

SUPREME COURT STATE OF NEW YORK
COUNTY OF NEW YORK

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PEOPLE OF THE STATE OF NEW YORK BY
ERIC T. SCHNEIDERMAN, ATTORNEY GENERAL
OF THE STATE OF NEW YORK,

PLAINTIFF,

v.

GLAXOSMITHKLEIN, LLC.

DEFENDANT.
-----X

TO: THE ABOVE NAMED DEFENDANT:

SUMMONS

Index No. _____
IAS Part _____
Justice _____

Plaintiff designates New York
County as the Place of Trial

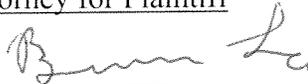
YOU ARE HEREBY SUMMONED to answer in this action and serve a copy of your answer, or if the complaint is not served with the summons to serve a notice of appearance, on the plaintiff's attorney within twenty (20) days after the service of the summons, exclusive of the day of service. If the summons is not personally served upon you, or if the summons is served upon you outside of the State of New York, then your answer or notice of appearance must be served within thirty (30) days. In case of your failure to appear or answer, judgment will be taken against you by default, for the relief demanded in the complaint.

Dated: New York, New York
June 4, 2014

Respectfully submitted,

ERIC T. SCHNEIDERMAN
Attorney General of the
State of New York
Attorney for Plaintiff

By:



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TO: THE SUPREME COURT OF THE STATE OF NEW YORK

Plaintiff, the People of the State of New York, by their attorney, Eric T. Schneiderman, Attorney General of the State of New York, alleges the following upon information and belief:

JURISDICTION & PARTIES

1. Plaintiff is the People of the State of New York, by Eric T. Schneiderman, Attorney General of the State of New York.
2. The Attorney General brings this complaint pursuant to Executive Law § 63(12) and General Business Law (“GBL”) §§ 349 and 350. Executive Law § 63(12) authorizes the Attorney General to seek injunctive relief, restitution, damages and costs when any person or business entity has engaged in or otherwise demonstrated repeated fraudulent or illegal acts in the transaction of business. GBL § 349 empowers the Attorney General to seek injunctive relief and restitution when any person or entity has engaged in deceptive acts or practices in the conduct of any business. GBL § 350 empowers the Attorney General to seek injunctive relief and restitution when any person or entity has engaged in false advertising. GBL § 350-d empowers the Attorney General to seek civil penalties in the amount of \$5,000 for each violation of GBL §§ 349 and 350.

3. Defendant GLAXOSMITHKLINE, LLC (“GSK”) is a Delaware corporation with its principal place of business at 5 Crescent Drive, Philadelphia, Pennsylvania 19112. GSK transacts business in New York and nationwide by manufacturing, marketing, promoting, selling and distributing prescription drugs including those known by the trade names Advair, Paxil and Wellbutrin.

FACTUAL ALLEGATIONS

4. Drug companies are prohibited by the Food Drug and Cosmetic Act of 1938, 21 USCA § 321 *et seq* (“FDCA”) from promoting drugs for indications (uses) that are not approved by the U.S. Food and Drug Administration (“FDA”). This practice is referred to as “off-label” marketing.

5. In order to obtain FDA approval to lawfully market a drug in the United States, a drug company must submit clinical trials that prove by substantial evidence that the drug is safe and effective for its intended use.

6. Federal and state laws allow physicians to prescribe FDA-approved drugs for conditions or diseases for which specific FDA approval has not been obtained when, through the exercise of independent professional judgment, the physician determines the drug in question is an appropriate treatment for an individual patient.

I. ADVAIR

A. The Basic Medicine of Asthma

7. The National Institute of Health (NIH) published consensus guidelines for the diagnosis and treatment of asthma, which categorize patients into those with mild, moderate, and severe asthma.

8. Patients with occasional symptoms are categorized as mild “intermittent.”

9. The NIH recommended treatment for mild intermittent asthma is a short-acting beta agonists (SABA), such as albuterol, on an as needed basis in response to symptoms.

10. Patients with regular asthma symptoms are categorized as persistent.

11. For persistent asthma, the NIH guidelines recommend using a “controller” in addition to a SABA.

12. For mild persistent asthma, the NIH Guidelines recommend an inhaled corticosteroid (ICS) used to treat inflammation in the airways as a “first line” treatment as a controller along with a SABA on an as needed basis as “rescue medicine” to open up airways during acute asthma attacks. In the asthma context, “first line” use refers to the first controller medication a patient is prescribed.

