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# **Microbiology Data for Systemic Antibacterial Drugs — Development, Analysis, and Presentation Guidance for Industry**

**U.S. Department of Health and Human Services  
Food and Drug Administration  
Center for Drug Evaluation and Research (CDER)**

**August 2016  
Clinical/Antimicrobial**

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# **Microbiology Data for Systemic Antibacterial Drugs — Development, Analysis, and Presentation Guidance for Industry<sup>1</sup>**

This guidance represents the current thinking of the Food and Drug Administration (FDA or Agency) on this topic. It does not establish any rights for any person and is not binding on FDA or the public. You can use an alternative approach if it satisfies the requirements of the applicable statutes and regulations. To discuss an alternative approach, contact the FDA office responsible for this guidance as listed on the title page.

## **I. INTRODUCTION**

The purpose of this guidance is to assist sponsors in the development, analysis, and presentation of microbiology data during antibacterial drug development.<sup>2</sup> Specifically, this guidance addresses the Food and Drug Administration's (FDA's) current thinking regarding the overall microbiology development program needed to support clinical development and approval of antibacterial drugs administered systemically as well as microbiology information collected after approval.<sup>3</sup>

In general, FDA's guidance documents do not establish legally enforceable responsibilities. Instead, guidances describe the Agency's current thinking on a topic and should be viewed only as recommendations, unless specific regulatory or statutory requirements are cited. The use of the word *should* in Agency guidances means that something is suggested or recommended, but not required.

## **II. MICROBIOLOGY DEVELOPMENT PROGRAM**

Microbiology data provide important information to guide clinical development of an investigational new drug. Microbiology data guide clinicians on the use of an antibacterial drug for its intended indications.

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<sup>1</sup> This guidance has been prepared by the Division of Anti-Infective Products in the Center for Drug Evaluation and Research at the Food and Drug Administration.

<sup>2</sup> For the purposes of this guidance, all references to *drugs* include both human drugs and therapeutic biological products unless otherwise specified.

<sup>3</sup> This guidance addresses the types of microbiology information that should be provided to support an investigational new drug application (IND), a new drug application (NDA), a biologics license application (BLA), and a supplemental NDA or BLA. The term *sponsor* is used in this guidance and refers to sponsors submitting an IND as well as applicants submitting an NDA or BLA.

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### **A. Early Development Nonclinical Considerations**

#### **1. *Antibacterial Spectrum of Activity***

Sponsors should evaluate the activity of an antibacterial drug, including its active components and major circulating metabolites, against a test panel of relevant bacteria early in clinical development. Sponsors should provide data on a sufficient range of clinically relevant bacteria to allow an assessment of the potential clinical efficacy of the antibacterial drug for the intended indication. Appendix A provides the suggested number of genera and species that should be tested, and recommended characteristics and diversity of the test isolates.

When conducting studies of the spectrum of activity, sponsors should test in parallel FDA-approved antibacterial drugs, especially those with the same mechanism of action as the investigational drug. In the case of a drug that acts by a new mechanism of action, we recommend that sponsors include FDA-approved antibacterial drugs with a spectrum of activity similar to the investigational drug. In the event there is no FDA-approved antibacterial drug with a similar spectrum of activity, we recommend that sponsors discuss with the FDA the approved drugs to include in these studies.

Sponsors should evaluate the minimum inhibitory concentrations (MICs) in the relevant target bacteria and provide the rationale for an estimate of the epidemiologic cutoff (EC) of the investigational drug against target bacteria.

Appendix B provides an example of the recommended elements of the study reports on antibacterial spectrum of activity.

#### **2. *Mechanism of Action***

Sponsors should evaluate the mechanism of action of an investigational drug (e.g., inhibition of cell wall synthesis, lysis of cell membrane, protein synthesis). Information about the drug's chemical structure and a description of any structural or biological similarities to known antibacterial drugs should be provided. Data to substantiate both physiological and morphological effects on the microbial cells can provide a basis for understanding the development of resistance through alterations in the drug's target sites. Studies evaluating microbial killing (e.g., microbial kill curves) should also be provided.

#### **3. *Intracellular Antimicrobial Concentration Assessment***

The ability of an antibacterial drug to achieve significant intracellular concentrations may have clinical importance when the target organism can reside within the cell (e.g., *Listeria*, *Chlamydophila*, *Legionella*). In situations where the antibacterial drug is intended to treat infections caused by microorganisms that reside within the cell, sponsors should provide data on the drug's ability to penetrate into host cells and demonstrate the drug's activity against target microorganisms inside the cell (e.g., assessment of viable intracellular microorganisms following exposure of the cells to various concentrations of an antibacterial drug).

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### *4. Resistance Studies*

Characterization of the resistance mechanisms and their distribution within the proposed target bacteria may delineate the potential clinical usefulness of the drug. Mechanisms include alterations of the drug by production of enzymes (e.g., beta-lactamases, extended spectrum beta-lactamases), inability to reach the target, and changes in the affinity of the antibacterial drug for the target site. To determine if there may be a proportion of bacteria in the overall population that are resistant to the antibacterial drug (i.e., hetero-resistance), testing should be done to evaluate for the presence of such bacteria. When possible, we recommend that sponsors provide the genotypic characteristic of resistance mechanisms.

