

UNITED STATES

FOOD AND DRUG ADMINISTRATION

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In the matter of:)
)
FOOD AND DRUG ADMINISTRATION)
MODERNIZATION ACT OF 1997)
Section 406(b))
)

COMMUNICATING WITH STAKEHOLDERS
REPORTER'S TRANSCRIPT OF PROCEEDINGS

Friday, August 28, 1998

Edward R. Roybal Auditorium
Federal Building
1301 Clay Street
Oakland, California 94612-5217

ORIGINAL

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1 A P P E A R A N C E S

2 Held at: Edward R. Roybal Auditorium
3 Federal Building
4 1301 Clay Street
5 Oakland, California 94612-5217

6 Introduction:

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8 Regional Director, Pacific Region

9 Panelists for the FOOD AND DRUG ADMINISTRATION:

10 MARK A. ELENGOLD, Chair
11 Deputy Director, Operations
12 Center for Biologics Evaluation and Research

13 LINDA SUYDAM
14 Associate Commissioner for Strategic Management
15 Center for Biologics Evaluation and Research

16 JAY SIEGEL, M.D.
17 Director, Office of Therapeutics Research and Review
18 Center for Biologics Evaluation and Research

19 Panelists for the STAKEHOLDERS:

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21 NANCY ISAAC, J.D., MPH
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AIDS Project Los Angeles

1 Friday, August 28, 1998

9:05 a.m.

2 - - - - -

3 MR. BALDWIN: Good morning. My name is
4 Richard Baldwin. I'm the regional director since March
5 in the Pacific Region.

6 I wanted to just take a couple of minutes
7 this morning to welcome you to one of Food and Drug's
8 stakeholder meetings. These are a part of some strong
9 suggestions, you could say, in our Modernization Act,
10 that we have stakeholder meetings.

11 We haven't waited for that suggestion in the
12 Pacific Region. We've been doing them for quite a
13 while. In fact, we've been kind of busy recently with a
14 number of outreach activities. A few weeks ago we had a
15 workshop for the industry to have a better understanding
16 of the premarket approval process, and we had some good
17 attendance there. And this week we're also doing some
18 training for the cheese industry, so that they can
19 manufacture soft cheeses and make them safe.

20 Pacific Region is committed to an open
21 dialogue with the industry and our customers, and this
22 is a part of that process. I'm pleased that we're
23 actually doing some of these stakeholder meetings in the
24 field. I did have the opportunity to participate in the
25 CVM stakeholder meeting in Rockville, and I hope that we

1 have as lively and as fruitful a dialogue today as I've
2 heard about some of the others.

3 I'm not going to take a lot of time. I just
4 want to welcome you here. I'll be sticking around all
5 morning, using the breaks to try and meet folks, so you
6 can meet me, and shake my hand, and you can get to know
7 me, because I need to get to know you. And thank you
8 for this opportunity.

9 I also note that this is a reminder that we
10 have to do a better job of getting our home in order so
11 that we can eat a healthier diet.

12 MR. ELENGOLD: Thank you, Richard. I'm Mark
13 Elengold. I'm the Deputy Director for Operations of the
14 Center for Biologics Evaluations and Research. I'm here
15 today to chair this meeting, and learn from you what you
16 think our needs, our priorities, and other things should
17 be.

18 I bring you greetings from Dr. Katherine
19 Zoon, who is the Director of CBER, who, on the short
20 notice when we put this meeting together, had
21 conflicting plans. Otherwise, Kathy would be here
22 herself to listen to you. But we are taking extensive
23 minutes. There will be a transcript of this meeting,
24 and we will go over it with the senior management of
25 FDA.

1 The other folks who are up here with me on
2 the dias are Ms. Linda Suydam, who is the Associate
3 Commissioner for Strategic Management, and Dr. Jay
4 Siegel, who is the Director of the Office of
5 Therapeutics Research and Review with CBER. We're here
6 to learn from you, and we'll have a few opening remarks.

7 I just want to say that we want to thank the
8 folks in the Pacific Region for their hospitality and
9 assistance in setting this up. When we were deciding
10 how to implement 406(b), the way we were to do it, it
11 occurred to us that so many of the stakeholders of the
12 biologics industry are on the West Coast, that we wanted
13 to do a meeting out here.

14 There are two reasons for that. One is,
15 there are a lot of you. And also, very importantly,
16 Mark Roh, the small business representative here in the
17 Pacific Region, is extremely active, and the industry
18 here owes him a big debt of thanks for strongly
19 representing their interests with us back in Rockville..

20 We do more things out here. I know Mark has
21 me traveling out here an awful lot. I did a videotape a
22 couple of weeks ago, for one thing, and he has me coming
23 out in two more weeks to do a grass-roots meeting in
24 Irvine. So we are very interested in working with you.
25 And people here, on the way out, you should probably

1 just thank Mark for representing those of us in
2 Headquarters.

3 There are some other folks in the region and
4 district I'd like to acknowledge, since they came. From
5 the FDA Headquarters, Marie Urban, who is the ORA 2000
6 coordinator, over there, Marie. Pat Ziobro, who is the
7 District Director of the San Francisco District, back
8 there. Phil Lindeman, who is the one of the compliance
9 officers on Team Biologics, is over there. Let's see, I
10 think that's all, folks.

11 The other people I want to thank for their
12 assistance in getting this together are folks from the
13 regional office, Judy Keast and Faye Gill, who have done
14 a lot of the administrative work. We also want to thank
15 Chris Neilsen and the GSA folks in this building, who
16 were here late yesterday and early this morning working
17 with us to set up this facility, which is an excellent
18 one for a meeting of this type.

19 Back in Rockville, I just want to say that we
20 thank Gail Sherman and Kathy Everhart of the Office of
21 Communication Training Manufacturers Assistance at CBER
22 for doing some of the administrative work, and the
23 person who's coordinated most of our 406 activities,
24 Dennis Strickland. Dennis is up there in the front.

25 This is an important activity which, as

1 Richard hinted at, was mandated by FDAMA. But it
2 continues a process that we in CBER also began several
3 years ago when we developed our strategic plan, which
4 I'll talk about in a little while. And a major focus of
5 that plan is communicating with our customers, both the
6 regulated industry and the consumers.

7 Just some administrative announcements. The
8 most important, of course, the restrooms are outside.
9 You walk out the back door, and the ladies' room is on
10 the left, and the men's room is on the right. There are
11 telephones back there.

12 We will be taking a break. During that
13 break, there is a cafeteria on the fifth floor, if
14 anybody is in need of coffee. You can't bring the food
15 back in here. So if you do get coffee, please finish it
16 before you come back in.

17 The docket for the 406(b) process will remain
18 open after this meeting. And we will be having two more
19 meetings of the general Agency type, one on September 8
20 in Bethesda, and that is directed at health care
21 professionals, and a general overall Agency summation
22 meeting on the 406(b) process on September 14th, also in
23 Bethesda. So I urge you to, if you can, attend those.

24 We will also, as I said, have a grass-roots
25 meeting out here next month in Irvine. And any

1 information that we pick up in the course of that we
2 will also include in the FDAMA docket, so that comments
3 there will also be included.

4 I'm really happy to introduce our next
5 speaker, someone I've known for a number of years, who I
6 guess I first met when she worked at the Center for
7 Devices and Radiological Health. She was in our
8 Commissioner's Office. She was Associate Commissioner
9 for Operations, left, and has now returned to the fold
10 of those of us who fight the good fight. It's Linda
11 Suydam, the Associate Commissioner for Strategic
12 Management, who has some remarks on the general purpose
13 and things we hope to learn at this meeting.

14 Linda.

15 MS. SUYDAM: Thank you. Thank you, Mark, and
16 thank you, Richard, for welcoming us, and for hosting
17 this meeting in the Pacific Region.

18 We are particularly pleased to be able to
19 have a stakeholders' process, so that we can consult
20 with FDA's stakeholders, and we're using that term in
21 the broadest possible way.

22 The FDA Modernization and Accountability Act
23 of 1997, Section 406(b), says that FDA must consult with
24 appropriate scientific and academic experts, health care
25 professionals, representatives, patient and consumer

1 advocacy groups, and the regulated industry. And when I
2 came back to the Agency on July 6th, my job was to
3 manage this process, and to assure that we meet the
4 requirements of the FDAMA plan. And we will have a plan
5 based on this section issued to Congress on November
6 21st. That's the legally mandated time frame that we're
7 operating under.

8 This is the fifth in the series of
9 stakeholder meetings that we are having. The first four
10 have been held in the D.C. area. They were incredibly
11 successful. We learned a lot of things. Even though at
12 times the FDA staff believe that they've heard
13 everything, in this case, that's not true. We did hear
14 lots of new things, and we're looking for new ways and
15 new alternative methods of being able to do our job.

16 And let me tell you now a little bit about
17 the plan itself. The plan has to address six
18 objectives. And the six objectives -- two of those
19 relate to the availability and clarity of information.
20 And we have actually heard from our stakeholders in the
21 previous meetings that this is something that they are
22 very concerned about, that people want clear, concise,
23 transparent, and predictable processes, and they want to
24 be able to understand those processes, and our job is to
25 be able to clarify that information and get it to those

1 people.

2 In addition, people are interested in new
3 products, and they want to know exactly what the new
4 products are all about, and they don't find that
5 necessarily the industry itself is giving them the kind
6 of information they want. They want FDA to help with
7 the availability of that information.

8 The next two objectives relate to two things
9 that we at the FDA are quite concerned about. The next
10 objective is the implementation of our inspection and
11 postmarket monitoring activities in the Agency. And
12 these are activities that have, in fact, I think,
13 suffered over the last few years because of our major
14 focus on premarket review.

15 And the fourth objective is ensuring the
16 scientific infrastructure that we think is critical to
17 the FDA being able to do its job. We are a scientific
18 -- we believe we are a scientific consumer protection
19 regulatory agency, and we need to have individuals
20 working for us who are scientifically and technically
21 competent, and that's incredibly important. And that,
22 too, has suffered because of our resource limitations.

23 And then the final two objectives relate to
24 time frames for meeting established statutory
25 requirements. We have to have mechanisms in place by

1 July of '99 to tell the Congress how we are going to
2 meet those time frames, and in fact, have the backlog of
3 all review applications and submissions finished by
4 January of 2000.

5 This is a daunting task. We are looking for
6 input from our stakeholders on how we will do these
7 activities. But in addition to that, the FDA, in its
8 FDA Message to Stakeholders, which is available on our
9 Web site, raised seven areas of concern. And some of
10 these overlap with the requirements under FDAMA, but
11 some of them are product- and program-specific.

12 The first of these is adverse event and
13 injury reporting. As an agency, I mentioned that we
14 have been focusing a lot of our attention and resources
15 on the premarket side of things. And we now want to
16 start looking at: How are we doing adverse event
17 reporting? How are we feeding back information to
18 health professionals and consumers and to the industry,
19 and how can we better improve that process?

20 Also, in product safety assurance, we need to
21 understand better how we can be more effective in our
22 product safety assurance activities, but also, how can
23 we dedicate more resources to that activity.

24 And product application reviews has to stay
25 on the list, because we continue to get increased

1 workload, and we continue to get time frames that are
2 more and more restrictive, and we have to meet those
3 time frames according to the FDAMA act.

4 The final four activities that we're
5 interested in and are focusing on in our 2000 budget
6 which will go to OMB this fall is food safety, which is
7 a presidential initiative, and is an activity that we
8 are undertaking in conjunction with the Center for
9 Disease Control and the Department of Agriculture. We
10 want to make sure that our outreach activities are
11 efficient and effective. These two have suffered in the
12 last few years of budget cuts, and we believe that we
13 need to have more activities such as this to build up
14 the outreach.

15 The FDA in the past has often been a fairly
16 insular kind of organization, and we're now making a
17 major effort to reach out and to hear from people who
18 are affected by our activities.

19 Scientific infrastructure and research I
20 mentioned earlier. I think the new management of the
21 Agency believe that research is critical to the function
22 of this Agency. It is not a superfluous activity. It
23 is part of the mainstream activity of the Food and Drug
24 Administration. There is research, and the research is
25 obviously applied. It is applied to the regulatory

1 responsibilities we have, and to the mission of the
2 Agency. But this is research that no one else will do
3 if the Food and Drug Administration doesn't do it.

4 And finally, tobacco is on here, because it,
5 too, was a major initiative of the Agency. And despite
6 what has happened in the Fourth Circuit in Richmond,
7 Virginia, the FDA continues to place a high priority on
8 regulation of tobacco. We will await the findings of
9 that court appeal which is going to the full circuit,
10 and hopefully the Agency will be allowed to continue in
11 its activities to assure that the youth of this country
12 are not smoking at greater rates than they currently
13 are.

