of 12 the -- the key references included here. Right? 13 In this section? 14 A You want me to go through the entire 15 declaration to see whether we do or don't 16 reference the New England Journal of Medicine 17 paper? I'm a little confused. 18 Q No, no, no. I will -- I will stipulate 19 that throughout your declaration at certain points 20 you refer to that New England Journal article from 21 Tardif 2019. Not disputing that. 22 My question is just confirming that here 130 1 in Section D and then the subsections 1 through 5, 2 you don't have as one of your references you're 3 describing as that paper. Right? 4 A So, Matt, I -- I see lots of other 5 things here that say, you know, EX100 this, 100 6 that, do you want me to check every single one of 7 them? I -- I don't -- I haven't -- I don't know 8 what these all are. I can't tell looking at them 9 what they are. I have to go and check them all. 10 I don't guess that's what you want me to do. 11 Q That's fine. It's not -- it'll be a 12 waste of our time. 13 So let's, instead, if you can, go to 14 page 73. 15 A Okay. 16 Q Okay. Do you see subsection B, 17 ground 2? 18 A Yes. 19 Q Okay. And it's your opinion that: 20 Claims 27, 29 through 36, and 39 are 21 anticipated by COLCOT protocol. 22 Do you see that?	131 1 A I see it's written there. We'd probably 2 have to walk through 27, 29, 30, 31, 32, 33, 34, 3 35, 36, and 39 to review this, but that is what it 4 says. 5 Q Okay. And the COLCOT protocol is a 6 reference that you rely on. And you see down here 7 at footnote 163 labeled as Exhibit 1006. Do you 8 see that? 9 A I see it, yes. 10 Q Okay. Do you -- do you recall whether 11 or not that exhibit is the New England Journal 12 article? 13 A Traditionally, the New England Journal 14 of Medicine publishes the main manuscript. And 15 almost always in modern times the protocol is 16 published as a supplement with that. Whether or 17 not this is that supplement or another protocol 18 from the trial, I can't tell without looking. 19 But -- 20 Q Okay. Let's -- without -- without being 21 too frustrating to you because I understand you 22 have limited space, let's go back up to page 45 132 1 where you have your description of the COLCOT 2 protocol. And it begins at paragraph 76 if that's 3 helpful. 4 A Okay. 5 Q Do you see in that first sentence there, 6 you say: 7 COLCOT protocol is an updated version of 8 the protocol of the COLCOT trial, parens with the 9 study number, published on clinicaltrials.gov 10 website on March 8th, 2017. 11 Do you see that? 12 A I do. 13 Q Okay. So do you understand that the 14 reference you're calling the COLCOT protocol is 15 basically what is purporting to be a snapshot in 16 time of clinicaltrials.gov? 17 A Well, it says it's an updated version of 18 that. So I don't know that it's a snapshot of -- 19 I -- we can -- we can pull it and look at it. 20 That might be easier. 21 Q And we definitely will. I guess I was 22 trying to capture that you're -- you're relying on
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133 1 this version from -- from the March 8th, 2017 -- 2 A Actually, so, Matt, again with all due 3 respect, if -- when we pull it, I can affirm if 4 that's the one I relied on or not. But it says 5 here it's an updated version. So that's what it 6 says, right? 7 Q Yep, that's fine. 8 MR. WILKERSON: Can we have Tab 4 9 please. You can get Tab 4. And we'll be marking 10 this as Ridker Exhibit 7. 11 (RIDKER Exhibit 7 was marked for 12 identification and is attached to the transcript.) 13 Q Okay. Do you see this document? 14 A Yes. And I have it in front of me. 15 Q Okay. Do you recognize this document? 16 A This is a printout from the 17 Clinicaltrials.gov website that gives very brief 18 summaries of clinical trials that are ongoing. 19 Q Okay. And is this the reference that 20 you relied on in your declaration that you called 21 "COLCOT protocol"? 22 A I don't recall exactly, but I kind of	135 1 whatever you're asking me here. So I'm going 2 to -- COLCOT protocol acknowledges that, one, 3 atherosclerosis is the most common cause 4 (indiscernible reading). 5 Okay. And three -- likely -- okay. All 6 right. Okay. Pretty vanilla. All right. 7 Q Yep. And I guess the key purpose here 8 is the footnote 105. 9 A Yes. 10 Q And do you see that is Exhibit 1006? 11 A Yes. But, Matt, I think you asked me 12 what I relied on. And I relied on what we 13 scientifically call the protocol, which comes in 14 lots of different forms. So if you're asking 15 which one I relied on, I'm sure this is one -- one 16 of them. Right? 17 Q Do you understand that for anticipation, 18 that you rely on a single reference? Do you 19 recall that? 20 A Are you ask -- I'm sorry. Are you 21 asking me a legal -- a legal question again? 22 Q So we saw a little bit ago, just a
134 1 doubt it. I would have probably used the 2 protocol. 3 Q Okay. If you look at the bottom right 4 of the first page. 5 A Bottom right, yes. 6 Q Do you see the footnote "Murray & Poole 7 Exhibit 1006"? 8 A Yes. 9 Q And if you want, you can flip back to 10 where we just were in your declaration? 11 A Help me, Matt. 12 Q Yeah, sure. Page 46 actually is where 13 the footnote's going to drop in. And if you're at 14 page 46, do you see paragraph 77? 15 A Yes, I see paragraph 77. 16 Q And there's a big, long sentence that 17 concludes with footnote 105? 18 A I do see that sentence. 19 Q Okay. And if we go down to footnote 20 105, it says "Exhibit 1006 parens COLCOT 21 protocol"? 22 A Well, hang on. Let me just read	136 1 couple minutes ago, down on page, I don't know, 2 70-something, that ground 2 that you've offered 3 opinions on is that certain claims, so Claim 27, 4 29 through 36, and 39 are anticipated by COLCOT 5 protocol. 6 Do you remember that? 7 A Yes. 8 Q Okay. And now we're looking at the 9 COLCOT protocol that you relied on. And for 10 anticipation, you rely on one reference. Do you 11 understand that? 12 A Let me -- let me go back to where we 13 were several hours ago. I've been in this field 14 for 30, 35 years. When I say rely on the 15 protocol, it could be from reading the actual 16 protocol, it could be some of my own clinical 17 trials, from writing the actual protocol, 18 sometimes we work on clinical -- I mean, 19 "protocol" means a lot of -- I mean, it's -- you 20 know, it's -- the protocol is how will this 21 clinical trial be conducted. What's on the 22 clintrials.gov website is usually a very brief

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137 1 summary of that. 2 Q Let's go -- I -- I hate to bounce 3 around. I'm really sorry for doing this. But if 4 we go to page 16 of your declaration. 5 A 16. Okay. Hang on. 6 Q Yep. 7 A Okay. 8 Q And we look at page 20. 9 A I'm sorry. 10 Q Oh, sorry. Paragraph 20. My -- no, no. 11 My -- I misspoke. Page 16, paragraph 20. Do you 12 see that? 13 A I see that. 14 Q Okay. And in paragraph 20, you wrote: 15 I have been informed by counsel and I 16 understand that the claims of a patent are, quote, 17 anticipated or not novel if a prior art reference 18 discloses every limitation in the claim. 19 Do you see that? 20 A I see that. 21 Q So do you understand that it has to be 22 a, as in singular, prior art reference discloses?	139 1 you know, I don't -- I don't understand what 2 you're asking me. 3 Q I -- I -- I'm trying to understand 4 because I want to make sure we're on the same 5 page that when we were looking just a minute ago 6 at Exhibit 7, which from your definition is 7 Exhibit 1006 that that's the same reference that 8 you had your opinions that these claims are 9 anticipated by. 10 A And what I'm trying to say, Matt, is 11 that in my recollection of thinking through all 12 the complexities of this issue and all the various 13 things that go into a scientific idea and a 14 scientific concept over time, and as someone who's 15 lived in this field intimately for at least 16 30 years, I can't tell you explicitly which one of 17 these. But I can tell you that it says an updated 18 version of what you're asking me about. 19 So I'm assuming it was an updated 20 version, which is probably the actual trial 21 protocol, not this brief summary. But I can't -- 22 I mean, that's, you know, I've asked -- you've
138 1 Do you understand that? 2 A As we said before, Matt, this was 3 written with a group of attorneys who were 4 interviewing me about the content. So I suspect 5 this is their language. 6 Q I under- -- I -- I definitely understand 7 how that can work. I guess my question is just 8 whether or not you understand that concept. 9 A It says I have been informed by counsel 10 and I understand the claims of -- and you're 11 emphasizing "a" I guess, are anticipated or not 12 novel if a prior art reference discloses 13 limitations. 14 Okay. 15 Q Okay. And then as we saw at page 73, 16 for ground 2, the prior art reference that you 17 relied on to conclude that Claims 27, 29 through 18 36, and 39 are anticipated is the COLCOT protocol. 19 A Matt, we've already been through the 20 fact that it says somewhere else in this bouncing 21 around business that the COLCOT protocol was an 22 updated version of this document. So that's --	140 1 asked me that several times now. 2 Q So is it your opinion that you're -- 3 you're unsure of which reference you relied upon 4 to -- to conclude that Claims 27, 29 through 36 5 and 39 are anticipated? 6 A Do you know, Matt -- 7 MR. LAURENCE: Objection; form. 8 THE WITNESS: I couldn't even tell you 9 what those claims are right now. If you want to 10 go through them slowly, we can. But my point is, 11 it says an updated version. To me, in plain 12 English, that suggests it's probably the actual 13 protocol, not this brief summary. But I don't 14 know what else to tell you. 15 BY MR. WILKERSON: 16 Q Okay. If you want, let's go to the -- 17 to the Appendix B at page 315 through 318. And if 18 you can -- 19 A I'm sorry. Appendix -- Appendix B of 20 what document? 21 Q Of your declaration. 22 A Okay. And can you give me the

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141 1 page number again? 2 Q Yeah. 315. 3 A All right. Thank you. Just a sec. 4 Q Yeah, no problem. 5 A I'm doing my best to keep this thing 6 from hitting the floor. 7 Okay. I'm on 315. 8 Q Okay. And then 315 goes through 318 for 9 Appendix B. 10 A Yes. 11 Q Do you have cited anywhere in there what 12 you're referring to as the actual protocol? 13 A Going through this briefly, I don't see 14 anything referring to any protocol in this 15 particular appendix. 16 Q Okay. So for the purposes of this 17 declaration, the specific document you relied on 18 is only this summary in clinicaltrials.gov for the 19 COLCOT protocol. Is that right? 20 A Matt, we seem to be asking and answering 21 the same question. I believe somewhere in this 22 line of questioning, somewhere in this thing, it	143 1 understand that? 2 A Matt, this is a clinicaltrials.gov 3 website. By definition, it gives very brief 4 summaries of -- of what a general clinical trial 5 will be about. The detailed protocol is what 6 investigators follow, what the investigators 7 write, it's what the clinical sites deal with, and 8 it's what the New England Journal publishes along 9 with their paper. And I'm pretty confident, yet 10 again, that what it says in my declaration is an 11 updated version -- 12 Q An updated -- 13 A -- which I assume is (indiscernible). 14 Q There's an updated version of the 15 protocol of the COLCOT trial published on the 16 clinicaltrials.gov on March 8th, 2017, and then it 17 cites to the clinicaltrials.gov website and this 18 document here. And if you look in the right-hand 19 corner, there's a date highlighted. Do you see 20 that? It says October 20, 2017? 21 A I'm sorry. Maybe you can show me on the 22 screen. I don't -- what am I looking at here?
142 1 said an updated version. I'm interpreting that as 2 the protocol of the trial. I don't -- you know, 3 you're asking me specifically which one it was, 4 and, you know, there's lots of versions of these 5 things. But the protocols are the protocol. I 6 mean -- 7 Q Okay. I mean, we can pick -- pick back 8 up exhibit -- Exhibit 7. Ridker Exhibit 7, which 9 has the clinicaltrials.gov website. It's on the 10 screen right now. 11 MR. WILKERSON: You can scroll to the 12 top, please, Sue. 13 THE WITNESS: I have it right here. 14 BY MR. WILKERSON: 15 Q Okay. So I guess -- and, again, 16 apologies. I'm not trying to be difficult. I'm 17 not trying to dupe you or anything like that, even 18 if I could. Right? 19 And I understand what you're saying is 20 that there's an updated version. And I just want 21 to be clear. I did not choose this document, 22 right? You put this in your declaration. Do you	144 1 Q Yeah. So up at the top, there's -- with 2 black and a yellow highlight, it says 3 October 20th, 2017? 4 A Mine says April 11th, 2023. 5 Q Right -- right below that? 6 A I see something that says October 20th, 7 2017. 8 Q Okay. So let me -- let's -- let's take 9 a step back that maybe can help some things here 10 and some of the confusion. 11 Do you see the URL at the very top? 12 H-T-T-P-S, colon, slash, slash web.archive.org? 13 A Yes. 14 Q Okay. Are you familiar with that 15 website? 16 A Do I know that URL by heart? No. 17 Q Are you familiar with the website 18 referred to as the WayBack Machine? 19 A The what machine? 20 Q WayBack. 21 A The way -- no, I don't know. I don't 22 know what the WayBack Machine is.