Sponsors should compare the activity of an investigational antibacterial drug to the activity profile of approved and other existing antibacterial drugs with the same mechanism of action to assess the possibility of cross-resistance.

Under some circumstances, tentative inferences can be drawn about cross-resistance between antibacterial drugs within a specific population of isolates from regression analyses (i.e., MIC versus MIC or zone diameter versus zone diameter) of one drug compared to another drug. If cross-resistance exists between both the investigational and control drug, a strong correlation between the MICs of both drugs would be expected to be observed; with a majority of the MICs clustered on a 45-degree diagonal. If resistance affects the activity of one drug over the other, the cluster is usually skewed in the direction of one drug or the other and away from the expected diagonal.

Detailed information on the mechanism of action, resistance, or cross-resistance for an antibacterial drug with a novel mechanism of action may not be available for sponsors to include in the initial investigational new drug application. This information should be provided early in drug development, and ideally before initiation of phase 2 clinical development.

Appendix B provides an example of the recommended elements of study reports evaluating resistance.

### **B. In Vitro Antimicrobial Susceptibility Test Methods During Drug Development**

#### *1. Early Clinical Development*

Before conducting clinical trials, sponsors should describe the methods used for generating susceptibility data. Sponsors can reference a standard method,<sup>4</sup> or evaluate susceptibility by other methods including modification of the method. Sponsors should provide a detailed description of the method, including the justification for the modification of the method, the effect on susceptibility results, and performance characteristics of the method (i.e., sensitivity, specificity, precision, linearity). Sponsors should discuss any modification of an established in

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<sup>4</sup> Standard methods for susceptibility testing are developed by organizations such as the Clinical and Laboratory Standards Institute; information can be found at <http://clsi.org>. Sponsors can describe the standard method that they have used by referencing a recognized testing methodology.

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vitro susceptibility test method with the FDA before implementation in the drug development program.

Modifications can include the addition of any substance (e.g., blood, body fluids, polysorbate). In some cases, isolates obtained during clinical trials may need to be tested for their susceptibility in the presence and absence of the substance and the results of both methods correlated with clinical and microbiological results. Sponsors also should conduct studies to address the influence of the growth medium (e.g., pH, divalent cations), inoculum density, incubation conditions (e.g., concentration of CO<sub>2</sub>), and additives (e.g., polysorbate), in both broth and agar medium on in vitro susceptibility test results.

If sponsors propose to use freeze-dried panels to assess the MIC of clinical isolates, they should conduct a comparative study to demonstrate comparability of MIC results for the frozen and freeze-dried panels. Sponsors should discuss this proposed study with the FDA to ensure that appropriate data are developed for the equivalency assessment. The data should be submitted to the FDA before initiating phase 2 trials.

### *2. Provisional Antibacterial Susceptibility Test Interpretive Criteria*

Provisional antibacterial susceptibility test (AST) interpretive criteria usually are based on the limited information available before the initiation of phase 3 clinical trials. In vitro microbiology data include distributions of MICs or zone diameters that are obtained by testing the antibacterial drug against a population of recent clinical isolates that represent the target bacteria for the indications being sought (see Appendix A for guidelines in the selection of target bacteria). Sponsors should provide testing data on a sufficient range of clinically relevant bacteria for the intended indications. Sponsors should identify the prominent genotypes, serotypes, biotypes, and isolates with known mechanisms of resistance and include these in the test panel. In addition, the mechanism of action of the investigational antibacterial drug and other drugs with the same mechanism of action should be considered when establishing susceptibility testing methods and provisional AST interpretive criteria.

When an investigational drug has a similar mechanism of action to an approved drug, the data justifying provisional AST interpretive criteria for the investigational drug should be presented as regressions of MIC versus MIC and zone diameter versus zone diameter. These data should be examined for clusters of isolates that are substantially different from those clusters near the expected regression line of MIC versus MIC or zone versus zone plots. For example, a cluster in a position away from the expected regression line suggests that one of the drugs is affected by a resistance mechanism that does not affect the other drug. Therefore, the two drugs are not interchangeable and provisional AST interpretive criteria of the investigational drug may not be similar to the AST interpretive criteria of an approved drug with a similar mechanism of action. When developing an antibacterial drug with a specific mechanism of action for the treatment of bacteria resistant to other antibacterial drugs with the same mechanism of action, these types of analyses can be extremely useful in demonstrating the activity of the investigational drug.

The data should be analyzed in terms of frequency distributions (e.g., histograms) of AST results. Frequency distribution analyses can help define which populations of isolates harbor

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specific resistance mechanisms that sponsors should identify. Frequency distributions can be analyzed for both dilution and diffusion susceptibility testing methods. Frequency distributions call for evaluation for each target bacteria, especially if there is no clear demarcation between the resistant and susceptible populations. EC values should be estimated for each targeted species or bacterial group.

Additional considerations to the provisional AST interpretive criteria include the methodological variability between diffusion and dilution susceptibility testing methods. Sponsors can suggest adjustments to the provisional AST interpretive criteria by evaluating scattergrams of dilution testing results compared with diffusion testing results of the same isolates tested with both methods. This evaluation can be performed by the Error Rate Bounding method that compares diffusion testing to dilution testing. The computational algorithm generates AST interpretive criteria that minimize the number of isolates with diffusion testing results that fall outside these criteria.

