EXHIBIT A

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

IN RE: GLUCAGON−LIKE PEPTIDE−1 RECEPTOR AGONISTS (GLP−1 RAs) PRODUCTS LIABILITY	**MDL 3094** **PLAINTIFF FACT SHEET**

PLAINTIFF FACT SHEET

Each plaintiff alleging injury from the use of a glucagon-like peptide 1 receptor agonist ("GLP-1 RA") must complete this Plaintiff Fact Sheet ("PFS"). If you are completing this PFS in a representative capacity for someone who has died or who otherwise cannot complete the PFS, please answer as completely as you can for that person.

In completing this PFS, you are under oath and must provide information that is true and correct to the best of your knowledge and recollection, and your answers must be as complete as the information currently reasonably available to you permits. If you cannot recall all of the details requested, please provide as much information as you can. You must supplement your responses if you learn that they are incomplete or incorrect.

The parties, through their counsel, have agreed to limit the scope of the information and documents being requested from plaintiffs at this time to that which is set forth in this PFS.

This PFS is completed pursuant to the Federal Rules of Civil Procedure. Your responses to the PFS shall be treated as answers to interrogatories and subject to the requirements of the Federal Rules of Civil Procedure and the applicable Local Rules. Information provided in response to this PFS will be used only for purposes related to this litigation and is subject to the Protective Order, entered in this MDL as Case Management Order No. 11, and may be disclosed only as permitted by the Protective Order in this litigation.

I. GENERAL INFORMATION

A. Name of person completing this PFS:_____

B. Please state the following for the civil action which you filed:

1. Case Caption: _____

2. Case No: _____

3. Principal attorney(s) representing you and his/her contact information:

_____
Name

_____
Firm

_____
E-mail Address

C. If you are completing this PFS in a representative capacity, please complete the following:

1. Your name and **Social Security number**:

_____

2. Your current address:

_____

3. The name of the individual or estate you are representing, and in what capacity you are representing the individual or estate:

_____

4. If you were appointed as a representative by a court, state the:

_____ _____
Court Date of Appointment

5. Your relationship to the plaintiff on whose behalf you are completing this PFS: _____

6. If you represent a decedent's estate, state the date and place of the decedent's death:

a. Date of Decedent's Death: _____
b. Place of Decedent's Death: _____

The remainder of this Fact Sheet requests information about the person who alleges injury from the use of a GLP-1 RA and/or GLP-1 RA/GIP RA (hereinafter, "GLP-1 RA"). If you are completing this PFS in a representative capacity, please respond to the remaining questions with respect to the person who allegedly used the GLP-1 RA, unless the question instructs you otherwise. Questions using the term "You" refer to the person who allegedly used the GLP-1 RA, unless instructed otherwise. Append additional pages if more space is necessary.

II. PERSONAL INFORMATION ABOUT THE GLP-1 RA USER

A. Full Name: _____

B. **Social Security Number** (if not provided above): _____

C. Medicare Beneficiary Identifier (if any): _____

D. Biological sex at birth: _____

E. Maiden name or other names used or by which you have been known, and the date(s) you were known by those other names: _____

F. Current address (or last address, if the person you allege was injured is deceased): _____

G. Date of birth: _____

H. Are you currently employed? ☐ Yes ☐ No

I. If you are currently employed, please provide the following information regarding your current employer:

1. Name of Employer: _____
2. Dates of employment: _____
3. Occupation / Job duties: _____

J. Are you claiming or do you expect to claim that you **lost earnings or impairment of earning capacity** as a result of any injury/condition(s) you contend was/were caused by your use of GLP-1 RAs? ☐ Yes ☐ No

1. If yes:

a. State the total amount of time you have lost from work as a result of any injury/condition(s) you claim or believe was/were caused by your use of GLP-1 RAs: _____
b. Your weekly wage / salary: _____
c. The amount of income you lost: _____