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145 1 Q Okay. That's fine. 2 A Are we -- 3 Q Let's -- 4 A I'm sorry. Are we time traveling now? 5 I don't quite get it. What's that all about? 6 Q You know, that's -- it's a -- it's a 7 website tool where you can find archived webpages 8 and -- and since you did not speak with Mr. Cruitt 9 or read his declaration, you know, I don't think 10 there's really much we can talk -- talk about 11 regarding the WayBack Machine. 12 A Okay. 13 Q But is all I really wanted to establish 14 here was that this is the document that you relied 15 on in your declaration. Is that right? 16 A Matt, the reason we're struggling here 17 is that it clearly says an updated version. And, 18 again, as someone who lives in the world and 19 understands what this is all about, I'm pretty 20 confident that I would have relied on the actual 21 protocol as well as this. 22 But I don't know -- you're asking me in	147 1 that, you know, pharmaceutical companies can't 2 hide what they're doing. So it's -- it's a public 3 disclosure website, right? That's what its 4 purpose is. But it's not meant to be definitive 5 protocol. 6 The protocol is the other document, and 7 it's -- and, again, you know, we say there it's -- 8 that my opinion's based on an updated version, 9 which is to me the -- again, if you want pull the 10 updated version, we can go through that. That'd 11 be fine. 12 Q Okay. Great. That's -- that's fine 13 with me. 14 MR. WILKERSON: Can we -- can we have 15 Tab 5 please? And we'll mark that as Ridker 16 Exhibit 8. 17 (RIDKER Exhibit 8 was marked for 18 identification and is attached to the transcript.) 19 Q And, Dr. Ridker, do you have the 20 document? 21 A Yes. 22 Q Okay. Do you recognize this document?
146 1 my deposition what did I specifically rely on, and 2 it says updated version. If you want to show me 3 an updated version, I can describe -- 4 Q Is -- 5 A -- whether that looks like what I saw or 6 not. I don't know. I mean. 7 Q Is there any reason that you believe 8 that this is not the reflection of what would have 9 been the updated version as of March 2017 when 10 this is coming from October 20th of 2017? 11 A Oh, absolutely. Clintrials.gov is -- 12 these -- these are brief summaries. We don't -- 13 these are not the full, detailed -- I mean, I -- I 14 don't have it here. May- -- maybe it's in one of 15 these things here. Maybe not. I don't know. 16 But I mean, the full protocol is 17 usually -- I mean, sometimes they go on to 150, 18 200, 300, you know, pages. This is -- this is -- 19 this is, by definition, meant to be a website that 20 people go to to, you know, do a quick search, what 21 are -- what are people studying out there? And 22 it's a website -- it's a very important website so	148 1 A At first glance, it does not look 2 familiar to me, no. 3 Q Okay. 4 A But, I mean, I don't know if it's part 5 of -- I don't know. 6 Q Do you see that this is from 7 clinicaltrials.gov? 8 A Yes. 9 Q Okay. And do you see in the top left 10 corner there's a date and timestamp? 11 A I see March 18th, 2024. 12 Q Okay. And then if you go down to the 13 bottom of this first page, do you see the 14 footnote? 15 A Maybe you can circle it or something. 16 I'm not quite sure what we're looking at. 17 Q Yeah, the footnote with the full web 18 address. Do you see that? 19 A I see a web address down there. 20 Q Okay. Great. 21 Do you recognize this to be a page from 22 clinicaltrials.gov for COLCOT trial?

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149 1 A If you say so. I mean -- 2 Q Okay. No, that's fine. I'll -- I'll 3 represent to you that this is the record history 4 report from clinicaltrials.gov for COLCOT. 5 A Okay. 6 Q And we were talking about protocol 7 submissions. So if you go to page 13 of this 8 document. 9 A Matt, do you -- since I'm not super 10 familiar with this document, do you want me to 11 read this? I'm a little confused what we're doing 12 here. 13 Q I'm going to ask you a question about a 14 portion of the document. If you need to -- to 15 flip through it to familiarize yourself, please 16 do? 17 A Just because -- just I want to make sure 18 I understand. You -- you suggested this is some 19 sort of a record of -- of what? 20 Q You -- well, you had -- you had 21 requested that we look at the updated 22 (indiscernible), right? So -- so here's the	151 1 Q And then there's a document label, and 2 it says a date of the document. Do you see where 3 it says 2018 November 15th? 4 A I see that. 5 Q And then right below that, it says 6 "uploaded 2020 July 16th"? 7 A I see that. 8 Q Okay. 9 MR. WILKERSON: So now we can turn to 10 Tab 6. And we'll mark this as Ridker Exhibit 9. 11 (RIDKER Exhibit 9 was marked for 12 identification and is attached to the transcript.) 13 THE WITNESS: I'm sorry, Matt. Just 14 because I don't have a lot of table space, are we 15 done with this? 16 BY MR. WILKERSON: 17 Q Yeah, you can put that -- you can put 18 that away. 19 A Okay. 20 Q Okay. And do you have the Exhibit 9 in 21 front of you? 22 A Yes.
150 1 summary from clinicaltrials.gov updated with the 2 record history included? 3 A Ah, I see where our confusion lies. 4 When I say "updated," to me that means the 5 published protocol of the trial. You're taking me 6 to a document that looks like something very 7 different than what I'm familiar with. 8 Q Okay. If you'll bear with me, our next 9 stop will be the document I think that you're 10 familiar with. 11 A Okay. 12 Q So if -- if -- if you're comfortable, 13 can we go to page 13? 14 A Okay. 15 Q And do you see it says "Document 16 Section"? 17 A I see that. 18 Q About halfway down? 19 A I see it on your screen, yes. 20 Q Yep. And then right below that, it says 21 "Study Protocol"? 22 A Yes.	152 1 Q Okay. Do you recognize this document? 2 A This looks more familiar to me than the 3 other ones do, yes. I -- 4 Q Okay. And do you see in the upper 5 left-hand corner, there's a date, November 15th, 6 2018? 7 A Yes. 8 Q Okay. And this looks familiar to you. 9 Did you review it in forming your opinions for 10 this case? 11 A In forming my opinions in this case, I 12 did review at various times the main paper of 13 COLCOT. I did review its protocol. Whether it's 14 this exact one or not, my guess is the one I would 15 have reviewed probably would have been the one 16 that one can download in the public space from the 17 New England Journal. 18 But I mean, it's probably quite similar, 19 if not the same. I can't -- I'd have to actually 20 read the thing and cross tab it to make sure. But 21 at least it looks a lot closer than the other ones 22 you've showed me. Let's put it that way.

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153 1 Q Okay. And as we saw in your Appendix B, 2 Materials Cited, you did not include this document 3 in that appendix. Correct? 4 A I don't think Appendix B had any 5 protocols in it. 6 Q Okay. Great. You can put that aside. 7 A Okay. 8 MR. WILKERSON: We've been going a 9 little more than an hour if you need a break. 10 Otherwise, I will keep going. But it just -- it 11 was a decent stopping point. So I wanted to 12 afford you that opportunity. 13 THE WITNESS: I'm -- I'm okay. But if 14 other people want a -- it's up to you guys. 15 There's a lot of other people besides me here, 16 Matt. 17 MR. LAURENCE: We've -- we've ordered 18 lunch to arrive at noon. 19 MR. WILKERSON: Okay. So do you want to 20 take a break at noon? 21 MR. LAURENCE: Yeah. 22 THE WITNESS: Okay.	155 1 page 10 of this document? 2 Q And then before we scroll anywhere, 3 Dr. Ridker, to -- to aid us with patent 4 navigation, you'll see that there's two columns. 5 At the top of each page, there's a bolded number 6 and that identifies the column number? 7 A I see that. 8 Q Yeah. So if I refer to a column, that's 9 what I'm referring to. 10 So on page 10, and if we look at the 11 left-hand column, which is Column 15, at the 12 beginning of the last paragraph. Do you see that? 13 A Yes. 14 Q And this paragraph describes different 15 amounts, concentrations, and dosages of the 16 composition, which we can go look if you need to 17 confirm, but it's colchicine. And then it lists a 18 variety of ranges of dosages. 19 Do you see that? 20 A Yes. 21 Q Okay. And then if we continue over to 22 the right-hand side towards the top at Column 16.
154 1 MR. WILKERSON: Okay. Great. 2 Can we pull up Tab 7 please? And we'll 3 mark that as Ridker Exhibit 10. 4 (RIDKER Exhibit 10 was marked for 5 identification and is attached to the transcript.) 6 THE TECHNICIAN: Yes, sir. 7 BY MR. WILKERSON: 8 Q Do you have that document in front of 9 you, Dr. Ridker? 10 A Yes. 11 Q And do you recognize this document? 12 A Yeah. At some point in the past, I have 13 seen this or something that looks very much like 14 it. This looks to be the original patent from 15 Dr. Nidorf. 16 Q It's the '891 patent. Your declaration 17 simply refers to this document as Nidorf. Is that 18 fair? 19 A Yes. I understand this to be the Nidorf 20 patent, yeah. 21 Q Okay. 22 MR. WILKERSON: Can we go down to	156 1 And do you see the second -- sorry, the first full 2 paragraph on that page, which begins at Line 8? 3 It begins "in a preferred embodiment." 4 A Matt, just give me a second. I'm trying 5 to read the full paragraph prior to that because I 6 want to make sure the context is understood here. 7 So just give me a second. 8 Q Yeah, that's fine. 9 A Okay. So now I'm up to your Line 8. 10 Q Okay. 11 A I think. Okay. 12 Q And it says: 13 In a preferred embodiment, the 14 amount/concentration of colchicine as used herein 15 can be administered at the first day of 16 administration in a higher dose, parens 17 concentration/amount, close parens, compared to 18 the administration of colchicine at the following 19 days of administration, parens maintenance 20 administration/maintenance dose of administration, 21 close parens. 22 Do you see that?