Finally, evaluation of the frequency distribution analyses relative to the pharmacokinetic/pharmacodynamic (PK/PD) characteristics of the investigational antibacterial drug can further refine the provisional AST interpretive criteria.

#### ***3. Establishing In Vitro Antibacterial Susceptibility Test Interpretive Criteria***

Sponsors should perform an analysis of the correlation between the clinical cure and microbiologic eradication rates in the clinical trials with the provisional AST interpretive criteria results to determine their clinical relevance. When appropriate, the clinical response and microbiologic eradication rates should be assessed as overall rates and as individual rates against bacteria with resistance to other antibacterial drugs as well as specific virulence factors. The available human PK/PD information, including target attainment analyses, assists in the selection of AST interpretive criteria. These analyses help to form the basis for the final selection of the AST interpretive criteria.

The purpose of establishing AST interpretive criteria is to guide the selection of appropriate antibacterial therapy. The accuracy and clinical relevance of such tests depend on adherence to standardized methods and appropriate consideration of the test results.

Consideration should also be given to the time it takes to develop a susceptibility test. The coordination of susceptibility test development with drug development is encouraged so that susceptibility testing is available to inform use of the drug after it is marketed.

Appendix C provides the recommended electronic database format for the data from clinical trials as it pertains to AST interpretive criteria.

#### ***4. Quality Control Parameters***

Quality control (QC) parameters for AST should be established before determining the activity of the antibacterial drug to ensure the generation of precise, accurate, and reproducible results. Routine QC procedures involve performance testing of designated QC strains that are genetically



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stable and have well-characterized susceptibility characteristics. Generally, the establishment of QC parameters should involve the use of 3 different lots of test medium, frozen panels in the case of MICs, 2 different lots of disks in the case of disk diffusion, and 10 replicates of each QC strain over 3 days in at least 7 different laboratories. This testing is done to generate enough data points to determine appropriate QC parameters.

Sponsors should obtain reference bacteria recognized from a reputable source such as the American Type Culture Collection (ATCC). In the event that sponsors do not use these recommended QC bacteria, they should justify the use of other well-characterized bacteria. If a QC bacterium is chosen that is different from these recommended QC bacteria, it should be deposited in a recognized culture collection (e.g., ATCC).

The use of established methods and concomitant use of QC strains lends confidence to the in vitro susceptibility data generated from the testing of bacteria. Therefore, QC data should be provided with all susceptibility test results done on bacteria at each facility that is conducting susceptibility testing for clinical trials. Alternatively, if in vitro susceptibility tests are performed by a central laboratory, we recommend that sponsors provide the QC data generated by the central laboratory. In addition, we recommend that sponsors analyze the QC data generated during the conduct of clinical trials to determine whether adjustments to the QC ranges are necessary.

### **C. Other Considerations**

#### ***1. First and Second Lists of Target Bacteria in Labeling***

The *Microbiology* subsection of labeling contains two lists of bacteria. Sponsors should format this section as described in Appendix D.

The first list is based on bacteria evaluated during clinical trials that are included in the INDICATIONS AND USAGE section of labeling (21 CFR 201.57(c)(2)(i)(C)).

The second list is based on the relevance of the bacteria to the indication and its susceptibility to concentrations of the antibacterial drug that can be achieved using the proposed dosage. Appendix E provides a summary of the information needed to support the inclusion of bacteria in the second list. The inclusion of bacteria in the second list is not based on results from adequate and well-controlled clinical trials. Sponsors should provide information in support of the second list for each species proposed for inclusion by indication.

#### ***2. Antibacterial Interactions and Fixed Combination Studies***

Drug interaction studies may provide information (e.g., synergy, antagonism, indifference) on the effects one antibacterial drug may have on another. Potential for interaction usually can be determined by qualitative or quantitative in vitro studies when the activity cannot be accurately anticipated from general knowledge of the drug characteristics. The preferred methods for the characterization of antibacterial interaction are kill curves. Another method is the checkerboard titration analyzed by fractional inhibitory concentration.

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For fixed combination drug products, including drugs that contain an antibacterial drug and a component that counteracts a resistance mechanism (e.g., beta-lactam and beta-lactamase inhibitor combination), we recommend that sponsors provide the in vitro and/or in vivo data to support the contribution of each of the drugs (separately and in combination) to the activity.

### *3. Additional Nonclinical Studies of Antibacterial Drugs*

Antibacterial drugs may have various effects on target bacteria and/or interactions with the host. These phenomena include, but are not limited to, postantibiotic effect, postantibiotic leukocyte effect, sub-MIC effects, effects on endotoxin, effects on virulence factors, and interactions with the host immune system. The sponsor should provide data from studies that are designed to investigate these effects of the investigational antibacterial drug.

Some antibacterial drugs may be inactive when protein bound, or there may be insufficient free active drug at trough concentrations. Therefore, we recommend that sponsors characterize the effects of human serum proteins and other human body fluids (e.g., lung surfactant), when appropriate, on the in vitro and in vivo activity of the drug. The effects of human serum proteins and human body fluids on activity of the drug should be evaluated over the range of clinically relevant concentrations of the antibacterial drug.