K. If you are not currently employed, did you leave the last job for a medical reason? ☐ Yes ☐ No

1. If yes, describe why you left your last job: _____

L. Identify each insurance carrier (including government health programs) with whom you have had health insurance coverage beginning five (5) years before your first GLP-1RA prescription at issue in this litigation:

Insurance Co.	Policy No.	Policy Holder	Approx. Dates of Coverage

III. USE OF GLP-1 RA MEDICATIONS

A. To the best of your current recollection, identify each and every GLP-1 RA that you have ever been prescribed or used; include medicines prescribed even if you did not end up using them:

Medicine	Check If Ever Prescribed	Check If Ever Taken
Adlyxin® (lixisenatide)		
Bydureon BCise® (exenatide)		
Byetta® (exenatide)		
Compounded dulaglutide		
Compounded semaglutide		
Compounded tirzepatide		
Mounjaro® (tirzepatide)		
Other (specify): _____		
Other semaglutide (other generic manufacturer / supplier)		
Other tirzepatide (other generic manufacturer / supplier)		
Ozempic® (semaglutide)		
Rybelsus® (semaglutide)		
Saxenda® (liraglutide)		
Soliqua® (insulin glargine and lixisenatide)		
Trulicity® (dulaglutide)		
Victoza® (liraglutide)		
Wegovy® (semaglutide)		
Xultophy® (Insulin degludec/liraglutide)		
Zepbound® (tirzepatide)		

B. For each GLP-1 RA identified as having been taken above, please provide the information requested below. You must answer each question separately for each GLP-1 RA you have taken, including separately for compounded and branded products.

1. Medicine:_____

2. Are you claiming use of this medicine caused or is related to any injury you are suing for: ☐ Yes ☐ No

3. List the condition(s) for which you used this medicine:

   ☐ Glycemic control for Type 2 Diabetes

☐ Chronic Weight Management/Obesity
☐ To reduce risk of major adverse cardiovascular events
☐ Other weight loss
☐ Other (specify): _____

4. When did you use this medicine?
   a. Date of First Use: _____
   b. Weight at the Time of First Use: _____
   c. Date of Last Use: _____
   d. Weight at the Time of Last Use: _____
5. For every dosage taken of this medicine, please provide:
   a. Dose: _____
   b. Date you began taking this dose: _____
   c. Frequency of use: _____
   d. All other start and stop dates for this dose: _____
   e. Last date medication taken at this dosage: _____

Add Another Dosage

6. Do you still use the medicine? ☐ Yes ☐ No

7. During your use of this medicine, did you use any other GLP-1 RA? ☐ Yes ☐ No
   a. If yes, please identify the GLP-1 RA(s) used: _____

8. Identify the name, affiliation, address, and contact information of each and every healthcare provider ("HCP") who prescribed this medicine to you:

   HCP Name: _____
   Affiliation/Practice: _____
   Address: _____
   Is this provider a telemedicine provider: ☐ Yes ☐ No
   Is this provider a medical spa/medspa, wellness clinic, or similar location? ☐ Yes ☐ No
   First Date of Prescription(s):
   Month _____ Year _____
   Most Recent Date of Prescription(s) :
   Month _____ Year _____

9. Identify the name and address of each and every pharmacy location where you filed a prescription for this medicine.

   Pharmacy Name: _____
   Address: _____
   Online/Mail Order Pharmacy: ☐ Yes ☐ No

IV. INJURIES AND CLAIMS

A. Please identify each and every injury for which you are suing and that you claim was caused or worsened by use of any GLP-1 RA:

Claimed Injury	Check If Injured or Symptom Claimed
Gastroparesis	
Indigestion (Dyspepsia)	
Nausea	
Vomiting	
Constipation	
Decreased Appetite	
Stomach (Abdominal) Pain	
Diarrhea	
Intestinal/Bowel Obstruction/Blockage	
Ileus	
Malnutrition	
Dehydration	
Pulmonary Aspiration	
Pulmonary Embolism	
Deep Vein Thrombosis	
Wernicke encephalopathy/Wernicke-Korsakoff Syndrome	
Cholelithiasis (Gallstones)	
Cholecystitis (Gallbladder Inflammation)	
Gallbladder Removal	
Acute Kidney Injury	
Pancreatitis (Inflammation of Pancreas)	
Death	
Other (Specify): _____	

B. For each claimed injury, please provide the information requested below. You must answer each question separately for each injury you allege.

