Guidance for Industry

Waiver of In Vivo Bioavailability and Bioequivalence Studies for Immediate-Release Solid Oral Dosage Forms Based on a Biopharmaceutics Classification System

U.S. Department of Health and Human Services
Food and Drug Administration
Center for Drug Evaluation and Research (CDER)
August 2000
BP

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GUIDANCE FOR INDUSTRY[1]

Waiver of In Vivo Bioavailability and Bioequivalence Studies for Immediate-Release Solid Oral Dosage Forms Based on a Biopharmaceutics Classification System

I. INTRODUCTION

This guidance provides recommendations for sponsors of investigational new drug applications (INDs), new drug applications (NDAs), abbreviated new drug applications (ANDAs), and supplements to these applications who wish to request a waiver of in vivo bioavailability (BA) and/or bioequivalence (BE) studies for immediate release (IR) solid oral dosage forms. These waivers are intended to apply to (1) subsequent in vivo BA or BE studies of formulations after the initial establishment of the in vivo BA of IR dosage forms during the IND period, and (2) in vivo BE studies of IR dosage forms in ANDAs. Regulations at 21 CFR part 320 address the requirements for bioavailability (BA) and BE data for approval of drug applications and supplemental applications. Provision for waivers of in vivo BA/BE studies (biowaivers) under certain conditions is provided at 21 CFR 320.22. This guidance explains when biowaivers can be requested for IR solid oral dosage forms based on an approach termed the Biopharmaceutics Classification System (BCS).

II. THE BIOPHARMACEUTICS CLASSIFICATION SYSTEM

The BCS is a scientific framework for classifying drug substances based on their aqueous solubility and intestinal permeability. When combined with the dissolution of the drug product, the BCS takes into account three major factors that govern the rate and extent of drug absorption from IR solid oral dosage forms: dissolution, solubility, and intestinal permeability.[2] According to the BCS, drug substances are classified as follows:

Class 1:	High Solubility – High Permeability
Class 2:	Low Solubility – High Permeability
Class 3:	High Solubility – Low Permeability

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[1] This guidance has been prepared by the Biopharmaceutics Classification System Working Group of the Biopharmaceutics Coordinating Committee in the Center for Drug Evaluation and Research (CDER) at the Food and Drug Administration (FDA). This guidance represents the Agency's current thinking on the topic. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternative approach may be used if such an approach satisfies the requirements of the applicable statutes, regulations, or both.

[2] Amidon, G. L., H. Lennernäs, V. P. Shah, and J. R. Crison, "A Theoretical Basis For a Biopharmaceutics Drug Classification: The Correlation of In Vitro Drug Product Dissolution and In Vivo Bioavailability," *Pharmaceutical Research*, 12: 413-420 (1995).

Class 4: Low Solubility – Low Permeability

In addition, IR solid oral dosage forms are categorized as having rapid or slow dissolution. Within this framework, when certain criteria are met, the BCS can be used as a drug development tool to help sponsors justify requests for biowaivers.

Observed in vivo differences in the rate and extent of absorption of a drug from two pharmaceutically equivalent solid oral products may be due to differences in drug dissolution in vivo.[2] However, when the in vivo dissolution of an IR solid oral dosage form is rapid in relation to gastric emptying and the drug has high permeability, the rate and extent of drug absorption is unlikely to be dependent on drug dissolution and/or gastrointestinal transit time. Under such circumstances, demonstration of in vivo BA or BE may not be necessary for drug products containing Class 1 drug substances, as long as the inactive ingredients used in the dosage form do not significantly affect absorption of the active ingredients. The BCS approach outlined in this guidance can be used to justify biowaivers for *highly soluble* and *highly permeable* drug substances (i.e., Class 1) in IR solid oral dosage forms that exhibit *rapid in vitro dissolution* using the recommended test methods (21 CFR 320.22(e)). The recommended methods for determining solubility, permeability, and in vitro dissolution are discussed below.