### *4. Animal Models of Infection*

The goal of the animal models is to investigate the antibacterial activity of the investigational drug. Ideally, the animal model of infection should be similar to the infection of interest in humans and the bacteria used in the animal model should be similar in character (e.g., antibacterial resistance, virulence factors) to bacteria that cause human disease.

In addition to measuring survival, bacterial burden in blood and relevant affected organs should be measured. For example, an evaluation of antibacterial activity in relevant issue sites can be important to characterize the drug's potential in the treatment of particular body site infections in humans. Animal models can provide preliminary information on PK/PD parameters as they pertain to microbiology data (e.g., area under the unbound plasma concentration time cure over the MIC, time above MIC).

Sponsors can conduct comparative studies of the investigational antibacterial drug with other antibacterial drugs exhibiting the same mechanism of action or drugs with the same spectrum of activity. Results can be reported as 50 percent effective dose (ED50), 50 percent protective dose (PD50), or 50 percent curative dose (CD50). The bacterial burden data at baseline and various time points should also be provided.

### *5. Microbiology Information Collected in Clinical Trials*

We recommend that a central laboratory be used for microbiologic testing (including confirmation of bacteria identification and AST) during clinical trials. We recommend that sponsors provide clinical trial protocols and laboratory procedure manuals (including details of

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specimen collection, isolate/specimen transport, isolate characterization and identification, isolate preservation, and susceptibility testing methods) to the FDA for review before trial initiation.

### ***6. Electronic Submission of Microbiology Information***

Sponsors should provide microbiology information in the electronic common technical document (eCTD) as described in the guidance for industry *Providing Regulatory Submissions in Electronic Format — Certain Human Pharmaceutical Product Applications and Related Submissions Using the eCTD Specifications*.<sup>5</sup> Generally, the information on microbiology should be provided in two sections of the eCTD as follows:

- Module 2, Section 2.7, Clinical Summary, subsection 2.7.2.4, Special Studies. This section should contain the microbiology summary reports and the information used to justify the microbiology information included in the labeling.
- Module 5, Clinical Study Reports, subsection 5.3.5.4, Other Study Reports. This section should contain the nonclinical study and clinical trial reports used in the construction of the summary information provided in subsection 2.7.2.4. All of the study and trial reports used to construct the summary report presented in section 2.7.2.4 should be cross-linked to the summary report. Both of these sections should be cross-referenced to each other.

### ***7. Postmarketing Microbiology Information***

Over time after approval, additional information may become available regarding the methods for in vitro AST and/or the QC parameters used to monitor the performance of the test as well as how the susceptibility test results should be interpreted. Changes in AST interpretative criteria may translate into a lack of efficacy and/or safety concerns when out-of-date AST information leads to failure to appropriately treat the infectious disease. Consequently, it is important that the in vitro AST methods, the QC parameters, and the AST interpretive criteria be reviewed on a regular basis and updated to reflect the most current information. The rationale for any changes in the in vitro AST methods, QC parameters, spectrum of activity, or AST interpretive criteria, as well as new information regarding emergence of resistance, should be indicated in an applicant's annual report under the new drug application. The procedures for updating microbiology labeling information can be found in the guidance for industry *Updating Labeling for Susceptibility Test Information in Systemic Antibacterial Drug Products and Antimicrobial Susceptibility Testing Devices*.

For applicants submitting a labeling supplement with supporting data to update or change the method of determining the AST, we recommend the description of the old and new methods with the changes noted, as well as validation data and QC parameters of the new method. Any change to a test method (e.g., microbroth dilution) should be accompanied by data to show that the

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<sup>5</sup> We update guidances periodically. To make sure you have the most recent version of a guidance, check the FDA Drugs guidance Web page at <http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm>.

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results correlate with other methods (e.g., agar dilution, disk diffusion testing) by which susceptibility testing can be done. The results of validation studies should be included when information to change the QC parameters is provided.

We recommend including the following information when providing changes to the existing AST interpretive criteria:

- Rationale for change
- The MIC and zone diameter distributions against the genera and species of interest; data should be from isolates collected in the preceding 3 years of the submission
- Susceptibility to the antibacterial drug to determine microbiologically supported cutoffs (e.g., histograms)
- Categorical agreement between MIC and zone diameter breakpoints in graphical form
- Error-rate bounded method of Metzler and DeHaan (Metzler and DeHaan 1974) to determine discrepancies between the two methods; the Metzler and DeHaan method usually needs to be modified because two MIC values are normally described to define an *intermediate* category (Bruden, Zurenko, et al. 1992)
- Relevant human PK data
- Clinical data from adequate and well-controlled trials and literature reports

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**APPENDIX A:  
GUIDELINES FOR BACTERIAL ISOLATE SELECTION  
FOR STUDIES OF IN VITRO ANTIBACTERIAL ACTIVITY**

For the purposes of determining the antibacterial activity of a new molecular entity and for establishing correlation of test methods (i.e., minimum inhibitory concentration (MIC) and disk diffusion), we recommend that the sponsor provide antibacterial susceptibility test (AST) data for bacterial isolates intended for inclusion in labeling. The sponsor should consult with the division to determine an adequate number of tested isolates in those situations, as well as for special types of studies where significant information may be obtained using few isolates (e.g., bactericidal studies, time-kill studies).

Table A lists the suggested number of bacterial isolates of each species or bacterial group that should be tested in nonclinical studies, when those species will be included in labeling for the antibacterial drug (i.e., in either the first or second list of target bacteria).

