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Alliance for Pharmacy Compounding

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Division of Dockets Management (HFA-305)
Food and Drug Administration
Department of Health and Human Services
5630 Fishers Lane, Room 1061
Rockville, MD 20852

Docket No. FDA-2016-D-0271

RE: Comments to the Revised Draft Guidance for Industry: *Hospital and Health System Compounding Under the Federal Food, Drug, and Cosmetic Act*

Thank you for the opportunity to submit comments on the recent revision (Revision 1, October 2021) to the Food and Drug Administration's (FDA) Draft Guidance for Industry (GFI) - *Hospital and Health System Compounding Under the Federal Food, Drug, and Cosmetic Act* (FDCA). We appreciate the opportunity to provide input to the FDA on this important GFI before it is finalized.

The Alliance for Pharmacy Compounding (formerly IACP) is the voice for pharmacy compounding, representing compounding pharmacists and technicians in 503A state-licensed pharmacies, 503B outsourcing facilities, and in both 503A and 503B hospital and health system pharmacies. Many providers, educators, researchers, and suppliers in the compounding space are also APC members. Compounding pharmacists work directly with prescribers – including physicians, physician assistants, nurse practitioners, and veterinarians – to create customized medication solutions for patients and animals whose health care needs cannot be met by manufactured medications.

APC endorses the agency's proposed revisions to the 2016 version of this GFI that remove the one-mile radius limitation and relaxes the documentation required for a prescriber's determination that a compounded drug provides a "significant difference" to a patient over an FDA-approved drug for purposes of meeting the "essentially a copy" prohibition.

However, the GFI indicates that FDA does not intend to take action on the prescription requirement in 503A of the FDCA if "the compounded drug products are used or discarded within 24 hours of transfer out of the pharmacy." APC is concerned that this time frame is arbitrary and not evidenced-based to best balance patient safety with patient access to necessary medications. We strongly recommend that

this provision of the GFI be further revised to allow for a system based on the beyond use dates (BUD) contained in USP 795 and USP 797 chapters on non-sterile and sterile compounding respectively, which should be rooted in scientific evidence and tailored to the individual substances being compounded. An arbitrary, 24-hour use-or-discard requirement could lead to patient access problems within hospitals or hospital systems and increased physician or nurse bedside compounding – instead of compounding by pharmacy professionals who are state board licensed and USP-compliant.

APC reiterates our comments submitted in July 2016 regarding the previous version of this GFI: We have strong concerns about a GFI carving out exceptions to the prescription requirement in 503A of the FDCA for hospital pharmacies to meet the urgent medical needs of patients when an FDA-approved drug or a drug compounded by an outsourcing facility is unavailable – while the agency takes the position that the exact same statutory language in the FDCA precludes any such guidance for patients being treated in non-hospital clinical settings.

APC and other pharmacy compounding stakeholders have for years attempted to engage FDA on a consensus solution to allow providers to be able to obtain limited quantities of compounded drugs from 503A pharmacies – under state and USP standards and tight safety guardrails – to meet an urgent medical need when those drugs are unavailable commercially or from an outsourcing facility. Unfortunately, our efforts have been consistently disregarded by the FDA. Yet the agency's stated reason for that disregard is strikingly inconsistent: FDA says that under the exact same statutory language in the FDCA as passed by Congress, only hospital pharmacies should be allowed any flexibility on the statute's prescription requirement to meet their patients' needs, while other state-licensed and -compliant 503A pharmacies cannot be trusted to do so. But that's not at all what the statute says.

Since the issuance of the 2016 hospital compounding GFI, as well as many other guidance documents FDA has issued to implement the Drug Quality and Security Act of 2013, we now have years of data and experience (including a global pandemic) by which to measure the effectiveness of these policies as they relate to Congress' intent for doctors and patients to be able to access safe compounded drugs from 503A pharmacies when FDA-approved products or those from outsourcing facilities are unavailable. Indeed, last year during the height of the pandemic, FDA recognized this need and issued temporary guidance allowing for 503A pharmacies to compound for hospitalized patients a limited list of COVID drugs that were in shortage, with regulatory guardrails dealing with beyond-use dating and documentation of patient information.

That temporary GFI on compounding COVID drugs was a long-overdue recognition and affirmation by the FDA of a critical patient need in hospital settings that also also occurs in other clinical settings. The emergency GFI allowed dozens of pharmacies and hospital systems across America to source essential COVID shortage drugs safely – and the flexibility provided by that temporary guidance has no doubt saved lives. Yet this new proposed guidance restricts the ability of hospitals, clinics and other providers to access compounded drugs needed for administration to patients in urgent medical situations from 503A pharmacies when unavailable commercially or from outsourcing facilities. Its effect will be to encouraging compounding by the medical offices and clinics instead of in USP-compliant pharmacies.

