

IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT
IN AND FOR MIAMI-DADE COUNTY, FLORIDA

IN RE: INSULIN PRICING LITIGATION

STATE OF FLORIDA, OFFICE OF THE
ATTORNEY GENERAL, DEPARTMENT OF
LEGAL AFFAIRS,

Plaintiff,

v.

ELI LILLY AND CO.; NOVO NORDISK
INC.; SANOFI-AVENTIS U.S. LLC;
EVERNORTH HEALTH, INC. (F/K/A
EXPRESS SCRIPTS HOLDING CO.);
EXPRESS SCRIPTS, INC.; EXPRESS
SCRIPTS ADMINISTRATORS, LLC;
MEDCO HEALTH SOLUTIONS, INC.; ESI
MAIL PHARMACY SERVICES, INC.;
EXPRESS SCRIPTS PHARMACY, INC.;
ASCENT HEALTH SERVICES, LLC; CVS
HEALTH CORP.; CVS PHARMACY, INC;
CAREMARK RX, LLC; CAREMARKPCS
HEALTH, LLC; CAREMARK, LLC; ZINC
HEALTH SERVICES, LLC;
UNITEDHEALTH GROUP, INC.; UNITED
HEALTHCARE SERVICES, INC.;
UNITEDHEALTHCARE INSURANCE CO.;
OPTUM, INC.; OPTUMRx INC.;
OPTUMINSIGHT, INC.; EMISAR PHARMA
SERVICES, LLC,

Defendants.

CIVIL DIVISION

Case No. _____

COMPLAINT

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Plaintiff, the State of Florida, Office of the Attorney General, Department of Legal Affairs (the “State” or “Florida”), sues each of the Defendants named in the caption above (collectively, “Defendants”) for violations of the Florida Deceptive and Unfair Trade Practices Act, Fla. Stat. §§ 501.201–501.213, and the Florida Antitrust Act of 1980, Fla. Stat. §§ 542.15–542.36, and for injunctive relief, restitution, disgorgement, civil penalties, damages, and all other relief authorized by law. In support of this action, Florida states as follows:

I. INTRODUCTION

1. Diabetes is a serious public-health concern in Florida. “Approximately 2,318,000 adults in Florida, or 10% of the adult population, have diagnosed diabetes,” with many more at elevated risk of developing the disease.¹ Diabetes is a leading cause of blindness, kidney failure, lower-limb amputations, and other serious complications.

2. The economic burden of diabetes in Florida is staggering— diabetes costs the State an estimated \$30.5 billion annually.² In 2022, diabetes imposed \$24 billion in direct medical expenses and \$6.5 billion in lost productivity.³ In 2025 alone, Florida recorded more than 67,000 hospitalizations attributable to diabetes.⁴

3. For Floridians with Type 1 diabetes, insulin is not optional. They will die without it. Many Floridians with type 2 diabetes also use insulin, glucagon-like peptide-1 (“GLP-1”) receptor agonists, other diabetes medications, or a combination of treatments to manage and control the disease.

¹ American Diabetes Association, *The Burden of Diabetes in Florida* (Feb. 2026), available at <https://diabetes.org/sites/default/files/2026-02/florida-diabetes-02-15-26.pdf> (last visited Sept. 22, 2026).

² *Id.*

³ *Id.*

⁴ Florida Health Charts, *Hospitalizations from Diabetes*, available at <https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=NonVitalInd.Dataviewer&cid=9750> (last visited Sept. 22, 2026).

4. Approximately 14% of Americans who used insulin—more than 1.1 million people—experienced “catastrophic” spending on insulin, defined as spending at least 40% of their income remaining after food and housing expenses on insulin alone.⁵ Separately, approximately one in four patients reported rationing their insulin supply because of its cost.⁶

5. Despite the life-saving need for insulin, manufacturing costs of only a few dollars per vial, and limited changes to the underlying formulations of several longstanding products, Manufacturer Defendants increased the price of certain insulin products⁷ by amounts that, in some instances, **exceeded 1,000%**, reaching approximately **\$350 per vial** during the relevant period.⁸ Yet the underlying formulations of several flagship analog insulins remained substantially similar to products introduced in the 1990s, when insulin was priced at approximately **\$20 a vial**.

6. These price increases far outpaced general inflation and imposed substantial costs on payors and consumers through a pricing system distorted by the challenged rebate and formulary agreements, rather than corresponding increases in manufacturing costs or product innovation.

⁵ Baylee F. Bakkila, Sanjay Basu & Kasia J. Lipska, *Catastrophic Spending on Insulin in the United States, 2017–18*, 41 Health Affairs 1053, 1053–60 (2022), available at <https://doi.org/10.1377/hlthaff.2021.01788> (last accessed Sept. 22, 2026).

⁶ Darby Herkert et al., *Cost-Related Insulin Underuse Among Patients With Diabetes*, 179 JAMA Internal Medicine 112, 112–14 (2019) (last accessed Sept. 22, 2026).

⁷ For purposes of this Complaint, “insulin,” the “at-issue insulin products,” or “diabetes medications” include Apidra, Basaglar, Humalog, Humulin N, Humulin R, Humulin R U-500, Humulin 70/30, Lantus, Levemir, Novolin N, Novolin R, Novolin 70/30, NovoLog, Toujeo, and Tresiba. The “insulin-adjunct products” or “insulin adjuncts” include Ozempic, Trulicity, Victoza, and Soliqua, as well as any other non-insulin diabetes medications or combination insulin/GLP-1 products specifically identified as having been included in the challenged rebate, formulary, or bundled arrangements.

⁸ Unless otherwise indicated, the relevant period at issue is January 1, 2011, to January 1, 2023.

Figure 1: Price Increase of Insulin vs. Selected Consumer Goods, 1997-2018

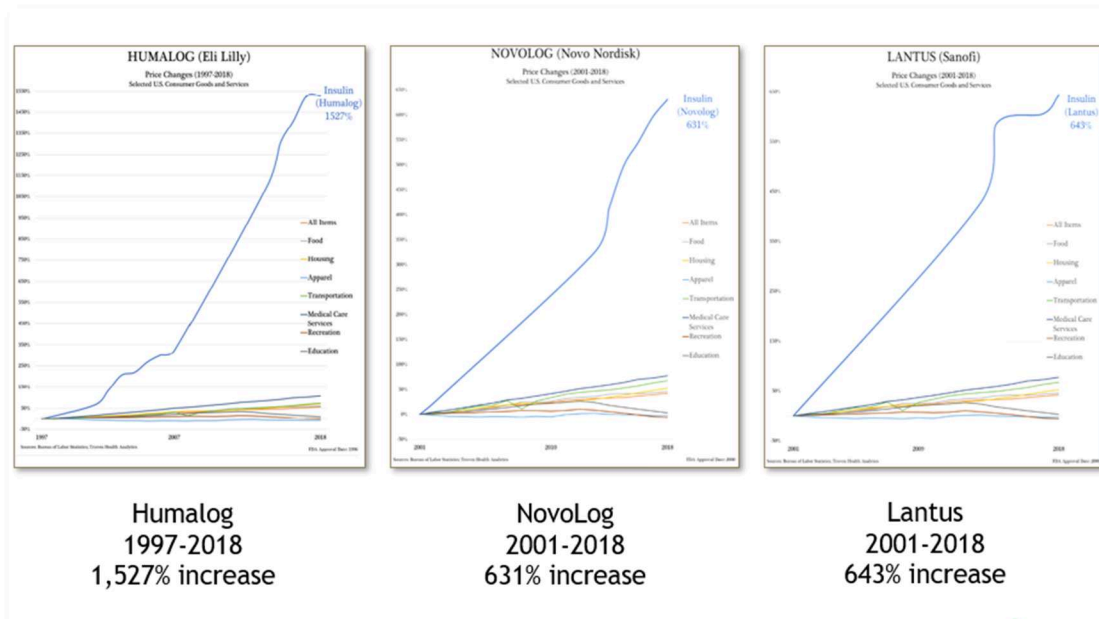
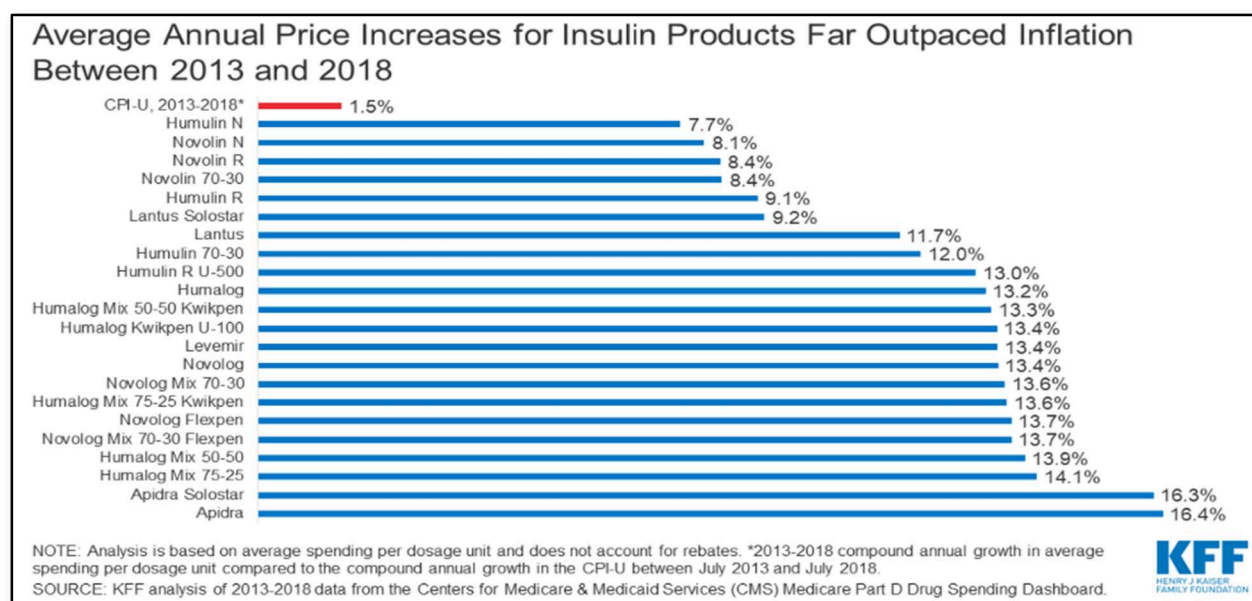


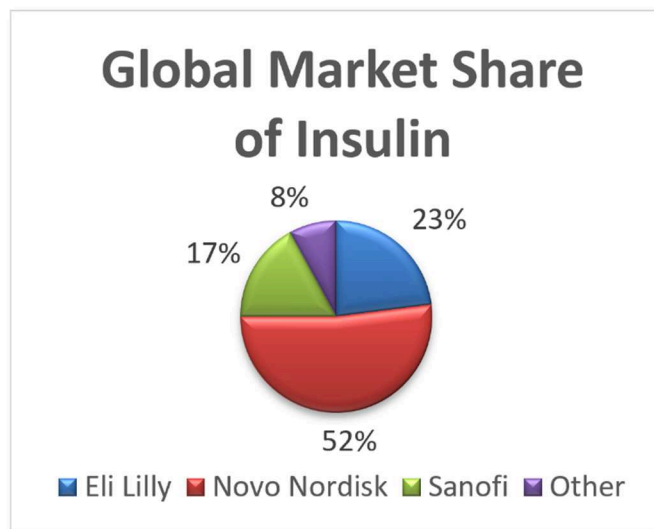
Figure 2: Average annual price increases of insulins vs. inflation, 2013-2018



7. Defendants Eli Lilly, Novo Nordisk, and Sanofi (collectively, the “Manufacturer Defendants” or “Manufacturers”) manufacture the vast majority of at-issue diabetes medications. Collectively, they control over 90% of the global insulin

supply by volume and revenue.

Figure 3: Global Market Share of Insulin



8. Defendants CVS Caremark, Express Scripts, and OptumRx (collectively, the “PBM Defendants” or “the PBMs”) process approximately 80% of all prescription claims nationwide, operate three of the five largest dispensing pharmacy businesses, and share common ownership with three of the nation’s largest health insurers, Aetna, Cigna, and UnitedHealthcare, respectively.

Figure 4: PBMs, PBM-Affiliated Insurers, and PBM-Affiliated Pharmacies

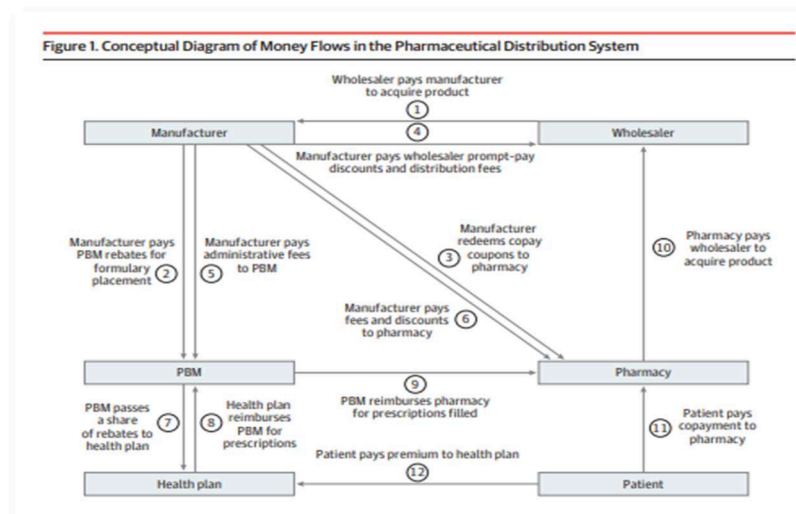
PBM	PBM-Affiliated Insurer	PBM-Affiliated Pharmacy
CVS Caremark	Aetna	CVS Pharmacy
Express Scripts	Cigna	Express Scripts Pharmacy Inc.
Optum	UnitedHealthcare	OptumRx

9. Florida’s PBM market was increasingly concentrated during the relevant period. An American Medical Association analysis of commercial drug-coverage lives found that, as of January 1, 2021, Florida’s PBM market for rebate negotiation had a

Herfindahl-Hirschman Index (“HHI”) of 2,395, reflecting substantial concentration among a limited number of PBMs. The same study found extensive vertical integration between insurers and PBMs nationally, with approximately 69% of commercial drug-coverage lives covered by a vertically integrated, insurer-PBM in 2020 and 70% in 2021. More recent AMA analyses confirm that these structural conditions persisted: in 2023, the four largest PBMs collectively accounted for approximately 67% of rebate-negotiation services nationally, 79% of regional rebate-negotiation markets were highly concentrated under the 2023 federal merger guidelines, and 77% of commercial and Medicare Part D drug lives were covered by vertically integrated insurer–PBM organizations.

10. The PBM Defendants administer prescription-drug benefits and exercise substantial control over formulary access, reimbursement, and dispensing. Among other functions, PBMs develop formularies, process claims, establish pharmacy networks, negotiate reimbursement terms with pharmacies, and contract with Manufacturers for rebates, fees, and other remuneration, as illustrated in Figure 5.

Figure 5: The pharmaceutical payment chain⁹



⁹ See Karen Van Nuys, et al., Estimation of the Share of Net Expenditures on Insulin Captured by US Manufacturers, Wholesalers, Pharmacy Benefit Managers, Pharmacies, and Health Plans From 2014 to 2018, JAMA HEALTH FORUM (Nov. 5, 2021), <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2785932>.

11. The challenged Manufacturer–PBM agreements, Manufacturer Payments, formulary restrictions, list-price increases, and related representations and omissions that artificially inflated insulin prices, restricted competition, and obscured the economic incentives affecting formulary placement and patient cost-sharing are referred collectively as the “Insulin Pricing Scheme.”

12. The Insulin Pricing Scheme operated through a series of vertical commercial relationships among Manufacturers, PBMs, and affiliated Rebate Aggregators:¹⁰

- a. Each Manufacturer Defendant entered into and implemented rebate and formulary agreements with one or more PBM Defendants governing rebates, fees, other remuneration, and the terms on which particular diabetes medications would receive preferred or exclusive formulary placement. Through these bilateral relationships, Manufacturers and PBMs negotiated formulary position and other conditions affecting commercially meaningful market access.
- b. The Manufacturers and the PBMs also exchanged information relevant to those vertical commercial relationships, including drug-utilization data, claims information, financial data, and information concerning formulary performance. PBMs used these data to evaluate utilization, rebate economics, and formulary placement, while Manufacturers used them to evaluate pricing, contracting, and market-access strategies. These exchanges are alleged as part of the operation and implementation of the challenged vertical agreements, not as evidence of horizontal price coordination among competing Manufacturers or competing PBMs.
- c. Certain agreements also required Manufacturers to support implementation of preferred or exclusive formulary decisions, including patient-transition and provider-education efforts. For example, internal records reflect that Eli Lilly discussed providing additional rebates in connection with UnitedHealth Group and OptumRx clients converting to formularies that exclusively preferred certain Lilly products, including Humalog, and agreed to support the resulting patient-transition and provider-education efforts.

¹⁰ Between 2019 and 2021, each PBM Defendant created or utilized rebate aggregators Zinc Health Services, LLC (“Zinc”), Ascent Health Services, LLC (“Ascent”), and Emisar Pharma Services, LLC (“Emisar”) (collectively, the “Rebate Aggregator Defendants”). Zinc, Ascent, and Emisar are affiliated with CVS Caremark, Express Scripts, and OptumRx, respectively.

13. Under these agreements, Manufacturers provided rebates, fees, price-protection payments, and other remuneration—often calculated by reference to list price—in exchange for preferred or exclusive formulary placement, restrictions on competing products, patient-switching requirements, or bundled treatment of insulin and insulin-adjunct products. These rebates, fees, price-protection payments, and other remuneration are referred to collectively as the “Manufacturer Payments.”

14. Manufacturer Payments themselves are not alleged to be unlawful merely because they took the form of rebates, fees, or other remuneration. Rather, the alleged anticompetitive conduct arises from the quid pro quo by which these payments were exchanged for preferred or exclusive formulary placement and other exclusionary conditions that restricted or disadvantaged competing and lower-list-price products from meaningful access to diabetics in Florida.

15. By conditioning commercially meaningful formulary access on Manufacturer Payments and the exclusionary conditions alleged here, the challenged agreements rewarded higher-list-price products, disadvantaged lower-priced alternatives, suppressed price competition, distorted formulary competition, and foreclosed or materially disadvantaged competing products—all to the detriment of Florida diabetics.

16. The challenged agreements distorted competition by requiring Manufacturers to compete for commercially meaningful formulary access not simply through lower net prices, but through the magnitude of rebates, fees, and other Manufacturer Payments. This structure favors a higher-list-price, highly rebated product over a lower-list-price alternative offering a substantially similar net price—thereby discouraging competition through lower list prices and restricting the ability of lower-priced products to obtain formulary access.

17. These challenged arrangements also obscured the economic incentives affecting formulary placement, drug costs, and patient cost-sharing. Defendants publicly represented that their respective roles in the prescription-drug system promoted lower costs, affordability, and patient access, while failing to disclose material information concerning the economic incentives created by Manufacturer

Payments and the terms, amounts, recipients, and disposition of those payments. PBM Defendants represented that they used their purchasing and formulary power to lower drug costs; Manufacturer Defendants represented that their pricing and contracting practices supported patient access and affordability; and Rebate Aggregator Defendants participated in the negotiation, receipt, processing, and allocation of Manufacturer Payments without disclosing the material economic incentives associated with those payments.

18. These representations and omissions were material because they concealed or obscured the financial incentives influencing formulary placement, drug pricing, and patient cost-sharing—including incentives that favor higher-list-price products and disadvantage lower-priced alternatives.

19. Because of the challenged agreements and deceptive practices, Florida consumers paid higher out-of-pocket costs, experienced reduced access to lower-priced alternatives, and faced formulary restrictions and switching requirements influenced by rebate economics rather than product-specific price or clinical value.

20. Defendants' representations and omissions constitute unfair or deceptive acts or practices under FDUTPA, Fla. Stat. § 501.204, and the challenged Manufacturer–PBM agreements violate the Florida Antitrust Act, Fla. Stat. § 542.18. The State seeks the relief available, including restitution, disgorgement, civil penalties, attorneys' fees and costs, and appropriate injunctive and equitable relief.¹¹

¹¹ Although the Manufacturer Defendants subsequently announced list-price reductions for certain legacy insulin products, effective in 2023 and 2024, those post-period changes do not erase the historical overpayments, competitive effects, or other consequences of the challenged conduct during the relevant period. Nor do they establish that the challenged rebate, formulary, exclusion, and contracting practices have ceased. The State therefore seeks prospective relief to prevent the continuation, renewal, or use of materially similar successor arrangements, notwithstanding the later reduction in list prices for certain insulin products. The State also does not seek relief that would duplicate or conflict with any final order issued by the Federal Trade Commission. Rather, it seeks relief for Florida-specific injuries and for Defendants, products, practices, and agreements not fully addressed by any such order, including conduct involving the Manufacturer Defendants, bundled agreements, and continuing, renewed, or successor agreements.

II. PARTIES

A. Plaintiff

21. Plaintiff, the State of Florida (the “State” or “Florida”), by and through James Uthmeier, Attorney General of Florida, brings this action in its sovereign and quasi-sovereign capacities, and through the Department of Legal Affairs in its capacity as the enforcing authority under Florida law, to protect Florida consumers from Defendants’ unlawful conduct and to obtain all relief authorized by law.

22. The Attorney General brings the State’s claims under the Florida Antitrust Act, Fla. Stat. §§ 542.15–542.36, pursuant to Fla. Stat. § 542.27. The Department of Legal Affairs, as the enforcing authority under Fla. Stat. § 501.203(2), brings the State’s claims under the Florida Deceptive and Unfair Trade Practices Act (“FDUTPA”), Fla. Stat. §§ 501.201–501.213, pursuant to Fla. Stat. § 501.207.

23. The State of Florida has sovereign and quasi-sovereign interests in protecting the health, safety, and economic well-being of Florida diabetic citizens and in protecting consumers from unfair or deceptive acts and practices. Defendants’ Insulin Pricing Scheme has caused, and absent injunctive relief will continue to cause, Florida consumers to pay more for the at-issue medications and to face reduced access to lower-priced alternatives.

24. The Attorney General is an enforcing authority of the Florida Deceptive and Unfair Trade Practices Act, which prohibits unfair or deceptive acts or practices or unfair methods of competition in the conduct of any trade or commerce. He has determined that this enforcement action serves the public interest.

25. Acting in its sovereign and *parens patriae* capacities, the Attorney General institutes this enforcement action to protect the health and economic interests of Florida residents and businesses and the integrity of Florida’s healthcare system.

26. The State seeks restitution and other monetary relief on behalf of affected persons as authorized by law, as well as civil penalties, disgorgement, injunctive relief, and all other relief available to remedy Defendants’ violations of Florida law.

B. The Manufacturer Defendants

Eli Lilly

27. Defendant Eli Lilly and Company (“Eli Lilly”) is an Indiana corporation with its principal place of business at Lilly Corporate Center, Indianapolis, Indiana 46285.

28. Eli Lilly is registered to do business in the State of Florida.

29. In Florida and nationally, Eli Lilly manufactures, promotes, and distributes several at-issue diabetes medications, including: Humulin N (first U.S. approval in 1982), Humulin R (first U.S. approval in 1982), Humalog (first U.S. approval in 1996), Trulicity (first U.S. approval in 2014), and Basaglar (first U.S. approval in 2015).

30. Eli Lilly’s domestic revenues from 2020 through 2022 were approximately \$14.44 billion from Trulicity, \$4.00 billion from Humalog, \$2.43 billion from Humulin, and \$1.90 billion from Basaglar.¹²

31. Eli Lilly’s global revenues in 2022 were approximately \$7.44 billion from Trulicity, \$2.06 billion from Humalog, \$1.02 billion from Humulin, and \$760 million from Basaglar.¹³

32. Eli Lilly transacts business in Florida, targeting these markets for its products, including the at-issue diabetes medications.

33. Eli Lilly employs sales representatives throughout Florida to promote and sell Humulin N, Humulin R, Humalog, Trulicity, and Basaglar and it uses wholesalers (McKesson, AmeriSource Bergen and Cardinal Health) to distribute the at-issue products to pharmacies and healthcare professionals within Florida.

34. Eli Lilly also directs advertising and informational materials to Florida physicians and potential users of Eli Lilly’s products.

35. At all times relevant hereto, in furtherance of the Insulin Pricing Scheme, Eli Lilly published its prices for the at-issue diabetes medications

¹² Eli Lilly & Co., Annual Report (Form 10-K) (FYE Dec. 31, 2022), at 66.

¹³ Eli Lilly & Co., Annual Report (Form 10-K) (FYE Dec. 31, 2022), at 65–66.

throughout Florida with the express knowledge that payment and reimbursement by Florida consumers would be based on those inflated list prices.

36. During the relevant period, consumers in Florida spent millions of dollars per year out of pocket on Eli Lilly's at-issue drugs at a price based on Eli Lilly's artificially inflated list prices generated by the Insulin Pricing Scheme.

37. All Eli Lilly diabetes medications related to the at-issue transactions were paid for and/or reimbursed by Florida consumers based on the specific false and inflated prices Eli Lilly caused to be published in Florida in furtherance of the Insulin Pricing Scheme.

Sanofi

38. Defendant Sanofi-Aventis U.S. LLC ("Sanofi") is a Delaware limited liability company with its principal place of business at 55 Corporate Drive, Bridgewater, New Jersey 08807.

39. Sanofi is registered to do business in the State of Florida.

40. Sanofi manufactures, promotes, and distributes pharmaceutical drugs both in Florida and nationally, including several at-issue diabetes medications, such as: Lantus (first U.S. approval in 2000), Apidra (first U.S. approval in April 2004), Toujeo (first U.S. marketing authorization in February 2015), and Soliqua (first U.S. approval in November 2016).