We recommend that sponsors identify the prominent genotypes, serotypes, biotypes, and isolates with known mechanisms of resistance and include these in the test panel. When appropriate, the spectrum of activity against hetero-resistant bacteria should be determined (e.g., vancomycin hetero-resistant *Staphylococcus aureus*). The organisms tested should be recent clinical isolates that have been collected within the last 3 years of the new drug application with susceptibility profiles that are representative of antibacterial drugs used to treat infections caused by the target bacteria for the indication being sought. Summary data by subset of organisms demonstrating resistance should be provided (e.g., methicillin-resistant *S. aureus* (MRSA), extended spectrum beta-lactamases).

We recommend that at least 75 percent of isolates analyzed in these studies be collected in the United States. Sponsors who include isolates from outside the United States should compare the characteristics of those isolates with the same species found in the United States (e.g., phenotype, genotype, serotype, susceptibility profile, and virulence factors).

Susceptibility testing should be performed using a range of drug dilutions that will minimize reporting *greater than or equal to* or *less than or equal to* MIC values (e.g.,  $\geq 16$  mcg/mL,  $\leq 0.012$  mcg/mL). All AST data should be determined using standard reference methods, unless modifications of the standard methods are needed. Sponsors should present a summary of susceptibility testing results as MIC histograms or other frequency distributions displaying any proposed in vitro AST interpretive criteria. All susceptibility test data should be accompanied by appropriate quality control data.

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**Table A: Suggested Number of Isolates for Determination of In Vitro Antibacterial Activity and for Correlation of MIC and Disk Diffusion Methods**

<b>Organism Group</b>	<b>Number of Isolates</b>
<i>Enterobacteriaceae</i>	≥ 300
<i>Pseudomonas aeruginosa</i>	≥ 100
<i>Acinetobacter</i> spp.	≥ 100
<i>Staphylococcus</i> spp. <sup>1,2</sup>	≥ 100
<i>Enterococcus</i> spp. <sup>1,2</sup>	≥ 100
<i>Haemophilus influenzae</i> and <i>H. parainfluenzae</i>	≥ 100
<i>Neisseria gonorrhoeae</i>	≥ 100
<i>Streptococcus pneumoniae</i>	≥ 100 (prefer > 300)
Beta-hemolytic streptococci <sup>1</sup>	≥ 100 (prefer > 300)
Alpha-hemolytic streptococci (other than <i>S. pneumoniae</i> ) <sup>1</sup>	≥ 100 (prefer > 300)
Other single species	≥ 100

<sup>1</sup> Bacterial isolates in these genera or bacterial groups should be identified to species level (or, in some cases, to more specific groups (e.g., *Streptococcus anginosus* group)). In these cases, the recommended number of isolates applies to the particular species or group.

<sup>2</sup> When a particular phenotype (e.g., MRSA, vancomycin-resistant *Enterococcus faecalis*) will be included in labeling, the recommended number of isolates applies to that phenotype.

**APPENDIX B:  
STUDY REPORTS OF SPECTRUM OF ACTIVITY AND RESISTANCE**

**Study Reports of Spectrum of Activity**

We recommend that study reports of spectrum of activity include the following elements:

- The name and location of each investigator conducting or contributing to the study
- The standardized methods for bacterial identification and antibacterial susceptibility test (AST) used to determine the activity of the antibacterial drug; details of the method and the performance characteristics of the assay in the actual laboratory where such testing is done should be included if a nonstandard method is used
- A description of all susceptibility testing quality control (QC) measures; all AST results should be accompanied by QC data
- The number of isolates tested in each laboratory, the specimen source, and the geographical region from which the isolates were obtained
- A description of the spectrum of activity by all regions and individual geographic regions
- The phenotypic and/or genotypic characterization of isolates relative to their resistance to other antibacterial drugs; the methodology and the criteria used to characterize isolates as resistant should be described
- The phenotypic and/or genotypic characterization of isolates relative to virulence characteristics

Results from studies evaluating antibacterial activity should be presented in tabular form under appropriate sections as described below:

- Genera and species tested — species with unique mechanisms of resistance should be grouped separately; serotype, phenotype, and/or genotype should be included if known
- Drug name
- The minimum inhibitory concentration (MIC) range and the number of isolates tested
- The values for the MIC required to inhibit growth of 50 percent of bacteria (MIC<sub>50</sub>) and the MIC required to inhibit growth of 90 percent of bacteria (MIC<sub>90</sub>)
- Minimum bactericidal concentration (MBC)
- MIC:MBC ratio for members of clinically relevant genera



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### **Study Reports of Resistance**

Results from studies evaluating resistance should be presented in tabular form under appropriate sections as described below:

- Genera and species tested — species with unique mechanisms of resistance should be grouped separately; if serotype, phenotype, and/or genotype are known then that information should be included
- Drug name
- MIC range — for each group of organisms and the number of isolates tested in each laboratory
- MIC<sub>50</sub> and MIC<sub>90</sub> values
- MBC

The complete study report should include stability and lot numbers of the drug used for microbiology testing. In addition, reproducibility of test results should be submitted. If the data are derived from a publication, a copy of the publication should be included in the submission.

