IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

JAZZ PHARMACEUTICALS, INC.,	)	
	)	
Plaintiff,	)	
	)	
v.	)	C.A. No. 21-691 (GBW)
	)	
AVADEL CNS PHARMACEUTICALS LLC,	)	**PUBLIC VERSION**
	)	
Defendant.	)	

JAZZ'S RESPONSE TO AVADEL'S MOTION TO EXPEDITE CONSIDERATION OF ITS RENEWED MOTION FOR PARTIAL JUDGMENT ON THE PLEADINGS

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Plaintiff Jazz Pharmaceuticals, Inc. ("Jazz") submits this response to Defendant Avadel CNS Pharmaceuticals, LLC's ("Avadel") motion to expedite consideration of Avadel's renewed motion for partial judgment on the pleadings regarding Avadel's counterclaim seeking an order to delist U.S. Patent No. 8,731,963 (the "'963 patent") from the Orange Book.

I. INTRODUCTION & BACKGROUND

Avadel seeks to burden this Court and to prejudice Jazz by rushing to adjudicate its Rule 12(c) motion before this Court decides claim construction and before consideration of Avadel's motion for a preliminary injunction in its related lawsuit against the FDA, which has a hearing tentatively set for September 30, 2022. In so doing, Avadel seeks to deprive this Court (and Jazz) of the context necessary to fully and fairly adjudicate Avadel's Rule 12(c) motion.

This is one of three coordinated Hatch-Waxman and declaratory judgment patent-infringement actions in which Jazz has accused the product described in Avadel's 505(b)(2) New Drug Application ("NDA")—which relies on efficacy and safety studies for Jazz's branded Xyrem® (sodium oxybate) drug product—of infringing seven of Jazz's patents. Avadel's motion concerns only one of those patents, the '963 patent. The '963 patent claims methods of safely distributing sodium oxybate to treat narcolepsy patients while avoiding abuse, misuse, and diversion of that drug. These methods cover conditions of using Xyrem® according to its FDA-approved labeling, including the Risk Evaluation and Mitigation Strategy ("REMS") developed by Jazz.

As explained in previous briefing, the '963 patent is properly listed in the Orange Book, and Avadel's arguments to the contrary lack merit. *See* D.I. 132 at 46-49, 57-62; D.I. 153 at 9-18; D.I. 155-1 at 1-4. In fact, over Avadel's objections, the FDA required that Avadel submit a patent certification for the '963 patent that results in a statutorily-mandated 30-month stay of FDA approval of Avadel's 505(b)(2) NDA while the parties litigate. The FDA decision thus puts Avadel

in the ***same position as every other 505(b)(2) NDA or Abbreviated New Drug Application ("ANDA") filer*** that chooses to piggyback on the work of an innovator pharmaceutical company[1]—Avadel must abide by the statute that sets aside time to resolve patent disputes. Expediting just a portion of the case based solely on Avadel's inability to gain final approval during the pendency of the 30-month stay would set a dangerous precedent for Hatch-Waxman litigation.

Here, because Avadel took a commercial gamble—divesting every revenue-generating product in its portfolio and focusing exclusively on one product in development, FT-218 (what Avadel refers to as "LUMRYZ")—Avadel now demands that it be treated differently than everyone else. Avadel has thus: (1) sued the FDA in the District of Columbia, seeking an expedited ruling that FDA's requirement that Avadel certify to the '963 patent violated the Administrative Procedure Act (*see Avadel CNS Pharmaceuticals, LLC v. Becerra, et al.*, C. A. No. 22-2159, D.I. 1 (D.D.C.)); and (2) consistently demanded that this Court expeditiously resolve whichever issues Avadel unilaterally deems to be time sensitive at a particular moment, when in fact they are not (*see* D.I. 26, 88, 119, 150).

But no matter the outcome of Avadel's suit against the FDA and Avadel's motion for partial judgment on the pleadings in this case, Avadel still cannot lawfully market FT-218. Jazz has seven patents-in-suit that Avadel would infringe and that must be adjudicated on their merits on an appropriately-developed record. Additionally, the FDA has not determined whether Orphan Drug Exclusivity ("ODE") that the FDA granted to Jazz's product precludes approval of Avadel's 505(b)(2) NDA until 2027—it currently does. *See* Ex. 1 at 1 n.1.

[1] This includes the nine generic manufacturers that filed ANDAs referencing Xyrem®, each of which filed a Paragraph IV certification related to Jazz's '963 patent, and each of which was subject to the same 30-month stay as Avadel.

In short, while Jazz is eager to enforce its patent portfolio, Jazz understands that these cases against Avadel are only three among nearly 400 cases that were just assigned to this Court's docket, and Jazz would like the issues in this case to be decided in context and on an appropriately-developed record—not just the single issue that Avadel wants expedited. Jazz respectfully submits that a proper context for Avadel's motion includes, at the very least: (1) a status conference with the Court to introduce Your Honor to these matters; (2) resolution of the parties' claim-construction disputes following a claim-construction hearing, as Judge Noreika had planned[2]; and (3) consideration of Avadel's preliminary injunction motion against the FDA, which has a hearing tentatively set for September 30, 2022. Each of these events will provide context and additional information that goes to the merits of Avadel's delisting counterclaim, upon which its Rule 12(c) motion is based. For example, if Avadel is successful in its suit against the FDA, then Jazz would have an additional standing argument against the delisting counterclaim (and, in turn, Avadel's Rule 12(c) motion). As such, judicial efficiency and the interest of justice require a more measured approach than Avadel demands.

II. ARGUMENT

A. Avadel Does Not Substantiate Any Harm to Justify Expedited Proceedings

In its motion, Avadel accuses Jazz of "resist[ing] the prompt resolution of Avadel's fully briefed 12(c) Motion," claiming that "Jazz knows that justice delayed is justice denied," and accusing Jazz of "gamesmanship." (Mot. at 1, 8.) This is not correct, nor are Avadel's characterizations of the parties' meet and confer. Rather, when the parties discussed Avadel's intended motion to expedite, Jazz asked for the factual and legal bases for Avadel's request and

[2] Judge Noreika denied Avadel's first motion to delist the '963 patent because, among other reasons, it raised issues of claim construction. *See* D.I. 55.

how Avadel could possibly meet the high standard for expediting this particular issue when the Court had just inherited hundreds of cases, many with important pending issues. Avadel gave Jazz different responses to those questions than it gave to the Court in its motion.

With respect to the purported factual basis for expedition, Avadel told Jazz that it was considering filing a declaration with its motion to substantiate the purported "harm" to Avadel in the absence of expedition. Jazz responded that it would consider seeking limited discovery to test the veracity of any assertions by Avadel's declarant, which of course is common practice in this District, but Avadel would not agree to any such discovery. Ultimately, Avadel's as-filed motion did not attach any declaration, but it nonetheless accuses Jazz of seeking discovery "[a]s yet another delay tactic" while failing to inform the Court that Jazz made the request in connection with a paper Avadel chose not to file. Ignoring its own conduct, Avadel accuses Jazz of "gamesmanship."

As for the legal basis for Avadel's extraordinary request, on the meet and confer Avadel stated that it would rely on Federal Rule of Civil Procedure 1, and precedent from this District expediting decisions of pending motions. Avadel does rely on Rule 1, but nothing in that Rule states or suggests that the Court needs to give Avadel's Rule 12(c) motion preference over any of the other matters, especially here where there are other outstanding issues that will impact Avadel's motion. And the "authority" Avadel cites and attaches as exhibits to its motion is inapposite because, among other things, each was in the context of preliminary injunction proceedings, and none support the proposition that a Court should expedite deciding a partial Rule 12(c) motion. *See* Mot. at Exs. B-C (granting expedited consideration of a motion to strike three weeks prior to a preliminary injunction hearing after receiving over 2,000 pages in new declarations and exhibits), *id.* at Exs. D-E (order on a motion for a TRO and preliminary injunction after defendants arranged

to have plaintiff's "products taken down from Amazon.com …during the busiest shopping season of the year"), *id.* at Exs. F-G (again in a preliminary injunction context with no expedition ordered and the expedition motion ultimately denied six months later as "moot" (C.A. No. 21-27-LPS, D.I. 96)).

Expedited resolution requires "a sufficiently colorable claim and a sufficient possibility of a threatened irreparable injury to justify the extra costs." *TQ Delta, LLC, v. Zyxel Communic'ns, Inc.*, No. 13-2013, 2018 WL 2932728, at *5 n.13 (D. Del. Jun. 12, 2018). The word "irreparable" appears nowhere in Avadel's motion to expedite and, at bottom, the only "harm" that Avadel cites is its inability to get on to the market prior to the expiration of the '963 patent in June 2023. (*See* Mot. at 1.) As noted above, however, the '963 patent is not the sole roadblock that Avadel attempts to make it seem, and Avadel has presented no evidence that it will be able to commence sale of its product if it prevails on its Rule 12(c) motion. Regardless, the mere potential of lost sales does not establish irreparable harm, and Avadel has not demonstrated otherwise. *See Abbott Cardiovascular Sys. v. Edwards Lifesciences Corp.*, No. 19-149, 2019 WL 2521305 at *19 (D. Del. June 6, 2019). In fact, if potential lost sales provided a basis for expedited action, then every Hatch-Waxman defendant would be entitled to such relief.

In addition, Avadel's claims of harm are devoid of any factual support, in the form a company declaration or otherwise. Jazz submits that the reason why that evidence is lacking is clear: Avadel recently told its investors in a public disclosure that (unlike its sealed motion to this Court) Avadel has a "cash runway [that] extends to at least the middle of 2023" (Ex. 2 at 6), and has recently secured authority to issue and sell additional shares of its stock to raise more capital if needed. *See* https://www.sec.gov/Archives/edgar/data/1012477/000110465922096576/tm2224869d1_s3.htm. If Avadel submitted a sworn statement of alleged commercial

harm, it would be directly contrary to what it has told its shareholders and the market and could lead to securities class action claims in addition to those already under investigation. *See, e.g.*, https://www.prnewswire.com/news-releases/shareholder-alert-pomerantz-law-firm-investigates-claims-on-behalf-of-investors-of-avadel-pharmaceuticals-plc---avdl-301564559.html.

Moreover, Avadel neglects to inform the Court that any alleged commercial harm would be entirely of its own making. Avadel once had several revenue-generating products (Ex. 3 at 1), but from 2018-2020, Avadel decided to divest all of those products and to become "singularly focused on supporting the regulatory approval process, market planning and maximizing shareholder value for FT218." Ex. 4. It is, of course, not Jazz's fault that Avadel's strategic commercial risk did not bear fruit.

And although Avadel claims that the FDA required it to submit a patent certification regarding Jazz's '963 patent "[i]n turn" following Jazz's filing of suit (Mot. at 3), that is not an accurate description of what happened. Rather, Jazz hastened these proceedings by filing suit ***long before*** Avadel submitted its patent certification. The reason for the unorthodox order of events in this Hatch-Waxman suit is Avadel's unorthodox and now-unsuccessful regulatory strategy: When Avadel initially filed its 505(b)(2) NDA with the FDA in December 2020, it refused to file ***any*** patent certification with respect to the Orange Book-listed '963 patent. Avadel refused to do so despite having submitted a 505(b)(2) NDA relying on the clinical studies that Jazz conducted and submitted to the FDA for its Xyrem® product. *See, e.g.*, D.I. 1, Ex. F at 13. A 505(b)(2) NDA sponsor is permitted to "rely on clinical studies that were previously submitted to [the] FDA in support of another drug and that were not conducted or licensed by the 505(b)(2) [sponsor]." *Veloxis Pharms., Inc. v. U.S. Food & Drug Admin.*, 109 F. Supp. 3d 104, 108-09 (D.D.C. 2015) (alteration in original). To that end, the 505(b)(2) NDA pathway is "often used when the new drug

differs only slightly from the pioneer [or reference listed] drug." *Id.* Avadel could (and should) have filed a patent certification for the '963 patent at least as early as December 2020 when it submitted its 505(b)(2) NDA, and has only itself to blame for not doing so. Despite this, Avadel now seeks to burden the Court and to prejudice Jazz by demanding "expedited consideration" of its delisting counterclaim. (Mot. at 2.) Again, Avadel's alleged predicament is entirely of its own making, especially considering that it chose to pursue an unsuccessful regulatory strategy at the FDA (i.e., ignoring the '963 patent altogether), and because a 30-month stay on ***potential*** approval of its 505(b)(2) NDA[3] is now in place until June 2023 (about 9 months from now).

B. Other Pending Issues Will Impact Avadel's Motion

As Avadel appears to acknowledge, claim construction proceedings are necessary prior to addressing its delisting motion. (Avadel at 5.) Indeed, Judge Noreika denied Avadel's first attempt to delist the '963 patent via a Rule 12(c) motion because, among other reasons, Avadel's "arguments depend in no small part on claim construction," and the Court "decline[d] to engage in claim construction at this early stage of the case." D.I. 55 at 5-6. Jazz respectfully proposes that, after the Court holds a hearing and renders its opinion on claim construction, Avadel's Rule 12(c) motion can be decided in context.[4]

Avadel also mentions in passing that it has brought a separate suit against the FDA seeking to challenge FDA's decision that Avadel must file a patent certification for the '963 patent. (Avadel at 3 n. 3.) *See Avadel CNS Pharmaceuticals, LLC v. Becerra, et al.*, C. A. No. 22-2159,

[3] Avadel's tentative approval letter states that it "does not address whether any orphan drug exclusivity (ODE) recognized for Xyrem . . . or for Xywav . . . affects the approvability of Avadel's application." Ex. 1 at 1 n.1. ODE would prevent approval of Avadel's NDA until 2027.

[4] Claim construction in this case concerns issues beyond the '963 patent. Specifically, the parties dispute six claim terms that are spread across the seven patents-in-suit. *See* D.I. 145.

D.I. 1 (D.D.C.). There, Avadel has taken positions regarding the scope of the '963 patent's claims, whether the '963 patent is appropriately listed in the Orange Book, the scope of the listing code for that patent, and how Avadel's accused product compares to that information. *See id.* at D.I. 2. The D.C. Court has tentatively scheduled a hearing for September 30, 2022. Arguments in that case, and whether the D.C. Court grants Avadel's requested relief, could have significant impact on this case, including with respect to Avadel's delisting counterclaim and Jazz's defenses thereto.