FDA itself has indicated that sterility conditions in medical office compounding are a problem. Shortly after issuing the revised hospital GFI, the agency issued a statement on October 25, 2021, expressing concerns with insanitary conditions associated with compounding in medical offices and clinics. Yet that practice will only be encouraged by FDA's own guidance documents, based on the agency's flawed

interpretation of the prescription requirement in 503A of the FDCA. We also note that boards of pharmacy in states that do allow prescriber compounding are grappling with the problem of oversight, since boards of pharmacy have no jurisdiction to inspect or cite physicians and other prescribers. While APC recognizes the need for physicians to be allowed, in certain circumstances, to compound medications in-clinic, that compounding should be performed in facilities and conditions that meet the requirements of state and federal law and are properly and consistently regulated.

Additionally, it is concerning that the GFI establishes a policy at FDA to require hospitals to purchase compounded drugs from 503B outsourcing facilities and to maintain standard operating procedures for doing so, regardless of whether the hospital has a system 503A pharmacy able to meet the needs of patients within the system as determined by their attending providers. It seems well beyond the scope of a guidance establishing enforcement discretion for 503A state-licensed and regulated hospital compounding pharmacies to dictate to those hospitals that they utilize another sector of the compounding industry, outsourcing facilities, or be in violation of the statute as interpreted by FDA through this and other GFI.

APC strongly urges FDA to rescind both the revised hospital compounding GFI and the prescription requirement GFI (Docket No. FDA- 2016-D-0269) and issue a new GFI that implements 503A consistently between hospital and non-hospital pharmacies. The plain language of the statute makes no distinction for hospital pharmacies, and a new GFI should provide flexibility for providers and patients in both hospital and non-hospital clinical settings to access critical compounded drugs when needed in urgent medical situations but unavailable commercially or from an outsourcing facility.

As you know, bipartisan legislation has been introduced in Congress, *HR 3662, the Patient Access to Urgent-Use Compounding Act of 2021,* by Rep. Griffith (R-VA) and Rep. Cuellar (D-TX) that would amend section 503A to allow for limited distributions of compounded drugs to a provider, prior to receipt of a prescription, to administer to patients with urgent medical needs when the drug is unavailable commercially or from an outsourcing facility. The bill would require adherence to state and USP standards. It would also require a patient-specific prescription to be sent back to the pharmacy within seven days. The legislation would also codify current FDA policy allowing for the compounding of drugs on the agency shortage list and would expand that provision to include drugs on the ASHP shortage list as well.

HR 3662 is based closely on the FDA's own temporary guidance on compounding of COVID drugs, as well as the documented need by many providers for access to compounded drugs for administration to patients and the ongoing inability to get them commercially or from outsourcing facilities. If passed, HR 3662 would apply to both hospital and non-hospital 503A pharmacies and would render both the revised 2021 hospital and the 2016 prescription requirement GFI unnecessary; It will codify these exceptions to the prescription requirement and the "essentially a copy" requirements in a way that much better reflects the actual needs of providers and patients while also protecting patient safety. This improved access framework will also disincentivize medical offices and clinics from doing their own bedside compounding and allow them to obtain essential drugs for their patients from 503A state-licensed pharmacies, alleviating the related concerns recently raised by the FDA.

Again, APC respectfully requests that FDA rescind both this revised hospital compounding GFI and the prescription requirement GFI and issue one guidance that applies to all 503A compounding pharmacies and that provides flexibility to allow pharmacies to compound drugs for administration to patients in a

clinical setting, whether in a hospital or not, when needed to meet an urgent medical need and unavailable commercially or from an outsourcing facility. At the same time, FDA should support common-sense legislation like HR3662 to codify these exceptions to 503A's requirements in a manner consistent with congressional intent and with the legal weight and authority that is lacking from continued implementation of the DQSA through non-binding guidance documents. In so doing, the agency will affirm a far more consistent and rational framework for urgent-use compounding, and enhance patient safety in the process.

Thank you in advance for your consideration of these comments. Should you have any questions, please feel free to contact me directly at scott@a4pc.org, or contact our legislative and regulatory counsel David Pore at dpore@hslawmail.com.

Sincerely,

Scott Brunner, CAE
Chief Executive Officer