13. For moderate asthma, the NIH Guidelines recommend adding a second controller medication, such as a long-acting beta agonist (LABA), used to keep airways open and intended for chronic use, to the ICS along with as needed use of a SABA for acute episodes.

B. Advair’s Label

14. ADVAIR DISKUS® (Advair) is GSK’s trade name for an inhaled combination drug for treatment of a number of respiratory conditions, including asthma.

15. Advair is a combination of two other GSK drugs: Flovent® (fluticasone propionate), an ICS, and Serevent® (salmeterol xinafoate), a LABA.

16. Advair is sold in three strengths: Advair Diskus 100/50, Advair Diskus 250/50, and Advair Diskus 500/50.

17. On August 24, 2000, the FDA approved Advair for sale in the United States.

18. At the time of FDA approval in August 2000, Advair label’s Indications section stated that it was “indicated for the long term, twice-daily, and maintenance treatment of

asthma.” However, the Dosage and Administration section of the label provided that Advair was for “patients who are not currently on an inhaled corticosteroid, whose disease severity warrants treatment with 2 maintenance therapies”

19. In 2001, GSK submitted a supplemental New Drug Application (sNDA) for Advair that sought a broader first-line dosing instruction by providing additional clinical data and by removing “whose disease severity warrants treatment with 2 maintenance therapies” from the Dosage and Administration section of the label.

20. The FDA did not approve the sNDA and in 2002, GSK withdrew the application.

21. In early 2003, GSK halted a clinical trial relating to salmeterol (one of Advair’s component drugs).

22. In August 2003, the FDA required the addition of a black box warning to Advair’s label that stated “data from a large placebo-controlled US study that compared the safety of salmeterol (SEREVENT® Inhalation Aerosol) or placebo added to usual asthma therapy showed a small but significant increase in asthma-related deaths in patients”

23. In March 2006, the Indications section of the Advair label was modified to state that Advair was not indicated for patients with asthma controlled on ICS and SABAs alone. The Dosage and Administration section of the Advair label was also changed to state that “physicians should only prescribe ADVAIR DISKUS® for patients not adequately controlled on the other asthma-controller medications . . . or whose disease severity clearly warrants initiation of treatment with 2 maintenance therapies.”

24. In June 2010, the black box warning on the Advair label was revised to state that the currently available data were inadequate to determine if drugs like Advair provide a level

of control that mitigates the increased risk of death from LABA, and that LABA increases the risk of asthma-related hospitalization in pediatric and adolescent patients.

25. The revised black box warning also directs physicians to “step down” patients and discontinue Advair if possible after asthma control is achieved and maintained.

26. This black box revision also added “[d]o not use ADVAIR DISKUS® for patients whose asthma is adequately controlled on low or medium dose inhaled corticosteroids.”

C. GSK’S Marketing of Advair

27. From the time of Advair’s launch in 2000 until the 2010 label changes, GSK used false and misleading representations to promote Advair as a first line treatment for all asthma patients, including mild asthma patients who were not on ICS medication and only used SABAs intermittently.

28. GSK promoted Advair as a first line treatment for mild asthma patients by distributing information from clinical trials that had been determined by the FDA to be insufficient evidence for the first line treatment for mild asthma patients to health care professionals, without disclosing to health care professionals that the FDA rejected that evidence as insufficient.

29. Beginning in 2001, GSK sales representatives used sales aids such as the “Freedom Detail,” which consisted of a pamphlet using the slogan “Freedom to do More” expressing the idea that Advair could improve “symptoms that may interfere with normal daily activities.”

30. Accompanying these slogans were patient vignettes emphasizing that mild asthma patients were being overlooked and that their conditions could be ameliorated with Advair.

31. GSK also included “studies” by doctors including Dr. Anne Fuhlbrigge and Dr. William Calhoun suggesting the efficacy of Advair to treat cases of mild asthma.

32. Dr. Fuhlbrigge’s study was based on a telephone survey. Dr. Calhoun’s study concerned a clinical trial of moderate to severe asthma patients which speculated that mild asthma patients were being overlooked and should be prescribed Advair.