III. CONCLUSION

For the reasons set forth herein, Avadel has failed to establish that expedited proceedings are required or justified. Jazz looks forward to discussing the issues in this case at the Court's convenience.

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September 13, 2022

EXHIBIT 1

U.S. FOOD & DRUG ADMINISTRATION

NDA 214755

TENTATIVE APPROVAL

Avadel CNS Pharmaceuticals, LLC
Attention: Marla E. Scarola
Vice President, Regulatory Program Management
The Weinberg Group
1129 Twentieth St, NW, Suite 600
Washington, DC 20036

Dear Ms. Scarola:

Please refer to your new drug application (NDA) dated December 15, 2020, received December 15, 2020, and your amendments, submitted pursuant to section 505(b)(2) of the Federal Food, Drug, and Cosmetic Act (FD&C Act) for Lumryz (sodium oxybate) extended-release oral suspension.

This NDA provides for the use of Lumryz (sodium oxybate) extended-release oral suspension for the treatment of cataplexy or excessive daytime sleepiness (EDS) in adults with narcolepsy.

We have completed our review of this application, as amended. It is tentatively approved under 21 CFR 314.105 for use as recommended in the agreed-upon enclosed labeling (text for the Prescribing Information, Instructions for Use, and Medication Guide) and submitted labeling (cartons submitted November 15, 2021, and container labeling submitted November 4, 2021). This determination is based upon information available to the Agency at this time (i.e., information in your application and the status of current good manufacturing practices (cGMPs) of the facilities used in the manufacture and testing of the drug product). This determination is subject to change on the basis of any new information that may come to our attention.

A listed drug(s) upon which your application relies is subject to a period of patent protection and your application contains a certification(s) to one or more patents under section 505(b)(2)(A)(iv) of the FD&C Act stating that the patent(s) is/are invalid, unenforceable, or will not be infringed by your manufacture, use, or sale of, this drug product under this application ("paragraph IV certification").[1]

Section 505(c)(3)(C) of the FD&C Act provides that approval of a new drug application submitted pursuant to section 505(b)(2) of the FD&C Act that includes a paragraph IV

[1] This letter does not address whether any orphan drug exclusivity (ODE) recognized for Xyrem under NDA 021196 or for Xywav (calcium, magnesium, potassium, and sodium oxybates) oral solution under NDA 212690 affects the approvability of Avadel's application.

certification shall be made effective immediately, unless an action is brought for infringement of one or more of the patents that were the subject of a paragraph IV certification and for which patent information was submitted to FDA before the date on which you submitted your 505(b)(2) application. You notified us that you complied with the requirements of section 505(b)(3) of the FD&C Act.[2] However, the 45-day period described in section 505(c)(3)(C) of the FD&C Act has not yet expired, and your application is only eligible for a tentative approval at this time. If such a patent infringement action is brought prior to the expiration of 45 days from the later of the date the notice provided under section 505(b)(3) is received by the patent owner or approved application holder, your application would be subject to a 30-month stay of approval, unless other conditions are met.

To obtain final approval of this application, submit an amendment two or six months prior to the: (1) expiration of the patent(s) or (2) date you believe that your NDA will be eligible for final approval, as appropriate. In your cover letter, clearly identify your amendment as **"REQUEST FOR FINAL APPROVAL"**. This amendment should provide the legal/regulatory basis for your request for final approval and should include a copy of any relevant court order or judgment settlement, or licensing agreement, as appropriate. In addition to a safety update, the amendment should also identify changes, if any, in the conditions under which your product was tentatively approved, i.e., updated labeling; chemistry, manufacturing, and controls data; and risk evaluation and mitigation strategy (REMS). If there are no changes, clearly state so in your cover letter. Any changes require our review before final approval and the goal date for our review will be set accordingly.

Until we issue a final approval letter, this NDA is not approved.

The drug product may not be legally marketed until you have been notified in writing that this application is approved.

RISK EVALUATION AND MITIGATION STRATEGY REQUIREMENTS

Section 505-1 of the FD&C Act authorizes FDA to require the submission of a risk evaluation and mitigation strategy (REMS), if FDA determines that such a strategy is necessary to ensure that the benefits of the drug outweigh the risks.

In accordance with section 505-1 of FD&C Act, we have determined that a REMS is necessary for Lumryz (sodium oxybate) to ensure the benefits of the drug outweigh the risks of serious adverse outcomes resulting from inappropriate prescribing, misuse, abuse, and diversion.

Your proposed REMS must also include the following:

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[2] See NDA 214755, Notice of Paragraph IV Certification Amendment (Module 1.2) (June 7, 2022). In this correspondence, Avadel also states "[w]ith this amendment, Avadel requests tentative approval for the LUMRYZ NDA pursuant to 21 C.F.R. § 314.105(a)."

Elements to assure safe use: Pursuant to 505-1(f)(1), we have determined that Lumryz (sodium oxybate) can be approved only if elements necessary to assure safe use are required as part of the REMS to mitigate the risks of serious adverse outcomes resulting from inappropriate prescribing, misuse, abuse, and diversion[3] listed in the labeling of the drug.

Your REMS includes the following elements to mitigate these risks:

- Healthcare providers that prescribe the drug have particular experience or training, or are specially certified
- Pharmacies, practitioners, or health care settings that dispense the drug are specially certified
- The drug is dispensed to patients with evidence or other documentation of safe-use conditions

Implementation System: The REMS must include an implementation system to monitor, evaluate, and work to improve the implementation of the elements to assure safe use (outlined above) that require: pharmacies, practitioners, or health care settings that dispense the drug be specially certified and the drug be dispensed to patients with documentation of safe use conditions.

Your proposed REMS, submitted on December 15, 2020, as amended is appended to this letter.

The REMS consists of elements to assure safe use, an implementation system, and a timetable for submission of assessments of the REMS.

- Upon final approval, your REMS must be fully operational before you introduce Lumryz (sodium oxybate) into interstate commerce.
- The REMS assessment plan must include, but is not limited to, the following:

Program Implementation and Operations

1. **REMS Program Implementation (1st assessment after approval)**

    a. REMS Program implementation date

[3] The goal of mitigating diversion in this REMS refers to preventing the sale or transfer of the drug outside the framework of the REMS in order to mitigate the risks of central nervous system depression, respiratory depression, abuse, and misuse.

b. Date of first commercial distribution of Lumryz (sodium oxybate)

c. Date when the Lumryz REMS call center became operational

d. Date when the Lumryz REMS website became live and operational

e. Date(s) when the Dear Healthcare Provider Letter and Dear Professional Society Letter were provided

i. Number of letters sent by method of distribution (mail/email)

ii. Number of letters returned/undeliverable and number of unopened emails for each mailing

2. **REMS Enrollment Statistics (per previous two reporting periods, current reporting period, and cumulatively)**

a. Patients

i. Number and percentage of newly enrolled patients stratified by age, geographic region (defined by US Census), and gender

ii. Number and percentage of active patients enrolled (patients who received at least one shipment of Lumryz (sodium oxybate) during the current reporting period) stratified by age, geographic region (defined by US Census), and gender

iii. Number and percentage of patients who have discontinued Lumryz (sodium oxybate) after receiving at least one shipment of Lumryz (sodium oxybate). Include demographics of discontinued patients and reasons for discontinuation

b. Healthcare Providers

i. Number and percentage of newly certified healthcare providers stratified by professional designation (i.e., MD, DO, PA, NP, Other), medical specialty, and geographic region (defined by US Census)

ii. Number and percentage of active certified healthcare providers (healthcare providers who have written at least one prescription for Lumryz (sodium oxybate) during the reporting period) stratified by professional designation (i.e., MD, DO, PA, NP, Other), medical specialty, and geographic region (defined by US Census)

iii. Number of active patients (patients who received at least one shipment of Lumryz (sodium oxybate) during the reporting period) by current enrolled prescriber

c. Certified Pharmacies

i. Number of newly certified pharmacies and total certified pharmacies

ii. Number of active pharmacies (e.g., dispensed one or more Lumryz (sodium oxybate) prescriptions)

3. Utilization Data (per previous two reporting periods, current reporting period, and cumulatively)

a. Number of shipments, including number of nightly dose packets, shipped by wholesalers, distributors, and other entities to pharmacies

b. Number and percentage of Lumryz (sodium oxybate) prescriptions (new and refill) dispensed by pharmacies to patients

c. Number and percentage of Lumryz (sodium oxybate) packets and shipments sent by pharmacies to patients stratified by dose strength

4. REMS Program Operation and Performance Data (per previous two reporting periods, current reporting period, and cumulatively)

a. REMS Program Databases Report

i. Number and percentage of contacts by stakeholder type (e.g., patients, healthcare providers, pharmacy, other)

ii. Summary of reasons for contacts (e.g., enrollment questions) by reporter (authorized representative, patient, healthcare provider, other)

iii. Summary of frequently asked questions by stakeholder type and topic

iv. Summary of any REMS-related problems identified and a description of any corrective actions taken

v. If the summary reason for the calls indicates a complaint, provide details on the nature of the complaint(s) and whether they indicate potential REMS burden (e.g., pharmacy calls to other REMS for oxybate products) or patient access issues (e.g., patient's therapy

delayed due to unwillingness of other REMS for oxybate products to provide necessary information)

vi. Summary of program or system problems and a description of any corrective actions taken

5. REMS Program Compliance (per previous two reporting periods, current reporting period, and cumulatively)

a. Audits: Summary of audit activities including but not limited to:

i. A copy of the audit plan for certified pharmacies and wholesalers, distributors, and other entities that distribute Lumryz (sodium oxybate)

ii. The number of audits expected, and the number of audits performed

iii. The number and type of deficiencies noted

iv. For those with deficiencies noted, report the status of corrective and preventative action (CAPA) proposed to address the deficiencies, including completion dates

v. For any that did not complete the CAPA within the timeframe specified in the audit plan, describe actions taken

vi. Provide details on deviations for the CAPA proposed, including timelines, and mitigating steps to address the deviations

vii. Confirm documentation of completion of training for relevant staff

viii. Review of cumulative findings to identify any trends of potential repeat issues, and steps to be taken to address these findings

ix. A summary report of the processes and procedures that are implemented to be in compliance with the REMS requirements

b. A summary report of noncompliance, associated corrective and preventive actions (CAPA) plans, and the status of CAPA plans including but not limited to:

i. A copy of the Noncompliance Plan which addresses the criteria for noncompliance for each stakeholder, actions taken to address noncompliance for each event, and under what circumstances a

stakeholder would be suspended or decertified/disenrolled from the REMS

ii. The number of instances of noncompliance accompanied by a description of each instance and the reason for the occurrence (if provided). For each instance of noncompliance, report the following information:

1. The unique ID(s) of the stakeholder(s) associated with the noncompliance event to enable tracking over time
2. The source of the noncompliance data
3. The results of root cause analysis
4. What action(s) were taken in response

c. Healthcare Providers

i. Number and percentage of certified prescribers who were decertified and reasons for decertification. Include if any prescribers were re-certified

ii. Number and percentage of Lumryz (sodium oxybate) prescriptions filled from a prescriber who was not certified

d. Certified Pharmacies

i. Number and percentage of Lumryz (sodium oxybate) prescriptions dispensed for more than a 30 days' supply (first fill) or more than a 90 days' supply (refills) and reasons

ii. Number and percentage of Lumryz (sodium oxybate) shipments lost in delivery (and unrecovered) with number of DEA 106 Forms and *Risk Management Reports* completed

iii. Number and percentage of initial Lumryz (sodium oxybate) shipments sent to patients without completion of the Lumryz (sodium oxybate) REMS Patient Counseling Checklist

iv. Number and percentage of pharmacy decertifications and reasons for decertification. Include if any pharmacies were re-certified

e. Patients

i. Number and percentage of patients who were disenrolled from the program and reasons for disenrollment

ii. Number and percentage of patients who received prescriptions from more than one prescriber during their therapy

iii. Number and percentage of patients prescribed a daily dose of Lumryz (sodium oxybate) of >9 g

iv. Number and percentage of patients with overlapping Lumryz (sodium oxybate) prescriptions (more than one active prescription shipped)

v. Number of duplicate patients detected by certified pharmacies

vi. Number and percentage of duplicate patients who were shipped Lumryz (sodium oxybate) under more than one name or identifier

vii. Number and percentage of patients who were shipped Lumryz (sodium oxybate) after being disenrolled

viii. Number of patients found to have active, overlapping prescriptions for Lumryz (sodium oxybate) and any other oxybate product (e.g., Xywav, Xyrem, or generic Sodium Oxybate)

ix. Number and percentage of patients who requested an early refill of Lumryz (sodium oxybate) and reason for the request

1. Number and percentage of requests approved

2. Number and percentage of requests denied by the prescriber

3. Number and percentage of requests denied by the certified pharmacy

4. Number and percentage of patients with multiple (more than 1) requests for early refills

Safe Use Behaviors

6. Pharmacy Notifications (per previous two reporting periods, current reporting period, and cumulatively)

a. A summary of the notifications by pharmacies to prescribers for Lumryz (sodium oxybate). Each of the following situations will include the number and percentage of notifications, number of unique patients, the outcome of the pharmacy notification (e.g., counseled patient, discussed with prescriber) and outcome of Lumryz (sodium oxybate) prescription disposition (e.g., prescriber approved shipment, prescriber requested shipment hold, prescriber denied shipment, pharmacy approved shipment):

   i. Use with sedative-hypnotics indicated for sleep (e.g., eszopiclone, zaleplon, zolpidem, temazepam, suvorexant, quazepam, estazolam, flurazepam, triazolam, tasimelteon, ramelteon). Indicate specific actions taken by the prescriber and the prescriber rationale for continuing treatment in response to the notification including the following:

      1. Treatment with Lumryz (sodium oxybate) will discontinue
      2. Sedative hypnotic will be discontinued
      3. Dosage of sedative hypnotic has been/will be reduced
      4. Information unavailable
      5. No action (continue sedative hypnotic with Lumryz (sodium oxybate))
      6. Prescriber's rationale for continued use of sedative hypnotic with Lumryz (sodium oxybate)