41. Lantus remained one of Sanofi's leading products through the end of the relevant period. In 2022, Lantus generated approximately €2.259 billion in worldwide net sales, including approximately €757 million in the United States. Sanofi reported that U.S. Lantus sales declined 22.1% at constant exchange rates in 2022, reflecting, among other things, "prior formulary losses" and erosion of the basal insulin market.¹⁴

¹⁴ Sanofi, Annual Report (Form 20-F) (FYE Dec. 31, 2022), at 73 (reporting €2.259 billion in 2022 Lantus net sales, including €757 million in the United States, and attributing declining U.S. sales in part to prior formulary losses and erosion of the basal insulin market).

42. In 2022, Sanofi also reported approximately €1.117 billion in worldwide net sales from Toujeo, an increase of 9.8% at constant exchange rates.¹⁵

43. Sanofi transacts business in Florida, targeting these markets for its products, including the at-issue diabetes medications.

44. Sanofi employs sales representatives throughout Florida to promote and sell Lantus, Toujeo, Apidra, and Soliqua, and it uses wholesalers to distribute the at-issue products to pharmacies and healthcare professionals within Florida.

45. Sanofi also directs advertising and informational materials to Florida physicians and potential users of Sanofi's products for the specific purpose of selling the at-issue drugs in Florida and profiting from the Insulin Pricing Scheme.

46. At all times relevant hereto, in furtherance of the Insulin Pricing Scheme, Sanofi published its prices of its at-issue diabetes medications throughout Florida for the purpose of payment and reimbursement by Florida consumers.

47. During the relevant period, consumers in Florida spent millions of dollars per year out of pocket on Sanofi's at-issue drugs at a price based on Sanofi's artificially inflated list prices generated by the Insulin Pricing Scheme.

48. All Sanofi diabetes medications related to the at-issue transactions were paid for and/or reimbursed by Florida consumers based on the specific false and inflated prices Sanofi caused to be published in Florida in furtherance of the Insulin Pricing Scheme.

Novo Nordisk

49. Defendant Novo Nordisk Inc. ("Novo Nordisk" or "Novo") is a Delaware corporation with its principal place of business at 800 Scudders Mill Road, Plainsboro, New Jersey 08536.

50. Novo Nordisk manufactures, promotes, and distributes pharmaceutical drugs in Florida and nationally, including Novolin R (first U.S. approval in 1991), Novolin N (first U.S. approval in 1991), Novolog (first U.S. approval in June 2000), Levemir (first U.S. approval in June 2005), Victoza (first U.S. approval in January

¹⁵ *Id.* (reporting €1.117 billion in 2022 Toujeo net sales).

2010), Tresiba (first U.S. approval in 2015), and Ozempic (first U.S. approval in 2017).

51. In 2022 alone, Novo Nordisk generated approximately \$9.45 billion in U.S. sales from its diabetes-care products.¹⁶

52. Novo Nordisk's global diabetes-care sales totaled approximately \$19.71 billion in 2022, reflecting the substantial commercial importance of its diabetes portfolio during the relevant period.¹⁷

53. Novo Nordisk's substantial diabetes business continued after the relevant period, with global revenues for "total diabetes care" over that three-year period (2023 through 2025) of approximately DKK 588 billion (roughly USD \$85 billion).¹⁸

54. Novo Nordisk transacts business in Florida, targeting these markets for its products, including the at-issue diabetes medications.

55. Novo Nordisk employs sales representatives throughout Florida to promote and sell Novolin R, Novolin N, Novolog, Levemir, Tresiba, Victoza, and Ozempic, and it uses wholesalers to distribute the at-issue products to pharmacies and healthcare professionals within Florida.

56. Novo Nordisk also directs advertising and informational materials to Florida physicians and potential users of Novo Nordisk's products.

57. At all times relevant hereto, in furtherance of the Insulin Pricing Scheme, Novo Nordisk published its prices of its at-issue diabetes medications throughout Florida for the purpose of payment and reimbursement by Florida consumers.

58. During the relevant period, consumers in Florida spent millions of dollars per year out of pocket on Novo Nordisk's at-issue drugs at a price based on

¹⁶ Novo Nordisk A/S, *Annual Report 2022* (2023) (reporting 2022 U.S. diabetes-care sales of DKK 66.881 billion and worldwide diabetes-care sales of DKK 139.548 billion); Board of Governors of the Federal Reserve System, *Foreign Exchange Rates—G.5A Annual*, Jan. 9, 2023 (reporting a 2022 average exchange rate of 7.0786 Danish kroner per U.S. dollar), <https://www.federalreserve.gov/releases/g5a/20230109/> (last visited Sept. 22, 2026).

¹⁷ *Id.*

¹⁸ Novo Nordisk, *Annual Report* (Form 20-F) (Feb. 4, 2026).

Novo Nordisk’s artificially inflated list prices generated by the Insulin Pricing Scheme.

59. All Novo Nordisk diabetes medications related to the at-issue transactions were paid for and/or reimbursed by Florida consumers based on the specific false and inflated prices Novo Nordisk caused to be published in Florida in furtherance of the Insulin Pricing Scheme.

C. The PBM Defendants

CVS Caremark

60. Defendant CVS Health Corporation (“CVS Health”) is a Delaware corporation with its principal place of business at One CVS Drive, Woonsocket, Rhode Island 02895.

61. CVS Health transacts business and has locations throughout the United States and Florida.

62. CVS Health—through its executives and employees, including its CEO, Chief Medical Officer, Executive Vice Presidents, Senior Executives in Trade Finance, Senior Vice Presidents, and Chief Communication Officers—is directly involved in creating and implementing the company policies that inform its PBM services and formulary construction, including with respect to the at-issue drugs involved in the Insulin Pricing Scheme.

63. CVS Health’s conduct had a direct effect in Florida.

64. On a regular basis, CVS Health executives and employees communicate with and direct its subsidiaries related to the at-issue PBM services and formulary activities.

65. In annual reports filed with the SEC throughout the last decade, CVS Health (or its predecessor) has repeatedly and explicitly stated that CVS Health itself:

- designs pharmacy benefit plans that minimize the costs to the client while prioritizing the welfare and safety of the clients’ members;
- negotiates with pharmaceutical companies to obtain discounted acquisition costs for many of the products on CVS Health’s drug lists, and these

negotiated discounts enable CVS Health to offer reduced costs to clients; and

- uses an independent panel of doctors, pharmacists, and other medical experts, referred to as its Pharmacy and Therapeutics Committee, to select drugs that meet the highest standards of safety and efficacy for inclusion on its drug lists.

66. CVS Health publicly represents that it lowers the cost of the at-issue diabetes medications. For example, in 2016, CVS Health announced a new program to “reduce overall spending in diabetes” that is available in all states, including Florida, “available to help the company’s pharmacy benefit management (PBM) clients to improve the health outcomes of their members, *lower pharmacy costs [for diabetes medications]* through aggressive trend management and decrease medical costs.”¹⁹ CVS further represented that “participating clients could save between \$3,000 to \$5,000 per year for each member who successfully improves control of their diabetes.”²⁰

67. A 2017 CVS Health report stated: “*CVS Health* pharmacy benefit management (PBM) strategies reduced trend for commercial clients to 1.9 percent per member per year the lowest in five years. Despite manufacturer price increases of near 10 percent, *CVS Health* kept drug price growth at a minimal 0.2 percent.”

68. In November 2018, CVS Health acquired Aetna for \$69 billion and became the first combination of a major health insurer, PBM, and mail-order and retail pharmacy chain. As a result, CVS Health controls the health plan/insurer, the PBM, and the pharmacies used by approximately 22 million Aetna members (and roughly 39 million people across all Aetna products) in the United States, including in Florida. CVS Health controls the entire drug payment chain for these Americans.

¹⁹ CVS Health, *CVS Health Introduces New “Transform Diabetes Care” Program to Improve Health Outcomes and Lower Overall Health Care Costs* (Dec. 13, 2016) (emphasis supplied), <https://www.pharmacytimes.com/view/cvs-health-introduces-new-transform-diabetes-care-program-to-improve-health-outcomes-and-lower-overall-health-care-costs>.

²⁰ *Id.*

69. CVS Health is the immediate or indirect parent of many pharmacy subsidiaries that own and operate hundreds of pharmacies throughout Florida, including CVS Pharmacy, Inc., which is registered to do business in the state. These pharmacies dispensed and received payment for the at-issue diabetes medications throughout the relevant period.

70. According to CVS Health’s 2026 Form 10-K filed with the U.S. Securities and Exchange Commission, the company “maintains a national network of approximately 65,000 retail pharmacies, consisting of approximately 37,000 chain pharmacies (which include CVS Pharmacy locations) and approximately 28,000 independent pharmacies, in the United States.”²¹

71. Defendant CVS Pharmacy, Inc. (“CVS Pharmacy”) is a Rhode Island corporation whose principal place of business is at the same location as CVS Health.

72. CVS Pharmacy—a wholly owned subsidiary of CVS Health—is registered to do business in the State of Florida.

73. CVS Pharmacy is the immediate or indirect parent of many pharmacy subsidiaries that own and operate hundreds of pharmacies throughout Florida and is directly involved in these pharmacies dispensing and payment policies related to the at-issue diabetes medications.

74. CVS Pharmacy is also the immediate and direct parent of Defendant Caremark Rx, LLC.

75. CVS Pharmacy holds numerous pharmacy licenses (d/b/a CVS Health) in Florida.

76. During the relevant period, CVS Pharmacy provided retail pharmacy services in Florida that gave rise to the Insulin Pricing Scheme, which damaged consumers in Florida.

77. Defendant Caremark Rx, LLC is a Delaware limited liability company and an immediate or indirect parent of many subsidiaries, including pharmacy benefit management and mail-order subsidiaries that engaged in the activities in

²¹ CVS Health Annual Report (Form 10-K) (Feb. 10, 2026).

Florida that gave rise to this action.

78. Caremark Rx, LLC is a subsidiary of Defendant CVS Pharmacy, which is a wholly owned subsidiary of Defendant CVS Health, and its principal place of business is at the same location as CVS Pharmacy and CVS Health.

79. During the relevant period, Caremark Rx, LLC provided PBM and mail-order pharmacy services in Florida that gave rise to the Insulin Pricing Scheme and damaged Florida consumers.

80. Defendant Caremark, LLC is a California limited liability company with the same principal place of business as CVS Health.

81. Caremark, LLC is a subsidiary of Caremark Rx, LLC, which is a subsidiary of Defendant CVS Pharmacy, which is a wholly owned subsidiary of Defendant CVS Health.

82. Caremark, LLC is registered to do business in Florida.

83. Caremark, LLC holds numerous pharmacy licenses in Florida. During the relevant period, Caremark, LLC provided PBM and mail-order pharmacy services in Florida that gave rise to the Insulin Pricing Scheme, which damaged consumers in Florida.

84. Defendant CaremarkPCS Health, LLC (“CaremarkPCS Health”) is a Delaware limited liability company whose principal place of business is at the same location as CVS Health.

85. CaremarkPCS Health is a subsidiary of CaremarkPCS, LLC, which is a subsidiary of Caremark Rx, LLC, which is a subsidiary of Defendant CVS Pharmacy, which is a wholly owned subsidiary of Defendant CVS Health.

86. CaremarkPCS Health is registered to do business in Florida.

87. CaremarkPCS Health, doing business as CVS Caremark, provides pharmacy benefit management services.

88. During the relevant period, CaremarkPCS Health provided PBM services in the State of Florida, which gave rise to and implemented the Insulin Pricing Scheme, which damaged consumers in Florida.

89. Defendant Zinc Health Services, LLC (“Zinc”) is a Delaware limited liability company with its principal place of business at One CVS Drive, Woonsocket, Rhode Island 02895.

90. Zinc is a direct subsidiary of CVS Pharmacy, which is a direct subsidiary of CVS Health.

91. CVS Health established Zinc as a GPO for CVS Caremark’s PBM business in March 2020. Zinc was founded, at least in part, to negotiate rebates with drug manufacturers for CVS Caremark.

92. During the relevant period, Zinc negotiated rebates with the Manufacturers for at-issue drugs sold and distributed in Florida.

93. Defendants CaremarkPCS Health, Caremark, LLC, and Zinc are agents and/or alter egos of Caremark Rx, LLC, CVS Pharmacy, and CVS Health.

94. Because of numerous interlocking directorships and shared executives, Caremark Rx, LLC, CVS Pharmacy, and CVS Health are directly involved in the conduct of and control CaremarkPCS Health’s and Caremark, LLC’s operations, management, and business decisions related to the at-issue formulary construction, Manufacturer Payments, and mail-order and retail pharmacy services. For example:

a. Common officers and directors, including:

- Thomas S. Moffatt, Vice President and Secretary of Caremark Rx, LLC, CaremarkPCS Health, and Caremark, LLC, has also served as Vice President, Assistant Secretary, and Senior Legal Counsel at CVS Health and the Vice President, Secretary and Senior Legal Counsel of CVS Pharmacy;
- Melanie K. St. Angelo, Assistant Secretary of Caremark Rx, LLC, CaremarkPCS Health, and Caremark, LLC, has also served as Manager of Corporate Services at CVS Health;
- Carol A. Denale, Senior Vice President and Treasurer of Caremark Rx, LLC, has also served as Senior Vice President, Treasurer, and Chief Risk Officer at CVS Health Corporation;
- John M. Conroy has been Vice President of Finance at CVS Health since 2011, and has also served as President and Treasurer of Caremark, LLC and CaremarkPCS Health in 2019;

and

- Sheelagh Beaulieu has been the Senior Director of Income Tax at CVS Health while also acting as the Assistant Treasurer at CaremarkPCS Health and Caremark, LLC.
- b. CVS Health owns all the stock of CVS Pharmacy, which owns all the stock of Caremark Rx, LLC, which owns all the stock of Caremark LLC. CVS Health directly or indirectly owns CaremarkPCS Health and Zinc.
- c. CVS Health, as a corporate unit, does not operate as separate entities. Rather, its public filings, documents and statements present its subsidiaries—including CVS Pharmacy, Caremark Rx, LLC, Caremark, LLC, and CaremarkPCS Health—as divisions or departments of one unified “diversified health services company” that “works together across our disciplines” to “create unmatched human connections to transform the health care experience.” CVS Health’s public filings during the relevant period disclose that the company “operates a group purchasing organization that negotiates pricing for the purchase of pharmaceuticals and rebates with pharmaceutical manufacturers on behalf of its participants,” without identifying Zinc by name.²² The day-to-day operations of this corporate unit reflect these public statements. These entities constitute a single business enterprise and should be treated as such as to all legal obligations discussed in this Complaint.²³
- d. All executives of CaremarkPCS Health, Caremark, LLC, Caremark Rx, LLC, CVS Pharmacy, and Zinc ultimately report to the executives at CVS Health, including its President and CEO.
- e. CVS Health’s CEO, Chief Medical Officer, Executive Vice Presidents, Senior Executives in Trade Finance, Senior Vice Presidents and Chief Communication Officers are directly involved in the policies and business decisions by Caremark, LLC and CaremarkPCS Health.

²² CVS Health Corp. Form 10-K, FYE Dec. 31, 2020, 2021, 2022, 2023.

²³ CVS Caremark/CVS Health, Annual Report (Form 10-K) (Dec. 31, 2009-2019); CVS Health, *Our Purpose*, <https://cvshealth.com/about-cvs-health/our-purpose> (last visited Sept. 22, 2026); CVS Health, *Quality of Care*, <https://cvshealth.com/health-with-heart/improving-health-care/quality-of-care> (last visited Sept. 22, 2026).

95. Defendants CVS Health, CVS Pharmacy, Caremark Rx, LLC, Caremark, LLC, CaremarkPCS Health, and Zinc, including all predecessor and successor entities, are referred to collectively as “CVS Caremark.”

96. CVS Caremark is named as a Defendant in its capacities as a PBM, a rebate aggregator, and as a mail-order pharmacy.

97. In its capacity as a PBM, CVS Caremark entered into and implemented vertical rebate and formulary agreements with Novo Nordisk, Eli Lilly, and Sanofi concerning Manufacturer Payments, and the terms on which those Manufacturers’ diabetes medications would receive preferred or exclusive placement on CVS Caremark’s formularies. These agreements are among the vertical Manufacturer–PBM agreements challenged here.

98. CVS Caremark has the largest PBM market share based on total prescription claims managed. Its pharmacy-services segment provides, among other things, plan design offerings and administration, formulary management, retail pharmacy network management services, mail-order pharmacy, specialty pharmacy and infusion services, clinical services, and medical spend management. In 2023, CVS Health consolidated its PBM, mail-order, and specialty pharmacy services into a newly formed reporting segment named the Health Services segment. Its Health Services segment generated total revenues of approximately \$186.8 billion in 2023, \$173.6 billion in 2024, and \$190.4 billion in 2025.²⁴

99. At all relevant times, CVS Caremark offered pharmacy benefit services nationwide to health plans, employers, other plan sponsors, and payors, including entities providing prescription-drug coverage to Florida residents with diabetes, and derived substantial revenue from those services. In providing those services, CVS Caremark (a) made misrepresentations to its clients while concealing the Insulin Pricing Scheme and (b) used the artificially inflated prices generated by the Insulin Pricing Scheme to administer formularies, negotiate rebates and other payments, and process prescription-drug claims.

²⁴ CVS Health Annual Report (Form 10-K) (Feb. 14, 2025).

100. At all relevant times, CVS Caremark offered PBM services nationwide and maintained standard formularies that were used nationwide, including in Florida. Those formularies included diabetes medications, including those at issue here, and CVS Caremark participated in pricing the at-issue drugs based off the list prices it knew to be false.

101. CVS Caremark purchased drugs directly from manufacturers for dispensing through its pharmacy network.

102. Further, in its capacity as a retail pharmacy, CVS Caremark knowingly profited from the inflated list prices produced by the Insulin Pricing Scheme by pocketing the spread between the acquisition cost for the at-issue drugs (an amount well below the list price generated by the Insulin Pricing Scheme) and the amounts it received from payors and consumers (amounts that were based on the inflated list prices and, in many cases, were set by CVS Caremark in its capacity as a PBM).

103. During the relevant period, CVS Caremark provided mail-order and retail pharmacy services nationwide and within the State of Florida and employed prices based on the inflated list prices generated by the Insulin Pricing Scheme.

104. At all relevant times, CVS Caremark dispensed the at-issue medications nationwide and within the State of Florida through its mail-order and retail pharmacies and it derived substantial revenue from these activities in Florida.

105. At all times relevant, CVS Caremark had express agreements with Novo Nordisk, Sanofi, and Eli Lilly related to the Manufacturer Payments paid by the Manufacturer Defendants to CVS Caremark, as well as agreements related to the Manufacturers' at-issue drugs sold through CVS Caremark's mail-order pharmacies.

Express Scripts

106. Defendant Evernorth Health, Inc. ("Evernorth"), formerly known as Express Scripts Holding Company, is a Delaware corporation with its principal place of business at One Express Way, St. Louis, Missouri 63121.²⁵

²⁵ Until 2021, Evernorth Health, Inc. conducted business under the name Express Scripts Holding Company. For the purposes of this Complaint "Evernorth" refers to Evernorth Health, Inc. and Express Scripts Holding Company.

107. Evernorth, through its executives and employees, including its CEO and Vice Presidents, is directly involved in shaping the company policies that inform its PBM services and formulary construction, including with respect to the at-issue drugs, related to the Insulin Pricing Scheme.

108. Evernorth's conduct has had a direct effect in Florida.

109. On a regular basis, Evernorth executives and employees communicate with and direct Evernorth's subsidiaries related to the at-issue PBM services and formulary activities.

110. Evernorth is the immediate or indirect parent of pharmacy and PBM subsidiaries that operate throughout Florida that engaged in the activities that gave rise to this action.

111. In 2018, Evernorth merged with Cigna in a \$67 billion deal to consolidate their businesses as a major health insurer, PBM, and mail-order pharmacy. As a result, the Evernorth corporate family controls the health plan/insurer, the PBM, and the mail-order pharmacies used by approximately seventeen million Cigna members in the United States, including in Florida. Evernorth controls the entire drug payment chain for these seventeen million Americans.

112. In annual reports filed with the SEC during the relevant period, Cigna repeatedly described Evernorth as the platform through which it provided pharmacy-benefit and related services, including pharmacy benefits, home-delivery pharmacy, specialty pharmacy, and care-management solutions. Cigna further represented that these services were designed to reduce the total cost of care for clients and customers.²⁶

113. Evernorth's pharmacy-benefit operations included Express Scripts PBM and related formulary, rebate, and purchasing functions. Cigna disclosed that Evernorth participated in group purchasing organizations that negotiated pharmaceutical pricing and formulary rebates with manufacturers, while Express Scripts provided formulary-management services designed to assist clients and

²⁶ Cigna Annual Report (Form 10-K) (FYE Dec. 31, 2022).

physicians in selecting clinically appropriate, cost-effective drugs. In 2022, Evernorth reported approximately \$140.3 billion in adjusted revenues, up from approximately \$131.9 billion in 2021.²⁷

114. Defendant Express Scripts, Inc. is a Delaware corporation and is a wholly owned subsidiary of Defendant Evernorth. Express Scripts, Inc.'s principal place of business is at the same location as Evernorth.

115. Express Scripts, Inc. is registered to do business in Florida.

116. Express Scripts, Inc. is the immediate or indirect parent of pharmacy and PBM subsidiaries that operate throughout Florida and engaged in the conduct that gave rise to this action.

117. During the relevant period, Express Scripts Inc. was directly involved in the PBM and mail-order pharmacy services that gave rise to the Insulin Pricing Scheme and damaged consumers in Florida.

118. Defendant Express Scripts Administrators, LLC, doing business as Express Scripts and formerly known as Medco Health, LLC, is a Delaware limited liability company and is a wholly owned subsidiary of Evernorth.

119. Express Scripts Administrators, LLC's principal place of business is at One Express Way, St. Louis, Missouri 63121—the same location as Evernorth.

120. During the relevant period, Express Scripts Administrators, LLC provided PBM services in Florida that gave rise to the Insulin Pricing Scheme that damaged Florida consumers.

121. Defendant Medco Health Solutions, Inc. ("Medco") is a Delaware Corporation with its principal place of business located at the same address as Evernorth. Until its acquisition by Express Scripts, Medco's principal place of business was in Franklin Lakes, New Jersey.

122. In 2012, Express Scripts acquired Medco for \$29 billion.

123. Before the merger, Express Scripts and Medco were two of the largest PBMs in the United States and in Florida.

²⁷ Cigna Annual Report (Form 10-K) (FYE Dec. 31, 2021).

124. Before the merger, Medco provided the at-issue PBM and mail-order services, which gave rise to the Insulin Pricing Scheme and damaged consumers within Florida.

125. Following the merger, all of Medco's PBM and mail-order pharmacy functions were combined into Express Scripts. The combined company (Medco and Express Scripts) continued under the name Express Scripts with all of Medco's payor customers becoming Express Scripts' customers. The combined company served more than 100 million Americans at the time of the merger.²⁸

126. At the time of the merger the companies publicly represented that the combination would "accelerate efforts to lower the cost of prescription drugs and improve the quality of care for Americans," and Express Scripts' chairman and chief executive officer, George Paz, stated that the merger would "better protect American families from the rising costs of prescription medicine."²⁹

127. Defendant ESI Mail Pharmacy Service, Inc. is a Delaware corporation and is a wholly owned subsidiary of Defendant Evernorth.

128. ESI Mail Pharmacy Service, Inc.'s principal place of business is the same location as Evernorth.

129. ESI Mail Pharmacy Service, Inc. is registered to do business in Florida.

130. ESI Mail Pharmacy Service, Inc. holds active pharmacy licenses in Florida.

131. During the relevant period, ESI Mail Pharmacy Service, Inc. provided the mail-order pharmacy services to Florida consumers discussed in this Complaint, which gave rise to the Insulin Pricing Scheme and damaged consumers.

²⁸ Express Scripts, Inc., Form 425, Ex. 99.9 (July 21, 2011) (client letter describing the combined companies as serving "more than 100 million Americans"); *see also* Express Scripts, Inc., Form 8-K, Ex. 99.1 (July 21, 2011) (Medco "making medicine smarter for more than 65 million members").

²⁹ Express Scripts, Inc., Form 8-K, Ex. 99.1, Express Scripts and Medco Health Solutions Sign Definitive Merger Agreement (July 21, 2011).

132. Defendant Express Scripts Pharmacy, Inc. is a Delaware corporation and is a wholly owned subsidiary of Defendant Evernorth.

133. Express Scripts Pharmacy, Inc.'s principal place of business is at the same location as Evernorth.

134. Express Scripts Pharmacy, Inc. is registered to do business in Florida.

135. During the relevant period, Express Scripts Pharmacy, Inc. provided the mail-order pharmacy services to Florida consumers discussed in this Complaint, which gave rise to the Insulin Pricing Scheme and damaged Florida consumers.

136. Defendant Ascent Health Services LLC ("Ascent") is a Delaware limited liability company with its principal place of business at Mühlentalstrasse 36, 8200 Schaffhausen, Switzerland.

137. Ascent is part of Evernorth and a subsidiary of Cigna Corporation.

138. Express Scripts established Ascent in 2019 as a GPO for Express Scripts' PBM business. Ascent was founded, at least in part, to negotiate rebates with drug manufacturers for Express Scripts and now performs this service for Express Scripts and third-party clients.

139. During the relevant period, Ascent negotiated rebates with the Manufacturers for at-issue drugs sold and distributed in Florida.