14 I want to also then look at resource efforts
15 in the Agency, and I want to give you some information
16 about the FDA budget. I'm calling this chart "Visible
17 FDA." And as you can see, the top line looks like the
18 Agency's budget has significantly increased from 1993 to
19 the year 1999. And so from the outside, if one looked
20 at the FDA in just raw numbers, you'd say, "Oh, the FDA
21 budget has grown from \$800 million to \$1.2 billion in a
22 six-year period. Why are they complaining about
23 resources?"

24 Well, the answer is that because those
25 resources have been dedicated to particular activities,

1 and we have had an inflation factor, that has really
2 caused the Agency to maintain its base activities at
3 lower levels than where we were in 1993. And you can
4 see those base activities are represented by the yellow
5 color on this chart, and you will see that there is a
6 \$90 million reduction from 1993 to 1999.

7 Why is that? Well, a couple of things
8 happened. In 1992, we had the Prescription Drug User
9 Fee Act which passed. What that meant was that the
10 Prescription Drug User Fee Program, with its base
11 resources, would never be cut. So even if the Agency
12 suffered reductions in its total program, that program
13 was protected.

14 And so the additive user fees are in the
15 budget, but they are dedicated only to the Prescription
16 Drug User Fee Program. So you'll see how that is
17 represented by the purple line. And that includes both
18 Prescription Drug User Fee, the Mammography Quality
19 Assurance Act, which was also a user fee program -- both
20 of which, by the way, I want to point out, were very
21 successful programs, which would lead one in a general
22 way to say that user fees would be the way to go in
23 funding the Agency in the future.

24 And also in that purple band is dollars for
25 the Food Safety Initiative and the Tobacco Initiative,

1 which this year in the budget were guaranteed a
2 particular level. And therefore, that reduction -- that
3 guarantee meant that the rest of the Agency had to take
4 a reduction in resources.

5 So by the action of the Congress, I think the
6 next chart particularly shows what we're calling the
7 shrinking FDA. And that is, as I said, the base
8 resources and the unfunded workload. And what this
9 Agency believes is that in order for the base resources
10 of this Agency to be funded at an adequate level, we
11 really need to have another \$300 million to fund those
12 base resources. So I don't want to spend too much time
13 on this, but I do want to make sure that we put the
14 comments that we're hearing today in context.

15 In summarization, the docket is open, as Mark
16 mentioned; 98N-0339, that's the docket number. We will
17 be accepting comments in the CBER docket and all the
18 document-specific dockets until September 11. The FDA
19 overall meeting is going to be held September 14th, and
20 we will be accepting comments on that meeting until
21 September 21st.

22 You have three ways to comment. You can do
23 it the standard, traditional way: Write your comments
24 and mail them in to us. You can do it via the Internet,
25 and you can also do it by e-mail. So we're hoping that

1 we will hear from lots of people with creative ideas
2 about how the Food and Drug Administration can do its
3 job. And I look forward to hearing from you today, and
4 hearing the kind of information you're going to give us.

5 I think Mark is going to come back to the
6 podium and talk specifically about the CBER program, and
7 so we can put your comments in context of CBER itself.

8 MR. ELENGOLD: Thank you, Linda. I actually
9 have to apologize. I forgot to introduce two people
10 when I was thanking people. First, the person in the
11 San Francisco District that I've known the longest,
12 which is why I probably forgot to mention him: Steve
13 Kendall, who is the compliance director in the district.
14 And somebody that came from Headquarters in the back,
15 who you can see illuminated by the screen -- there seems
16 to be a computer permanently attached to her -- is Karen
17 Groover, who is our executive secretary, who is taking
18 the minutes of these meetings, and putting them in
19 various forms that we will have available for review,
20 inclusion in the docket, and posted on the Internet. So
21 I wanted to take care of that oversight.

22 As Linda said, I'm going to put it in context
23 a little bit about CBER. Since this is the only meeting
24 on the West Coast, I'm going to do some general
25 information about CBER in case there are folks from the

1 drug/device/veterinary medicine industry that are here.

2 This is our mission. It is one we decided
3 upon about five years ago. Long before the FDA
4 Modernization Act dictated the Agency have a mission
5 statement, we decided we needed one. I will read it
6 just so it appears in the record.

7 "The mission of Center for Biologics
8 Evaluation and Research is to protect and
9 enhance the public health through the
10 regulation of biological and related products
11 including blood, vaccines, and biological
12 therapeutics according to statutory
13 authorities. The regulation of these
14 products is founded on science and law to
15 ensure their purity, potency, safety,
16 efficacy, and availability."

17 And I just want to point out that last word,
18 that "availability" was put there a long time before the
19 Agency focused on the need to make sure that needed
20 products were available.

21 Just to give us an idea of the kind of
22 products we regulate, the slide we used to show was a
23 rainbow, but we didn't have enough room on the rainbow
24 to show all of our products. And it's interesting, when
25 we start to look at it, how they all seem to go around

1 in a circle. So we decided upon this. You start with
2 the whole blood, blood components, blood derivatives,
3 vaccines, basically blood and immunogenic production,
4 allergenic factors, monoclonal antibodies, biotech-
5 derived therapeutics, somatic cell and gene therapy,
6 xenotransplantation, which are the latest products we
7 have been charged with regulating, and tissue. I
8 learned back when I was in school many years ago that
9 blood is a tissue. So we're right back where we
10 started, at whole blood.

11 We are very proud of what we have
12 accomplished, both under the Prescription Drug User Fee
13 Act and on our other products. And interestingly
14 enough, if you look at the average time to approval
15 going back from '89 to '97, the largest reduction in
16 average time to approval was in the nonuser fee
17 products. And the reason for that is the user fee
18 products have always been the highest profile, most
19 medically important. So they were given a high priority
20 even prior to PDUFA, and we have cut the time of
21 approval about in half.

22 And if you look at the others, it is an even
23 more striking reduction. And the reason for this is as
24 long as we were revising, studying, and optimizing our
25 review process, whether it was applied to PDUFA or not,

1 it was applied to all of our products.

2 Next one, please. Average time to approval
3 for supplements, again, now, the decrease isn't quite as
4 striking, the difference. But the times, considering
5 the fact that we've received no user fee money, and the
6 user fee base is protected and cannot be diverted to the
7 nonuser fee product, also shows a significant reduction
8 in the time to approval of supplements.

9 Next one, please. This is all done in the
10 context of our IND workload and INDs. And CBER also
11 regulates certain medical devices that are related to
12 the blood banking industry, so we also have IDEs,
13 investigational device exemptions. You can see the IND
14 workload fluctuates quite a bit. Someone suggested we
15 compare this to the average stock prices of the biotech
16 industry. And if you look, the increase in recent years
17 in biotech and other INDs incidentally coincide with
18 stock market activity in the biotech industry.

19 That is one of the difficulties that we face
20 in FDA. We don't decide when IND or PLA or whatever
21 comes in, since a company may have an IND they have been
22 working on, and for strategic business reasons, or
23 others not related to anything we do, they submit them
24 when they want.

25 We're always fascinated at the -- you know, a

1 few years ago we were soundly criticized for doing a lot
2 of approvals in the month of December. And one time I
3 recall we had fully a third of our applications approved
4 in December. And something people aren't aware of too
5 widely, we also receive a very large number of
6 applications in December. And the reason for that, I'm
7 told by my colleagues in industry, is they have
8 performance goals and strategic plans, and their
9 milestone is to submit them before the end of the year.

10 So we're at the mercy of the submission
11 pipeline. We have no way to control that. And as you
12 can see, the workload is staying constant or steadily
13 increasing.

14 Well, we're pretty proud of what we've done
15 over the past few years. Under our strategic plan, we
16 have our reinventing government initiatives, which
17 included things like the elimination of the
18 establishment license and a single biologics products
19 license. Some of the things that were incorporated in
20 FDAMA to codify in statute, some of the things we have
21 already done in our Prescription Drug User Fee Act
22 goals.

23 We have met all the goals: Our strategic
24 plan implementation, begin updating of blood regulations
25 production, participation at a very high level in the

1 International Conference on Harmonization to provide
2 worldwide common goals and requirements, the WHO
3 standardization activities -- CBER is a WHO laboratory,
4 and we work with WHO to develop and enforce worldwide
5 standards on products -- our regulation of cellular and
6 gene therapy, the new hottest item in the world of
7 medicine, and we're also the first FDA center to have an
8 external review of our research programs where we
9 brought in a panel of outside experts from academia,
10 industry, and other government agencies, other country
11 agencies, to review our research programs to make sure
12 that they are providing the information that a
13 regulatory agency like we have needs.

14 What are the strategic goals? Now, we came
15 up with this plan about four years ago. It runs out to
16 2002. Goal No. 1: A managed and integrated process
17 from discovery through post-marketing, and that is the
18 new managed review process that we implemented on the
19 marketing application process that led to those
20 reductions. In addition, we have now expanded that
21 effort and have developed a managed review process from
22 pre-IND submission through post-marketing. And we are
23 now close to having that finalized, and it will be
24 available through our Internet site soon to accomplish
25 that managed review from discovery through follow-up.

1 A high quality research program which
2 contributes to the regulatory mission. We have
3 regularly reviewed our research program to make sure
4 it's focused on our mission. After doing that, we
5 invited these outside advisors in who provided us with a
6 report.

7 A high-quality, diverse work force. Our
8 people are our most important asset. That is actually
9 the truth. Without the great people that we have in
10 CBER, we would not accomplish what we are able to
11 accomplish with our resources.

12 Interactive information systems which are
13 integral to all CBER activities. Anybody in business or
14 government going into the next millennium knows you
15 can't do what you need to do without effective ADP
16 support and management.

17 Leveraging resources. This is an attempt to
18 try and partner with other government agencies, academic
19 institutions, and yes, even the industry to try and
20 accomplish more with the resources that we have
21 available from our appropriated and PDUFA funds.

22 Next one, please. Our major initiatives and
23 action plans. Number one, we are committed to
24 implementing the FDAMA legislation. We have met all of
25 the milestones dictated so far, and we fully intend to

1 meet every other one. The fact that we are here and you
2 are here today shows our commitment.

3 PDUFA II, we have not failed to meet any goal
4 in PDUFA I. We do not intend to miss any goals in PDUFA
5 II.

6 Support of ICH. We are attending the latest
7 meeting to finalize some more documents in Tokyo next
8 week.

9 Implementing our strategic plan, which, if
10 you are interested at all, it is available on our Web
11 page, on our fax-on-demand, or you can actually call up
12 and ask for it in a good, old-fashioned hard copy.

13 Implementing Team Biologics, our new paradigm
14 for inspection that takes the best elements of our field
15 investigators trained to do enforcement and compliance
16 work, to go thorough GNP experts with the scientific
17 knowledge of our CBER Headquarters folks.

18 Implementing the tissue regulatory framework
19 and action plan which was developed and published last
20 year.

21 Our blood action plan, which is a
22 comprehensive set of activities that are designed to
23 further enhance the safety and availability of blood and
24 blood products.

25 And the latest thing we are endeavoring to

1 do, which is xenotransplantation, the use of
2 cross-species organs and tissues.

3 If I could have the next one, please. What
4 are our challenges? Well, it's funny. They seem to be
5 the same ones, which reminds me of 27 years in the FDA,
6 things stay pretty much the same. We have the
7 implementation of new legislation, harmonization, to be
8 aware and careful and have strategies to deal with
9 emerging infectious diseases, xenotransplantation, and
10 human cloning and reproductive technologies. Those are
11 very important things coming along.

12 Our funding challenges? Gee, they also look
13 about the same. Linda went over some of the Agency-wide
14 budget challenges. We're faced with these major
15 initiatives, including bioterrorism. We are part of the
16 government-wide strategy to deal with bioterrorist
17 activities, since many of the things used to counteract
18 these weapons of mass destruction are vaccines and
19 therapeutics. So we are working with the rest of the
20 federal government to further enhance our research
21 program, which we now believe we have honed and studied
22 and brought to really being a focused one based on our
23 mission, and we need to have the funds to try and now
24 implement the strategy we've developed so carefully.

25 Next one. Linda mentioned some of the things

1 that came along that helped to grow our resources. This
2 is just a summary slide to show you that over the past
3 several years, beginning in 1976, but really picking up
4 since 1990, many, many laws have been passed that impact
5 on our ability to do our job. Some, like PDUFA down at
6 the bottom, also brought enhanced funding. But at the
7 same time, it created management problems by freezing
8 the base of those products, so that any cuts have to be
9 borne in a disproportionate manner by the other programs
10 we have.

11 Could I have the next one, please. Our
12 operating budget, well, this is pretty simple to
13 understand. It's gone down, gone down by significant
14 extent. It's broken into three categories. We have the
15 PDUFA funds, the salary and expense appropriation, and
16 other funds, which are moneys we receive through
17 interagency agreements and things like that.