         - Sedative hypnotic will not be taken at the same time as Lumryz (sodium oxybate)
         - Sedative hypnotic will be taken at the same time as Lumryz (sodium oxybate)
         - Sedative hypnotic will be taken as a sleep aid
         - Sedative hypnotic will be taken for different indication per medical need
         - Lumryz (sodium oxybate) dose regimen changed
         - No rationale provided

   ii. Benzodiazepines (e.g., diazepam, alprazolam or any not listed in metric 6.a.i.). Indicate specific actions taken by the prescriber and the prescriber rationale for continuing treatment in response to the notification including the following:

      1. Treatment with Lumryz (sodium oxybate) will discontinue
      2. Benzodiazepine will be discontinued

3. Dosage of benzodiazepine has been/will be reduced
4. Information unavailable
5. No action (continue benzodiazepine with Lumryz (sodium oxybate))
6. Prescriber's rationale for continued use of benzodiazepine with Lumryz (sodium oxybate)
   - Benzodiazepine will not be taken at the same time as Lumryz (sodium oxybate)
   - Benzodiazepine will be taken at the same time as Lumryz (sodium oxybate)
   - Benzodiazepine will be taken as a sleep aid
   - Benzodiazepine will be taken for different indication per medical need
   - Lumryz (sodium oxybate) dose regimen changed
   - No rationale provided

iii. Use with other concomitant CNS-depressant medications (sedating antidepressants or antipsychotics, sedating anti-epileptics, sedating antihistamines, general anesthetics, muscle relaxants, opioid analgesics, or illicit CNS depressants)

iv. Patient report of alcohol use

v. Patient report of diagnosis of sleep apnea

vi. Patient report of diagnosis of asthma, COPD, or other conditions affecting breathing

vii. Suspected abuse, misuse, or diversion

viii. Alerts regarding potential abuse, misuse, or diversion on the patient profiles

ix. Prescription error

x. Early refill requests

7. *Risk Management Reports (RMRs)* (per previous two reporting periods, current reporting period, and cumulatively)

a. Number and percentage of *RMRs* submitted

b. Number and percentage of unique patients with an *RMR*

c. Number and percentage of unique patients with multiple *RMRs*

d. Number and percentage of alerts generated from *RMRs*

e. Number and percentage of *RMRs* generated from early refill requests

f. Number and percentage of *RMRs* generated for other reasons, stratified by reasons

g. Number and percentage of prescriber-related *RMRs*

h. Number and percentage of *RMRs* that included reporting of an adverse event.

8. REMS Program *Patient Counseling Checklist* (per previous two reporting periods, current reporting period, and cumulatively)

a. Summary table from REMS Program *Patient Counseling Checklists* of the number and percentage of patients taking the following concomitant medications and who subsequently received at least one shipment of drug:

i. Sedative hypnotics indicated for sleep (e.g., eszopiclone, zaleplon, zolpidem, temazepam, suvorexant, quazepam, estazolam, flurazepam, triazolam, tasimelteon, ramelteon)

ii. Alcohol

iii. Other potentially interacting agents:

1. Benzodiazepines (e.g., diazepam, alprazolam, or any not listed in metric 8.a.i.)

2. Sedating antidepressants or antipsychotics, sedating anti-epileptics, and sedating antihistamines

3. General anesthetics

4. Muscle relaxants

5. Opioid analgesics

6. Illicit CNS depressants (e.g., heroin or gamma-hydroxybutyrate [GHB])

b. Summary table for Lumryz (sodium oxybate) from REMS Program *Patient Counseling Checklists* of the number and percentage of patients who have

been diagnosed with the following conditions and who subsequently received at least one shipment of drug:

i. Sleep apnea

ii. Asthma, COPD, or other conditions affecting the respiratory system

9. Verification of Disenrollment or Active Prescriptions in Other Oxybate REMS

a. Information on patients with active, overlapping prescription or disenrollment or deactivation for misuse, abuse, etc., in other Oxybate REMS and outcomes

i. For unsuccessful attempts or those that resulted in a treatment delay indicate the REMS program contacted

ii. Number and dates of unsuccessful contact attempts to other REMS, including hold times per contact attempt

iii. For contacts resulting in a delay, the total number of contact attempts, and time from receipt of prescription to successful contact with other Oxybate REMS

iv. The number of prescriptions delayed or unable to be filled divided by the number of valid prescriptions received

v. Reason not dispensed (e.g., active prescription in other REMS, other Oxybate REMS unresponsive, patient disenrolled or discontinued due to abuse, misuse or diversion)

vi. Reports of any negative outcomes due to any treatment delay

vii. Number of prescriptions dispensed without verification of current overlapping prescription or disenrollment from other Oxybate REMS

Health Outcomes and/or Surrogates of Health Outcomes

10. Pharmacovigilance/surveillance (per reporting period)

a. Summary table for Lumryz (sodium oxybate) of the number of reports of serious adverse events, including the following data fields (CIOMS II line listings): date, report ID, report type, notifier, age, gender, start and stop date, dose, frequency, onset date, system organ class, outcome, and causality. Tables will include an overall narrative summary of the adverse events and data fields reported.

i. All cases of death

1. Number, percentage, and type of *RMRs*, notifications, and alerts within 6 months of the reported deaths

ii. All outcomes of death, emergency department visits (when admitted to hospital), or hospitalizations resulting from or associated with the following:

1. Use with concurrent sedative hypnotics and alcohol by concomitant sedative hypnotics usage.
2. Intentional misuse
3. Abuse
4. Overdose
5. Medication error

iii. Cases of sexual abuse

iv. Proportion of discontinued patients who were associated with a report of a serious adverse event, including death

Knowledge

11. Knowledge, Attitude, and Behavior (KAB) Surveys of Patients and Healthcare Providers (to be submitted annually)

a. Assessment of patients' and healthcare providers' understanding of the following:

i. The risk of significant CNS and respiratory depression associated with Lumryz (sodium oxybate) even at recommended doses

ii. The contraindicated uses of Lumryz (sodium oxybate) with sedative hypnotics and alcohol

iii. The potential for abuse, misuse, and overdose associated with Lumryz (sodium oxybate)

iv. The safe use, handling, and storage of Lumryz (sodium oxybate)

v. The Lumryz (sodium oxybate) REMS Program requirements

12. KAB Surveys of Pharmacists (to be submitted annually)

a. Assessment of pharmacists' understanding of the following:

i. The risk of significant CNS and respiratory depression associated with Lumryz (sodium oxybate) even at recommended doses

ii. The contraindicated uses of Lumryz (sodium oxybate) with sedative hypnotics and alcohol

iii. The potential for abuse, misuse, and overdose associated with Lumryz (sodium oxybate)

iv. The safe use, handling, and storage of Lumryz (sodium oxybate)

v. The Lumryz (sodium oxybate) REMS Program requirements

13. Certified Pharmacy Knowledge Assessments (per reporting period and cumulatively)

a. Number of pharmacy staff who completed post-training knowledge assessments including method of completion and the number of attempts needed to complete

i. Breakdown of scores within the Pharmacy Staff Knowledge Assessment and Pharmacist Knowledge Assessment

b. Summary of the most frequently missed post-training Pharmacy Staff Knowledge Assessment questions

c. Summary of the most frequently missed post-training Pharmacist Knowledge Assessment questions

d. Summary of potential comprehension or perception issues identified with the post-training knowledge assessments

e. Number of pharmacy staff and pharmacists who did not pass the knowledge assessments

14. The requirements for assessments of an approved REMS under section 505-1(g)(3) include with respect to each goal included in the strategy, an assessment of the extent to which the approved strategy, including each element of the strategy, is meeting the goal or whether 1 or more such goals or such elements should be modified.

We remind you that in addition to the REMS assessments submitted according to the timetable in the approved REMS, you must include an adequate rationale to support a proposed REMS modification for the addition, modification, or removal of any goal or element of the REMS, as described in section 505-1(g)(4) of the FD&C Act.

We also remind you that you must submit a REMS assessment when you submit a supplemental application for a new indication for use as described in section 505-1(g)(2)(A). This assessment should include:

a) An evaluation of how the benefit-risk profile will or will not change with the new indication;

b) A determination of the implications of a change in the benefit-risk profile for the current REMS;

c) *If the new, proposed indication for use introduces unexpected risks*: A description of those risks and an evaluation of whether those risks can be appropriately managed with the currently approved REMS.

d) *If a REMS assessment was submitted in the 18 months prior to submission of the supplemental application for a new indication for use*: A statement about whether the REMS was meeting its goals at the time of the last assessment and if any modifications of the REMS have been proposed since that assessment.

e) *If a REMS assessment has not been submitted in the 18 months prior to submission of the supplemental application for a new indication for use:* Provision of as many of the currently listed assessment plan items as is feasible.

f) *If you propose a REMS modification based on a change in the benefit-risk profile or because of the new indication of use, submit an adequate rationale to support the modification, including*: Provision of the reason(s) why the proposed REMS modification is necessary, the potential effect on the serious risk(s) for which the REMS was required, on patient access to the drug, and/or on the burden on the health care delivery system; and other appropriate evidence or data to support the proposed change. Additionally, include any changes to the assessment plan necessary to assess the proposed modified REMS. *If you are not proposing a REMS modification*, provide a rationale for why the REMS does not need to be modified.

If the assessment instruments and methodology for your REMS assessments are not included in the REMS supporting document, or if you propose changes to the submitted assessment instruments or methodology, you should update the REMS supporting document to include specific assessment instrument and methodology information at least 90 days before the assessments will be conducted. Updates to the REMS supporting document may be included in a new document that references previous REMS supporting document submission(s) for unchanged portions. Alternatively, updates may be made by modifying the complete previous REMS supporting document, with all changes marked and highlighted. Prominently identify the submission containing

the assessment instruments and methodology with the following wording in bold capital letters at the top of the first page of the submission:

NDA #214755 REMS ASSESSMENT METHODOLOGY

Upon final approval, an authorized generic drug under this NDA must have an approved REMS prior to marketing. Should you decide to market, sell, or distribute an authorized generic drug under this NDA, contact us to discuss what will be required in the authorized generic drug REMS submission.

We remind you that section 505-1(f)(8) of FD&C Act prohibits holders of an approved covered application with elements to assure safe use from using any element to block or delay approval of an application under section 505(b)(2) or (j). A violation of this provision in 505-1(f) could result in enforcement action.

Upon final approval, prominently identify any submission containing the REMS assessments or proposed modifications of the REMS with the following wording in bold capital letters at the top of the first page of the submission as appropriate:

NDA 214755 REMS ASSESSMENT

or

NEW SUPPLEMENT FOR NDA 214755/S-000
CHANGES BEING EFFECTED IN 30 DAYS
PROPOSED MINOR REMS MODIFICATION

or

NEW SUPPLEMENT FOR NDA 214755/S-000
PRIOR APPROVAL SUPPLEMENT
PROPOSED MAJOR REMS MODIFICATION

or

NEW SUPPLEMENT FOR NDA 214755/S-000
PRIOR APPROVAL SUPPLEMENT
PROPOSED REMS MODIFICATIONS DUE TO SAFETY LABELING CHANGES SUBMITTED IN SUPPLEMENT XXX

or

NEW SUPPLEMENT (NEW INDICATION FOR USE)
FOR NDA 214755/S-000
REMS ASSESSMENT

U.S. Food and Drug Administration
Silver Spring, MD 20993
www.fda.gov

PROPOSED REMS MODIFICATION (if included)

Should you choose to submit a REMS revision, prominently identify the submission containing the REMS revisions with the following wording in bold capital letters at the top of the first page of the submission:

REMS REVISION FOR NDA 214755

To facilitate review of your submission, we request that you submit your proposed modified REMS and other REMS-related materials in Microsoft Word format. If certain documents, such as enrollment forms, are only in PDF format, they may be submitted as such, but the preference is to include as many as possible in Word format.

If you have any questions, contact Teresa Wheelous, Regulatory Project Manager, at teresa.wheelous@fda.hhs.gov.

Sincerely,

{See appended electronic signature page}

Teresa Buracchio, MD
Director
Division of Neurology 1
Office of Neuroscience
Office of New Drugs
Center for Drug Evaluation and Research

ENCLOSURES:

- Content of Labeling
  - Prescribing Information
  - Medication Guide
  - Instructions for Use
- REMS

EXHIBIT 2

REFINITIV STREETEVENTS

PRELIMINARY TRANSCRIPT

AVDL.OQ - Q2 2022 Avadel Pharmaceuticals PLC Earnings Call

EVENT DATE/TIME: AUGUST 09, 2022 / 12:00PM GMT

REFINITIV

CONFERENCE CALL PARTICIPANTS

>>Ami Fadia - Needham & Company, LLC, Research Division

>>Brandi Robinson - Senior Key Executive

>>Gregory Divis - CEO

>>Jennifer Gudeman

>>Richard Kim - Senior Key Executive

>>Thomas McHugh - CFO

>>François Brisebois - Oppenheimer & Co. Inc., Research Division

>>Oren Livnat - H.C. Wainwright & Co, LLC, Research Division

>>Eason Lee - SVB Securities LLC, Research Division

>>David Amsellem - Piper Sandler & Co., Research Division

>>Adam Evertts - LifeSci Capital, LLC, Research Division

>>Chase Knickerbocker - Craig-Hallum Capital Group LLC, Research Division

TRANSCRIPT

PRESENTATION

>>Ami Fadia - Needham & Company, LLC, Research Division

Greetings, and welcome to Avadel Pharmaceuticals Second Quarter 2022 Earnings Call. (Operator Instructions) It is now my pleasure to introduce Brandi Robinson. Thank you. You may begin.

>>Brandi Robinson - Senior Key Executive

Good morning, and thank you for joining us on our conference call to discuss second quarter 2022 earnings.

As a reminder, before we begin, the following presentation includes several matters that constitute forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements are subject to risks and uncertainties that could cause actual results to differ materially from those contemplated in such forward-looking statements. These risks include risks that products in the development stage may not achieve scientific objectives or milestones or meet stringent regulatory requirements, uncertainties regarding market entry and acceptance of products and the impact of competitive products and pricing. These and other risks are described more fully in Avadel's public filings under the Exchange Act included in the Form 10-K for the year ended December 31, 2021, which was filed on March 16, 2022, and subsequent SEC filings. Except as required by law, Avadel undertakes no obligation to update or revise any forward-looking statements contained in this presentation to reflect new information, future events or otherwise.