157 1 A Yes. 2 Q Okay. So a POSA reading this would 3 understand that Nidorf discloses the possibility 4 of using colchicine with a loading dose and then a 5 maintenance dose. Is that right? 6 A He's talking here about potentially 7 using a higher dose on the first day. That's what 8 it says, right? 9 Q Okay. And if you go down in that 10 paragraph to Line 23, the sentence begins 11 "preferably the composition of". 12 A So, again, let me just -- can we just 13 read in between there. I -- I don't like -- 14 Q Yeah, certainly. 15 A If you don't mind. 16 Q No. That's absolutely -- that's 17 absolutely fine. Why don't you feel free to go 18 ahead and read that full paragraph. 19 A Okay. (Indiscernible reading.) 20 The course of treatment in any such as 21 described above, the higher dose, amount, 22 concentration (indiscernible reading) can be	159 1 A Well, the word "loading dose" is not 2 here. It talks about giving a prior dose followed 3 by a stable lower dose. 4 Q Would you understand that as a loading 5 dose? 6 A I understand it as a higher dose and 7 a -- and a lower dose. 8 Q As opposed to generally, would you 9 regard a first dosage at a higher amount or 10 concentration to be the same as a loading dose? 11 A I'm not trying to be difficult here. I 12 mean, it's -- it's -- to use the really horrible 13 phrase in recent history, it's quite 14 context-dependent. 15 Q Okay. 16 A Yeah. 17 Q Before -- 18 A It says -- it just says higher and 19 lower. So that's what I think we're safe on. 20 Q Well -- well, let me ask this. Before 21 being used in the CV context, colchicine was used 22 for other diseases and disorders. Right?
158 1 any -- any as described above. (Indiscernible 2 reading) the maintenance dose. 3 (Indiscernible reading) following a 4 higher dose, amount, concentration is lower than 5 the initial dose concentration, e.g. the first 6 day. 7 Okay. Now I'm down to your part. 8 Preferably, the composition of the 9 invention is administered with a dose of between 10 one and two. Preferably (indiscernible reading). 11 With the sole editorial comment being I 12 wish you lawyers would go to writing school, I 13 have now read it. 14 Q Okay. And would you agree that a POSA 15 would understand this paragraph describing that 16 you can initiate colchicine with a loading dose 17 and then a maintenance dose? 18 A Again, it seems that in this legal 19 document, they're covering lots of waterfront 20 here. 21 Q Okay. And part of that is using a 22 loading dose and then a maintenance dose?	160 1 A Correct. 2 Q That would include gout and FMF? 3 A Among others, yes. 4 Q Okay. And in those contexts, was 5 colchicine commonly understood to be used as 6 initiated with a loading dose and then a 7 maintenance dose? 8 A So, again, in the example of colchicine, 9 but also in the example of many other drugs, 10 that's why I said context does matter. So let's 11 parse these carefully. 12 In the setting of gout, yes. We 13 typically would give a higher dose initially. 14 Very commonly followed by another decently large 15 dose. Because we're at a very acute inflammatory 16 setting, the patient's in pain, we're trying to 17 help relieve that pain, and it's a very different 18 setting. 19 And by the way, in that setting, gout, I 20 mean, we typically treat for, I don't know, maybe 21 two or three days. And generally stop therapy in 22 some really high-risk patients who have had a long

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161 1 history of recurrent gout, some physicians would 2 treat on a chronic basis. But gout's 3 fundamentally an intermittent, you know, 4 refractory thing that you treat very short term at 5 high doses because you're trying to help the 6 patient out. 7 But let's flip to your second example, 8 which was, I believe, familial Mediterranean 9 fever. Let me stipulate right here that I've 10 never treated a patient with familial 11 Mediterranean fever. My colleagues who live in 12 North Africa, Jordan, Israel, Syria, Lebanon will 13 have treated tens of thousands of such patients. 14 But I -- I have not. 15 But my understanding is that's a 16 disorder, again, where you're on a very long-term 17 chronic exposure to colchicine. 18 So as I say, it's -- it's extremely, you 19 know, disease and -- and an unfortunate word, 20 context-dependent. 21 Q Okay. I think that's fair. But I think 22 just to make sure we're clear, we agree that this 162 1 paragraph in Nidorf describes this preferable 2 administration where colchicine is administered on 3 day one of 1 to 2 milligrams and then the 4 maintenance dose on the following days is between 5 half a milligram and 1 milligram. Is that fair? 6 MR. LAURENCE: Objection; form. 7 THE WITNESS: I'm sorry. What -- what 8 are we doing? 9 BY MR. WILKERSON: 10 Q Yeah. I just was trying to make sure we 11 were clear after parsing out the loading dose 12 versus higher and lower -- or, sorry. Yeah, 13 loading dose and higher and lower dose. 14 Just making sure that we at least agree 15 on the fact that Nidorf says here that preferably 16 the colchicine is administered with a dose on day 17 one of 1 to 2 milligrams, and then after that, a 18 maintenance dose on the following days is between 19 half a milligram and 1 milligram? 20 MR. LAURENCE: Objection; form. 21 THE WITNESS: I -- I'm sorry. What are 22 we --	163 1 MR. LAURENCE: You still have to answer. 2 THE WITNESS: Oh, I still have to 3 answer. Oh, I'm sorry. 4 I see that this says that. Of course, 5 the clinical trial they did simply gave a fixed 6 dose at 0.5 once a day. It's what they did. 7 BY MR. WILKERSON: 8 Q What was that clinical trial? 9 A That was the original low-dose 10 colchicine trial. What I call LoDoCo 1. I guess 11 some people -- I don't -- I don't -- we'd have to 12 figure out how you -- what you guys are calling 13 it. The original study from Nidorf. The early -- 14 early -- the early study. 15 Q Was LoDoCo 1 placebo-controlled? 16 A No. It was a open-label study. 17 Q Okay. 18 MR. WILKERSON: You can pull that down. 19 THE WITNESS: Give that back to you? 20 MR. LAURENCE: Okay. 21 MR. WILKERSON: I'm sorry? 22 THE WITNESS: No, I'm sorry. I'm just 164 1 handing the documents around here. 2 MR. WILKERSON: Oh, okay. Yeah, no 3 problem. 4 I would like to go to Tab 10, which 5 we'll mark as Ridker Exhibit 11. 6 (RIDKER Exhibit 11 was marked for 7 identification and is attached to the transcript.) 8 Q And I apologize for the version of this. 9 Do you have that document? 10 A I do. 11 Q Okay. And I -- I am confident I know 12 the answer, but do you recognize this document? 13 A I do. 14 Q Okay. And what is this document? 15 A Well, this is the cover of the New 16 England Journal. I'm assuming that what follows, 17 and I look at it, is -- is my own manuscript from 18 what we call the CANTOS trial. 19 MR. WILKERSON: Yeah. Sue, can you 20 scroll down to page 2 please? 21 Q And my apologies that your work is 22 depicted in this scanned version, but nonetheless,
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165 1 yeah. So you said this is the -- the publication 2 from the CANTOS trial. Is that right? 3 A Correct. 4 Q And what did you investigate in the 5 CANTOS trial? 6 A Wow. Okay. In my field, which has been 7 trying to understand the role of inflammation as a 8 potential -- one of many potential causal agents 9 in atherosclerotic disease, we and others have 10 published a lot of work leading up to this trial 11 describing how inflammatory biomarkers are 12 elevated in patients at risk. We had done some 13 previous landmark clinical trials showing that 14 statin therapy is effective in patients who have 15 this thing we call residual inflammatory risk. 16 But up until this particular 17 publication, there was no fundamental proof that 18 lowering inflammation, per se, lowers 19 cardiovascular event rates. This is what we call 20 a cardiovascular outcomes trial. We're trying to 21 show not changes on a biomarker or changes on a 22 surrogate endpoint, but if we give a -- in this	167 1 took many years to complete, and it provided the 2 field with the first evidence that, ah-ha, this 3 actually works. So it's sort of a landmark paper 4 in the field. 5 Q So it never tests colchicine, though, 6 does it? 7 A No. 8 Q Okay. And, you know, you described that 9 it showed and provided evidence that targeting the 10 anti-inflammatory pathway can reduce 11 cardiovascular events. And I'll also up front 12 apologize at any point if I overgeneralize your 13 work. But is that accurate? 14 A Well, it's not the inflammatory pathway. 15 There are many, many pathways of inflammation. 16 And for better or for worse, there's many types of 17 inflammation that affect the body in many, many 18 different ways. 19 Without getting too far into the weeds 20 here, we could spend days talking about it if we 21 wanted to. This is a -- this particular drug, 22 canakinumab, inhibits a very specific pathway of
166 1 case, a very targeted anti-inflammatory 2 intervention, happens to be a drug called 3 canakinumab, which is a monoclonal antibody 4 targeting a certain cytokine called interleukin-1 5 beta, and that has the scientific advantage of 6 being a very, very sharply-honed scalpel. 7 Monoclonal antibodies have some ups and downs, but 8 one of the beauties of them scientifically is we 9 know exactly what it does. 10 In prior work developing this concept, 11 we have shown that this drug, for example, doesn't 12 affect cholesterol levels. That's probably the 13 best example I can give you. We're trying -- 14 we're trying to establish that giving an 15 anti-inflammatory drug could lower actual heart 16 attacks and strokes, things like that, without 17 confounding by other factors. 18 So in any event, this is the pivotal 19 study in the field of does targeting inflammation 20 at least with this particular intervention lower 21 cardiovascular event rates or not. And, you know, 22 it's a roughly 10,000-patient clinical trial that	168 1 innate immune function that -- and I apologize. 2 Some of this is just going to be jargon because I 3 don't know how else to express it. Leads from 4 something called the NLRP3 inflammasome, which we 5 all have. It's very important for childhood 6 survival, for dealing with infections, for dealing 7 with foreign tissues and things. 8 That inflammasome, through some 9 extremely complicated biology, activates certain 10 inflammatory signaling cytokines. They go by the 11 names of interleukin-18 and interleukin-1 beta. 12 These have some direct effects on the vascular 13 system that are adverse. We and others have 14 proven that in the past. 15 Just to finish this -- and I apologize. 16 Interleukin-1 beta, in turn, will regulate -- 17 up-regulate a central signaling cytokine known as 18 interleukin-6, which has very important functions 19 that are -- are not, I mean, we can -- I don't 20 want to go into it right now. But a very 21 important inflammasome process. 22 And ultimately, that interleukin-6 and

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169 1 some of these other related cytokines sort of tell 2 the liver, produce the biomarker of this process, 3 something called C-reactive protein, that we 4 measure with a clinical assay called 5 high-sensitivity C-reactive protein, which is the 6 biomarker that says my patient is at risk for a 7 future heart attack or stroke, not necessarily 8 because of their cholesterol or their blood 9 pressure or they're smoking, but because they have 10 a high CRP. 11 So I'm sorry for that description, but 12 this study blocks that pathway at the level of the 13 interleukin-1 beta, and then without going through 14 the details show that that indeed will reduce the 15 risk of a heart attack or a stroke in patients who 16 are already getting what we call 17 guideline-directed medical care. They're on all 18 the good therapies that you'd want to be on. 19 So the addition of this, it is a 20 placebo-controlled trial, but of course, a placebo 21 group that is getting very aggressive background 22 care. And so this paper demonstrates that 170 1 blocking that pathway, at least at the level of 2 interleukin-1 beta, resulted in a clinical benefit 3 that was meaningful. 4 Q Yeah. Thank- -- thankfully, we're not 5 letting the placebo group just hang out there 6 without any treatment. 7 So on a -- on a individual level -- 8 well, actually, let's -- let's step back. I'm 9 sorry. Strike that. 10 Would you agree that the cause of a 11 cardiovascular event like an MI is multifactorial? 12 A Yes. 13 Q Okay. So there are circumstances in 14 which you could effectively control for the high 15 sensitivity -- high-sensitivity CRP, and a patient 16 still then have an MI? 17 A Oh, just like you can control LDL 18 cholesterol or blood pressure and still have a 19 heart attack. These are -- these are things we do 20 to lower the risk. But they don't take that risk 21 to zero, no. 22 Q Yes, absolutely.	171 1 Okay. And -- and would you say that 2 because of the multifactorial nature of CV events 3 that the effectiveness of treatments or 4 preventions is -- is less predictable? 5 A I'm sorry. The -- can you say that 6 again? 7 Q Sure. Does the multifactorial nature of 8 CV events make the predictability of treating or 9 preventing them more or less? 10 MR. LAURENCE: Objection; form. 11 THE WITNESS: It's not how physicians 12 think. So this -- this is a clinical trial -- 13 the -- the reason it has very large numbers, it's 14 10,000 patients -- and, again, I don't -- I don't 15 want to be pedantic here, but maybe it's just 16 worth saying it. The reason we do randomized 17 trials is to directly address kind of what you're 18 intuiting. Although, I can't really guess what it 19 is you're intuiting, I suppose. 20 But -- but the reason we randomize 21 patients is to guarantee as best we possibly can 22 that all the things that we're smart enough to 172 1 know about that might associate with a heart 2 attack, high cholesterol, smoking, blood pressure, 3 behaviors, lifestyle, and all the things that 4 we're not smart enough as scientists to know about 5 that we can't even name, that they're equally 6 distributed in Group A and B. 7 And then in a double-blind manner in 8 this particular case have -- well, in this case, 9 it's actually -- it's a little complicated here 10 because there's three different treatment doses. 11 But some are getting active therapy, some are 12 getting the placebo on top of aggressive care, and 13 that allows us to say at the end of the study, if 14 there's a difference between the groups, that 15 there's a fundamental improvement based on this, 16 in this case, extremely narrow biologic 17 intervention. 18 Q No, I -- 19 A I don't know -- 20 Q And I -- 21 A I don't know if that answered your 22 question or not.
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173 1 Q No, not at all. I -- I -- thank you for 2 the explanation. And I was getting a little 3 different. 4 So kind of outside of the -- I don't 5 know, if I abbreviate, RCT world, if we look at -- 6 just generally speaking, if the cause of a, let's 7 say disease is one factor, one factorial. We know 8 it's -- we know what causes it and -- and we can 9 target that, the effectiveness of a therapy, would 10 you consider that to be rather predictable or not? 11 MR. LAURENCE: Objection; form. 12 THE WITNESS: So, again, to use this 13 phrase that the ex-president of Harvard had 14 trouble with, this is extraordinarily 15 context-dependent, Matt. 16 You know, some diseases have one cause, 17 some diseases have multiple causes. And the 18 reason we have to do these large randomized trials 19 is to figure out what truth is. I, you know -- I 20 mean, it's what we do. 21 BY MR. WILKERSON: 22 Q I -- I -- that's fair. I guess I'm	175 1 MR. LAURENCE: Yeah, let's go ahead and 2 take a break. 3 MR. WILKERSON: Great. Let's go off the 4 record. 5 THE VIDEOGRAPHER: We are going off the 6 record at 12:06 p.m. 7 (Whereupon, there was a recess in the 8 proceedings.) 9 THE VIDEOGRAPHER: We're going back on 10 the record. The time is 12:47 p.m. 11 THE WITNESS: (Indiscernible.) 12 UNKNOWN SPEAKER: (Indiscernible.) 13 THE WITNESS: Anybody else -- 14 MR. WILKERSON: Let's go back off the 15 record quick and see if we can fix the echo before 16 we start. 17 THE WITNESS: I think you need to turn 18 your sound off there. At least on my end. 19 THE VIDEOGRAPHER: We're going off the 20 record. The time is 12:48 p.m. 21 (Brief pause off the record.) 22 THE VIDEOGRAPHER: We're going back on
174 1 trying to understand a little bit if you have any 2 opinions about whether the ability for a new 3 therapy to treat a disease is -- is any different 4 predictability based on whether it's a very 5 complex disease or a very simple disease. 6 A Don't I wish there were simple diseases, 7 Matt. Let me tell you, for the patient who has 8 that disease, it's not simple no matter what it 9 is. So I -- you know. 10 Q So your answer is -- is there's no -- 11 there's no difference? 12 A I don't -- 13 MR. LAURENCE: Objection; form. 14 THE WITNESS: I don't think -- you can 15 ask your question again if you want, but. 16 BY MR. WILKERSON: 17 Q No, that's fine. I think -- I think we 18 can move on. 19 MR. WILKERSON: It's, like, 12:05. I 20 don't know if your lunch is there. We can take a 21 break. If not, we can plow on until your lunch 22 arrives.	176 1 the record. The time is 12:49 p.m. 2 BY MR. WILKERSON: 3 Q Okay. Welcome back, Dr. Ridker. I hope 4 you had a nice lunch. 5 A Thank you. 6 Q Before the break, we had just been 7 discussing the CANTOS trial. Do you recall that? 8 A Yes. 9 Q Okay. Now I'd like to switch gears a 10 little bit, and we can look at what is Tab 8 in 11 your binder. 12 MR. WILKERSON: And I believe this will 13 be Exhibit 12. 14 (RIDKER Exhibit 12 was marked for 15 identification and is attached to the transcript.) 16 THE WITNESS: What -- what is that? 17 Just so we know. 18 MR. WILKERSON: Yeah. It's the 2017 ESC 19 Guidelines. 20 MR. LAURENCE: We haven't pulled that 21 out yet, right? 22 MS. BROUGHER: No.