1. Injury: _____
2. Which medication(s) do you claim caused or worsened your [INJURY]?

GLP-1 RA Medication Used	Do you claim the product caused your [INJURY]?	Do you claim this product worsened your [INJURY]?
[PRODUCT #1]	☐No ☐ Yes	☐No ☐ Yes
[PRODUCT #2]	☐No ☐ Yes	☐No ☐ Yes
[PRODUCT #3]	☐No ☐ Yes	☐No ☐ Yes
[PRODUCT #4]	☐No ☐ Yes	☐No ☐ Yes

3. Describe when you experienced [INJURY]:

   a. When did you first experience or otherwise learn of your [INJURY]? _____

   b. Has your [INJURY] resolved? ☐ Yes ☐ No
   If so, when: _____

   c. If not, when did you most recently experience [INJURY]? _____

   d. How often did your experience your [INJURY]?
   ☐ One time only
   ☐ Daily
   ☐ Weekly
   ☐ Monthly
   ☐ Other (explain): _____

4. How do you describe the severity of your [INJURY]?
   ☐ Mild
   ☐ Moderate
   ☐ Severe

   a. Has the severity your [INJURY] changed over time? ☐ Yes ☐ No
   If so, when did they change? _____

   How did they change? _____

5. For each medication you claim worsened your [INJURY], provide the following information:

   a. Medication: _____

b. With respect to your claim that [PRODUCT #1] worsened your [INJURY], when did your [INJURY] worsen? _____

c. With respect to your claim that [PRODUCT #1] worsened your [INJURY], describe how your [INJURY] got worse?

_____

_____

d. What was the severity of your [INJURY] before you first used [PRODUCT #1]?

☐ Mild
☐ Moderate
☐ Severe

e. What was the severity of your [INJURY] after your use of [PRODUCT #1]?

☐ Mild
☐ Moderate
☐ Severe

6. Has an HCP told you that you have [INJURY] or diagnosed you with [INJURY]? ☐ Yes ☐ No

a. If Yes, please identify following information:
HCP Name: _____
Affiliation/Practice: _____
Address: _____
Date first contacted: _____
Date of diagnosis:_____

7. Has an HCP ever provided treatment for [INJURY]? ☐ Yes ☐ No

a. If Yes, identify each healthcare provider from whom you have received treatment for your injury:
HCP Name: _____
Affiliation/Practice: _____
Address: _____

b. Describe the treatment and dates received (e.g., medication, surgery)
_____

Add Another Treatment for [INJURY]

8. Were you ever admitted to the hospital or treated at the hospital for [INJURY]? ☐ Yes ☐ No

If yes, provide the following information for each hospital visit:

Admission Date: Month _____ Day _____ Year _____
Discharge Date: Month _____ Day _____ Year _____
Hospital: _____
Address: _____

9. Has any HCP told you that the [INJURY] was caused by your use of GLP-1 RAs? ☐ Yes ☐ No ☐ Unsure

If yes, for [INJURY], state who told you and the date and form of that communication: _____

10. Please identify all diagnostic tests that you have undergone to evaluate and/or diagnose your alleged [INJURY] (complete all that apply).

Diagnostic Test	**Have you undergone this test to evaluate/diagnose your alleged [INJURY]?**	**Date**	**Location**	**Check if you have copies of the results of this test in your possession.**
Abdominal CT				
Abdominal MRI				
Abdominal Ultrasound				
Abdominal X-Ray				
Colonoscopy				
Gastric Emptying Study				
Upper GI Endoscopy				
Other (Specify)				

C. Are you claiming that emotional distress or a psychiatric injury or condition was caused or worsened as a result of your use of [PRODUCT #1], beyond the pain and suffering, emotional distress and mental anguish from the underlying claimed physical injury?