On the call today are Greg Divis, Chief Executive Officer; Dr. Jennifer Gudeman, Vice President of Medical and Clinical Affairs; Richard Kim, Chief Commercial Officer; and Tom McHugh, Chief Financial Officer.

At this time, I'll turn the call over to Greg.

>>Gregory Divis - CEO

Good morning, everyone, and thank you for joining us to discuss our second quarter 2022 results. .

This was an important quarter for Avadel, where we continue to make progress in our mission to bring LUMRYZ to all once-at-bedtime eligible patients living with narcolepsy, which included the receipt of a notable and important regulatory milestone for LUMRYZ in the form of a tentative approval, the active pursuit of additional legal and regulatory strategies to accelerate a final FDA decision for LUMRYZ prior to June of 2023 or when the REMS patent we certified on will expire and the continued execution of our commercial preparations with a focus on shortening the time between final approval and launch while we took the necessary actions to ensure, as required, we have the liquidity to carry us to the potential outer date of a final FDA approval decision.

With that, I will start by commenting on our most recent company update. On July 19, we announced that the FDA granted tentative approval of LUMRYZ, formerly known as FT218, our investigational once at bedtime oxybate therapy for the treatment of cataplexy or excessive daytime sleepiness in people with narcolepsy. Receiving tentative approval is an important step toward a final approval. By granting tentative approval, the FDA has validated the clinical and safety profile of LUMRYZ and confirms that LUMRYZ is approvable as a once at bedtime therapy for eligible patients living with narcolepsy, which we believe is a meaningful derisking regulatory event for the company.

LUMRYZ is has a demonstrably strong clinical profile with an improved dosing regimen that, per our extensive research, is preferred by patients and sleep specialists. This, along with our comprehensive launch strategy, gives us the confidence in the potential significant role LUMRYZ can play in the $3 billion-plus market opportunity.

Further and perhaps most importantly, receiving tentative approval confirms that the potential latest date we could receive a final approval decision for LUMRYZ is after expiry of the REMS patent, which is June 17, 2023, or just 10 months and 8 days from today. As previously stated, we are and will continue to aggressively pursue legal and regulatory strategies with a clear objective of potentially leading to a final approval decision prior to June 2023 and, depending on timing and results of these legal actions, possibly by the end of this year. In this regard, we filed a motion in the U.S. District Court for the District of Delaware to delist the REMS patent from the FDA's Orange Book on June 23 as we do not believe the substance of the REMS patent qualifies as an eligible Orange Book listable patent. A court order requiring the patent holder to delist the REMS patent from the Orange Book could provide a pathway for a final approval of LUMRYZ prior to June 2023. As the court previously stated that a claim construction hearing is required before ruling on the motion to delist, the next step in this process is the Markman or claim construction hearing, which is scheduled for August 31. Additionally, we recently announced that we filed an Administrative Procedure Act lawsuit against FDA alleging that their decision requiring us to file a patent certification on the REMS patent was arbitrary, capricious and contrary to applicable law. In this lawsuit, we are asking the court to vacate the FDA's patent certification decision and order FDA to take final action on the LUMRYZ NDA within 14 days after vacating their decision.

A successful outcome in this APA suit could also lead to a potential final approval of LUMRYZ prior to June of 2023. An accelerated briefing schedule order has been approved by the court, and we currently expect this case to be heard at the end of September 2022.

In addition to these opportunities to accelerate a potential final approval, we are also focusing on launch preparation activities that will shorten the time to launch following final approval. This includes completion of manufacturing and primary packaging for our commercial supply and operationalizing our REMS program both in advance of a final approval and before the end of this calendar year.

In summary, we are well positioned to execute on all of these priorities to potentially accelerate bringing LUMRYZ to a final approval prior to June 2023 and subsequent launch as soon as possible thereafter. As you will hear next, Jennifer will provide details on the data we presented this quarter at SLEEP 2022. And following, Richard will give an update on our launch readiness actions now with the tentative approval in hand.

With that, I'll turn the call over to Jennifer.

>>Jennifer Gudeman

Thanks, Greg, and good morning.

As Greg said, this was an important quarter for Avadel. Tentative approval for LUMRYZ is a significant milestone that validates its efficacy and safety profile and also has facilitated us starting our REMS build-out, which will shorten our time to launch following final approval. Furthermore, we had

a strong presence at SLEEP 2022 with considerable interest in the body of evidence supporting LUMRYZ, as described in our 9 posters. The poster that we had the most engagement with described the new interim data on dosing and titration from the ongoing RESTORE open-label extension SWITCH study of our LUMRYZ drug candidate. 62% of participants switching from twice-nightly oxybate formulations had a stable dose equal to their starting dose, which will help clinicians understand that switching to LUMRYZ is a straightforward process. Additionally, participants not currently taking oxybate formulations or oxybate naive participants reached a stable dose with 2 to 4 dose titrations within 4 weeks. This is particularly relevant as we hear anecdotes of patients having to spend months trying to find a stable and consistent dosing regimen of twice-nightly oxybate.

We also presented updated results from patient preference and the nocturnal adverse event questionnaire with patients switching from twice-nightly oxybate in the RESTORE study. These interim data confirmed previous data we have presented showing that a high proportion of patients switching from twice-nightly oxybate formulations experience difficulty in taking the second dose, with nearly 2/ 3 reporting accidentally missing their second dose at least once in the past 3 months and more than 80% of those reporting that they experienced worse narcolepsy symptoms the next day.

Also consistent with data we have previously presented 92.5% stated a preference for the once-nightly dosing regimen. As we talk about RESTORE, I want to highlight that we have extended this study so participants can stay in RESTORE through FDA approval and up to launch of LUMRYZ to then transition to commercially available product. I have had the opportunity to speak directly with a number of participants in RESTORE who have expressed their gratitude for this extension specifically because they don't want to go back to waking up in the middle of the night after successfully taking Avadel's investigational once at bedtime sodium oxybate.

Going back to our posters, we had 5 posters from Reston which continue to reinforce the strong efficacy demonstrated in this pivotal trial, including in subgroups of both NT1 and NT2 and those with and without concomitant stimulant on measures of disrupted nighttime sleep.

Lastly, we published results from our second discrete choice experiment, or DCE. As some may recall, we have published the results of our first DCE in patient preference and adherence which clearly showed that the most important driver of patient choice for sodium oxybate is a single bedtime dose. The second DCE was expanded to include clinicians and the mixed salt oxybate and affirmed our first DCE. Patients clearly placed the highest priority of treatment selection among the 3 oxybate profile for once at bedtime dosing.

For the 100 clinicians participating in the DCE, the data also demonstrated that the most important driver of clinician choice is once at bedtime dosing. The SLEEP meeting provided us the opportunity to connect directly with KOLs and explain the delay in FDA decision on approval of LUMRYZ. We have been communicating extensively with both the medical and patient communities following the tentative approval, including a fact sheet available at avadel.com about what this means and a letter to the community reiterating our commitment to bringing LUMRYZ to patients.

We recognize patients with narcolepsy will be critical in shared decision-making with their clinicians. To that end, we were thrilled to publish a plain language summary in future neurology describing the primary results from our pivotal trial, so people with narcolepsy can access these results. The totality of the data we continue to present supports the robust clinical efficacy, the well-established safety profile, ability to switch from twice-nightly oxybate and patient preference of LUMRYZ. Now that we have the tentative approval secured, the community is even more eager to see this potential treatment option receive final FDA approval and made available to patients.

We are proud of all of our hard work that continues to drive LUMRYZ forward. I will now turn the call over to Richard to provide details on the commercial opportunity and our preparations for launch. Richard?

>>Richard Kim - Senior Key Executive

Thank you, Jennifer. With the tentative approval in hand, we are well positioned to continue to advance our launch preparations as we work towards bringing once at bedtime LUMRYZ to adults with narcolepsy. Despite a longer-than-anticipated time for the final approval of LUMRYZ, one thing that has not changed is the fundamental belief in the potential for this drug candidate to help patients manage their excessive daytime sleepiness or cataplexy while also providing them with an opportunity for a more natural sleep cycle.

It has been an amazing journey spending time within our community, sleep specialists, medical societies and patient organizations. Throughout the year, we made significant progress in expanding our reach our reach with sleep specialists through major congresses like World Sleep in March and the SLEEP 2022 Conference in June along with one-on-one meetings.

This year alone, we estimate that we have been in front of over 1,000 people from the narcolepsy community. As a reminder, less than 1,600 sleep specialists make up 80% of the current overall oxybate prescription volume. As we get ready to transition from the summer to the fall, we are also preparing for a number of meetings and conferences that will give us continued exposure to patient organizations and sleep specialists. We have both the American Neurological Association and CHEST meetings continue to engage with sleep specialists this October along with key patient advocacy organization meetings in the next couple of months.

We also continue to see strong interest in our disease education campaign, Narcolepsy Disrupts. In June, we began to make a sleep diary available that helps patients charge how they are managing their narcolepsy. And we have already shipped more than 3, 000 to individuals across the country. After assessing all that we have accomplished to date with Narcolepsy Disrupts, we anticipate launching additional enhancements in the early fall.

Our actions this year have really put Avadel on the map with our key stakeholders as a patient's first company who will not relent until we can bring a new treatment option to people with narcolepsy. For the payers, we have made very good progress in our conversations this year. Now with the tentative approval in hand and, more importantly, the outer battery of a final approval decision now just over 10 months away, we are accelerating our actions with payers, including the 3 GPOs and the affiliate PBMs that represent over 85% of commercially insured lives.

Our team has done excellent work in establishing the clinical value proposition of once at bedtime LUMRYZ. And now we look forward to advancing contract discussions. The reception has been very positive as the payers look to gain post-approval access to a new therapy that we believe can go beyond the limitations of the current standards of care.

Now we continue to be nimble and dynamic in our readiness planning to ensure that we are ready to fully launch at the earliest time after receipt of a final approval. We retained relationships with our key partners, where the work takes the longest to prepare for launch. With the REMS requirements from the FDA being finalized, our program build-out is in full motion. The same can be said for the work being done by our team in advancing our commercial launch supply.

For product fulfillment, our patient services center will be ready to go live upon final approval. And now we will look to finalize our specialty pharmacy distribution agreements as we head towards a potential final approval.

In summary, the collective work that we have done across REMS, supply, distribution and fulfillment has put us on track to launch as soon as we can once we have final FDA approval for LUMRYZ. We know that once at bedtime LUMRYZ has the potential to address significant unmet need with patients and that our market research and data analytics shows the market potential for LUMRYZ to be roughly double that of the current twice-nightly oxybate market with more than 30,000 potential eligible narcolepsy patients. Recall, the total PAP patient population consists of 3 key segments: first, approximately 16, 000 actively treated twice nightly patients; second, an estimated 10,000 to 15,000 potential patients previously treated with oxybate who have discontinued therapy; and third, roughly 3,000 new oxybate patient starts. And in this segment, we expect robust yearly growth of 25% to 50% per year in the future.

All 3 patient segments have expressed high levels of interest in LUMRYZ. And physicians and patient groups both have indicated that once at bedtime dosing is the most important attribute in choosing an oxybate.

We are a forward-looking team. And now with the outer boundary timing for a final approval decision just over 10 months away, we are fully focused on executing our plans to deliver LUMRYZ to patients as effectively and as quickly as we can. I look forward to providing more updates on future calls.

Now let me turn the call to Tom for an update on the company's financials. Tom?

>>Thomas McHugh - CFO

Thank you, Richard. I'll provide a few highlights for the quarter and also note that full financial results are available in the press release and the 10-Q.

I'll start with the balance sheet, where we reported $104.1 million of cash, cash equivalents and marketable securities as of June 30, 2022. Also as of June 30, we had approximately $17 million of tax refunds pending, of which $10 million was received in July. We currently expect that the remaining $7 million will be received in the second half of 2022.

As a reminder, earlier this year, we completed an exchange and 8-month maturity extension of approximately 80% of $143.8 million of convertible notes. As a result, $117.4 million now matures in October 2023, and $26.4 million will mature in February of 2023.

R&D expenses were $4. 5 million in the quarter ended June 30, 2022, compared to $6.8 million for the same period in 2021. The period-over-period decrease was due primarily to lower purchases of active pharmaceutical ingredients used in the manufacture of LUMRYZ. SG&A expenses were $21.8 million in the quarter ended June 30, 2022, compared to $15.2 million for the same period in 2021. The period-over-period increase is primarily the result of fees associated with the exchange of the convertible notes. Higher legal and compensation costs were mostly offset by the reversal of previously accrued expenses due to the restructuring. This quarter, we recorded a restructuring charge of $3.6 million primarily for severance benefits associated with the reduction in the company's workforce. The workforce reduction will be completed during the third quarter 2022, and we expect to reduce quarterly cash operating expenses, excluding inventory purchases, to $12 million to $14 million.

Income tax expense was $3.2 million in the quarter ended June 30, 2022, compared to income tax benefit of $3.8 million for the same period in 2021. Income tax expense this quarter is due primarily to the valuation allowance recorded against deferred tax assets. The valuation allowance is noncash and does not impact our ability to utilize NOLs in the future when the company begins to generate taxable income.

Net loss for the second quarter of 2022 was approximately $63.4 million or $1. 07 per diluted share compared to net loss of approximately $19.6 million or $0.33 per diluted share in the same period in 2021. Finally, with $104 million of cash on hand at June 30, the $10 million of tax refunds received in July and the $7 million of tax refunds still to be received, together with the cost reductions we implemented, we believe that the cash runway extends to at least the middle of 2023. And with the tentative approval now granted and as we progress toward a final approval decision that could occur by June 2023 or earlier, we will seek opportunities to strengthen the balance sheet and ensure we have the capital resources available to prepare for the launch of LUMRYZ into what we believe is a greater than $3 billion market opportunity.

I'll now turn the call back to Greg for closing remarks.

>>Gregory Divis - CEO

Thanks, Tom. To summarize, we are pleased but certainly not satisfied with our recent milestone of receiving tentative approval for LUMRYZ, marking a critical step for Avadel.

With tentative approval in hand, we are committed to keep moving forward to unlock LUMRYZ's clear and intuitive value proposition with a once at bedtime treatment that could be transformative for people with narcolepsy by providing the potential of an uninterrupted night sleep while also managing daytime symptoms of narcolepsy. We look forward to keeping you up to date on our continued progress with our regulatory and legal actions as well as our ongoing efforts to prepare for and shorten the time to commercial launch upon receipt of final approval.