A. Solubility

The solubility class boundary is based on the highest dose strength of an IR product that is the subject of a biowaiver request. A drug substance is considered *highly soluble* when the highest dose strength is soluble in 250 ml or less of aqueous media over the pH range of 1-7.5. The volume estimate of 250 ml is derived from typical BE study protocols that prescribe administration of a drug product to fasting human volunteers with a glass (about 8 ounces) of water.

B. Permeability

The permeability class boundary is based indirectly on the extent of absorption (fraction of dose absorbed, not systemic BA) of a drug substance in humans and directly on measurements of the rate of mass transfer across human intestinal membrane. Alternatively, nonhuman systems capable of predicting the extent of drug absorption in humans can be used (e.g., in vitro epithelial cell culture methods). In the absence of evidence suggesting instability in the gastrointestinal tract, a drug substance is considered to be *highly permeable* when the extent of absorption in humans is determined to be 90% or more of an administered dose based on a mass balance determination or in comparison to an intravenous reference dose.

C. Dissolution

In this guidance, an IR drug product is considered *rapidly dissolving* when no less than 85% of the labeled amount of the drug substance dissolves within 30

minutes, using *U.S. Pharmacopeia* (USP) Apparatus I at 100 rpm (or Apparatus II at 50 rpm) in a volume of 900 ml or less in each of the following media: (1) 0.1 N HCl or Simulated Gastric Fluid USP without enzymes; (2) a pH 4.5 buffer; and (3) a pH 6.8 buffer or Simulated Intestinal Fluid USP without enzymes.

III. METHODOLOGY FOR CLASSIFYING A DRUG SUBSTANCE AND FOR DETERMINING THE DISSOLUTION CHARACTERISTICS OF A DRUG PRODUCT

The following approaches are recommended for classifying a drug substance and determining the dissolution characteristics of an IR drug product according to the BCS:

A. Determining Drug Substance Solubility Class

An objective of the BCS approach is to determine the equilibrium solubility of a drug substance under physiological pH conditions. The pH-solubility profile of the test drug substance should be determined at 37 ± 1°C in aqueous media with a pH in the range of 1-7.5. A sufficient number of pH conditions should be evaluated to accurately define the pH-solubility profile. The number of pH conditions for a solubility determination can be based on the ionization characteristics of the test drug substance. For example, when the pKa of a drug is in the range of 3-5, solubility should be determined at pH = pKa, pH = pKa +1, pH = pKa-1, and at pH = 1 and 7.5. A minimum of three replicate determinations of solubility in each pH condition is recommended. Depending on study variability, additional replication may be necessary to provide a reliable estimate of solubility. Standard buffer solutions described in the USP are considered appropriate for use in solubility studies. If these buffers are not suitable for physical or chemical reasons, other buffer solutions can be used. Solution pH should be verified after addition of the drug substance to a buffer. Methods other than the traditional shake-flask method, such as acid or base titration methods, can also be used with justification to support the ability of such methods to predict equilibrium solubility of the test drug substance. Concentration of the drug substance in selected buffers (or pH conditions) should be determined using a validated stability-indicating assay that can distinguish the drug substance from its degradation products.[3] If degradation of the drug substance is observed as a function of buffer composition and/or pH, it should be reported along with other stability data recommended in section III.B.3.

The solubility class should be determined by calculating the volume of an aqueous medium sufficient to dissolve the highest dose strength in the pH range of 1-7.5. A drug substance should be classified as highly soluble when the highest dose strength is soluble in ≤ 250 ml of aqueous media over the pH range of 1-7.5.

[3] See the FDA guidance for industry on *Submitting Documentation for the Stability of Human Drugs and Biologics* (February 1987), posted at http://www.fda.gov/guidance/index.htm.