140. Because of numerous interlocking directorships and shared executives, Evernorth (f/k/a Express Scripts Holding Company, Inc.) and Express Scripts, Inc. control Express Scripts Administrators, LLC, ESI Mail Pharmacy Service, Inc., Medco Health Solutions, Inc., Express Scripts Pharmacy, Inc., and Ascent's operations, management, and business decisions related to the at-issue formulary construction, negotiations, and mail-order pharmacy services to the ultimate detriment of consumers. For example:

a. Common officers and directors, including:

- Officers and/or directors shared between Express Scripts, Inc. and Evernorth include Bradley Phillips, Chief Financial Officer; David Queller, President; Jill Stadelman, Managing Counsel; Dave Anderson, VP of Strategy; Matt Perlberg, President of Pharmacy Businesses; Bill Spehr, SVP of Sales; and Scott

Lambert, Treasury Manager Director;

- Executives shared between Express Scripts Administrators, LLC and Evernorth include Bradley Phillips, Chief Financial Officer; and Priscilla Duncan, Associate Senior Counsel;
 - Officers and/or directors shared between ESI Mail Pharmacy Service, Inc. and Evernorth include Bradley Phillips, Chief Financial Officer; Priscilla Duncan, Associate Senior Counsel; and Joanne Hart, Treasury Director; and
 - Officers and/or directors shared between Express Scripts Pharmacy, Inc. and Evernorth include Bradley Phillips, Chief Financial Officer; Jill Stadelman, Managing Counsel; Scott Lambert, Treasury Manager Director; and Joanne Hart, Treasury Director.
- b. Evernorth directly or indirectly owns all the stock of Express Scripts Administrators, LLC, Medco Health Solutions, Inc., ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy, Inc., Express Scripts, Inc., and Ascent.³⁰
- c. The Evernorth corporate family does not operate as separate entities. Evernorth's public filings, documents, and statements present its subsidiaries, including Express Scripts Administrators, LLC, ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy, Inc., Express Scripts, Inc., and Ascent as divisions or departments of a single company that "unites businesses that have as many as 30+ years of experience ... [to] tak[e] health services further with integrated data and analytics that help us deliver better care to more people," and which "includes a broad range of coordinated and point solution health services and capabilities, as well as those from partners across the health care system, in pharmacy solutions, benefits management solutions, care delivery and care management solutions and intelligence solutions to deliver custom and flexible solutions that meet the needs of our clients and customers." The day-to-day operations of this corporate family reflect these public statements. All of these entities comprise a single business enterprise and should be treated as such as to all legal obligations detailed in this Complaint.
- d. All of the executives of Express Scripts Administrators, LLC, ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy, Inc., Express Scripts,

³⁰ Express Scripts Annual Report (Form 10-K, Exhibit 21) (FYE Dec. 31, 2018).

Inc., and Ascent ultimately report to the executives, including the CEO, of Evernorth.

- e. Evernorth's CEO and other executives and officers are directly involved in the policies and business decisions of Express Scripts Administrators, LLC, ESI Mail Pharmacy Service, Inc., Medco Health Solutions, Inc., Express Scripts Pharmacy, Inc., Express Scripts, Inc., and Ascent that gave rise to Plaintiff's claims in this Complaint.

141. Defendants Evernorth Health, Inc., Express Scripts, Inc., Express Scripts Administrators, LLC, ESI Mail Pharmacy Service, Inc., Medco Health Solutions, Inc., Express Scripts Pharmacy, Inc., and Ascent, including all predecessor and successor entities, are referred to collectively as "Express Scripts."

142. Express Scripts is named as a Defendant in its capacities as a PBM, rebate aggregator, and mail-order pharmacy.

143. In its capacity as a PBM, Express Scripts entered into and implemented vertical rebate and formulary agreements with Novo Nordisk, Eli Lilly, and Sanofi concerning Manufacturer Payments and the terms on which those Manufacturers' diabetes medications would receive preferred or exclusive placement on Express Scripts' formularies. These agreements are among the vertical Manufacturer–PBM agreements challenged here.

144. Before merging with Cigna in 2018, Express Scripts was the largest independent PBM in the United States.³¹ During the period covered by this Complaint, Express Scripts controlled up to 30% of the PBM market in the United States.

145. The Express Scripts network offers more than 68,000 retail pharmacies nationwide, including in Florida.

146. Express Scripts transacts business throughout the United States and Florida.

³¹ *Id.*

147. At all times relevant, Express Scripts derived substantial revenue from providing retail and mail-order pharmacy benefits to Florida consumers using prices based on the inflated list prices for the at-issue drugs.

148. At all times relevant, and contrary to its express representations, Express Scripts knowingly insisted that its payor clients use the inflated list prices produced by the Insulin Pricing Scheme as the basis for reimbursement of the at-issue drugs.

149. At all times relevant, Express Scripts concealed its critical role in the generation of those inflated list prices.

150. At all times relevant, Express Scripts maintained standard formularies that are used nationwide, including in the State of Florida. Those formularies included drugs produced by the Manufacturer Defendants, including the at-issue diabetes medications.

151. In its capacity as a mail-order pharmacy, Express Scripts received payments from Florida consumers for, and set the out-of-pocket price paid for, the at-issue drugs based on the falsely inflated prices generated by the Insulin Pricing Scheme and, as a result, damaged Florida consumers.

152. At all relevant times, Express Scripts offered PBM services nationwide and maintained standard formularies that are used nationwide, including in Florida. During the relevant period, those formularies included diabetes medications, including all of those at issue here.

153. Express Scripts purchases drugs directly from Manufacturers for dispensing through its mail-order pharmacy.

154. At all times relevant, Express Scripts dispensed the at-issue medications nationwide and directly to Florida consumers through its mail-order pharmacies and derived substantial revenue from these activities in Florida.

155. During the relevant period, Express Scripts negotiated directly with the Manufacturer Defendants concerning Manufacturer Payments and formulary-access terms for the at-issue drugs. For example, in 2013 and 2014, Express Scripts worked with OptumRx in negotiating rebate and formulary arrangements involving Lilly

products. A February 2014 internal Lilly email described the resulting structure as a “Russian nested doll situation,” reflecting the multiple layers of PBM, plan, and rebate relationships involved.

156. In 2016, while soliciting bids for its 2017 national commercial formulary, Express Scripts advised Sanofi that, “with the right competitive price,” it would have no significant difficulty moving from Lantus and Toujeo to Lilly’s Basaglar and indicated that Sanofi needed to increase its then-current rebate rate to preserve formulary access. Sanofi then increased its rebate offer to nearly 55% off WAC.

OptumRx

157. Defendants UnitedHealth Group, Inc., United Healthcare Services, Inc., UHI, OptumRx, Inc., OptumInsight, Inc., Optum, Inc., and Emisar, as defined below, are collectively, “OptumRx.” Together, United Healthcare Services, Inc. and UHI are referred to as “United Healthcare.”

158. Defendant UnitedHealth Group, Inc. (“UnitedHealth Group”) is a corporation organized under the laws of Delaware with its principal place of business at 9900 Bren Road East, Minnetonka, Minnesota, 55343.

159. UnitedHealth Group is a diversified managed healthcare company. Its 2025 revenue was approximately \$447.6 billion. The company ranks third on the 2026 Fortune 500 list.³²

160. UnitedHealth Group offers various products and services including health insurance plans through its wholly owned subsidiaries and prescription drugs through its PBM, OptumRx. Over one-third of the overall revenues of UnitedHealth Group come from OptumRx, which operates a network of more than 67,000 pharmacies.

161. UnitedHealth Group, through its executives and employees, is directly involved in the company policies that shape its PBM services and formulary construction, including with respect to the at-issue drugs and related to the Insulin

³² Fortune, Fortune 500 Ranking (2026), <https://fortune.com/ranking/fortune500/> (last visited Sept. 22, 2026).

Pricing Scheme. For example, UnitedHealth Group executives structure, analyze, and direct the company's overarching policies, including as to PBM and mail-order services, to maximize profitability across the corporate organization.

162. UnitedHealth Group's 2020 Sustainability Report states that "OptumRx works directly with pharmaceutical manufacturers to secure discounts that lower the overall cost of medications" and develops formularies intended to promote access to appropriate medications. UnitedHealth Group continued to emphasize these functions through the end of the relevant period. In 2022, it reported that its pharmacy-care businesses operated through OptumRx and UnitedHealthcare and identified manufacturer rebates, formularies, utilization-management tools, specialty-drug pricing, and pharmacy-network reimbursement as core aspects of the PBM business subject to regulation. UnitedHealth Group also explained that it negotiates with pharmacies to lower costs at the point of sale, operates prescription home-delivery and specialty-pharmacy services, and works directly with drug wholesalers and distributors to maintain the supply of brand-name and generic drugs.

163. Aside from being a PBM and a mail-order pharmacy, UnitedHealth Group owns and controls a major health insurance company, UnitedHealthcare. As a result, UnitedHealth Group controls the health plan/insurer, the PBM, and the mail-order pharmacies used by more than 50 million UnitedHealthcare members in the United States. UnitedHealth Group controls the entire drug payment chain for these 50 million Americans.

164. UnitedHealth Group states in its annual reports that UnitedHealth Group uses Optum's capabilities to help coordinate patient care, improve affordability of medical care, analyze cost trends, manage pharmacy benefits, work with care providers more effectively and create a simpler consumer experience. Its 2022 annual report states plainly that it is "involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members" As of year-end 2022 and 2021, UnitedHealth Group's "total

pharmaceutical manufacturer rebates receivable included in other receivables in the Consolidated Balance Sheets amounted to \$8.2 billion and \$7.2 billion, respectively,” up from \$6.3 billion in 2020.”³³

165. UnitedHealth Group’s conduct had a direct effect in Florida.

166. **Defendant United Healthcare Services, Inc.** is a Minnesota Corporation with its principal place of business in Minnetonka, Minnesota. United Healthcare Services is a direct subsidiary of UnitedHealth Group, Inc.

167. United Healthcare Services, Inc. provides administrative services to UnitedHealthcare payors.

168. **Defendant UnitedHealthcare Insurance Co. (“UHI”)** is a Connecticut corporation with its principal place of business in Hartford, Connecticut. It is an indirect subsidiary of UnitedHealth Group, Inc.

169. UHI provides healthcare insurance coverage to payors and insureds.

170. **Defendant Optum, Inc.** is a Delaware corporation with its principal place of business in Eden Prairie, Minnesota.

171. Optum, Inc. is a health services company managing subsidiaries that administer pharmacy benefits, including Defendant OptumRx, Inc.

172. Optum, Inc. is directly involved, through its executives and employees, in the company policies that inform its PBM services and formulary construction, including with respect to the at-issue drugs and related to the Insulin Pricing Scheme, which had a direct effect in Florida.

173. UnitedHealth Group described Optum as an “information and technology-enabled health services business” serving the “broad health care marketplace,” including payers, care providers, employers, governments, life sciences companies, and consumers, through its Optum Health, Optum Insight, and Optum

³³ UnitedHealth Group Annual Report (Form 10-K, Ex. 21) (FYE Dec. 31, 2021); UnitedHealth Group Annual Report (Form 10-K, Ex. 21) (FYE Dec. 31, 2022).

Rx businesses.³⁴ UnitedHealth Group further identified OptumInsight, OptumHealth, and OptumRx as Optum’s business units and stated that the CEOs of those businesses reported to the CEO of Optum.

174. Defendant OptumRx, Inc. is a California corporation with its principal place of business at 2300 Main Street, Irvine, California, 92614.

175. OptumRx, Inc. operates as a subsidiary of OptumRx Holdings, LLC, which, in turn, operates as a subsidiary of Defendant Optum, Inc.

176. OptumRx, Inc. is registered to do business in Florida.

177. During the relevant period, OptumRx, Inc. provided the PBM and mail-order pharmacy services to Florida consumers.

178. Defendant OptumInsight, Inc. (“OptumInsight”) is a Delaware corporation with its principal place of business located in Eden Prairie, Minnesota.

179. OptumInsight, Inc. is registered to do business in Florida.

180. Defendant Emisar Pharma Services LLC (“Emisar”) is a Delaware limited liability company with its principal place of business 1 Optum Circle, Eden Prairie, Minnesota 55344 and operations in the United States and Ireland.

181. Emisar is a wholly owned indirect subsidiary of UnitedHealth Group Inc.

182. Optum established Emisar in June 2021, as a GPO for Optum’s PBM business. Emisar negotiates rebates with drug manufacturers on behalf of Optum’s commercial clients.

183. During the relevant period, Emisar negotiated rebates with the Manufacturers for at-issue drugs sold and distributed in Florida.

184. Because of numerous interlocking directorships and shared executives, UnitedHealth Group, OptumRx Holdings, LLC, and Optum, Inc. are directly involved in the conduct of and control United Healthcare Services, Inc., UHI, OptumInsight, Optum Rx, Inc., and Emisar’s operations, management, and business decisions related to the at-issue formulary construction, negotiations, and mail-order pharmacy

³⁴ UnitedHealth Group Inc., Annual Report (Form 10-K) (FYE Dec. 31, 2022), at 1–2, <https://www.sec.gov/Archives/edgar/data/731766/000073176623000008/unh-20221231.htm> (last visited Sept. 22, 2026).

services. For example:

a. Common officers and directors, including:

- Stephen J. Hemsley is the Chief Executive Officer and Chair of the Board of Directors of UnitedHealth Group;
- Andrew Witty served as Chief Executive Officer of Optum, Inc. (2018-2021) and of UnitedHealth Group (2021-2025);
- Dan Schumacher has served as Chief Strategy and Growth Officer at UnitedHealth Group since April 2021; he previously served as President and Chief Operating Officer of Optum, Inc. (2019-2021) and of UnitedHealth Group (2017-2019), and concurrently served as Chief Executive Officer of OptumInsight from April 2022 to January 2023;
- Dirk McMahon served as President and Chief Operating Officer of UnitedHealth Group from 2021 until his retirement in April 2024. He served as President and Chief Operating Officer of Optum from 2017 to 2019 and as Chief Executive Officer of OptumRx from 2011 to 2014.
- John Rex served as Executive Vice President and Chief Financial Officer of UnitedHealth Group from 2016 until September 2025, having joined the company in 2012 as Chief Financial Officer of Optum, Inc.
- Terry Clark served as Chief Marketing Officer of UnitedHealth Group from 2014 until early 2026 while concurrently serving, beginning in 2022, as Chief Marketing and Customer Officer of Optum, Inc.
- Tom Roos served as Senior Vice President and Chief Accounting Officer of UnitedHealth Group from August 2015 until March 2026, when he became Chief Financial Officer of OptumInsight.
- Heather Cianfrocco joined UnitedHealth Group in 2008 and held numerous senior leadership positions across United Healthcare and Optum, including Chief Executive Officer of OptumRx (2021-2023), President and then Chief Executive Officer of Optum, Inc. (2023-2025), and Executive Vice President of Governance, Compliance and Information Security of UnitedHealth Group (2025-2026).
- John Santelli served as UnitedHealth Group's Chief Information Officer beginning in 2007 while also leading Optum Technology, the technology division of Optum, Inc.

- Eric Murphy served as Chief Executive Officer of OptumInsight beginning in 2017 and later as Chief Growth and Commercial Officer of Optum, Inc.
- b. UnitedHealth Group directly or indirectly owns all the stock of Optum, Inc., OptumRx, Inc., OptumInsight, and Emisar;
 - c. The UnitedHealth Group corporate family does not operate as separate entities. The public filings, documents, and statements of UnitedHealth Group present its subsidiaries, including United Healthcare Services, Inc., UHI, Optum, Inc., OptumRx, Inc., OptumInsight, and Emisar, as divisions, departments, or “segments” of a single company that is “a diversified family of businesses” and that “leverages core competencies” to “help[] people live healthier lives and helping make the health system work better for everyone.” Indeed, UnitedHealth Group’s annual filings state that “[t]he terms ‘we,’ ‘our,’ ‘us,’ ‘its,’ ‘UnitedHealth Group,’ or the ‘Company’ . . . refer to UnitedHealth Group Incorporated and its subsidiaries” and that “[w]e provide pharmacy care services through our Optum Rx and UnitedHealthcare businesses,” “[t]he Company is . . . involved in . . . determining which drugs will be included in formulary listings,” and (in offering PBM services) “the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts.” The day-to-day operations of this corporate family reflect these public statements. These entities are a single business enterprise and should be treated as such as to all legal obligations detailed in this Complaint.³⁵
 - d. All executives of United Healthcare Services, Inc., UHI, Optum, Inc., OptumRx, Inc., OptumInsight, and Emisar ultimately report to the executives, including the CEO, of UnitedHealth Group.
 - e. UnitedHealth Group’s executives and officers are directly involved in the policies and business decisions of United Healthcare Services, Inc., UHI, Optum, Inc., OptumRx, Inc., OptumInsight, and Emisar that gave rise to Plaintiff’s claims.
185. In 2022, OptumRx managed \$124 billion in pharmaceutical spending.³⁶
186. For the years 2018-2022, OptumRx managed \$91 billion, \$96 billion, \$105 billion, \$112 billion, and \$124 billion in pharmaceutical spending, respectively.³⁷

³⁵ UnitedHealth Group, Quarterly Report (Form 10-Q) (Mar. 31, 2017).

³⁶ UnitedHealth Group Annual Report (Form 10-K) (FYE Dec. 31, 2022).

³⁷ Id.

187. In 2019, Optum Rx’s revenue (excluding UnitedHealthcare) totaled \$74 billion. By 2022, it had risen to more than \$99 billion.³⁸

188. OptumRx is named as a Defendant in its capacities as a PBM, rebate aggregator, and mail-order pharmacy.

189. OptumRx is a pharmacy benefit manager and, as such, coordinates with Novo Nordisk, Eli Lilly, and Sanofi regarding the price of the at-issue diabetes medications, as well as for the placement of these Manufacturers’ diabetes medications on OptumRx’s drug formularies.

190. OptumRx provides pharmacy care services to more than 65 million people in the nation through a network of more than 67,000 retail pharmacies and multiple delivery facilities. It is one of UnitedHealth Group Inc.’s four reportable segments, along with UnitedHealthcare, Optum Health, and OptumInsight. OptumRx was the largest PBM in the U.S. in 2023, with a 22.2% market share—up slightly from 20.8% in 2022.³⁹

191. At all times relevant, OptumRx offered PBM services nationwide and maintained standard formularies that are used nationwide, including in Florida. Those formularies included diabetes medications, including all of those at issue in this Complaint. OptumRx purchased drugs directly from Manufacturers for dispensing through its pharmacy network.

192. At all times relevant, and contrary to its express representations, OptumRx knowingly insisted that its payor clients use the inflated list prices produced by the Insulin Pricing Scheme as the basis for reimbursement of the at-issue drugs.

193. At all times relevant, OptumRx concealed its critical role in the generation of those inflated list prices.

³⁸ Id.

³⁹ American Medical Association, *PBM markets are at risk of harming patients* (July 31, 2025).

194. In its capacity as a mail-order pharmacy with a contracted network of retail pharmacies, OptumRx received payments from Florida consumers for, and set the out-of-pocket price paid for, the at-issue drugs based on the inflated prices produced by the Insulin Pricing Scheme and, as a result, damaged Florida consumers.

195. At all times relevant, OptumRx dispensed the at-issue medications nationwide and in Florida through its mail-order pharmacies and derived substantial revenue from Florida consumers through these activities in Florida. OptumRx purchases drugs produced by the Manufacturer Defendants, including the at-issue diabetes medications, for dispensing through its mail-order pharmacies and network of retail pharmacies.

196. At all times relevant, OptumRx had express agreements with Novo Nordisk, Sanofi, and Eli Lilly related to the Manufacturer Payments paid by the Manufacturer Defendants to OptumRx, as well as agreements related to the Manufacturers' at-issue drugs sold through OptumRx pharmacies.

III. JURISDICTION AND VENUE

A. Subject-Matter Jurisdiction

197. This Court has subject-matter jurisdiction pursuant to Article V, section 5(b) of the Florida Constitution and section 26.012(2)(a), Florida Statutes, which confer original jurisdiction upon Florida circuit courts over actions at law and equity.

198. The State of Florida, acting through the Office of the Attorney General and the Department of Legal Affairs, brings this action under Florida law, including the Florida Antitrust Act, Fla. Stat. §§ 542.15–542.36, and the Florida Deceptive and Unfair Trade Practices Act (“FDUTPA”). Fla. Stat. §§ 501.201–501.213. Sections 501.203(2), 501.207, and 542.27, Florida Statutes, authorize the Attorney General and the Department of Legal Affairs to enforce those statutes.

199. This Court has jurisdiction over Plaintiff's Florida Antitrust Act claims regardless of the amount in controversy under section 542.30, Florida Statutes, and has authority to grant the declaratory, injunctive, monetary, and other legal and equitable relief authorized by Florida law.

B. Personal Jurisdiction

200. This Court has specific personal jurisdiction over each Defendant under section 48.193(1)(a), Florida Statutes. Each Defendant, personally or through its agents: (a) operated, conducted, engaged in, or carried on business or a business venture in Florida; (b) committed one or more of the unlawful acts in Florida; and/or (c) caused injury to persons or property in Florida through acts or omissions occurring inside or outside the State while engaging in solicitation or service activities in Florida or placing products into the Florida market.

201. Plaintiff's claims arise out of or relate to each Defendant's Florida-directed conduct. Among other things, Defendants marketed, promoted, sold, dispensed, covered, and reimbursed the at-issue diabetes medications in Florida; provided pharmacy-benefit, formulary-management, rebate-aggregation, and pharmacy services affecting Florida consumers; and entered into or implemented rebate and formulary arrangements that affected the price and availability of the at-issue medications in Florida.

202. The challenged conduct was directed at Florida and had the foreseeable and intended effect of causing injury to Florida consumers. Defendants derived substantial revenue from the sale, coverage, reimbursement, and dispensing of the at-issue medications in Florida.

203. By purposefully directing these activities toward Florida and systematically serving the Florida market for diabetes medications and related pharmacy-benefit services, each Defendant purposefully availed itself of the privilege of conducting business in Florida and could reasonably anticipate being haled into a Florida court concerning claims arising from that conduct.

204. The exercise of personal jurisdiction over each Defendant comports with due process because there is a substantial connection among each Defendant's Florida-directed conduct, the injuries alleged in this Complaint, and the State of Florida.

C. Venue

205. Venue is proper in the Circuit Court of the Eleventh Judicial Circuit in and for Miami-Dade County, Florida, under section 542.30, Florida Statutes, because Defendants conduct business in more than one judicial circuit in Florida, including Miami-Dade County, and the causes of action asserted arose, at least in part, in Miami-Dade County and acts in furtherance of the challenged conduct occurred in Miami-Dade County.

206. Defendants conducted business affecting Miami-Dade County by providing pharmacy-benefit, formulary-management, rebate-aggregation, mail-order pharmacy, and retail pharmacy services to Miami-Dade County residents and governmental entities and by promoting, selling, dispensing, covering, or reimbursing the at-issue medications in Miami-Dade County.

207. The challenged rebate and formulary arrangements were implemented in Miami-Dade County through the sale, coverage, reimbursement, and dispensing of the at-issue medications and caused Florida consumers and governmental entities located in Miami-Dade County to pay allegedly inflated prices and incur other injuries alleged in this Complaint.

208. Venue is also proper for Plaintiff's FDUTPA claims under section 47.051, Florida Statutes, because those claims accrued, at least in part, in Miami-Dade County.

IV. FACTUAL ALLEGATIONS

A. The At-Issue Medications and Relevant Product Markets

209. Diabetes is a chronic disease in which the body either does not produce sufficient insulin or cannot effectively use the insulin it produces. Insulin regulates blood glucose, and inadequate insulin can cause serious complications—including cardiovascular disease, kidney disease, vision loss, and death. For people with Type 1 diabetes, exogenous insulin is medically necessary for survival. Many people with Type 2 diabetes also require insulin or other prescription diabetes medications to manage the disease.

210. Insulin products are not reasonably interchangeable with all other diabetes medications. For patients who require insulin, non-insulin diabetes medications do not provide a therapeutically equivalent substitute. The inclusion of insulin-adjunct products in this action therefore does not expand the relevant product market for insulin. Rather, those products compete, where applicable, within separate therapeutic classes or product categories based on their clinical indications, mechanisms of action, patient populations, prescribing practices, and reasonable therapeutic substitutability.

211. For many patients, insulin-adjunct medications do not provide a clinically equivalent substitute for insulin. Likewise, products within different non-insulin therapeutic classes are not necessarily interchangeable with one another. The relevant competitive inquiry therefore turns on the particular therapeutic class or category in which products compete for prescriptions, utilization, and formulary placement.

212. Within those distinct therapeutic categories, the PBM Defendants exercised the same types of formulary and reimbursement control, including preferred and non-preferred placement, exclusions, prior-authorization requirements, step therapy, and other utilization-management restrictions. Manufacturers of insulin-adjunct products therefore also competed for favorable formulary access and were required to offer rebates and other Manufacturer Payments to obtain or preserve that access.

213. The challenged conduct involving insulin-adjunct products thus concerns separate relevant product markets or submarkets and does not broaden the relevant insulin market to include all diabetes medications.

214. The insulin products at issue include both human insulin and insulin analogs. Beginning in the 1990s, the Manufacturer Defendants introduced rapid-acting and long-acting analog insulins, including Lilly's Humalog, Novo Nordisk's NovoLog and Levemir, and Sanofi's Lantus and Apidra. Additional analog products introduced during the relevant period included Toujeo, Basaglar, and Tresiba. Use of analog insulin increased substantially before and during the relevant period, and

analog products came to account for the overwhelming majority of insulin used in the United States.

215. Even among insulin products, reasonable interchangeability is not unlimited. Differences in onset of action, duration, dosing, delivery method, clinical indication, and patient-specific treatment needs limit substitution across therapeutic categories. Relevant insulin submarkets therefore include distinct therapeutic categories in which products compete most directly for the same or substantially similar patients, prescriptions, and formulary placement, including rapid-acting and long-acting or basal insulin products.