With that, we will open the call for questions, and I'll turn it back to the operator.

QUESTIONS AND ANSWERS

Operator

(Operator Instructions) Our first question comes from François Brisebois with Oppenheimer.

>>François Brisebois - Oppenheimer & Co. Inc., Research Division

Just all right, so the time lines have changed a little bit. We've been tracking. We've got the potential REMS expiration. But you mentioned just between the filing of the lawsuit and the Markman hearing and what can come of that, you mentioned possibly having news by the end of '22. I just wanted to make sure I understood what that referred to. And also maybe hearing about -- I believe it was a lawsuit by the end of September, so maybe if you could just kind of put it all together and just make sure we know what to expect for a potentially earlier approval decision than June of '23.

>>Gregory Divis - CEO

Yes. Thanks, Frank. So both of them being the Markman hearing leading into the motion to delist on one track and, on the other track, the APA action against FDA. So taking the first one, again, in that case, we have asked the court assuming they agree with our position on the actual REMS patent not being eligible -- not being listed eligible -- Orange Book eligible to be listed, we are asking the court to order the delisting of that. Upon receipt of that delisting, we would then facilitate the process to, in essence, refile the necessary documents with FDA seeking their approval to move from a tentative approval to a final approval.

So obviously, the Markman hearing is on August 31. We certainly are seeking to have the motion to delist heard as quickly thereafter as possible. And depending on the timing of those decisions, whenever that occurs, that will set the time frame for us to then file the necessary documentation with the FDA to convert the tentative approval to final approval, which, again, per FDA guidance, generally speaking in that situation, is recommended anywhere from 2 months to 6 months. So depending upon when that occurs and how quickly the FDA acts in that setting could create a situation where a final approval decision could be had, depending on when that final delisting motion occurs.

On the APA case, what has occurred is a briefing schedule has been agreed to, which is we'll go through basically the middle of September. And currently, tentatively, that hearing is expected to be heard at the end of September. And again, what we're requesting from the court there is, if they agree with our position, that they vacate the requirement, the decision to require certification and ask the FDA to make a final decision within 14 days. So depending upon how long from the hearing to when the judge makes a final decision or ruling on that, if they rule in our favor, then a final decision could occur as early as 14 days after that point in time.

So again, both of those potentially provide windows where if the decisions happen relatively efficiently and they go in our favor, a decision could potentially occur prior to the end of the year.

>>François Brisebois - Oppenheimer & Co. Inc., Research Division

Perfect. That's very helpful. And then just maybe more for Richard. On the payer side, you guys obviously are doing a lot of work there. I was just wondering, any thoughts -- would you share any thoughts strategically of maybe giving out samples for free just to make sure that based on the fact that you have to titrate this medication, it can take time. In these patients, there is a high discontinuation rate for for these types of medicines. Any thoughts about from the script being prescribed to getting in the patient's hand to make sure that happens as quickly as possible, thoughts about just giving out some samples for free to make sure that patients get access quickly.

>>Richard Kim - Senior Key Executive

Yes. Frank, thanks for the question. It's an interesting thought. The one thing we are absolutely focused in on is making sure we can get patients a great experience with LUMRYZ as fast as possible upon final approval. So through our patient services center, we will offer a bevy of services. If it's a quick-start programs where you're waiting for insurance and other things for applicable patients to ensure that patients can get the experience with LUMRYZ with -- obviously, once they've been certified as quickly as possible. So we do know those initial experiences are going to be absolutely pivotal for us, which is why we have invested so heavily in ensuring that our patient services center will have not only that but other services aimed at both patients themselves and the offices as well.

So it's a good idea, Frank. There's obviously some legalities we'd have to work through, but we are working on making sure that we have a full suite of services to ensure that patients can get on therapy as fast as possible.

Operator

Our next question comes from Oren Livnat with H.C. Wainwright.

>>Oren Livnat - H.C. Wainwright & Co, LLC, Research Division

I have a couple. Just can you remind us upon FT218 or LUMRYZ tentative approval, did you get or do you expect to receive in due course, an indication regarding potential orphan exclusivity of your own product for -- that would apply to any future once-nightly sodium oxybate? I have a follow-up, sir.

>>Gregory Divis - CEO

Yes. Thanks, Oren. Again, as we've shared in the past, this is a topic we've had engagement with during the pendency of the review with FDA and fundamentally believe that the orphan exclusivity review was by and large complete although not decided upon formally because, technically, until there's a basis for a timing for a final decision, the FDA just isn't going to make that final decision -- that formal decision until the time is right.

And there's a lot of reasons for that, including that things could change in the marketplace or whatnot between now and that point in time. That being said, what's been communicated to us in our tentative approval letter, which I do believe is online now, you'll see what was noted in that approval letter was the REMS patent as we previously identified as the issue that we need to climb over.

So again, from our perspective, in our discussions with FDA, although not a formal decision, this issue is the same as it was prior to missing the PDUFA date and whatnot. And we believe both in the context of the robustness of our submission on the basis of clinical superiority that we provided to be granted orphan drug exclusivity. But as we've also stated based upon the statute, we don't necessarily believe orphan drug exclusivity is required to be granted a full and final approval.

>>Oren Livnat - H.C. Wainwright & Co, LLC, Research Division

Okay. And as we think about the launch scenarios and the timing to launch, Francois touched on this, but what -- how long do you think it would take to actually get this product out the door, which includes having to enroll physicians and REMS, et cetera, post approval? And if you were approved in fall or year-end, how many months do you think it would take to actually get some scripts rolling through the system and maybe even revenue producing?

>>Gregory Divis - CEO

Richard, do you want to start on that?

>>Richard Kim - Senior Key Executive

Yes. So on the great news with the tenant approval on hand under Jen's leadership, the REMS program is in full build-out right now as well. So previously, that would have been viewed as sort of one of the long poles in the tent. But now with us having the TA, that's going forward, so our belief is our work will be shortly after -- very shortly after our final approval, that will be up and going. And obviously, once the REMS is up and going, we can actually begin to certify both physicians and patients. .

So depending on timing, we'll either have time to do that a little bit before product is out there or it will be done concurrently. So that one element has really shrunk down a significant part of our prelaunch readiness here. So -- but it will still take us potentially a few months from the final approval before the first product is shipped out.

Greg, would you like to add on to that?

>>Gregory Divis - CEO

Yes, I think that's right. I think, Oren, the best way to think about it is, in the scenario where good news comes early and we have that as a tailwind and we're building toward a launch date on the back of an approval, there are certain things that will continue to be worked on that otherwise would have been completed if we go all the way until June of next year. So I think in the scenario where an approval comes by the end of this year, we may be launching a few months after that into the early part of next year into perhaps even depending on when the approval comes in the early part of maybe Q2. Unlike if a launch, if it goes all the way until after June 17, then we're likely towards the end of Q2 before final approval, we're obviously likely launching in the subsequent quarter.

>>Oren Livnat - H.C. Wainwright & Co, LLC, Research Division

Okay. And just if I may, you talked about your increased optimism for the oxybate market growth potential with several different buckets. Given all that work you've done in the interim, what's the latest view on the resources necessary to successfully launch the product, realize sort of those ambitions? What sort of footprint, marketing, I guess, just you probably wouldn't comment on total cost, but just as we try to understand the magnitude of investment necessary.

>>Gregory Divis - CEO

Go ahead, Richard.

>>Richard Kim - Senior Key Executive

Yes. No, Oren, it's a great question. I mean the 1 thing that's always really key for us to think about for the narcolepsy market is it's relatively compact, right? Once again, we know that as far as the treater base of oxybate prescribers are concerned for narcolepsy, there's only about 5,000, and 1,600 make up 80% of the total oxybate volume. So for us, it's been -- it's relatively compact. .

Our initial plans are still about the same where we're probably focusing at around 50 representatives that will allow us to cover that entire universe and add some. We've really invested very heavily in our data analytics platform so that we can really effectively target the right physicians at the right time. And a lot of the work that we've done up to this point is our foundation going forward, which is a great base for us. Everything from our disease education with Narcolepsy Disrupts to the engagement that we had with patients digitally, we have this to build upon.

So the great news for us is I don't think it's like we need a massive bolus. We're just going to keep building upon what we have. Clearly, we're going to have to spend more to hire sales force again and things like that. But the fact that this is a compact marketplace and then from making good inroads into those -- that core, there's clearly room to expand in the future. But that's what makes this marketplace, from my perspective, really

attractive to execute on is we don't have to do like multiple things. We can really focus on the physician engagement, the patient engagement and the payer engagement. And we've got great plans going against all 3 segments.

Operator

Our next question comes from Ami Fadia with Needham.

>>Eason Lee - SVB Securities LLC, Research Division

This is Eason Lee on for Ami. Just 2 from us. Maybe first, I'm curious, ahead of kind of the August 31 Markman hearing, is there any read-through that we could get from that in terms of potentially getting a favorable rule in regards to the delisting counterclaim?

And then maybe second, we just love your latest thoughts kind of on pricing of LUMRYZ and kind of in this market in general given the entry of authorized generics looking like they'll kind of start off in the beginning of next year.

>>Gregory Divis - CEO

Yes, thanks. As it relates to kind of any read-through from that perspective, it's probably not appropriate for us to speak on any of those specifics relative to this ongoing litigation other than the fact that when it comes to this specific 9, 6, 3 grams patent, again, I think what we're -- what we believe based upon the components of the patent that it is a computer system patent given it describes things such as processors and servers and screenshots and whatnot and believe that, that is not a listable -- Orange Book listable patent, which really is tied to formulation or method of use of that specific product, and therefore, again, we've asserted this because we believe in our position. And we look forward to the first step in this process in just a few weeks from now to advance it.

As it relates to pricing and the market dynamics, I'll turn it over to Richard.

>>Richard Kim - Senior Key Executive

Yes, Eason, thanks for the question. So obviously, when it comes to the marketplace, first and foremost, we've seen the oxybate market to be relatively flat as far as narcolepsy is concerned. And all of our plans that we've made in prelaunching our post-approval plans have actually been contemplating an AG in the marketplace. Now we don't really see the AG significantly impacting the potential for once a bedtime LUMRYZ at all. We've made plans whether not they make some further inroads or not here as well.

But regardless, when it comes to AG, it's always remember, important to remember that it's still going to be a twice-nightly product as are all the current oxybate as well. And we believe our work that we've done with the payers has really been to establish a clinical value proposition of the once at bedtime Lumeris as well.

So we definitely take that into account as well. We don't anticipate them really having significant pricing erosion, but we'll adjust our plans with whatever goes on there. And also keep in mind, the AG is really generally not attractive to payers as far as really increasing the uptake off of our assumptions today.

And as far as your question on pricing, we've stated right from the beginning, our goal with payers is to be sort of in a parity access position with the best of oxybates overall. And so our pricing, we've always stated to be sort of in the zone of where we believe the branded oxybate will be in the future as well.

Operator

Our next question comes from Chris Howerton with (inaudible).

>>Unidentified Analyst

This is A.J. for Chris at Jefferies. A quick housekeeping question. Do you have a target budget for API stocking? I just see it was the only item excluded from your expenditure guidance. .

>>Gregory Divis - CEO

Tom, do you want to answer that?

>>Thomas McHugh - CFO

You broke up a little bit. Your question was do we have guidance on the amount of our API purchases?

>>Unidentified Analyst

Yes.

>>Thomas McHugh - CFO

Yes, we're not providing a specific guidance around that. The API purchases are included in our R&D costs at this point?

>>Unidentified Analyst

Okay. Got you. And a quick follow-up question on the Narcolepsy Disrupts program. Do you have an update on what kind of engagement you're seeing with patients?

>>Gregory Divis - CEO

Yes. No, we've seen really great enrollment so far. We're closing at about 6,000 individuals who are registering to our program. And I think as I mentioned during the prepared remarks, what's been really cool to sort of see is we offered what we deem as a very simple but a very essential tool around a sleep diary. And in the first sort of month and a bit, we had over 3,000 individuals request getting it.

So our discussions with the patients, our engagement has been very good. And as I mentioned as well, we're sort of looking to sort of have a larger revamp to sort of take that next wave of engagement as we go into the early part of fall. But so far, we're super pleased with the impact that the campaign has really had and the continued engagement and dialogue that we're having with patients online.

Operator

Our next question comes from David Amsellem with Piper Sandler.

>>David Amsellem - Piper Sandler & Co., Research Division

So most of my questions have been answered, but I did want to ask you a couple of questions on commercialization. Number one, can you talk through where you think early adoption is going to come from? And in particular, do you expect that most of your earlier patients will have had exposure to the Xyrem authorized generic before they get on LUMRYZ? So that's number one.

Number two is, as you look at your IP runway, just makes sense for you to run a registration quality study in idiopathic hypersomnia. Is that something that's in the cards?

>>Gregory Divis - CEO

Thanks, David. Richard, do you want to take the first one?

>>Richard Kim - Senior Key Executive

Sure. No, great question, David. So as far as early adoption is concerned, I mean, first, I sort of think about it from the prescriber base. And clearly, our assumption is we'll have the earliest adoption from the most experienced oxybate prescribers. We know that there is less than 500 physicians that account for over 50% of the oxybate volume in the marketplace right now as well. .

And actually, what we see in our market research is a great opportunity for patients who are currently on twice nightly oxybate discontinued in de novo. But if you think about the SWITCH patients themselves, we actually know that wave patients tend to be the earliest adopters of innovative new therapies. So we absolutely do see a good opportunity for patients there to be attracted to the LUMRYZ value proposition as are the current Xyrem patients were potentially that -- which makes the most intuitive sense.

And as far as the AG is concerned, like I said, we still see it having limited impact in the marketplace. Now clearly, we'll have -- likely have some time to see that. But we absolutely do see the switch from existing twice nightly oxybate being a relatively large segment in the oxybate experienced physicians. We also see that opportunity with patients who tried twice nightly but are no longer on them for various reasons. And we also do believe we're going to get a good share of the de novo patients because, as many physicians have told me, when you offer the chance to not have to wake up in the middle of night with de novo patients, it's a pretty clear value proposition as well.

So we feel fortunate that we know that we have a great opportunity of the switch patients, but we absolutely sort of see the opportunity for growth in all 3 of those patient segments overall.