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177 1 MR. WILKERSON: Correct. It should be 2 labeled with -- with a number 8 on the tab. 3 MR. LAURENCE: Oh, 8. Okay. I thought 4 you said 12 for some reason. Sorry. 5 MR. WILKERSON: No problem. 6 BY MR. WILKERSON: 7 Q And, Dr. Ridker, do you have the 8 document now? 9 A I do. 10 Q Okay. And do you recognize this 11 document? 12 A Yes. 13 Q What is this document? 14 A Cardiovascular societies worldwide 15 intermittently put out guidelines on how to do 16 various things so that the practice is, you know, 17 reasonably standardized across structures. And 18 this happens to be the European -- the version of 19 the European Society of Cardiology, sort of is the 20 most prominent European cardiovascular society. 21 So this is their guidelines for management of 22 acute myocardial infarction in patients with ST	179 1 Q And, to the best of your knowledge 2 why -- why is it unlikely to be in here? 3 A Because the trials that -- so -- so 4 these guidelines are based on, again, what I said 5 earlier about evidence-based medicine, what's 6 our -- what's our best evidence show us? And at 7 that point in time, the published colchicine trial 8 was the Nidorf one and the other two, what we 9 shorthand as COLCOT LoDoCo 2. I don't -- they had 10 not -- they had not published by then. So. 11 Q Okay. 12 A Typically, it takes a couple of positive 13 trials for the guidelines to actually shift. 14 Q And you mentioned this is the -- the 15 European Society of Cardiology guidelines. Is 16 there a -- a U.S. or American society of cardi- -- 17 cardiology guidelines? 18 A Absolutely. That would typically be put 19 out -- it's usually put out jointly by the 20 American College of Cardiology, The American 21 Heart -- and the AHA, American Heart Association. 22 They're remarkably similar. I mean, guidelines on
178 1 elevation. 2 Q Okay. Okay. And are you familiar with 3 this reference? 4 A Yeah, I'm not intimate with it. These 5 are guidelines that are long and a tad dull, but I 6 certainly -- I certainly have a general sense of 7 what's in it. 8 Q Okay. And did you rely on this 9 reference in your declaration? 10 A Yes. 11 Q Okay. And anywhere in this reference 12 does it describe the use of colchicine in patients 13 after an MI? 14 A If we want to be definitive about that, 15 I'd have to check. My guess is not because my 16 memory is it's not until these guidelines would 17 come out a few years later where colchicine is 18 part of the guidelines. I'm pretty confident that 19 happened sometime in, you know, 2000 -- I -- at a 20 later date. 21 So this is a 2017, it would be very 22 unlikely to be in here.	180 1 a worldwide basis are quite similar. 2 Q Is there any particular reason why you 3 point to the European guidelines in your 4 declaration as compared to the American 5 guidelines? 6 A Not really. I mean, I suspect that the 7 attorneys picked this because it's a European 8 company. But I mean, they're -- the content is 9 remarkably consistent across all guidelines. 10 Q Okay. Let's go back to your 11 declaration, and we're going to go to the bottom 12 to your Appendix B again. 13 A Matt, just to be clear, do you want me 14 to put this one aside for a bit? 15 Q Yes. 16 A Okay. 17 Q Thank you. 18 A But do you want it to be relatively 19 close by? 20 Q No, that's okay. 21 A Okay. 22 Q That one -- that one can go back away.

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181 1 A Okay. 2 THE TECHNICIAN: Counsel, do you have a 3 page number? 4 MR. WILKERSON: Yeah, it starts on 315. 5 THE TECHNICIAN: Thank you. 6 MR. WILKERSON: I'll -- I'll actually be 7 more helpful to you. We can go all the way to 8 318, so the very last page. 9 THE WITNESS: Okay. I see that on the 10 screen and I have it in front of me. 11 BY MR. WILKERSON: 12 Q Okay. And as you recall from this 13 morning, we looked at this table of references you 14 relied on. Do you remember that? 15 A Yes. 16 Q Okay. And so do you see Exhibit 1045? 17 A Yes. There's -- there's your WayBack 18 Machine. 19 Q And -- and that appears to refer to 20 the -- the clinicaltrials.gov summary of the 21 CONVINCING trial. Do you see that? 22 A Yes.	183 1 MR. WILKERSON: And we'll mark this 2 as -- I've lost my notes. I think this should be 3 Exhibit 14. 4 THE WITNESS: And, again, Matt, can I 5 take this big one and put it aside? 6 MR. WILKERSON: Yeah. 7 THE WITNESS: Okay. Thank you. 8 MR. WILKERSON: And we will be going 9 back to that throughout the day, just so you know. 10 But. 11 THE WITNESS: It's nearby. It's just 12 it's kind of bulky. 13 MR. WILKERSON: Okay. Great. 14 And, Sue, is this Exhibit 14? 15 THE TECHNICIAN: I have 13. 16 MR. WILKERSON: Okay. Exhibit 13. 17 We're just waiting for her to pull that up. 18 (RIDKER Exhibit 13 was marked for 19 identification and is attached to the transcript.) 20 BY MR. WILKERSON: 21 Q Okay. Do you recognize this document? 22 A It looks like a clinicaltrials.gov
182 1 Q Okay. And if you look at Exhibit 1046, 2 do you see that one? 3 A Yes. 4 Q And that similarly refers to a 5 clinicaltrials.gov summary which appears to be the 6 CLEAR-SYNERGY trial? 7 A Yes. I am -- I am -- I have some 8 familiarity with both CONVINCING and CLEAR-SYNERGY. 9 Q Okay. And then if we go to the last 10 entry, which is Exhibit 1048, do you see that 11 entry? 12 A Yes. 13 Q And that appears to be the COLCARDIO-ACS 14 study in Australia New Zealand? 15 A Yes. 16 Q Are you familiar with this Australia New 17 Zealand Clinical Trials Registry? 18 A It's -- it's a similar clinical trials 19 residency to the one you were at before, 20 clinicaltrials -- it just covers Australia. 21 Q Okay. Great. 22 So let's go to Tab 16 in your box.	184 1 document for the CONVINCING trial. 2 Q Okay. And we talked about it a little 3 bit, but we had this WayBack web archive thing in 4 the top. And so you have the June 1st, 2023, 5 date. That's the date that this website was 6 accessed. But below it, you have date that 7 they're trying to archive of December 14th, 2019. 8 Do you see that? 9 A Yes, I see in -- that in yellow. 10 Q Okay. And so you understand this is 11 purportedly what this webpage looked like on that 12 date. Right? We discussed that earlier. 13 A If -- if you say so. 14 Q Okay. And I want to look at just really 15 simply on this first page, do you see about 16 halfway down there's tabs, "the study details, 17 tabular view, no results posted"? 18 A I -- I certainly see the tabs, yes. 19 Q Okay. And I want to focus on the "no 20 results posted." Do you see that? 21 A Yes. 22 Q So someone referring to this website

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185 1 would understand that as of December 14th, 2019, 2 there were no results for the CONVINC trial? 3 A The CONVINC trial's still ongoing. 4 Q Okay. So we still don't have the 5 results for the CONVINC trial? 6 A That is correct. To the best of my 7 knowledge, the CONVINC investigators have very 8 recently completed their trial, and my colleagues 9 and I eagerly await the results of this study. 10 But it has not been -- I -- but I don't know the 11 results, and it hasn't been re- -- publicly 12 presented yet as far as I know. 13 Q And so we don't know whether or not this 14 study met any of its endpoints? 15 A I -- I don't know. Yeah. 16 Q That's at least not publicly available. 17 Right? 18 A Right. I -- I -- I have to assume that 19 the -- since the trial's done, the primary 20 investigator might know by now. 21 Q Yeah. 22 A But that would be his private	187 1 not. 2 Q Okay. So, again, we don't know, one way 3 or the other, whether or not the CLEAR-SYNERGY 4 trial met any of its endpoints? 5 A Correct. This is -- this is -- this is 6 also an ongoing trial that, you know, by rumor 7 only is also supposed to end sometime perhaps 8 later this year, early next year, something like 9 that. 10 Q Okay. Let's go now -- you can put that 11 away and we can finally go to Tab 14. 12 MR. WILKERSON: We'll mark this as 13 Exhibit 15. 14 (RIDKER Exhibit 15 was marked for 15 identification and is attached to the transcript.) 16 Q And, Dr. Ridker, do you recognize this 17 document? 18 A Well, I don't recognize it, per se. I 19 don't go to the Australian trial registry as much 20 as I go to the clintrials.gov because that's the 21 one that governs my work. But it appears to be 22 the, you know, Australian correlate of the same
186 1 information. I -- I don't know and the general 2 public does not know. Yeah. 3 Q Okay. We can put that aside. 4 MR. WILKERSON: And can we get Tab 15, 5 and we'll mark this one as Exhibit 14. 6 (RIDKER Exhibit 14 was marked for 7 identification and is attached to the transcript.) 8 Q Okay. And do you recognize this 9 document, Dr. Ridker? 10 A It similarly looks like a clintrials.gov 11 brief summary of the CLEAR-SYNERGY trial. 12 Q Okay. And you're familiar with the 13 CLEAR-SYNERGY trial? 14 A Yeah, I have a general familiarity with 15 it, yes. 16 Q Okay. And we see, if we look at the 17 same tabs, again, it says here "no results 18 posted." Do you see that? 19 A I do. 20 Q Do you know whether the results of the 21 CLEAR-SYNERGY trial are publicly available today? 22 A To the best of my knowledge, they are	188 1 concept. 2 Q Okay. Are you familiar with the 3 COLCARDIO-ACS study? 4 A I -- again, in a general level, yes. I 5 don't know the details particularly. I'd have to 6 remind myself of the details. But I -- I 7 certainly know it's an ongoing trial. 8 Q Okay. So this is also an ongoing trial, 9 we don't have the results for it yet? 10 A I believe -- I believe that's true. 11 Q Okay. And so we don't know, one way or 12 the other, if the endpoints will be met? 13 A Correct. 14 Q Okay. We can close that out. 15 You, in your declaration, cite to 16 certain references to support the notion that a 17 POSA would have had a reasonable expectation that 18 following the treatment regimen in the '063 patent 19 would have been obvious. Is that right? 20 MR. LAURENCE: Objection; foundation. 21 THE WITNESS: Matt, can you just try to 22 remind me -- when you say '063, it helps me to