216. Within those categories, competing insulin products frequently served similar therapeutic functions and competed directly for preferred formulary status. For example, Lilly's Humalog, Novo Nordisk's NovoLog, and Sanofi's Apidra competed within the rapid-acting insulin category, while Sanofi's Lantus and Toujeo, Lilly's Basaglar, and Novo Nordisk's Levemir and Tresiba competed within the long-acting or basal insulin category.

217. Formulary placement was commercially significant because PBMs and health plans could designate therapeutically similar products as preferred, non-preferred, or excluded. A product excluded from a major formulary could lose access to substantial numbers of covered patients, even where it remained clinically available and therapeutically comparable to competing products.

218. Entry and expansion in these markets are constrained by substantial regulatory, patent and exclusivity, development and manufacturing, clinical, and formulary-access barriers. Manufacturer Defendants possess substantial portfolio leverage through their control of established insulin and insulin-adjunct products, while PBM Defendants exercise substantial control over commercially meaningful formulary access.

219. These market characteristics gave PBMs substantial leverage over manufacturers seeking commercially meaningful access to covered lives. Manufacturers therefore competed not only on clinical characteristics and price, but also through rebates and other Manufacturer Payments tied to formulary position,

exclusivity, and access.

220. The markets for the at-issue insulin products were highly concentrated and characterized by substantial barriers to entry and expansion. During much of the relevant period, there were no true generic substitutes for the principal insulin products and only limited biosimilar competition.

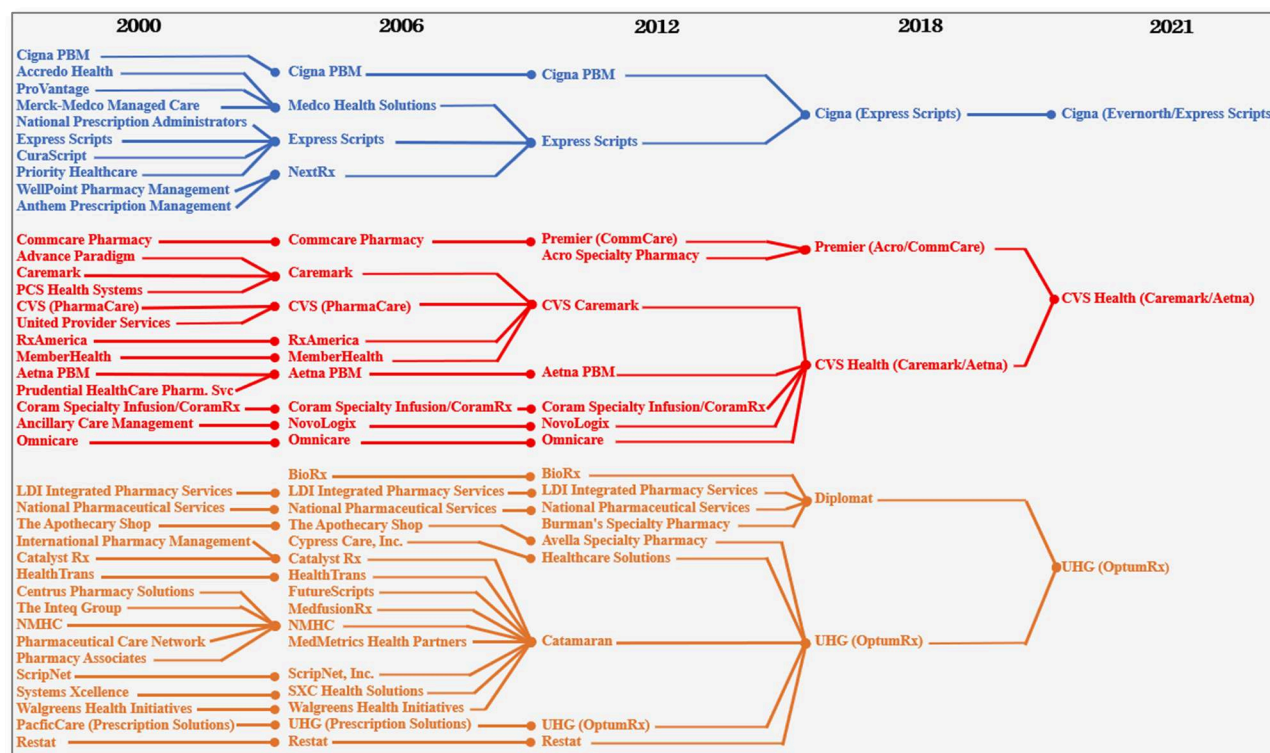
221. Eli Lilly, Novo Nordisk, and Sanofi manufactured nearly all insulin sold in the United States during the relevant period. Their market positions were reinforced by substantial barriers to entry, including regulatory requirements, manufacturing complexity, extensive patent portfolios surrounding principal insulin products, secondary patents obtained after initial FDA approval, limited biosimilar competition, and the commercial difficulty of obtaining meaningful formulary access.

222. These barriers limited the ability of new entrants and lower-priced alternatives to constrain the incumbent manufacturers, particularly where commercially meaningful access depended on obtaining favorable formulary placement from dominant PBMs.

223. At the same time, the PBM market became increasingly concentrated. Between 2000 and 2021, nearly forty PBM entities combined into what are now the PBM Defendants, each of which became affiliated with another significant participant in the prescription-drug supply and payment chain, including major health insurers, pharmacies, and other related entities.

224. Collectively, the PBM Defendants control more than 80% of drug benefits for more than 270 million Americans. Over the past two decades, substantial consolidation reduced the number of major PBMs, leaving CVS Caremark, Express Scripts, and OptumRx as the dominant PBMs in the United States.

Figure 6: PBM Consolidation



225. Throughout the relevant period, the PBM Defendants publicly represented that their scale and resulting purchasing and formulary leverage allowed them to negotiate with manufacturers on behalf of payors and consumers to reduce prescription-drug costs and improve access to affordable medications.

226. In reality, the PBM Defendants used that leverage to negotiate rebate and formulary agreements with Manufacturers that rewarded *higher*-list-price products offering greater Manufacturer Payments and disadvantaged *lower*-priced alternatives through preferred or exclusive formulary placement and other exclusionary conditions. A 2022 report by the Community Oncology Alliance described the dynamic as follows: “PBM formularies tend to favor drugs that offer higher rebates over similar drugs with lower net costs and lower rebates.”⁴⁰

⁴⁰ Community Oncology Alliance & Frier Levitt, Pharmacy Benefit Manager Exposé: How PBMs Adversely Impact Cancer Care While Profiting at the Expense of Patients, Providers, Employers, and Taxpayers (Feb. 2022), <https://communityoncology.org/wp->

227. Under the challenged agreements, Manufacturer Payments were tied to preferred or exclusive formulary placement, restrictions on competing products, patient-switching requirements, and other conditions affecting market access. These arrangements distorted competition by making rebate value, rather than lower price alone, an important determinant of commercially meaningful formulary access and thereby reducing incentives to compete through lower list prices.

228. Against this concentrated and rebate-driven market structure, the list prices of the at-issue insulin products rose dramatically during the relevant period.

B. Insulin Prices Rose Dramatically During the Relevant Period

229. The list price of certain analog insulin products has increased by more than 1000% (10x) since their introduction in the 1990s. By comparison, \$165 worth of consumer goods and services in 1997 dollars would, in 2021, have cost \$289 (1.75x).⁴¹

230. Since 1996, Eli Lilly has increased the published average wholesale price (“AWP”)⁴² of Humalog from less than \$100 to \$663 for a package of pens and from less than \$50 to \$342 per vial. Novo Nordisk likewise increased Levemir’s list price from \$162 in 2006, to \$555 in 2020 for a package of pens and from less than \$100 to \$370 per vial, and increased NovoLog’s list price from \$108 in 2002, to \$671 in 2021,

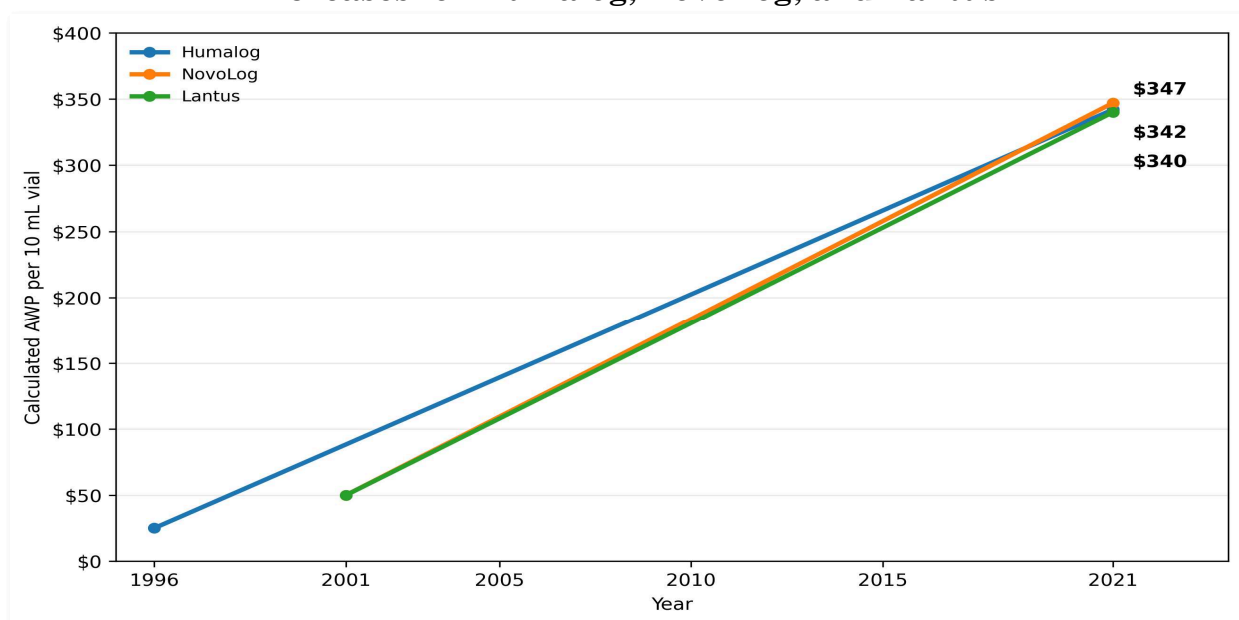
content/uploads/2022/02/COA_FL_PBM_Expose_2-2022.pdf (last visited Sept. 22, 2026).

⁴¹ The Consumer Price Index (CPI) measures “the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services.” available at https://www.bls.gov/data/inflation_calculator.htm (last visited Sept. 22, 2026).

⁴² Two commonly published drug-price benchmarks are wholesale acquisition cost (“WAC”) and average wholesale price (“AWP”). WAC, commonly referred to as a manufacturer’s “list price,” generally reflects the manufacturer’s published price to wholesalers or other direct purchasers before rebates, discounts, or other price concessions. AWP is a separately published benchmark that historically has been derived from WAC, often by applying a markup of approximately 20%. AWP does not generally reflect the price paid in an actual wholesale transaction and does not account for rebates, discounts, or other negotiated price concessions. Both WAC and AWP, depending on the context, are sometimes colloquially referred to as “list price.”

for a package of pens and from less than \$50 to \$347 per vial. Sanofi similarly increased the list price of its flagship analog insulin, Lantus, from less than \$200 in 2006, to more than \$500 in 2020, for a package of pens and from less than \$50 to \$340 per vial.

Figure 7: Historical Average Wholesale Prices (AWP) Increases for Humalog, NovoLog, and Lantus



231. The substantial increases in insulin prices did not correspond to comparable increases in manufacturing or research-and-development costs associated with the underlying drug formulations. Many of the at-issue insulin formulations had been marketed for decades before the challenged price increases.

232. A 2018 study published in BMJ Global Health estimated that, based on production costs, a reasonable and profitable annual price for human insulin was approximately \$48 to \$71 per patient and approximately \$78 to \$133 for analog insulin.⁴³

233. But insulin prices in the United States substantially exceeded prices for the same products in other developed countries. In 2018, the average U.S. price per

⁴³ Gotham D, Barber MJ, Hill A., Production costs and potential prices for biosimilars of human insulin and insulin analogues. BMJ GLOBAL HEALTH 2018;3:e000850.

vial across insulin products was \$98.70, compared with \$14.40 in Japan, \$12.00 in Canada, \$11.00 in Germany, \$9.08 in France, \$7.52 in the United Kingdom, and less than \$7.00 in Australia.⁴⁴

234. During the relevant period, manufacturer gross prices for insulin also increased far faster than general inflation, including average annual increases of approximately 13% between 2007 and 2018.⁴⁵

235. While research and development (or “R&D”) costs often contribute significantly to the price of a drug, the initial basic insulin research—original drug discovery and patient trials—occurred one hundred years ago and those costs have long since been recouped. And even recent costs, such as developing the recombinant DNA fermentation process and the creation of insulin adjuncts, were incurred decades ago. In recent years, the lion’s share of R&D costs were incurred in connection with the development of new insulin-related devices and equipment, not in connection with the drug formulations themselves.

236. The House Committee on Oversight and Reform also found that R&D costs “d[id] not justify price increases.” According to the committee, “when drug companies did invest in R&D, those expenditures often went to research designed to protect existing market monopolies.” The committee also found that “drug companies often invested in development only after other research—much of it federally funded—demonstrated a high likelihood of financial success.”

237. Facing increased scrutiny after the relevant period, the Manufacturer Defendants announced substantial list-price reductions for certain legacy insulin products, including reductions effective in 2023 and 2024. Those post-period reductions were prospective, applied only to certain products, and do not eliminate the historical overpayments or competitive effects of the challenged rebate and

⁴⁴ *The Astronomical Price of Insulin Hurts American Families*, RAND (Jan. 6, 2021), <https://www.rand.org/blog/rand-review/2021/01/the-astronomical-price-of-insulin-hurts-american-families.html> (last visited Sept. 22, 2026).

⁴⁵ Andrew W. Mulcahy, Daniel Schwam, Comparing Insulin Prices in the United States to Other Countries, RAND Corporation at 1.

formulary arrangements.

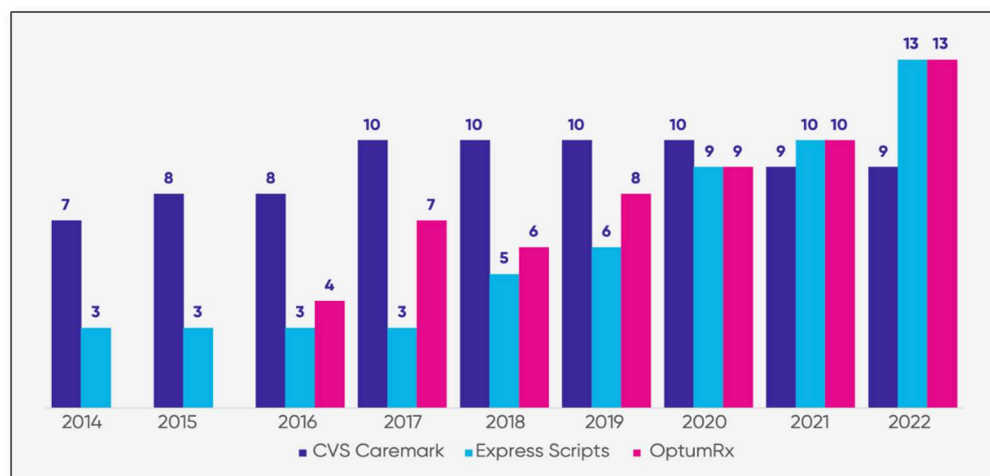
C. PBMs Control Commercially Meaningful Formulary Access

238. Beginning in the early 2010s, PBMs increasingly used formulary exclusions in the insulin therapeutic class as leverage in negotiations with Manufacturers. Exclusion from a formulary could sharply reduce a Manufacturer's access to covered patients and force patients either to switch products or bear substantially higher out-of-pocket costs to remain on a nonpreferred medication.

239. Manufacturers responded to the threat of exclusion by offering larger rebates and other remuneration to preserve preferred formulary access and market share. Because many of those payments were calculated by reference to list price, the resulting rebate demands created upward pressure on insulin list prices and reduced Manufacturers' incentives to compete through lower list prices.

240. Insulin was among the first classes of drugs to face PBM formulary exclusions, and the number of insulins excluded increased.⁴⁶ In 2014, Express Scripts and CVS Caremark excluded six and seven insulins, respectively. OptumRx excluded four insulins in 2016, its first year with an exclusion list. As of 2022, insulins have faced 193 total plan-years of exclusion across the PBMs, as illustrated below:

Figure 8: Insulin Exclusions by Plan Year



⁴⁶ Xcenda, Skyrocketing growth in PBM formulary exclusions continues to raise concerns about patient access (May 2022).

241. The challenged rebate and formulary agreements gave PBMs leverage to demand greater rebates by threatening exclusion or less favorable formulary placement. Internal Manufacturer documents reflect that these demands affected pricing decisions. Eli Lilly's Chief Executive Officer, David Ricks, publicly acknowledged the same mechanism, explaining that formulary access required increasing rebates and fees and that those payments placed upward pressure on list prices:

Getting on [a] formulary is the best way to ensure most people can access our medicines affordably—once again, that's how insurance is supposed to work. But that requires manufacturers to pay ever-increasing rebates and fees, which can place upward pressure on medicines' list prices. If we cannot offer competitive rebates, our medicines may be excluded from formularies, and people cannot access them. Last year alone, to ensure our medicines were covered, Lilly paid more than \$12 billion in rebates for all our medicines, and \$1 billion in fees. Last year, about eighty cents of every dollar spent on our insulins went to pay rebates and fees.⁴⁷

242. The Manufacturers' pricing decisions were also influenced by the economics of their relationships with PBMs. Because many rebates, discounts, fees, and other Manufacturer Payments were calculated as a percentage of list price, a higher list price increased the dollar value of the remuneration available to PBMs. Internal documents reflect that Manufacturers considered not only the effect of pricing decisions on their own net revenues, but also the effect on PBM rebate economics and formulary access, recognizing that loss of preferred formulary placement materially reduced a product's market share.

243. These rebate-driven incentives affected competition from lower-list-price insulin products. Lower-priced follow-on, authorized-generic, and biosimilar insulins became available during the relevant period, yet PBMs at times excluded those

⁴⁷ Eli Lilly and Co., Lilly Cuts Insulin Prices by 70% and Caps Patient Insulin Out-of-Pocket Costs at \$35 Per Month (Mar. 1, 2023) (statement of David A. Ricks, Chair and CEO).

products while covering higher-list-price alternatives capable of generating larger rebates. For example, beginning in 2020, two PBM Defendants excluded lower-list-price authorized-generic insulins while covering their higher-list-price branded equivalents.⁴⁸

244. The same pattern appeared with lower list-priced biosimilar versions, which also faced PBM formulary exclusion. In 2021, two identical versions of the same biosimilar insulin were introduced—one with a higher list price and larger rebates and one with a lower list price and limited rebates. In 2022, each of the three PBM Defendants excluded the lower-list-price version while covering the identical higher-list-price version.⁴⁹ This formulary outcome illustrates the competitive effects of the rebate-driven formulary arrangements: a higher-list-price product capable of generating greater Manufacturer Payments received more favorable formulary treatment than an otherwise identical lower-priced alternative.

245. Excluding lower list-priced medicines from formularies can substantially increase out-of-pocket costs for patients in plans using deductibles or coinsurance, where cost-sharing is typically determined based on the medicine's full list price.⁵⁰ This trend of favoring higher list-priced products has dramatically affected patient affordability and access to insulins.

246. The PBM Defendants used their substantial purchasing and formulary leverage, including the threat of exclusion, to negotiate larger rebates, discounts, fees, and other Manufacturer Payments from Manufacturers. The challenged rebate and formulary agreements thereby created incentives that rewarded higher-list-price

⁴⁸ Tori Marsh, *Can't access generic Humalog? There's an even cheaper insulin option available*, GOODRX. (Aug. 26, 2019), <https://www.goodrx.com/blog/admelog-now-cheaper-than-generic-humalog> (last visited Sept. 22, 2026).

⁴⁹ Adam Fein, *Five takeaways from the big three PBMs' 2022 formulary exclusions* (Jan. 19, 2022), available at <https://www.drugchannels.net/2022/01/five-takeaways-from-big-three-pbms-2022.html>.

⁵⁰ Adam Fein, *Express Scripts vs. CVS Health: five lessons from the 2020 formulary exclusions and some thoughts on patient impact* (Jan. 2020), available at <https://www.drugchannels.net/2020/01/express-scripts-vs-cvs-health-five.html>.

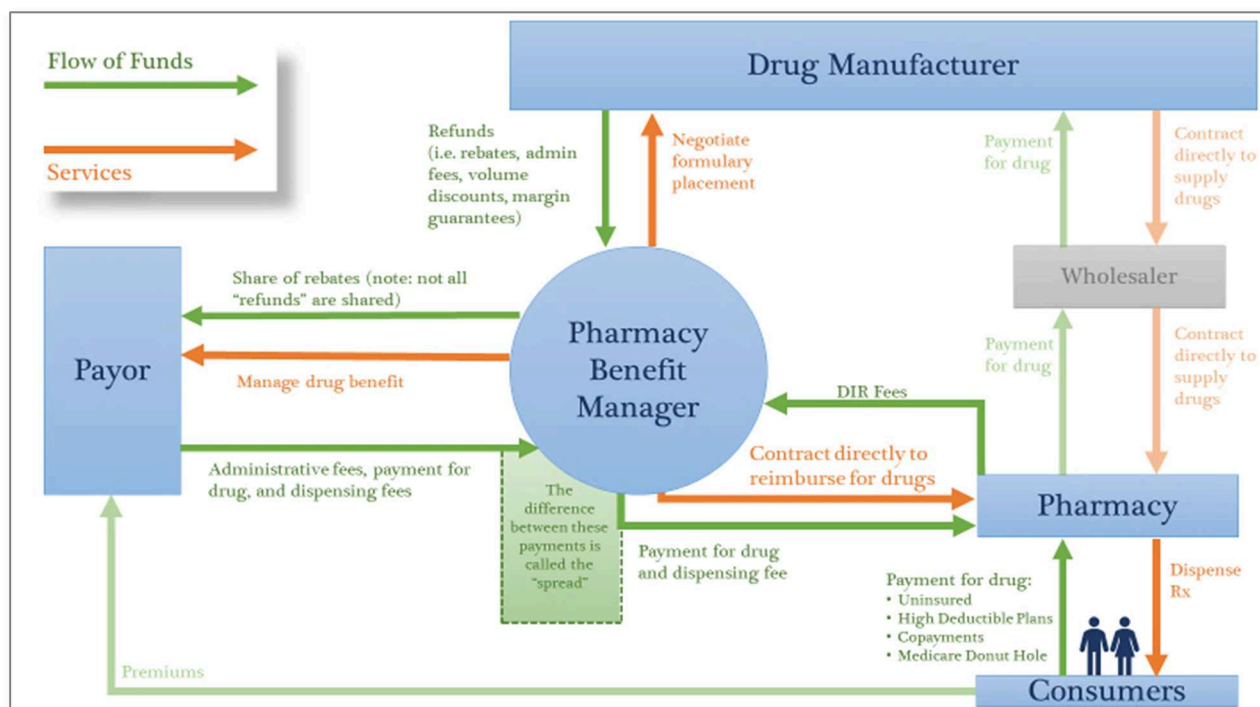
products and reduced incentives for Manufacturers to compete by lowering list prices. Exclusion of lower-list-price products also increased out-of-pocket costs for patients whose deductibles or coinsurance were tied to the price of the covered product.

247. At the same time, the PBM Defendants publicly represented that they used their purchasing and formulary power to lower drug costs and improve affordability, without disclosing the material rebate-driven incentives that favor higher-list-price products. These rebate and formulary arrangements contributed to higher insulin prices, reduced competition through lower list prices, and increased costs for Florida consumers.

D. Defendants Concealed the Economic Incentives Driving Formulary Decisions

248. The prescription drug industry is comprised of a deliberately opaque network of entities engaged in the distribution of, and payment for, prescription medications, including manufacturers, wholesalers, PBMs, pharmacies, payors, and patients, as illustrated in Figure 9, below:

Figure 9: Insulin distribution and payment chain



249. Prescription drugs may move through several different distribution channels. Generally, branded prescription drugs, including the at-issue diabetes medications, are distributed: (a) from the manufacturer to a wholesaler, then to a retail pharmacy and ultimately to the patient; (b) from the manufacturer to a mail-order pharmacy and then to the patient; or (c) from the manufacturer to a mail-order pharmacy that dispenses the drug in connection with benefits administered for a self-insured payor.

250. Drug-pricing compendia—including First DataBank—publish WAC and AWP information that may be incorporated into contracts and used as benchmarks in prescription-drug reimbursement and payment calculations.

251. The PBM Defendants occupy a central position in these payment flows. Among other things, the PBM Defendants:

- negotiate with payors concerning the terms under which prescription-drug benefits are administered;
- negotiate reimbursement terms with pharmacies participating in their networks;
- establish or administer certain fees and other payment terms applicable to network pharmacies;
- establish pricing and reimbursement terms for drugs dispensed through affiliated mail-order and specialty pharmacies; and
- negotiate with Manufacturers concerning rebates, fees, price-protection payments, and other Manufacturer Payments associated with covered drugs.

252. The amounts paid or received at different points in this system—including Manufacturer Payments, pharmacy reimbursement, PBM compensation, and net drug costs—are not generally visible to all participants in the transaction. Yet for the majority of these transactions, the PBMs are privy to the amount that any other entity in this supply chain is paying or receiving for the same drugs.

253. This lack of transparency for consumers and payors can obscure the relationship between published drug prices, Manufacturer Payments, formulary

incentives, pharmacy reimbursement, and the amounts ultimately borne by payors and consumers, and affords Defendants the opportunity to extract billions of dollars from this payment and supply chain without detection.

