Statement of Consumers Union, publisher of Consumer Reports
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before
FDA's Public Meeting on
Prescription Drug User Fee Act
February 16, 2007

Ladies and Gentlemen of the FDA Panel:

Thank you for the opportunity for Consumers Union, the independent, non-profit publisher of *Consumer Reports*, to comment on the proposed fourth extension of the Prescription Drug User Fee Act (PDUFA IV).

Support General Appropriations for all of FDA's Budget

We believe that your duties are so essential for the health and safety of the American public that they ought to be fully funded out of the general Treasury. If a user fee system is necessary because of the pressures on the budget, then there should be no strings attached to the money—no hoops to jump through to meet industry goals. Comments submitted to the Union of Concerned Scientists by many FDA employees clearly show that the current system is having a corrupting influence and is putting products before American consumers with outstanding safety issues. Therefore, we strongly endorse legislation that has been offered in the past by Congressman Maurice Hinchey that proposes any FDA revenues derived from the regulated industry not be burdened with conditions on their use set by the industry.

Good Budget News—but still Woefully Inadequate in Post Approval Safety Area

We are pleased that the final FY 2007 Congressional action singled out the FDA for increased appropriations, and that the President's budget request for FY 2008 also provides a noticeable increase for the agency, especially when compared to many other HHS agencies.

But the amounts provided and requested do not make up for years of resource erosion or allow the FDA to do the job that a "gold standard" agency should be doing.

More resources are needed, if not through appropriations, then through user fees that give new emphasis to post-approval safety. As the September Institute of Medicine report said,

> Regardless of the source of the funds, the committee reiterates that the functioning of a drug safety system that assesses a drug's risks and benefits

> throughout its lifecycle is too important a public health need to continue to be under funded.

As the Federal Register notice describes, under PDUFA, we have gone from very careful review of new drug applications, which caused the FDA to be considered the 'Gold Standard' in drug approvals, to being one of the quickest approvers of new applications. Consumers Union supports rapidly bringing life-saving medicines to market. But now that we lead the world, we also face a 'safety gap' in which Americans are at times being used as, if you will, "guinea pigs" for new, mass marketed medicines. We would like to see the same emphasis given to closing the safety gap as has been dedicated to closing the so-called drug approval gap. We need to match the high speed of approvals with a high-quality safety system.

The tentative PDUFA IV agreement calls for an increase in safety issues of about $29 million, and the proposal thankfully removes the limit on the period of time that PDUFA funds can be used for safety work. That's a start—but woefully inadequate. The IOM report called for far more than $100 million (see discussion in Chapter 7) in new safety and scientific resources.

Start Over—Give Safety More Meaningful Specifics

But even more, we urge the FDA—or if it is too late for the FDA, for Congress—to start over. Put this deal on hold, and start over. When you look at the user fees that go to speeding approval, they are very detailed, date specific deliverables.

But we don't get the same treatment on the safety side. The entire tone and structure of the safety provisions are different. They are, frankly, very fuzzy, very academic, very bland.

The industry gets 90 percent of new drug applications decided within a certain number of days, and requests for meetings answered within two weeks.

What does the consumer public get? We get sentences like

> "…FDA would use these funds to continue to enhance and improve communication and coordination between pre- and postmarket review staff."

Or

> "Potential activities in this area might include integration of certain proposed recommendations made by the [IOM]."

We get

> "a public workshop to identify best practices in this emerging field, ultimately developing a document that addresses epidemiology best

practices…"

As someone once said, 'where's the beef?'

And where is the sense of urgency? The February 7, 2007 issue of JAMA carries a new article estimating that 2,000 unnecessary deaths occur each year from the use of Trayslol. That means about two fellow citizens will die during the course of this meeting, yet this is an issue that has been before the FDA for more than a year.

As consumers, we would like to see some tough deliverables, just like PhRMA gets. The meetings and better communication described in the agreement may be necessary, but we need more resources for of specific, "on-the-street" safety work. The following list is just illustrative, and assumes that legislation similar to S. 484, the Kennedy-Enzi bill, is enacted. It is important that PDUFA IV raise enough resources to ensure the full implementation of important legislation that gives the FDA the powers it needs to ensure true drug safety:

> --increase by 100 percent (that is, double) the percent of clinical trial data and Investigational Review Board applications audited to ensure the ethical treatment of enrollees, the experiments' integrity, and the sponsor's compliance with good scientific practice[1]. As one witness testified before the Energy and Commerce on February 13th, the IRB process is 'broken' and patients are subject to needlessly dangerous, unscientific proposals. As for the quality of RCT data, how many more Keteks are 'out there;'
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> --each year, identify **X** of the most commonly used off-label drugs and require a Phase IV trial to determine whether there is scientific basis to support the safe and effective use of those drugs for that off-label purpose. This proposal would in no way interfere with a physician's right to prescribe or deny drugs to patients, but it would institutionalize a way of bringing some science to this are of pharmacology. A recent report estimated that 21 percent of 160 commonly prescribed drugs are prescribed off-label, and in 73 percent of the cases, there was little or no scientific support;
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> --set a date certain for IT modernization that will ensure the electronic filing of all applications, amendments, petitions, adverse event reports, and other data required by FDCA laws relating to drugs. Additional resources for a modern IT system are essential. The FDA has estimated that it needs about $20 million a year for each of the next five years for IT modernization. Consumer groups have been told that at the end of 2006, about half of all the FDA's computer systems