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189 1 know which one we're talking about. 2 BY MR. WILKERSON: 3 Q Yes, certainly. The '063 patent is 4 the -- the patent at issue here. That's 5 Dr. Tardif's patent. 6 A Okay. Not -- not the original Nidorf 7 patent. Okay. Thank you. 8 So -- and can you repeat your question? 9 Q Yeah, certainly. 10 So in your declaration, it's your 11 opinion that the prior art would have rendered the 12 claims of the '063 patent obvious? So the regimen 13 claimed in the '063 patent obvious? 14 A Yes. 15 Q And that's in part because following 16 those steps in your opinion, a POSA would have had 17 a reasonable expectation of preventing the 18 subsequent CV event. Is that right? 19 A Well, based on the published first 20 LoDoCo trial, giving .5-milligram of colchicine 21 daily that showed benefit, the likelihood of 22 benefit was significantly higher in the second and	191 1 grab Tab 19 in your binder. 2 A Okay. 3 MR. WILKERSON: And we can mark that as 4 Exhibit 16. And this has got a cover page, so, 5 Sue, if you could scroll to the second page of 6 this document. It looks like we can even go 7 further, to page 6. 8 (RIDKER Exhibit 16 was marked for 9 identification and is attached to the transcript.) 10 THE WITNESS: In -- in my version, it 11 starts on page 10, for what it's worth. 12 MR. WILKERSON: Page 10? Okay. 13 Page 10. 14 Thank you. 15 Q And, Dr. Ridker, do you recognize this 16 document? 17 A I do. 18 Q And what is it? 19 A This is the print primary report from 20 the clinical trial that most of us call LoDoCo 1, 21 the original low-dose colchicine trial from 22 Dr. Nidorf and his colleagues.
190 1 third study. So yes. 2 Q In the LoDoCo trial, at what point were 3 patients initiated on colchicine? 4 A My memory's pretty good, and I could 5 probably get that correct, but it might be just 6 nice to have it in front of us so we're all 7 absolutely certain. 8 Q Certainly. Let's -- if it's okay with 9 you, let's use a reference we already have, and we 10 can look at the Nidorf patent. 11 A Matt, if it's actually okay with you, 12 the way a scientist's mind works, I -- I know the 13 papers far better than I know the patents. That 14 might not surprise you. So if -- if -- if we have 15 somewhere here in the stack that article from JACC 16 from some time ago, it's much easier for me. But 17 if you want to do it some other way, I guess it's 18 your nickel. So. 19 Q That's -- that's -- that's fine and I 20 don't think it will matter. I'm just trying to 21 try to kind of mirror how you use the references 22 in your declaration. But you can go ahead and	192 1 Q Okay. And if we go to -- beginning on 2 page 11, do you see the section "Methods"? 3 A I do. 4 Q Okay. So based on -- it looks like 5 we're going to have to go to the right-hand 6 column. Do you know when patients were initiated 7 on colchicine in this study? 8 A Yeah. So my memory is that they had to 9 be six months out from the acute event. I'm 10 trying to find out here where that might be, so 11 give me just a second. 12 Q Actually, I can guide you. I -- I 13 misspoke. 14 Left-hand column. 15 A Yeah, I was going to say it's not on the 16 right-hand side, so -- 17 Q The -- the paragraph on about halfway 18 down. Second paragraph under "study size and 19 eligibility." 20 A Uh-huh. 21 Q Begins "Patients were eligible." 22 A Yes. There it is. Number three,

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193 1 clinically stable, very important, for at least 2 six months. So that -- my memory's fine on this. 3 Q Okay. So this investigated in an 4 open-label study the effect of colchicine added 5 after a patient was clinically stable for six 6 consecutive months. Is that right? 7 A I believe -- 8 Q Or sorry, six months? 9 A -- that's right. Yeah. 10 Q Okay. We can set that aside. 11 And I want to ask you, other than the 12 LoDoCo 1 study, were there other studies before 13 November of 2019 where they -- the investigators 14 assessed the effectiveness of colchicine after MI? 15 A Other than the study we just looked at? 16 Q Yes. 17 A So, again, let's just be careful. If 18 the question is were there other studies other 19 than what we call the LoDoCo 1 study that had 20 what, in my parlance is hard clinical endpoints, 21 did we prevent heart attacks, did we prevent 22 strokes, did we prevent cardiovascular death, I 194 1 think the answer is no. 2 The next one would be, in my memory, 3 COLCOT, and the one after that would be what we 4 call LoDoCo 2. 5 Q Okay. Are you familiar with the COPS 6 trial? 7 A I am. 8 Q Okay. 9 MR. WILKERSON: Can we pull up Tab 25? 10 And we can mark -- thank you. And we'll mark this 11 as Ridker Exhibit 17. 12 (RIDKER Exhibit 17 was marked for 13 identification and is attached to the transcript.) 14 Q Dr. Ridker, do you recognize this 15 document? 16 A Well, again, I recognize it's sort of 17 like a non-PDF printout of the article that I am 18 familiar with. And it seems -- I mean, I got to 19 be honest with you, it seem -- at least the copy I 20 have in front of me seems to be missing pieces. 21 So, again, if we -- do we have a PDF of 22 this actual article? It'd be a lot easier to go	195 1 off the actual article than to go off of a thing 2 like this. Does that exist? 3 Q I -- I -- I can pull the PDF version, 4 however, I don't have it in print for you. That 5 was -- 6 A Matt, I'll -- I'll tell you why. I 7 can -- just scanning this, this is how my brain 8 works. I went down to the bottom here and I'm 9 just reading the results. And it just suddenly 10 cuts off at the bottom. So maybe on your version 11 it's different than mine. But at the bottom it 12 says, "There was a higher rate of total deaths." 13 And then the next sentence just seems like it's 14 missing. 15 Q And where -- where are you looking at? 16 Sorry. 17 A Well, between -- just scroll down a 18 little bit. It feel -- it feels to me in my 19 memory of what this paper actually says that -- 20 Q Okay. 21 A -- something's missing in the results. 22 It kind of -- like a -- like a whole chunk of the 196 1 results is just missing here. I could be wrong, 2 but it doesn't feel like it's a sentence, right? 3 It goes, "there was a higher risk of 4 total death." And then it says "were 5 predominantly gastrointestinal," no 6 (indiscernible). 7 And so I feel like there's a misprint or 8 something missing in this, which is, again, why I 9 always believe we should use the PDFs that we all 10 agree on because this -- this is printed 11 incorrectly, as far as I can tell. 12 Q That is -- that is fine. I can propose 13 two options to you. One is during the next break, 14 I -- I email to counsel the PDF version, and it 15 can be printed, or I can pull up the PDF version 16 to -- to our ShareFile and it's only electronic. 17 So whichever one works for you, that's fine. But 18 let me know. 19 A I think in the spirit of all going home 20 a little earlier, I'd be happy to try to do 21 electronically. How about that? 22 Q Okay. I'm going to -- I'm going to move
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197 1 on to something else and we'll come back to this, 2 and we'll just look at it electronically. All 3 right? Just so we're not -- again, like you said, 4 in the interest of all of us getting home, and -- 5 and not wasting time, is that okay with you? 6 A Sure. 7 Q Okay. Now, aside from initiating 8 colchicine exclusively after MI, are there other 9 studies that looked at the use of low-dose 10 colchicine in the cardiovascular setting? 11 A Give me the first half of that question 12 again. 13 Q Yeah. So we specifically were initially 14 talking about, you know, post-MI prevention of 15 recurrent CV events, those studies for low-dose 16 colchicine. Right? 17 A Yes. 18 Q And that's the -- the LoDoCo 1 and 2, we 19 said COLCOT, and we said COPS. Right? 20 A So far, yes. 21 Q Okay. My question is: Are there other 22 studies that investigated the usefulness or	199 1 A Sure. 2 MR. WILKERSON: Let's look at Tab 38, 3 which we can mark as Ridker Exhibit 18. 4 (RIDKER Exhibit 18 was marked for 5 identification and is attached to the transcript.) 6 THE WITNESS: So I'm sorry for laughing 7 out loud, but this is what they just handed me. 8 Can you -- can you see this? I'd have to be a 9 magician to read this. It's like -- it looks 10 like -- it looks like something for a 11 (indiscernible) person. 12 MR. WILKERSON: My -- my apologies. 13 THE WITNESS: Maybe -- maybe you can put 14 it on screen in a much larger size. 15 MR. WILKERSON: Yep. I did not know 16 that's how it would print, so my apologies for 17 that. 18 BY MR. WILKERSON: 19 Q Do you recognize this document, though? 20 A I have to say I don't think so, but I -- 21 I can -- I'm happy to read it if you want -- well, 22 I can't read it off this thing, but.
198 1 effectiveness of low-dose colchicine in the CV 2 context? 3 A I'm sure there are. There are -- I 4 mean, I can think of others. There are studies -- 5 a lot of studies are done using surrogate 6 endpoints. By which I mean, not how many heart 7 attacks or death, but, you know, smaller studies 8 looking for mechanistic studies, smaller studies 9 looking at different settings. And, again, you've 10 got to remember this drug is also used in the 11 cardiovascular arena to treat pericarditis, so I'm 12 sure certain there is pericardiac -- there's 13 pericardial studies and things like that. 14 Q Great. And, to your knowledge, has 15 colchicine consistently met those clinical trial 16 endpoints? 17 MR. LAURENCE: Objection; foundation. 18 THE WITNESS: What endpoints are we 19 talking about? 20 BY MR. WILKERSON: 21 Q Let's -- let's go through a couple 22 examples, if that's all right.	200 1 Q Okay. Do you see first of all, that 2 this was published in JACC? 3 A Yes, I see that. 4 Q And are you familiar with that journal? 5 A Oh, yeah. 6 Q And do you regard it as a well-respected 7 journal? 8 A Yeah, it's a good journal. 9 Q And do you see the author -- first-named 10 author there is James H. O'Keefe? 11 A I -- I see that. 12 Q Okay. And that this was published in 13 1992? 14 A A little blurry, but looks like '92. 15 Q Okay. And then it can be tough to read, 16 but do you see here the -- the abstract? 17 A I see it. It's a bit hazy, but I see 18 it. 19 Q And that first sentence says: 20 Colchicine, an anti-mitogenic agent, has 21 shown promises in preventing restenosis after 22 coronary angioplasty in experimental animal