33. GSK also used purported “thought leaders” and “key opinion leaders” to promote the idea that moderate or even persistent asthma is often incorrectly diagnosed as mild intermittent asthma and that it was appropriate to treat such misdiagnosed patients with Advair. Such thought leaders advocating this position included Dr. David S. Pearlman and Dr. Robert Nathan.

34. GSK employed ghostwriters to author favorable journal articles concerning the use of Advair to treat mild asthma. Dr. William J. Calhoun published an article in the American Journal of Critical Care (Volume 164) that was ghostwritten by GSK employee Kim Poinsett-Holmes that implied that Advair was appropriate for treatment of mild persistent asthma.

35. GSK provided financial incentives to its sales representatives to promote Advair for mild asthma patients, which encouraged sales representatives to make false and misleading representations to health care professionals.

36. GSK promoted ADVAIR DISKUS 500/50 to treat Chronic Obstructive Pulmonary Disease (COPD), even though it was never approved by the FDA to treat COPD and there is no clinical data supporting its use to treat COPD.

37. GSK promoted Advair for use in pediatrics before Advair received a pediatric indication in April, 2004.

38. By concealing and misrepresenting information regarding the efficacy of Advair and by falsely promoting Advair for off-label purposes, Defendant engaged in false and misleading advertising in violation of GBL § 350, deceptive acts or practices in the conduct of its business in violation of GBL § 349, and repeated and persistent fraud and illegality in violation of New York Executive Law § 63(12).

39. The off-label promotion of Advair, misrepresentation of its efficacy and concealment of information concerning its ineffectiveness in treating certain conditions contributed dramatically to increased sales for the drug.

II. PAXIL

40. Paxil® is GSK's trade name for the drug paroxetine hydrochloride, which is one of a class of drugs known as selective serotonin reuptake inhibitors (SSRIs).

41. In 1992, the FDA approved Paxil to treat depression in adults, and it was subsequently approved for other uses in adults.

42. The FDA never approved Paxil for patients under the age of 18.

43. Nonetheless, between 1999 and 2003, GSK deceptively promoted Paxil as safe and effective for children and adolescents, despite lack of FDA approval and three GSK clinical trials that both failed to demonstrate Paxil's effectiveness in children and adolescents and raised concerns that Paxil may be associated with an increased risk of suicide in such patient population.

GSK's Studies Concerning the Safety and Efficacy of Paroxetine in Treating Children and Adolescents with Major Depressive Disorder (MDD)

44. GSK conducted three randomized, placebo-controlled, double-blind clinical studies to assess the safety and efficacy of paroxetine in treating children and adolescents diagnosed with MDD. These studies are referred to by GSK as studies 329, 377 and 701.

45. GSK has represented that studies 329, 377 and 701 were “well designed and appropriate to investigate whether paroxetine was efficacious in children and adolescents with MDD.” The FDA has also referred to them as “well-controlled trials.”

46. GSK’s studies did not demonstrate that paroxetine was efficacious in treating children and adolescents with MDD. In evaluating the effectiveness of paroxetine, GSK specified seven measures of efficacy, two of which it identified as “primary” endpoints and five as “secondary” endpoints. The efficacy of paroxetine was not measured as superior to placebo at a level of statistical significance on either of the primary measures. It was measured as superior to placebo on three of the five secondary ones, as well as on an endpoint that was added to the analysis.

47. Two of the three GSK placebo-controlled studies (377 and 701) failed to show that paroxetine was more effective than placebo or that there was any evidence of efficacy for treating MDD in children and adolescents.

48. Study 377 found that “[n]o clinically or statistically significant differences were detected between paroxetine and placebo in either of the [two] primary efficacy variables,” or on any of the secondary measures.

49. In study 701, placebo actually outperformed paroxetine on the primary efficacy measure and there were no statistically significant differences between paroxetine and placebo on any of the secondary measures.

50. Another placebo-controlled trial, study 329, presented a mixed picture of paroxetine's efficacy in treating MDD in a pediatric population. Before study 329 began, GSK specified seven measures of efficacy, two of which it identified as "primary" endpoints and five as "secondary" endpoints. The efficacy of paroxetine was not measured as superior to placebo at a level of statistical significance on either of the primary measures.

51. It was measured as superior to placebo on three of the five secondary ones, as well as on an endpoint that was added to the analysis. GSK's studies showed the possibility of a link between paroxetine and an increased risk of suicidal thoughts and acts in adolescents. Combined, studies 329, 377, and 701 showed that certain possibly suicide-related behaviors were approximately two times more likely in the paroxetine group than the placebo group.

