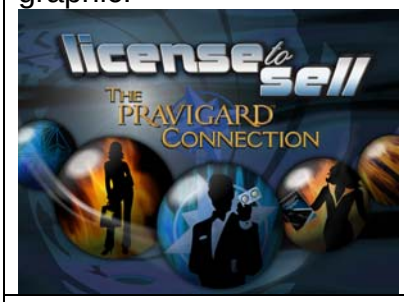
Countdown Clock 9:30 – 10:00

Video	Audio
License to Sell Your briefing will begin in [00] Minutes	

Broadcast Opener 10:00 – 10:05

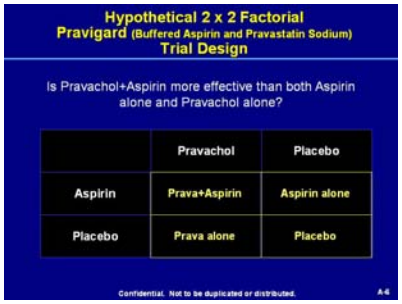
Video	Audio
TRANSITION to theme graphic:  	MUSIC: [Adventurous, thrilling.]
Q on the studio set. In the background is a table with various gadgets and sales materials.	Q (*to camera*): Ah, good morning Special Agents. Are you ready to make the Pravigard connection? Ready to receive the powerful tools that will equip you for this mission? Before we begin your briefing, we should review the day's schedule.
Making the PRAVIGARD Connection • Medical Presentation • Marketing/Positioning • Selling to Physicians • Lunch • Customer Concerns • Full Role-Play • Selling in Hospitals • Pravachol POA 1	We will begin with a Medical Presentation on the genuine need for this product, followed by an explanation of how we will position Pravigard with respect to the competition. You'll see how you will actually sell Pravigard to physicians. Then we will pause for a tasty lunch. After lunch, an explanation of how to respond to key customer concerns, followed by practice of what you will actually say in a full role-play. We'll take a careful look at hospitals, where a patient's regimen is often determined at discharge. We'll take a brief break and head into the Pravachol

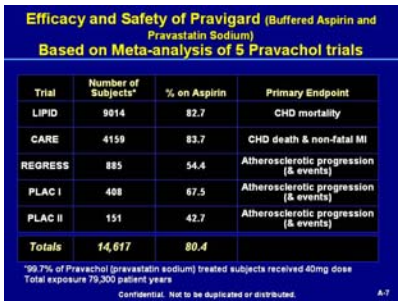
Video	Audio
	POA.
Picks up a copy of the participant guide.	This would be a good time for you to locate your *Agent Briefing Kit*. It contains guidelines for your role-plays and space to build your call plans for your practice calls tomorrow. We have a full agenda. So let us begin with the medical presentation.

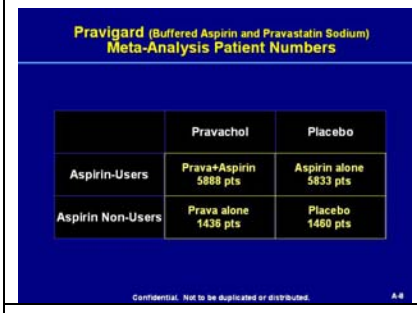
Medical Presentation 10:05 – 10:25

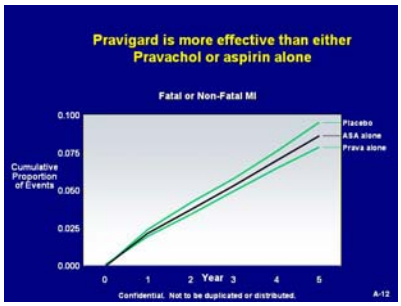
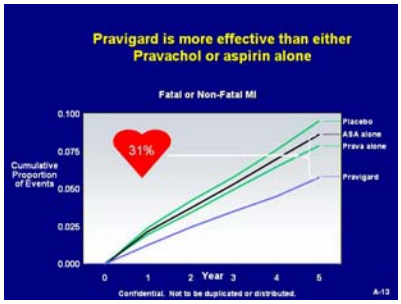
Video	Audio
Bond-style poster: **The Aspirin is Not Enough** Medical Presentation	MUSIC: [Introductory sting.]
Picks up a pocket flashlight.	Q: Welcome back, special agents. I thought we might begin by introducing you to a handy device that will help you on your sales calls. It appears to be an ordinary pocket flashlight.
Points it to the side.	Point it at any white surface, however…
CUT to an image of the annotated PI, projected on a white wall.	…and it projects a readable image of the Pravigard annotated PI, suitable for presentation. Please do us favor and try not to lose it?
Turns off the flashlight, picks up an "AA" battery from the table, and holds it up very meaningfully.	(*portentously*) Now do you know what this is? It's just a double-A battery. But it's also a calling card … left here by agents "A" and "A" – *Andrew* Walker and *Al* D'Alonzo.
Walks over to Andrew and Al. SUPER: Andrew Walker Associate Director, Global Medical-Marketing, Pravachol Lifecycle	I believe they have prepared a medical briefing for you. Gentlemen? ANDREW: Thank you, Q. Al and I would like to brief you on the medical rationale behind Pravigard – how it meets a real need. I'll review what the studies