201 1 models. 2 Do you see that? 3 A Okay. Yes. 4 Q And then it says: 5 A prospective trial was conducted 6 involving 197 patients randomized in a 2 to 7 1 fashion to treatment with oral colchicine, 8 0.6 milligrams twice daily, 130 patients, or 9 placebo, 67 patients, for six months after 10 elective coronary angioplasty. 11 Do you see that? 12 A Yes. 13 Q And it also says that the treatment in 14 all these patients began between 12 hours before 15 angioplasty and 24 hours after angioplasty. 16 Do you see that? 17 A I'm looking for that. Where -- can 18 you -- can you put your cursor on that for me? 19 It's really tiny here. 20 Q Yep. 21 MR. WILKERSON: It's that third 22 sentence, Sue.	203 1 "in conclusion"? 2 A Yes. 3 Q It says: 4 In conclusion, colchicine was 5 ineffective for preventing restenosis after 6 coronary angioplasty. 7 Do you see that? 8 A I see it says that. I -- we haven't 9 gone through the results yet. But I see that's 10 what their interpretation is. I'd -- I'd have to 11 go through the results to -- 12 Q That's -- that's absolutely fine. Just 13 trying to cover the bases of that's what it says 14 for this part. 15 Are we on the same page? 16 A That's what their conclusion is by the 17 authors, yes. 18 Q Okay. And then I know -- I apologize. 19 I, again, didn't realize that's what -- what the 20 print would look like, but if we go down to 21 page 2, at the bottom of page 2, on the right-hand 22 side is where the results begin.
202 1 THE WITNESS: Yeah. Okay. I see that. 2 Treatment began between 12 and 24 hours. Okay. 3 BY MR. WILKERSON: 4 Q Great. 5 MR. LAURENCE: If I could interrupt for 6 just a minute, Matt. 7 MR. WILKERSON: Yeah. 8 MR. LAURENCE: Paul, you can make this a 9 little bit bigger on your screen. Maybe that will 10 help. 11 THE WITNESS: Actually, I can't. 12 MR. LAURENCE: Oh, okay. 13 THE WITNESS: They control the screen 14 size from there. 15 MR. LAURENCE: Oh, okay. 16 THE WITNESS: But that's okay. I mean, 17 if they use their cursor, I think I can follow 18 along. 19 MR. LAURENCE: Okay. 20 BY MR. WILKERSON: 21 Q Okay. And then the end of this 22 abstract, do you see the last sentence that begins	204 1 Do you see that? 2 A Yes. 3 Q And you first see the -- the demographic 4 data? 5 A Yes. 6 Q And the adverse effects. And then there 7 was "angiographic follow-up." Do you see that? 8 A I do. 9 Q Okay. And if we go down one page. 10 Actually, let's just -- let's just 11 short-circuit for you, Dr. Ridker. Do you have 12 any reason to believe that the conclusion would be 13 inaccurate if it was published in this journal? 14 A I -- I don't know what that question 15 means. I mean, what -- what are you asking me? 16 Q Yeah. So you agreed that the conclusion 17 states what it states. Right? 18 A I guess we have to go back and decide 19 what we're talking about first. So what -- what 20 conclusion it is that you want me to state that I 21 think the authors are stating that might or might 22 not have been accurate? I'm really confused.

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205 1 Q In the abstract, we read the last 2 sentence: 3 In conclusion colchicine was ineffective 4 for preventing restenosis after coronary 5 angioplasty. 6 Do you remember that? 7 A Can you go back up there, please? 8 MR. WILKERSON: Go to the very first 9 page. Stop. 10 THE WITNESS: So, Matt, the reason I'm 11 being very careful is I don't know this paper. I 12 am trying to learn it on the fly rather than 13 spending lots of our time valuable to both of us 14 to sit down and read it, which if you want me to, 15 I can. But the reason I'm being careful here is 16 that I'm a very careful reader and a very careful 17 investigator. 18 That last sentence, again, at risk of 19 being taken out of context, this is a study of 20 patients, as far as I can tell, who have elective 21 angioplasty. So that means these are stable 22 patients.	207 1 that in stable patients, the colchicine was not 2 effective for preventing restenosis after coronary 3 angioplasty. 4 Is that -- is that fair? 5 A There are lots of papers that are 6 published that give different results. That's why 7 we do large outcome trials to actually find out 8 what truth is. 9 Again, without going through this in 10 detail, sometimes you get neutral results because 11 you're underpowered, sometimes you get neutral 12 results because you're looking at the wrong time 13 frame. I mean, you're asking me to generalize 14 about a paper I've never read. So. 15 Q Not even asking you to generalize. 16 Asking you to confirm that that's what this paper 17 says, that they reached this conclusion. 18 A Well, this is what the authors are 19 saying. I -- again, I -- you're asking me do I 20 agree or not without having -- I mean, again, if 21 you wish to spend the hour for me to read this, 22 I'm happy to. It's up to you.
206 1 So a conclusion that at least would be 2 reasonably consistent with what's going on here is 3 the possibility that in this small, under-powered 4 study that, you know -- that colchicine, at least 5 in this study -- let's acc- -- let's -- we -- we 6 haven't looked at the data, but you're asking me 7 to accept a priori, did not prevent restenosis 8 after a percutaneous coronary intervention in 9 patients who were, electively, that was performed. 10 Q Yeah. No. I understand that, and -- 11 and that's why I was -- went back up here to try 12 and circumvent things, and not make you digest 13 this paper on the fly. I -- I'm not trying to -- 14 to dupe you and make you do homework on the fly 15 or -- or waste anyone's time. 16 So I guess -- 17 A By the way, Matt, I'm happy -- I'm happy 18 to do the homework. It doesn't bother me. 19 Q No, I appreciate that. 20 I guess is what -- is what I really want 21 to get at here is that this paper, O'Keefe 1992, 22 illustrates an example where researchers concluded	208 1 Q I'm -- I'm not asking you to agree with 2 their conclusions. I'm asking -- 3 A I think you -- 4 Q -- you -- 5 A I think you are, Matt. 6 Q I promise you I'm not. So let me 7 rephrase the question in a way to make it more 8 fair. 9 I'm asking you if you agree with what 10 was published -- let me rephrase that again 11 because that is going to run into the same 12 problem. 13 Do you agree that I've accurately 14 summarized what is written in this abstract? 15 A So, Matt, again, without trying to be 16 pejorative here, you know, scientific intercourse 17 is based on the idea that people can have 18 different opinions on what's written and what's 19 presented. This is what the authors have chosen 20 to conclude. I could give a litany of examples -- 21 in fact, I teach courses on this where what 22 authors state and sometimes gets through the

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209 1 peer-reviewed process, unfortunately, is just not 2 supportable by what's actually in the paper. And 3 I hate to say this to you, that's probably 4 relevant for this -- for this litigation. 5 Q Why is that your opinion that it's 6 relevant for this litigation? 7 A Because sometimes authors say things 8 that may or may not agree with what other people 9 think about what the data are. 10 Q And that could be true here in O'Keefe 11 1992? Is that -- is that your testimony? 12 A Again -- again, I'm -- if you'd like me 13 to do so, I'm happy to read the paper, Matt. I 14 just -- you know. 15 Q Well, and I'm just -- just trying to 16 follow your logic here. Could that also be true 17 for the LoDoCo trial? 18 A It could be true for any published piece 19 of science anywhere. That's why we have peer 20 review, and that's why we ask the authors to 21 present the actual data. We don't just present 22 the abstract. We -- it's why we present the	211 1 MR. WILKERSON: Can you take down that 2 exhibit? 3 And let's just for two minutes, Kylan, 4 let's go off the record. We can all stay on the 5 line, and figure out how we want to best upload 6 the PDF of the COPS trial. 7 THE VIDEOGRAPHER: We're going off the 8 record at 1:24 p.m. 9 (Brief pause off the record.) 10 THE VIDEOGRAPHER: We're going back on 11 the record. The time is 1:26 p.m. 12 MR. WILKERSON: Okay. 13 THE WITNESS: Sit tight. Sit tight. 14 BY MR. WILKERSON: 15 Q Dr. Ridker, I'm sorry about the 16 technical issue there. And now that we have 17 this -- what's been marked as Ridker 19, do you 18 recognize this document? 19 A Matt, I'm sorry to disappoint you, but 20 this is not the same thing you had before. This 21 is a different paper altogether. 22 Q You're -- you're -- you're absolutely
210 1 protocols. It's, you know -- it's -- it's 2 scientific interchange. It's, you know -- it's -- 3 we -- we have -- again, maybe -- maybe it's 4 just -- to lay it out. 5 We have something in my world called 6 journal club where we typically will take a paper, 7 it can often be a controversial paper or 8 non-controversial paper. Sometimes we'll review 9 it for issues of methodology, sometimes we review 10 it for issues of its epidemiology, sometimes we 11 review it for its statistical analysis approach. 12 And it's very common in the journal club 13 setting because we're trying to teach graduate 14 students and students, you know, and it's not 15 uncommon at the end of journal club to say, hmm, I 16 don't know if that paper showed what I thought it 17 showed or not. 18 So I'm happy to read it, but it doesn't 19 sound like that's what you want me to do. 20 Q We can -- we can take it down. It's -- 21 it's served my purpose, to be honest. So we can 22 take it down.	212 1 right. This is the letter. 2 All right. That's fine. We will still 3 come back to this. All right? 4 MR. WILKERSON: You can take that down. 5 Q Can you take out Tab 22? 6 THE TECHNICIAN: Counsel, were we 7 leaving that one marked? 8 MR. WILKERSON: No. You -- can you 9 switch -- take that mark off, and Tab 22 will 10 receive Ridker Exhibit 19? 11 THE TECHNICIAN: Will do. 12 (RIDKER Exhibit 19 was marked for 13 identification and is attached to the transcript.) 14 MR. LAURENCE: We've already pulled it 15 is no. 16 THE WITNESS: I'm sorry. What's 19? 17 BY MR. WILKERSON: 18 Q It should be Tab 22. And it's a -- 19 MR. LAURENCE: Tab 22? 20 MR. WILKERSON: Yep. A paper that 21 begins "COLIN trial." 22 MR. LAURENCE: (Indiscernible.)

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213 1 THE WITNESS: (Indiscernible.) 2 I'm not -- yeah. 3 MR. LAURENCE: I don't see a 22. Oh, 4 there -- 5 MR. WILKERSON: A label -- the label 6 might say "22 Akodad." 7 MR. LAURENCE: Correct. Sorry. 8 MR. WILKERSON: No problem. 9 BY MR. WILKERSON: 10 Q Dr. Ridker, do you recognize this paper? 11 A I do not, unfortunately. 12 Q Okay. Are you familiar at all with the 13 COLIN trial? 14 A I am not. 15 Q Okay. Do you see this paper was 16 published in the archives of Cardiovascular 17 Disease? 18 A I -- I do see that. I have to admit 19 it's not a journal that I'm familiar with. 20 Q Okay. And you see that it was published 21 in 2017? 22 A Yes.	215 1 you see the "Aims" subsection? 2 A Yes. 3 Q So here they're trying to evaluate 4 whether colchicine has an impact on inflammation 5 in patients admitted for STEMI. 6 Do you see that? 7 A I do. 8 Q Okay. And if you'd like, please take a 9 moment to read the "Methods" summary, the 10 "Results" summary. 11 THE WITNESS: Can I draw on this thing? 12 I don't want to do anything -- am I supposed to 13 touch this or not? I can do that? Okay. 14 MR. LAURENCE: That's fine. 15 THE WITNESS: Okay. Sorry. First time. 16 Okay. Again, in the spirit of hoping to 17 go home, for now I won't insist on my opportunity 18 to read the entire paper, much less read it in 19 French. But, okay. 20 BY MR. WILKERSON: 21 Q Well, I -- I understand that. But it -- 22 do you have any reason to believe that there's any
214 1 Q Okay. And the title is "Confidential 2 Trial, colon, Value of Colchicine in the Treatment 3 of Patients with Acute Myocardial Infarction and 4 Inflammatory Response." 5 Do you see that? 6 A I do. 7 Q And you see the first-named author is 8 Mariama Akodad? 9 A I see that. 10 Q Okay. And I think we'll agree on the 11 first part, but if you look at the bottom of 12 page 1, do you see the summary section starts 13 there? 14 A I -- I see it. Okay. 15 Q Okay. And you see they're describing 16 the background. And they're describing that 17 inflammation is involved during acute MI, and 18 could be a target for preventing the ischemia 19 reperfusion injuries. 20 Do you see? 21 A I do. 22 Q Okay. And if we go to the next page, do	216 1 difference between the English versions and the 2 French versions? 3 A I -- I would hope not. No. But, I 4 mean, I obviously -- as I said, I have not seen 5 this paper before, I have not read it before. But 6 I'm willing to attempt to answer your questions. 7 But if I have to stop and read it, I guess we 8 will. But maybe -- maybe I don't have to. I 9 don't know. 10 Q I understand. But you'd agree that the 11 authors concluded that they could not demonstrate 12 the effect of colchicine on inflammation in the 13 STEMI context? 14 A Well, again, as we previously discussed, 15 whether I agree with what the authors do or don't 16 say is an intellectual issue. They certainly 17 write that. I can just tell scanning this article 18 that it's an extremely small sample size. And in 19 my world -- world, this would be considered an 20 uninformative neutral paper. It doesn't really 21 tell us much at all. 22 And I don't mean to demean the authors