52. Because its studies failed to demonstrate efficacy for paroxetine in treating MDD in children and adolescents and suggested a possible increased risk of suicidal thinking and acts for these youth, GSK sought to limit physicians' access to only the most favorable aspects of the data from these studies. To accomplish this, GSK embarked on a campaign both to suppress and conceal negative information concerning the drug and to misrepresent the data it did reveal concerning the drug's efficacy and safety.

53. An internal GSK document from 1998 concluded that, in light of the mixed efficacy outcomes from study 329 and the entirely negative results of study 377, GSK's "target" was "[t]o effectively manage the dissemination of these data in order to minimise any potential negative commercial impact."

54. As part of its campaign to "manage the dissemination of these data," the document recommended that GSK prepare and cause the publication of a full article on the only study with some favorable conclusions, study 329.

55. Thereafter, and in accordance with the recommended plan, an article that described and analyzed the results of study 329 was published in a professional journal. The authors of this article included two GSK employees who authored GSK's final clinical report for study 329.

56. Although it allowed the data from study 329 to be published, GSK concealed and suppressed studies 377 and 701, which failed to show that paroxetine was more effective than placebo in treating MDD in children and adolescents.

57. While information from study 377 was presented at a medical convention in 1999, neither study 377 nor study 701 has ever been published, and they remain unavailable to physicians, as are the results of the extension phase of study 329 and study 716. (Interim results from study 716 were presented at a medical conference in 2002.)

58. The data in studies 377 and 701, as well as the data from the extension phase of study 329 and study 716, are material to the risk-benefit balance and, therefore, to a physician's decision whether to prescribe paroxetine for a child or adolescent with MDD. This is especially true in light of the publication of study 329.

59. GSK has repeatedly misrepresented the safety and efficacy outcomes from its studies of paroxetine as a treatment for MDD in a pediatric population to its employees who promote paroxetine to physicians. These sales representatives are the GSK personnel who routinely have personal contact with the physicians who decide whether to write prescriptions for paroxetine.

60. In December 1999, Dr. Karen Wagner, one of the authors listed on the published article concerning study 329, spoke at a meeting of GSK Neuroscience consultants, at which she discussed study 329. She was quoted by an internal GSK newsletter as having said, "We can say

that paroxetine has both efficacy and safety data for treating depression in adolescents.”

Although study 377 had also been completed when this newsletter was distributed, its negative results were not mentioned.

61. GSK provides information concerning off-label uses of its drugs to physicians through its Medical Information Letters, but only when the physician makes an unsolicited request for the information.

62. As of November 2001, GSK had completed and approved the final clinical reports on studies 329, 377 and 701, and the extension phase of study 329. GSK issued Medical Information Letters in November 2001 and January 2003, both of which misrepresented the information concerning the safety and efficacy of paroxetine for treating MDD in children and adolescents as GSK knew it at the time. GSK enclosed the published article concerning study 329 with some of the Medical Information Letters.

63. Neither of these Medical Information Letters reported the four efficacy outcomes from study 329 that were not statistically significant.

64. GSK reported emotional lability data from its MDD paroxetine studies in only one of the two Medical Information Letters it sent to physicians during this period. Even when GSK reported the emotional lability information in one Letter, which was exclusively from study 329, it did so only for the paroxetine group. Without the comparative data from the placebo group, these data on possibly suicide-related thinking and acts lost much of their meaningfulness.

GSK's Disclosure of the Studies to Regulatory Agencies and its Admissions Concerning Efficacy and Safety

65. In 2002, as part of its application for FDA approval of paroxetine to treat OCD in children and adolescents, GSK submitted the final clinical reports for studies 329, 377 and 701, which assessed the safety and efficacy of paroxetine in the treatment of MDD in pediatric

patients. GSK subsequently provided these materials to the drug-regulatory agencies of other countries.

66. The studies raised issues for all the drug-regulatory agencies regarding the efficacy and safety of pediatric use of paroxetine for treating MDD.