254. Defendants created an opaque system in which Florida consumers were not privy to the negotiations or agreements governing Manufacturer Payments, including the role of rebate-aggregator entities in negotiating, receiving, and processing those payments. The Payments were described by varied labels—including rebates, administrative fees, credits, discounts, and price-protection payments—pooled or processed through affiliated rebate aggregators. These structures obscured the financial incentives affecting formulary placement, restrictions on competing products, and consumers’ access to the at-issue medications.

E. The Manufacturer-PBM Rebate and Formulary Agreements

i. Written Agreements Tied Manufacturer Payments to Formulary Access

255. The Manufacturer Defendants entered into written rebate and formulary agreements with the PBM Defendants governing the terms on which particular insulin and insulin-adjunct products would receive formulary access. Those agreements provided for drug-specific rebates, price-protection payments, administrative fees, and other remuneration, with the amount of such payments varying according to the formulary position and access afforded to the Manufacturer’s products.

256. Internal records reflect bilateral Manufacturer–PBM arrangements in which increased rebates, fees, price-protection payments, and other consideration were conditioned on preferred or exclusive formulary placement, restrictions or exclusion of competing products, patient-switching requirements, bundled treatment of multiple products, or other preferential access terms. These agreements included, among other examples, Sanofi’s agreements and negotiations with Express Scripts and OptumRx concerning Lantus and Toujeo and Novo Nordisk’s exclusive-rebate arrangements tied to formulary treatment of its insulin products and Victoza.

257. Under these agreements, Manufacturers competed for commercially meaningful formulary access in part through the size of rebates and other payments calculated by reference to WAC. Each PBM Defendant separately negotiated rebate, administrative-fee, data-fee, price-protection, and other payment terms with individual Manufacturer Defendants.

258. The challenged agreements did more than establish ordinary discounts off a drug's price. They linked substantial Manufacturer Payments to conditions affecting the ability of competing products to obtain comparable formulary access. Depending on the agreement, those conditions included exclusive or preferred placement, exclusion or disadvantage of competing products, restrictions on grandfathering existing patients, patient switching, and bundled formulary treatment across multiple products.

259. Because the PBM Defendants controlled access to substantial numbers of covered lives, loss of preferred formulary status materially reduced a Manufacturer's access to patients and market share. This gave PBM Defendants substantial leverage to demand increased Manufacturer Payments and exclusionary formulary terms as a condition of commercially meaningful access.

260. Manufacturer Defendants responded to that leverage by entering into agreements providing greater rebates and other remuneration in exchange for preferred or exclusive formulary treatment. The resulting arrangements make the economic value of the rebate to the PBM, rather than competition through a lower list price alone, a significant determinant of formulary access.

261. The structure of these agreements disadvantaged lower-list-price products and competing products offering smaller rebates. A Manufacturer seeking to reduce list price could reduce the dollar value of percentage-based rebates and fees, while a higher-list-price product could support greater Manufacturer Payments and thereby compete more effectively for preferred formulary access.

262. Certain Manufacturer-PBM agreements also included payments tied directly to list-price increases. Under some arrangements, Manufacturer Defendants agreed to pay additional "inflation fees" when a drug's list price increased above a

specified threshold, with the amount of the payment calculated by reference to the drug's price. These provisions gave PBM Defendants an additional economic interest in list-price increases.

263. In some instances, the threshold triggering a Manufacturer's inflation payment to the PBM was lower than the threshold triggering the PBM's separate price-protection obligation to its plan-sponsor client. Thus, a PBM could receive an additional payment from the Manufacturer attributable to a list-price increase without owing a corresponding payment to the plan sponsor.

264. The challenged Manufacturer-PBM agreements thereby created economic incentives that reward higher-list-price products, disadvantage lower-priced alternatives, restrict competing products' access to covered patients, and reduce Manufacturers' incentives to compete by lowering list prices. In the concentrated insulin and PBM markets, those restraints foreclosed or materially disadvantaged competing products from commercially meaningful formulary access and suppressed price and formulary competition.

265. The State does not allege that rebates, fees, exclusivity, or formulary management are unlawful merely because they exist. Rather, the State challenges the Manufacturer Payments exchanged for preferred or exclusive formulary treatment and other exclusionary conditions that restricted or disadvantaged competing products and, in the context of Defendants' market power, unreasonably restrained competition.

266. These vertical restraints were not reasonably necessary to achieve lower net drug prices or ordinary formulary administration. Less restrictive alternatives were available, including formulary competition based on net cost and clinical value without conditioning commercially meaningful access on exclusionary terms restricting competing or lower-priced products.

267. As a result, the challenged agreements reduced competition among insulin and insulin-adjunct products, raised barriers to commercially meaningful formulary access, diminished incentives to compete through lower prices, and increased costs borne by Florida consumers and payors.

ii. Manufacturers Offered Larger Rebates for Preferred or Exclusive Formulary Treatment

268. Internal Manufacturer documents reflect that, when considering lower list prices, Eli Lilly and Novo Nordisk executives recognized that PBMs derived substantial revenue from rebates and fees calculated as a percentage of a drug's list price.

269. Internal Novo Nordisk documents reflect that its pricing decisions considered the payments CVS Caremark would receive. In an August 6, 2015 email, Novo Nordisk executives considered delaying a planned price increase for an at-issue drug because CVS had expressed concern that the timing of Novo's increases reduced CVS's price-protection, administrative-fee, and rebate payments. The email states that the timing had "been costing CVS a good amount of money." The Manufacturer Defendants also understand that because of the PBMs' market dominance, payors are forced to accept the baseline national formularies offered by the PBMs with respect to the at-issue drugs.

270. Sanofi's internal documents also reflect that rebate and formulary competition affected its pricing strategy for Lantus. In 2013, Sanofi believed that Novo Nordisk was seeking to narrow perceived clinical differences between Lantus and Levemir while offering increased rebates and portfolio arrangements to displace Lantus from favorable formulary positions. In response to these competitive pressures, Sanofi evaluated pricing and contracting strategies designed to preserve Lantus's formulary access and market position. An internal Sanofi memorandum stated that closing the price differential between the Lantus vial and pen before loss of exclusivity was "critical to the overall long-term success of the franchise."

271. Sanofi's internal materials reflect that it considered increasing Lantus's list price in part to support larger rebate and discount offerings while preserving net revenue and formulary access.

272. At the time, Sanofi faced increased pressure from its payor and PBM clients to offer more generous rebates and price protection terms or face exclusion from formularies, developments that were described as "high risk for our business"

that had “quickly become a reality.” This market environment created an enormous challenge for Lantus and, to protect its flagship diabetes franchise, Sanofi increased Lantus’s list price so that it could improve its rebate and discount offering to payors while maintaining net sales.

273. Sanofi understood the risk of its decision and “went into 2013 with eyes wide open that the significant price increases planned would inflame [its] customers,” and that its aggressive pricing would cause a quick reaction from Novo Nordisk. But Sanofi sought to make up for “shortfalls with Lantus demand generation and global profit shortfalls,” which it said “put pressure on the US to continue with the price increases to cover gaps.” The company conceded that it was “difficult to determine whether we would face these risks anyway if we hadn’t taken the price increases.”

274. Novo Nordisk’s pricing decisions for Levemir were made in the context of its efforts to obtain and preserve favorable formulary access. Internal materials reflect that Novo evaluated list-price changes together with payor reactions, product profitability, market performance, and the rebate economics associated with competing for formulary placement.

275. For example, at a May 19, 2014 pricing-committee meeting, Novo Nordisk evaluated potential Levemir pricing actions by considering, among other factors, anticipated payor reactions, profitability, and product and company performance. These materials reflect that Novo’s pricing decisions were influenced by the commercial environment in which it negotiated rebates and formulary access with PBMs.

276. Novo Nordisk’s internal materials also reflect the use of exclusive rebate offers to obtain preferred formulary access from PBMs. In a January 27, 2014 presentation concerning CVS Caremark, Novo Nordisk described its bids for CVS’s business as “pivotal” and considered offering “attractive exclusive rebates to large, receptive customers” to obtain exclusive formulary treatment for Levemir. Novo Nordisk recognized that such an arrangement could provoke a competitive response from Sanofi, but concluded that exclusive access could generate “immediate volume and value” and potentially secure CVS Caremark’s commercial formulary business.

277. Although the PBM Defendants have insisted they had no control over how the Manufacturers price their insulin products, their threats of formulary exclusion illustrate how they used new insulin competitors with lower prices to leverage even higher rebates on the existing insulin drugs.

278. In the face of formulary exclusion threats based on new entrants in the insulin market, the Manufacturers have willingly met the PBM Defendants' demands for increased rebates to retain preferred formulary placement and block competitors. For example, in 2016, Sanofi and Novo Nordisk enhanced their rebate offers at the same time Eli Lilly introduced Basaglar, a follow-on biologic to Lantus. Basaglar is a long-acting insulin and is "[c]linically . . . very similar" to Sanofi's Lantus. Because of its near clinical equivalence, Basaglar posed a competitive threat in the long-acting insulin market. The PBMs threatened to switch to Basaglar because it was priced lower, and they expected Eli Lilly to offer larger discounts in response.

279. To try to avoid PBMs switching to Basaglar, Sanofi and Novo Nordisk increased their rebate bids to respond to Eli Lilly. For example, according to Sanofi internal memoranda, sometime around April 2016, Express Scripts requested bids for its 2017 national commercial formulary and indicated its desire to add only one insulin glargine product to its basal insulin category. Express Scripts communicated to Sanofi that "with the right competitive price, [it] would not have significant challenges moving [from Lantus and Toujeo] to Basaglar" and that Sanofi must enhance its current rebate rate of 42% to maintain access for their basal insulins.

280. Rebate contracts confirm that Sanofi increased its offer up to almost 55% off its WAC of \$248.51 for Lantus vials and \$372.76 for Lantus pens.

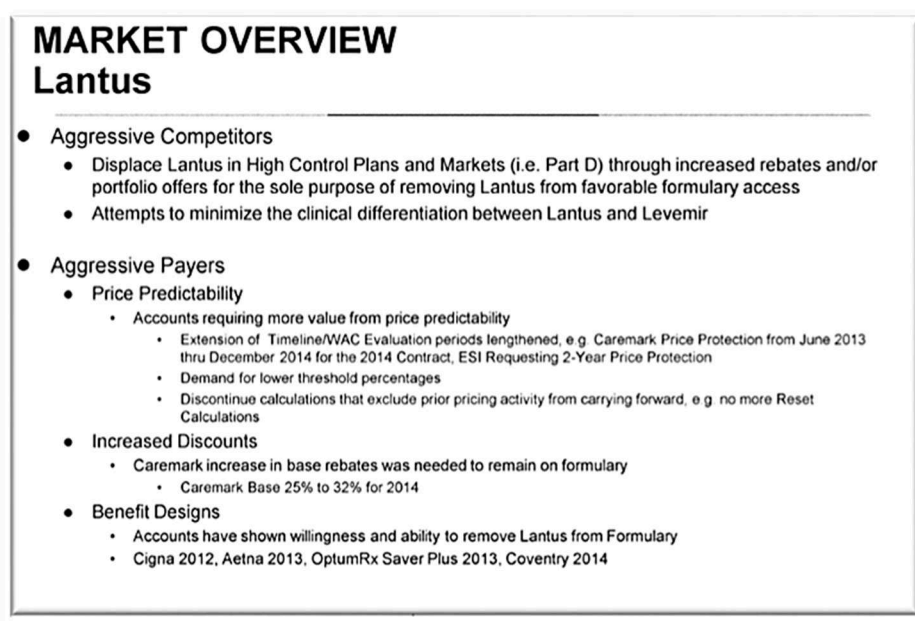
281. For the Manufacturers, the mere threat of exclusion has pressured them to offer substantially greater rebates to maintain formulary position. This is because formulary exclusions are likely to cause significant loss of a manufacturer's market share, leading to lower revenue. On the other hand, being the exclusive therapy on a formulary has the opposite effect, which incentivizes Manufacturers to offer large discounts to acquire or maintain such status. The use of formulary exclusions has thus led to a market dynamic in which Manufacturers offer ever-higher rebates to

avoid exclusion, which has led to higher list prices.

282. For example, before 2013, Sanofi offered an average rebate of approximately 5% on Lantus. Beginning in 2013, however, Sanofi faced increasing rebate pressure from both competitors and PBMs. Internal Sanofi materials noted that competitors sought to “[d]isplace Lantus in High Control Plans and Markets (i.e. Part D) through increased rebates and/or portfolio offers” for the purpose of removing Lantus from favorable formulary access. In response, Sanofi increased its rebate and discount offerings to preserve formulary access.

283. A Sanofi market overview illustrates this dynamic. The presentation identified both “Aggressive Competitors” using increased rebates and portfolio offers to displace Lantus and “Aggressive Payers” demanding greater discounts and price protection. Sanofi noted that Caremark required an increase in base rebates “to remain on formulary,” with the Caremark base rebate increasing from 25% to 32% for 2014. The presentation also identified multiple payors—including Cigna, Aetna, OptumRx, and Coventry—that had demonstrated a willingness and ability to remove Lantus from formulary. *See* Figure 10.

Figure 10: Sanofi Memo on Increased Rebates for Lantus



284. While the PBM Defendants have touted that using formulary exclusions in the insulin therapeutic class was a way to drive down costs for their clients, internal correspondence and memoranda show that increased use of formulary exclusions did exactly the opposite: WAC (list) prices have continued to increase, leading to higher costs for payors and higher prices for patients at the pharmacy counter.

285. For example, in 2013, when Express Scripts threatened to move patients to other diabetes drugs to “break even on [the] rebate line” unless Sanofi increased its Medicare Part D rebate offer for Lantus, Sanofi considered increasing its rebate offer from 7.45% to 15% in order to prevent formulary exclusion. Sanofi also faced similar pressure to increase rebates for Express Scripts’ commercial contracts. Internal Sanofi memoranda show that “Sanofi was notified by [Express Scripts] that Lantus was positioned to be removed from the formulary effective 2013 . . . [and as a result] rebates were re-negotiated.” An excerpt from this memo, discussing the threat to Lantus, illustrates that the threats used by Express Scripts to drive up rebates on Sanofi’s flagship insulin product Lantus:

Figure 11: Sanofi Presentation on Formulary Threats to Lantus

Lantus Contracting History with ESI
Account Management and Contracting have worked closely together to maintain a 5% rebate for Commercial contracts through 2012. Sanofi was notified by ESI that Lantus was positioned to be removed from formulary effective 2013. Rebates were re-negotiated resulting in a 6% Lantus Vial & 9% Lantus SoloStar rebate (no price protection).

Lantus Overall Threat
The Commercial business is at additional threat due to competitive rebate pressures and changing formulary design as well as Lantus pricing actions.

- ESI has shared that Novo has been extremely aggressive the last few months and this has triggered the need to revise our offer.
 - For 2014 ESI made Humalog exclusive in the RAI category, moving Novolog to Not Covered and made Byetta & Bydureon the only options in the GLP1 category, moving Victoza to Not Covered.
- Comments during discussion with ESI confirmed that modeling has occurred and that the current contracted offer will result in a Not Covered position for 2015. This is based on competitive offers by Novo and client plans requesting exclusive offers for comparison.
- They have shared that the basal category is under consideration for exclusion list status for 2015. This interest in an exclusive offer is consistent with recent actions they have taken to reduce the number of branded options available to patients.
- Lantus price increases over the past two years have positioned Sanofi as a cost driver that has triggered significant attention from ESI.

286. According to internal memoranda, in 2014, Express Scripts and its affiliated businesses managed the prescription drug claims of over 4.6 million people, representing 15% of the total business in the Medicare Part D channel. Rebate agreements confirm Sanofi renegotiated rebates and entered into an agreement to provide up to 10.625% for Lantus, effective January 1, 2014. Rebates were renegotiated again that same year, and Sanofi increased its rebate offer up to 14.625%, effective October 1, 2014.

287. CVS Caremark and OptumRx used similar formulary exclusion threats to drive up Lantus rebates. Around this same time, other PBMs learned that Sanofi had offered competitive rebates to Express Scripts which caused them to question their rebate status with Lantus. As a result, they too demanded higher rebates and threatened to exclude Lantus from their formulary to achieve this result.

288. For example, in 2014, OptumRx threatened to remove Lantus from its commercial formulary. Sanofi offered an enhanced rebate for FY2015 in the 15% range, but OptumRx rejected Sanofi's offer and took steps to remove Lantus from its commercial formulary. Sanofi responded with a last-minute bid of a 45% rebate for Tier 2, which OptumRx countered with 45% for Tier 3. According to Sanofi, OptumRx's counteroffer was "ultimately accepted over access concerns to future products and the need to secure access to patient lives."

289. In 2016, Express Scripts threatened to remove Lantus and Toujeo from its Medicare Part D formulary and demanded that Sanofi submit its "best and final offer" to avoid exclusion. Internal Sanofi memoranda reflect that Express Scripts cited Sanofi's prior years of price increases and Novo Nordisk's more competitive rebate offer in support of the threatened exclusion. In response, Sanofi considered increasing its rebate offer to as much as 40%, together with a 4% price-protection provision for Lantus and Toujeo. The increased rebate offer was negotiated against list prices that Sanofi had raised in prior years.

290. Although contracts with PBMs included larger and larger rebates, the Manufacturers still expected to remain profitable. For example, on July 28, 2017, one Sanofi official wrote to colleagues after considering their offer to CVS Caremark for

placement on the Part D formulary: “After inclusion of additional fees, we are still profitable up to an 89% rebate.” The official included an analysis that assumed “CVS would need to shift 68.9% of [its] glargine volume to Novo to break even (at an assumed 81% rebate offer).” In its analysis, Sanofi compared various negotiation scenarios including a “no contract” scenario, which it determined would be more profitable to the company even with the resulting reduction in sales volume and revenue.

291. As the PBMs expanded the practice of using formulary exclusions to extract greater rebates, Sanofi’s counterstrategy was to bundle unrelated products that had been excluded—Lantus and an epinephrine injection called Auvi-Q—to win formulary inclusion for both.

292. During the relevant period, Sanofi entered rebate arrangements that linked the rebate economics of one product to formulary treatment of other products. During negotiations for the 2015/16 plan year, for example, Express Scripts advised Sanofi that it would need to offer substantially more aggressive rebates to obtain access to the PBM’s commercial book of business. Internally, Sanofi officials warned that “Novo, specifically Levemir, has changed the game with regard to rebates,” and that Sanofi would “need to rebate aggressively.” A separate presentation described an arrangement under which rebates on Lantus would increase if Auvi-Q received formulary placement, thereby linking the rebate terms applicable to Lantus to formulary treatment of another Sanofi product. Sanofi also considered a broader three-product arrangement involving Toujeo, but had concerns about potential Medicaid best-price implications.

293. This counterstrategy was not limited to Sanofi. For example, Novo Nordisk secured contract terms from CVS Caremark’s Part D business in 2013, that tied its “exclusive” rebates for insulin to formulary access for its type 2 diabetes drug Victoza. The exclusive rebates of 57.5% for Novolin, Novolog, and Novolog Mix 70/30 were more than three times higher than the 18% rebate for plans that included two insulin products on their formulary. To qualify for the exclusive rebate, the plans would also need to list Victoza, a GLP-1 agonist, on their formulary, exclude all

competing insulin products, and ensure “existing patients using a [c]ompeting [p]roduct may not be grandfathered.”

294. By linking rebate levels on one product to formulary treatment of additional products, such arrangements extend the competitive effects of the rebate agreement beyond a single product and disadvantage competing products seeking formulary access.

295. At an April 2019 Congressional hearing,⁵¹ Defendants publicly acknowledged that that rebates affected formulary access and that percentage-based payments create incentives favoring higher-list-price products.

296. Mike Mason, Senior Vice President of Eli Lilly, testified:

Seventy-five percent of our list price is paid for rebates and discounts \$210 of a vial of Humalog is paid for discounts and rebates. . . . We have to provide rebates [to PBMs] in order to provide and compete for that [formulary position] so that people can use our insulin.

297. In the next question, Mr. Langa of Novo Nordisk was asked, “[H]ave you ever lowered a list price?” His answer, “We have not.”

298. Sanofi likewise acknowledged that percentage-of-list-price payments created economic incentives favoring higher list prices. Sanofi’s Executive Vice President for External Affairs, Kathleen Tregoning, testified:

The rebates [are] how the system has evolved. . . . I think the system became complex and rebates generated through negotiations with PBMs are being used to finance other parts of the healthcare system and not to lower prices to the patient.

Her written response to questions for the record acknowledged that “it is clear that payments based on a percentage of list price result in a higher margin [for PBMs] for

⁵¹ On April 10, 2019, the U.S. House of Representatives Committee on Energy and Commerce held a hearing on industry practices titled, “Priced Out of a Lifesaving Drug: Getting Answers on the Rising Cost of Insulin,” during which representatives from all Defendants testified. Transcripts *available at* <https://www.congress.gov/event/116th-congress/house-event/109299?s=1&r=3> (last visited Sept. 22, 2026) (hereinafter *Priced Out of a Lifesaving Drug*).

the higher list price product than for the lower list price product.”

299. The PBM Defendants also conceded at the April 2019 Congressional hearing that they grant preferred, or even exclusive, formulary position because of higher Manufacturer Payments paid by the Manufacturer Defendants.

300. In her responses to questions for the record, Amy Bricker—former President of Express Scripts and a former PCMA board member—confirmed that “manufacturers lowering their list prices” would give patients “greater access to medications.” Yet when asked to explain why Express Scripts did not grant an insulin with a lower list price preferred formulary status, she answered: “Manufacturers do give higher discounts [i.e., payments] for exclusive [formulary] position” When asked why the PBM would not include both costly and lower-priced insulin medications on its formulary, Ms. Bricker stated plainly, “We’ll receive less discount in the event we do that.”⁵²

301. As Dr. Dutta, Senior Vice President of OptumRx, reasoned, the cheaper list-priced alternative Admelog is not given preference on the formulary because “it would cost the payer more money to do that . . . [b]ecause the list price is not what the payer is paying. They are paying the net price.”⁵³

302. Consumers, however, do not necessarily receive the benefit of those negotiated rebates or lower net prices. Patients whose out-of-pocket obligations are based on list price or related benchmarks—including uninsured patients and patients

⁵² Buried in Express Scripts’ 2017 10-K is the following: “We maintain contractual relationships with numerous pharmaceutical manufacturers, which provide us with, among other things administrative fees for managing rebate programs, including the development and maintenance of formularies that include particular manufacturer’s products” That is, the Manufacturers pay the PBMs to effectively participate in the creation of formularies that payors must adopt as a condition for obtaining PBM services. Express Scripts Annual Report (Form 10-K) (FYE Dec. 31, 2017) at 24. It adds that its business would be “adversely affected” if it were to “lose [its] relationship with one or more key pharmaceutical manufacturers.” *Id.*

⁵³ *Priced Out of a Lifesaving Drug* at lines 1394–95. As noted during the hearing, even the lower-list-price alternative Admelog “costs over \$200 a bottle.” *Id.* at lines 3121–26.

subject to deductibles or percentage-based coinsurance in Florida—may pay more when higher-list-price, highly rebated products receive preferred formulary placement over lower-list-price alternatives.

303. The manufacturer-reported “net price” also does not necessarily represent the ultimate net cost incurred by a particular health plan. In addition to rebates, PBMs may receive administrative fees, data fees, price-protection payments, credits, and other forms of Manufacturer Payments through the challenged agreements, and the extent to which those amounts are passed through to a plan depends on the terms of the PBM’s contract with that plan. Accordingly, a lower manufacturer net price does not, standing alone, establish that a particular payor or patient realized the full economic benefit of the Manufacturer Payments.

304. These added forms of compensation are material to understanding the economics of the challenged arrangements because they may affect both the PBM’s incentive to prefer one product over another and the ultimate cost borne by the plan and its members.

305. By giving preference to drugs with higher list prices based on the illusion of a lower net price, the PBMs are causing payors to pay more while the PBMs keep greater profits for themselves.

306. The Insulin Pricing Scheme was born from a series of vertical rebate and formulary agreements between individual Manufacturer Defendants and PBM Defendants. Under those agreements, Manufacturers provided rebates, fees, and other Manufacturer Payments—often calculated by reference to list price—in exchange for preferred or exclusive formulary placement and other conditions affecting competing products. As list prices increased, the dollar value of certain Manufacturer Payments also increased, reinforcing incentives that favored higher-list-price products and reduced incentives to compete through lower list prices. This unlawful conduct harmed Florida consumers.

iii. PBMs Threatened Formulary Exclusion to Obtain Greater Manufacturer Payments

307. In exchange for the Manufacturers artificially inflating their prices and

paying the PBMs substantial amounts in Manufacturer Payments, the PBM Defendants grant the Manufacturer Defendants' diabetes medications elevated prices and preferred status on their national formularies. During the relevant period, the rebate amounts (as a proportion of the list price) grew year-over-year while list prices themselves increased.

308. For example, in July 2013, Sanofi offered rebates between 2% and 4% for preferred placement on CVS Caremark's commercial formulary. Five years later, in 2018, Sanofi rebates were as high as 56% for preferred placement. In 2015, Sanofi offered OptumRx rebates up to 42% for Lantus for preferred formulary placement. That figure grew to 79.75% by 2019. Similarly, in 2014, Novo Nordisk offered Express Scripts 25% rebates for Levemir. That figure climbed to 47% in 2017.

309. Beyond increased rebate demands, the PBM Defendants have also sought and received larger and larger administrative fees from the Manufacturers during the relevant period.

310. A 2019 report by the Pew Charitable Trust estimated that annual PBM administrative fees, direct and indirect remuneration, and spread-pricing revenue increased from approximately \$5.9 billion in 2012 to approximately \$16.6 billion in 2016—nearly tripling over four years. Over the same period, manufacturer rebates paid to PBMs increased from approximately \$26.4 billion to approximately \$66.0 billion. Although a growing share of rebates was passed through to insurers, PBMs' overall net revenue on drugs increased from approximately \$11.6 billion in 2012 to approximately \$22.4 billion in 2016.⁵⁴

311. Thus—and contrary to their public representations—the PBM Defendants' negotiations and agreements with the Manufacturer Defendants (and the formularies that result from these agreements) have caused and continue to cause precipitous price increases for the at-issue drugs —increases passed on to consumers.