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217 1 of this paper in any way. But you're asking me 2 without reading the paper. But, you know, again, 3 I -- I don't know this journal, so I would 4 anticipate higher-quality journals with quality 5 editorial review probably didn't accept the paper. 6 And so I -- you know, I -- I -- but if you want me 7 to read it and give you my opinion of it, I can. 8 Q Can you go to page 7 of the PDF? 9 A My PDF doesn't have page numbers on it, 10 so you'll have to give me the page number of the 11 actual -- 12 Q 4 -- 13 A -- publication page. 14 Q 401. 15 A Okay. 16 Q Do you see at the top left it begins the 17 "Discussion" section? 18 A Again, I see it. I have never read this 19 paper, so. 20 Q Yeah, I -- I under- -- I understand you 21 haven't read it. 22 And do you see the second paragraph in	219 1 study, 151, so that must be the other paper. 77 2 with colchicine, reduced infarct size, reduction 3 CK curve. Okay. 4 And then we're at the sentence you seem 5 to be focused on. 6 Q And that sentence is: 7 However, the timing and methods of 8 colchicine administration were different, 9 colchicine that was administered orally, but 10 directly in the catheterization laboratory, and 11 just before the reperfusion, a 2 mg loading dose 12 and continued for five days. 13 Do you see that? 14 A Yes. But what -- can you just clarify 15 which of these two studies that sentence refers 16 to? 17 Q Yeah, that -- that refers to the 18 Deftereos study. 19 A Okay. 20 Q And then if you go to the next -- sorry. 21 If you go to the -- the last paragraph of this -- 22 right before "study limitations" begins colchicine
218 1 this section that begins "Despite the smaller 2 population"? 3 A I -- I see the words, yes. 4 Q Do you see the authors there wrote: 5 Despite the smaller population, these 6 results differ strongly from those reported in the 7 recent trial by Deftereos, et al.? 8 A I see the words, yes. 9 Q Okay. Within that same paragraph, if 10 you go down to the sentence that begins -- and you 11 can read in between if you need to. The sentence 12 that begins, "However, the timing and methods of 13 colchicine administration"? 14 A All right. So, Matt, let me -- again, 15 because context does matter, let me just read the 16 intermediate piece, which sounds like it's their 17 description of the Deftereos paper, which we could 18 always pull. I'm sure it must be here somewhere. 19 Someone's files. But let me just read it. 20 So they're referring now, I assume, to 21 this is their interpretation of Deftereos because 22 that's the cite. So, indeed, in this prospective	220 1 experts. Sorry. "Colchicine exerts." 2 Do you see that? 3 A I see colchicine exerts and 4 anti-inflammatory effect. 5 Q And "may limit reperfusion injury." 6 Is that what it says? 7 A That's what it says. But yes. 8 Q Okay. And then the next sentence says: 9 The lack of effect of colchicine in our 10 study could be explained by late administration in 11 the intensive care unit after the reperfusion and 12 without a loading dose. 13 Do you see that? 14 A It does say that. 15 Q And then the last sentence there says: 16 These results may indicate that the 17 treatment should be given at the onset of 18 reperfusion as soon as possible to optimize its 19 action and to reduce reperfusion injuries 20 associated with inflammation burden. 21 Do you see that? 22 A I see it.

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221 1 Q Okay. 2 MR. WILKERSON: Can you take that down? 3 And I did send in the chat the corrected PDF. My 4 apologies. 5 THE WITNESS: I'm sorry. Are we -- 6 THE TECHNICIAN: And we're marking this 7 one as 20? 8 MR. WILKERSON: Yes. 9 THE WITNESS: That's it for this paper? 10 We're just simply acknowledging what the author is 11 saying? 12 MR. WILKERSON: Correct. 13 THE WITNESS: Okay. 14 (RIDKER Exhibit 20 was marked for 15 identification and is attached to the transcript.) 16 BY MR. WILKERSON: 17 Q And if you want, feel free to download 18 from the chat. It looks like Sue is also pulling 19 it up here. 20 And, Dr. Ridker, do you recognize this 21 document? 22 A Yes. This looks more like the COPS	223 1 Q And I don't want to necessarily even 2 look at the -- the content that we're worried 3 about having getting cut out in PDF-ing this. But 4 I want to focus on the date that says "originally 5 published." 6 Do you see that? 7 A It says August 29, 2020. 8 Q Okay. Now we're going to go back to 9 something crazy from this morning, and that's the 10 European Heart Journal 2020. 11 MR. WILKERSON: Which, Sue, I believe is 12 Exhibit 3. 13 THE WITNESS: Is that the one I can't 14 pronounce the first author's name? 15 MR. WILKERSON: Yes. 16 THE WITNESS: Okay. I have that in 17 front of me. 18 BY MR. WILKERSON: 19 Q And do you see right below the author 20 affiliations, there's a listing of dates? Events 21 and dates? 22 A Yes.
222 1 trial document that I'm familiar with. 2 Q Okay. And have you read this before? 3 A Some time ago, yes. 4 Q Okay. But you did not include this 5 reference in your declaration. Is that right? 6 A I'd have to go back and check. I -- I 7 think we included a number of papers showing that, 8 you know, in the setting of acute coronary care, 9 we don't have an answer to the question you're 10 asking, that we have ongoing trials that are going 11 to tell us this. 12 But I am familiar with this paper. 13 Q Okay. You know what, let's actually -- 14 we can use the online version for one purpose. If 15 you want to go back to Exhibit 17. 16 A And sorry. What is 17? 17 Q Oh, the online version. Can you go to 18 the top? 19 A Okay. So it's the one that's missing 20 things? Okay. 21 MR. WILKERSON: Can you go to the top, 22 Sue?	224 1 Q And what was the -- there's a date for 2 online publish ahead of print. Do you see that? 3 A I do. 4 Q And that's August 29th, 2020. Right? 5 A That's correct. 6 Q And that's the same date we just saw for 7 the COPS publication. 8 A That's correct. 9 Q Okay. So we can put those aside. Just 10 we needed to establish that. 11 And if we go to the actual correct COPS 12 paper, Exhibit 20. 13 A I'm sorry. I'm getting a little lost in 14 the shuffle here -- 15 Q Yeah, I understand. 16 A -- so (indiscernible) -- 17 Q So just column 2020, from Circulation? 18 A Okay. So we're back on the screen. 19 Q Yep. 20 A And that's the one we don't have? 21 Q Yep. 22 A All right.

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225 1 Q And just wanted to -- to confirm that a 2 POSA will understand that this publication and 3 the -- what we've called the European Heart 4 Journal 2020 publication were effectively 5 contemporaneous. Right? 6 A I'm going to guess -- I can look it up 7 if it is necessary, that since the online release 8 date is the same date, they probably were 9 presented at the same scientific conference 10 because it's quite common to do so. If that was 11 important, we could go look up the conference 12 schedule. But I -- I would guess that's what 13 happened here. 14 Q Yeah. It's -- it's certainly not 15 important. I'll represent you're actually spot 16 on. I just want to make sure that we're on the 17 same page that both of these had the same 18 publication date. Right? 19 A Yes. 20 Q And so they both became available to the 21 public on the same date. Right? 22 A It appears to be so.	227 1 A But it's a totally different patient 2 population. So they -- all right. 3 Q So -- so in your opinion, a POSA would 4 find the CANTOS study more relevant to the COLCOT 5 study than COPS, which uses the exact same drug in 6 a very similar context? 7 MR. LAURENCE: Objection; form. 8 THE WITNESS: I'm sorry. I -- I'm 9 afraid, Matt, you're mixing metaphors from my 10 perspective. These studies -- let's -- let's just 11 be careful here. The -- this -- the Tong study, 12 the COPS study, is similar to COLCOT in that it's 13 using the same drug, yes. But it's quite 14 dissimilar in what it's actually studying. 15 COLCOT, again, to be clear, is patients 16 who have stable disease, and these are patients 17 who, by definition, have acute coronary ischemia. 18 So it's a very different population. 19 BY MR. WILKERSON: 20 Q If we look at -- 21 MR. WILKERSON: Can you scroll down a 22 tiny bit, Sue?
226 1 Q Okay. And although there is some 2 differences in the studies, I don't disagree with 3 that. You would agree that they both investigated 4 different outcomes for using half a milligram -- 5 strike that. Strike that. We can restart. 6 Both studies, COPS and COLCOT, 7 investigated using low-dose colchicine after 8 myocardial infarction. Right? 9 A Oh, no. Come on. Matt, please. 10 Q No. 11 A These are extremely different contexts, 12 right? One is -- one is acute coronary ischemia 13 and one is stable atherosclerosis. We're not 14 going back there, are we? 15 Q I -- I -- I will caveat, I will grant 16 you, and we will totally agree that there are 17 differences in the studies, right? 18 A (Indiscernible.) 19 Q That's fine. We're not disagreeing. 20 A I'm just simply saying because I don't 21 want to chase dogs' tails that much longer. 22 Q Okay.	228 1 Q Do you see the "Methods" section? 2 A I'm going to try to -- oh, we don't have 3 this one. Hmm. 4 MR. PHILLIPS: Driving me crazy. 5 MR. WILKERSON: Sue, can you zoom in, 6 please? 7 THE WITNESS: Just bear with me here. 8 I'm trying to see if we can't -- the methods 9 section that actually matters to me is the methods 10 in the paper not in the abstract, sorry. 11 BY MR. WILKERSON: 12 Q That's fine. 13 A You're asking me to do this from memory, 14 so. 15 Q That's -- we can go to the -- I was 16 trying to shortcut for you. We can go to the 17 methods in the paper. 18 MR. WILKERSON: It looks like we want to 19 go to the second page of the PDF, Sue, which on 20 the bottom right is page 1891. 21 Q In the right-hand column, we see the 22 methods. Do you see that?

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229 1 A I -- I -- I see it now, yes. 2 Q Okay. And do you see the Study Patients 3 paragraph? If you scroll down a little bit. 4 A Eligible patients were adults, 18 to 5 85 years of age, who presented with acute coronary 6 syndrome and had evidence of coronary disease 7 defined by a greater than or equal to 30 percent 8 luminal stenosis in epicardial vessel of greater 9 than 2.5-millimeter luminal diameter on coronary 10 angiography, managed with either percutaneous 11 coronary intervention or medical therapy at the 12 discretion of the treating team. Acute coronary 13 syndrome was defined as symptoms of acute 14 myocardial infarction associated with either 15 elevated troponin or ECG changes, which included 16 STEMI, non-STEMI, and unstable angina. Patients 17 with coronary artery disease requiring surgical 18 revascularization with preexisting long-term 19 colchicine use or, I presume, any other immune 20 suppressant therapy or with hepatic immuno disease 21 or malignancy were excluded. 22 And there's details, which matter by the	231 1 These patients here would not be going 2 home. 3 Q Are there guidelines that define what -- 4 what metrics would establish stability for a 5 patient post-MI? 6 A There may or may not be guidelines. 7 But, I mean, I think most -- certainly, most POSAs 8 would understand what stable means. I mean, 9 again, stable literally means I'm -- I'm willing 10 to send the patient home. 11 Q And is that decision made purely from, 12 you know, the traditional aggregate of your 13 clinical decision making? 14 A I hope so. 15 Q I'm -- I'm -- I'm just trying to 16 understand. I'm not trying to play stupid. I -- 17 I don't -- frankly, just don't know. So I'm just 18 trying to understand a little bit from you, you 19 know, in a -- in an objective as possible sense 20 what we could look for to -- to identify 21 stability. 22 A Let -- let me -- let me try to answer
230 1 way. So if you really want to go through this, we 2 could pull the supplement. 3 Q Well, I guess from this paragraph, my 4 question is, could there be patients included that 5 were stable? 6 A The description here is patients who are 7 in the acute phase that we talked about earlier, 8 very early on. But if you want to go to the -- I 9 mean, this is -- this is a very brief summary of a 10 protocol. If you want to go to some other 11 material, we can go through the protocol. 12 Q That's fine. I -- we don't need to do 13 that. I'm just -- I'm just trying to understand, 14 and I think you already answered it. 15 And we talked about the -- the acute 16 phase. I'm curious, is there a clinical 17 definition for when the acute phase concludes? 18 A Again, as we said earlier, individual 19 patients are individual human beings with 20 different things happening. In my world, we 21 usually agree on what stable means because, 22 typically, that's when they're going to go home.	232 1 and try to be helpful here if I can. 2 At least reading this paragraph -- 3 again, if -- if we want to pull the actual 4 protocol and go through details, I'm more than 5 happy to. 6 The authors here are describing patients 7 in that acute setting who have just within the 8 last -- I can't tell. There's no timing here 9 listed. But you get the sense it's within minutes 10 to hours of when they have had their angio- -- 11 percutaneous intervention, if they got it. But 12 then it also says for medical therapy at the 13 discretion of the treating team, so there's a lot 14 of differences here. 15 But the authors are -- what is this one 16 here? I mean, the -- the -- again, I'm going off 17 the other one because -- or you can scroll up. 18 Maybe -- maybe scroll up here. Go back to the 19 abstract. 20 The -- the authors usually say in their 21 background what it is they intend to study. And 22 so they say here, We sought to determine potential