☐ Yes ☐ No

1. If Yes, describe the emotional distress or a psychiatric injury or condition you attribute to your use of the GLP-1 RA(s) identified above: _____
_____
_____

2. For each identified psychiatric injury or condition, please separately provide the following information:

   a. State whether you were treated for the condition(s) prior to your use of the GLP-1 RA: ☐ Yes ☐ No

   b. State the name and address of each physician, therapist, mental healthcare provider, or other healthcare provider from whom you have received treatment for such condition(s)_____
   _____

   c. Dates on which treatment was received: _____

3. If you are claiming worsened emotional distress or psychiatric injury or condition of the injury, state the date of original diagnosis. _____

V. MEDICAL / HEALTH BACKGROUND

A. Height: _____

B. Current weight: _____

C. Highest weight: _____ Date: _____

D. Name of current primary care physician or healthcare provider: _____

E. Address of current primary care physician or healthcare provider: _____

F. Have you ever been diagnosed with Type 2 diabetes? ☐ Yes ☐ No

1. If Yes, please state date of diagnosis and diagnosing healthcare provider: _____

2. If Yes, please provide all medications ever taken for diabetes treatment and dates used: _____

3. If Yes, please identify all HCPs (including primary care, endocrinologists, urgent care facilities or hospitals that have ever diagnosed or treated your Type 2 diabetes or any complications related to your Type2 diabetes) and the dates of diagnosis or treatment: _____
_____

G. Have you ever consulted with an endocrinologist, including for matters related to diabetes or prediabetes or weight? ☐ No ☐ Yes

1. If Yes, Name and address of most recent endocrinologist: _____

_____

H. Have you ever discussed bariatric surgery with a healthcare provider?

☐ No ☐ Yes

1. If Yes, have you ever had bariatric surgery? ☐ No ☐ Yes

a. If yes, please provide date, facility where the procedure occurred, and the healthcare provider who performed the surgery:

_____

_____

2. Have you used any GLP-1 RA for overweight or obesity indications, or in order to lose weight? ☐ No ☐ Yes

a. If yes, what other weight loss methods or medicines (not including a GLP-1 RA) have you tried?

_____

b. Excluding pregnancy, have you ever intentionally lost more than 20 pounds without weight loss surgery or medicine? ☐ Yes ☐ No

c. Excluding pregnancy, have you ever unintentionally lost more than 20 pounds without weight loss surgery or medicine? ☐ Yes ☐ No

I. Identify each of your **HCPs** (including primary care, endocrinologist, and anyone involved in treating the condition for which you were prescribed GLP-1 RA and the injuries you allege were caused by the GLP-1 RA), from five (5) years prior to your first GLP-1 RA prescription to present:

_____

Name

_____

Approximate Dates

_____

Address

Add Another HCP

J. Identify each hospital, clinic, or healthcare facility where you have received **inpatient treatment**, from five (5) years prior to your first GLP-1 RA prescription to present:

Name

Address

Dates of Admission

Reason for Admission

Add Another Inpatient Facility

K. Identify each hospital, clinic, or healthcare facility where you have received **outpatient treatment** (including treatment in an emergency room), from five (5) years prior to your first GLP-1 RA prescription to present:

Name

Address

Dates of Treatment
Add Another Date of Treatment at Same Outpatient Facility

Reason for Treatment

Add Another Outpatient Facility

L. Identify on the chart below each **prescription medication** (excluding antibiotics and antivirals) you have taken in the five (5) years prior to your first treatment with any GLP-1 RA up to the present:

Medication	Reason Prescribed	Dates of Use	Prescriber	Dispensing Pharmacy or Where Purchased

M. Identify on the chart below each **Over-the-Counter ("OTC") medication, including vitamins, herbal remedies, and supplements**, you have routinely taken in the five (5) years prior to your first treatment with any GLP-1 RA up to the present:

Medication	Reason Prescribed	Dates of Use	Prescriber	Dispensing Pharmacy or Where Purchased

N. To the best of your knowledge, have you ever experienced, or been told by a physician or other healthcare provider, that you presently have, may have, or had any of the following at any time in your life (check all that apply)?