[11] It is reported that the FDA is revising regulations allowing drugs used in a Phase 1 trial to be exempt from quality control manufacturing requirements. If this is accurate, there should be some system of sampling a certain percentage of these drugs for purity and safety. See Triangle Business Journal, Nov. 3, 2006, "Triangle scientists reticent about FDA shift." Additional resources in this sector will be especially needed because of the growth in trials overseas. ("Up to Two-Thirds of Clinical Trials May be Done Abroad, Study Says," Washington Drug Letter, January 8, 2007, p. 8.

would no longer be served by vendors because they are so antiquated. Neither the appropriations budget nor this PDUFA agreement (which provides for another $4 million) does enough to meet that need. The language in the PDUFA agreement clearly shows the inadequacy of the agreement: the agreement uses the phrase "more integrated" rather than just the word "integrated;" "would accelerate the movement" rather than "achieve." PDUFA IV should see the realization of a modern IT system that will ensure the best tracking of safety problems;

--set a date certain that the FDA will be able to use de-identified information from the CMS databases to conduct epidemiological studies, and conduct **X** studies per year;

--investigate all serious adverse event reports within 15 days, and conduct at least **XX** investigations per year into patterns or clusters of adverse event reports to determine if REMS[2] action should be taken;

--increase by 100 percent the inspection of manufacturing (including compounding) facilities for compliance with FDCA laws;

--through active outreach and recruitment, develop and maintain a list of potential advisory committee specific experts who have no conflicts of interest and who have indicated a willingness to be appointed to future relevant advisory committee vacancies, and such advisory committee specific list shall equal at least 50% of the number of individuals serving on each such advisory committee;

--assuming the FDA is given the legal authority, in addition to the clinical trial registry and results databases established by Title III of S. 484 for drug applications received after the enactment of this Act, develop over a phased-in four-year period ending in 2012 a similar registry of clinical trials and clinical trial results for those trials initiated or completed after 1997 and before the effective date of this Act.

--take action, which may include the levying and collection of civil monetary penalties provided under section 502(f)(3) (as added by S. 484) against at least 50 percent of the applicants who have failed to complete follow-up safety studies or trials as provided under section 505(o)(4)(D) and (E) (as added by this Act).

--ensure that all scientific opinions and safety concerns from FDA-funded staff are made publicly and easily available during the advisory committee process

--address the unapproved drugs problem. Currently about 2 percent of all prescriptions are 'unapproved' drugs, drugs which generally were on the market before 1962 and have not had to prove efficacy, or in some cases of drugs approved before 1938, have not even proved safety. The FDA has indicated that

[2] Risk Evaluation and Mitigation Strategies, a term used in S. 484, a bill by Senators Kenney and Enzi.

budget restraints prevent them from moving faster to determine the safety and efficacy of these drugs.[3]

Generics and Biogenerics

We appreciate the budget effort to reduce the backlog of generic drugs. We hope that the budget and, if necessary, the PDUFA agreement, will be able to assist in the implementation of legislation such as the Waxman-Schumer biogenerics legislation, once that legislation is enacted. Biogeneric approval will be much more resource intensive than traditional pharmaceuticals, and we will need substantially more resources to make the promise of lower cost biogenerics a reality.

Delegation of Nomenclature to Companies that have violated FDA Rules and Laws?

We urge that the proposal for "a pilot program that shifts responsibility for testing proposed proprietary names from the FDA to the pharmaceutical industry" be limited to companies which have not been found in violation of DTC or other violations of the public trust. For example, the New York Attorney General's investigation of Paxil's clinical trials should disqualify that sponsoring company from public trust in the reporting of proprietary names for at least a number of years.

DTC User Fees: Will They Work Unless Congress Gives the FDA Civil Monetary Penalty Authority?

We support pre-clearance of television and, frankly, all other advertisements for prescription drugs. Consumers Union's past investigation have found that companies repeatedly violate advertising standards, complete ad cycles before the FDA catches up with them, and escape without effective penalty for misleading the American public. For example, in our February 2003 Consumer Reports magazine, we noted that Claritin had received a total of 11 regulatory letters about problems with their ads. The FDA needs stronger authority in this area.

While we understand that there is initial industry interest, we are not sure the DTC user fee program will work. Since pre-clearance is voluntary, and since the FDA has little real power to discipline those who violate the standards, some companies may avoid paying the user fees and hope they get away with the deceptions. This is especially a problem because of the need to build up a reserve fund at the beginning of the program through much higher fees.

We are lobbying the Congress to make it clear that the Civil Monetary Penalties in a bill like Senators Kennedy and Enzi's apply to violations of DTC standards, and that repeat

[3] See letter to Rep. Markey from the FDA, described in Inside Health Policy, January 9, 2007, "Markey Eyes Bill On Stronger Unapproved Drugs Enforcement."

violators pay a much higher penalty. Unless Congress enacts a requirement for pre-clearance or strong, automatic penalties for violations, this new user fee initiative may not work.

Also, we are concerned that there are many other advertising formats—the Internet, continuing medical education forums, magazines, and pamphlets to doctors—where the adequacy and honesty of the information being provided should be audited. Clearly, in many ways, the companies repeatedly violate the rules against off-label promotion. The FDA needs to monitor more of those advertising modes—for which it will need additional PDUFA resources.

PDUFA V: Patients and Consumers Should be at the Negotiating Table

Finally, we hope that the FDA will support Congressional language requiring that when we consider PDUFA V in 2012, that consumers and patients get to participate in the real negotiations. We thank you for this meeting and the many previous consultations. But since PDUFA triggers taxpayer appropriations, and since some of the money is now being spent on consumer patient safety issues, that part of the public should be at the negotiating table.