⁵⁴ The Pew Charitable Trusts, *The Prescription Drug Landscape, Explored*, app. B at 35 (Mar. 2019), https://www.pewtrusts.org/-/media/assets/2019/03/the_prescription_drug_landscape-explored.pdf (last visited Sept. 22, 2026).

312. Because of the Insulin Pricing Scheme, every payor that pays or reimburses for the at-issue drugs has been overcharged.

313. Moreover, the PBMs use this artificially inflated price to misrepresent the amount of “savings” they generate for diabetics, payors, and the healthcare system. For example, in January 2016, Express Scripts’ president Tim Wentworth stated at the 34th annual JP Morgan Healthcare Conference that Express Scripts “saved our clients more than \$3 billion through the Express Scripts National Preferred Formulary.”⁵⁵ Likewise, in April 2019, CVS Caremark president Derica Rice stated: “Over the last three years . . . CVS Caremark has helped our clients save more than \$141 billion by blunting drug price inflation, prioritizing the use of effective, lower-cost drugs and reducing the member’s out-of-pocket spend.”⁵⁶

314. In making these representations, the PBM Defendants fail to disclose that the purported “savings” are often measured against a list-price benchmark that does not reflect the substantially lower prices generated after rebates and other Manufacturer Payments. At the same time, Florida consumers may remain exposed to the higher list price through deductibles, percentage-based coinsurance, or purchases made without insurance, even though they do not necessarily receive the benefit of the rebates and other payments used to calculate the purported savings. Thus, the same higher list price that can increase the apparent amount of a PBM’s negotiated “savings” can also increase out-of-pocket costs for Florida consumers whose cost-sharing obligations are tied to list price or related pricing benchmarks.

⁵⁵ Surabhi Dangi-Garimella, *PBMs Can Help Bend the Cost Curve: Express Scripts’ Tim Wentworth*, AJMC (Jan. 12, 2016), <https://www.ajmc.com/view/pbms-can-help-bend-the-cost-curve-express-scripts-tim-wentworth> (last visited Sept. 22, 2026).

⁵⁶ CVS Health, *CVS Health PBM Solutions Blunted the Impact of Drug Price Inflation, Helped Reduce Member Cost, and Improved Medication Adherence in 2018* (Apr. 11, 2019), <https://www.prnewswire.com/news-releases/cvs-health-pbm-solutions-blunted-the-impact-of-drug-price-inflation-helped-reduce-member-cost-and-improved-medication-adherence-in-2018-300830167.html> (last visited Sept. 22, 2026).

iv. The Agreements Included Exclusion, Switching, and Bundling Formulary Conditions

315. Manufacturers and PBMs also negotiated bundled rebate arrangements involving insulin and insulin-adjunct products, including GLP-1 receptor agonists. Under these arrangements, increased rebates or other Manufacturer Payments on one or more insulin products conditioned on favorable formulary treatment for additional diabetes medications.

316. For example, in 2013, Novo Nordisk offered substantially greater rebates on Novolin, NovoLog, and NovoLog Mix 70/30 in connection with an exclusive formulary arrangement that also required formulary access for Victoza. The exclusive rebate was approximately 57.5%, compared with approximately 18% where a plan included two insulin products. To qualify for the larger rebate, the plan also had to exclude competing insulin products and transition existing patients from certain competing diabetes medications.

317. These bundled arrangements linked Manufacturer Payments to exclusionary formulary conditions affecting multiple products and thereby disadvantage competing products and restrict competition for commercially meaningful formulary access.

v. The Agreements Discouraged Competition Through Lower List Prices

318. The agreements the Manufacturers had with the PBM Defendants deterred competition on lowering prices. For example, following its April 2018 list price increase, Novo Nordisk began to face pressure from payors, the media, and Congress to reduce the prices of its insulin drugs. On May 29, 2018, Novo Nordisk's U.S. Pricing Committee debated whether it should reduce the list price of its insulin drugs by 50% after a string of news reports detailed how patients (including Florida consumers) were struggling to afford their medications. Novo Nordisk understood that a 50% cut would be a meaningful reduction to patients, significantly narrow the list-to-net gap, head off negative press attention, and reduce "pressure" from Congressional hearings. However, Novo Nordisk was concerned that a list price reduction would pose significant financial risk to the company.

319. The company's primary concerns were retributive action from other entities in the vertical pharmaceutical supply chain, many of which derive payments that are based on a percentage of a drug's WAC price. A PowerPoint slide created for this meeting suggests that the reasons not to lower prices were that "many in the supply will be negatively affected (\$)" and may retaliate" and that its "[c]ompetitors may not follow putting [Novo Nordisk] at a disadvantage:"

Figure 12: Novo Nordisk presentation on reduced list prices

Why would we do this?	Why wouldn't we?
+ Relieves pressure from media and Congressional hearings	- Financial risk without eliminating industry wide legislation changes
+ Closes list to net price gap while supporting patient affordability	- Does not alleviate overall US drug spend as net price would remain
+ Aligns to HHS's call for affordable pricing options	- Upset payers may pressure GLP1 portfolio
+ Mitigates increased Coverage Gap exposure and upcoming 2020 "cliff"	- Many in the supply chain will be negatively affected (\$) and may retaliate
+ Mitigates potential uncapping of Medicaid rates	- Competitors may not follow putting NNI at a disadvantage

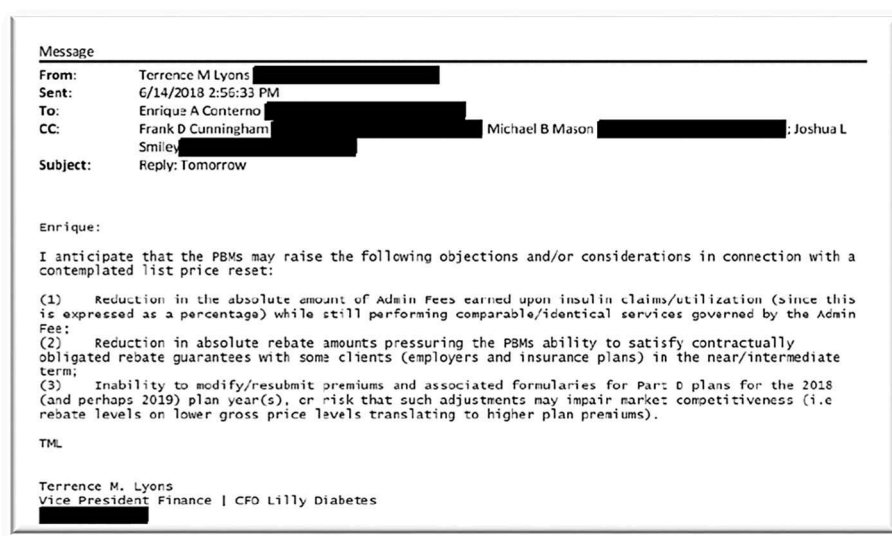
320. Despite these concerns, internal memoranda suggest that Novo Nordisk was still prepared to lower its list price by 2019 or 2020 if its "must haves" were met, which included an agreement from the PBMs that they would not retaliate against them by changing their formulary placement and would accept lower rebate percentages.

321. According to internal memoranda, Novo Nordisk's board of directors voted against this strategy in June 2018 and recommended that the company continue its reactive posture. The rationale for this decision was the "\$33 million downside identified (NovoLog only)," "risk of payor [PBM] backlash or demand for current rebate on new NDC," and "high likelihood of immediate pressure to take similar action on other products." Following the decision by its board of directors, on August 30, 2018, Novo Nordisk continued its strategy to "monitor the market . . . to determine if other major pharma companies are taking list price [increases]."

322. Internal communications also show that existing PBM contractual arrangements impede efforts to reduce insulin list prices. For example, a June 23, 2018 email memorializes a conversation Eli Lilly’s President of the Diabetes Unit, Enrique Conterno, had with the CEO of OptumRx, who allegedly “re-stated that [OptumRx] would be fully supportive of Lilly pursuing a lower list price option,” but indicated that OptumRx would encounter challenges, namely, “the difficulty of persuading many of their customers to update contracts without offering a lower net cost to them.”

323. In response, an Eli Lilly executive noted, “we wouldn’t be able to lower our list price without impacting our net price,” and counseled waiting until early 2020 to reduce prices. Two weeks before this email, Eli Lilly executives had raised the possibility that PBMs would object to a list price reset because it would (a) result in a reduction in administrative fees for PBMs, (b) reduce rebates, which would impact PBMs’ ability to satisfy rebate guarantees with some clients, and (c) impair their clients’ ability to lower premiums for patients, thereby impacting their market competitiveness. An excerpt of this email is shown below:

Figure 13: Eli Lilly internal email re potential price reductions



324. The economics and contractual commitments embedded in the Manufacturer–PBM relationship make a list-price reduction difficult to implement

without affecting rebates, net prices, and obligations to PBM clients.

vi. Industry Forums Facilitated Manufacturer-PBM Agreements

325. PBM and Manufacturer executives also interacted regularly through industry organizations and conferences, including events hosted by the Pharmaceutical Care Management Association (“PCMA”), the principal trade association for PBMs. PCMA’s annual meetings and business forums brought together senior PBM executives, drug manufacturers, and other industry participants and expressly provided opportunities for private meetings and one-on-one business discussions.⁵⁷

326. The PCMA is governed by senior PBM executives. During the relevant period, executives from the PBM Defendants held leadership positions within PCMA. In 2022, for example, Express Scripts President Amy Bricker served as Vice Chair and then Chair of PCMA’s Board of Directors, while senior executives from CVS Health and OptumRx also participated in PCMA leadership and programming. The PBM Defendants were members of PCMA and, through these leadership positions and their participation in the association, exercised substantial influence over PCMA’s activities.

327. The Manufacturer Defendants are also affiliate members of the PCMA and have been “Partners,” “Platinum Sponsors,” or “Presidential Sponsors” of these PBM conferences.

328. Many of the forums at these conferences are specifically advertised as offering opportunities for private, non-public communications. For example, PCMA’s 2021 Annual Meeting was described as an executive conference tailored to PBMs and affiliated business partners, including drug manufacturers, and its agenda included private meeting rooms, member-company receptions, and sessions devoted to PBM–

⁵⁷ The PCMA’s industry funding in the form of “membership dues” is set out in its 2019 Form 990, <https://projects.propublica.org/nonprofits/organizations/383676760/202042969349301134/full> (last visited Sept. 22, 2026).

pharmaceutical-industry relationships. Similar private meeting opportunities appeared at PCMA events in 2019, 2020, and 2022.⁵⁸

329. Representatives from each Manufacturer Defendant have routinely met privately with representatives from each PBM Defendant during the Annual Meetings and Business Forum conferences that the PCMA holds (and the Manufacturers sponsor) each year.

330. In addition, all PCMA members, affiliates and registered attendees of these conferences are invited to join PCMA-Connect, “an invitation-only LinkedIn Group and online networking community.”⁵⁹

331. These industry forums provided opportunities for PBMs and Manufacturers to negotiate and manage the vertical commercial relationships, including rebate, formulary, contracting, and market-access arrangements.

332. Key price increases occurred immediately after PCMA meetings. For example, on May 30, 2014, just weeks after the 2014 PCMA spring conference, Sanofi made its list price increase on Lantus and Novo Nordisk raised the list price of Levemir. Likewise, on October 1, 2017, just days after the PCMA’s annual conference, Sanofi increased Lantus’s list price by 3% and Toujeo’s list price by 5.4% and Novo Nordisk recommended that their company make a 4% list price increase effective on January 1, 2018.

333. In addition, communications among Defendants are facilitated by the fluidity and frequency with which executives move from one Defendant to another. For example:

- Mark Thierer spent approximately ten years as an executive at Caremark Rx (now CVS Caremark) before becoming Chief Executive Officer of

⁵⁸ PCMA, *The PCMA Annual Meeting 2021 Will Take Place at the Broadmoor in Colorado Springs, CO September 20 and 21*, <https://www.pcmanet.org/events/past-events/pcma-annual-meeting-2021/> (an event “tailored specifically for senior executives from PBMs and their affiliated business partners” with “private reception rooms” and “interactions between PBM members, drug manufacturers, and other industry partners”) (last visited Sept. 22, 2026).

⁵⁹ PCMA, *PCMA-Connect*, <https://www.pcmanet.org/contact/pcma-connect/> (last visited Sept. 22, 2026).

OptumRx following UnitedHealth Group's acquisition of Catamaran in 2015; Thierer also served as Chairman of the Board of PCMA in 2012;

- CVS Health's Chairman and Chief Executive Officer, David Joyner, succeeded Karen Lynch in 2024.
- Karen Lynch previously held senior executive positions at Cigna before later serving as President of Aetna and Chief Executive Officer of CVS Health;
- Amar Desai, who has held senior leadership positions at Optum beginning in 2019, later served as President for Health Care Delivery at CVS Health, and subsequently returned to Optum Health, where he served as Chief Executive Officer of Optum Health until June 2025;
- Krista Nelson has served as Chief Executive Officer of Optum Health since November 2025, after serving as its Chief Operating Officer;
- Trip Hofer held leadership positions at OptumHealth and CVS Health before becoming Chief Executive Officer of AbleTo and, following Optum's acquisition of AbleTo, Chief Executive Officer of Optum Behavioral Solutions;
- Bill Wolfe served as President of the Catalyst Rx and later held a senior pharmacy leadership role at Aetna; while at Aetna, Wolfe also served on PCMA's Board of Directors;
- Derica Rice, former Executive Vice President of CVS Health and President of CVS Caremark, previously served as Executive Vice President and Chief Financial Officer of Eli Lilly;
- Albert Thigpen held senior executive positions at both CVS Caremark and OptumRx/UnitedHealth;
- Harry Travis held senior leadership positions at Medco/Accredo and Aetna, including as Vice President of Aetna's Specialty and Home-Delivery Pharmacy business, and later served as Senior Vice President at CVS Caremark; and
- Bill Kiefer served for many years in senior leadership at Express Scripts, and later as Senior Vice President of Strategy at UnitedHealth Group.

F. Defendants Misrepresented and Obscured the Rebate Economics Driving Formulary Decisions

334. PBM Defendants received compensation from Manufacturers in multiple forms: payments once called "rebates" were termed "administrative fees," "volume discounts," "service fees," "inflation fees," or other classifications designed to obscure the full economic incentives associated with formulary placement and access to the

at-issue medications.

335. For Express Scripts, administrative-fee amounts materially exceeded formulary and price-protection rebates billed during the same period. These added forms of remuneration were material to understanding the economic incentives affecting PBM formulary decisions and the total compensation PBMs received from Manufacturers.

336. A heavily redacted complaint filed by Defendant Express Scripts in 2017 also revealed that Express Scripts retains up to thirteen times more in “administrative fees” than it remits to payors in rebates. In fact, administrative fees can dwarf rebates. In just one alleged invoice Express Scripts was seeking payment for in that lawsuit, “administrative fees” were more than three-and-a-half times the amount billed for formulary rebates and price protection rebates *combined*.⁶⁰

337. Although the proportion of rebates retained by PBMs remains a secret, commentators have suggested that PBMs “designate as much as twenty-five or thirty percent of the negotiated rebates as fees to avoid sharing the rebates.”⁶¹

338. In an attempt to quantify the revenue PBMs receive from retained rebates, a 2023 report found that PBM compensation from rebates and other kickbacks doubled between 2018 and 2022, from \$3.8 billion to \$7.6 billion.⁶² “This growth was fueled by increases in traditional administrative fees as well as the emergence of new data and PBM contracting entity fees.”⁶³

⁶⁰ *Express Scripts, Inc. v. Kaleo, Inc.*, No. 4:17-cv-01520-RLW (E.D. Mo. 2017).

⁶¹ Joanna Shepherd, *Pharmacy Benefit Managers, Rebates, and Drug Prices: Conflicts of Interest in the Market for Prescription Drugs*, YALE L. & POL. REV., https://openyls.law.yale.edu/bitstream/handle/20.500.13051/17295/auto_convert.pdf?sequence=3&isAllowed=y (last visited Sep. 22, 2026).

⁶² Eric Percher, Trends in Profitability and Compensation of PBMs and PBM Contracting Entities, Nephron Research (Sept. 18, 2023), available at https://cdn.ymaws.com/www.wsparx.org/resource/resmgr/legislative_session/2024/pbm_campaign/nephron_pbm.pdf (last visited Sept. 22, 2026).

⁶³ *Id.*

339. These so-called administrative fees were calculated based on a percentage of the drug price—as opposed to a flat fee—such that even if the actual “administrative” cost associated with processing two drugs is the same, the “administrative fee” would be correspondingly higher for the higher-priced drug—which again creates (by design) a perverse incentive to give preference to more expensive drugs.

340. In certain PBM contracts with plan sponsors, “rebates” were narrowly defined by reference to patient drug utilization. Manufacturer payments tied to formulary placement were characterized as “administrative fees” and excluded from rebate pass-through and audit provisions.

341. The opaque nature of these arrangements makes it impossible for a given payor or consumer to discover, much less assess or confront, the harm caused by the Insulin Pricing Scheme.

342. PBM Defendants have used varied labels for Manufacturer Payments, including rebates, administrative fees, credits, discounts, and price-protection payments. Those labels and the terms governing the payments obscured the financial incentives associated with formulary placement and access to the at-issue medications.

343. For example, certain Manufacturer Payments now known as “inflation fees” were calculated by reference to increases in a drug’s list price. The terms governing those payments differ from the “price protection” amounts that PBM Defendants agreed to provide to plan sponsors, allowing PBM Defendants to retain revenue associated with list-price increases.

344. Under these arrangements, the Manufacturer Defendants agreed to pay the PBM Defendants an additional “inflation fee” when a drug’s list price increased by more than a specified threshold during a defined period. The thresholds for these payments were commonly set at around 6% to 8% and the additional fee was calculated as a percentage of the drug’s list price. These arrangements gave PBM Defendants an additional financial incentive tied to higher list prices.

345. In certain contracts with plan sponsors, the PBMs Defendants provided separate “price protection guarantees” at a higher rate than the thresholds that trigger the Manufacturers’ “inflation fees,” usually around 10%-15%, under which the PBMs would credit or remit a portion of the amount to the client if aggregate drug-price increases exceeded a specified threshold during a defined period.

346. As a result, when the Manufacturers increased their list prices more than the 6% (or 8%) inflation fee rate, but less than the 10%-15% client price protection guarantee rate, the PBMs kept all of these “inflation fee” payments. This is a loss for Florida consumers but a win-win for the Manufacturers and PBM Defendants—they share and retain the entire benefit of these price increases while the PBM contracts with payors imply that payors are protected from price hikes by their price protection guarantees. This structure created an additional financial incentive tied to higher list prices and obscured the full effect of those incentives on formulary decisions and consumer costs.

347. As explained above, Defendants themselves acknowledged that these percentage-based Manufacturer Payments affected formulary placement and created incentives favoring higher-list-price products. At the same time, the PBM Defendants publicly represented that they used their purchasing power, formulary management, and rebate negotiations to lower prescription-drug costs and improve affordability. Those representations omitted material information concerning the rebate-driven incentives, including that larger Manufacturer Payments are associated with preferred or exclusive formulary treatment and that percentage-based rebates and fees favor higher-list-price products over lower-priced alternatives.

348. Rebate Aggregator Defendants participated in the negotiation, receipt, processing, pooling, or allocation of Manufacturer Payments on behalf of their affiliated PBMs, while the material terms governing those payments—including their amount, characterization, disposition, and relationship to formulary placement—were not generally disclosed to Florida consumers.

349. The PBM Defendants did not separately disclose revenue derived from rebate-aggregator activities in their public SEC reporting, and the contractual

arrangements governing those activities were not generally available to Florida consumers.

350. Certain PBM Defendants created and used affiliated rebate aggregators as additional intermediaries in the negotiation, receipt, allocation, and transmission of Manufacturer Payments. Some of those entities were organized or located offshore, including Express Scripts affiliate Ascent Health in Switzerland and OptumRx affiliate Emisar Pharma Services in Ireland. The use of these affiliated intermediaries added layers between manufacturers, PBMs, and plan clients, making it more difficult to determine the amounts received, retained, allocated, or passed through in connection with formulary access and rebate arrangements.

G. Consumers Did Not Receive the Benefit of Manufacturer Payments

351. Because of the increased list prices, and related Manufacturer Payments, the PBMs' profit per prescription has grown exponentially during the relevant period. Between 2014 and 2018, the share of insulin expenditures retained by PBMs increased substantially. A 2021 study published in *JAMA Health Forum* estimated that, out of every \$100 in net insulin expenditures, the amount retained by PBMs increased from \$5.64 in 2014 to \$14.36 in 2018—an increase of approximately 155%.⁶⁴ Over the same period, the amount retained by pharmacies increased from \$6.21 to \$20.42. By 2018, PBMs, pharmacies, and wholesalers collectively accounted for 42.9% of insulin expenditures, compared with 16.5% in 2014.

352. For transactions in which the PBM Defendants control the PBM and the pharmacy (e.g., CVS Caremark-CVS pharmacy), the PBMs were capturing an approximately 35 cents of every dollar of net insulin expenditures (up from approximately 12 cents just four years earlier), even though they do not contribute to

⁶⁴ Karen Van Nuys et al., Estimation of the Share of Net Expenditures on Insulin Captured by US Manufacturers, Wholesalers, Pharmacy Benefit Managers, Pharmacies, and Health Plans From 2014 to 2018, 2 *JAMA Health Forum* e213409 (2021).

the development, manufacture, innovation, or production of the product.⁶⁵

353. Consumers did not receive the benefit of Manufacturer Payments at the pharmacy counter. Florida consumers subject to deductibles or percentage-based coinsurance remained responsible for all or a substantial portion of the prescription price at the point of sale, while rebates and other Manufacturer Payments were reconciled elsewhere in the payment chain and were not passed through to reduce the consumer's point-of-sale cost. As a result, those consumers paid cost sharing based on prices that did not reflect the rebates and other concessions ultimately received by PBMs and other intermediaries.

354. The Insulin Pricing Scheme also injured Florida consumers who purchase the at-issue medications without using insurance—including uninsured consumers, underinsured consumers, and insured consumers who elect to pay cash rather than run a claim through their plan (collectively, “consumers”). Consumers do not purchase through a PBM-administered benefit, are not subject to any formulary, and receive no rebate. But the price they pay is built on the same rebate-inflated list price that the challenged agreements produced. Each Manufacturer Defendant publishes a single WAC and AWP for each at-issue product; it does not publish one list price for claims adjudicated by a PBM and a lower list price for everyone else. When a Manufacturer Defendant raised the list price of an at-issue product to fund the larger rebates and fees that the PBM Defendants demanded as the price of formulary access, that increase applied to every unit sold in Florida, including units sold to consumers.⁶⁶

355. The retail price that pharmacies charge consumers is set by reference to those published benchmarks—typically WAC or AWP plus a markup or dispensing

⁶⁵ Van Nuys, *supra*.

⁶⁶ See *supra* ¶¶ 240–243 (formulary exclusion threats and Manufacturer Defendants' responsive rebate offers; David Ricks statement that formulary access “requires manufacturers to pay ever-increasing rebates and fees, which can place upward pressure on medicines' list prices”); ¶¶ 274–275 (Sanofi raised Lantus's list price to fund increased rebates demanded by the PBM Defendants).

fee.⁶⁷ The consumer therefore pays a price derived from the full, rebate-inflated list price with no offsetting rebate, discount, or price concession of any kind. Every other participant in the payment chain—the PBM, the plan sponsor, the wholesaler, and the pharmacy—transacts at or below list price, net of the Manufacturer Payments. The consumer is the only participant who pays gross. And because a cash purchase generates no rebate to any payor, the rebate premium embedded in the list price of a consumer’s insulin is simply retained. Where the dispensing pharmacy is owned by a PBM Defendant, as with CVS Caremark’s retail pharmacies, the PBM Defendant itself sets and collects that inflated cash price.⁶⁸

356. The challenged agreements harmed consumers in a second, independent way: they foreclosed the lower-list-price alternatives that consumers otherwise would have been able to buy. As alleged above, lower-list-price follow-on, authorized-generic, and biosimilar insulins—products priced to compete at the pharmacy counter rather than on rebate value—were excluded from the PBM Defendants’ formularies in favor of higher-list-price, higher-rebate equivalents.⁶⁹ Because the PBM Defendants control formulary access for the overwhelming majority of insured patients, exclusion deprived those lower-priced products of the prescription volume, pharmacy stocking, and prescriber familiarity needed to compete, and, as the Manufacturer Defendants’ own internal deliberations confirm, deterred the Manufacturers from reducing list prices at all.⁷⁰ A consumer cannot buy a lower-list-price insulin that is not stocked, is not prescribed, or was never launched. The competitive market that the challenged restraints foreclosed—one in which

⁶⁷ See *supra* ¶¶ 366–370 (Manufacturer Defendants published list prices to pharmacies, which used those prices to set the amounts charged to consumers).

⁶⁸ See *supra* ¶ 104 (CVS Caremark’s retail pharmacies set and collect the prices paid by consumers).

⁶⁹ See *supra* ¶¶ 245–247 (exclusion of lower-list-price authorized-generic and biosimilar insulins); see also *infra* ¶¶ 402–404 (exclusion of Insulin Lispro).

⁷⁰ See *supra* ¶¶ 320–325 (Novo Nordisk’s May 2018 pricing-committee deliberations and board decision not to reduce list price; June 2018 Eli Lilly and OptumRx communications regarding contractual barriers to list-price reductions).

Manufacturers competed for formulary access through lower list prices—would have lowered the pharmacy-counter price paid by every Florida consumer, insured or not.