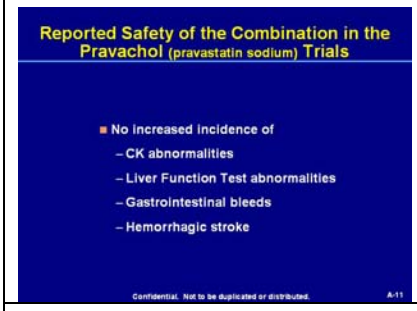
Video	Audio
Management	show and why the data is so exciting. You'll find out why our boffins in HQ were so shaken – and even stirred!
SUPER: Al D'Alonzo Director, Medical Operations	AL: Then I will take you through the [draft] annotated PI and help you find your way around it to the key information you'll use. Q: And where will this leave us, agents double-A? By the way, you're not double agents, are you? AL: No, we're just … two agents. Q: Ah. That's reassuring. Just as it's reassuring to have two CV agents included in one prescription. Getting back to your briefing, where will this leave us when you are finished?
The Aspirin is Not Enough Medical Presentation • Medical need • Pravigard efficacy • Pravigard safety • Dosing options • Annotated PI	AL: It will leave us with an understanding of the medical need that Pravigard meets, how its efficacy was firmly established in a meta-analysis of clinical data. We'll understand the basis for its safety profile and be familiar with the Pravigard dosing options. And we'll know where this information is supported in the annotated PI.
	Q: Very good. Would you like to begin, then, Agent … A? ANDREW: Yes. We might want to start with the fact that 15 people are going to die during my presentation.
TEXT: Every 29 seconds, an American has a heart attack, and every minute	That's right. Every 23 seconds, somewhere in America, a person has a heart attack. And every minute, someone dies from one. These are powerful statistics, but we shouldn't forget the

Video	Audio
someone dies from it.	human dimension.
PHOTOS of patients: 	Each of these incidents represents a life – a mother, father, husband or wife – with terrible, traumatic impact on their spouses and families.
ACC/AHA Guidelines For Secondary Prevention • Aspirin • ACE inhibitor • Beta-blocker • Statin • Plavix	As Dr. Milani highlighted this morning, the ACC/AHA has developed guidelines for people who have clinically evident coronary heart disease, for example, unstable angina or a heart attack, to help them prevent a second, possibly fatal, event. The recommendations call for them to take aspirin, an ACE inhibitor, a beta-blocker, Plavix, and a statin. These recommendations are based on extensive clinical data that demonstrate each component's ability to significantly reduce risk. What we didn't know was, "Does each component simply contribute its share to risk reduction? Or is there perhaps some additive benefit to *combining* any of them?" With its extensive clinical research history in secondary prevention with Pravachol, BMS is uniquely positioned to look into this issue. We approached the FDA with the idea of conducting a retrospective outcome analysis for patients treated with Pravachol *and* aspirin.
"Is Pravachol with aspirin more effective than aspirin alone or Pravachol alone?"	Our question was, "Is Pravachol with aspirin more effective than aspirin alone or Pravachol alone?" Let me first explain why you need to answer this through a retrospective analysis.
 This slide should build as	Ideally, you would answer this question by conducting a two-times-two factorial study, where you randomize patients first to Pravachol or placebo, and then re-randomize them to aspirin or placebo – a double randomization. If you did that, you would have the four patient groups you see here: a quarter of your patients on both drugs, a quarter on aspirin alone, a quarter on Pravachol alone, and a quarter on placebo.

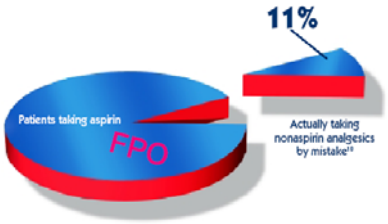
Video	Audio
Andrew describes the study.	You could compare the groups and answer the FDA's question. However, it would not be ethical to do this study in a secondary prevention population. Three quarters of your population would be treated sub-optimally. They'd be on aspirin alone, Pravachol alone, or even on placebo, getting no protection at all. The FDA understands this, so its guidance to us was to look instead at the extensive database of Pravachol secondary prevention studies. In these studies, CHD patients were randomized to either Pravachol or placebo. Many of them were also taking aspirin, but the aspirin wasn't randomized. So we conducted a meta-analysis of this database.
 Animate graphic to highlight the 40mg Pravachol use while Andrew makes this point.	These are the five studies. You know the LIPID and CARE studies very well. You may be a little less familiar with REGRESS, PLAC I and PLAC II. These were two- and three-year atherosclerotic prevention studies, but they also measured clinical events. Looking at the size of the populations, LIPID and CARE dominate. And over 80% of patients in those two large studies were aspirin users at baseline, although, obviously, they weren't randomized to aspirin and non-aspirin. In REGRESS, PLAC I, and PLAC II, roughly 40% to 65% of the patients were aspirin-users at baseline. Putting all these studies together in a meta-analysis, we have about 14,500 patients split between Pravachol and placebo, with approximately 80% in each group also taking aspirin. Notice the Pravachol dose in this meta-analysis was almost always 40mg, so that's where our evidence base is.

Video	Audio
	If we go back to the grid we saw just a minute ago, what we have effectively is a Pravigard group (that is, aspirin plus Pravachol) of about 5,800 patients, an aspirin-only group of about 5,800 patients, a Pravachol-only group of about 1,500 patients, and a placebo group of about 1,500 patients. Let's see what the clinical event rates were like in these groups.
Risk Reduction of Pravastatin/Aspirin Compared to Pravastatin Alone Fatal or non-fatal MI ↓ 26% CHD death or non-fatal MI ↓ 37% Ischemic stroke ↓ 31% CHD death, non-fatal MI or revascularization procedures ↓ 11% CHD death, non-fatal MI, revascularization procedures or ischemic stroke ↓ 14%	As you might expect, adding aspirin to pravastatin dramatically reduced the risk of a secondary event. We see that the risk of a fatal or non-fatal MI went down by 26%, the risk of CHD death or non-fatal MI went down by 37%. Ischemic stroke risk declined by 31%, as well. You'll notice that the risk reduction in outcomes that include revascularization procedures were not quite as impressive. That's because aspirin doesn't reduce the risk of these procedures. These results aren't really surprising. Physicians would expect to see them because the efficacy of aspirin in secondary prevention is well known. But what's *really* surprising is the difference that emerges when you compare aspirin alone to aspirin plus Pravachol.
Risk Reduction of Pravastatin/Aspirin Compared to Aspirin Alone Fatal or non-fatal MI ↓ 31% CHD death or non-fatal MI ↓ 31% Ischemic stroke ↓ 29% CHD death, non-fatal MI or revascularization procedures ↓ 24% CHD death, non-fatal MI, revascularization procedures or ischemic stroke ↓ 24% Major point to emphasize on graphic -- ABOVE AND	In other words, "By how much do you reduce the risk of death, MI, or other cardiovascular events if patients are treated with Pravigard instead of just aspirin?" This is the key data that forms the basis for our efficacy claims and this is what shakes our martini. We start with the endpoint of fatal or non-fatal MI. Comparing Pravigard to aspirin alone, we found that Pravigard reduced the risk of fatal or non-fatal MI by 31%. Note that this was an *incremental* reduction – it went *above and beyond the reduction already achieved by aspirin alone!* That's a fantastic result. None of us, when we started looking at this data, believed that we would see a difference as great as that.