67. On June 19, 2003, the FDA issued a Talk Paper, which stated that it was reviewing the data from studies of paroxetine use in children and adolescents with MDD to assess possible increased risk of suicidal thinking and attempts in this population. Noting the absence of evidence of efficacy, the FDA also stated that although the review of the safety data was not complete, “FDA is recommending that Paxil not be used in children and adolescents for the treatment of MDD.” In a second Talk Paper in October 2003, the FDA did not retract its finding that “*three* well-controlled” clinical trials of paroxetine did not establish its efficacy in treating MDD in the pediatric population, but it noted the scientific fact that the lack of evidence of efficacy in any “*particular*” study is not “*definitive*” evidence that the drug is not effective. (Emphasis added.) It also stated that the possibility of a link between paroxetine and an increased risk of suicidal thoughts and acts was under agency review and advised that paroxetine and other drugs in its class (Selective Serotonin Reuptake Inhibitors or “SSRIs”) be used with caution. The FDA strengthened its advice to use SSRIs with caution in a third FDA Talk Paper issued March 22, 2004.

68. On July 15, 2003, after discussions with Health Canada, the Canadian regulatory agency, GSK issued a public advisory “alerting patients, their parents or guardians, and healthcare professionals that until further information is available Paxil should not be given to pediatric patients (children and adolescents under 18 years of age), due to concerns of a possible increased risk of suicidal thinking, suicidal attempts or self-harm. Paxil must not be used in

pediatric patients with major depressive disorder, due to the additional fact that studies have failed to show that Paxil was effective in this patient population.”

69. On April 22, 2004, the Committee for Proprietary Medicinal Products of the EMEA announced that, following its review of scientific data, it was recommending to the European Commission that paroxetine not be prescribed for pediatric patients. Despite its 2003 admissions to regulatory agencies and to the public in the UK and Canada, and despite the agencies’ negative assessment of efficacy and articulated safety concerns about the use of paroxetine by children and adolescents with MDD, GSK continued in its medical information letters to misrepresent and conceal information in an ongoing effort to encourage physicians to prescribe paroxetine to these youngsters.

70. GSK took affirmative steps to conceal negative information about the use of paroxetine to treat MDD in children and adolescents from the American public. Unlike GSK’s June 10, 2003 press release in Britain, which disclosed that GSK had “seen a difference between [paroxetine] and placebo in terms of suicidal thinking or attempts [in its MDD studies], particularly in adolescents,” GSK’s June 19, 2003 American press release noted only that “there is no evidence that Paxil is associated with an increased risk of suicidal thinking or acts in adults” and that “not a single person [who participated in the pediatric paroxetine trials] committed suicide.” The American press release provided no safety or efficacy information material to treatment decisions for pediatric patients with MDD.

71. By concealing and misrepresenting information regarding the efficacy of Paxil and by falsely promoting Paxil for off-label purposes, Defendant engaged in false and misleading advertising in violation of GBL § 350, deceptive acts or practices in the conduct of its business in

violation of GBL § 349, and repeated and persistent fraud and illegality in violation of New York Executive Law § 63(12).

72. The off-label promotion of Paxil, misrepresentation of its efficacy and concealment of information concerning its risks and ineffectiveness in treating certain conditions contributed dramatically to increased sales for the drug.

III. WELLBUTRIN

73. Wellbutrin® is GSK's trade name for the drug bupropion hydrochloride, which is one of a class of drugs known as norepinephrine-dopamine reuptake inhibitors (NDRIs).

74. In 1985, the FDA approved Wellbutrin to treat major depressive disorder in adults.

75. Between 1999 and 2003, Wellbutrin was not approved for any use other than treating major depressive disorder in adults.

76. Despite this limited indication, between 1999 and 2003, GSK promoted Wellbutrin for various indications for which GSK had never submitted substantial evidence of safety and efficacy to the FDA, including weight loss and the treatment of obesity; treatment of sexual dysfunction; treatment of Attention Deficit Hyperactivity Disorder; treatment of addictions; treatment of anxiety; treatment of bipolar disorder; and treatment of patients under the age of 18.

77. GSK engaged in the off-label promotion of Wellbutrin by encouraging sales representatives to advocate the off-label uses of Wellbutrin to health care professionals directly; through speaker programs that promoted off-label; through continuing medical education programs; by paying health care professionals to attend lavish meetings in places like Jamaica and Bermuda where GSK provided off-label information about Wellbutrin; and by paying health

care professionals to be “consultants” on “advisory boards” where they were presented with information about off-label uses.

78. GSK developed a marketing campaign with the slogan “happy, horny, skinny drug” to promote Wellbutrin for off-label uses including to feel better, lose weight and improve sexual function.