357. Consumers are among the Floridians most severely harmed by the Insulin Pricing Scheme. Uninsured patients and patients in the deductible phase of their coverage have paid prices based on the full list price of insulin at the pharmacy counter, and cost-related rationing of insulin—with its attendant hospitalizations and deaths—has been concentrated among precisely these patients.⁷¹ Florida consumers in this position are the consumers on whom the rebate-inflated list price falls with its greatest force, because no rebate, formulary negotiation, or plan design stands between them and the published price.

358. The Centers for Medicare & Medicaid Services (“CMS”) recognized this consequence. CMS explained that when manufacturer rebates and other price concessions are not reflected in a drug’s point-of-sale price, beneficiaries may receive lower premiums but “do not benefit through a reduction in the amount they must pay in cost-sharing” and therefore bear a greater share of the drug’s actual cost.⁷²

359. CMS further observed that the resulting higher cost-sharing can impede access to necessary medications. When rebates and other price concessions are not reflected in the negotiated point-of-sale drug price, it “can impede beneficiary access to necessary medications, which leads to poorer health outcomes and higher medical care costs for beneficiaries”⁷³

⁷¹ See Staff of S. Comm. on Fin., 116th Cong., *Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug*, S. Prt. 116-51, at 13–14 (Comm. Print 2021) (finding that patients who are uninsured or in the deductible phase of their coverage pay prices based on the full list price of insulin at the pharmacy counter); Herkert et al., *supra* note 4; Bakkila et al., *supra* note 3.

⁷² Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program, 82 Fed. Reg. 56,336, 56,419–20 (Nov. 28, 2017) (proposed rule).

⁷³ *Id.*

360. The effect is particularly significant where higher-list-price products receive preferred formulary treatment over lower-list-price alternatives. Manufacturer rebates generally are paid or reconciled after the point of sale and are not necessarily applied to reduce the consumer's pharmacy-counter price. Accordingly, consumers whose deductibles, coinsurance, or other out-of-pocket obligations are calculated by reference to list price or related pricing benchmarks can pay more for a preferred higher-list-price product even where rebates reduce the manufacturer's net price or generate economic benefits elsewhere in the payment chain.

361. Thus, the challenged rebate and formulary arrangements generate substantial Manufacturer Payments and other financial benefits for Defendants while Florida consumers bear the burden of higher out-of-pocket costs and reduced access to lower-priced alternatives.

H. The Challenged Conduct Harmed Competition and Florida Consumers

362. At all times relevant, the Manufacturer Defendants knew that the rapidly increasing list prices of their insulin products did not reflect corresponding improvements in efficacy, manufacturing costs, or product innovation. But the Manufacturers made public statements concerning insulin and pharmaceutical pricing that defended the pricing of their products. They falsely attributed the increase in pricing to pharmaceutical innovation, research and development. When pressed on the widening gap between list and net prices, they failed to disclose that the increasing difference between list price and net price funded increased rebates and fees paid to the PBMs. Additionally, they failed to disclose that those increased rebate and fee payments were the price of preferred formulary placement and that list prices had been raised to fund them. This created the false impression that insulin prices reflected legitimate product costs when they did not.

363. At the same time, the Manufacturer Defendants' own pricing decisions and internal analyses reflected that insulin list-price increases were driven in substantial part by profitability objectives, competitors' pricing and rebate strategies,

and the need to fund increasingly large rebates and other financial concessions associated with formulary access. The Manufacturer Defendants therefore knew that the prices paid by consumers and payors were materially influenced by the rebate and formulary incentives rather than by corresponding increases in manufacturing costs or product innovation.

364. The Manufacturer Defendants knew that payors and consumers relied on the inflated list prices generated by the Insulin Pricing Scheme to pay for the at-issue drugs.

365. The Manufacturer and PBM Defendants also knew that payors and consumers expected to pay a price reflecting the lowest fair market value for these life-saving drugs.

366. Despite this knowledge, the Manufacturer Defendants published list prices generated by the Insulin Pricing Scheme throughout the United States and Florida through publishing compendia, in various promotional and marketing materials distributed by entities downstream in the drug supply chain, and directly to pharmacies, who then used these prices to set the amount that the pharmacies charged for the at-issue drugs.

367. The Manufacturer Defendants also published these prices to the PBMs, which used them as benchmarks in administering pharmacy benefits and calculating reimbursement and patient cost-sharing obligations for the at-issue drugs.

368. By publishing their prices in every U.S. state for use as pricing benchmarks, the Manufacturers represented that the prices were legitimate reference points for determining reimbursement and patient cost-sharing, even though those prices were artificially inflated by the rebate and formulary arrangements at issue.

369. These representations were false. The Manufacturer Defendants knew that their artificially inflated list prices were not remotely related to their cost, their fair market value in a competitive market, or the net price received for the at-issue drugs.

370. During the relevant period, the Manufacturer Defendants published

prices for at-issue drugs in every state within the U.S. that reached hundreds of dollars per vial, even though the Manufacturers could have sold those same products profitably at prices below \$10 per dose.

371. At the same time, the Manufacturer Defendants publicly represented that the prices of the at-issue drugs reflected, among other things, the product's value to the health care system and the need to fund research and innovation. For example, briefing materials prepared for Eli Lilly CEO Dave Ricks in connection with the 2017 Forbes Healthcare Summit included "Reactive Key Messages" on pricing that emphasized the significant research and development costs for insulin. During the relevant period, executives from Sanofi and Novo Nordisk likewise identified research and development costs as a justification for insulin price increases.

372. The Manufacturer Defendants knew that the substantial increases in insulin prices were driven in material part by rebate economics, formulary competition, competitive pricing strategies, and profitability objectives rather than corresponding increases in research-and-development or manufacturing costs.

373. Contrary to the Manufacturer Defendants' public emphasis on research and development as a justification for insulin pricing, internal documents reveal that the amount spent on research and development was a small fraction of the Manufacturers' revenue for their respective drugs. For example, Eli Lilly reported that it spent \$680 million on R&D costs related to Humalog globally, while earning \$31.35 billion in *net* sales during that same period—46 times more than reported R&D costs.⁷⁴

374. The PBM Defendants also treated certain at-issue insulin products as therapeutically interchangeable for formulary purposes and used rebate levels, access terms, and other economic concessions to determine which products received preferred formulary placement and which were excluded or disadvantaged.

⁷⁴ Letter from WilmerHale, on behalf of Eli Lilly, to Chairman Elijah E. Cummings, House Committee on Oversight and Reform (Feb. 22, 2019).

I. The PBM and Rebate Aggregator Defendants' Conduct is Unfair or Deceptive

375. Through the rebate and formulary agreements described here, the PBM Defendant —acting in concert with Rebate Aggregator Defendants—granted preferred or granted exclusive formulary placement to higher-list-price at-issue drugs in exchange for Manufacturer Payments. The PBM Defendants also used list-price-based benchmarks in certain reimbursement, cost-sharing, and fee arrangements, while their affiliated Rebate Aggregator Defendants negotiated, received, processed, and retained Manufacturer Payments associated with those arrangements. These practices distorted formulary competition by rewarding higher-list-price products, disadvantaging lower-priced alternatives, increasing costs and restricting access to lower-priced alternatives for Florida consumers.

376. The PBM Defendants and their affiliated Rebate Aggregator Defendants used rebate aggregation, pooling, and varied labels for Manufacturer Payments in connection with the challenged rebate and formulary arrangements. These practices obscured the net prices and financial incentives associated with the at-issue medications, making it difficult for Florida consumers to understand how Manufacturer Payments affected formulary placement, medication access, and out-of-pocket costs.

377. At all times relevant, the PBM Defendants publicly represented that their Manufacturer agreements and formulary-management decisions were designed to lower prescription-drug costs and promote patient access. At the same time, the PBM Defendants did not disclose material information concerning the extent to which their rebate and formulary arrangements were tied to Manufacturer Payments, including payments negotiated, received, processed, or retained through affiliated Rebate Aggregator Defendants, and the resulting incentives to prefer higher-list-price drugs. Representative public statements include:

- CVS Health has represented that its pharmacy-benefit business seeks to lower overall health-care costs and improve health outcomes. CVS Health has also described clinical review processes used in connection

with formulary development.

- The Cigna Group, through its Evernorth business, has represented that its pharmacy-benefit services are intended to manage prescription-drug costs and improve health outcomes.
- UnitedHealth Group, through Optum Rx, has represented that its pharmacy-benefit and formulary-management services are intended to help clients manage prescription-drug costs and improve access to medications.

378. In addition to these general misrepresentations, the PBM and Rebate Aggregator Defendants have purposefully, consistently, and routinely made misrepresentations about the at-issue diabetes medications. Representative examples include:

- In 2016, CVS Health introduced its Transform Diabetes Care program and represented that it would help PBM clients improve members' health outcomes while reducing costs. CVS stated that the program would "lower pharmacy costs through aggressive trend management and decrease medical costs" and that participating clients could save between \$3,000 and \$5,000 per year for each member who successfully improved control of diabetes.⁷⁵
- In 2016, Express Scripts represented that its Diabetes Care Value Program would "broaden insulin options for patients and bend down the cost curve of what is currently the costliest class of traditional prescription drugs." Express Scripts further stated that the program would help its clients and diabetes patients "prevail over cost and care challenges" associated with diabetes.⁷⁶
- In 2017, Express Scripts' CEO, discussing a program involving insulin, "disputed the idea that Express Scripts contributes to rising drug

⁷⁵ CVS Health, *CVS Health Introduces New "Transform Diabetes Care" Program to Improve Health Outcomes and Lower Overall Health Care Costs* (Dec. 13, 2016), <https://www.prnewswire.com/news-releases/cvs-health-introduces-new-transform-diabetes-care-program-to-improve-health-outcomes-and-lower-overall-health-care-costs-300377101.html> (last visited Sept. 22, 2026).

⁷⁶ Express Scripts, *Express Scripts Launches Diabetes Care Value Program, Guaranteeing More Affordable, Higher-Quality Diabetes Care* (Aug. 23, 2016), <https://www.prnewswire.com/news-releases/express-scripts-launches-diabetes-care-value-program-guaranteeing>

costs.”⁷⁷

- In 2016, Glen Stettin, Senior Vice President and Chief Innovation Officer at Express Scripts, said in an interview with a national publication that “[d]iabetes is wreaking havoc on patients, and it is also a runaway driver of costs for payors . . . [Express Scripts] helps our clients and diabetes patients prevail over cost and care challenges created by this terrible disease.”⁷⁸ Mr. Stettin also claimed that Express Scripts “broaden[s] insulin options for patients and bend[s] down the cost curve of what is currently the costliest class of traditional prescription drugs.”⁷⁹
- In 2016, Mark Merritt, then-President of PCMA, represented that “the PBMs he represents are continuing to leverage their formulary to obtain greater discounts while offering point-of-sale rebates to aid patients in high-deductible plans.”⁸⁰
- CVS Caremark’s Chief Policy and External Affairs Officer claimed in the April 2019 hearings that CVS Caremark “has taken a number of steps to address the impact of insulin price increases. We negotiate the best possible discounts off the manufacturers’ price on behalf of employers, unions, government programs, and beneficiaries that we serve.”⁸¹
- In April 2019, Dr. Sumit Dutta, SVP and Chief Medical Officer of

⁷⁷ Katie Thomas, *Express Scripts to Offer Cheaper Drugs for Uninsured Customers*, N.Y. TIMES, May 8, 2017, available at <https://www.nytimes.com/2017/05/08/health/express-scripts-drug-prescriptions-prices.html> (last visited Sept. 22, 2026).

⁷⁸ Angela Mueller, *Express Scripts Launches Program to Control Diabetes Costs*, ST. LOUIS BUS. J. (Aug. 31, 2016), <https://www.bizjournals.com/stlouis/news/2016/08/31/express-scripts-launches-program-to-control.html> (last visited Sept. 22, 2026).

⁷⁹ Express Scripts, PR NEWSWIRE, *Express scripts Launches Diabetes Care Value ProgramSM, Guaranteeing More Affordable, High-Quality Diabetes Care*, Aug. 31, 2016, <https://www.prnewswire.com/news-releases/express-scripts-launches-diabetes-care-value-program-guaranteeing-more-affordable-higher-quality-diabetes-care-300320485.html#:~:text=The%20new%20program%20%E2%80%93%20part%20of,a nticipated%20increase%20in%20diabetes%2Ddrug> (last visited Sept. 22, 2026).

⁸⁰ Dave Muoio, *Insulin Prices: Are PBMs and Insurers Doing Their Part?*, Population Health Learning Network (Dec. 2016), <https://www.hmpgloballearningnetwork.com/site/frmc/article/insulin-prices-are-pbms-and-insurers-doing-their-part> (last visited Sept. 22, 2026).

⁸¹ Priced Out of a Lifesaving Drug at lines 715–18.

OptumRx, testified before Congress that for “insulin products,” OptumRx “negotiate[s] with brand manufacturers to obtain significant discounts off list prices on behalf of our customers.”⁸²

- In 2020, PCMA represented that PBMs “work hard to drive down costs using formulary management and rebates,” while acknowledging that the insulin market is highly consolidated and that limited competition contributes to higher list prices for insulin.⁸³
- In 2022, Optum represented that it was working to improve access to affordable insulin and lower prescription-drug costs through its pharmacy-benefit capabilities, including by negotiating discounts and lower prices on behalf of its customers.
- In May 2023, after the relevant time period, OptumRX’s CEO, Heather Cianfrocco, told the U.S. Senate Committee on Health, Education, Labor, and Pensions that OptumRx “has been at the forefront of efforts to improve access to affordable insulin and provide comprehensive care to patients with diabetes.”⁸⁴

379. The PBM and Rebate Aggregator Defendants falsely represent that they negotiate with the Manufacturer Defendants to lower the price of the at-issue diabetes medications not only for payors, but also for diabetic patients. For example:

- Express Scripts’ code of conduct, effective beginning in 2015, states: “At Express Scripts we’re dedicated to keeping our promises to *patients and clients* . . . This commitment defines our culture, and all our collective efforts are focused on our mission to make the use of prescription drugs

⁸² *Id.* at lines 903-06.

⁸³ PCMA, *PCMA on National Diabetes Month: PBMs Lowering Insulin Costs, Providing Support to Patients* (Nov. 16, 2020), <https://www.pcmanet.org/pcma-on-national-diabetes-month-pbms-lowering-insulin-costs-providing-support-to-patients/> (last visited Sept. 22, 2026); Visante, *Insulins: Managing Costs with Increasing Manufacturer Prices* (2020), <https://capitol.texas.gov/tlodocs/86R/handouts/C3202020081100001/bf51aae3-bba5-4b3a-9870-9a0670c7fa1f.PDF>.

⁸⁴ Heather Cianfrocco Written Testimony, *The Need to Make Insulin Affordable for All Americans* (May 10, 2023), https://www.help.senate.gov/imo/media/doc/Cianfrocco%20Written%20Testimony%20HELP%20Committee%20_Final.pdf.

safer and more affordable.”⁸⁵

- Amy Bricker—former President of Express Scripts and PCMA board member—testified before Congress in April 2019: “At Express Scripts we negotiate lower drug prices with drug companies on behalf of our clients, *generating savings that are returned to patients* in the form of lower premiums and reduced out-of-pocket costs.”⁸⁶
- Ms. Bricker also testified that “Express Scripts remains committed to . . . *patients* with diabetes and creating affordable access to their medications.”⁸⁷
- In its 2017 Drug Report, CVS Caremark stated that the goal of its pharmacy benefit plans is to ensure “that the cost of a drug is aligned with the value it delivers in terms of *patient* outcomes . . . [I]n 2018, we are doing even more to help keep drugs affordable with our new Savings *Patients* Money initiative.”⁸⁸
- The PCMA website touts PBMs as “the only entity in the prescription drug supply and payment chain dedicated to reducing drug costs” and (contradicting the PBM representatives’ Congressional testimony), that “when new manufacturers enter the market at a lower list price, PBMs use the competition to drive costs down.”⁸⁹

380. The material information concerning the challenged rebate and formulary arrangements was not disclosed to Florida consumers, who could not reasonably evaluate the extent to which those arrangements affected their medication options and out-of-pocket costs.

381. Throughout the relevant period, Defendants have consistently and

⁸⁵ Express Scripts, *Code of Conduct*, <https://www.express-scripts.com/aboutus/codeconduct/ExpressScriptsCodeOfConduct.pdf> (last visited Sept. 22, 2026).

⁸⁶ Priced Out of a Lifesaving Drug at lines 803-06.

⁸⁷ *Id.* at lines 838-40.

⁸⁸ CVS Health, *2017 Drug Trend Report* (Apr. 5, 2018), https://docs.publicnow.com/viewDoc?filename=34267%5CEXT%5C4F636CE6CF7C500B75A272601FEB8D493D976064_E5A9CE50A379B6F1FF8B0CFD6DCB6BD22523324C.PDF, (last visited Sept. 22, 2026).

⁸⁹ PCMA, PBMs Reduce Insulin Costs: PBMs are working to improve the lives of patients living with diabetes and their families, <https://www.pcmanet.org/pbms-reduce-insulin-costs/> (last visited Sept. 22, 2026).

repeatedly represented that: (a) their interests are aligned with their payor clients; (b) they work to lower the price of the at-issue drugs and, in doing so, achieve substantial savings for consumers; and (c) that monies they receive from manufacturers and their formulary choices are for the benefit of payors and consumers.

382. Indeed, the PBM Defendants have promised to avoid conflicts of interest. For example, the PCMA has Principles of Professional and Ethical Conduct to which all PCMA members, including the three PBM Defendants, have agreed.⁹⁰ This code of ethics requires the PBM Defendants to “[a]void any and all conflicts of interest and advise all parties . . . of any situations where a conflict of interest exists.”⁹¹

383. Each PBM Defendant has published a code of conduct requiring its employees and affiliated entities to identify, disclose, and avoid or appropriately manage conflicts of interest.⁹² Those representations stand in tension with the PBM Defendants’ financial incentives under the challenged rebate and formulary arrangements. The PBM Defendants derived substantial revenues from Manufacturer Payments tied to formulary access while simultaneously representing to clients, payors, and consumers that they acted to reduce prescription-drug costs. Those conflicting financial incentives contributed to higher insulin prices and increased costs for Florida consumers.

384. The PBM Defendants understand that Florida consumers and plan sponsors rely on them to negotiate lower prescription-drug costs and to administer

⁹⁰ *Principles of Professional and Ethical Conduct*, PCMA, <https://www.pcma.org/about/principles-of-professional-and-ethical-conduct/> (last visited Sept. 22, 2026).

⁹¹ *Id.*

⁹² Code of Conduct, Express Scripts, <https://www.express-scripts.com/aboutus/codeconduct/ExpressScriptsCodeOfConduct.pdf> (last visited Sept. 22, 2026); Code of Conduct, CVS Caremark, https://media.corporate-ir.net/media_files/irol/99/99533/corpgov/codeofconduct03.pdf (last visited Sept. 22, 2026); Code of Conduct, UnitedHealth Group, https://www.optum.com/content/dam/optum3/professional-optumrx/resources/FWA_CoCs_2018.pdf (last visited Sept. 22, 2026).

formularies that determine access to the at-issue medications.

385. Throughout the relevant period, the PBM Defendants also falsely claimed they are transparent about the Manufacturer Payments and that the amounts are remitted (or not) to payors. In fact, the PBM Defendants' disclosures of their ties to the Manufacturer Defendants were vague, equivocal, and misleading.

386. OptumRx has publicly represented that a transparent PBM relationship is "open, honest, and straightforward," requiring disclosure concerning "performance, revenue, sourcing, pricing, and business values." OptumRx further represented that it provides clients "full transparency" regarding how formulary decisions are made and will "share the math" demonstrating the basis for those decisions.⁹³

387. In a 2017 CBS News interview, Express Scripts' CEO represented, among other things, that Express Scripts was "absolutely transparent" about the Manufacturer Payments they receive and that payors "know exactly how the dollars flow" with respect to these Manufacturer Payments.⁹⁴

388. During the relevant period, the PBM Defendants represented that they constructed formularies and negotiated with the Manufacturer Defendants for the benefit of payors and patients to maximize drug cost savings while promoting the health of diabetics.

389. The falsity of these representations is further reflected in the substantial price differentials associated with the challenged pricing and rebate structure. For example:

- a. In 2018, the United States spent \$28 billion on insulin compared with \$484 million in Canada. The average American insulin user spent \$3490

⁹³ Optum Rx, *Lowest Net Cost of Drugs and Your Bottom Line*, <https://www.optum.com/en/business/insights/pharmacy-care-services/page.hub5.strategies-lowest-net-cost-prescription-drugs.html> (last visited Sept. 22, 2026).

⁹⁴ CBS News, *Express Scripts CEO Tim Wentworth Defends Role of PBMs in Drug Prices* (Feb 7, 2017), <https://www.cbsnews.com/news/express-scripts-tim-wentworth-pbm-rising-drug-prices-mylan-epipen-heather-bresh/> (last visited Sept. 22, 2026).

on insulin in 2018 compared with \$725 among Canadian insulin users.⁹⁵

- b. Government purchasers operating outside the commercial PBM rebate structure also paid materially lower drug prices. In a 2020 report, the U.S. Government Accountability Office found that, for a sample of 399 prescription drugs, the Department of Veterans Affairs paid an average of 54% less per unit than Medicare Part D in 2017, even after accounting for rebates and other price concessions in Medicare Part D. GAO attributed the differential in part to structural differences in the programs, including the VA's centralized purchasing and unified formulary.⁹⁶

390. Defendants knew, or should have known, that these representations were false or misleading. Each Defendant failed to disclose material information concerning the rebate and formulary arrangements that affected the cost, availability, and placement of the at-issue medications for Florida consumers.

391. Defendants concealed the falsity of their representations by closely guarding their pricing negotiations, structures, agreements, sales figures, and the flow of money and other consideration between them.

392. Defendants have not publicly disclosed the full drug-specific amounts or material terms of the Manufacturer Payments exchanged in connection with the challenged rebate and formulary arrangements. As a result, Florida consumers could not determine the extent to which those payments affected formulary placement, access to competing products, or the amounts consumers paid for the at-issue medications.

393. The PBM Defendants did not disclose the material terms of the agreements they make with the Manufacturers, including the full amount and drug-specific allocation of Manufacturer Payments. Nor do they disclose the details related to their agreements (formal or otherwise) with pharmacies.

⁹⁵ Schneider, T., Gomes, T., Hayes, K. N., Suda, K. J., & Tadrous, M., Comparisons of Insulin Spending and Price Between Canada and the United States. *Mayo Clinic Proceedings*, 97(3), 573–78 (2022).

⁹⁶ U.S. Gov't Accountability Off., Prescription Drugs: Department of Veterans Affairs Paid About Half as Much as Medicare Part D for Selected Drugs in 2017, GAO-21-111 (Dec. 15, 2020) <https://www.gao.gov/products/gao-21-111>.

394. Although PBM Defendants negotiated rebates, fees, and other payments associated with particular drugs, Florida consumers were not provided a drug-by-drug accounting of those payments or the terms governing them. Any rebate information provided to plan sponsors was generally aggregated and did not allow consumers to determine the payments associated with a particular diabetes medication. As a result, consumers could not assess the financial incentives affecting formulary placement, restrictions on competing products, or their medication costs.

395. Florida consumers who require the at-issue diabetes medications must obtain them to manage serious medical conditions and often depend on formulary coverage to access those medications. The challenged rebate and formulary arrangements can directly increase out-of-pocket costs for uninsured consumers, consumers in deductible phases, and consumers subject to percentage-based coinsurance where those obligations are calculated by reference to list price or related pricing benchmarks. The same arrangements also reduced competition from lower-priced alternatives and diminished competitive pressure that otherwise could have resulted in lower net prices.

396. In sum, the entire Insulin Pricing Scheme created by the Defendants—from the artificially inflated prices to the Manufacturers’ misrepresentations related to the reasons behind the prices, to the inclusion of the artificially inflated prices in payor contracts, to the non-transparent Manufacturer Payments, to the misuse of formularies, to the PBMs’ representations that they work to lower prices and promote the health of diabetics—is both unconscionable, deceptive, and unfair and immensely lucrative for Defendants.

397. Florida consumers did not know, because the Defendants affirmatively concealed, (a) that the Manufacturers and PBMs agreed to create the PBM formularies in exchange for money and other consideration; (b) that the list prices were falsely inflated; (c) that the list prices were manipulated to satisfy PBM profit demands; (d) that the list prices and net costs (purchase prices) paid by Florida consumers bore no relationship to the fair market value of the drugs themselves or the services rendered by the PBMs in coordinating their pricing; or (e) that the entire

insulin pricing structure Defendants created was false.

J. Continuing Effects and Post-Period Conduct

398. In reaction to mounting political and public outcry, Defendants have taken steps on Capitol Hill and in the public relations space to protect and further the Insulin Pricing Scheme.

399. Throughout the relevant period, and notwithstanding the list-price reductions later announced, the rebate, formulary, exclusion, and contracting practices that produced the challenged effects did not cease. Lower-priced insulin products continued to face formulary exclusions and other access restrictions, demonstrating the continuing importance of PBM formulary decisions to commercially meaningful market access.

400. For example, in March 2019, Eli Lilly announced that it would introduce an authorized generic version of Humalog, Insulin Lispro, describing it as the same insulin molecule as Humalog but offered at half the list price and representing that the product would make insulin more affordable.⁹⁷

401. Despite its lower list price, Insulin Lispro did not receive equivalent formulary access. Express Scripts excluded the lower-priced product from its formulary while Humalog remained covered⁹⁸, illustrating how formulary incentives favored products associated with larger rebate opportunities over lower-list-price alternatives.

402. Lilly subsequently reduced the list price of Insulin Lispro by an additional 40%, effective January 1, 2022. Yet by January 2023, lower-priced insulin products continued to face exclusions or unfavorable formulary treatment by major PBMs.