Video	Audio
BEYOND THE REDUCTION ACHIEVED BY ASPIRIN ALONE!!!	We saw impressive and consistent risk reductions across all the other endpoints as well, including stroke, CHD death and revascularization procedures.
	We used another meta-analysis technique that spreads the data over five years to give you a feel for how the different groups might fare over time. We graphed something called the cumulative proportion of events. This is a statistical analysis that adds the number of events at each time point. When we look at the aspirin-alone group, we see that there is some reduction in the cumulative proportion of MI events compared to placebo. The lowest line on this graph represents patients who took Pravachol alone – no aspirin. You also see some benefit, but it's about the same as with aspirin alone.
	But look at the combination. The purple line at the bottom represents the Pravigard group. The result is a 31% relative risk reduction compared to patients on aspirin alone. Something very special is happening when patients take both of these drugs together. Call it kismet, call it chemistry. These two were simply meant to be together. We'd always thought that might be the case, but we never had the data to prove it. This data, for the first time, shows us the benefit of putting the two drugs together. The efficacy data are very impressive – better than we ever expected. But what about safety?
Aspirin Contraindications • Allergies o NSAIDs o Patients with	Although it is included in the ACC/AHA guidelines, aspirin is not without safety issues. But this safety profile is well-understood by physicians. Aspirin is contraindicated in patients with known allergies to non-steroidal anti-inflammatory drugs, and in patients with the syndrome of asthma, rhinitis and nasal polyps. It should not be used in children or

Video	Audio
asthma, rhinitis and nasal polyps • Children under 18 with known or suspected viral infections (due to risk of Reye's syndrome)	teenagers for viral infections, with or without fever, due to the risk of causing Reye's Syndrome.
Aspirin Warnings & Precautions • Alcohol • Coagulation abnormalities • Peptic ulcer disease • Pregnancy • Severe renal failure • Hepatic insufficiency • Sodium-restricted diets	Aspirin also comes with a number of warnings. Patients who consume three or more alcoholic drinks per day should be counseled about the bleeding risks involved. Because aspirin is an acid, it can damage the gut mucosa and increase bleeding risk. And because it's an anti-platelet agent, it prevents bleeds from stopping as quickly as they usually do. There are also warnings about coagulation abnormalities, GI side effects, peptic ulcer disease, and pregnancy. Aspirin use should be avoided in patients with severe renal failure, severe hepatic insufficiency, and on sodium-restricted diets. You should read the PI and become familiar with these warnings before you discuss aspirin with doctors. The question is, "Did we increase the incidence of adverse events when we added Pravachol to aspirin?"
	The answer is no. We looked in detail at four types of adverse events that you might expect to increase with this combination: statin-related CK and liver function abnormalities, and the risk of aspirin-related GI bleeds and hemorrhagic stroke. There was no statistically significant difference in adverse events vs aspirin alone.
A High Number of Scripts A typical CHD patient might take: • Aspirin • ACE inhibitor	Another issue many CHD patients face is managing a large number of medications. The typical CHD patient is taking multiple medications. But he or she is often treated for other conditions beyond CHD, including depression, arthritis and other pain, diabetes and more. As Dr. Milani pointed out, the more medications a patient is

Video	Audio
• Beta-blocker • Statin • Plavix As well as medications for: • Depression • Arthritis • Pain management • Diabetes • More….	taking, the greater the concern for drug interactions. The components of Pravigard are not metabolized by the CYP450 system to a clinically significant extent. That's another reason why doctors should consider Pravigard. It has a low potential for these types of drug interactions.
Pravigard Indications Pravigard is indicated, along with diet, to reduce the occurrence of cardiovascular events, including death, myocardial infarction or stroke in patients who have clinical evidence of cardiovascular and/or cerebrovascular disease.	And that, indeed, is the clinical story behind Pravigard. Now let's take a look at its [proposed] indications. Pravigard is indicated, along with diet, to reduce the occurrence of cardiovascular events, including death, myocardial infarction or stroke in patients who have clinical evidence of cardiovascular and/or cerebrovascular disease. This is a broad indication that can help extend the lives of millions. Not only does Pravigard reduce CV risk, it helps address a significant undertreatment problem. Let me explain why. Unless there are contraindications, most patients who have had an MI, or an episode of unstable angina, should be treated with aspirin and a statin.
Statin & Aspirin Undertreatment [Create pie chart with 100% of patients on aspirin, but only 35% on lipid-lowering therapy.] Source: National Registry of Myocardial Infarction	Unfortunately, that just isn't happening. According to the National Registry of Myocardial Infarction, a nationwide survey of 138,000 CHD patients who were discharged from hospital, 80% received aspirin, but only 32% were prescribed lipid-lowering therapy. The proportion receiving both therapies was even smaller. Only 35% of the patients who received aspirin at discharge were also prescribed lipid-lowering therapy at that time. On top of that, patients who are instructed to take aspirin – and who try to follow that advice – face an interesting question, "What do I actually buy?"