And Greg, I'll turn the IP question back to you.

>>Gregory Divis - CEO

Yes. Thanks, David. It's an important question because what's next is an important consideration for us in terms of how do we build the franchise around the innovation that is once-nightly LUMRYZ. And I think the short answer is there's a tremendous amount of interest from the clinician community amount of interest from the clinician community amount of interest from the clinician community to want to study a true once-nightly dose, once a bedtime administration for IH patients.

So yes, I think in short, we're evaluating that very seriously. We've done a tremendous amount of work in terms of understanding what that trial design could be like and whether or not should we consider a registration quality study or whatnot. I think you'll hear more about that as we go forward, but it is an important consideration as one of the tools in terms of building out the full value of LUMRYZ, whether that's in IH or whether that's in the work we're doing with the additional formulation work as well on our own low-sodium formulation -- no sodium formulations.

Operator

The next question comes from Adam Evertts with LifeSci Capital.

>>Adam Evertts - LifeSci Capital, LLC, Research Division

Question on the commercial side. On Jazz's earnings call, they reported that there are more patients on Xywav in Xyrwm. Of course, part of that is the idiopathic hypersomnia indication for Xywav. Just curious if that impacts your commercial strategy, perhaps messaging or otherwise.

>>Gregory Divis - CEO

Yes. And thanks for the question. Yes, you're right. I think what they reported is more patients for Xywav overall. But if we actually look at the narcolepsy market, it still slightly tilt towards Xyrem. The good news for us is we see the opportunity uniquely favorable for both of those segments. As I mentioned before, what we -- our research tells us is, in general, Xywav patients with narcolepsy tend to be earlier adopters, younger patients who have been diagnosed with narcolepsy for last years seeking more new innovative therapies as well. So we believe that bodes very well for the value proposition of LUMRYZ once it's available in the market as well.

And then once again, so it likely will be a bifurcated market between Xyrem and Xywav patients as far as oxybates are concerned. For Xyrem patients, our value proposition is probably the clearest and most intuitive overall there as well. So going from twice at night to a once at bedtime a once at bedtime therapy, that, in essence, is the same sort of compound. So we believe we're really well positioned for both. And a lot of it is also going to be driven by some of the patient engagement that we have overall as well. So despite the fact that there's about a 50-50 split in the marketplace right now, we believe we're positioned for both of those segments very well in addition to the discontinued patients and the de novo patients as well.

>>Adam Evertts - LifeSci Capital, LLC, Research Division

Fantastic. I appreciate that. And then one quick clarification. I think I know the answer to this, but will we get any more color on the label or we'll need to wait until full approval to see any more details there?

>>Gregory Divis - CEO

Yes, it won't be released until a final approval, Adam. But our view on it, where it stands today, it's in really good shape and, I think, gives us something really good to work within the marketplace.

Operator

The next question comes from Marc Goodman with SVB Securities.

>>Unidentified Analyst

This is (inaudible) for Marc. Similarly to the previous participant, I think most of the questions have been answered. But maybe just a follow-up on the last question. Do you expect any additional edits to the label or REMS upon the request for final approval?

>>Gregory Divis - CEO

Not at this time. We don't -- we believe that's complete. I would say that that's our expectation, unless new information or new data is learned during the pendency of the tentative approval period. But at this stage, we would expect that to be in its final form.

Operator

Next question comes from Matt Kaplan with Ladenburg Thalmann.

>>Unidentified Analyst

This is Raymond in for Matt. Just 2 quick questions. Impressive data showing that dosing is a key factor in patient preference. I was just wondering to ask, just digging deeper, is there alignment between patients and clinicians on the relative preference for sodium content in making treatment choice? And is that something maybe a patient education campaign or that might be helped in aligning patients with clinicians? And my second question is do you expect any update from RESTORE study later this year? Or is that more of a next year?

>>Gregory Divis - CEO

Jen, can you handle those?

>>Jennifer Gudeman

Yes, absolutely. Thank you for the question. So the poster that we had presented at sleep on the discrete choice experiment shows that both patients and clinicians do not place the same value on the sodium content as they do on the dosing frequency. So that came through very clearly for those patients and clinicians that the # 1 driver of treatment selection is the dosing frequency in preference of a once at bedtime dose as compared to twice-nightly dosing.

As far as it pertains to RESTORE, yes, we will be presenting more data at the upcoming congresses, both the CHEST and ANA Congress that are being held mid-October. We will have posters that continues to update our open-label data from RESTORE.

Operator

The next question comes from Chase Knickerbocker with Craig Hallum.

>>Chase Knickerbocker - Craig-Hallum Capital Group LLC, Research Division

Number one, just first for me, can you speak a bit to how your REMS program and the existing oxybate REMS would have to interact and would there have to be some cooperation between 2 of you to ensure oxybate patients properly managed between the 2 programs? If you could just speak to any challenges here as you are building out your REMS program sort of around there, so that would be helpful here.

>>Gregory Divis - CEO

Yes. Thanks, Chase. I think the first answer to that question is that upon a final approval, both REMS programs are going to have to communicate with each other and cooperate. So it's not just theirs cooperating with our or ours cooperating with theirs. Both companies are going to have the requirement to ensure a patient only has one active oxybate prescription at a time.

There is a process for which the FDA is approved and how that's going to work on our part. That's part of our REMS program and our design. And if you look at our tentative approval letter online, you'll see that components of the REMS document, the REMS program has been provided by FDA. And inclusive of that is Section 9, which is a section that basically requires us to report how the other party is responding to -- and the timeliness of those response -- the response in our inquiries to determine if a patient has an active prescription or not.

Our assumption is that will be reciprocal on their side as well, but I don't know that for sure. But clearly, there is a mechanism to report the responsiveness of the other REMS program to FDA at their request.

>>Chase Knickerbocker - Craig-Hallum Capital Group LLC, Research Division

Awesome. That's helpful color. Then just last for me, can you provide some details of what specific business functions were cut or reduced in the workforce reduction and cost optimization or what will need to be added or added back upon full approval?

>>Gregory Divis - CEO

Yes, I would say there was no area that was spared, so to speak, from that standpoint. And I would characterize it in really a couple of ways. The first way is, in part, it was part of the G&A organization that was built to prepare for an onboarding of a significant expansion of headcount in the organization, more than a doubling of it by far as we would -- as we were heading towards a potential final approval. And clearly, those aren't physicians we need in place right now, although the infrastructure and systems have been built to support that in the future.

And then secondly, I would say it's roles where there are certain roles that we've done a lot of work to get ready for launch, and now it is ready to go, and there's no really active work that's required from those functions. So we've made the decision on those sorts of roles to let them go but really keep critical roles that we need to continue to execute to shorten the time from approval -- from final approval to launch.

Operator

Next question comes from Paul Matteis with Stifel.

>>Unidentified Analyst

This is James on for Paul. I just wanted to understand the exact steps behind getting a full approval. It sounds like from the press release, you'll receive full approval kind of immediately following the expiry of the REMS patent. And I guess is that the case? Or is there anything that needs to happen at the FDA first? For example, will they need to make a decision on ODE following patent expiry? And I guess, what's the risk that could cause a further delay?

>>Gregory Divis - CEO

Yes. As previously shared, there is a process. If we're heading toward the situation where June 17 is the expiry of the patent and that's the last remaining item for us to move to from a tentative approval to a final approval decision, we would begin the process in notifying the FDA and filing all of our related documentation well in advance of that per FDA guidance such that upon that expiry or shortly thereafter, we would expect a final decision to be made on LUMRYZ.

So I think the short answer to the question is, not speaking directly for how long after June 17 that will occur, but we will take the necessary steps to file the necessary documentation and request the FDA to begin the process to make whatever final decision needs to be made to convert from a tentative approval to final approval in advance of that such that when that patent expires, the FDA should be in a position to do so.

Operator

This concludes our question-and-answer session. I would like to turn the conference back over to Greg Divis for any closing remarks.

>>Gregory Divis - CEO

Thank you, operator. Thank you, everyone, for joining us today. We look forward to keeping you up to date on our progress on a number of these fronts in these matters and wish you a great rest of the day and look forward to any follow-up necessary. Take care. Thank you.

Operator

The conference has now concluded. Thank you for attending today's presentation. You may now disconnect.

EXHIBIT 3

Company Name: Avadel Pharmaceuticals PLC
Company Ticker: AVDL US Equity
Date: 2021-09-22

Oppenheimer Fall Healthcare Life Sciences & Med Tech Summit

Company Participants

- Gregory J. Divis, Chief Executive Officer

Other Participants

- Francois Brisebois

Presentation

Francois Brisebois {BIO 20127501 <GO>}

Okay. Hi, everyone. Thanks for joining today. My name is Frank Brisebois, I'm Senior Biotech Analyst here at Oppenheimer. It's my pleasure to introduce Avadel Pharmaceuticals, ticker is AVDL. From the company, we have CEO, Greg Divis to present. Avadel is a biopharmaceutical company. They're working on -- are you hearing some echo, Greg? Are you? No.

Gregory J. Divis {BIO 16183530 <GO>}

A little bit.

Francois Brisebois {BIO 20127501 <GO>}

A little bit. Yes. If the webcast might be open in your thing, if not it should be okay. So, all right, so Avadel is working on the development and commercialization of product called FT218 is for in the narcolepsy space here. So in terms of format, we will just have a fireside chat, feel free to send over any questions and Q&A tab at the bottom of your screen, I'll do my very best to get to them. So with that, Greg, thank you so much. And maybe just to help people not too familiar, it's a very important time with the company PDUFA date very, very shortly here, but for those may be not familiar just a quick background on Avadel.

Gregory J. Divis {BIO 16183530 <GO>}

Yes. Avadel although has been around for over 30 years has gone through quite a transformation over the last two-and-a-half to nearly three years and really today where we sit as a biopharmaceutical company will be focused on transforming medicines to really transform the lives of patients. We apply innovative solutions to medications to address challenges that patients face. And as you noted Franc, our lead drug candidate FT218, it's an investigational formulation of sodium oxybate that leverages our own proprietary drug delivery technology, that is designed to be taken once at bedtime for

the treatment of excessive daytime sleepiness and cataplexy in adults with narcolepsy. And as you note, our PDUFA date is 23 days away, October 15 and we're really excited about the progress we've made and getting to that next important milestone.

Questions And Answers

Q - Francois Brisebois {BIO 20127501 <GO>}

(Question And Answer)

Okay. Great. So I think to start, we have to talk about the PDUFA date. So I just want to be clear here I think that this has probably been touched on, you've been kind of a story where no news is good news. But as we have you here just in case, I just want to make sure that if there was any certification, Paragraph IV anything like that, this would be just have to be disclosed to the investment community. Is that fair?

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes. I think we certainly have stated going back over nine-months ago when we filed we filed our NDA that if we were to be asked to certify Paragraph IV for that we would notify the investment community as soon as we were able, and we definitely would do that. And again, with just 23 days to go until our PDUFA date, no news remains to be good news. And we've not been -- still not been asked by the FDA to certify P4. And again, as we stated, our NDA does not include a P4 certification, and based upon our data and packaging and propose a labeling, we just don't believe there's a basis to request such a certification. So again, no news remains good news, Franc.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. And it seems like, Jazz has tried to add a little news to Avadel not too long ago with the lawsuit, which I can't say seems very shocking. But so the lawsuit talked about formulation and orphan drug, exclusivity the ODE. So maybe, can you just help us remind us of when you got orphan drug designation for FT218? And what were the basis for that?

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes. Maybe before I just want to make a comment, because I really think it's important to share again with investors or your clients as well as that. From an intellectual property standpoint and from an FT218 perspective, we remain highly confident in our product and in our portfolio, and the fact that we were the first and we're the only company to develop a once nightly extended-release oxybate formulation that delivered both the PK release profile and the subsequent clinical results that we demonstrated in over 10 Phase 1 studies and again our highly statistically significant Phase 3 REST-ON trial, right? So we're very excited and confident in what we've developed and the intellectual property and the benefit that we have around it and the benefits of what a once-nightly oxybate product can do for patients.

As it relates to our orphan drug, we were granted orphan drug designation in January of 2018, and that was granted on the plausible hypothesis that FT218 may be, clinically

superior to the twice nightly formulation of sodium oxybate already approved by the FDA for those with narcolepsy. Due -- primarily due to the ramifications associated with the middle of the night dosing of the currently approved products, so orphan drug designation was granted in January of 2018 and subsequent to that as part of our NDA submission, we provided a robust data set to support our request to be granted orphan drug exclusivity as part of our exclusivity claim in module 1 over NDA, we remain very confident in our submission, but again I think it's important to note that despite our confidence in our submission and the robustness of our submission and the data supporting both the potential clinical superiority and the major contribution into patient care that we believe a once-nightly once-at-bedtime FT218 offers. We also don't believe that ODE or orphan drug exclusivity is necessary for us to obtain full FDA approval.

Q - Francois Brisebois {BIO 20127501 <GO>}

Interesting. And if you were just a couple of questions that are already coming in here. If you were to get ODE, if granted is that something that, that would be around PDUFA, that you would find out? When would we find out?

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes, that is our expectation as that will be decided upon at the time of PDUFA.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. And it's fair to say that, that so far the questions coming in labeling discussions is just no real surprises so far from your end?

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes.. I think what we've said as it relates to the NDA overall is that as you think about stepping back and thinking about the different major milestones you transition through with the last few weeks of that being kind of packaging information for use, labeling, and all those sorts of things whether it's acceptance, mid-cycle review, late cycle review or the last stage of this being labeling and related activities. Everything continues to be on track from our perspective. And as we step through those different milestones, and we're obviously in the throes of it right now and excited about where we sit, recognizing we still have 23 days to go and more work to do.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. Great. And when you mentioned, you don't need ODE to get approval. Do you need it to launch as well or no?

A - Gregory J. Divis {BIO 16183530 <GO>}

Well, again, I think when it comes to specific matters of the NDA or orphan drug exclusivity, we don't really want to talk in detail about it. It's just -- we firmly believe that in addition to the robustness of our submission that we don't think it's necessary to get our full approval from that standpoint.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. Great. And then, it seems like there's been some developments a little bit on -- it seems like a lot of these decisions will be taking care of very quickly in terms of the -- a potential for an injunction or what's -- can you just remind us of the timelines of a potential PI?