**APPENDIX C:  
DATABASE FOR FINAL IN VITRO ANTIBACTERIAL  
SUSCEPTIBILITY TEST INTERPRETIVE CRITERIA**

We recommend a single electronic database for the clinical trial with the subject level data presented in columns. Each column heading should identify the scope of information below it. For instance, a subject identification (ID) number can include a coding arrangement that differentiates the trial center as well as the individual subject. Sponsors should discuss the format of the microbiology datasets with the FDA at the time of the pre-new drug application or pre-biologics license application meeting. We recommend that the following information be provided in the database under appropriate columnar headings:

- Clinical trial center number
- Subject ID number
- Treatment group
- Sample source
- Species of bacterial isolate
- Indication
- Subject-by-subject clinical evaluations including separate rows for each subject, the subject's status of microbiological eradication, and the subject's overall clinical response (e.g., cure, failure)
- Antibacterial susceptibility test (AST) results by diffusion methods for the investigational drug and the comparator drug
- AST results by dilution methods for the investigational drug and the comparator drug

Sponsors should provide an interpretation of the data described below for the investigational drug and comparator drugs. Because of possible geographic differences in antibiograms and the clonal nature of bacteria, data should be presented in both combined and separate formats (e.g., United States and non-United States in separate tables). Where appropriate, we recommend that U.S. data be broken down into regions (e.g., Northeast, Southeast, Midwest, Northwest, Southwest), and that non-U.S. data be broken down by region (e.g., Asia, Europe, Africa) and within region by country (e.g., France, Germany).

We recommend that the following be included in the database:

1. Minimum inhibitory concentration (MIC) values and subject microbiological responses for each baseline bacterium within each proposed indication; all subsets of bacteria demonstrating unique mechanisms of resistance (e.g., methicillin-resistant

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*Staphylococcus aureus*, beta-lactamase-positive *Haemophilus influenzae*) and virulence should be listed separately.

2. MIC values and subject clinical response for each baseline bacterium for each proposed indication; all subsets of bacteria demonstrating unique mechanisms of resistance and virulence should be listed separately.
3. Zone diameter values and subject microbiological responses for each bacterium for each proposed indication; all subsets of bacteria demonstrating unique mechanisms of resistance and virulence should be listed separately.
4. Zone diameter values and subject clinical responses for each bacterium for each proposed indication; all subsets of bacteria demonstrating unique mechanisms of resistance and virulence should be listed separately.
5. For each subset of bacteria requiring defined AST interpretive criteria, all individual isolates in the range of MICs from two dilutions below the susceptible and two dilutions above the resistant provisional AST interpretive criteria.
6. For each subset of bacteria requiring defined zone diameter AST interpretive criteria, all individual isolates in the range of zone diameters from 4 to 6 millimeters above the susceptible and 4 to 6 millimeters below the resistant provisional AST interpretive criteria.
7. By indication and bacteria relevant to the indication, all MICs for isolates associated with microbiological failures. The bacteria should be identified to the species level.
8. By indication and bacteria relevant to the indication, all zone diameters for isolates associated with microbiological failures. The bacteria should be identified to the species level.
9. For each bacterium (e.g., nonfastidious, fastidious, and anaerobic), the MIC value indicating the number and percent of isolates at that MIC associated with each microbiological response. MIC values should be grouped by bacterial type.
10. For each bacterium (e.g., nonfastidious, fastidious), the zone diameter indicating the number and percent of isolates at the zone diameter associated with each microbiological response. Zone diameter information should be grouped by bacterial type.
11. For each group of bacteria, a histogram showing the number of isolates at each MIC from clinical trials overlaying isolates from nonclinical studies. Sponsors should present bacteria with characterized phenotypic resistance and virulence markers as a subset.
12. For each group of bacteria, a histogram showing the number of isolates at each zone diameter from clinical trials overlaying isolates from nonclinical studies. Sponsors

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should present bacteria with characterized phenotypic resistance and virulence markers as a subset.

**APPENDIX D:  
EXAMPLE FORMAT FOR SECTIONS OF LABELING  
THAT PERTAIN TO MICROBIOLOGY**

Recommended language for and organization of the microbiology information that is discussed in the CLINICAL PHARMACOLOGY section of labeling are provided below along with additional recommendations in italics.<sup>6</sup> For additional information concerning this section of labeling, see the draft guidance for industry *Clinical Pharmacology Labeling for Human Prescription Drug and Biological Products — Considerations, Content, and Format*.<sup>7</sup> Also included are recommended citations for the REFERENCES section of labeling. We recommend a consistent formatting approach for headings and subheadings in the CLINICAL PHARMACOLOGY section and the other sections of labeling to help organize the information (e.g., underlining for headings and italics for subheadings). We recommend the use of title case for headings and subheadings.

## **12 CLINICAL PHARMACOLOGY**

### **12.1 Mechanism of Action**

X is an anti- (e.g., bacterial, as appropriate) drug [*see Microbiology (12.4)*].<sup>8</sup>

*Recommendation: The antimicrobial mechanism of action should be described in subsection 12.4 Microbiology.*

### **12.4 Microbiology**

Mechanism of Action

Resistance

Interaction With Other Antimicrobials

[Heading Title] [Other relevant information to be determined on a case-to-case basis]

*Recommendation: Additional relevant microbiological information that provides characterization of the antimicrobial drug should be placed under another appropriately named heading.*

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<sup>6</sup> As provided for in the final rule “Requirements on Content and Format of Labeling for Human Prescription Drug and Biological Products” (71 FR 3922, January 24, 2006), the microbiology portion of labeling should be added as subsection 12.4 under the CLINICAL PHARMACOLOGY section.