⁹⁷ Eli Lilly and Co., Mar. 4, 2019, Press Release, *Lilly to Introduce Lower-Priced Insulin*, available at <https://investor.lilly.com/node/40881/pdf> (last viewed Sep. 27, 2026).

⁹⁸ See Adam Fein, *Express Scripts vs. CVS Health: Five Lessons from the 2020 Formulary Exclusions and Some Thoughts on Patient Impact*, Drug Channels (Jan. 2020), <https://www.drugchannels.net/2020/01/express-scripts-vs-cvs-health-five.html> (last visited Sept. 22, 2026).

403. In March 2023, after the relevant period, the Manufacturer Defendants announced substantial reductions in the list prices of certain insulin products and expanded or publicized affordability initiatives.⁹⁹ Those post-period changes do not eliminate the historical overpayments, competitive effects, or continuing consequences of the challenged rebate and formulary arrangements.

404. These developments, both during and after the relevant period, reinforce the continuing significance of the challenged rebate and formulary arrangements. Reductions in list prices for particular products did not eliminate the PBMs' ability to determine commercially meaningful access through formulary placement, exclusions, utilization-management requirements, and successor contracting arrangements.

405. The State therefore seeks prospective relief directed to continuing, renewed, or successor arrangements that reproduce the same anticompetitive incentives and effects.

V. TOLLING OF THE STATUTES OF LIMITATION

406. The State's claims are timely under the applicable accrual and tolling rules. Defendants concealed material facts concerning the challenged rebate, formulary, and payment arrangements and the resulting injuries, including facts uniquely within Defendants' possession. In addition, Defendants repeatedly renewed, implemented, and performed the challenged arrangements, giving rise to separately accruing claims for injuries caused by those acts.

A. Discovery Rule

407. The PBM and Manufacturer Defendants refused to disclose the actual prices of diabetes medications realized by Defendants or the details of Defendants' negotiations, agreements, and payments between each other or their pricing

⁹⁹ See Eli Lilly and Co., Lilly Cuts Insulin Prices by 70% and Caps Patient Insulin Out-of-Pocket Costs at \$35 Per Month (Mar. 1, 2023); Novo Nordisk, Novo Nordisk to Lower U.S. Prices of Several Pre-filled Insulin Pens and Vials Up to 75% (Mar. 14, 2023); Sanofi, Sanofi Cuts U.S. List Price of Lantus, Its Most-Prescribed Insulin, by 78% (Mar. 16, 2023).

structures and agreements—Defendants labeled these trade secrets, shrouded them in confidentiality agreements, and circumscribed payor audit rights to protect them.

408. Each Defendant group also affirmatively blamed the other for the price increases. All disavowed wrongdoing and falsely claimed that their dealings with consumers and payors were honest and transparent.

409. Plaintiff did not discover the Rebate Aggregators' roles earlier due to information asymmetry and Defendants' exclusive control over rebate and contracting data. Discovery and public disclosures through the FTC's investigation and complaint in or around 2024, have now confirmed that the PBM Defendants used these captive entities to centralize rebate flows, obscure true net prices, and insulate themselves from liability, while continuing to drive supracompetitive insulin prices.

410. Even today, lack of transparency in the pricing of diabetes medications and the arrangements, relationships, and agreements between and among the Manufacturer Defendants and the PBM Defendants, i.e., the Insulin Pricing Scheme, continue to obscure Defendants' unlawful conduct from Plaintiff and the public.

411. For these reasons, the applicable statutes of limitations did not begin to run until 2024, at the earliest.

B. Fraudulent Concealment

412. Through the acts, omissions, and misrepresentations alleged throughout this Complaint, Defendants fraudulently concealed the fact of Plaintiff's economic injury and its cause.

413. Defendants cannot rely on any statute-of-limitations defense because they purposefully concealed the Insulin Pricing Scheme, their generation of inflated list prices, and the fact that the prices for the at-issue diabetes medications were artificially inflated. The Defendants deliberately concealed their behavior and active role in the Insulin Pricing Scheme and other unlawful conduct.

414. Defendants' acts, omissions, and misrepresentations were calculated to—and did—lull and induce payors, including Plaintiff, into forgoing legal action or any inquiry that might lead to legal action. Defendants' acts, omissions, and representations were intended to and, in fact, did prevent Plaintiff from discovering

its claims.

415. Defendants knowingly and fraudulently concealed the facts alleged here. Defendants knew of the wrongful acts set forth above, had information pertinent to their discovery, and concealed them from the public. Because of Defendants' conduct, Plaintiff did not know, and could not have known through the exercise of reasonable diligence, of the existence or scope of the Insulin Pricing Scheme or of Plaintiff's causes of action.

416. Defendants continually and secretly engaged in the Insulin Pricing Scheme. Only Defendants and their agents knew or could have known about Defendants' unlawful actions because Defendants made deliberate efforts to conceal their conduct. Because of the above, Plaintiff could not obtain vital information bearing on its claims absent any fault or lack of diligence on its part.

417. Defendants affirmatively concealed: (a) that the Manufacturers and PBMs coordinated to create the PBM formularies in exchange for money and other consideration; (b) that the list prices were falsely inflated and manipulated; (c) that the list prices and net costs (purchase prices) paid by payors and patients bore no relationship to the fair market value of the drugs themselves or the services rendered by the PBMs in coordinating their pricing; (d) that the at-issue insulin drugs were selected for inclusion or preferred status on the formularies based on higher prices (and greater potential revenues for Defendants) rather than because of cost-effectiveness or because they were beneficial to payors' Beneficiaries; (e) the exchange of various payments and pricing agreements between the Manufacturers and PBMs; and (f) that the entire insulin pricing structure Defendants created was false.

418. The PBM Defendants, acting in concert with their recently-formed Rebate Aggregators, have blocked drug pricing transparency efforts.

419. Defendants concealed the Insulin Pricing Scheme through vague and manipulable definitions of terms in their contracts, including by hiding the fees that the Manufacturer Defendants paid to the PBM Defendants and which the PBM Defendants retained and did not pass along to payors as Rebates.

420. The PBM Defendants also concealed payments they received from the

Manufacturer Defendants through their affiliated Rebate Aggregators, hiding them in complex contractual relationships—often with other Defendants—and not reporting them on their quarterly SEC filings.

421. Plaintiff did not know, and could not reasonably have discovered, the full extent of agreements and payments between the Defendants because Defendants actively concealed these agreements and payments.

422. Defendants intended that their actions and omissions would be relied upon by the public, to include payors and patients. Plaintiff did not know, and did not have the means to know, the truth due to Defendants' actions and omissions.

423. Florida consumers reasonably relied on Defendants' affirmative statements that Defendants were working to lower insulin prices and provide payors with cost savings.

424. The purposes of the statute of limitations are satisfied because Defendants cannot claim any prejudice because of an alleged late filing where the Plaintiff filed suit promptly upon discovering the facts essential to its claims, described here, which Defendants knowingly concealed.

425. In light of the information set forth above, Defendants had actual or constructive knowledge that their conduct was deceptive, in that they consciously concealed the schemes set forth here.

426. Any applicable statutes of limitation therefore have been tolled.

C. Equitable Estoppel

427. Defendants were under a continuous duty to disclose to Plaintiff the true character, quality, and nature of the prices upon which payments for diabetes medications were based, and the true nature of the services being provided—all of which would be and are now material to Plaintiff.

428. Rather than disclosing these facts, Defendants knowingly misrepresented and concealed them with a reasonable expectation that Plaintiff would act upon the misrepresentations and omissions.

429. Being unaware of the true facts and the economic harm it was suffering, and having no cause to inquire further, Plaintiff did indeed rely in good faith to its

detriment on Defendants' misrepresentations and omissions.

430. In short, through Defendants' acts, omissions, and misrepresentations as alleged throughout this Complaint, Defendants knowingly misrepresented and concealed material facts with the expectation that Plaintiff would act upon them, which Plaintiff did in good faith and to its detriment.

431. Accordingly, Defendants are equitably estopped from relying on any statutes of limitations in defense of this action.

D. Continuing Violations and Separate Accrual

432. The challenged conduct also involved recurring and separately actionable acts. Under the Florida Antitrust Act, a cause of action accrues when a defendant commits an overt act that causes antitrust injury, and recurring overt acts that independently injure consumers give rise to separately accruing claims.

433. The challenged conduct did not consist solely of a single completed agreement or act outside the limitations period. During the relevant period, Defendants repeatedly renewed, implemented, and performed the challenged rebate and formulary arrangements through, among other things, new rebate bids, Manufacturer Payments, preferred or exclusive formulary placement, exclusion or disadvantage of competing products, patient-switching requirements, and sales and payments affected by those arrangements.

434. Each renewed agreement, rebate bid, payment, formulary implementation, exclusion, switching program, and other independently injurious implementation of the challenged restraints constituted an overt act that caused new injury to competition and Florida consumers. These recurring acts included, among other things:

- Negotiating and paying Manufacturer Payments tied to preferred or exclusive formulary treatment;
- Renewing or implementing formulary exclusions and restrictions affecting competing insulin and insulin-adjunct products;
- Maintaining preferred formulary treatment for higher-list-price products while disadvantaging lower-priced alternatives; and

- Implementing switching and other formulary-management programs pursuant to the challenged agreements.

435. Each such act constituted a new implementation or performance of the challenged restraints and caused additional injury to competition and Florida consumers.

436. Accordingly, even apart from any delayed-discovery, fraudulent-concealment, or equitable-estoppel doctrine, the State's claims are timely as to independently injurious acts occurring within the applicable limitations period and the damages caused by those acts. The State also seeks relief concerning continuing, renewed, and successor arrangements. To the extent earlier injuries are subject to a limitations defense, the State further relies on the fraudulent-concealment and equitable-estoppel allegations above.

VI. CLAIMS FOR RELIEF

COUNT I

Florida Deceptive and Unfair Trade Practices Act, Fla. Stat. §§ 501.201-501.213 (Against All Defendants—Insulin)

437. Plaintiff re-alleges and incorporates paragraphs 1 through 436 as if fully set forth here.

438. FDUTPA makes unlawful “[u]nfair methods of competition, unconscionable acts or practices, and unfair or deceptive acts or practices in the conduct of any trade or commerce.” Fla. Stat. § 501.204(1).

439. Defendants violated FDUTPA when they engaged in deceptive and unfair trade practices or acts when formulating and operating the Insulin Pricing Scheme described here.

440. Through the Insulin Pricing Scheme, Defendants negotiated generous rebates, discounts, and fees, while Manufacturer Defendants increased the list price for insulin products.

441. Defendants dominate the prescription-drug market and control the negotiation, processing, aggregation, and disposition of nearly all Manufacturer Payments associated with insulin sold in Florida.

442. Defendants employ a complex web of interdependent entities to confuse

and mislead consumers and payors regarding each Defendant's role in insulin pricing, while attempting to evade liability for the scheme as a whole and for the acts and omissions of the enterprise's coordinated participants.

443. At the same time, Defendants publicly represented that their pricing, purchasing, and formulary practices were intended to lower drug costs and improve patient access. But the challenged rebate and formulary arrangements created incentives that favored higher-list-price products and increased the economic significance of Manufacturer Payments. Those arrangements increased costs borne by Florida consumers and payors, including consumers whose deductibles, coinsurance, or other out-of-pocket obligations were tied to published drug-price benchmarks, and consumers who purchased the at-issue medications without insurance at pharmacy-counter prices derived from those same benchmarks.

444. Defendants misrepresented or omitted material information related to the nature and economic effect of the services and arrangements they purported to provide, including the financial incentives affecting formulary placement and drug costs. Defendants knew that the challenged arrangements increased costs borne by Florida consumers and payors while publicly representing that their practices promoted lower drug costs and improved patient access.

445. Defendants' misrepresentations and omissions were material because they concerned the economic incentives affecting formulary placement, patient access, and out-of-pocket costs. A reasonable consumer would consider it important to know that arrangements represented as reducing drug costs could create financial incentives favoring higher-list-price products and discourage competition through lower list prices.

446. Defendants' actions through the Insulin Pricing Scheme shock the conscience.

447. Defendants' actions, representations, and misrepresentations demonstrate callous disregard for not only the rule of law but also public health, safety, and well-being.

448. Defendants' coordinated conduct constitutes unfair methods of

competition and unfair acts and practices under FDUTPA because it caused substantial consumer injury, could not reasonably be avoided by consumers, and provided no countervailing benefits to consumers.

449. Further Defendants have willfully engaged in the acts and practices described above in that they knew or should have known that such acts and practices were unfair, deceptive, unconscionable, or otherwise prohibited by law.

450. Through the actions and related business practices as part of the Insulin Pricing Scheme, Defendants are committing acts or practices in trade or commerce that offend established public policy and are unethical, oppressive, unscrupulous, or substantially injurious to consumers.

451. As a direct and proximate result of Defendants' unfair and deceptive acts and practices, Florida consumers suffered actual damages, including paying artificially inflated prices for insulin.

452. Defendants have caused substantial economic injury to the public.

453. Thus, Defendants have engaged in unfair methods of competition, unfair or deceptive or unconscionable practices in the conduct of trade or commerce in violation of FDUTPA.

454. The unfair and deceptive acts and practices alleged here are ongoing, systematic, and affect the public interest.

COUNT II
Florida Deceptive and Unfair Trade Practices Act,
Fla. Stat. §§ 501.201-501.213
(Against All Defendants—Insulin Adjuncts)

455. Plaintiff re-alleges and incorporates paragraphs 1 through 436 as if fully set forth here.

456. FDUTPA makes unlawful “unfair methods of competition, unconscionable acts or practices, and unfair or deceptive acts or practices in the conduct of any trade or commerce.” Fla. Stat. § 501.204.

457. Defendants violated FDUTPA when they engaged in deceptive and unfair trade practices or acts when formulating and operating the Insulin Pricing Scheme described here.

458. Through the Insulin Pricing Scheme, Defendants negotiated generous rebates, discounts, and fees, while Manufacturer Defendants increased the list price for insulin adjunct products.

459. Defendants dominate the prescription-drug market and control the negotiation, processing, aggregation, and disposition of nearly all Manufacturer Payments associated with insulin adjuncts sold in Florida.

460. Defendants employ a complex web of interdependent entities to confuse and mislead consumers and payors regarding each Defendant's role in insulin adjunct pricing, while attempting to evade liability for the scheme as a whole and for the acts and omissions of the enterprise's coordinated participants.

461. At the same time, Defendants publicly represent that they work to lower drug prices and promote the health of diabetics. In reality, and directly contrary to those representations, Defendants knowingly drove up the prices of the insulin adjuncts and harmed Florida consumers and payors by demanding ever-increasing Manufacturer Payments that inflated retail prices and consumer cost-sharing.

462. Defendants misrepresented the nature, value, and purpose of the services they purported to provide, while reaping profits far in excess of the fair market value of those services; all with knowledge that their conduct increased insulin adjunct prices and harmed Florida consumers; and for the purpose of inducing reliance by Florida consumers and payors in connection with the purchase of insulin adjuncts.

463. Defendants barricaded competition for insulin adjuncts, like GLP-1s, through maintaining exclusive patents and regulatory exclusivities in the same way they did for insulin products initially.

464. Defendants entrenched their position with insulin adjuncts through negotiating rebates and other fees with the PBM Defendants by bundling insulin and insulin adjacent products.

465. Due to limited competition in the insulin adjunct landscape, Defendants use their disproportionate pricing power to inflate the price of insulin adjuncts, consistent with the broader Insulin Pricing Scheme.

466. PBM Defendants receive Manufacturer Payments that are negotiated, processed, pooled, or allocated through Rebate Aggregator Defendants. Because many of those payments are calculated by reference to list price, higher-list-price products can generate greater Manufacturer Payments. Consumers, however, do not necessarily receive the benefit of those payments at the point of sale, and patients whose cost-sharing obligations are tied to list price or related benchmarks may incur higher out-of-pocket costs when higher-list-price products receive preferred formulary treatment.

467. By representing that their formulary and rebate practices reduced drug costs and improved affordability, while omitting material information concerning Manufacturer Payments and the economic incentives influencing formulary placement, Defendants engaged in unfair or deceptive acts or practices within the meaning of Fla. Stat. § 501.204.

468. Defendants' misrepresentations and omissions were material because they concerned the economic incentives affecting formulary placement, patient access, and out-of-pocket costs. A reasonable consumer would consider it important to know that arrangements represented as reducing drug costs could create financial incentives favoring higher-list-price products and discourage competition through lower list prices.

469. Defendants' actions through the Insulin Pricing Scheme shock the conscience.

470. Defendants' actions, representations, and misrepresentations demonstrate callous disregard for not only the rule of law but also public health, safety, and well-being.

471. Defendants' coordinated conduct constitutes unfair methods of competition and unfair acts and practices under FDUTPA because it offended established public policy; was immoral, unethical, oppressive, unscrupulous, and substantially injurious to consumers; caused substantial economic injury to Florida consumers through inflated prices and increased out-of-pocket costs; could not reasonably be avoided by consumers dependent on formulary coverage and medically

necessary diabetes medications; and provided no countervailing benefits to consumers or competition.

472. Further Defendants have willfully engaged in the acts and practices described above in that they knew or should have known that such acts and practices were unfair, deceptive, unconscionable, or otherwise prohibited by law.

473. Through the actions and related business practices as part of the Insulin Pricing Scheme, Defendants are committing acts or practices in trade or commerce that offend established public policy and are unethical, oppressive, unscrupulous, or substantially injurious to consumers.

474. As a direct and proximate result of Defendants' unfair and deceptive acts and practices, Florida consumers suffered actual damages, including paying artificially inflated prices for insulin adjuncts.

475. Defendants' actions relating to the Insulin Pricing Scheme have caused substantial economic injury to the public.

476. The unfair and deceptive acts and practices alleged here are ongoing, systematic, and affect the public interest.

Count III
Violation of Florida Antitrust Act, Fla. Stat. §542.18.
(Against All Defendants)

477. Plaintiff re-alleges and incorporates paragraphs 1 through 436 as if fully set forth here.

478. The Florida Antitrust Act prohibits any contract, combination, or conspiracy in restraint of trade or commerce in Florida, Fla. Stat. § 542.18.

479. During the relevant period, Manufacturer Defendants and PBM Defendants entered into and implemented bilateral rebate and formulary agreements concerning the at-issue insulin and insulin-adjunct products. Those agreements conditioned substantial Manufacturer Payments on preferred or exclusive formulary access and other exclusionary terms. PBM Defendants acted in part through their affiliated Rebate Aggregator Defendants, which participated in negotiating, receiving, processing, pooling, allocating, or otherwise administering Manufacturer

Payments and the contractual arrangements through which those payments were tied to formulary access.

480. Through the challenged agreements, Manufacturer Defendants and PBM Defendants agreed to terms—including percentage-of-list-price payments, rebate guarantees, formulary tiers, exclusivity provisions, and restrictions on competing products—that rewarded higher prices for the at-issue insulin and insulin-adjunct products and disadvantaged lower-list-price alternatives.

481. The challenged agreements unreasonably restrained trade by suppressing price competition, foreclosing lower-cost insulin and insulin-adjunct products, distorting formulary competition, and preventing Florida consumers from benefiting from lower pricing and increased choice.

482. Because of these restraints, lower-list-price insulin and insulin-adjunct products were denied meaningful formulary access, insulin prices in Florida were higher than they would have been in a competitive market, and consumer choice was driven by exclusionary formulary terms and rebate incentives rather than price or value.

483. The relevant product markets for purposes of this Count include relevant markets for insulin products and insulin-adjunct products sold or reimbursed in Florida. Within those broader categories, distinct therapeutic classes or product categories constitute relevant submarkets where products outside the category are not reasonably interchangeable for particular patients, treatment regimens, or formulary purposes.

484. The challenged agreements affected competition in relevant product markets for the at-issue insulin products and, where applicable, relevant product markets for the at-issue insulin-adjunct products. These markets include products that compete for the same or substantially similar therapeutic use and formulary placement.

485. Entry and expansion in these markets are constrained by substantial regulatory, patent, manufacturing, clinical, and formulary-access barriers. Manufacturer Defendants possess substantial portfolio leverage through their control

of established insulin and insulin-adjunct products, while PBM Defendants exercise substantial control over commercially meaningful formulary access.

486. CVS Caremark, Express Scripts, and OptumRx collectively administer approximately 80% of prescription-drug claims nationwide. Their presence is also substantial in Florida, where the commercial PBM market is highly concentrated and each PBM Defendant serves a substantial number of covered lives.

487. Because the PBM Defendants determine formulary placement and reimbursement for a substantial share of covered lives in Florida, exclusion from their formularies deprives competing insulin and insulin-adjunct products of access to a substantial distribution channel and materially limits the alternatives available to Florida consumers.

488. Within these markets, Manufacturer Defendants competed for commercially meaningful formulary access through rebates, fees, price-protection payments, and other Manufacturer Payments. The challenged agreements conditioned that access on rebate economics and other exclusionary terms, thereby restricting competing products' access to—and otherwise disadvantaging them in competing for—the same patients and formulary placement.

489. Certain challenged agreements linked the rebate economics of multiple products or therapeutic classes. Through these bundled or portfolio arrangements, enhanced rebates on one product were conditioned on preferred or exclusive formulary treatment of another product, restrictions on competing products, or patient-switching requirements. These conditions enabled Manufacturer Defendants to use established product portfolios to obtain formulary access that was not based solely on the price or value of the individual insulin or insulin-adjunct product.

490. These bundled arrangements further distorted competition by restricting competing products' formulary access, conditioning insulin rebates on treatment of adjunct products, and reducing product-specific price competition.

491. Individual Manufacturer Defendants regularly communicated with particular PBM Defendants regarding rebate bids, formulary tiers, preferred or exclusive placement of their own insulin products, restrictions on competing

products, and programs designed to switch patients to the products favored under the parties' agreements. These communications and the resulting written agreements provide direct evidence of concerted action between the participating Manufacturer and PBM.

492. After Zinc, Ascent, and Emisar became operational, the Rebate Aggregator Defendants negotiated, processed, received, pooled, or allocated Manufacturer Payments under the challenged Manufacturer–PBM arrangements on behalf of their affiliated PBMs. Their participation facilitated the continued implementation and concealment of the agreements' rebate and formulary terms.

493. Although legitimate rebate negotiations may reduce net drug costs, the challenged exclusivity provisions, competitor exclusions, percentage-of-list-price compensation, and concealed payment arrangements were not reasonably necessary to achieve those benefits. Their anticompetitive effects—including foreclosure of lower-priced products, reduced formulary choice, and higher prices—substantially outweighed any asserted procompetitive benefits.

494. Ordinary price discounts that permit products to compete on price are not challenged. The challenged Manufacturer conduct consisted of agreeing to payments and other consideration conditioned on exclusive or preferred formulary placement, exclusion or disadvantage of competing products, patient switching, bundling, or preferential treatment of products carrying higher list prices. Those restraints were more restrictive than reasonably necessary to secure formulary access or reduce net prices.

495. The challenged agreements conditioned commercially meaningful formulary access on rebate economics and other exclusionary terms, thereby restricting or disadvantaging competing products seeking access to the same patients and formularies.

496. The anticompetitive effects resulted from the express terms and implementation of the challenged agreements. Those restraints were not reasonably necessary to achieve any legitimate procompetitive benefit because less restrictive alternatives were available, including nonexclusive formulary placement, rebates

based on net rather than list price, inclusion of lower-list-price equivalent products, and transparent fixed-fee compensation.

497. Defendants' challenged rebate and formulary agreements—including their renewal, implementation through new rebate bids, continued preferred or exclusive formulary placement, exclusion of competing products, and patient-switching programs—are ongoing and will likely continue and are likely to recur unless permanently restrained and enjoined.

498. Florida consumers were directly harmed by the challenged agreements because lower-list-price products were excluded or disadvantaged, competitive formulary bidding was distorted, and Florida consumers—insured and uninsured alike—paid more for insulin than they would have paid in a competitive market.

499. Florida consumers were further harmed by increased cost-sharing, restricted access to lower-priced insulin products, reduced formulary choice, and forced or incentivized switching to products selected because of their rebate value rather than their price or clinical value.

500. As a direct and proximate result of Defendants' anticompetitive conduct, lower-priced insulin and insulin-adjunct products in Florida were foreclosed from commercially meaningful formulary access, competition and consumer choice were diminished, and insulin prices in Florida were higher than they would have been absent the challenged restraints. Florida consumers therefore suffered injury of the type the antitrust laws were intended to prevent.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for entry of judgment against the Defendants for all the relief requested and to which the Plaintiff may otherwise be entitled, including:

- A. That the Court determine that Defendants have violated the Florida Deceptive and Unfair Trade Practices Act and the Florida Antitrust Act;
- B. Judgment in favor of Plaintiff and against the Defendants for damages in excess of the minimum jurisdictional requirements of this Court, in a specific amount to be proven at trial;

C. That Plaintiff be granted the following specific relief:

- i. Permanently enjoin the Defendants, their officers, agents, servants, employees, attorneys, and those persons in active concert or participation with them, who receive actual notice of the injunction, from engaging in the acts and practice in violation of the state laws set forth in this Complaint;
- ii. be awarded restitution, damages, disgorgement, penalties and/or all other legal and equitable monetary remedies available under the state laws set forth in this Complaint, and the general equitable powers of this Court in an amount according to proof;
- iii. be awarded civil penalties under §§ 501.2075, 501.2077 and 542.21 and treble damages under § 542.22 to the extent available to the State;
- iv. be awarded pre- and post-judgment interest as provided by law, and that such interest be awarded at the highest legal rate from and after the date of service;
- v. recover its costs of suit, including its reasonable attorney's fees, as provided by law; and
- vi. be awarded such other, further, and different relief as the case may require and the Court may deem just and proper under the circumstances.

JURY DEMAND

Plaintiff demands trial by jury on all issues so triable.

Dated: September 22, 2026.

Respectfully submitted,

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