Alliance for Pharmacy Compounding

Compounding the Joy of Living®

Email Vote – APC Board of Directors

7 August 2024

Board Members: Chair Joseph Navarra, Vice President Gina Besteman, Treasurer Alexander Pytlarz, Immediate Past Chair Anthony Grzib, Gopesh Patel, Philip Smyth, Cheri Garvin, Matt Martin, Mark Filosi, Melissa Stefko, Stacy Hightower, Stephanie Chacon, Matt Johnson, Dave Hill, Erin Michael, Peter Koshland, Amy Frost, and Shaun Noorian, and PCF President Jennifer Burch.

Staff: CEO Scott Brunner

1. **NEED BOARD APPROVAL OF SHORTAGE DRUG BEST PRACTICES DOC.** Attached draft is the work of a group of our members (chaired by Gina Besteman and supported by Tenille Davis) to create pharmacy best practices guidance for shortage drug compounding. It's particularly timely in this extended moment we're in with GLP1s in shortage. Plan is to release it to members this Friday in our e-newsletter – provided you approve it – and then to newsmedia and Boards of Pharmacy on August 14. Our member relations folks are arranging a reporter roundtable or two for the 14th, and I've invited NABP's Al Carter to join us for those roundtables; he's trying to arrange his schedule.

   The work group determined that we were better served by making these more general to all shortage drugs – the doc will have a longer shelf life, in addition to other reasons – than to create a document specifically focused on GLP1 compounding.

   No later than 5pm ET this Wednesday, August 7, please review and the reply-all with "Yay" (meaning you approved of the document) or "Nay" (meaning you do not approve). If you have questions, ask away.

All APC Board of Directors approved of the shortage drug best practices document on August 7, 2024.

Alliance for Pharmacy Compounding

Compounding the Joy of Living®

Best Practices When Compounding FDA-Approved Drugs Listed in Shortage
August 2024

The Alliance for Pharmacy Compounding supports the responsible compounding and dispensing by compounding pharmacies of "essentially copies" of FDA-approved drugs when those drugs are listed as "currently in shortage" on the FDA Drug Shortage List, as allowed for in FDA guidance.

These best practices are tailored to 503A state-licensed compounding pharmacies. ***Pharmacies should seek legal counsel on the matter before compounding copies of FDA-approved drugs in shortage. Moreover, APC makes no claim that adhering to these best practices will protect a pharmacy from drugmaker lawsuits, regulatory citation, or legal action.***

BACKGROUND

Federal law delineates precise criteria for what active pharmaceutical ingredients may be used in compounded human-health medications. To be eligible for compounding, an active pharmaceutical ingredient must:

1. Have an applicable USP or National Formulary monograph; or
2. Be a component of an FDA-approved product; or
3. Appear on the final or interim 503A or 503B Bulks lists published by FDA.

Generally, federal law prohibits the compounding of a medication that is a copy of an FDA-approved drug, but provides for a few important exceptions, including during drug shortages.

According to FDA guidance, a compounding pharmacy may prepare "essentially a copy" of an FDA-approved drug when that drug is listed as "currently in shortage" on the FDA drug shortage webpage. FDA has affirmed this in media reports. This exception is not a loophole. It's an intentional and essential policy for assuring patients can continue to access necessary drug therapies when any FDA-approved drug is in shortage. For years, traditional compounding pharmacies have helped assure that continuation of care. Based on a patient-specific prescription from a provider, they compound copies of FDA-approved drugs that can be lifesaving for some patients.