Video	Audio
	You might think, “That’s easy. Just go in and buy aspirin.” But many patients get it wrong.
	For example, here are six heavily advertised analgesics that contain no aspirin whatsoever. If a patient doesn’t understand what an anti-platelet agent is, or that aspirin is more than just a painkiller, he might think the doctor just meant “take a painkiller every day because you might have another heart attack and that first one sure did hurt bad!” It’s like when Miss Moneypenny asks you to pop out to the corner shop and buy her shampoo. They probably all look the same to you. You’re a spy, for goodness sake. You don’t know how they work. You just buy a brand you’ve seen advertised on TV.
	As a result, many patients who *think* they are taking aspirin are actually taking the wrong thing. In a recent survey, 11% were taking a non-aspirin analgesic for secondary prevention. They were taking acetaminophen or ibuprofen. They mistakenly assumed that these medicines gave them the same sort of cardioprotection as aspirin. “That means, Doctor, that more than one in ten patients who think they’re taking aspirin aren’t actually taking aspirin.” And remember, multiple doses of aspirin are available for multiple conditions. Not all are intended for cardioprotection. The beauty of Pravigard is that it allows the physician to prescribe an appropriate and specific dose of aspirin. Patients actually get aspirin – at the dose the physician intended….

Model Sales Call 11:25 – 11:28

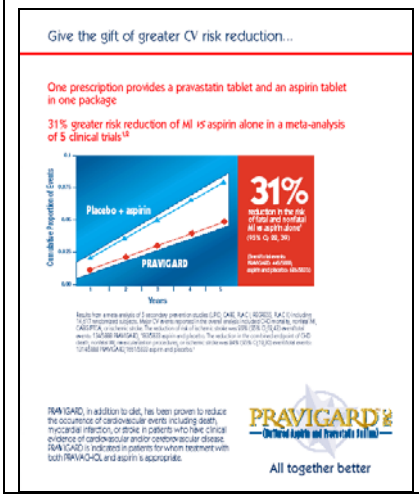
Video	Audio
Bond-style poster: **The Doc Who Loved Me** Selling to Physicians	MUSIC: [Introductory sting.]
Q, Betsy and Matt	Q: We're back. Ready to deliver the next part of your presentation, the features and benefits of Pravigard? MATT: Yes. Q: Proceed.
SUPER: **R**isk reduction of 31% Shows her Table 5 from page 8 in PI	MATT: Dr. Hanna, a meta-analysis of five clinical trials evaluated the effect of PRAVIGARD vs. aspirin alone. This analysis included over 14,000 patients with clinically evident CHD. If you take a look at this table, you see that 10.7% of patients taking aspirin alone suffered a fatal or non-fatal MI – in comparison to 7.6% of the patients taking Pravigard. This translates into a 31% relative risk reduction of *suffering a fatal or non-fatal MI!* BETSY: Hmm! MATT: You'll also notice significant risk reductions in CHD death, stroke, and revascularization procedures. What that means is, when you prescribe Pravigard, you provide greater CV risk reduction compared to aspirin alone. BETSY: That's impressive, but what's the tradeoff in terms of safety?

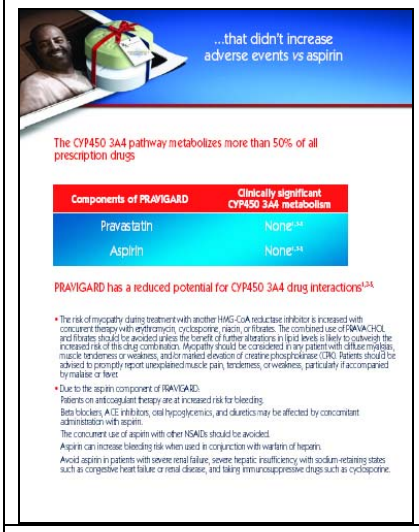
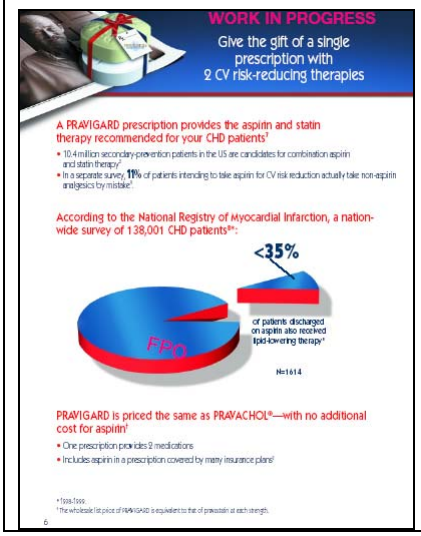
Video	Audio
SUPER: **I**nteractions and incidence of adverse events	MATT: Excellent question, Dr. Hanna. Let's consider drug interactions. The ACC/AHA guidelines recommend many medications for patients who have suffered an MI or unstable angina. Many of these patients will be taking beta blockers, ACE inhibitors, and other medications for various medical conditions. But polypharmacy can increase the risk of drug interactions. BETSY: That's right. MATT: As you know, the CYP450 3A4 pathway metabolizes more than 50% of all prescription drugs.
Shows her the DRUG INTERACTIONS section for Pravachol on page 12 of the annotated PI.	And you can see here that pravastatin is not metabolized by CYP450 3A4 to a clinically significant extent.
Stays at same place.	In addition, this is not an issue for aspirin. Aspirin is not metabolized by the CYP450 3A4 enzyme. Thus, Pravigard has a low potential for these types of drug interactions. Wouldn't you agree that this is an important consideration in patients taking multiple medications? BETSY: You betcha. MATT: (*To audience*) This is also the appropriate place to discuss with the doctor the important safety information for Pravigard found in your highlighted PI.
Points to the Pravigard ADVERSE REACTIONS section on page 15 of the annotated PI.	(*To Betsy)* Additionally, the meta-analysis demonstrated that Pravigard's greater CV risk reduction was achieved without an increase in adverse events compared to aspirin alone. You see, Dr. Hanna, Pravigard is a proven safe and

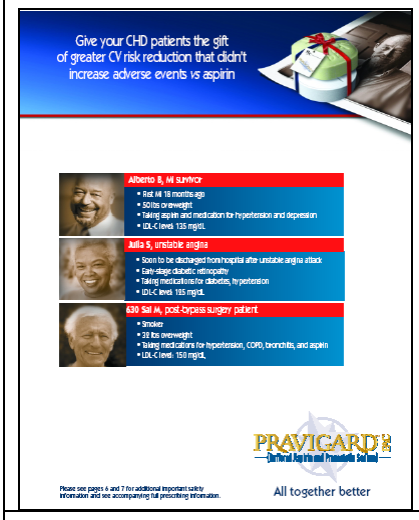
Video	Audio
	effective therapy. BETSY: Good to know. Q: Good work, Matt. These are important points. Let's pause again and let our operatives practice delivering them.