<sup>7</sup> When final, this guidance will represent the FDA’s current thinking on this topic. For the most recent version of a guidance, check the FDA Drugs guidance Web page at <http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm>.

<sup>8</sup> Note that this is an exception to the preferred presentation of cross-referencing in the Full Prescribing Information, which is to use the section heading followed by the numerical identifier.

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### Antimicrobial Activity

[Name of drug] has been shown to be active against most isolates of the following microorganisms, both in vitro and in clinical infections [*see Indications and Usage (1)*]:

*Recommendation: Each organism in this list must be associated with an indication in the INDICATIONS AND USAGE section (e.g., acute bacterial skin and skin structure infections caused by susceptible isolates of Staphylococcus aureus) (21 CFR 201.57(c)(2)(i)(C)).*

[Microorganisms should be listed under the following categories in alphabetical order]

- Aerobic bacteria
  - Gram-positive bacteria
  - Gram-negative bacteria
- Anaerobic bacteria
  - Gram-positive bacteria
  - Gram-negative bacteria
- Other microorganisms (as applicable)

The following in vitro data are available, but their clinical significance is unknown.<sup>9</sup> At least 90 percent of the following bacteria exhibit an in vitro minimum inhibitory concentration (MIC) less than or equal to the susceptible breakpoint for [name of drug] against isolates of similar genus or organism group. However, the efficacy of [name of drug] in treating clinical infections caused by these bacteria has not been established in adequate and well-controlled clinical trials.

[Microorganisms should be listed under the following categories in alphabetical order]

- Aerobic bacteria
  - Gram-positive bacteria
  - Gram-negative bacteria
- Anaerobic bacteria
  - Gram-positive bacteria
  - Gram-negative bacteria
- Other microorganisms (as applicable)

*Recommendation: For an organism to be included in the above list (i.e., the second list), the organism at a minimum should: (1) be relevant to an indication granted in the labeling; and (2) have an MIC<sub>90</sub> below the concentration of the antimicrobial achievable in the plasma or at the infection site using the dosing regimen approved in the labeling as determined from in vitro testing of the targeted species or organism group. See Appendix A for the recommended number and characteristics of test isolates. See Appendix E for a summary of information for microorganisms to be included on the second list as well as additional information.*

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<sup>9</sup> This statement must be included for the second list of bacteria; see 21 CFR 201.57(c)(13)(ii)(A).

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### Susceptibility Test Methods

When available, the clinical microbiology laboratory should provide cumulative reports of in vitro susceptibility test results for antimicrobial drugs used in local hospitals and practice areas as periodic reports that describe the susceptibility profile of nosocomial and community-acquired pathogens. These reports should aid in the selection of an appropriate antibacterial drug for treatment.

*Recommendation: If standardized susceptibility test methods are not used, information and unusual characteristics of the antibacterial susceptibility test procedure can be placed under the susceptibility test method that is pertinent.*

### *Dilution Techniques*

Quantitative methods are used to determine antimicrobial MICs. These MICs provide estimates of the susceptibility of bacteria to antimicrobial compounds. The MICs should be determined using a standardized test method<sup>1,2</sup> (broth and/or agar). The MIC values should be interpreted according to criteria provided in Table [insert table number].

*Recommendation: Proposed references, as denoted by the numbers 1, 2, 3, and 4 in superscript, are listed below in the example for the REFERENCES section.*

### *Diffusion Techniques*

Quantitative methods that require measurement of zone diameters can also provide reproducible estimates of the susceptibility of bacteria to antimicrobial compounds. The zone size should be determined using a standardized test method.<sup>2,3</sup> This procedure uses paper disks impregnated with [x] mcg [name of drug] to test the susceptibility of bacteria to [name of drug]. The disc diffusion breakpoints are provided in Table [insert table number].

### *Anaerobic Techniques*

For anaerobic bacteria, the susceptibility to [name of drug] can be determined by a standardized test method.<sup>4</sup> The MIC values obtained should be interpreted according to the criteria provided in Table [insert table number].

*Recommendation: An example of the table referenced in dilution, diffusion, and anaerobic techniques is provided below.*

**Table [insert table number]. Susceptibility Test Interpretive Criteria for [name of drug]**

Pathogen	Minimum Inhibitory Concentrations (mcg/mL)				Disk Diffusion (zone diameters in mm)		
	S	I	R		S	I	R
Pathogen #1	< #	# - #	>#		>#	# - #	< #
Pathogen #2	< #	# - #	>#		>#	# - #	< #
etc.	etc.				etc.		

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A report of *Susceptible (S)* indicates that the antimicrobial drug is likely to inhibit growth of the pathogen if the antimicrobial drug reaches the concentration usually achievable at the site of infection. A report of *Intermediate (I)* indicates that the result should be considered equivocal, and, if the microorganism is not fully susceptible to alternative, clinically feasible drugs, the test should be repeated. This category implies possible clinical applicability in body sites where the drug is physiologically concentrated or in situations where a high dosage of the drug can be used. This category also provides a buffer zone that prevents small uncontrolled technical factors from causing major discrepancies in interpretation. A report of *Resistant (R)* indicates that the antimicrobial drug is not likely to inhibit growth of the pathogen if the antimicrobial drug reaches the concentration usually achievable at the infection site; other therapy should be selected.