18 Next one, please. Here it is, for those who
19 don't like charts, the numbers. You can see our total
20 operating budget has dropped from \$41.5 million in FY
21 '94 to 32.1 in the year we're currently operating.

22 Can I have the next one, please. Here it is
23 in graphic form, broken down so you can see that the
24 research budget has taken a disproportionate hit. And
25 the reason for that is under PDUFA I, our researcher

1 review model, which differentiates the CBER review
2 process from the drug review process, was eliminated.
3 The funding for PDUFA for our research activities was
4 removed. So any research we're doing is coming out of
5 our appropriated base, not off of PDUFA money.

6 Next one, please. FTEs, they've remained
7 relatively stable, but you can see that the non-PDUFA
8 FTEs have declined by a fairly significant extent. And
9 that again shows that items other than PDUFA-funded have
10 taken the hit, which makes that slide I showed earlier
11 of the decrease in time of non-user-fee approvals even
12 more amazing and a credit to our review staff.

13 The next one, please. And this one may look
14 familiar, since Linda showed pretty much the same slide.
15 This is the section that we're here to implement today.

16 Can I have the next one, please. There are
17 three ways to comment. That also looks familiar, and
18 therefore I would like to now move to the next section
19 of this meeting, which is the -- turn the lights back
20 up. Here we go.

21 The first panel, these are folks from the
22 regulated industry. This has worked pretty well. Let
23 me just go over the way we did this in Washington, and
24 we'll try and do it the same way here. We have tried to
25 group people in some kind of logical order. They are

1 free to either make their remarks sitting there at the
2 table, or come up here to the podium, whichever they
3 prefer.

4 At the end of the panel, we will ask any
5 questions that we have as the FDA representatives. We
6 will then permit any questions from the audience. And
7 the questions we will ask, and the questions we ask you
8 to limit yourselves to, are to be of a clarifying
9 nature, not to get involved in a debate, not to discuss
10 the validity of any comments, but just to clarify
11 anything.

12 Also, at the end of the panels, we will have
13 an open microphone for a short presentation from anyone
14 who is not registered as a speaker.

15 The first panel is Anna Longwell, Director,
16 and Nancy Isaac, Associate Director, Regulatory Affairs,
17 Becton Dickenson; and Susan Hellmann, Senior Vice
18 President for Development, Genentech. For the order, I
19 have Ms. Longwell first. Is that okay with the panel?

20 MS. LONGWELL: Fine. Actually, I'm not going
21 to say very much. I'm going to introduce Nancy, who is
22 responsible for the division that deals mainly with
23 biologics, has dealt with biologics in the past, with
24 therapeutic monoclonal antibodies, and is presently
25 dealing with biologics, with devices employed in blood

1 banks, and has had some experience -- Becton deals with
2 every branch of FDA, depending on which division we're
3 talking about right now.

4 For example, we appreciate FDA's really
5 innovative approaches to combining the various divisions
6 in order to give review to products. Right now we have
7 a combination product that's being reviewed. The
8 investigation is being carried out under an IND. The
9 product is a device, a combination product, and will go
10 the PMA route when it is actually reviewed.

11 There is a team composed of both people in
12 CBER -- not CBER, sorry -- in CDRH, and devices, working
13 on product development -- very closely with a product
14 development team. This is quite different than the old
15 days. It used to be very difficult to get two divisions
16 to talk to each other.

17 So one of the things that we are going to
18 urge you to think about is other ways in which people
19 can share expertise. There really is expertise in all
20 three divisions, and we'd like to see more of this
21 interaction in order to get the best and most efficient
22 reviews, and yet the most scientifically sound reviews
23 of products.

24 So with that, I'm going to do the slides, and
25 Nancy's going to do the talking on her own experience.

1 MS. ISAAC: I wanted to also thank you all
2 very much for inviting us here. We have always had very
3 good experiences with CBER. And this is, I think, as
4 Mark said, another experience in which they will
5 continue to improve, and have done many things even
6 before FDAMA.

7 So what I'd like to do again is say Becton
8 Dickenson is a global medical device company. Primarily
9 the division I work with is Becton Dickenson
10 Immunocyclometry Systems located in San Jose,
11 California. The majority of our products right now are
12 handled under CDRH, but we do have devices, in vitro
13 diagnostics, that are reviewed under CBER.

14 In the past, when we've had a choice whether
15 to go to CBER or CDRH, we have chosen to go to CBER. We
16 have found the quality to be very good there. We have
17 found in certain circumstances they were closer to the
18 actual use of the in vitro diagnostic than the CDRH
19 people, so I just wanted to say that before I started.
20 We've had about 30 510(k)s going through CDRH. We've
21 had about five go through CBER.

22 Next slide, Anna. The other things I wanted
23 to say, too, even with some of the restraints in
24 resources, et cetera, and some of the delayed time
25 frames that we have observed with in vitro diagnostics

1 at CBER, we have still found CBER staff to be very
2 dedicated, and hardworking, and have continued to work
3 with us. And they have explained to us that they've
4 been overwhelmed at times with the number of in vitro
5 diagnostic reviews that they've had to do, in addition
6 to the other responsibilities that they've had. And
7 they've expressed that at times the device in vitro
8 diagnostic reviews take a lower priority. That is
9 something they've expressed to us, but still have been
10 very attentive to us, and have kept us apprised of where
11 our products have been in the queue.

12 The other comment I wanted to make that Anna
13 alluded to before is, CBER may want to take advantage of
14 some experienced reviewer resources at CDRH, especially
15 if we've had analogous or similar products. There are
16 some devices that are reviewed by CBER, it is not a
17 choice, and they are very similar to things that have
18 gone through CDRH. So there may be some sharing there
19 and opportunities to work with reviewers with CDRH for
20 some of these products.

21 Next slide. The other point we wanted to
22 make is, perhaps maybe using fewer resources for review
23 of some of the in vitro diagnostic submissions. For one
24 product that we submitted last year, CBER requested nine
25 copies of the submission, and there was quite an

1 extensive review of this product. And at one point I
2 think the person who was trying to coordinate the review
3 was having difficulty determining whether or not people
4 were actually finished, whether or not outstanding
5 issues had been resolved between reviewers. And I
6 wonder maybe if that could be looked at in terms of
7 making sure, you know, having the right people, but
8 maybe not having as many people involved, or having key
9 reviewers that would be responsible for making the
10 determination as to the substantial equivalents of the
11 device.

12 Also, too, we have experienced significant
13 increases in delays in IVDs. And I think that the
14 slides that were shown earlier show an overall trend,
15 despite these constraints that shrinking budgets have
16 placed on the agency. But this is just our personal
17 experience. So we put together a table that we'll show
18 you in a minute.

19 But one of the suggestions we thought -- next
20 slide, Anna -- was, we would like to make sure that the
21 times for devices in in vitro diagnostics might be
22 pulled out separately and looked at the way CDRH does.
23 And then also, if CBER could track the devices or IVDs
24 separately, and make those times available. There are
25 statutory 90-day time frames for those products.

1 And then we think also some of the
2 reengineering efforts that have been put in place by
3 Dr. Gutman's group over at CDRH -- the DCLD is the group
4 we primarily work with over there -- might help in terms
5 of developing and implementing the systems and processes
6 that they've used. For example, the special and
7 abbreviated 510(k)s, I think those are -- just seeing
8 some statistics on those, those are looking pretty good;
9 the use of PDPs, if appropriate, of course, and pre-PMA
10 meetings for the device-type things, obviously not the
11 PLA-type things, which have their own rules and
12 regulations.

13 The other thing I think was very effective
14 over at CDRH is the use of exempting Class 1 510(k)
15 devices from premarket review. So that is another tool
16 you might use to actually cut down on your workload.
17 These tools have been worked out in the other division,
18 and you should see if these can't be pulled over under
19 device review for CBER.

20 Here is a slide of our experience. I want to
21 tell you, too, there are a very small number of
22 submissions, only five at CBER for in vitro diagnostics.
23 We had two between 1993 and 1997. These are our fiscal
24 years. We had an average of one round of questions per
25 review. And the total time is the first number, 171

1 days, and the FDA clock is the time that it was under
2 review at FDA. Obviously, the clock was started again,
3 but it's interesting to see that it was 171 lapsed days.

4 In our recent experience, where we've had
5 three products under review, two have been cleared. We
6 had an average round of one question per review. Our
7 total time is 363 days, so that has significantly
8 increased from our personal experience, and the FDA
9 review time is 258. And of course, the clock was
10 started again.

11 If you break these out, we had one product
12 that was in FDA for 563 days total. The second product
13 went much faster, and then we have another product
14 that's still under review, but has been there since last
15 summer, and we haven't received any questions yet on
16 that product.

17 Just to contrast that with the experience
18 we've had last year with CDRH, we had seven products
19 under review. We had an average of .7 questions. We
20 had total review time of 210 days, but total FDA time of
21 65 days.

22 Now, the reason why the first number is large
23 there is because we submitted five submissions of the
24 seven that were contingent upon another product that FDA
25 wanted us to bring in and have cleared before they felt

1 comfortable clearing those other five products, so we
2 just left them there at the Agency. But really, the
3 total review time there was 65 days, which is in line
4 with what they've been publishing for review time. So
5 we thought we would show that as our personal experience
6 with IVD. And it is a small number of products, so we
7 wanted to make that comment.

8 Any questions?

9 MR. ELEGOLD: Let's wait. We'll take care
10 of the panel as we come back. How does that sound?

11 MS. ISAAC: Okay.

12 MR. ELEGOLD: Dr. Hellmann.

13 DR. HELLMANN: My name is Sue Hellmann, and
14 I'm Senior Vice President and Chief Medical Officer at
15 Genentech, and I just wanted to express our appreciation
16 for having a chance to comment.

17 I'm going to specifically address my remarks
18 to three of the six questions that were proposed for
19 comments and suggestions. So if I could have the first
20 overhead, Taylor, thanks.

21 The first thing I'd like to comment on is the
22 issue of eliminating backlogs in the review process, and
23 specifically, the focus on timely product reviews, which
24 is incredibly important to us at Genentech. We believe
25 that to be successful in eliminating backlogs, it's

1 going to be necessary for FDA to manage information flow
2 and the control and archiving of documentation more
3 efficiently.

4 Another and interrelated answer to this
5 question will be facilitating the submission and review
6 of regulatory documentation that supports the marketing
7 approval process. So it really comes down to efficient
8 management of information flow and documentation, and we
9 believe that this will result in better databased
10 analysis and more expeditious decision-making on the
11 part of the Agency.

12 Most importantly, this will make treatments
13 addressing unmet medical needs available to the American
14 public sooner. This has a significant potential to help
15 alleviate suffering, prolong life, and increase the
16 quality of life of individuals suffering from disease,
17 and that is our mission statement.

18 So I think that the mechanism to accomplish
19 these goals will be the establishment of an electronic
20 information environment at FDA. Congress has provided
21 funds through the extension of PDUFA and given FDA the
22 mandate to complete the task by 2002. Several elements
23 will be important. Most important is the electronic
24 regulatory submission of the review process. But there
25 really needs to be efficient electronic information

1 exchange within and across centers and together between
2 FDA and industry.

3 These information systems must also meet the
4 business administrative needs of the industry. And we
5 think it's really important to note that the Agency has
6 already been diligently collaborating with industry
7 groups to solicit their input into the information
8 management systems and programs that the Agency is
9 developing to support electronic submissions and the
10 review process.

11 The Agency has been partnering very well with
12 industry on the technical solutions needed to meet the
13 mandate to be capable of receiving and reviewing
14 submissions electronically by 2002. And we would
15 specifically like to congratulate the Agency on these
16 efforts, and encourage them to continue and expand these
17 initiatives. We have had several employees directly
18 involved in this, and have been pleased with the
19 interactions.

20 Finally, it is important for industry as a
21 whole to adapt their systems and be compatible and to
22 interface with industry. Once agreed upon, it is
23 imperative that industry actively embrace the standards
24 and technical approaches. Since industry generally has
25 more resources available to it, it is incumbent upon us

1 to follow the lead of the Agency, as compared to trying
2 to have the Agency fit its systems to those used by
3 industry.

4 The next slide. The second point I'd like to
5 address is the one regarding information. And the
6 question was, how can the Agency maximize the
7 availability and clarity of information regarding new
8 products?

9 We believe that it's a very important issue
10 for the Agency. Being successful in facilitating the
11 availability of critical product information can have a
12 significant impact on the health of our nation. And in
13 particular, since we have very novel products, this is a
14 major issue for Genentech.

15 There are currently two mechanisms by which
16 primary product-related information is made available.
17 One is via the FDA, and the other is via industry. Both
18 are important and should be concordant in the messages
19 being sent. To be successful, this will involve close
20 communication during the development of those messages
21 by both parties.

