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To: Dockets Management Branch (HFA-305) **Date:** January 19, 2004
Food and Drug Administration
5630 Fishers Lane, Room 1061
Rockville, MD 20852
Docket No. 03N-0016

Subject: Docket No. 2003N-0529. Amending MedWatch Forms to Collect Postmarketing Adverse Event Data Relating to Race and Ethnicity. 68 Fed.Reg. 68402, December 8, 2003.

Dear Sir/Madam:

Wyeth respectfully submits these comments on the Food and Drug Administration's (FDA) proposal to amend the MedWatch form to collect postmarketing adverse event (AE) data relating to "race" and "ethnicity." Wyeth is one of the world's largest research-based pharmaceutical and healthcare products companies, and is a leading developer, manufacturer and marketer of prescription drugs, biological products and over-the-counter medications. As such, Wyeth is required to use the MedWatch form for reporting AEs to FDA that may occur with their pharmaceutical and biological products.

As detailed below, Wyeth does not support amending the MedWatch form to collect "race" and "ethnicity" data. Such an amendment would increase the disparity between the MedWatch form and the Council for International Organizations of Medical Sciences (CIOMS I) form – the form used for reporting AE information to international regulatory authorities worldwide – and hence would decrease international AE reporting harmonization. In addition, while Wyeth agrees that systematically collecting and analyzing clinical trial data regarding the effects of pharmaceutical and biological products on different "race" and "ethnic" groups (depending on how those terms are defined) may provide some useful pharmacogenetic information, the postmarketing AE reporting system is unlikely to yield useful data in this regard. Any such systematic data collection should be limited to clinical trials because they are much more likely to yield useful information than sporadic and incomplete data collected via spontaneous reports. Finally, Wyeth encourages FDA to work via the International Conference on Harmonization (ICH) process to better define the

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categories of “race” and “ethnicity” to adopt a harmonized, worldwide approach to collecting and analyzing this type of information before imposing any additional US data collection requirements.

Specifically, Wyeth has the following comments on the proposal:

1. Wyeth discourages FDA from amending the MedWatch form to add fields not contained on the CIOMS I form. Such an amendment would defeat international harmonization, a stated FDA goal regarding AE reporting. *See* FDA Proposed Safety Reporting Requirements for Human Drug and Biological Products, 68 Fed.Reg. 12406 (March 14, 2003). Rather, Wyeth encourages FDA to harmonize the MedWatch form with the CIOMS I form in both data elements collected as well as format. In addition, changes to the MedWatch form would be expensive, requiring extensive drug safety computer system reprogramming and revalidation. As detailed below, it is unclear whether these costly changes would yield additional pharmacovigilance information. Finally, Wyeth encourages FDA to propose and effectuate MedWatch changes via a formal rulemaking, which is designed to take into account the economic impact of proposed FDA requirements and regulations.
2. Rather than unilaterally suggesting and adopting changes to postmarketing AE data collection schemes, Wyeth encourages FDA to bring their proposal to collect systematically “race” and “ethnicity” data to the ICH for discussion. This approach would promote and increase the likelihood of a unified, worldwide position on collecting such data. A harmonized approach would also likely increase the success of attempts to collect and analyze these data. That is, FDA’s proposed “race” and “ethnic” categories are based on US cultural understandings and do not necessarily reflect worldwide population differences nor are they based on scientific principles differentiating one proposed category from another. For example, FDA proposes the use of the category “Asian,” yet this term could be used to describe a large and heterogeneous portion of the world’s population from Russia to Japan to India. FDA also proposes the category “white,” which could be used describe the vast majority of Europe’s diverse population. If FDA’s intention is to gather data indicating how different population subgroups respond to drug products, then the data

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categories will have to be sufficiently descriptive and reflect real differences in the world's population to yield useful information. This is particularly true if FDA's goal is to use race as a surrogate for genetic markers to yield pharmacogenetic analyses of postmarketing data. As such, the analyses will only be valuable if the surrogates (eg, race categories) are reflective of possible genetic differences among the world's population. Discussing FDA's proposal at ICH is the most likely method to develop data collection categorizations that will yield valuable information.

3. FDA should not consider amending the MedWatch form or postmarketing data collections requirements as proposed until it finalizes its January 30, 2003 draft guidance "Collection of Race and Ethnicity Data in Clinical Trials." 68 Fed.Reg. 4788 (January 30, 2003). The draft guidance raises similar issues to those raised by this FDA proposal (see # 2, supra). Therefore, FDA should consider those issues in the context of the published draft guidance and the industry comments already submitted before turning to the postmarketing AE reporting system.
4. Given the nature of the spontaneous reporting system, attempts to gather "race" and "ethnicity" data (even if appropriate categories are developed) are unlikely to be successful. Spontaneous reports are intended to be a signaling system – they are not intended to provide full information for detailed data analyses. Because spontaneous reports rely on the cooperation of and limited information available to the reporter, they are not a good mechanism for systematic data collection. Unlike clinical trials where FDA and industry can dictate the data collected from study participants, spontaneous reporters will provide the information that they are willing and able to provide. Therefore, Wyeth does not agree with FDA's premise that because we seek to collect "race" and "ethnic" information in clinical trials, the same type of data should be collected via spontaneous reports – the data collection systems are different, serve different purposes and hence yield different data. Indeed, in Wyeth's experience, reporters often decline to provide patient "race" and "ethnic" information and indeed may find probing for this information offensive. International privacy laws also present an obstacle to collecting and reporting these types of patient information. Therefore, FDA should not

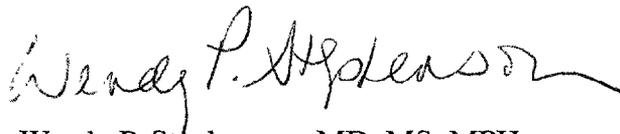
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require systematic collection of this information as part of spontaneous reporting system (nor change the MedWatch to record this information in a specific box). If reporters provide information on the patient's "race," this information can (and is) included on the MedWatch in existing data fields (eg, in the narrative).

5. FDA specifically requested comment on whether collection of this information would impact the ICH E2B guidance relating to the electronic submission of AE reports. Adding additional, required data fields will require companies to reprogram and revalidate drug safety computer systems, whether those fields are on the MedWatch form or other fields required for electronic submission. Reprogramming and revalidating drug safety computer systems is expensive. Wyeth discourages FDA from imposing this cost on industry without a clear pharmacovigilance benefit.

We hope that the Agency finds these comments useful.

Sincerely,



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