B. Determining Drug Substance Permeability Class

The permeability class of a drug substance can be determined in human subjects using mass balance, absolute BA, or intestinal perfusion approaches. Recommended methods not involving human subjects include in vivo or in situ intestinal perfusion in a suitable animal model (e.g., rats), and/or in vitro permeability methods using excised intestinal tissues, or monolayers of suitable epithelial cells. In many cases, a single method may be sufficient (e.g., when the absolute BA is 90% or more, or when 90% or more of the administered drug is recovered in urine). When a single method fails to conclusively demonstrate a permeability classification, two different methods may be advisable. Chemical structure and/or certain physicochemical attributes of a drug substance (e.g., partition coefficient in suitable systems) can provide useful information about its permeability characteristics. Sponsors may wish to consider use of such information to further support a classification.

1. Pharmacokinetic Studies in Humans

a. Mass Balance Studies

Pharmacokinetic mass balance studies using unlabeled, stable isotopes or a radiolabeled drug substance can be used to document the extent of absorption of a drug. Depending on the variability of the studies, a sufficient number of subjects should be enrolled to provide a reliable estimate of extent of absorption. Because this method can provide highly variable estimates of drug absorption for many drugs, other methods described below may be preferable.

b. Absolute Bioavailability Studies

Oral BA determination using intravenous administration as a reference can be used. Depending on the variability of the studies, a sufficient number of subjects should be enrolled in a study to provide a reliable estimate of the extent of absorption. When the absolute BA of a drug is shown to be 90% or more, additional data to document drug stability in the gastrointestinal fluid is not necessary.

2. Intestinal Permeability Methods

The following methods can be used to determine the permeability of a drug substance from the gastrointestinal tract: (1) in vivo intestinal perfusion studies in humans; (2) in vivo or in situ intestinal perfusion studies using suitable animal models; (3) in vitro permeation studies using excised human or animal intestinal tissues; or (4) in vitro permeation studies across a monolayer of cultured epithelial cells.

In vivo or in situ animal models and in vitro methods, such as those using cultured monolayers of animal or human epithelial cells, are considered appropriate for passively transported drugs. The observed low permeability of some drug substances in humans could be caused by efflux of drugs via membrane transporters such as P-glycoprotein (P-gp). When the efflux transporters are absent in these models, or their degree of expression is low compared to that in humans, there may be a greater likelihood of misclassification of permeability class for a drug subject to efflux compared to a drug transported passively. Expression of known transporters in selected study systems should be characterized. Functional expression of efflux systems (e.g., P-gp) can be demonstrated with techniques such as bidirectional transport studies, demonstrating a higher rate of transport in the basolateral-to-apical direction as compared to apical-to-basolateral direction using selected model drugs or chemicals at concentrations that do not saturate the efflux system (e.g., cyclosporin A, vinblastine, rhodamine 123). An acceptance criterion for intestinal efflux that should be present in a test system cannot be set at this time. Instead, this guidance recommends limiting the use of nonhuman permeability test methods for drug substances that are transported by passive mechanisms. Pharmacokinetic studies on dose linearity or proportionality may provide useful information for evaluating the relevance of observed in vitro efflux of a drug. For example, there may be fewer concerns associated with the use of in vitro methods for a drug that has a higher rate of transport in the basolateral-to-apical direction at low drug concentrations but exhibits linear pharmacokinetics in humans.

For application of the BCS, an apparent passive transport mechanism can be assumed when one of the following conditions is satisfied:

- A linear (pharmacokinetic) relationship between the dose (e.g., relevant clinical dose range) and measures of BA (area under the concentration-time curve) of a drug is demonstrated in humans

- Lack of dependence of the measured in vivo or in situ permeability is demonstrated in an animal model on initial drug concentration (e.g., 0.01, 0.1, and 1 times the highest dose strength dissolved in 250 ml) in the perfusion fluid