For example: When asked in APC's October 2023 Compounder Profile Survey to name a drug or drugs that had been listed on the FDA Drug Shortage List in the previous 12 months that the pharmacy had compounded based on a prescription, respondents named the following:

- Belladonna and Opium Suppository
- Bupivacaine HCl Injection
- Desmopressin Acetate Spray
- Dexamethasone Sodium Phosphate Injection
- Dextrose 50% Injection
- Diazepam Gel
- Gentamicin Sulfate Injection
- Ketamine HCl Injection
- Methotrexate Sodium Injection
- Oxytocin Injection
- Rifampin Injection
- Semaglutide Injection
- Sodium Bicarbonate Injection
- Sucralfate Tablet
- Tirzepatide Injection
- Viscous Lidocaine
- Lidocaine HCl Injection

Most recently, the shortage of blockbuster FDA-approved GLP-1 weight-loss drugs has shone a new spotlight on compounding, as providers write prescriptions for compounded versions of those medications – essentially copies of the FDA-approved drugs – and compounding pharmacies are preparing and filling those prescriptions.

BEST PRACTICES

Because shortage drug compounding by traditional compounding pharmacies is an essential part of the American drug supply chain – and, also because of the present spotlight on that practice as compounders prepare and dispense compounded GLP-1 drugs – APC offers these best practices for compounding pharmacies when preparing copies of FDA-approved drugs based on a prescription from a provider for a specific patient.

1. Review the FDA Drug Shortage List regularly.
    a. A 503A pharmacy may compound a copy of an FDA-approved product while it appears on the FDA Drug Shortage List.
        i. FDA's drug shortage website can be confusing, often listing certain dosage forms or strengths of a drug as "available." However, the precise language of the guidance document allowing shortage drug compounding is "currently in shortage." Any FDA-approved drug listed with that precise status may be compounded pursuant to a prescription.
        ii. The active pharmaceutical ingredient and dosage form of the FDA-approved drug are what is listed as "currently in shortage," not merely the API.

iii. Pharmacies should check the FDA drug shortage list prior to preparing a copy of an FDA-approved drug and should maintain documentation to demonstrate to regulators that the drug was in shortage at the time it was compounded.
    1. If the drug is to be compounded because the approved drug product is listed on the FDA drug shortage list, the prescriber or compounder should include a notation on the prescription that it was on the drug shortage list and the date the list was checked.

b. For 503B outsourcing facilities, FDA guidance allows a 60-day period in which facilities may continue to compound an essential copy after the drug comes off FDA's shortage list (once the status has been changed from "currently in shortage" to "resolved.") While some have reasoned that this should also apply to 503A pharmacies, allowing them to continue to dispense a copy up to 60 days after the drug comes off the shortage list, the legality of that argument has not been tested to determine if it is acceptable to regulators. Therefore, it's a best practice for 503As to cease preparing and dispensing copies of FDA-approved drugs immediately when the drug is removed from the shortage list.

c. When compounding a copy of an FDA-approved drug, it is best practice to prepare the compounded formulation, concentration and preservative to the same specifications as the FDA-approved drug to prevent confusion in prescribing or administration.

2. Sourcing and testing shortage-drug API
    a. Pharmacies may only source API from state-licensed wholesalers who purchase from FDA-registered manufacturers, or order directly from FDA-registered manufacturers. Verify from the wholesaler that the manufacturer is registered with FDA and the API meets all the requirements of section 503A, and that both hold the appropriate permits or licenses in their home state and the state being shipped into.
    b. If a pharmacy is sourcing API from a new or unfamiliar wholesaler or manufacturer, the pharmacy should send a sample of the API for independent third-party testing of the API's potency and purity before preparing and dispensing it for the first time.
    c. Pharmacies should expect that vendors have processes in place to verify the quality of the chemicals being sold, which includes identity testing to prove that the chemical is what it says it is on the label. Evaluate the overall processes of chemical vendors, ask questions. Relying only on the manufacturer's Certificate of Analysis is not adequate validation. Consider requesting the wholesaler's batch release testing, which should be an ID test at a minimum, but could also include purity and water content. This testing is performed in addition to the testing by the manufacturer.
    d. Adhere to USP Chapter <797> testing requirements for sterility, endotoxin, stability, particulate, antimicrobial effectiveness, and container closure integrity studies.
3. Dispensing
    a. Counseling must be offered to the patient or the patient's agent/caregiver. Providing written information that assists in the understanding of how to properly use the compounded medication is advised.

b. Instructions should be written in a way that a lay person can understand (especially directions including dosage titrations and conversions between milligrams and milliliters or units).
c. Multi-dose sterile vials should be labelled to be discarded 28 days after puncture.
d. If a medication is to be shipped or delivered, temperature verification studies should be performed to prove that the medication can be kept at the proper temperature throughout the delivery process.