22 One way in which the Agency can directly and
23 proactively maximize the availability of new product
24 information is to continue to improve and regularly
25 update its Web page. This electronic highway can

1 provide the health care professional and patients timely
2 information about product approvals and information
3 concerning the safety and efficacy of products following
4 their initial approval. This could encompass providing
5 information about new uses and dosing regimens of
6 products. Just as importantly, the Web can serve FDA as
7 a way to provide information about safety issues that
8 have arisen generated by post-marketing surveillance.

9 As part of this overall process, perhaps FDA
10 could be more proactive in preparing press releases and
11 electronic communications, such as videotapes, dealing
12 with important topical issues and information for
13 distribution to the media. Again, to reemphasize, it is
14 important for FDA and industry to collaborate on
15 messages being sent to their mutual customers.

16 Part of this depends on industry as well.
17 And it's our feeling that the information that a company
18 produces and disseminates about the safety and efficacy
19 of a new product or indication is the most important way
20 to get product information to large numbers of health
21 care practitioners and patients. Now, the availability
22 of resources to industry is larger, and we're in a
23 position to disseminate information broadly, and reach
24 large audiences of health care professionals and
25 patients. The use of our field staff who directly

1 contact health care professionals is important.

2 FDA input is important to us. Because of
3 that, we routinely voluntarily submit our professional
4 promotional materials to FDA for comment at the time of
5 any new ad campaigns.

6 Currently, CBER's advertising staff is
7 woefully understaffed, and as a consequence,
8 tremendously overworked. The demands placed upon them
9 by the number of new product approvals is significantly
10 increasing. As a result, it sometimes takes weeks or
11 months for companies to get important pieces of
12 information reviewed and available for dissemination.

13 We fully support and strongly recommend
14 adding significant additional staff to the APLS group at
15 CBER to allow for the timely review and comment on
16 promotional materials and advertising pieces. Doing so
17 will materially improve the availability and the clarity
18 of information concerning new products.

19 Finally, the third point I'd like to comment
20 upon is the scientific and technical expertise, and I am
21 giving a view that's specifically from the Genentech
22 perspective. We are a biotechnology and pharmaceutical
23 company who very strongly recognize the importance and
24 the critical contribution that is made by having a well-
25 managed and high-quality research program at CBER.

1 We speak not only as a biotechnology and
2 pharmaceutical company, but also as consumers who want
3 the best expertise in reviewing drug applications to
4 provide new and better therapeutics to the public. A
5 research program at CBER is an important component.

6 Genentech's long history in biotechnology has
7 repeatedly shown the value of active research scientists
8 at CBER. We were one of the first biotechnology
9 companies, and because of that, we've had a long history
10 of working closely with CBER, specifically on
11 scientifically driven issues.

12 In the initial days of the biotechnology
13 industry, there were numerous new issues that had to be
14 addressed, and which were considered by working
15 scientists at CBER. Without this expertise, decisions
16 would have been delayed, or might have been
17 inappropriate. With hands-on scientists whose expertise
18 is current and relevant in assessing many of these
19 issues, regulatory advice and decisions were
20 scientifically based. This need continues unabated
21 today.

22 We feel that the participation and
23 contribution by active scientists rightly instills
24 confidence in CBER's assessment of critical
25 scientifically based issues for both the manufacturer of

1 pharmaceutical/biotechnology products and the public.
2 There's constant improvements in our base of scientific
3 development which continues unabated, and this will
4 continue to challenge the regulatory assessments of
5 issues that were previously unthought of.

6 Our experience has shown the value of having
7 CBER personnel who are involved in current state-of-the-
8 art research. CBER's personnel that are involved in
9 research related to safety, efficacy, basic biology,
10 mechanism of action, and other associated areas provide
11 an important component for in-depth understanding of
12 issues and bring an understanding and response to issues
13 in a scientifically and regulatorily responsible and
14 appropriate manner.

15 So in summary, we believe that a strong,
16 well-managed, and appropriate program of research at
17 CBER provides an important component to high-quality,
18 scientifically-based regulatory assessments, and we
19 highly support that. Thanks for allowing me the time to
20 speak.

21 MR. ELEGOLD: Thank you. First, on the
22 panel, do you have any questions, Linda?

23 MS. SUYDAM: Yes, I do. My first question is
24 for Ms. Isaac. Seems like a comment generally. Sounds
25 like CDRH is doing good things. How do you think we can

1 sort of move that expertise or whatever to CBER? Is
2 there a specific mechanism that you are suggesting?

3 MS. ISAAC: Actually, I hadn't really thought
4 about a specific mechanism. I just thought that perhaps
5 some of the systems and processes and guidance documents
6 they've already written, you may be able to look at them
7 and implement them for whatever. I don't know the
8 differences in the internal structures, et cetera, but
9 they may be helpful to you. And I certainly couldn't
10 comment, because I don't really know how the
11 organization works internally.

12 MS. SUYDAM: Thank you.

13 And Dr. Hellmann, we at FDA often have
14 trouble explaining the importance of our science base.
15 And we have trouble explaining it to our outside
16 constituents both within the government, so within our
17 own structure of the Department of Health and Human
18 Services, and OMB, and the other budget offices, and
19 also to sort of our constituents in general. Do you
20 have any suggestions on how we might -- it sounds as if
21 we have a strong supporter in Genentech, and how can we
22 build on that kind of support?

23 DR. HELLMANN: Well, my suggestion would be
24 as much as possible to use actual examples. We're
25 having what I consider a very positive interaction with

1 FDA right now on an application for a new drug for
2 breast cancer. It's a monoclonal antibody, very novel,
3 and we've had the inspection process, and are going to
4 be at the advisory committee next week.

5 I think the public has a lot of trouble with
6 the technical aspects of what we're talking about, but
7 not a lot of trouble understanding unmet medical needs.
8 And I think if there's an emphasis by FDA on a disease,
9 be it cardiovascular disease, heart attacks, cancer, and
10 specifically how the scientific knowledge of FDA
11 scientists can expedite and, concurrently with industry,
12 do problem-solving, from where we sit, we think problem-
13 solving and seeking solutions is really enhanced by that
14 scientific knowledge on the part of FDA staff.

15 And I think when you give an example, when
16 you say, well, when I spoke to the FDA reviewer, and she
17 understood how breast cancer is treated, and some of the
18 challenges in treating patients, and the side effects,
19 and the consequences; or when we speak to the CMC
20 reviewers how biologics are made, how the newer process
21 is made for monoclonal antibodies, that is good for the
22 public. I would focus on the products and unmet needs.

23 MS. SUYDAM: Thank you very much.

24 MR. ELENGOLD: Jay.

25 DR. SIEGEL: I've got two questions, one for

1 each of the panelists. Ms. Isaac, I understand the
2 difference in review time between CDRH and CBER. I see
3 it as two components, though. And I'd just like to lay
4 those out, and see if you have any idea which one is the
5 greater of the difference in delay.

6 One obviously is, we have a different review
7 process, different structures, different managed-review
8 guidelines. The other difference, though, is one of
9 priority that we assign. At CDRH, in vitro diagnostics
10 are a relatively low-priority product. Their high-
11 priority products are long-term implantable, complex
12 electronic software devices, things like that.

13 The IVDs that we regulate at CBER are
14 critical to the main pillars of the safety of blood
15 supply, which is one of our major priority initiatives,
16 as well as the public and the Congress. How much of the
17 difference in review time do you think is derived from
18 the importance that we assign to it, versus the low
19 priority at CDRH, and how much do you think is a
20 management-process issue?

21 MS. ISAAC: Well, I think, first of all, I
22 should say that the products we send in to CBER are not
23 ones that are critical to the safety of the blood
24 supply. I'm sure the review times of those types of
25 products are different.

1 One of the things I think CDRH has done, in
2 the olden days we didn't want to send our products over
3 to CDRH, because we got a better and quicker review from
4 CBER. Things have kind of tilted a little. Now we are
5 more in CDRH, because their review times have gotten
6 better, and their expertise has come up to speed.
7 Although I think they rely on some of the CBER staff for
8 expertise there, and it is very good.

9 I think what we see is, we have some Class 1
10 510(k) devices that go over to CBER that maybe don't
11 really need to go through premarket notification. I
12 don't think they would be a high priority on either
13 side. They're sort of routine. A lot of the product
14 that we do even on CDRH, I think what they've done is
15 recognize low priority, low risk. If you look at the
16 MDR files and trends, in vitro diagnostics are not high-
17 risk products. I think CDRH has responded to that by
18 trying to down-class. When you have an already cleared
19 product, and you submit a declaration of compliance to
20 your own design control, FDA has recognized that these
21 things are really not the sole diagnostic product used
22 in making a treatment decision. It is not as though
23 it's a product -- you know, more important product for
24 treatment or something like that.

25 And I think CDRH has done a pretty good job

1 of actually putting the appropriate review and
2 importance on the products that do have the high risk,
3 and actually taking a better look, instead of just as if
4 it was a pre-1976 device, you know, is it a Class 3,
5 versus what is the real danger or potential danger for
6 the consumer with this product? And I think that that
7 probably, for our products, anyway, would really help
8 over on the CBER side. We're not doing safety blood
9 supply kind of products.

10 MR. ELENGOLD: Thank you. Dr. Hellmann, I'm
11 going to explore with you something that came up during
12 the last meeting we had at Washington with Dr. Spilker,
13 the PHARMA rep. You made one of the same points, which
14 is, we should be posting information on the Web, and
15 using video releases and things to inform the public
16 about the important products that we are finding safe
17 and effective.

18 One of the issue I brought up to Dr. Spilker,
19 and I will ask you to comment on, is those items are
20 very difficult to fund. I know that in CBER, we have an
21 extremely large Web site, and we've been maintaining and
22 building that with about one and a half FTEs; whereas I
23 know in an industry situation, to run a Web site that
24 size, it would probably be, I'm told, 11 to 12 people.

25 The video news releases, the other types of

1 streaming audio and other things that are available are
2 extremely costly, technically complex, and also
3 difficult for the government to attract the people to do
4 those. Does your company think it has a significant
5 enough initiative that it should receive priority
6 funding over those types of classical FDA efforts, even
7 to the point of being fundable, in your understanding of
8 the definition of PDUFA activities?

9 DR. HELLMANN: Well, I think that you're
10 asking a priority question. And I think that, in terms
11 of priorities, that the priority is of review times for
12 products for unmet medical needs, and our wish to have
13 reviews for our submissions for information sharing, I
14 frankly would give those higher priority.

15 I think within the -- in terms of the
16 industry sharing information, one of the things we've
17 looked at, we wouldn't put on 11 people to maintain a
18 Web site, and I think we're, just as you are, really
19 trying to push down costs and really increase
20 efficiencies.

21 But in terms of FDA's sharing of information,
22 I would put the highest priority on the Web site. And I
23 would put the priority on that higher than the video
24 releases, which I do understand are more costly.
25 Patients are out there on the Web, and one of my big

1 fears as a physician is patients are out there on the
2 Web getting sometimes very bad information about
3 products and their disease.

4 So I think the FDA can be a terrific source
5 of good information on a Web site. So that would be my
6 primary focus, and I also think that can be done very
7 efficiently.

8 One suggestion on the videos is to partner
9 with industry on both the production and on the cost of
10 those. I think that may be one mechanism to look at for
11 the video area.

12 MR. ELENGOLD: That was going to be a
13 follow-up question to your answer. Do you think perhaps
14 a partnership between industry and FDA might be the way
15 to get some resources to work towards that that we might
16 not otherwise have?

17 DR. HELLMANN: I think a partnership is a
18 terrific idea, and I think that that's one of the ways
19 where the company produces many, many resources for
20 patient information. And I think that sharing those,
21 and partnering with FDA in terms of what you consider
22 reliable safety and efficacy information I think would
23 be something that we would be very interested in doing.

24 MR. ELENGOLD: I'll just ask one last
25 question before we go to the break. I've been friends

1 with Bill Purvis for 25 years. How did he get you to
2 put two items in to get him more resources?

3 And on that note, I'll say let's take a
4 break. I have about a quarter after 10:00. Can we get
5 back here at 10:30? I'm going to put about five minutes
6 more, since we're running a little bit fast, and that
7 way we can get down to the cafeteria and get some
8 coffee, if you want. It won't be, hopefully, too long a
9 line at the restroom. Thank you very much.

10 (A recess was taken at 10:15 a.m.)

11 MR. ELENGOLD: Could everybody take their
12 seats. A couple of administrative announcements. We
13 always seem to have a lot of those. I'm going to ask
14 the industry folks, and anybody who uses the audience
15 mike, to speak into the microphone. We have had
16 comments that people have not heard the speakers.