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes. So to address that question about kind of litigation and related timing, if you go back towards late July, the court issued a full scheduling order, that sets forth all of the dates related to litigation related events in this process we have including a potential motion of preliminary injunction should the other party decide to pursue one. So, when it comes to the timing around a potential preliminary injunction, what the court has authorized or stated in the scheduling orders that should FT218 be approved on October 15. The other party has three days until October 18 to decide if they intend to file a preliminary injunction and they must notify the court by the 18th of October.

And the answer to that is that they are going to file that injunction, they actually have to have those papers filed by October 22. Now, furthermore the court has already said a date should that PI motion be filed to hear the oral arguments in that motion of November 23 of 2021, right? So again, everything will be decided and arbitrated on within five weeks or so post our approval.

Lastly, I think and important enough to state, although, it's not related the timing is that, as it relates to what the -- how court has limited, what can be asserted in the preliminary injunction motion is that the court has stated that the other party can only assert just one claim from one patent and nothing else, right? We at Avadel can then defend ourselves based on non-infringement on that one claim from that one patent, and we have our one invalidity defense against that one claim from that one patent. So we think it's a very streamlined process. It's very efficient scheduling. It requires both parties to come forward quickly and efficiently post our approval and based on what we know today and again, we continue to believe that this litigation will not be a barrier to us coming to market should we be approved on October 15.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. So, I get a lot of questions, what are the potential scenarios are? Obviously, if (inaudible), but if we get approval, it -- these are all the potential scenarios as you've mentioned here. This is the potential PI and when it gets resolved or whatnot, and there's nothing else to share on potential outcomes, is that fair?

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes. I think that's right. If we get an approval, a currently there, as we sit here today, if we got an approval based on what's happened on the litigation to-date, we would be continue to prepare to launch and come to market should have preliminary injunction be filed. Again it hasn't been filed yet. Then we'll go through that process through November 23, and our view is that, that will not be -- based on what we know today will not be a

barrier to us coming to market. From that standpoint and will be going forward accordingly.

Q - Francois Brisebois {BIO 20127501 <GO>}

And anyways, you've talked about launching probably more full launch in 2022, is that fair?

A - Gregory J. Divis {BIO 16183530 <GO>}

That's correct.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. Okay. All right. Great. And then yes, this is just a question that's come up. Love to hear your thoughts and it seems like it is the correct partnership. But any issues with potential manufacturing inspections here for the product?

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes. Again, I think as I just previously noted, we don't want to get into any specifics and speak on specifics of the NDA review. Other than that, the general commentary we made about how the NDA has gone through and what we believe tick through all the major milestones, in the major events that we -- that you need to go through from that standpoint, including no P4 certification to-date. As it relates to inspections on any of our facilities that are part of our GMP manufacturing processes, we haven't provided any really details on any individual facility. What we have said is that, specifically to the facility where the primary manufacturing FT218 occurs. It's important to note that, that instead facility was inspected by the FDA, really just prior to the pandemic. So within the last two years for PAI, same equipment, same quality systems, no observations, no 483s, it's a very good inspection. So, again, one of the important aspects of your NDA review is, inspection history and the history of that facility, which we think we got a great partner in that regard as a global manufacturing CMO.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. All right. Great. I think am I missing anything at all in time getting a lot of questions around label and discussions and all that. Anything that you would like to mention, because I did not do a good job, not ask you something I should have asked you around the label here?

A - Gregory J. Divis {BIO 16183530 <GO>}

No. I think right now we're 23 days away from our PDUFA date. I think the NDA has gone as we would have expected and we're ticking through all those states gates that you would expect us to tick through and we're deep in it now and recognize that we're not through the finish line yet, but we really like where we sit today, knowing there's more work to be done and we're excited about the progress we've made and we've got this important milestone coming up. So, I appreciate the questions.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. All right. Great. And on the -- all right, so I will turn it more a little bit on the commercial effort here. So, the rest on publication just happened, can you talk about the awareness, it seems like the twice nightly has been around for a while. Is everyone aware of this once a night and in the medical community and just how much does the rest on publication help for that?

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes. Again I think, speaking more broadly medical and scientific communication is just a very critical area for us and our overall strategy to prepare for the launch of FT218, right? We've done a number of things including launching really what we would describe as our comprehensive medical and scientific strategy earlier this year, which includes the critical education and awareness building related initiatives from that standpoint. So, it is very, very important and something that we look at and assess and recognize that we need to continue to build more and more awareness of FT -- of once at bedtime FT218 and Avadel.

And the sleep data, the rest on publication in the sleep journal recently is an important step in that direction for us for sure, those top line results published in the peer-reviewed sleep journal, certainly, helps build scientific awareness, but it's just not --it just doesn't end or begin or end with that. We've had additional data presented throughout this year at the Sleep Conference in June at earlier conferences this year presenting some of our pivotal data, our secondary data, post-hoc data, as additional means to disseminate scientific information into the community about really the clinical benefits of FT218 for patients.

But again, it doesn't stop with just that data dissemination either. We've deployed a field-based medical affairs team, who's been active engaging in the scientific exchange with healthcare professionals around narcolepsy, around treatment options, answering questions regarding our data. And as you can imagine, we've done other things. Continuing education in the form of CME, advisory boards with KOLs and physicians and patients and payers. Really just doing your work, we're in a position to fully capitalize on the potential clinical promise of FT218. So, I think we believe our data is unequivocal. We think we can make a tremendous impact on patients. We've done a lot of work and building awareness to-date, but that's not stopping. It's going to continue up to and through and continue through launch. And we're excited to continue to bring new information into the marketplace, including some new data that will be presented post-hoc data at this upcoming CHEST meeting and the AAN meetings, a little later in October.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. And has it been a little more difficult for maybe the people involved now that a lot of these things have been virtual? Or -- and just dealing with the pandemic kind of lingering and adjusting to what we thought we were done with it. Now Delta's coming around and the next is -- has this been something that's been tricky because your PDUFA is not changing, right, the date. So, how have you been dealing with that?

A - Gregory J. Divis {BIO 16183530 <GO>}

Well, yes. I think when you think about the scientific congresses and that have all gone virtual to-date. Virtual is better than nothing, but you can't beat in person and that's why our team is traveling, and going out, and meeting folks who are willing to meet us in person and gathering people together in person to be able to present and discuss and engage on the narcolepsy at large on treatment options. And really trying to again, answer questions and build the requisite scientific exchange with clinicians and payers and others and key stakeholders in this important condition. So virtual is better than nothing Fran, but it's certainly not ideal and certainly nothing beats in person from our perspective and we've made the decision to make sure we're out in person wherever we can be and where customers are willing to connect and engage directly.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. Okay. Great. And you talked about a lot of the post-hoc data that's been out there. Obviously as post-hoc is probably not part of label discussions or anything like that. But what's been the most -- for investors, what do you think people should pay the most attention to that's gotten the best reception from the medical community?

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes. Well, I think first and foremost, awareness of our pivotal data has been really, really important to really understand and put the bed was historically was a debate of whether you needed two peaks and it was the second peak that really mattered in the dosing of the twice-nightly product. We've put that to bed unequivocal, our primary data at week 3 of treatment, at week 8 of treatment and week 13 of treatment across 6, 7.5 and 9 grams across the three co-primary endpoints is unequivocal in terms of its clinical -- meaningful clinical benefit and statistical significance.

The additional post post-hoc data was really just to look for different subsets of patients and really comes out of a lot of discussions with key opinion leaders, and looking for the data that they think is relevant for clinicians day in and day out, right? So I think all of the data is really important and that will be true for the data we present coming up in the coming converses here, a little later this year. But the most recent post-doc data we presented really talked about and reviewed are the same performance of our study, but in subsets of patients. So patients with or without cataplexy.

How did we do in terms of improving excessive daytime sleepiness whether a patient had -- or didn't have cataplexy? And the same, how did we improve daytime sleepiness for patients who were already on a stable stimulant or we're not on a stable stimulant, because we had both cohorts in our study group. And I think it's important to note that in those different patient populations, we continue to demonstrate a strong statistically significant and clinically meaningful effect at all doses and at all time period study.

In addition as at potentially ancillary benefit, we looked at weight loss and change in BMI with patients. So, we present the data that showed a statistically significant reduction in weight loss and BMI with approximately 18% of patients achieving a 5% or greater reduction in weight. Now again, that was in discussions with our KOL is looking and

seeing if that information or that data was found in our -- with our drug and clearly if we demonstrated that with FT218. So I think all-in-all, all the data has been well received by the medical and scientific community as stakeholders really understand that no matter how you slice it the twice nightly treatments still remain a burden for patients and it goes beyond just having to wake up in the middle of the night to take a medication, right? And as patients seek new options to gain control over their lives, we feel really good about our clinical product profile. The safety profile of our drug of FT218 and the opportunity we have to positively impact patients, should we be approved in 23 days.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. And so if this is not on the label though, the sales reps can bring it up or add or try to --

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes, we don't expect a post-hoc data to be in our label. But again, we're pleased to be able to disseminate this data through the right scientific channels, which is what we'll continue to do as we go forward with additional analysis.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. Great. And any updates on, obviously launch preparations, REMS, patient hub, how reimbursement payers. Anything that as we're getting close to here is different?

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes. Again, I think we're executing against that plan exceptionally well. We built our team and our organization, we -- our key commercial leadership and operational roles, underneath them are in place across all the different disciplines as you can imagine. Marketing, sales, patient services, distribution, operations, data analytics. All of those pieces are up and running and executing. We've identified our key and have -- for quite some time, we've had our key partners in place for REMS and patient hub. We're working closely with potential distribution partners now, as we finalize that and made a lot of progress in all the things that we need to be doing to ensure that we are ready to deliver the kind of launch that patients and physicians are expecting and who want to get access to once at bedtime FT218.

Conversations would payers have been consistent, and continue to be productive from our standpoint as we go through their processes in terms of what we can do from a from a prior approval standpoint and sharing clinical information and engaging in that discussion to beginning the process of taking the steps to position us for the appropriate access that we're looking to achieve, when we come to market and launch officially in 2022. So I think all of those key stakeholders progress has been made very well and we're executing against all of our plans and just super excited about the caliber of talent and an experience that we're bringing on to the team that not only have great track records of success, but have -- are the type of cultural fit and people we want to help build, successful launch of FT218 and build a successful company with Avadel.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. Okay. Great. And just kind of doing a mix match here, a lot of questions are coming in. Any thoughts about formulary hurdles just turn to step at it's AGs will be coming in which is no surprise. Any thoughts about that to in order to get to FT218?

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes. I think, our view on this category and we've done a lot of benchmarking, looking at what's occurred in the marketplace with the recent launches and how this category in particular, this molecule is managed, and there's a lot of utilization management that occurs. There is a step at its that occur already between having to fail generic stimulants one or two of those, having to qualify from a diagnostic perspective or medical attestation perspective and a number of steps that have to happen before you get access to any oxybate. We don't think that that's going to change for us, and we think that's okay, right from that standpoint.

So from a reimbursement perspective, clearly that payers, certainly have their process as you need to go through to have a clinical presentation to present a P&T, to go through the formulary decision-making process. But again, our perspective on that and how we think utilization will occur and utilization management will occur for this category. Our goal is to secure parity access, our goal is to be treated the same as the other products in the category and we think FT218 will do quite well in that setting accordingly. So again, I don't need is any change to that.

As it relates to the potential launch of an authorized generic for the twice-nightly product, from our standpoint it's something we've had to plan for from the beginning. We knew it was going to occur at least no later than January 1 of 2023. So we had every expectation, it was likely going to happen sooner. Because when you control these patients, the way that the current product does being able to initiate switches should not be that challenging, absent any additional competition. But I think from our perspective, the launch of the AG, and we've done a lot of discussions with payers in this regard, is that we expected to be a similar typical AG launch. And when in public -- from based on public disclosure that the -- in this case, Jazz is keeping some margin relative to the relationship with the AG distributor.

We certainly expect price to remain relatively robust in this category. Our expectation from a payer standpoint is that they're going to treat based on their feedback to us is they'll treat the AG likely like an extension to the brand. It will have the same kind of step edit requirements and absent pricing of the AG being materially different than what we would expect to be or what payers expect to be at this stage. We would expect it to be just another agent in the marketplace treated similar to us.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. And the AG is obviously twice nightly. So there's no --

A - Gregory J. Divis {BIO 16183530 <GO>}

AG is twice-nightly.

Q - Francois Brisebois {BIO 20127501 <GO>}

I think it's yes -- it's interesting, sometimes you -- that's almost gets lost sometimes when people fear about the generics coming in here so. And then on the number, the sales reps, are you -- have you already started hiring, like contingent on approval? Or is this something that you're just going to go after full steam after the PDUFA?

A - Gregory J. Divis {BIO 16183530 <GO>}

No. Again, I think a lot of work has been done in this space as well. And the team has done a great job and executing our salesforce scale plan, which is very disciplined and very analytically driven. We've done the full analysis of our sales force deployment strategy. And again, I think it's important to note that this is a highly concentrated prescriber audience, right? 500 physicians, over half of the business for sodium oxybate. Less than 2,000 physicians, who write over 80% of the category, and really 4,000 who write a 100% of it. So, I mean this is the cohort of physicians that we're going to target. So when you think about fit -- salesforce deployment, you're talking 50 plus reps in the marketplace, you should expect that to be the case for us from that standpoint. And we've actually begun the process to recruit and identify candidates and began the interview process of selection -- of finding the final candidate for those positions and that will continue on through PDUFA, but we won't make any official job offers to our sales organization until we -- do we get through PDUFA.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. And is this just like a 50 to 60 right off the bat that you go full or do you start 20, 30, 40 as it ramps up or are you trying to target all the physicians right away?

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes. We'll go 50 as we start that's our plan to go to 50, we'll build that over a couple of months to the balance of this year post approval and get them trained and ready to go into the field towards the end of this year.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. And are you sensing, I think launches are always difficult based on expectations maybe sometimes or -- and just are you expecting here especially in the pandemic, but is there -- are you feeling any pent-up demand here or is this something that you would consider paradigm changing where it takes a lot of education or just it seems pretty straightforward it's ones versus twice? Any thoughts there?