Tour of Sales Aid 11:55 – 12:00

Video	Audio
Bond-style poster: **The Doc Who Loved Me** Selling to Physicians	MUSIC: [Introductory sting.]
Q holds up a gift-wrapped BOX.	Q: This appears to be an ordinary gift-wrapped parcel, doesn't it? But as you well know, appearances can be deceiving. What happens when I open the lid? A cloud of knock-out gas? A blinding flash of light? Even better…
He lifts the lid and takes out a mock-up of the sales aid.	I get a sneak peek at the upcoming sales aid for Pravigard. My colleague Matt Ruple will brief you on it.
SUPER: Matt Ruple, Product Manager, Pravigard	MATT: Thank you, Q. The sales aid is under review with the FDA and will be ready in a few weeks. In the meantime, I'll walk you through our proposed sales aid and show you how it supports our mnemonic of "WRITE Pravigard 40/81 or 40/325."

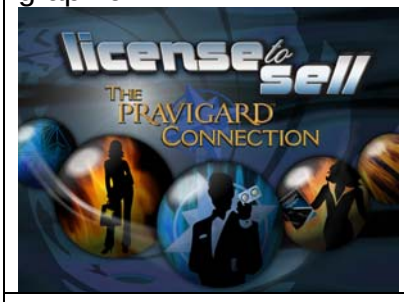
Video	Audio
	The cover headline helps you answer the question, "Who?" It challenges the physician to picture an effective therapy for CHD patients. These are patients who need greater CV risk reduction. You can use the photographs to discuss patient types the doctor might see in his or her practice.
	The first inside spread features a visual of the two tablets tied together by red and blue ribbons. . In a positive way, this introduces the idea of a co-pack and describes the packaging. It also introduces the theme of the sales aid. The doctor is giving his or her appropriate patients the *gift* of greater CV risk reduction. We also introduce our proposed tagline, "All together better."
	The facing page focuses – very powerfully – on "R," risk reduction of 31% for fatal or non-fatal MI vs aspirin alone.

Video	Audio
	The next two pages support your "I" messages: interactions and incidence of adverse events. We point out that the CYP450 3A4 pathway metabolizes more than 50% of all prescription drugs. Pravigard has a low potential for CYP450 3A4 drug interactions because neither component is metabolized by CYP450 3A4 system to a clinically-significant extent. This spread also provides important safety information to share with the physician.
	What's more, Pravigard showed no statistically significant difference in adverse events vs aspirin alone.
	The next page supports your "T" message, "together better." As the headline at the top states, a single Pravigard prescription gives patients two CV risk-reducing therapies. That's important because the NRMI survey showed that only 35% of CHD patients discharged from the hospital with aspirin were also prescribed lipid-lowering therapy. And 11% of CHD patients who are told to take aspirin actually take non-aspirin analgesics by mistake. This page also supports your "E" message, that Pravigard wholesale list price is equal to that of

Video	Audio
	Pravachol.
	The facing page lets you come back to your different patient types and discuss with the doctor how he or she might start prescribing Pravigard for each of them. You have a patient who experienced an MI 18 months ago, a patient with a history of unstable angina, and a patient who *recently* experienced an MI – two months ago.
Insert visual of safety information spread from sales aid	This spread contains additional important safety information for Pravigard.
	The back cover supports your summary. This is also the place for you to deliver your final selling message: The Pravigard recommended daily dose of 40mg pravastatin with either 81 or 325mg aspirin. The prescription pad demonstrates how the physician should write a Pravigard prescription. Until the sales aid is available, you can cover the same ground using the annotated PI, flash card, and dosing card. This will just combine all that information for you.
	Q: Much as Pravigard combines aspirin and Pravachol for your physicians. MATT: Yes, Q. Q: Thank you, Matt!

Video	Audio
	Well, Special Agents, I believe you've earned yourselves a break. Why don't you jet over to your favorite hot spot (the cafeteria) for a mid-day repast. I'll expect you back here at precisely 13:00 hours. (That's 1:00 sharp for you newer agents.) See you then.

Customer Concerns 1:00 – 1:05

Video	Audio
TRANSITION to theme graphic: 	MUSIC: [Adventurous, thrilling.]
Q on the set.	Q: Welcome back, special agents. I trust you enjoyed your mid-day repast? Ready to continue your training now? Let us consider how we will handle concerns.
Bond-style poster: **Dr. Yes** Handling Concerns	MUSIC: [Introductory sting.]
Q in the studio. He shows us a PHOTO OF A SCOWLING DOCTOR.	Q: Take a good look at this photo. This is the infamous Doctor No. But beneath his insidious disguise, you'll find the hidden …
Peels back an overlay to reveal a SECOND PHOTO of the same doctor, now happy.	… Doctor Yes! Your mission is to uncover this Dr. Yes.