*Recommendation: If there are no resistant criteria (R) because of the lack of data on resistant microorganisms, the following should be noted in the labeling: “The current absence of data on resistant isolates precludes defining any category other than ‘Susceptible.’ If isolates do not yield MIC results that are Susceptible, they should be submitted to a reference laboratory for additional testing.” If the drug is approved at one dosage, the paragraph above should not contain the statement “. . . or in situations where a high dosage of the drug can be used.”*

#### **Quality Control**

Standardized susceptibility test procedures require the use of laboratory controls to monitor and ensure the accuracy and precision of supplies and reagents used in the assay, and the techniques of the individuals performing the test.<sup>1,2,3,4</sup> Standard [name of drug] powder should provide the following range of MIC values noted in Table [insert table number]. For the diffusion technique using the [disk content of antimicrobial] mcg disk, the criteria in Table [insert table number] should be achieved.

*Recommendation: An example of the table referenced in Quality Control is provided below. This table should be included when appropriate quality control parameters should be provided for both broth and agar MIC tests.*

**Table [insert table number]. Acceptable Quality Control Ranges for [name of drug]**

	<b>Minimum Inhibitory Concentrations (mcg/mL)</b>	<b>Disk Diffusion (zone diameters in mm)</b>
QC strain #1	# - #	# - #
QC strain #2	# - #	# - #
etc.	etc.	etc.



## 15 REFERENCES

*Recommendation: We propose that the following references, as denoted above by the numbers 1, 2, 3, and 4 in superscript, be included in the REFERENCES section.*

1. Clinical and Laboratory Standards Institute (CLSI). Methods for Dilution Antimicrobial Susceptibility Tests for Bacteria That Grow Aerobically; Approved Standard – [Edition]. CLSI document M07-[Edition number]. Clinical and Laboratory Standards Institute, 950 West Valley Road, Suite 2500, Wayne, PA 19087, USA, [Year].
2. Clinical and Laboratory Standards Institute (CLSI). Performance Standards for Antimicrobial Susceptibility Testing; [Supplement Edition]. CLSI document M100-[Supplement Edition number]. Clinical and Laboratory Standards Institute, 950 West Valley Road, Suite 2500, Wayne, PA 19087, USA, [Year].
3. Clinical and Laboratory Standards Institute (CLSI). Performance Standards for Antimicrobial Disk Diffusion Susceptibility Tests: Approved Standard – [Edition]. CLSI document M02-[Edition number]. Clinical and Laboratory Standards Institute, 950 West Valley Road, Suite 2500, Wayne, PA 19087, USA, [Year].
4. Clinical and Laboratory Standards Institute (CLSI). Methods for Antimicrobial Testing of Anaerobic Bacteria; [Edition]. CLSI document M11-[Edition number]. Clinical and Laboratory Standards Institute, 950 West Valley Road, Suite 2500, Wayne, PA 19087, USA, [Year].

**APPENDIX E:  
INFORMATION REGARDING THE SECOND BACTERIA LIST IN THE  
MICROBIOLOGY SUBSECTION OF LABELING**

**Factors to Consider When Developing the Lists**

The following factors should be considered when developing the bacteria lists:

- Certain bacteria are disease-specific and therefore can be properly placed only in the first list. Examples of such pathogens are *Mycobacterium tuberculosis*, *Bacillus anthracis*, *Mycobacterium leprae*, *Yersinia pestis*, *Neisseria meningitidis*, *Neisseria gonorrhoeae*, and *Brucella species*.
- There should be scientific evidence demonstrating that the bacteria are frequently associated with an indication for which approval is being sought.
- Sponsors should support the species included in the second list with antibacterial susceptibility test (AST) results of recent clinical isolates (minimum inhibitory concentrations (MICs)) correlated with the achievable concentrations of the antibacterial drug using the recommended dosing regimen.
- Bacteria included in the second list should have MIC<sub>90</sub> values less than or equal to the clinically relevant AST interpretive criteria established for the particular genera, species, or group of bacteria related to a specific indication or indications.

**Summary Information for the Second List**

The summary should include the following information for the bacteria on the second list:

- A discussion of the relevance of the bacteria to a specific clinical indication
- The frequency in which the bacteria is shown to cause disease in the general population
- Relevant literature references and/or laboratory test data summary tabulations of susceptibility data (e.g., range, MIC<sub>50</sub>, MIC<sub>90</sub> for relevant antibacterial drugs) and annotated supporting literature for the listed bacteria
- In vitro susceptibility information for (e.g., MIC, MIC range, MIC<sub>50</sub>, MIC<sub>90</sub>) of the bacteria proposed for the second list (see Appendix C for the suggested number of isolates and characteristics of pathogens that should be included for testing), accompanied by appropriate quality control (QC) data
- A discussion of the methods used and their comparability to assess susceptibility as described in the supporting literature

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- Comparisons of U.S. and foreign data analyzed separately and together
- Susceptibility data that are accompanied by the appropriate QC data