17 Anyone that's come in late -- and I'll repeat
18 that in a minute -- there is no one at the registration
19 table right now, but it's extremely important that you
20 do go back there at the end of the meeting and sign in,
21 so we will have a record of everyone who attended.

22 I'm going to ask the speakers, if they
23 haven't already, to give us copies of their slides and
24 presentations. We'll need those for the record and
25 posting on the Web as part of this meeting in the

1 docket. So with those announcements -- and also, if
2 anybody does speak from the audience at some point
3 later, when you speak, would you identify yourself and
4 your affiliation, if any, and make sure that, at the
5 conclusion of the meeting, you let both the stenographer
6 and Ms. Groover in the back know your name and title.
7 Either drop off a card, or write your name down, so that
8 will appear on the record.

9 Next panel are folks that represent the
10 spectrum of the blood industry we regulate. We have a
11 representative of the component whole blood community
12 and the fractionation industry. First speaker is
13 Dr. Paul Holland, Medical Director and CEO of the
14 Sacramento Medical Education Foundation Blood Centers.
15 Dr. Holland.

16 DR. HOLLAND: Thank you, Mark. I'm the
17 medical director of a large, not-for-profit community
18 blood center which has a number of centers in Northern
19 California. And I emphasize that not-for-profit,
20 because among my comments are, we are different from the
21 for-profit industry in terms of resources.

22 I'd first of all, like the other speakers,
23 like to thank you for the opportunity to do this. I
24 think it's great that you would listen publicly to
25 stakeholders. I must say I'm very surprised and

1 disappointed that you weren't overwhelmed by blood
2 banking people here.

3 We do have a lot of concerns. I can only
4 address a few of them from my own perspective, and I can
5 only hope that the reason they are not up here speaking
6 is because they are not concerned about any adverse
7 effects on their processes.

8 In my comments, I want to commend you on some
9 things, but chide you for others. I hope it will be a
10 fairly balanced mixture.

11 First of all, I noticed and was pleased to
12 say that you have added to your mission statement the
13 word "availability." That is clearly important to us.
14 One of the main problems I'll be addressing is the
15 delays in reviews, the slowness of the process, the
16 inconsistency, and the fact that despite your concerns
17 about resources, which we share, too, that clearly these
18 reviews have to be speeded up, simplified, and we are
19 trying to help you with that. And I'm frankly surprised
20 that you aren't already adopting some of our
21 suggestions.

22 In any case, some of the issues I'd
23 specifically like to address are, for instance, error
24 and accident reporting. Clearly, decreasing the number
25 of items that are to be reported is very good. Clearly,

1 the reporting from registered as well as licensed
2 establishments is good. I think hopefully this will
3 focus on issues which are germane to the safety, purity,
4 potency, and efficacy of blood and blood components.

5 But I have to ask you, what are you going to
6 do with all this paper? You're already drowning in a
7 lot of materials that we send, and I'm not clear what
8 you're going to do with it, how you can handle it, and
9 whether it will result in something beneficial. Because
10 if it doesn't, then you and I are both wasting our time.

11 Recently the FDA approved a uniform donor
12 history, and we voted to adopt it in toto, which we
13 intend to do. We can go ahead and implement it. This
14 is a great idea, and long overdue. Clearly, it should
15 streamline the change process and make it easier for us
16 to actually interview our donors.

17 But among our donors are many people who are
18 multi-gallon donors who go through this interrogation of
19 45 or so questions every time they donate, sometimes
20 twice a week. And clearly, they and we are wasting a
21 lot of time. And I wonder if there cannot be an
22 abbreviated or interim history which can sort of ask,
23 "What happened since you were here the last time, two
24 days ago?" But to go through this long litany of
25 things, most of which they have answered two or three

1 days ago, or a week ago, or eight weeks ago, is wasting
2 our time and their time.

3 Another issue that's of concern to us is the
4 Prescription Drug Marketing Act. Recently we were told
5 that pooled solvent detergent plasma is a drug. But all
6 blood and all derivatives are drugs. And now we are
7 told that we must have a pharmacist on site, that we are
8 going to have to have a new license, we are going to
9 have to have more bureaucracy.

10 We have been handling derivatives for years.
11 What's different? What is the definition of what is a
12 blood product versus a derivative? Is it pooled or
13 single-donor? Is it manufactured or not? Is it stored?
14 And we get very conflicting reports, depending who we
15 speak to at the FDA.

16 We certainly often request changes to our
17 licensed blood products. Some of these take forever.
18 We recently -- some of them should be very simple. We
19 sent a request in early December, which was received by
20 the FDA on December 5th, for a change to your donor
21 suitability standard operating procedures. Why we have
22 to have approval, I'm not sure. But pending that,
23 clearly we know that it was received by you. At least
24 you acknowledged it six weeks later, and we haven't
25 heard anything on that. I think that's really taking a

1 lot of time for something which is extremely simple and
2 ought to pass through very quickly.

3 Just to give you another example, we recently
4 wanted to amend our fresh frozen plasma license to make
5 it donor-retested. We sent this in in early February.
6 It was received by the FDA -- we make sure that we have
7 everything signed for -- we received an acknowledgment
8 on March 16th, almost six weeks later, that they
9 received it. But we know from internal documents which
10 we received that they acted on it in early March, but it
11 sat on somebody's desk for three and a half months. It
12 was basically lost at the FDA before it was acted upon.
13 And in this case, after only six months, the fastest
14 time we've ever had anything get through the FDA, it was
15 approved. A very simple thing.

16 This is much better than a previous one we
17 sent in several years ago which we sent in seven times
18 over a two-and-a-half-year period, and at least three
19 times they frankly told us they lost it. It was signed
20 for; we know it was logged in.

21 And clearly, you need a tracking mechanism
22 for us and for you. We would bond for less if we could
23 get answers quicker and you knew where these things
24 were. Clearly, that wastes your time and my time,
25 trying to find things which are in the queue, and having

1 to re-send them.

2 There's a big push on quality initiatives and
3 compliance with the CGMPs. That should improve the
4 safety, purity, potency, and efficacy of our products.
5 That is a laudable goal. I wish that would apply to you
6 also. I really think if they did, I think you would
7 have some problems. But clearly, we accept them,
8 because we have no choice, and we certainly are going to
9 act on them. I think they need to apply to you also.

10 And finally, basically, we all have budget
11 problems. We all are trying to do more with less. You
12 are asking us daily to do more, have more compliance,
13 more quality, more documentation, and we have to do
14 that. But we have to do it with less and less
15 resources.

16 We are a not-for-profit center. We cannot
17 raise our prices. In fact, we are constantly being
18 forced to lower our prices. We have to be more cost-
19 effective. I challenge you to be more cost-effective,
20 to eliminate some of your paperwork, some of your
21 duplication, some of the wasted time and effort.
22 Clearly, if you want blood products to be available, and
23 I think we do, we both do, you've got to devise more
24 efficient ways to do it.

25 And as one example is the newly proposed BLA

1 process which, under the proposal, a manufacturer would
2 be required to submit only one supplement to the BLA
3 describing the change for all of the products and
4 locations involved. We suggested this to you over three
5 years ago, publicly and in writing. And finally, it was
6 put out for comment on July the 31st, and we can comment
7 on it until October the 14th.

8 I mean, clearly, this would save us both an
9 enormous amount of effort. But to have to have products
10 licensed at different sites, the same product, using the
11 same machines, and even the same personnel, is terribly
12 inefficient. And why has it taken three years even to
13 propose it for comment? Why not just adopt it?

14 I mean, clearly you need to go -- we're
15 trying to help you, but you have to sort of listen to
16 some of the suggestions and try to implement them.
17 Clearly, this is one that is long overdue. It would
18 save you a lot of paperwork, and time, and make a better
19 use of your resources.

20 That is my main message. Since we both have
21 the same goals of safety, purity, potency, and now
22 availability, let's work together to try to listen to
23 each other, and try to implement things which we both
24 agree are useful and appropriate, because then we can
25 both do our jobs better with our limited resources.

1 Again, thank you for the opportunity to
2 express my opinion.

3 MR. ELEGOLD: Thank you.

4 The next speaker is the only person on this
5 program who has the distinction of being introduced as a
6 former FDA employee. Mr. Dubinsky is the Director of
7 Regulatory Compliance of Alpha Therapeutics. And up
8 until a relatively short time ago, he was the Deputy
9 Director of the Office of Compliance of CBER. So it is
10 my great pleasure to introduce the speaker who, having
11 spent many years on the inside of the process, has now
12 been freed to give his opinion of both the inside of the
13 process and the outside.

14 Mike.

15 MR. DUBINSKY: I have to add a little caveat
16 to that, and that is, since I have come as a
17 representative of Alpha Therapeutic Corporation, I will
18 be offering a comment on behalf of the company, of
19 course, but I'll offer a thought or two at the end.

20 My name is Mike Dubinsky. I'm the Director
21 of Regulatory Compliance with Alpha Therapeutic
22 Corporation. And on behalf of Alpha, I wish to thank
23 the Food and Drug Administration, and CBER in
24 particular, for the opportunity and the forum to offer
25 some views from the standpoint of a member of regulated

1 industry about how FDA might improve its regulatory
2 effectiveness.

3 Alpha Therapeutic Corporation, located in Los
4 Angeles, California, holds several licenses for
5 therapeutic biologic products derived from human plasma,
6 has a number of licensed plasma donor centers in the
7 United States, and also manufactures several medical
8 devices subject to FDA regulation. In addition, we're
9 involved as the holder of an approved NDA. Alpha
10 therefore sees itself as a full stakeholder in the
11 matter of interacting with the FDA -- we don't run any
12 food stores, but that's about it -- we do so daily, and
13 across a wide range of product.

14 FDA offered seven questions related to each
15 of the objectives, and Alpha wishes to offer comment on
16 four of those areas.

17 Submission review process. The FDA's
18 available guidance and materials on what to submit is
19 not ostensibly lacking, but the opportunity to interact
20 with staff to discuss the day-to-day application of the
21 principles described in this submission process is where
22 the needs seem to arise.

23 The application of the submission guidance
24 differs across product line areas, and therefore, the
25 opportunity to speak with FDA staff relative to

1 preparing the submission becomes very important.
2 Sometimes the opportunity to speak to an advisor who
3 know the systems but is not directly related to the
4 day-to-day review process allows for an exchange of
5 information which is complete, but does not disturb the
6 review process.

7 The Center for Devices and Radiological
8 Health manufacturers' assistance group is an example.
9 CBER also has a manufacturers' assistance group, and
10 they, too, are most helpful. The expansion and
11 enhancement of such support units allows for better
12 communication and understanding, without necessarily
13 disturbing the review process.

14 For the actual submission-review process, the
15 policy of integrating consumer safety officers into the
16 review divisions of all of FDA represents a sound
17 approach. For Alpha, having a point-of-contact person
18 who is responsive and able to respond has proven to be
19 one of the most effective tools that FDA can bring to
20 bear to enhance the submission and application-review
21 process.

22 Secondly, work to ensure that products, both
23 domestic and foreign, are of high quality. Pursuing
24 initiatives which have as their end result criteria
25 accepted internationally is a goal that would well serve

1 the biological product industry and FDA goals.

2 The FDA has established a sound track record
3 for participation in ICH projects. Those experiences
4 have set down understood and accepted pathways to follow
5 as product development and application submission are
6 approached. Applying a similar mindset to dealing with
7 other aspects of product regulation also represents an
8 opportunity to ensure consumer protection, yet add
9 efficiency to the regulatory process.

10 We see initiatives in this area, especially
11 in dealing with devices, but there appears to be a
12 reluctance to adopt different approaches. Having
13 recently worked through the experience of pursuing a
14 device authorization using the EEC approach, we can say
15 that while different, it works and offers the consumer
16 protection elements that are necessary. That approach
17 involved the notified body assessment of a product and
18 the manufacturers' quality system approach to
19 manufacture.

20 FDA has described both third-party and
21 first-party approaches to the area of inspections. Both
22 of these concepts have merit, but there must be an
23 incentive to participate. That aspect has been elusive
24 as we understand it. Alpha would offer the thought that
25 if the FDA wishes to successfully pursue such

1 initiatives, it must be prepared to take a risk in terms
2 of trust and respect for the industries it regulates.
3 Industry must be prepared to take risks as it pursues
4 new products and innovative approaches to delivering
5 those products.

6 While we recognize that the public health
7 mission of FDA must be first, there is what could be
8 termed a balance point where CBER and its colleagues in
9 the FDA can find common points of agreement in terms of
10 our business interactions. For example, if one center
11 in the FDA can undertake a program of announced
12 inspections where investigators communicate fully during
13 an inspection, and even note that immediate corrective
14 actions have occurred, why can't the other FDA units
15 take the same risk?