- Lack of dependence of the measured in vitro permeability on initial drug concentration (e.g., 0.01, 0.1, and 1 times the highest dose strength dissolved in 250 ml) is demonstrated in donor fluid and transport direction (e.g., no statistically significant difference in the rate of transport between the apical-to-basolateral and basolateral-to-apical direction for the drug concentrations selected) using a suitable in vitro cell culture method that has been shown to express known efflux transporters (e.g., P-gp)

To demonstrate suitability of a permeability method intended for application of the BCS, a rank-order relationship between test permeability values and the extent of drug absorption data in human subjects should be established using a sufficient number of model drugs. For in vivo intestinal perfusion studies in humans, six model drugs are recommended. For in vivo or in situ intestinal perfusion studies in animals and for in vitro cell culture methods, twenty model drugs are recommended. Depending on study variability, a sufficient number of subjects, animals, excised tissue samples, or cell monolayers should be used in a study to provide a reliable estimate of drug permeability. This relationship should allow precise differentiation between drug substances of low and high intestinal permeability attributes.

For demonstration of suitability of a method, model drugs should represent a range of low (e.g., < 50%), moderate (e.g., 50 - 89%), and high (≥ 90%) absorption. Sponsors may select compounds from the list of drugs and/or chemicals provided in Attachment A or they may choose to select other drugs for which there is information available on mechanism of absorption and reliable estimates of the extent of drug absorption in humans.

After demonstrating suitability of a method and maintaining the same study protocol, it is not necessary to retest all selected model drugs for subsequent studies intended to classify a drug substance. Instead, a low and a high permeability model drug should be used as internal standards (i.e., included in the perfusion fluid or donor fluid along with the test drug substance). These two internal standards are in addition to the fluid volume marker (or a zero permeability compound such as PEG 4000) that is included in certain types of perfusion techniques (e.g., closed loop techniques). The choice of internal standards should be based on compatibility with the test drug substance (i.e., they should not exhibit any significant physical, chemical, or permeation interactions). When it is not feasible to follow this protocol, the permeability of internal standards should be determined in the same subjects, animals, tissues, or monolayers, following evaluation of the test drug substance. The permeability values of the two internal standards should not differ significantly between different tests, including those conducted to demonstrate suitability of the method. At the end of an in situ or in vitro test, the amount of drug in the membrane should be determined.

For a given test method with set conditions, selection of a high permeability internal standard with permeability in close proximity to the low/high permeability class boundary may facilitate classification of a test drug substance. For instance, a test drug substance may be determined to be highly permeable when its permeability value is equal to or greater than that of the selected internal standard with high permeability.

3. *Instability in the Gastrointestinal Tract*

Determining the extent of absorption in humans based on mass balance studies using total radioactivity in urine does not take into consideration the extent of degradation of a drug in the gastrointestinal fluid prior to intestinal membrane permeation. In addition, some methods for determining permeability could be based on loss or clearance of a drug from fluids perfused into the human and/or animal gastrointestinal tract either in vivo or in situ. Documenting the fact that drug loss from the gastrointestinal tract arises from intestinal membrane permeation, rather than a degradation process, will help establish permeability. Stability in the gastrointestinal tract may be documented using gastric and intestinal fluids obtained from human subjects. Drug solutions in these fluids should be incubated at 37°C for a period that is representative of in vivo drug contact with these fluids; for example, 1 hour in gastric fluid and 3 hours in intestinal fluid. Drug concentrations should then be determined using a validated stability-indicating assay method. Significant degradation (>5%) of a drug in this protocol could suggest potential instability. Obtaining gastrointestinal fluids from human subjects requires intubation and may be difficult in some cases. Use of gastrointestinal fluids from suitable animal models and/or simulated fluids such as Gastric and Intestinal Fluids USP can be substituted when properly justified.

