# EXHIBIT E

**From:** Cartt, Steve
**To:** Mayer, Eldon
**Sent:** 3/15/2011 7:47:17 PM
**Subject:** FW: Workshop Prep
**Attachments:** QCOR - RDSS Workshop Draft Speakers Notes V 1.0 March 2011.docx

We can talk this through tonight sometime, but I thought I'd start off tomorrow morning by taking a moment to set the tone and point out the success as an organization that we are having in early 2011 (above forecast, etc.), but that to grow the business in a way that we know is possible given the quality of the team we have assembled that we need all cylinders firing – ie everyone performing to their full potential, and sooner rather than later. We know with certainty this is possible because we have done it before.

Then I am going to ask the group to just step back for a moment and realize what it is we are doing – go into Dan's points about the strategy initially being for a true orphan situation in IS, but later really catching fire in the MS area, where we are selling perhaps the most expensive drug in the industry at $5k a day in a non-orphan situation. This is very different, unheard of really before we did it, and it is successful because we have a very precise strategy that is critically dependent on generating the right kind of referrals, having the physicians and staff properly prepared for appropriate follow up, and tight coordination between sales and reimbursement team. We're here to go through case studies and best practices on this very precise strategy. If each of you comes away with only one good idea, tip or tactic to implement it will have been worth it, but I am guessing you will come away with more than that.

Then I will turn it over to you. Maybe you can, among other things, note that we have fine tuned our selling approach etc. over the last three years and have learned over this time what works and what doesn't, have seen people struggle and then find their footing and go on to generate good results (maybe use Hoffman as an example?). Note the importance to get dialed in on this now as best we can before we roll out into Neph with a $250k Rx situation.

Just my thoughts and I'm sure you have others as well....Steve

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**From:** Dan Desmarais [mailto:Dan.Desmarais@BioSolutia.com]
**Sent:** Monday, March 14, 2011 12:57 PM
**To:** Cartt, Steve; Mayer, Eldon
**Cc:** Camp, Jason
**Subject:** Workshop Prep

Steve & Eldon,
As promised week before last and mentioned to Steve earlier today, attached are suggested themes that we believe would be powerful coming from the two of you as opening remarks to create a sense of context and reinforcing the uniqueness of our Acthar strategy. Obviously feel free to edit/adjust as appropriate as well as split among you as you see fit. Talk to you shortly.
Best Regards,
Dan

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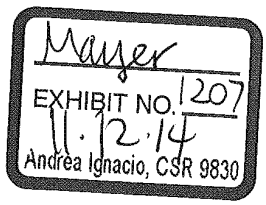

QUESTCOR

# Sales/RDSS WORKSHOP

## Wednesday March 16, 2011, Chicago

## Speakers' Notes

- Opening Remarks
  - Steve, Eldon (Suggested points/themes to touch upon)

  - We're doing well, MS sales steadily increasing

  - We're doing something truly unique in the pharma industry
    - Remember at NSM in Oct we mentioned QCOR # 1 in net margin in the pharma industry
    - We not only have one of the industry's most expensive, if not THE most expensive drugs, we have one of the industry's most unique situations within the highly expensive drug class, yet we're very successful to date based on our strategic approach and need to continually adjust that approach, that's why we're here today.
    - Typically very expensive drugs like Soliris for PNH (paroxysmal nocturnal hemoglobinuria) or Cinryze for HAE (hereditary angioedema), or Genzyme's enzyme replacement therapies are chronic treatments in the range of $ 250K to $ 400K per pt per year, or about $700 to $1,100 per treatment day)
    - Payer approval is usually pretty straight forward even though they're so expensive since basically, if the patient has the disease they're approved, and there are rarely any alternate treatments available, thus making them classic "orphan" diseases.
    - Acthar's initial focus on IS post-price increase fits that profile, however when you look more critically, our MS work is what is truly unique, challenging, and *hasn't been done before in the industry*, since it doesn't fit a classic "orphan" profile - we've just worked hard to have it treated that way.
    - MS exacerbations have several extremely less costly treatment options (eg PO, IV steroids) and are not considered a classic "orphan/rare disease" in that sense.
    - Payer approval is by no means automatic based on the clinical situation and treatment options, yet we have payer coverage levels that others would be jealous of and even with the current PA rates, our sales continue to grow nicely even though compared to the other high-cost

classic orphan drugs I mentioned earlier, we're at $ 5,000 per treatment day for MS.
- That success is a function of our unique approach and strategy, successfully executed by the people in this room and our colleagues.

- We took the bold step late last year and doubled our sales force, which is a significant undertaking considering the uniqueness of our approach with Acthar for MS.

- So far we've been on the "bleeding edge" in our approach and our success has been based on: 1) use of unique expertise in high cost drugs 2) our internal history of learning quickly and adjusting to marketplace issues and 3) sharing best practices as a team - *and that's why we're here today.*

- We'll go through some numbers a little later which show, overall as a team we've improved in several areas such as withdrawals, commercial shipped referrals, etc from Q4 to Q1. We'll also see that interestingly, some Regions are generating different results than others.

- We're here as a team today to spend some time discussing and understanding those differences, see where we can learn, and to specifically identify and expand things that we consider "Best Practices". A highly coordinated and unique approach has gotten us to this point, and we need to continue this as a team in order to continue our success.

- Short term vs long term implications.
  - In the short term, using Best Practices makes us more effective as a whole, increases our "yield" (ships vs referrals), and naturally increases sales and bonuses for everyone in the room.
  - We also need our short term strategy to coordinate nicely with our long term strategy, which for MS is to continue the judicious "care and feeding of the golden goose". In other words, to continue to derive maximum long term yield from our MS franchise. An MS referral that gets denied for reasons that "alarm" a payer is not only a short term loss of a sale but a potential long term negative impact on payer coverage for MS, which is delicate.
  - Looking ahead to Neph, if we can tighten our approach and consistency in MS, by identifying, sharing and using Best Practices as a group, we're in a much stronger position to make the migration to Neph when we decide to move more Sales activity in that direction.
  - We expect Neph to start with similar PA rates as MS (70 to 75%). However since there isn't much clear clinical information available about

treatment progression we expect payers may be inconsistent in how they review Acthar cases for Neph. A tightly organized approach internally, allows us to be better positioned and more nimble in making the inevitable adjustments we'll need to make to grow Neph successfully.