16 Scientific and technical expertise.

17 Partnerships with academia and technical institutions is
18 a mechanism that FDA has used, and could use more
19 effectively, to cultivate and maintain scientific and
20 technical expertise. Perhaps FDA could establish even
21 chairs at academic institutions, with the institutions
22 then providing laboratory facilities and opportunities
23 for enhancing the regulatory sciences. The FDA has
24 undertaken such an effort in the food area, as we
25 understand it. Could it work in others?

1 Burdens on the application review process.
2 Effectiveness in the review process can be a function of
3 an effective systems approach. Industry is expected to
4 have one in place. I'd like to thank Dr. Holland for
5 the intro to this area. It seems like, though far
6 apart, we were thinking along the same lines. FDA,
7 having procedures in place which are understood,
8 followed, and which staff are trained against, can go a
9 long way to making any process less burdensome.

10 We recognize that CBER has procedures in
11 place and is working on a fuller expression of the
12 managed-review process. As with industry validating the
13 system to show that it can reproducibly result in a
14 quality product, meeting customer expectations and
15 delivered on time would seem important.

16 In theory, the FDA system does have such
17 approaches built in, but the application and management
18 of those activities is of course the key to success.
19 Alpha would encourage adopting a policy of measuring
20 effectiveness in ways that can be communicated to the
21 constituencies with which FDA interacts.

22 Alpha recognizes the concepts such as the
23 ones we reflect on today are just that, concepts. The
24 theme of working together in a manner whereby the
25 regulator and the regulated industry better communicate

1 and are better understood is a complex undertaking.
2 Having said that, Alpha would offer individually or
3 through the appropriate channels to be a participant in
4 a CBER-managed review training seminar, specifically to
5 bring to the training table the experiences, concerns,
6 and the factors which accompany the application-review
7 process from another vantage point.

8 I'd like to thank you for the opportunity to
9 comment, and to offer just several additional comments
10 that were not in the written narrative that I turned in,
11 but which, I think, complement what I've said. Some
12 additional points are based on the thoughts that
13 modernization is sometimes, you might say, an approach
14 that is really back to basics. We call it
15 modernization, but sometimes we have to take a look at
16 what the basic things we are supposed to be doing are.

17 For instance, is the work we're doing
18 value-added? An example might be, Class 3 recalls with
19 the FDA. The effort and resource put into classifying,
20 researching, and follow-up on such situations should be
21 assessed as to the real contribution it makes to the
22 public health mission of FDA.

23 Accountability and effectiveness. Are
24 programs routinely evaluated against a set of objectives
25 to see whether they meet these objectives, and are they

1 still relevant? If not, then maybe the Agency ought to
2 be doing that to ensure that resources are being spent
3 where the real contributions are being made.

4 And evaluating communications. One of the
5 most difficult areas to put into perspective is
6 evaluating the effectiveness of communications. They
7 often require an assessment of credibility, of clarity.
8 Periodically evaluating whether certain types of
9 communications actually work would make sense.

10 I've heard several comments this morning
11 about the review process, its timeliness. In the short
12 time I've been with regulated industry, I've had a
13 number of experiences with the application-review
14 process. Where there was a clear line of communication
15 with a reviewer or a review group, that process went
16 very well, strong lines of communication, a single point
17 of contact, and the ability to discuss things openly.

18 And lastly, a priority setting. When those
19 priorities are identified, sometimes it does demand a
20 reprogramming of resources to meet those needs. It's
21 done in industry, and I'm sure it can be done in FDA.
22 Thank you once again.

23 MR. ELEGOLD: Thank you, Mike. Any
24 questions, Linda?

25 MS. SUYDAM: No, thank you. I don't have

1 any.

2 MR. ELEGOLD: Jay.

3 DR. SIEGEL: I had one question for
4 Dr. Holland. You mentioned accident reporting can be a
5 valuable activity, but also wondered what happened to
6 all the information. I wondered whether your suggestion
7 would be that we put more resources into evaluating it,
8 that we collect less, or perhaps is there a more
9 efficient way you might conceptualize of dealing with
10 accidents to deal more effectively with the resources
11 that we have?

12 DR. HOLLAND: Well, the simplest answer I
13 think you really want to hear is that we should only
14 have to report those which are important; that is,
15 meaning they really do impact safety, purity, potency,
16 and efficacy. If they don't, then to me we're wasting
17 our time.

18 If we do stick to that, and you stick to
19 that, and then you can see some trends, you can see some
20 value in terms of the evaluation of those, in terms of
21 something which is common to multiple centers, or
22 multiple sites, or different products, then I think you
23 can give us feedback. Because now you have all that
24 information to analyze, and I think you should.

25 But I said my concern is if you're going to

1 be overwhelmed with a lot of useless information which
2 you don't have the time or ability to process, in that
3 will be mixed some useful information which is going to
4 get buried and lost.

5 MR. ELEGOLD: Anything else?

6 I have a couple of questions for Dr. Holland.
7 In the licensing process comments that you made, you
8 acknowledge that we have published the BLA reg.
9 Unfortunately, just -- we can't make that change without
10 publishing it and accepting comments. That's the
11 Administrative Procedures Act. Why it took me three
12 years is a complex question, but the fact is that we
13 have to go through the end game here of publishing them
14 and accepting comments.

15 And I'd also like to point out that I left
16 something out. September 2nd in Bethesda we are having
17 a workshop on the BLA process based on that regulation.
18 And that's part of many workshops we've had this year
19 and are planning for next year on the changes we're
20 making.

21 But the question is, we have indicated as
22 part of our blood action plan that we are going to try
23 an experiment moving to a monograph-based system for
24 many of the blood components that blood banks produce.
25 Do you think this is a good step? Are you looking

1 forward to working with us, and do you think this will
2 achieve the kind of changes you believe are necessary?

3 DR. HOLLAND: Oh, absolutely. I think it is
4 long overdue. I understand you have to publish every
5 comment, but I look forward to its implementation. This
6 multiple pieces of paper to relicense, and get someplace
7 else licensed which is identical, at just a different
8 site, is really crazy. It takes so long that very
9 often, by the time it does get approved, it's already
10 outdated. It is obsolete, and we are on to the next
11 generation machine or test or whatever.

12 I really applaud the change in this plan. We
13 need more of that. It makes your life easier, and our
14 life easier, and it seems to me that would accomplish
15 our mutual goal, so I recommend that.

16 MR. ELEGOLD: Another question I have, you
17 brought up the need for internal quality assurance
18 within the center. We recognize that several years ago
19 we established a quality assurance group in the center.
20 Unfortunately, the person who was charged with setting
21 that up and implementing it succumbed to an offer from
22 industry, and we're now in the process of the final
23 stages of selecting a successor to that. In fact, we've
24 even upgraded it in the process to an associate director
25 of the Center for Quality Assurance.

1 Since this is going to be a new effort, what
2 do you think the priority areas would be for that person
3 when they are selected?

4 DR. HOLLAND: Well, I keep focusing on your
5 focus on availability. If we can't get these -- you
6 can't get these applications through faster, and really
7 simplify the process, and make them quality reviews,
8 then we're all spinning our wheels, and we're wasting a
9 lot of time and effort for the American public. Because
10 availability of these things which, in general, have a
11 good track record as far as safety and efficacy, ought
12 to be simpler and faster. So I would really encourage
13 you to apply it to that review process, to speed it up,
14 to simplify it, and to make sure it's of good quality.

15 MR. ELENGOLD: Okay. Thank you. One final
16 thing which I feel compelled to comment on, as the chief
17 operating officer of the Center, is that I'm very
18 concerned about your comments about lost applications
19 and applications sitting for three and a half months.
20 And one of your comments was, we need a tracking system.

21 I can tell you, in my previous position in
22 the Center, I was responsible for that operation. And
23 we have installed, many years ago, a tracking system for
24 just that purpose. And I would encourage you and anyone
25 else, either in the audience, or reading the transcript

1 of this, when those kind of activities occur, let
2 someone know in the center management structure.

3 It is not antagonistic. There is no
4 reprisal. But if we don't know of problems, we can't
5 address them. And many times when we do receive
6 comments like that, we check, and either there is a
7 systemic problem, or it was a one-time thing. But we'd
8 rather address them both to your satisfaction and to
9 ours.

10 And at the expense of causing more work for
11 some people, I will give the name of Jules Meisler, who
12 is the Deputy Director of the Division of -- what is
13 it -- Congressional Public Affairs, and the project
14 officer for our document room contract. Jules has been
15 with the center for close to 30 years, and I know of no
16 one else with enough institutional knowledge to be able
17 to track these things down. And if you are concerned
18 that a file is lost or something, Jules can track it
19 down.

20 Following that, my number is 301-827-0372.
21 My e-mail address is elengold@cber.fda.gov, and I would
22 be interested to hear if something can't be resolved,
23 because that's inexcusable. It is a horrible perception
24 for people to have unaddressed. I urge anyone who is in
25 that kind of situation to either notify Jules or me.

1 And I have to admit, because of a lot of
2 commitments, I'm not in the office. But I usually do
3 have my PC on the road, and I get my voice mail and my
4 e-mail. So please do not sit and suffer in silence.
5 You're not helping yourselves, your colleagues in
6 industry, or us, if you just silently suffer with those
7 kind of problems.

8 DR. HOLLAND: Could I just respond? I really
9 appreciate that, and it's nice to have one or two
10 contact people to be able to approach. I wish I could
11 say that we're the exception, but it seems more like the
12 rule. And really, to have to submit things multiple
13 times, I mean, luckily we always keep copies, but we
14 actually keep track. We send everything to you return-
15 receipt requested, so we know it got there. Then it's
16 really disappointing to go for months, or some period of
17 time, to say, "We can't find it, please send it again."
18 They don't apologize, actually. You do need a tracking
19 mechanism. And when we call in, we wouldn't call you so
20 often or bug you so often about this if you had one.

21 MR. ELEGOLD: I can tell you, the document
22 control center has a tracking option which allows it to
23 know where the document went. And at least my
24 understanding is someone who's been involved in managing
25 the place is -- in each of the operating offices, there

1 are systems, either the blood licensing and tracking
2 system, or RMS, our regulatory management system, should
3 tell us where they are. And those three systems are
4 cross-referenced.

5 And so if someone's telling you that there is
6 no record, I'd like to know about it. So I've given you
7 my phone number, my e-mail address. I'll stop short at
8 the paycheck. But please --

9 DR. HOLLAND: One more quick comment. I also
10 wanted to second a statement that was made earlier. We
11 really do support your doing research. We think it is
12 critical that you have knowledgeable, scientific-based
13 people who are doing research, helping out with the
14 reviews. I think it is in our interest, as well as your
15 interest, to do that, so we highly support that. You
16 need those people, we need those people, and we
17 certainly support your having them.

18 MR. ELENGOLD: Okay. No more questions.
19 Thank you very much.

20 And at the fear of being pretty much exactly
21 on time, I'll ask the next panel to come up: Mary
22 Chung, Robert Miller, and Lee Klosinski.

23 This next panel is representative of patient
24 organizations. I want to thank you particularly for
25 coming both on short notice, and because you are not

1 supported by any employer to come and do this. You do
2 this because it's something you believe in, and we thank
3 you for taking the time to come.

4 If you have no objections, we'll go by the
5 order that's on the program, and that would mean
6 Ms. Chung is first.

7 MS. CHUNG: Good morning. Thank you. My
8 name is Mary Chung. I'm the president and founder of
9 the National Asian Women's Health Organization. I'd
10 like to thank you for this opportunity to provide you
11 with some comments to the 1997 FDA Modernization Act.

12 The National Asian Women's Health
13 Organization, which I'm affiliated with, known as NAWHO,
14 is a nonprofit, community-based advocacy organization
15 which was founded in 1993. Our mission is to improve
16 the overall health status of Asian-American women and
17 families through research, education, leadership, and
18 public policy programs. We have offices in San
19 Francisco and in Washington, D.C. with 3,000 individual
20 and 150 organizational members from 25 states.

21 It is evident that the FDA has been a
22 tremendous force in protecting and promoting the health
23 of the American public. The FDAMA confirms many of the
24 innovative new practices of the FDA, while at the same
25 time, we believe, poses many challenges, especially in

1 maintaining the integrity of consumer protection in
2 light of streamlining operations.

3 I'd like to address very broadly such a
4 challenge in one of the FDAMA's objective areas:
5 information clarity on new products. This area is of
6 particular importance to Asian-Americans, as well as to
7 women from all different racial backgrounds who are
8 impacted by our work in health advocacy.

9 Clear and accessible information for
10 consumers is one of the utmost priority. While all of
11 us with an interest in public health push for innovation
12 in disease prevention and treatment, it is imperative
13 that consumer education and knowledge is able to keep up
14 with these new developments. To facilitate this, the
15 FDA and the Asian-American and other minority community
16 advocates must build meaningful partnerships to protect
17 the consumers first, and strengthen information
18 dissemination regarding new products, unapproved uses,
19 proper dosage, as well as clinical trial results of FDA-
20 approved products.