C. Determining Drug Product Dissolution Characteristics and Dissolution Profile Similarity[4]

Dissolution testing should be carried out in USP Apparatus I at 100 rpm or Apparatus II at 50 rpm using 900 ml of the following dissolution media: (1) 0.1 N HCl or Simulated Gastric Fluid USP without enzymes; (2) a pH 4.5 buffer; and (3) a pH 6.8 buffer or Simulated Intestinal Fluid USP without enzymes. For capsules and tablets with gelatin coating, Simulated Gastric and Intestinal Fluids USP (with enzymes) can be used.

Dissolution testing apparatus used in this evaluation should conform to the requirements in USP (<711> Dissolution). Selection of the dissolution testing apparatus (USP Apparatus I or II) during drug development should be based on a comparison of in vitro dissolution and in vivo pharmacokinetic data available for the product. The USP Apparatus I (*basket method*) is generally preferred for capsules and products that tend to float, and USP Apparatus II (*paddle method*) is generally preferred for tablets. For some tablet dosage forms, in vitro (but not in vivo) dissolution may be slow due to the manner in which the disintegrated product settles at the bottom of a dissolution vessel. In such situations, USP Apparatus I may be preferred over Apparatus II. If the testing conditions need to be modified to better reflect rapid in vivo dissolution (e.g., use of a different rotating speed), such modifications can be justified by comparing in vitro

[4] See the FDA guidance for industry on *Dissolution Testing of Immediate Release Solid Oral Dosage Forms* (August 1997).

dissolution with in vivo absorption data (e.g., a relative BA study using a simple aqueous solution as the reference product).
A minimum of 12 dosage units of a drug product should be evaluated to support a biowaiver request. Samples should be collected at a sufficient number of intervals to characterize the dissolution profile of the drug product (e.g., 10, 15, 20, and 30 minutes).

When comparing the test and reference products, dissolution profiles should be compared using a similarity factor (f_2). The similarity factor is a logarithmic reciprocal square root transformation of the sum of squared error and is a measurement of the similarity in the percent (%) of dissolution between the two curves.

$$f_2 = 50 \bullet \log \{[1+(1/n)\bullet_{t=1}^{n} (R_t - T_t)^2]^{-0.5} \bullet 100\}$$

Two dissolution profiles are considered similar when the f_2 value is ≥ 50. To allow the use of mean data, the coefficient of variation should not be more than 20% at the earlier time points (e.g., 10 minutes), and should not be more than 10% at other time points. Note that when both test and reference products dissolve 85% or more of the label amount of the drug in ≤ 15 minutes using all three dissolution media recommended above, the profile comparison with an f_2 test is unnecessary.

IV. ADDITIONAL CONSIDERATIONS FOR REQUESTING A BIOWAIVER

When requesting a BCS-based waiver for in vivo BA/BE studies for IR solid oral dosage forms, applicants should note that the following factors can affect their request or the documentation of their request:

A. Excipients

Excipients can sometimes affect the rate and extent of drug absorption. In general, using excipients that are currently in FDA-approved IR solid oral dosage forms will not affect the rate or extent of absorption of a highly soluble and highly permeable drug substance that is formulated in a rapidly dissolving IR product. To support a biowaiver request, the quantity of excipients in the IR drug product should be consistent with the intended function (e.g., lubricant). When new excipients or atypically large amounts of commonly used excipients are included in an IR solid dosage form, additional information documenting the absence of an impact on BA of the drug may be requested by the Agency. Such information can be provided with a relative BA study using a simple aqueous solution as the reference product. Large quantities of certain excipients, such as surfactants (e.g., polysorbate 80) and sweeteners (e.g., mannitol or sorbitol) may be problematic, and sponsors are encouraged to contact the review division when this is a factor.

B. Prodrugs

Permeability of prodrugs will depend on the mechanism and (anatomical) site of conversion to the drug substance. When the prodrug-to-drug conversion is shown to occur predominantly after intestinal membrane permeation, the permeability of the prodrug should be measured. When this conversion occurs prior to intestinal permeation, the permeability of the drug should be determined. Dissolution and pH-solubility data on both prodrug and drug can be relevant. Sponsors may wish to consult with appropriate review staff before applying the BCS approach to IR products containing prodrugs.