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes. Again, there's nothing we -- specifically we guided on and I think the answer to that question is probably yes to both of those points, right. I think it's really important to really understand this category in this market opportunity for us, right. For us, we're not just playing in kind of the 15,000 or 16,000 patients who are currently being treated with a twice-nightly product, right. When you think about the category, 170,000 diagnosed narcolepsy patients in the U.S. up to 130,000 are drug treated.

And a number of those who are sodium oxybate eligible, right, from that standpoint. So as we think about our target audience, it's not only those who are currently on treatment, right? It's those who have previously been on treating and discontinued. We've uncovered a cohort of patients who are sodium oxybate eligible, who have said no to treatment primarily due to the dosing related challenges. So again, I think each of those have a different kind of pent-up demand or uptake curve, as you think about it, right? There's obviously some intuitive low-hanging fruit for those who are on therapy today. We're having a hard time of the dosing, who maybe switches that occur early. Some may take a little longer to identify those.

But I think most importantly in that regard is that in all the research we've conducted, whether previously treated or currently treated or have said no to oxybate. Every patient, it's clear they rank once-at-bedtime dosing as the most important attributes. When we talked to hundreds of patients and physicians, when we talked to hundreds of physicians, really expect us to grab a meaningful share of the narcolepsy treatment market overall, right, among those oxybate eligible patients. So, we're excited about the prospects of what the market potential could be for us. As we continue to do our work and evaluate the opportunity for once-at-bedtime FT218.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. So -- but if you were to try to break down currently treated patients discontinued in newly diagnosed like you mentioned, and some are newly diagnosed and they would be treated but they said, no, I don't want to deal with twice-a-night, depends on how severe your narcolepsy as I guess. But we -- so you're saying the low-hanging fruit would probably be the discontinued, because it seems like the main reason for discontinuation is that second dosing or is it the currently treated clearly those are the ones that we think are easier to get. Do you have an idea yet or just the time will tell?

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes. And I think Franc, the really precise answer that a question is that it really depends on the target we're -- and that physician we're targeting. So if you're one of those 500 physicians, who treat and use over half of the sodium oxybate product in the marketplace today, you treat a lot of narcolepsy patients, but you're heavily penetrated in the sodium oxybate category. So in that situation, you're really looking for the low-hanging fruit, really maybe some switches and some discontinues, right? But within that same cohort.

As you think about those who are treat a lot of narcolepsy patients, but are a little bit under penetrated relative the sodium oxybate whether that's because they decided not to prescribe it for a patient or the patient has said no to it, I think the low-hanging fruit maybe something different, right, from that standpoint. It may take a little longer to get them, but I think we've got to think about it, with a cohort of targets that are this concentrated, we have an obligation. And quite frankly, requirement to be much more surgical of how we think about these things to ensure that, our messaging in our approach meets the needs of that office in terms of how they use narcolepsy treatments today.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. Is there in the space right now sodium oxybate, is there like a geographical discrepancy between certain docs in certain areas are much more prone to move on to sodium oxybate and certain are. Is there a difference here in terms of where you're approaching docs?

A - Gregory J. Divis {BIO 16183530 <GO>}

No. I don't really think that overall when you look at utilization kind of on a macro kind of U.S. map basis, big MSAs drive a lot of volume. You see larger stage drive a lot of volume for the most part, some states over represent themselves than they do relative kind of census -- then kind of prevalence or census related data. Ohio is a good example of that where they kind of punch above their weight for less than --for as a description relative to where they sit relative to total population or kind of epidemiology -- on an epidemiology basis. But again, we're fortunate to be able to be pretty surgical from that standpoint allow us to put our resources where the businesses today and where these patients exist today. And again, I think the concentrated nature of this category just makes it very efficient for us to be able to have the sort of kind of commercial infrastructure that you can build and execute against not have to go see 20,000, 30,000 doctors which really creates a diversion and what you have to build.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. And right. It seems like, between Xyrem, moving to Xywav's dynamic market, people are clearly trying stuff. But can you just remind us maybe the quit rates of people taking these sodium oxybate, right now? How long are they on them?

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes. We've done a lot of work to really try to understand that patient journey so to speak and what occurs leading up to diagnosis of an initiation of sodium oxybate and what occurs once the therapy is -- has been initiated. And when the sodium oxybate is initiated for de novo naive patient, what we see today after looking at 14,000 unique patients over a five-year period with longitudinal patient claims data, a very robust cohort of patients. We're able to see that for newly diagnosed patients. We see approximately 25% of those new starts discontinuing within the first four weeks of treatment.

And then through the balance of the first 12 months or for the next 11 months, you see another 25% discontinued. So, in total about half of all new starts, at least on the data we've looked at now is two different representative cohorts, demonstrates that there is a fall-off of about half of the patients within the first 12 months. Now, there's reasons for that. Some of that is dosing related, some of that is tolerability related, some of that is for other reasons, and we think we can potentially positively impact some of those patients who are eligible and should be on therapy but haven't been able to either handle the dosing schedule or too disruptive to their nighttime situation, and we're excited to try to help them in those patients.

Q - Francois Brisebois {BIO 20127501 <GO>}

Interesting. Okay. And a question just came in that's very similar to where I was going here. It's a good question. It's -- you mentioned recently you have about -- I think they

mentioned here about 80 patients enrolled in the Switch study, which would be switching from twice nightly to once nightly. Can you discuss it's open-label, any thoughts of the dropout rate of these patients and have any patients actually update or ask to switch back to twice nightly going from twice to once and saying, no, look it worked better for me twice nightly?

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes. I would say that of all the patients we've switched, it is predominantly, predominantly in preference and have had a positive experience on our once at bedtime FT218, right? From that standpoint. There's been very, very little churn of patients on our treatment and quite frankly the data we're capturing from them that will publish as we get closer to launch is only confirmatory of that in terms of their experience and their preference for the treatment that's highly, highly in favor of once at bedtime FT218.

And when you talk to some of these patients, the anecdotal commentary that they hear, that we hear from them and through their clinicians is really to us is going to be something that's a significant catalyst for our -- for once at bedtime FT218 over time. And specifically what I mean by that, when you hear patients say like I haven't slept through the night for 17 years and now I am, right, like that's really meaning and meaningful for us. If you hear patients saying, I can drive my car now, I had to quit driving for 10-years because of my middle of the night disruption.

Now, these are anecdotal comments for sure that are being played back to us. But as we go from 80 patients to 18 -- to 800 patients to 1,800 patients to whatever the number is going to be like though that will become a catalyst and this really tight-knit patient advocacy, patient community that we think is going to be something over time, that is going to really be a major driver for us -- for -- and for once at bedtime FT218.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. All right. Great. Well, we're coming close to the time here. I just want to double check on, obviously, it costs a lot of money to run these launches sometimes. And I was just wondering, can you mention your balance sheet, where were you at the end of the last quarter you reported? And you have a convert that matures I believe in '23 here. So any thoughts on that? And just to finish it up to, I know that the focus has been to bring it, first, second, third priority is FT218. But any thoughts about going back the other way and increasing the pipeline and/or just using the micro pump for something else?

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes. Great questions. So last reported a little over $200 million in cash as of June 30. We've obviously burned some cash incentive as we know close out the end of -- our end of Q3. So it's under $200 million today for sure. But we certainly think that that cash on hand is sufficient to fund the investments needed to complete the NDA to get ready to launch, to continue to present data and be fully ready to launch, right? I think it's important to note that, where -- as part of our always ongoing processes, we will have and will continue. And what we think is a very disciplined way to evaluate what are kind of

near and long-term cash needs to support the growth of Avadel is, but we certainly feel we've got a sufficient cash on hand to get us ready to launch for sure.

When it comes to the converts, they mature in February 2023, and although it's not an issue that we're solving for today. It's something we've thought a lot about and is certainly on our planning horizon from that standpoint. And I think as we navigate through an approval and navigate through a potential PI should there be one. I think, we'll find ourselves in a situation where we want to make sure we have the right plan to address those convertible notes appropriately in the overall strategy and the capital needs of a Avadel, but I will say lastly on this point that we're always mindful of really balancing those requirements and where we sit today. And the potential impact on our existing shareholders, we feel really thankful and blessed for the support we receive from our shareholders, the patient some of our shareholders have had over the last number of years despite what I think has been a lot of progress over the last two-and-a-half plus years and we want to make sure that we always see things through a lens of what's in their best interest and what's in the best interest of growing Avadel over time.

And in that regard, in terms of growing Avadel over time and we think about kind of what's next, you're right, priority 1, 1a, 1b, 1c is to continue to navigate FT218 ensure we're fully realized its full potential. But when you think about what's next Franc, there's really three what we consider kind of legs to that stool or that strategy, right? Although they're not necessarily sequential in nature. There are certain priorities that we will focus on to ensure that we deploy resources that gives us the best potential return to patients and of course to our shareholders. The first is, how do you maximize the 218 opportunity on itself, right. This is a lifecycle management strategy, this would consider additional indications as people have asked us about broadening target patient populations, as people have asked us about and potentially offering alternative formulations, leveraging our technology platform which people have asked us about as well. So all of that is designed to fully maximize the FT21 opportunity -- FT218 opportunity at large.

Second would be to maximize and leverage the infrastructure we're building in sleep and commercially overall. This likely takes us into more of a BD&L, our business development and licensing focus, is there opportunities to expand our portfolio through collaboration, leveraging the investment and capabilities, we're building and making across the organization, in rare diseases and specifically in sleep ideally or related adjacencies such as CNS. And then the third leg is the one you mentioned about our drug delivery technology platform. It's certainly provides a next opportunity for us, and the search for kind of the next FT218 like opportunity. But I think it's also important to say that, given the concentrated use of therapeutics in this kind of rare sleep medicine, this third leg of the strategy stool is one that likely moves us into an adjacency or some other area that may bring some synergy, but really not complete synergy.

So although, it's important. I think we really have a duty to maximize the 218 opportunity as a primary focus and the infrastructure build as a secondary focus as we do the work in our search for kind of the next FT218 like opportunity for our technology platform.

Q - Francois Brisebois {BIO 20127501 <GO>}

Okay. All right. Well, that's great. I think we're up on time. October 15 is coming shortly. So, thank you very much for your time here, Greg. I know it's been busy on here.

A - Gregory J. Divis {BIO 16183530 <GO>}

Yes. Thanks, Franc. Appreciate for the invite and the chance to participate. Have a great day.

Q - Francois Brisebois {BIO 20127501 <GO>}

Thank you.

EXHIBIT 4

Avadel Announces Sale of Hospital Sterile Injectable Drug Portfolio for $42.0 Million

July 1, 2020

DUBLIN, Ireland, July 01, 2020 (GLOBE NEWSWIRE) -- Avadel Pharmaceuticals plc (Nasdaq: AVDL), a company focused on developing FT218, an investigational, once-nightly formulation of sodium oxybate for treating excessive daytime sleepiness and cataplexy in patients with narcolepsy, today announced the sale of its portfolio of sterile injectable drugs used in the hospital setting, including three commercial products, Bloxiverz®, Vazculep®, and Akovaz®, as well as Nouress™, which is approved by the U.S. Food and Drug Administration, to Exela Sterile Medicines LLC for a total of $42.0 million.

"The sale of the sterile injectable drug portfolio is a significant milestone for the Company, as it further reflects our commitment to strategically focus on advancing FT218 through the regulatory review process and, if approved, bringing our once-nightly formulation of sodium oxybate to patients," said Greg Divis, Chief Executive Officer of Avadel. "By divesting our portfolio of sterile injectable drugs, we are now singularly focused on supporting the regulatory approval process, market planning and maximizing shareholder value for FT218."

Under the terms of the agreement, Avadel will receive $14.5 million upfront and the remaining $27.5 million will be paid out to Avadel over the next 13 months. The transaction closed on June 30, 2020.

About Avadel Pharmaceuticals plc
Avadel Pharmaceuticals plc (Nasdaq: AVDL) is an emerging biopharmaceutical company. The Company's primary focus is the development and potential FDA approval of FT218, which has completed a Phase 3 clinical trial for the treatment of narcolepsy patients suffering from excessive daytime sleepiness (EDS) and cataplexy. For more information, please visit www.avadel.com.

About FT218
FT218 is an investigational, once-nightly formulation of Micropump™ controlled-release (CR) sodium oxybate. The Company recently completed the REST-ON study, a pivotal, double-blind, randomized, placebo-controlled Phase 3 trial, to assess the efficacy and safety of FT218 in the treatment of excessive daytime sleepiness and cataplexy in patients suffering from narcolepsy. FT218 has been granted Orphan Drug Designation from the U.S. Food and Drug Administration (FDA) for the treatment of narcolepsy. The designation was granted on the plausible hypothesis that FT218 may be clinically superior to the twice-nightly formulation of sodium oxybate already approved by the FDA for the same indication. In particular, FT218 may be safer due to ramifications associated with the dosing regimen of the previously approved product.

Cautionary Disclosure Regarding Forward-Looking Statements
This press release includes "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934. These forward-looking statements relate to our future expectations, beliefs, plans, strategies, objectives, results, conditions, financial performance, prospects, or other events. Such forward-looking statements include, but are not limited to, the anticipated benefits of the sale of the Company's sterile injectable drug portfolio, the planned submission of the FT218 NDA to the FDA and the commercial launch of FT218, if approved. In some cases, forward-looking statements can be identified by the use of words such as "will," "may," "could," "believe," "expect," "look forward," "on track," "guidance," "anticipate," "estimate," "project," "next steps" and similar expressions, and the negatives thereof (if applicable).

Our forward-looking statements are based on estimates and assumptions that are made within the bounds of our knowledge of our business and operations and that we consider reasonable. However, our business and operations are subject to significant risks, and, as a result, there can be no assurance that actual results of our research, development and commercialization activities and the results of our business and operations will not differ materially from the results contemplated in such forward-looking statements. Factors that could cause actual results to differ from expectations in our forward-looking statements include the risk that the impact of the current COVID-19 pandemic on our financial results and results of operations could be greater than we anticipate and the risks and uncertainties described in the "Risk Factors" section of Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2019, which we filed with the Securities and Exchange Commission (SEC) on March 16, 2020 and subsequent SEC filings.

Forward-looking statements speak only as of the date they are made and are not guarantees of future performance. Accordingly, you should not place undue reliance on forward-looking statements. We do not undertake any obligation to publicly update or revise our forward-looking statements, except as required by law.

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