Responses to conditions listed with an asterisk ("") are designated as Highly Confidential under the Protective Order.

Alcoholism within five years of injury claimed in Section IV*	
Disordered Eating Diagnosis* (e.g. anorexia, bulimia, binge eating)	
Gastrointestinal complications from alcoholism* *(e.g., liver damage, gastritis, reflux, pancreatitis, etc.)*	
Gastrointestinal complications from opioid use disorder*	
Autoimmune disease	
Cancer	
Celiac disease	
Chronic constipation	
Chronic kidney disease	
Cyclic vomiting syndrome	
Cystic fibrosis	
Diabetes, Type 1	
Diabetes, Type 2	
Diverticulitis	
GI Issues *(i.e. Dyspepsia, dysphagia, reflux disorder (GERD) and/or indigestion)*	
Ehlers-Danlos Syndrome	
End Stage Renal Disease	
Esophageal injury	
Gallbladder injury/inflammation	
Gallstones	
Gastroparesis	
Heart disease *(i.e. congestive heart failure, peripheral arterial disease*	

(PAD), arrythmia, coronary artery disease (CAD), and/or peripheral vascular disease (PVD))	
Hernia (including hiatal)	
High cholesterol and/or triglycerides within five years of injury claimed in Section IV	
Hypothyroidism	
Ileus	
Intestinal obstruction/blockages	
Inflammatory bowel disease	
Intussusception	
Irritable bowel disease	
Malnutrition/malabsorption	
Metabolic syndrome	
Multiple sclerosis	
Pancreatitis	
Parkinson's Disease	
Peptic ulcer disease	
Peripheral neuropathy	
Prediabetes	
Pulmonary aspiration	
Scleroderma	
Severe gastrointestinal disease	
Severe or persistent nausea, vomiting or diarrhea (> 1 month)	
Stroke or Transient Ischemic Attack	
Treatment for weight management or obesity	
Vagus nerve injury	
Volvulus	

O. Within five years of injury claimed in Section IV, have you been diagnosed or treated for any of the following mental health conditions: anxiety, bipolar disorder, depression, schizophrenia and/or somatoform disorder? ☐ No ☐ Yes

1. If yes, please identify which conditions you have been diagnosed with _____

P. Have you been prescribed medication to lower cholesterol or triglycerides (e.g. statins, Lipitor)? ☐ No ☐ Yes

Q. For each condition checked above, please state the condition(s), the date of onset, any treatment received (including medication prescribed and/or taken), the name of the healthcare provider or other person who made the diagnosis or informed you of the condition(s), and their address.

1. Condition(s): _____

2. Onset date: _____

3. Treatments received, including Medications prescribed to treat or manage: _____

4. Has the condition resolved? ☐ Yes ☐ No

   a. If so, when:

5. Name and address of healthcare provider or other person: _____

R. Based on your current recollection and understanding, have you had any of the following medical tests or procedures?

Medical Test or Procedure	Yes	Approximate Date	Doctor or Hospital/ Facility
Abdominal ultrasound (other than pregnancy-related)			
Abdominal irradiation			
Abdominal surgery			
Cesarean Section			
Barium or Air Enema			
Barium Swallow / Upper GI Series			
Colonoscopy			
Computerized tomography (CT) scan of abdomen			
Coolsculpting			
Fundoplication (surgery for treatment of reflux)			
Gastric emptying breath test			
Gastric emptying scintigraphy (also called gastric emptying scan or gastric emptying test)			
GI endoscopy			
Isotope breath test			
Abdominal lipoplasty, liposuction, or suction lipectomy			
Magnetic resonance imaging (MRI) of abdomen			
Abdominal or Gastrointestinal surgery within five years of injury listed in Section IV (specify):			

Medical Test or Procedure	Yes	Approximate Date	Doctor or Hospital/ Facility
Partial gastric resection			
Vagotomy			
Whipple procedure			
Wireless motility capsule (sometimes called a SmartPill)			
X-ray of any part of the abdomen			
Other abdominal fat reducing procedure (specify):			
Pelvic surgery with or for complications within five years of injury listed in Section IV (specify):			

S. If you are claiming an injury in Section IV related to pulmonary aspiration, based on your current recollection and understanding, please identify all surgeries requiring general anesthesia not identified above.