C. Exceptions

BCS-based biowaivers are not applicable for the following:

1. Narrow Therapeutic Range Drugs[5]

This guidance defines narrow therapeutic range drug products as those containing certain drug substances that are subject to therapeutic drug concentration or pharmacodynamic monitoring, and/or where product labeling indicates a narrow therapeutic range designation. Examples include digoxin, lithium, phenytoin, theophylline, and warfarin. Because not all drugs subject to therapeutic drug concentration or pharmacodynamic monitoring are narrow therapeutic range drugs, sponsors should contact the appropriate review division to determine whether a drug should be considered to have a narrow therapeutic range.

2. Products Designed to be Absorbed in the Oral Cavity

A request for a waiver of in vivo BA/BE studies based on the BCS is not appropriate for dosage forms intended for absorption in the oral cavity (e.g., sublingual or buccal tablets).

V. REGULATORY APPLICATIONS OF THE BCS

A. INDs/NDAs

Evidence demonstrating in vivo BA or information to permit FDA to waive this evidence must be included in NDAs (21 CFR 320.21(a)). A specific objective is to establish in vivo performance of the dosage form used in the clinical studies that provided primary evidence of efficacy and safety. The sponsor may wish to determine the relative BA of an IR solid oral dosage form by comparison with an oral solution, suspension, or intravenous injection (21 CFR 320.25 (d)(2) and

[5] This guidance uses the term *narrow therapeutic range* instead of *narrow therapeutic index*, although the latter is more commonly used.

320.25 (d)(3)). The BA of the clinical trial dosage form should be optimized during the IND period.

Once the in vivo BA of a formulation is established during the IND period, waivers of subsequent in vivo BE studies, following major changes in components, composition, and/or method of manufacture (e.g., similar to SUPAC-IR Level 3 changes[6]) may be possible using the BCS. BCS-based biowaivers are applicable to the to-be-marketed formulation when changes in components, composition, and/or method of manufacture occur to the clinical trial formulation, as long as the dosage forms have rapid and similar in vitro dissolution profiles (see sections II and III). This approach is useful only when the drug substance is highly soluble and highly permeable (BCS Class 1), and the formulations pre- and postchange are *pharmaceutical equivalents* (under the definition at 21 CFR 320.1 (c)). BCS-based biowaivers are intended only for BE studies. They do not apply to food effect BA studies or other pharmacokinetic studies.

B. ANDAs

BCS-based biowaivers can be requested for rapidly dissolving IR test products containing highly soluble and highly permeable drug substances, provided that the reference listed drug product is also rapidly dissolving and the test product exhibits similar dissolution profiles to the reference listed drug product (see sections II and III). This approach is useful when the test and reference dosage forms are pharmaceutical equivalents. The choice of dissolution apparatus (USP Apparatus I or II) should be the same as that established for the reference listed drug product.

C. Postapproval Changes

BCS-based biowaivers can be requested for significant postapproval changes (e.g., Level 3 changes in components and composition) to a rapidly dissolving IR product containing a highly soluble, highly permeable drug substance, provided that dissolution remains rapid for the postchange product and both pre- and postchange products exhibit similar dissolution profiles (see sections II and III). This approach is useful only when the drug products pre- and postchange are pharmaceutical equivalents.