Video	Audio
PULL BACK to reveal Lisa wearing a lab coat and Mike Valenta with her.	My two associates here, Lisa McCabe, otherwise known as "L," and Mike Valenta, will brief you further.
SUPERS: Lisa McCabe, Manager, Therapeutic Training Mike Valenta, Associate Manager, Learning and Development	LISA: Thank you, Q. Every time you introduce a new product, you encounter occasional confusion, questions … and concerns. Mike and I will take you through the top customer concerns we anticipate with Pravigard and suggest how you might respond to them. You will have a list of other concerns and suggested responses in your *Agent Briefing Kit*. Q: And after you have done that?
Dr. Yes Handling Concerns • Handle the top four Pravigard concerns • Respond • Get back on track to close the sale	LISA: You will be prepared to handle the top four concerns you may encounter. You will know how to respond to these concerns and get back on track to close the sale. Q: Excellent. Carry on, then. LISA: The four key concerns we've identified are …
Pravigard Concerns • "All of my appropriate post-MI and unstable angina patients are already on a statin and aspirin." • "If I'm going to prescribe a statin and aspirin, I'll use Lipitor. • "Pravigard is just a co-pack, not a fixed-dose combination." • "You're telling me to	"All of my appropriate post-MI and unstable angina patients are already on a statin and aspirin." "If I'm going to prescribe a statin and aspirin, I'll use Lipitor." "Pravigard is just a co-pack, not a fixed-dose combination." And, "You're telling me to use Pravigard for my appropriate post-MI patients and your counterpart was just here telling me to use Pravachol. Which is it?"

Video	Audio
use Pravigard for my appropriate post-MI patients and your counterpart was just here telling me to use Pravachol. Which is it?"	
Addressing Customer Concerns • Perceive/Reflect/Probe • Prioritize • Position • Continue to dialog • Close	As always when addressing a concern, you want to follow the Engage! model. Perceive and reflect the physician's change in emotion, and use downstream probing to uncover the doctor's true concern. Establish your customer's priorities, so that you can address those concerns that are most important. Then position Pravigard according to those priorities. Once you have reduced the costs and risk of change, continue to dialog with your customer and increase the value of Pravigard. When you observe verbal or non-verbal buying signals, close with an action-oriented request for commitment, based on your incremental A to B shift. Let's look at the first concern…
"All of my appropriate post-MI and unstable angina patients are already on a statin and aspirin."	"All of my appropriate post-MI and unstable angina patients are already on a statin and aspirin." Many doctors assume that if they instruct the patient to take aspirin with a statin, that's what happens. If this concern comes from a GP/FP or an internist, how might you respond, Mike?
Perceive-Reflect Reinforce value of using a statin and aspirin for post-MI and UA patients	MIKE: I would start by reinforcing what the doctor has just told me: that she sees value in using a statin and aspirin for post-MI and UA patients. Once I gain her agreement on this, I can probe to uncover the path I want to take. LISA: And what are your choices? MIKE: My probe might uncover patients who need this treatment, but may not be receiving it, or lead to

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	closing the doctor on prescribing Pravigard for all *new* MI or UA patients. LISA: What would you actually say?
Probes • Only 35% of patients who are discharged from the hospital received lipid-lowering therapy. What's your secret? • Are there instances where the patient isn't *always* taking the aspirin you prescribed? • Is mistakenly taking a non-aspirin analgesic instead of aspirin? • What about patients you are starting on new therapy?	MIKE: Doctor McCabe, I'm glad you see the benefits of using a statin and aspirin for your post-MI and unstable angina patients. Unfortunately, not all physicians are as diligent as you are. According to the National Registry of Myocardial Infarction, a survey of CHD patients who were discharged from the hospital, 80% were on aspirin, but only 35% were also prescribed lipid-lowering therapy. If all of your post-MI and UA patients are on a statin and aspirin, then you are certainly way above these findings. What steps do you take to make sure these patients comply? LISA: Okay. What if I respond by telling you that I prescribe a statin and recommend aspirin to all my post-MI and UA patients. And what's more, I'm certain that they follow my instructions to the letter. Now what? MIKE: I could take one of two paths here – the first is to probe a bit further and try to find some instances where the patient isn't *always* taking the aspirin dose you recommended, or isn't buying aspirin. I could then explain the benefits of prescribing Pravigard for these patients. A second path is to create the opportunity for your next appropriate patient who has an MI to be placed on Pravigard. LISA: Which path would you like to demonstrate for us? MIKE: The second one. I'll save going after the patients you think are taking aspirin and a statin for another call and get your commitment to use Pravigard for

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	your next appropriate MI or UA patient on this call. LISA: Okay, and how would you do that?
Downstream Probes Do you ever see post-MI or unstable angina patients discharged from the hospital only on aspirin? • Hospital discharges every post-MI patient on statin & aspirin • Doctor follows up with patient	MIKE: With my downstream probing. Dr. McCabe, do you ever see post-MI or unstable angina patients discharged from the hospital who are only taking aspirin? LISA: There are probably two ways I could respond to that. I'd tell you that the hospital discharges every post-MI patient on a statin and aspirin. Or I might say that I follow up with my patients after discharge, write the statin script, and recommend aspirin. What would your positioning be at this point?
Position • Pravigard is an optimal treatment choice for these patients • 31% risk reduction • Not metabolized by CYP450 3A4 system to a clinically significant extent • No statistically significant difference in adverse events vs aspirin alone • Patients take statin and the aspirin dose you recommended • Pricing equal to that of Pravachol	MIKE: This is my opportunity to position Pravigard as an optimal treatment choice for these patients. If I use the mnemonic WRITE Pravigard as my guide, I have already established the W – by defining Who the patient is. The key points I'd make to support this discussion would be the R, I, T, and E messages. LISA: What would that sound like? MIKE: Dr. McCabe, the fact that all of your appropriate post-MI and unstable angina patients are on a statin and aspirin is a credit to your practice. So let's talk about your next patient who has an MI or unstable angina, and how you can give them proven CHD protection that didn't increase adverse events vs. aspirin alone. Pravigard demonstrated a 31% greater risk reduction of fatal or non-fatal MI versus aspirin alone. LISA: Uh-huh.