Medical Test or Procedure	Date	Doctor or Hospital / Facility

VI. DOCUMENTS AND THINGS

Please check "Yes" or "No" as appropriate below to indicate whether you, your parents, guardians or spouse, or your lawyers currently possess documents described by the various categories listed.

Document Request No.	Category/Description	Yes	No
1.	For [PRODUCTS], pharmacy records substantiating that you filled a prescription for that GLP-1 RA prior to the date of the alleged injury(ies)	☐	☐
2.	Regarding the injury(ies)/condition(s) you contend were caused by GLP-1 RA(s), medical records evidencing or otherwise reflecting the injury(ies)/condition(s)	☐	☐
3.	If you allege gastroparesis as an injury, medical records documenting proof of diagnosis, including any confirmatory testing	☐	☐
4.	A copy of all prescriptions for [PRODUCTS]	☐	☐

5.	Any unused GLP-1 RAs, including pens, containers, boxes, packaging, and/or labeling	☐	☐
6.	Receipts for [PRODUCTS]	☐	☐
7.	Photographs of medicine containers, bottles, pens, vials or packaging related to GLP-1 RAs	☐	☐
8.	Any other medical records that show the period during which you have taken [PRODUCTS], the dosage of the [PRODUCTS] and/or the frequency with which you took [PRODUCTS]	☐	☐
9.	Medical records, communications with medical providers and diagnostic imaging referring or relating to claims, information contained in this Plaintiff Fact Sheet, and pharmacy records for prescriptions filled (regardless of whether they were for GLP-1 RAs)	☐	☐
10.	Documents relating to your insurance coverage that is/are applicable to the illness, injury, or medical condition that forms the basis of your complaint, including any application to any insurer for coverage, whether insurance was obtained or not	☐	☐
11.	Any documents, communications (excluding those to or from your attorney), notes, summaries, diaries, recordings, videos, tapes, writing, social media posts, or other written or electronic material that describes, discusses, or relates to your use of GLP-1 RAs, your lawsuit, and/or any injury(ies)/condition(s) for which you seek recovery in this lawsuit.	☐	☐
12.	All materials or items that were referenced or referred to as part of completing this Fact Sheet	☐	☐
13.	Copies of death certificate of decedent (if applicable), letters testamentary, letters of administration, powers of attorney, guardianship or guardian *ad litem* orders or other documents relating to your status as plaintiff if you are suing on behalf of another individual	☐	☐

For each category of document for which you have indicated "yes," produce a copy of all the documents in the manner set forth in the CMO governing Plaintiffs Fact Sheets.

If you have indicated "no," for Document Request No. 1-2 in the chart above: within 90 days of initial service of your Plaintiff Fact Sheet, you must obtain copies of records sufficient to meet this requirement and produce those records in the manner set forth in the CMO governing Plaintiffs Fact Sheets.

To the extent these materials are currently in the possession, custody or control of you, your parents, guardians or spouse, or your lawyers, please produce.

In addition to the documents above, please provide signed blank authorizations in the forms attached as Exhibits B-Q. Please only fill out the highlighted portions asking for your (patient or personal representative) name, date of birth, and social security number. Please sign and date and have a witness sign/date. Do not fill out the un-highlighted portions requesting the name or address of the healthcare provider or the representative to whom the records should be released. You need to provide a signed Authorization for the Release of Mental Health Records (Exhibit C) only if you are claiming damages for psychological injury or mental or emotional distress. You need to provide a signed Authorization to Disclose Employment Information (Exhibit D) only if you are making a claim for lost wages.

VII. DECLARATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, recollection, information and belief.

_____ _____

Dated Signature