79. GSK promoted “obesity trials,” study data, as well as the 2001 Gadde study all of which purportedly established Wellbutrin’s effectiveness for weight loss.

80. GSK also used Faxbacks (collection of off-label materials that doctors could order by calling a toll free number) discussing off label studies to provide scientific support for the promotion of Wellbutrin for weight loss and sexual dysfunction.

81. GSK used purported “national thought leaders” including Drs. Brendon Montano, Harry Croft, Kishore Gadde and James Hudziak as speakers and presenters to promote Wellbutrin to treat weight loss and sexual dysfunction.

82. GSK promoted the use of Wellbutrin for the off-label treatment of Attention Deficit Hyperactivity Disorder (ADHD) in adults and children through its speaker programs, sponsored lectures and the use of Faxbacks to provide purported substantiation for the use of Wellbutrin for ADHD.

83. GSK sales representatives also detailed pediatric specialists promoting the use of Wellbutrin for ADHD.

84. GSK also promoted the off-label use of Wellbutrin to treat anxiety disorder including panic attacks, obsessive compulsive disorder, post-traumatic stress disorder, generalized anxiety disorder and phobias including social phobia and agoraphobia.

85. By concealing and misrepresenting information regarding the efficacy of Wellbutrin and by falsely promoting Wellbutrin for off-label purposes, Defendant engaged in false and misleading advertising in violation of GBL § 350, deceptive acts or practices in the conduct of its business in violation of GBL § 349, and repeated and persistent fraud and illegality in violation of New York Executive Law § 63(12).

86. The off-label promotion of Wellbutrin, misrepresentation of its efficacy and concealment of information concerning its ineffectiveness in treating certain conditions contributed dramatically to increased sales for the drug.

FIRST CAUSE OF ACTION
VIOLATION OF GENERAL BUSINESS LAW § 350

87. Plaintiff repeats, re-alleges, and incorporates paragraphs one through eighty- six contained herein.

88. GBL § 350 prohibits “[f]alse advertising in the conduct of any business, trade or commerce or in the furnishing of any service in [New York].”

89. GBL § 350-a further provides that “false advertising” is advertising that is “misleading in a material respect.”

90. By engaging in the advertising alleged above, Defendant has engaged in false advertising in violation of GBL § 350.

SECOND CAUSE OF ACTION
VIOLATION OF GENERAL BUSINESS LAW § 349

91. Plaintiff repeats, re-alleges, and incorporates paragraphs one through eighty-six contained herein.

92. GBL § 349 declares unlawful “[d]eceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service in [New York].”

93. By engaging in the acts and practices alleged above, Defendant has engaged in deceptive and misleading practices in violation of GBL § 349.

THIRD CAUSE OF ACTION
VIOLATION OF EXECUTIVE LAW § 63(12) (FRAUD)

94. Plaintiff repeats, re-alleges, and incorporates paragraphs one through eighty-six contained herein.

95. Executive Law § 63(12) authorizes the Attorney General to seek injunctive relief whenever any person engages in repeated fraudulent or illegal conduct or otherwise demonstrates persistent fraud or illegality in the carrying on, conducting, or transaction of business.

96. By the acts and practices alleged above, Defendant has engaged in repeated and persistent fraudulent and illegal conduct in violation of Executive Law § 63(12).

WHEREFORE, Plaintiff requests that this Court issue an Order and Judgment pursuant to Executive Law § 63(12) and GBL §§ 349, 350 and 350-d:

(a) permanently enjoining Defendant from engaging in the fraudulent, deceptive and illegal conduct alleged in the Complaint;

(b) directing Defendant to pay restitution and damages to injured consumers, known and unknown;

(c) directing Defendant to disgorge all profits illegally obtained in order to effectuate a just result, and make payment of such amounts to the State of New York;

(d) directing Defendant to pay a civil penalty to the State of New York pursuant to GBL § 350-d in the sum of five thousand dollars (\$5,000) for each violation of GBL § 349 and GBL § 350;

(e) directing Defendant to pay to Plaintiff the costs of this proceeding, including the sum of two thousand dollars (\$2,000) to cover additional costs pursuant to CPLR § 8303(a)(6); and

(f) granting Plaintiff such other and further relief as the Court deems just and proper.

Dated: New York, NY
June 4, 2014

Respectfully submitted,

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