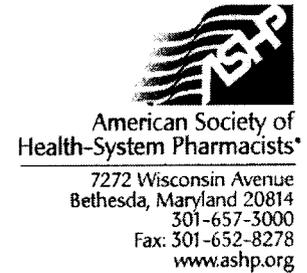


Statement of Gary C. Stein, Ph.D., Director of Federal Regulatory Affairs, American Society of Health-System Pharmacists, Before the Food and Drug Administration's Joint Meeting of the Gastrointestinal Drugs Advisory Committee and the Drug Safety and Risk Management Subcommittee of the Advisory Committee for Pharmaceutical Science, April 23, 2002.



Members of the Committees: My name is Gary C. Stein, and I am the Director of Federal Regulatory Affairs for the American Society of Health-System Pharmacists.

ASHP is the 31,000-member national professional and scientific association that represents pharmacists who practice in hospitals (including outpatient services), health maintenance organizations, long-term care facilities, home care agencies, and other components of organized health care systems. I am pleased to speak to this joint committee meeting about ASHP's perspectives on risk management of for the New Drug Application for Lotronex.

ASHP has a long-standing commitment to helping pharmacists manage the risks inherent in prescription and nonprescription medication use, and we recognize that the FDA has the same commitment, particularly in regard to newer, higher risk drugs. Unfortunately, many of the risk-management plans that have been implemented in recent years involve restricted drug distribution systems. There has been a substantial increase in the number of new pharmaceuticals that are available only through restricted, closed, or limited distribution systems over the last few years. Increased reliance on restricted drug distribution systems for new, high-risk drugs is a growing concern among ASHP's members. These systems often exclude individual hospital as well as community pharmacies from distributing medications and use other means of distribution to deliver

medications directly to patients, either through a central mail-order pharmacy, a patient's physician, or through the manufacturer itself. While a number of drugs have been relegated to restricted drug distribution systems, we lack information on how well these systems work.

Pharmacists are responsible for ensuring that medications are readily available for patients who need them. Disruptions and non-standardized distribution processes are not trivial matters; they create procedural confusion for pharmacy and other hospital staff and increase the potential for mistakes. Any restricted distribution or special handling procedure that disrupts that central oversight role of pharmacists represents an interruption in standard medication-use policies and procedures in the health-system setting.

In November of 2000, and again in January of this year, ASHP has drawn the FDA's attention to this issue. We have suggested that when a manufacturer implements a restricted distribution of a drug product, the FDA should obligate the company to ensure that a patient's usual pharmacist relationship is not disrupted. ASHP also recommended that, if a restricted distribution system is being considered by the FDA as a condition for marketing approval, practicing pharmacists, professional pharmacist societies, and patients should be consulted before any restricted distribution requirements are imposed on the product. Open hearings, at which patients and pharmacists can express their views concerning the design of such a system and the impact those systems may have on the safety and effectiveness of patient care, may be one mechanism to accomplish this.

While restricted distribution systems for individual drugs may have a safety *intent*, they paradoxically also represent corresponding safety *threats* in complex health-system

settings. Pharmacists must lead, balance, and manage all the considerations (including safety considerations) about drug distribution in these settings. Any distribution process that bypasses pharmacist control or requires exceptional procedures in such settings would be contrary to the best interest of patients. ASHP's members recognize that, despite this general principle and goal of standardization, some exceptions will inevitably have to be made in a patient's best interests. An important point, however, is that these should truly be extraordinary exceptions. The prospect of multiple, unique restrictive drug distribution systems is a frightening picture for health-system pharmacists. Deviations that are unique and that greatly differ from standard practices create obstacles in delivering and administering medications safely.

The patient-pharmacist relationship should not be misinterpreted as merely a product distribution function. The pharmacist's minimum responsibility is to assess the overall appropriateness of all medications with regard to dose, drug interactions, compliance, and patient counseling. Patient-pharmacist relationships in which this level of care is achieved depend on mutual trust, the pharmacist's thorough awareness of the patient's overall medication use, and the pharmacist's actions to ensure the timely supply of drug products. Restricted distribution systems that limit the pharmacist's ability to develop these relationships are disruptive. Restricted drug distribution systems that involve physician-to-patient delivery prevent pharmacists from providing medication appropriateness, dosage and interaction checks, patient education and counseling, monitoring, and follow-up evaluation.

Thoughtful consideration needs to be given to the fact that some of these medications may be initiated or continued for hospitalized patients. Hospital

pharmacies may not be able to acquire these medications in a timely manner.

This has an adverse effect on patient care and cost. Restricted distribution systems make it difficult for hospital pharmacies to acquire these drugs through their normal supplier channels. This pulls resources from hospital systems that are already stressed.

ASHP believes that, rather than unique drug product distribution schemes, the FDA, in consultation with stakeholders including pharmacists, physicians, nurses, other health care professionals, and patients, should develop models for managing patients for whom any high-risk drug product might be indicated and prescribed. Manufacturers should be required to design distribution procedures and supporting patient care materials in conformance with these models. Drug-specific requirements for a model should be developed during pre-approval demonstrations and adjusted over time based on post marketing surveillance. Pre-approval demonstrations – perhaps through the Centers for Education and Research on Therapeutics (CERT) -- should focus on requirements for ensuring appropriate use and monitoring, such as patient work-up and selection, provider and patient education, and patient monitoring. Such demonstration projects could answer a number of our concerns about important issues such as uniformity of procedures for patient selection, what kind of distribution systems are most supportive of continuity of care, and what kinds of approaches serve best for provider and patient education.