4. Working with prescribers
    a. Make sure physicians or other prescribers you work with understand that for a compounded drug to be dispensed – even if it is a copy of an FDA–approved drug – the prescription must be written for the compounded API. Pharmacists don't determine when a compounded drug is dispensed, prescribers do.
    b. Make sure physicians or other prescribers you work with understand that the price of the compounded drug is not a legal basis for prescribing it in lieu of the FDA-approved drug.
    c. See APC's "clinic billing" best practices document if you intend to bill a prescriber's office for patient-specific prescription and consult APC's Constructive Transfer brief if the shortage medication is intended to be administered in a prescriber's office and is a controlled substance.
    d. Like all medications, compounded drugs can only be prescribed in the presence of a valid patient-practitioner relationship and can only be dispensed by a pharmacy after receipt of a valid patient-specific prescription order.
    e. FDA recently published a compounding risk alert that details adverse events associated with prescribing errors of compounded GLP-1 drugs. Pharmacists have a duty to question prescribers when orders are written in a way that is outside of the normal titration or dosing schedule of a medication.
5. Marketing concerns
    a. Never claim or insinuate that any compounded drug is "FDA-approved" or claim to use "FDA-approved ingredients." FDA regulates but does not approve API. It only approves finished-form drug products.
    b. Never refer to a compounded preparation as "generic" or use the brand-name or image of the FDA-approved drug in any materials, even if the medication is a copy of an FDA-approved drug product.
    c. Never make a direct comparison between a compounded medication and a generic or brand-name manufactured product. Pharmacies may indicate in marketing materials that the compounded copy of the FDA-approved drug contains the same active pharmaceutical ingredient as the FDA-approved drug.
    d. Never make claims of safety or efficacy of the compounded product. "Safe" and "effective" have legal meanings in the Food, Drug & Cosmetic Act and may not be used to refer to compounded drugs.
    e. Do not use photos of the FDA-approved, brand-name product in your marketing. Those are the intellectual property of the drugmaker and using them can put your pharmacy at

risk of legal action. The pharmacy's website and other marketing may highlight accreditations, professional affiliations, testing protocols, patient-reported outcomes data, etc., that demonstrate the pharmacy's commitment to quality.

f. Advertising that patients will/may save money using compounded medications compared to manufactured products is not allowed.

Following these best practices can help keep patients safe as compounders can continue to help meet the need for medications that are otherwise unavailable due to drug shortages.

The Alliance for Pharmacy Compounding is the voice for pharmacy compounding, representing more than 500 compounding small businesses – including compounding pharmacists and technicians in both 503A and 503B settings – as well as prescribers, educators, researchers, and suppliers.

In traditional compounding, pharmacists create a customized medication, most often from pure ingredients, for an individual patient pursuant to a prescription. Pharmacists' ability to compound medications from pure ingredients is authorized in federal law and for good reason: Manufactured drugs don't come in strengths and dosage forms that are right for everyone, and prescribers need to be able to prescribe customized medications when, in their judgment, a manufactured drug is not the best course of therapy for a human or animal patient. Other times a medication is not available to a patient due to a shortage, and a compounding pharmacy is legally allowed to produce a copy of that medication.

Every day, APC members play a critical role in patients' lives, preparing essential, custom medications for a range of health conditions, including autism, oncology, dermatology, ophthalmology, pediatrics, women's health, animal health, and others.