21 This is critical for Asian-Americans, a
22 population that is still two-thirds immigrant, who face
23 tremendous barriers to health care and health care
24 knowledge. For too long, the specific health needs of
25 Asian-Americans have been underestimated due to

1 stereotypes such as the "model minority" myth, which
2 perpetuates the impression that all Asian-Americans are
3 prosperous, healthy, and educated. This stereotype
4 simply is not true for the vast numbers of Asians in the
5 United States, and has limited the implementation of
6 public health intervention and education programs
7 targeted to this particular population.

8 The lack of understanding about health care
9 needs of this community is complicated by the fact that
10 Asian-Americans living in the United States come from a
11 variety of ethnic backgrounds, and have varying levels
12 of English proficiency, cultural integration, and
13 economic status. For example, approximately 14 percent
14 of Asian-Americans live in poverty, but when broken down
15 by ethnic group, the rates range from 65 percent of
16 certain Southeast Asian groups, such as Hmong Americans,
17 living in poverty, to less than 10 percent for Japanese
18 Americans. Southeast Asians in general have the highest
19 welfare dependency rates of any ethnic groups. Thirty
20 percent of Asian-American households lack an English-
21 proficient speaker over the age of 14.

22 It is this diversity that challenges public
23 health professionals and community health activists in
24 ensuring that Asian-Americans have true access to drug,
25 biologic, and device information, particularly

1 cutting-edge innovations. In this regard, we urge the
2 FDA to utilize existing mechanisms and develop new
3 communications mechanisms to disseminate information to
4 this multi-lingual and multi-cultural population.

5 For example, there are many 1-800 hotlines in
6 English and in Spanish, but not in Asian languages.

7 It is critical that the FDA take the steps to
8 ensure that consumers will be educated about such
9 products that have not gone through aggressive scrutiny
10 for new promoted use. This resonates for minority
11 communities who have suffered from the lack of true
12 informed consent about health care products and
13 services. As the marketing of off-label uses will most
14 likely increase, limited-English-speaking Asian-
15 Americans become vulnerable to a lack of information
16 that the safety and effectiveness of such products have
17 not been proven in well-controlled clinical trials.

18 This need for detailed and explicit
19 information has been well documented in our own research
20 studies. In our work on reproductive health, we have
21 urged health care agencies to integrate patient
22 education into their own programs, such as information
23 about all the available FDA-approved contraceptive
24 methods, especially with regard to pregnancy prevention,
25 the effectiveness of available methods, and specific

1 short- and long-term side effects of different methods.

2 To educate the Asian-American consumer about
3 off-label use, new products, proper dosage, and other
4 FDA-related issues requires a well-rounded effort and a
5 multitude of partnerships. We urge the FDA to develop
6 partnerships with Asian community activist groups to
7 disseminate information out to different sectors of the
8 community, including consumers, health care
9 professionals, and Asian-American businesses.

10 For example, organizations like ours can
11 provide culturally competent training to health care
12 professionals to facilitate certain communication of
13 medical information from health care professionals to
14 Asian patients. Also, the FDA can engage in
15 partnerships with other health care professional groups
16 on providing information to their patients when
17 prescribing off-label products or to direct them to a
18 source for information. As it does with mammography,
19 the FDA can also provide translated educational
20 brochures about what off-label use of products means,
21 what are the purposes of clinical trials in product
22 approval, and why proper dosage is important.

23 Another important venue could be an
24 information hotline in different Asian languages that
25 provides recorded information about current off-label

1 uses for the most common drug treatments, of course,
2 complemented by aggressive outreach efforts to let
3 people know that such hotline does exist. Another is to
4 engage with Asian ethnic media to provide a health
5 information or a science column to their readers about
6 new products.

7 Finally, the expansion of the well-detailed
8 FDA Web site into a multi-lingual capacity would further
9 ease the flow of information to limited-English-speaking
10 populations.

11 As processes are streamlined, and time lines
12 shortened, public information and education becomes a
13 greater responsibility for the FDA. This again becomes
14 increasingly complicated as the American public changes
15 in its diversity and ethnic makeup. However, we believe
16 that through increased meaningful partnerships with
17 community groups to increase information dissemination,
18 that the FDA will be able to accomplish this ever-
19 expanding role and provide true health access for Asian-
20 Americans and other special populations. Thank you.

21 MR. ELENGOLD: Thank you very much. Next
22 speaker, Dr. Miller.

23 DR. MILLER: Thank you. Distinguished
24 members of the panel, ladies and gentlemen:

25 I appreciate the opportunity to speak to you,

1 this distinguished panel. And before I tell you what
2 I'd like to say, I'd like to tell you what I'm going to
3 say, which is that we're concerned about fast-track
4 issues for very serious diseases like ALS. We're
5 concerned about the need for true expert input by
6 clinicians who are very experienced with the disease,
7 and we're concerned about uniformity of treatment for
8 the various applications that have come before the FDA
9 with respect to a disease like ALS, which I'd like to
10 make a few comments about.

11 So I'd like to start off by saying my name is
12 Robert Miller. I'm director of the Norris ALS Center,
13 and Chair of Neurology at California Pacific Medical
14 Center, and Clinical Professor of Neurology at Stanford
15 and UCSF. I wear a number of hats which I won't bore
16 you with now, but my major interest is advocating with
17 patients for ALS and finding effective treatment for the
18 disease.

19 At this hearing today, I represent the ALS
20 Association, a patient advocacy group, and I believe I
21 also represent the entire ALS community, which includes
22 patient voluntary organizations, patients and families,
23 ALS experts, and pharmaceutical companies who are
24 working to produce drugs for this disease.

25 First I'd like to briefly describe the

1 disease ALS and the current status of the treatment.
2 ALS is a neurodegenerative disease that leads to death
3 generally within three or four years. Laypeople call
4 ALS Lou Gehrig's disease. Patients with ALS lose the
5 ability to move their body and their muscles. They lose
6 the ability to eat, to swallow, to speak, and eventually
7 to breathe.

8 Sometimes, a patient with ALS is described as
9 living in a body that's like a glass coffin. It's
10 worse, actually, than the majority of cancers, and even
11 AIDS, because ALS is fatal, in the majority of patients,
12 within, as I've said, three to four years. It is
13 estimated that up to 5,000 new patients in the U.S. are
14 diagnosed with this disease each year, and currently
15 there are about 30,000 patients who have ALS in the
16 United States.

17 The impact upon patients and families is
18 unimaginable, and the impact upon our society is very
19 substantial. There's only been one drug approved for
20 this disease. It is called Riluzole. It is now
21 available as a prescribable drug, but it has only modest
22 beneficial effects, extending survival on average by two
23 to three months. There is no cure. There is only
24 symptomatic treatment.

25 Worldwide, an increasing number of novel

1 therapeutic agents have been developed. The research in
2 this disease is truly exploding. Some of these agents
3 are already in the pipeline, and FDA has been helpful,
4 and their commitment in developing ALS therapies is
5 clear. In fact, as described below, the members of the
6 FDA have participated in the two Airlie House meetings
7 for ALS diagnosis and developing clinical trial
8 guidelines for screening agents in ALS.

9 With this opportunity, I want to present our
10 concerns about the guideline for fast-track product
11 review and approval, and also the way in which the
12 scientific advisory panel is constituted. Our concerns
13 are specifically related to Questions 4 through 7 that
14 the FDA has posed asking about scientific expertise,
15 timely product review, priorities in eliminating
16 backlogs, and also public expectations.

17 Because almost all neurologists agree that
18 ALS is the most devastating of diseases, we in the ALS
19 community believe that there is no higher priority for
20 all FDA centers, especially CBER, than to continue to
21 expedite the review and facilitate the development of
22 drugs for treating serious and rapidly fatal diseases
23 such as ALS.

24 Thus, it is imperative that FDA guidelines be
25 specific regarding fast-track diseases. The FDA should

1 solicit from AMA sections and from specialty
2 organizations such as the American Academy of Neurology,
3 American Neurological Association, or the World
4 Federation of Neurology, recommendations for the
5 priorities for a fast-track disease. The current
6 guideline described in the FDAMA Section 112 is still
7 not specific nor explicit, particularly about ALS. We
8 anxiously await the Agency's release of a guidance
9 document for this section, which must be released within
10 one year of enactment of the law, or November 1998.

11 We do not believe that the drug approval
12 process for ALS has been fair or accelerated. We're
13 hopeful that proper implementation of this section on
14 fast-track products will expedite the availability of
15 new therapies for diseases like ALS.

16 As the former commissioner, Dr. Kessler,
17 stated many years ago, "When dealing with serious and
18 life-threatening conditions, we cannot wait for all the
19 evidence to come in." With truly life-threatening
20 diseases such as ALS, the FDA can expedite the
21 availability of therapy to patients in desperate need by
22 providing greater authority to approved drugs that
23 strongly suggest effectiveness as stated in the public
24 law.

25 By permitting greater use of Phase IV post-

1 approval confirmatory trials, and yet adhering to high
2 standards, the FDA should be able to require substantial
3 evidence of effectiveness. This procedure has worked
4 well in AIDS, and we'll hear something about that in a
5 moment, and also in some areas of cancer research, and
6 we believe that fast-track products are intended to
7 expand that procedure to all drugs to treat serious and
8 life-threatening conditions such as ALS.

9 When all is said and done, 17 of the 20
10 Subpart H accelerated approvals that have occurred since
11 1992 have been in AIDS and cancer, and only three have
12 been in other life-threatening conditions, according to
13 the "Drug Information Journal."

14 New guidelines for ALS clinical trials have
15 been developed by the World Federation of Neurology, the
16 group that I chair, started in April of '94, and
17 recently revised in April of this year, and members of
18 the FDA, including Dr. Lieber, have been very gracious
19 in attending these meetings and supporting ALS
20 investigators and the pharmaceutical industry, so that
21 the FDA team has a growing understanding of the issues
22 of these clinical trials in this disease.

23 The FDA should consider efficacy relative to
24 safety. There's been a lot of experience with the drug
25 called Insulin-Like Growth Factor I, IGF-I. It's shown

1 minimal side effects. The safety record was really not
2 a concern. That experience should weigh in heavily,
3 even if there is only a small therapeutic benefit, we
4 believe. In particular, if two studies show safety, and
5 one shows efficacy, it is clear, in a disease like ALS,
6 where long-term exposure is probably not a safety
7 concern, we need to press ahead.

8 The approval of such safe, yet modestly
9 effective drugs, ensures Phase IV studies for long-term
10 efficacy. Many cancer drugs and immunosuppressive drugs
11 have been approved relative to safety. Again, ALS
12 trials have not been treated the same as other life-
13 threatening diseases in this regard.

14 Finally, ALS has, at present, no surrogate
15 markers as are available in cancers and AIDS. So
16 there's an urgent need for developing surrogate markers
17 for this disease. And continuous cumulative physical
18 disability shown by quantitative muscle strength
19 testing, and pulmonary testing, and a well-validated
20 functional ALS scale may well be sufficient to evaluate
21 the efficacy of a drug or biological product into the
22 fast-track approval process, in our view.

23 Next, I want to just briefly discuss the
24 scientific advisory panel, which is made up in Section
25 120 of the Modernization Act. Only two drugs for ALS,

1 Riluzole and IGF-I, have ever come before a panel, and
2 both were highly controversial, and actually, the
3 reviews were quite contentious. Given the great weight
4 that FDA places on the advisory panel decision, it is
5 critical that true experts in the actual disease under
6 review be represented under these panels. This was not
7 true in the panels which reviewed Riluzole and IGF-I.

8 We are not sure whether there are provisions
9 in CBER which require that when nerve growth factors and
10 other agents come before CBER, they will be reviewed by
11 the members of an advisory panel which include experts
12 on ALS. We implore that.

13 Public Law Subsection 120 states that two or
14 more members who are specialists or have other expertise
15 in the particular disease or condition for which the
16 drug under review is proposed to be indicated.

17 Undoubtedly, the members of the Scientific Advisory
18 Panel are the most capable and reputable members of the
19 medical community we have. However, the ALS community
20 feels that true ALS experts have not been represented on
21 the panel.

22 The World Federation of Neurology, our
23 Committee on Motor Neuron Diseases, provides independent
24 expertise in this review process, and we offer this to
25 you. There are approximately 100 neurologists worldwide

1 who have formed the International ALS Clinical Trial
2 Consortium. This group has developed the ALS clinical
3 trials guidelines. As I've mentioned, we have broad
4 experience with ALS clinical trials.

5 One solution may be the use of ad hoc
6 reviewers, again, from experts in such diseases. The
7 International ALS Clinical Trial Consortia that I've
8 just referred to could be helpful when acting as an
9 outside ad hoc panel.