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	MIKE: What's more, Pravigard is proven safe. Neither of its components is metabolized by the CYP450 3A4 system to a clinically significant extent. Furthermore, there was no statistically significant difference in adverse events versus aspirin alone. When your patients fill their Pravigard prescriptions, they will receive *both* the statin and the aspirin you recommended. They don't run the risk of getting a non-aspirin analgesic that doesn't give them the anti-platelet benefits. That's important because a survey showed that 11% of patients – more than one in ten – are taking a non-aspirin analgesic by mistake instead of aspirin. LISA: Hmm! MIKE: And, Pravigard wholesale list price is equal to that of Pravachol, with no additional cost for the aspirin. You get the added confidence of two CV risk reducing therapies in one prescription.
	LISA: Terrific. I'm going to stop you there Mike, before you position and close, because I have another scenario to run by you. How would your response differ if you were talking to a cardiologist, or to the person responsible for discharging patients from the hospital after an MI or episode of unstable angina? MIKE: My clarifying statement would be worded differently, but the point would still be the same. I want to acknowledge that the physician sees value in prescribing a statin and aspirin for these patients, but that not all physicians do. I would say something like, "I'm glad to hear that you see the benefits of using a statin and aspirin for your post-MI and unstable angina patients. Not all of your colleagues follow the ACC/AHA

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	guidelines as closely as you do." And then I'd present the same facts as I stated before. LISA: And what would your downstream probes be? MIKE: Dr. McCabe, do you think you have any patients who have slipped through the cracks and are only taking aspirin? Or, Dr. McCabe, how do you help your patients continue with the therapy that you recommend after they leave your care ? These probes would establish the W – or who the patient is and allow me to transition to the R,I,T,E message points. LISA: Thanks Mike. I think it's time for everyone to practice responding to this concern.
	Q: Yes, thank you. You will now have 10 minutes to role-play your own response to this concern. Your room facilitator will explain what happens next.

Verbalize Concern #1 1:05 – 1:18

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From "Doctor No" to "Doctor Yes" **"All of my appropriate post-MI and unstable angina patients are on a statin and aspirin."** Your briefing will resume in [00] minutes.	

Intro to Full Role-Play, Model Call 2:00 – 2:05

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Bond-style poster: **Thundercall** Full Role-play	MUSIC: [Introductory sting.]
Q in the studio, holding up a large PIZZA with black olives.	Q: Ingenious, isn't it? This looks like an ordinary pizza a TBM might bring for a Lunch and Learn – in strict accordance with the Pharma code, of course.
Close up as he points to one of the olives. It is a tiny, round lens.	But look carefully at this black olive, here. It's actually the lens of a hidden video camera.
Gestures to a TV or PC MONITOR.	Using this clever "Pizza-cam," we captured a complete model sales call for Pravigard. After we watch it, you'll have a chance to practice your own complete call.
Thundercall • Roadmap • WIIFM • Features and benefits (WRITE Pravigard) • P-R-P • Prioritize • Position • Close • Bridge	And when you have finished, you'll know how to OPEN with the WRITE message by presenting your Roadmap, WIIFM, and features and benefits. You'll be prepared to P-R-P and PRIORITIZE in order to effectively, POSITION, CLOSE and BRIDGE. In short, you'll be ready to start calling on Pravigard customers using the ENGAGE! sales model. Let's see the model call.
SUPER: Open	TBM: (*Referring to patient profile flashcard*) Dr. Smith, I want you to focus on your patients with clinically evident CHD.
SUPER: Roadmap	For example, think about your patients who have been hospitalized because of an MI or unstable angina and need CV protection. The ACC/AHA

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	guidelines recommend that these patients receive a statin and aspirin if their LDL-C is > 100 mg/dL. PHYSICIAN: Yes? TBM: While many of these patients are discharged on aspirin, only about a third of them also receive a statin. These patients need greater CV protection than aspirin alone.
SUPER: WIIFM	I would like to talk to you about an exciting new treatment option that can help you deliver greater CV protection, and didn't increase adverse events versus aspirin alone.
SUPER: Features and Benefits W	New Pravigard co-packages aspirin tablets and Pravachol tablets together. Now you can provide appropriate patients who have suffered an MI or Unstable Angina with these two proven therapies in a single prescription.
SUPER: R	A meta-analysis of 5 clinical trials evaluated the effect of Pravigard versus aspirin alone. This meta-analysis included over 14,000 patients with clinically evident CHD. If you take a look at this table, you see that 10.7% of patients taking aspirin alone suffered a fatal or non-fatal MI – in comparison to 7.6% of the patients taking Pravigard. This translates into a *31% relative risk reduction of suffering a fatal or non-fatal MI !* You'll also notice significant risk reductions in CHD death, stroke, and revascularization procedures. When you prescribe Pravigard you provide CV risk reduction that is much greater than aspirin alone. PHYSICIAN: That's impressive but what is the tradeoff in regards to safety?
SUPER: I	TBM: Excellent question, Dr. Smith. Let's consider drug-drug interactions. The ACC/AHA guidelines

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	recommend many medications for patients who have suffered an MI or Unstable Angina. Many of these patients will be taking beta blockers, ACE inhibitors, and other medications for various medical conditions. But polypharmacy can increase the risk of drug interactions. PHYSICIAN: That's right. TBM: As you know, the CYP450 3A4 pathway metabolizes more than 50% of all prescription drugs. As you can see here, pravastatin is not metabolized by CYP450 3A4 to a clinically significant extent. In addition, this is not an issue for aspirin. Aspirin is not metabolized by the CYP450 3A4 enzyme . Thus Pravigard has a low potential for these types of drug interactions. Wouldn't you agree that this is an important consideration in patients taking multiple medications? PHYSICIAN: Absolutely.
SUPER: Be sure to include important safety information at this point.	TBM: Additionally, the meta-analysis demonstrated the greater CV risk reduction was achieved without an increase in adverse events versus aspirin alone. As you can see Dr. Smith, Pravigard is a proven safe and effective therapy. PHYSICIAN: Good to know.
SUPER: T	However, according the National Registry of Myocardial Infarction, a nationwide survey of 138,000 CHD patients who were discharged from the hospital, 80% were discharged on aspirin. Of these patients, less than 35% also received lipid-lowering therapy. PHYSICIAN:

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	Wow, that's pretty low. TBM: Another survey shows that even among patients who *are* taking aspirin per their physicians' instructions, 11% – more than one in ten – are actually taking a non-aspirin analgesic by mistake. They are not getting the cardiovascular benefits of aspirin at all. Pravigard co-packages two proven cardiovascular medicines and makes them available in one prescription. When your patients fill their Pravigard prescriptions they will receive both of these medications — not one or the other. They will also receive Pravachol plus aspirin at the dose you specify.
SUPER: E	Pravigard is available at the same Wholesale List Price as Pravachol. Patients covered by a managed healthcare plan will get both medicines for one copay. For patients taking multiple medications, including those who have suffered an MI or Unstable Angina, this is one less medication to worry about purchasing.
SUPER: WRITE Pravigard 40/81 mg or 40/325 mg	Now you have one prescription that helps protect your appropriate post-MI and unstable angina patients. The recommended daily dose is pravastatin 40mg with either 81 or 325mg of aspirin. Just WRITE Pravigard 40/81mg or 40/325mg.
SUPER: P-R-P	TBM: (Noticing that the physician does not seem interested) Dr. Smith, you don't seem to be impressed with this information. Why is that? PHYSICIAN: Well I don't really see the need for this. TBM: Why not? PHYSICIAN:

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	I'm familiar with the guidelines and I treat my patients accordingly. All of my appropriate post-MI and Unstable Angina patients are already on a statin and aspirin. TBM: So you really do not see any benefit to prescribing Pravigard compared to what you are currently doing. PHYSICIAN: No not really.
SUPER: Prioritize	TBM: Are there any other reasons why you would not use Pravigard? PHYSICIAN: No, I just don't see any real advantage. TBM: If I can show you some potential advantages would you be willing to write Pravigard? PHYSICIAN: Sure, if I agree with you, I probably would. TBM: OK. You obviously value the benefit of using a statin and aspirin in your post-MI and unstable angina patients. Unfortunately, not all physicians are as diligent as you are. According to the National Registry of Myocardial Infarction, a survey of CHD patients who were discharged from the hospital, 80% were on aspirin, but only 35% of those patients were also prescribed lipid-lowering therapy. What factors do you think contribute to this treatment gap? PHYSICIAN: Some physicians are not following the guidelines but many also start statin therapy at follow-up visits. There are other factors that are contributing to the problem.

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	TBM: Like what? PHYSICIAN: Many patients just don't care or forget to get their prescriptions filled. We stress how important these medicines are but it does not guarantee that they will take them. TBM: Any other reasons? PHYSICIAN: Well, put yourself in the shoes of these patients. When they are discharged from the hospital they are instructed to take many medications—as many as 5-6 new medications. They may see this as a burden and be unlikely to take all of the medications they need. You and I know how beneficial these medicines are, but many patients are hearing news reports of safety problems with prescription drugs. They may be reluctant to continue taking everything they need because they are fearful of safety issues. It is a complicated situation.
SUPER: Position	TBM: I can see that there are many practical issues that make optimally treating patients who have suffered an MI or unstable angina a challenge. Maybe Pravigard can help. We agree that the clinical benefit is significant. Pravigard demonstrated a 31% greater risk reduction of fatal or non-fatal MI versus aspirin alone. So you can feel confident that Pravigard can help prevent a recurrent MI in these patients. You mentioned that many patients have safety concerns. Pravigard is a proven safe treatment option. Neither of its components is metabolized by the CYP450 3A4 system to a clinically significant extent. Furthermore, there was no statistically significant difference in adverse events versus

Video	Audio
	aspirin alone. When your patients fill their Pravigard prescription they will receive both the statin and the aspirin you recommended. Your patients don't run the risk of receiving a non-aspirin analgesic that doesn't give them the cardioprotective benefits of aspirin. That's important because a survey found that 11% of patients – more than one in ten – are taking a non-aspirin analgesic by mistake,. And, Pravigard's wholesale list price is equal to that of Pravachol, with no additional cost for the aspirin. Your patients get the added confidence of two CV risk-reducing therapies in one prescription. Dr. Smith, do you feel that there are some advantages to using Pravigard? PHYSICIAN: Well, you have made some good points.
SUPER: Close	TBM: Great. We agree that Pravigard is proven to reduce the risk of CV events to a greater extent than aspirin alone. We have also agreed that this additional reduction was achieved without an increase in adverse events versus aspirin alone. Furthermore, Pravigard has a low potential for CYP450 3A4 drug interactions. You shared some challenges you face in helping patients receive the CV medications you recommend. You also agree that Pravigard may help you overcome some of the specific challenges with aspirin that we discussed. The recommended daily dose of Pravigard is 40mg of pravastatin with either 81 mg or 325 mg of aspirin. Liver function tests are required prior to initiation of therapy, prior to elevation of dose, and when otherwise clinically indicated. Pravigard is preferred on XYZ formulary and in a Tier 2 copay position. This means that patients covered by this plan get a month's supply of

Video	Audio
	Pravigard for $20. Dr. Smith, will you prescribe Pravigard along with diet for your appropriate patients who are covered by XYZ MHC plan and have suffered an MI or Unstable Angina? PHYSICIAN: Yes, I will definitely give it a try. TBM: Great! I will leave you some samples to start your patients out.
SUPER: Bridge	Are you aware of the ACC/AHA guidelines for the use of anti-platelet therapy in patients who have suffered an MI or Unstable Angina?
Q in the studio, as he turns off the television monitor. He has forgotten himself, however, and in his other hand is a partially eaten slice of pizza.	Q: An excellent sales call. And remember two things, agents. First, you must provide important safety information when you discuss Pravigard. And second, it is vitally important to include managed care information that is specific to your local geography.
He quickly puts the pizza down, embarrassed.	Oh! Not to worry. The, uh “pizza-cam” is in this slice over here. Well, are you ready to try this sales call for yourself? Your room facilitator will explain what happens next.