VI. DATA TO SUPPORT A REQUEST FOR BIOWAIVERS

The drug substance for which a waiver is being requested should be highly soluble and highly permeable. Sponsors requesting biowaivers based on the BCS should submit the following information to the Agency for review by the Office of Clinical Pharmacology

[6] See the FDA guidance for industry on *Immediate Release Solid Oral Dosage Forms: Scale-Up and Post-Approval Changes* (November 1995).

and Biopharmaceutics (for NDAs) or Office of Generic Drugs, Division of Bioequivalence (for ANDAs):

A. Data Supporting High Solubility

Data supporting high solubility of the test drug substance should be developed (see section III.A). The following information should be included in the application:

- A description of test methods, including information on analytical method and composition of the buffer solutions
- Information on chemical structure, molecular weight, nature of the drug substance (acid, base, amphoteric, or neutral), and dissociation constants (pKa(s))
- Test results (mean, standard deviation, and coefficient of variation) summarized in a table under solution pH, drug solubility (e.g., mg/ml), and volume of media required to dissolve the highest dose strength
- A graphic representation of mean pH-solubility profile

B. Data Supporting High Permeability

Data supporting high permeability of the test drug substance should be developed (see section III.B). The following information should be included in the application:

- For human pharmacokinetic studies, information on study design and methods used along with the pharmacokinetic data
- For direct permeability methods, information supporting the suitability of a selected method that encompasses a description of the study method, criteria for selection of human subjects, animals, or epithelial cell line, drug concentrations in the donor fluid, description of the analytical method, method used to calculate extent of absorption or permeability, and where appropriate, information on efflux potential (e.g., bidirectional transport data)
- A list of selected model drugs along with data on extent of absorption in humans (mean, standard deviation, coefficient of variation) used to establish suitability of a method, permeability values for each model drug (mean, standard deviation, coefficient of variation), permeability class of each model drug, and a plot of the extent of absorption as a function of permeability (mean ± standard deviation or 95% confidence interval) with identification of the low/high permeability

class boundary and selected internal standard. Information to support high permeability of a test drug substance should include permeability data on the test drug substance, the internal standards (mean, standard deviation, coefficient of variation), stability information, data supporting passive transport mechanism where appropriate, and methods used to establish high permeability of the test drug substance.

C. Data Supporting Rapid and Similar Dissolution

For submission of a biowaiver request, an IR product should be rapidly dissolving. Data supporting rapid dissolution attributes of the test and reference products should be developed (see section III.C). The following information should be included in the application:

- A brief description of the IR products used for dissolution testing, including information on batch or lot number, expiry date, dimensions, strength, and weight

- Dissolution data obtained with 12 individual units of the test and reference products using recommended test methods in section III.C. The percentage of labeled claim dissolved at each specified testing interval should be reported for each individual dosage unit. The mean percent dissolved, range (highest and lowest) of dissolution, and coefficient of variation (relative standard deviation) should be tabulated. A graphic representation of the mean dissolution profiles for the test and reference products in the three media should also be included.

- Data supporting similarity in dissolution profiles between the test and reference products in each of the three media, using the f_2 metric

D. Additional Information

The manufacturing process used to make the test product should be described briefly to provide information on the method of manufacture (e.g., wet granulation vs. direct compression). A list of excipients used, the amount used, and their intended functions should be provided. Excipients used in the test product should have been used previously in FDA-approved IR solid oral dosage forms.

ATTACHMENT A

This attachment includes model drugs suggested for use in establishing suitability of a permeability method as described in section III. The permeability of these compounds was determined based on data available to the FDA. Potential *internal standards* (IS) and *efflux pump substrates* (ES) are also identified.

Drug	Permeability Class
Antipyrine	High (Potential IS candidate)
Caffeine	High
Carbamazepine	High
Fluvastatin	High
Ketoprofen	High
Metoprolol	High (Potential IS candidate)
Naproxen	High
Propranolol	High
Theophylline	High
Verapamil	High (Potential ES candidate)
Amoxicillin	Low
Atenolol	Low
Furosemide	Low
Hydrochlorthiazide	Low
Mannitol	Low (Potential IS candidate)
α-Methyldopa	Low
Polyethylene glycol (400)	Low
Polyethylene glycol (1000)	Low
Polyethylene glycol (4000)	Low (Zero permeability marker)
Ranitidine	Low