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233 1 usefulness in colchicine treatment with patients 2 with acute coronary syndrome. 3 So they're looking at that very early 4 period that we were talking about before, which -- 5 which is quite different than what COLCOT did. 6 That's -- that's the point here, right? 7 Q Okay. I appreciate that. 8 MR. WILKERSON: Can you scroll down 9 slightly? 10 Q And do you -- do you know what the 11 outcome of the COPS trial was? Because you had 12 reviewed it at some point. 13 A Let's just -- let's just read their 14 conclusion again here. 15 So they're saying it did not 16 significantly affect cardiovascular outcomes at 17 12 months. 18 Q Okay. 19 A And -- yeah. 20 MR. WILKERSON: We can take that down. 21 And, Kevin, you know, I think I'm pretty 22 close to wrapping up. If we could just take five	235 1 THE VIDEOGRAPHER: We're going off the 2 record at 1:57 p.m. 3 (Brief pause off the record.) 4 THE VIDEOGRAPHER: We're going back on 5 the record at 2:00 p.m. 6 EXAMINATION BY COUNSEL FOR THE PETITIONER, 7 MURRAY & POOLE ENTERPRISES LTD. 8 BY MR. LAURENCE: 9 Q Dr. Ridker, I'm handing you a copy of 10 Exhibit 1006 which was used as deposition 11 Exhibit 7 today. What's the term that is used for 12 that document typically outside of this 13 proceeding? 14 A The clinicaltrials.gov website. 15 Q Okay. 16 A That's a summary. 17 Q And -- and what is germane between the 18 clinicaltrials.gov document, Exhibit 1006, and 19 deposition Exhibit 9, which is the COLCOT 20 protocol? 21 A Well, the full protocol is the 22 definitive protocol that we follow when we do the
234 1 minutes for me to look over my notes -- 2 MR. LAURENCE: Okay. 3 MR. WILKERSON: -- and come back. 4 We can go off the record, please. 5 THE VIDEOGRAPHER: We're going off the 6 record. The time is 1:49 p.m. 7 (Whereupon, there was a recess in the 8 proceedings.) 9 THE VIDEOGRAPHER: We're going back on 10 the record at 1:57 p.m. 11 MR. WILKERSON: Great. 12 BY MR. WILKERSON: 13 Q Dr. Ridker, during any of the breaks 14 today, did you discuss the substance of your 15 testimony with counsel? 16 A No. 17 MR. WILKERSON: Okay. Thank you very 18 much for your time. Pending redirect from your 19 counsel, I have no further questions today. 20 MR. LAURENCE: Can we go off the record 21 for a moment? 22 MR. WILKERSON: Yeah.	236 1 clinical trial, and it's the thing that describes 2 it in detail. 3 Q And what is germane between the two 4 documents? 5 A Germane? What do you mean? 6 Q What -- what content do they have in 7 common? 8 A Well, the clinicaltrials.gov website is 9 meant to be a very brief summary, so it has the 10 highlights. But it doesn't have the details. 11 Q What are some of the highlights? 12 A What population is being studied, what 13 dose of drug is being studied. Usually has things 14 like sample size in it. 15 Q Does it have any temporal discussion? 16 Is there a discussion of -- of time periods? 17 MR. WILKERSON: Objection; vague. 18 BY MR. LAURENCE: 19 Q What was the time period -- excuse me. 20 A Well -- 21 Q Let me see the document. Sorry. 22 Under "Purpose," does it discuss how

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237 1 many days? 2 A I -- I'm guessing from memory that both 3 documents would talk about treatment within prior 4 30 -- 30 days since the acute coronary event. Is 5 that what you're asking me? 6 Q Yes. 7 MR. LAURENCE: Okay. No further 8 questions. 9 MR. WILKERSON: Just -- just two quick 10 follow-ups, and we can use those same two 11 documents. 12 Can you please first pull up Exhibit 7? 13 THE WITNESS: 7 is clintrials.gov? 14 MR. WILKERSON: Yes. 15 THE WITNESS: I have that. Okay. 16 FURTHER EXAMINATION BY COUNSEL FOR THE PATENT 17 OWNER, 18 INSTITUT DE CARDIOLOGIE DE MONTREAL 19 BY MR. WILKERSON: 20 Q Okay. And you see at the top, keep 21 going. And our WayBack date on this is 22 October 20th, 2017. Do you see that?	239 1 Dr. Ridker, for your reference. 2 Do you see in the top left what the date 3 of this document is? 4 A Well, I see that this one says 5 "Amendment 2A," so this is a couple amendments 6 down the road, I'm guessing. 7 Q Understood. 8 A The date here is November 15th, 2018. 9 But it's -- it's labeled Amendment 2A. So. 10 Q And I understand that. But this is not 11 the protocol that the Exhibit 7 is the summary of, 12 necessarily. Correct? 13 A This is the same clinical trial. I -- I 14 don't quite understand the distinction you're 15 drawing here. 16 Q Certainly. This was drafted after 17 Exhibit 7 was published. Correct? 18 A I can't -- I mean, this amended version 19 is dated November 15th. If you're asking me when 20 the original protocol was drafted, I can't tell 21 from this. I didn't draft it, so it's not my 22 study. But I mean, this simply -- this -- that
238 1 A I do. 2 MR. WILKERSON: And if you scroll down a 3 little bit. Stop. 4 Q Do you see on the right-hand side 5 clintrials.gov identifier, and it's a number? 6 A I do. 7 Q And do you see "first posted"? 8 A I do. 9 Q Do you see a "last update posted"? Do 10 you see that? 11 A I see that on here. I don't know if 12 it's the last update posted. It must be the last 13 update posted at the time this particular thing 14 was downloaded, I guess. But I do see that. 15 Q Correct. Correct. And that says -- I 16 agree with -- with your understanding of that. 17 And it says March 8th, 2017. Right? 18 A That's what it says, yes. 19 Q Okay. 20 MR. WILKERSON: Can you pull that down 21 and pull up Exhibit 9? 22 Q And that's the actual protocol,	240 1 date refers to Amendment 2A. 2 Q And you didn't review the full protocol 3 draft that was submitted back in whatever date, 4 2015, 2017. Is that correct? 5 A I'm sorry. 6 MR. LAURENCE: Objection. 7 THE WITNESS: I'm confused, Matt. 8 I'm sorry. 9 MR. LAURENCE: Sorry. 10 BY MR. WILKERSON: 11 Q Yeah. Sorry. Let's -- let me rephrase 12 that. 13 For this case, you did not review the 14 earlier versions of this. This says Amendment 2A, 15 and you did not review the earlier versions. 16 Correct? 17 MR. LAURENCE: Objection; foundation. 18 THE WITNESS: I'm sorry. Do I answer or 19 not? 20 MR. LAURENCE: You do. 21 THE WITNESS: Okay. 22 Matt, as I -- as I think I said earlier,

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241 1 and as I'm pretty confident my declaration says, 2 it's an updated version is what I was talking 3 about in my declaration. Which actual version and 4 which actual amendment, I mean, it could have well 5 been the final one with -- the New England Journal 6 paper is probably the best -- that would be the 7 protocol of record. 8 You're asking me which of these 9 exactly -- I mean, they're all pretty similar, so 10 I don't -- I mean. 11 BY MR. WILKERSON: 12 Q So you don't know which exactly. Right? 13 A I'd -- I'd have to do a lot of pulling 14 up old files to figure out exactly which one. But 15 I'm -- I'm not sure what -- yeah. I mean. 16 Q No, that's fine. 17 A This was -- yeah, okay. 18 Q That's fine. 19 MR. WILKERSON: I have no further 20 questions. 21 MR. LAURENCE: Okay. No further 22 questions.	243 1 ACKNOWLEDGMENT OF DEPONENT 2 I, PAUL RIDKER, M.D., do hereby acknowledge 3 that I have read and examined the foregoing 4 testimony, and the same is a true, correct, and 5 complete transcription of the testimony given by 6 me, and any corrections appear on the attached 7 Errata sheet signed by me. 8 9 _____ 10 (DATE) (SIGNATURE) 11 12 13 14 15 16 17 18 19 20 21 22
242 1 MR. WILKERSON: Great. We can go off 2 the record. 3 THE VIDEOGRAPHER: This marks the end of 4 the deposition of Dr. Paul Ridker. We're going 5 off the record at 2:06 p.m. 6 (Off the record at 2:06 p.m.) 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	244 1 CERTIFICATE OF SHORTHAND REPORTER - NOTARY PUBLIC 2 I, CASSIDY WESTERN, RPR, the officer before 3 whom the foregoing deposition was taken, do hereby 4 certify that the foregoing transcript is a true 5 and correct record of the testimony given; that 6 said testimony was taken by me stenographically 7 and thereafter reduced to typewriting under my 8 direction; that reading and signing was requested; 9 and that I am neither counsel for, related to, nor 10 employed by any of the parties to this case and 11 have no interest, financial or otherwise, in its 12 outcome. 13 IN WITNESS WHEREOF, I have hereunto set 14 my hand this 5th day of April, 2024. 15 My commission expires August 4, 2025. 16 17 18  19 _____ 20 Cassidy Western, RPR Date 21 22

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abbreviate 173:5	150:18, 157:6, 159:2, 167:20, 172:1, 172:4, 174:2, 178:14, 179:5, 184:2, 184:15, 189:1, 192:17, 196:21, 197:14, 198:19, 204:19, 207:14, 209:9, 211:15, 223:3, 230:7, 230:15, 233:4, 237:3, 241:3	accurately 208:13 achieve 64:21, 94:13 achieved 67:2 acknowledge 87:12, 243:2 acknowledges 135:2 acknowledging 221:10 acknowledgment 243:1 across 35:15, 177:17, 180:9 action 220:19 activates 168:9 active 26:14, 172:11 actual 51:8, 136:15, 136:17, 139:20, 140:12, 141:12, 145:20, 166:15, 194:22, 195:1, 209:21, 217:11, 224:11, 232:3, 238:22, 241:3, 241:4 actually 11:7, 17:8, 21:15, 23:20, 24:4, 31:8, 32:5, 45:20, 47:8, 47:22, 48:11, 54:1, 62:17, 64:6, 70:4, 85:15, 86:7, 87:8, 93:21, 95:2, 97:13, 101:10, 101:13, 103:21, 113:1, 121:20, 121:22, 133:2,	134:12, 152:19, 167:3, 170:8, 172:9, 179:13, 181:6, 190:11, 192:12, 195:19, 202:11, 204:10, 207:7, 209:2, 222:13, 225:15, 227:14, 228:9 acute 6:18, 6:34, 7:5, 7:15, 7:19, 59:3, 59:15, 64:12, 66:12, 68:2, 68:6, 93:5, 93:20, 94:11, 97:9, 102:2, 160:15, 177:22, 192:9, 214:3, 214:17, 222:8, 226:12, 227:17, 229:5, 229:12, 229:13, 230:7, 230:15, 230:17, 232:7, 233:2, 237:4 added 193:4 addition 34:20, 169:19 additional 117:16 address 10:6, 31:9, 95:8, 148:18, 148:19, 171:17 addressing 97:8 administer 89:10 administered 100:12, 103:6, 103:11, 115:12, 156:15, 158:9, 162:2, 162:16 administering 86:19, 87:2, 89:8, 114:21,
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