10 I'd like to briefly comment on the current
11 forum of a publicly open scientific advisory panel
12 meeting. In this forum, the patient's testimonial is
13 allocated, and we believe it is extremely important.
14 However, these testimonials are so powerful and
15 sometimes so very emotional that I personally wonder how
16 panel members can make their judgment based on purely
17 scientific grounds.

18 On some occasions, it appeared that the panel
19 had made prior decisions, being that some members left
20 the room during portions of patient testimony. This
21 type of forum, although extremely important, may need to
22 more effectively be incorporated in the entire process.
23 Both expert testimony and patient testimony need to be
24 given their just due. I'm almost finished.

25 Next, I'd like to point out a question that I

1 have as regards both CDER and CBER. My confusion
2 springs from recent experiences with IGF-I. IGF-I is a
3 recombinant biological product. However, CDER required
4 two independent clinical trials. Other neurotrophic
5 factors such as CNTF, BDNF and GDNF, as we understand
6 it, were to be evaluated by CBER requiring only one
7 clinical trial. These inconsistencies, two trials
8 versus one, should be eliminated across different
9 centers within the FDA. We believe that a single strong
10 trial should be sufficient.

11 I believe also that the FDA should
12 aggressively educate patients' advocacy groups,
13 disease-specific organizations, disease experts, and new
14 biotech companies that have never filed their product to
15 the FDA. The FDA must inform these groups of its
16 function, process, and scope now more than ever, because
17 recent progress in therapeutics will increase drug
18 approval applications exponentially.

19 Regarding future direction of the fast-track
20 process, the FDA should solicit from disease-specific
21 groups information regarding potentially effective drugs
22 in such disease. The FDA should proactively plan the
23 future drug approval process for fast-track diseases and
24 should then formalize and implement a plan.

25 Currently the FDA supports some research in

1 new drug development; however, we propose that the FDA
2 should also fund research in developing surrogate
3 markers in fast-track diseases that have no surrogate
4 markers at present, such as ALS. It is of great urgency
5 to help the American people that suffer from this
6 devastating disease. Since the NIH budget has increased
7 in the several years, we believe that the FDA budget
8 should have a parallel increase. Without such a budget
9 increase, the FDA will not be able to meet the needs of
10 the American people.

11 On behalf of the ALS Association, and all the
12 patients, and ALS experts, we appreciate this
13 opportunity to present our views, and thank you very
14 much for your attention.

15 MR. ELENGOLD: Thank you very much. Final
16 speaker of the planned program is Dr. Klosinski.

17 DR. KLOSINSKI: On the privilege and the
18 pressure of being last, good morning. My name is Lee
19 Klosinski, and I am the Director of Education at AIDS
20 Project Los Angeles, a community-based organization
21 which provides free services to over 7300 women, men,
22 and children with symptomatic HIV disease. Sixty
23 percent of our clients are people of color. Ten percent
24 are women. I'm grateful for the opportunity to make
25 these public comments in response to the Food and Drug

1 Administration's open invitation.

2 Out of urgency and desperation in the mid-
3 1980s, the HIV community initiated a series of
4 interactions with the FDA to expedite the delivery of
5 promising anti-HIV drugs to people with AIDS.
6 Undoubtedly, many of you recall this history, and some
7 of us were part of it.

8 Whether it was gaining access to ribavirin
9 from Mexico, the 1987 march on FDA Headquarters, or the
10 development of the process of accelerated approval of
11 anti-HIV drugs, the HIV community has played an
12 essential role in the modernization of the FDA for over
13 ten years. That role, at times confrontational and
14 fraught with drama, more recently constructive and
15 collaborative, always has been motivated by two core
16 values: the needs of the FDA to be timely in response
17 to emerging needs, and to protect the public safety.

18 I am very proud to argue that the FDA is
19 today different because the HIV community acted up and
20 fought back. The FDA can be different tomorrow if it
21 learns lessons from its interaction with the HIV
22 community.

23 AIDS Project Los Angeles feels that intense
24 working relationships between stakeholders and the FDA
25 patterned after those initiated by the HIV community in

1 the 1980s and continuing today is a viable model for the
2 Agency to use to meet many of its statutory regulations.

3 Many stakeholder groups apart from HIV
4 already exist, having formed themselves after seeing the
5 success of the HIV community, and advocating for its
6 needs, and becoming the dialogue partner at the table
7 with both FDA and industry. A strategic and aggressive
8 use of these stakeholder groups initiated by the FDA
9 could reap tremendous benefits.

10 AIDS Project Los Angeles and the HIV
11 community, along with other groups of people challenged
12 with life-threatening illness, believes in a strong,
13 responsive FDA with regulatory authority aimed
14 throughout the product pre- and post-approval process.
15 The HIV community's experience with the FDA is that a
16 combination of political pressure, reasoned discussion,
17 and recognition of common goals can lead to
18 institutional, bureaucratic, and regulatory changes.
19 Given this history, the HIV community was not supportive
20 of a legislative fix which could lower the Agency's
21 standards and authority.

22 We are especially concerned that the Section
23 406 time lines do not drain valuable staff time away
24 from other urgent statutory obligations, thereby tipping
25 the balance toward industry and away from consumers.

1 To fulfill its mission, the FDA needs strong
2 leadership. We believe the Agency has been severely
3 challenged by the absence of a permanent director. This
4 executive and congressional inertia has been a serious
5 impediment to the Agency's ability to reform itself. We
6 hope that Dr. Henney's appointment is approved
7 expeditiously and without political intrigue.

8 We strongly urge Dr. Henney to make her first
9 task the development of a realistic working budget for
10 the Agency. This budget must include funding of
11 additional staff and necessary equipment to meet the
12 Agency's needs, as well as an eye toward the future and
13 the increasing demands that scientific advances will
14 place on the Agency.

15 Part of budget development must be a concrete
16 plan to advocate for its funding on Capitol Hill.
17 Section 406 can only be operationalized with a realistic
18 budget. It is urgently needed.

19 AIDS Project Los Angeles is extremely
20 concerned about the FDA maintaining its role as a sentry
21 of product safety. Please think for a moment about the
22 development and approval of the HIV protease inhibitor
23 class of drugs. This was the first group of HIV drugs
24 to be approved under the expedited process. Now, after
25 two years of use, it is clear that some consumers of

1 them are experiencing a lipodystrophy syndrome which
2 many believe to be associated with their use. It is
3 essential to the health and safety of our clients that
4 Phase IV trials be completed on these drugs, and health
5 concerns associated with their ongoing use be
6 documented, as clearly as the dramatic effect they have
7 had on restoring the health and productivity of many
8 people with HIV has been documented.

9 Some of our colleagues testifying in similar
10 meetings in Washington two weeks ago have advocated for
11 the creation of an Office of Drug Safety. AIDS Project
12 Los Angeles enthusiastically supports this proposal.

13 In fact, nothing about the implementation of
14 the Modernization Act's objectives must compromise
15 consumer safety.

16 It is appropriate that a Center for Biologics
17 Evaluation and Research-sponsored hearing receive
18 comment from a representative of the HIV community.
19 Many of the most promising developments in HIV disease
20 -- vaccines, monoclonal antibodies, gene therapy, and
21 xenotransplantation -- are in fact emerging areas of
22 immense potentially preventative and therapeutic value
23 and are part of CBER's regulatory responsibilities.
24 They are also new frontiers in science, and therefore
25 suggest complicated ethical and practical questions.

1 AIDS Project Los Angeles reminds the FDA that
2 the safety of participants in clinical trials,
3 especially in clinical trials in these newer areas, is
4 part of our concern for the comprehensive safety of
5 consumers. It must be monitored very closely. This
6 happens at the local level through strong institutional
7 review boards. We applaud the recent effort to review
8 the work of these IRBs and urge this review's
9 institutionalization.

10 Now let me summarize my remarks. The HIV
11 community has been one of the most powerful and
12 effective forces in the modernization of FDA. The model
13 between stakeholders and FDA initiated by the HIV
14 community deserves replication and is a practical, cost-
15 effective means of sharing information about products
16 and monitoring their safety at every stage of the pre-
17 and post-approval process.

18 Second, to successfully operationalize its
19 mission, the FDA needs a strong leader who can grow its
20 staff, research capacity, and budget, and advocate
21 strongly for its needs to the executive and legislative
22 branches of government.

23 Third, consumer safety must remain the
24 Agency's core value.

25 AIDS Project Los Angeles and the HIV

1 community recognized the importance of this consultative
2 process unfolding today. Rarely have so few civil
3 servants been asked to do so much to protect the health
4 of so many generations with so little money. And rarely
5 have we as a community been so committed to being not
6 only stakeholders, but also partners in this reform.
7 After all, for many of us, our lives depend upon it.

8 Thank you.

9 MR. ELEGOLD: Thank you very much, all the
10 panelists. Thank you very much. Do you have any
11 questions, Linda?

12 MS. SUYDAM: I guess I have a comment. I
13 found Mr. Klosinski's comments especially poignant, and
14 I also found them perhaps reinforcing something that
15 I've been saying at the Agency since I've been back, in
16 that I do believe that the AIDS advocate model is in
17 fact one we should be replicating across the Agency.
18 And it was a tremendously effective one, and I think
19 it's one we need to continue to foster. So I definitely
20 am resonating to the things that you said. I'm a little
21 concerned.

22 My next comment is with Dr. Miller, and it's
23 a comment kind of question. I'm concerned about the
24 comments about the advisory committees. We've gone --
25 we went through, before I left the Agency in '95, a

1 major advisory committee review. But it sounds to me,
2 as one who is just now back after three years being in
3 the university, that there is still an issue with
4 advisory committees. And would you care to make any
5 more comments on that?

6 DR. MILLER: Well, I think that the Agency is
7 aware of the need for expert representation on the
8 panel. But I don't think it's been given sufficiently
9 high priority. On the panel that was evaluating IGF-I,
10 an ALS expert neurologist was appointed to the panel,
11 but he was not able to attend.

12 In the prior panels, there was a lay
13 representative from the ALS community -- we are very
14 grateful about that -- but there were no clinical
15 experts in the disease, and the Agency didn't seem to
16 give that a high priority. We think it's a very
17 important issue.

18 MR. ELEGOLD: Jay.

19 DR. SIEGEL: I could probably go on forever
20 with comments, but I won't make any of them. Perhaps
21 after the meeting. But I do have a couple of questions.

22 MR. ELEGOLD: Let me just say something to
23 put that into context. Dr. Siegel is on vacation this
24 week, and he came here to participate on his own time,
25 of his own free will. And he's also been a participant

1 in a lot of the issues that have been discussed.

2 I believe Jay was at one of those early House
3 meetings, and has been involved in working on defining
4 efficacy, surrogate end points, single versus dual
5 trials, as well as consolidated small trials to make one
6 good, big, viable trial. So I'm sure Jay has a lot of
7 comments. And I'm glad that he's here to participate,
8 particularly in this forum.

9 DR. SIEGEL: Thank you, Mark. Those are all
10 issues -- all the issues that were discussed that I care
11 deeply about, and I much appreciate the input, and I'll
12 leave my comments to that, and try to get just a little
13 bit of clarification on a couple of issues.

14 First, Ms. Chung, you mentioned you advocated
15 better FDA communication efforts in a number of areas,
16 and notably, one on your list was off-label use, and
17 referenced the potential vulnerability of the community
18 you represent, and concerns about changes in the
19 Modernization Act in that area.

20 I'm wondering if you could clarify. Are you
21 thinking that the Agency should provide specific
22 information about specific uses, and what data there are
23 in support of uses that we have not reviewed or
24 approved, or is the concept more providing more
25 information? You alluded to the role of clinical

1 trials, perhaps more information regarding the process,
2 and the difference between an approved use and
3 unapproved use, and what the data are, and what the
4 actual approved versus off-label uses are.

5 MS. CHUNG: Thank you. I feel that there's a
6 tremendous opportunity at the FDA. There is certainly
7 the Office of Women's Health that has been doing a lot
8 of consumer information and outreach effort to simply
9 educate women about medication, you know, how to read
10 labels, and what to ask you or your physicians, and that
11 sort of thing.

12 And in light of all of that, we feel that
13 women that we work with simply sometimes do not
14 understand, for example, what "clinical trial" is. And
15 when it comes to treatment options or, you know, even
16 just -- even I guess there's some differences between
17 prevention and treatment trials. But you know, women,
18 and we're talking about both English-speaking women and
19 non-English-speaking women, they would come to us and
20 say, "Well, what is this process and, you know, what is
21 a clinical trial?"

22 Off-label use, you know, we're very -- what
23 we're advocating for is very simple, basic information
24 that women need in order for them to make informed
25 decisions. We're not advocating for any specific

1 medical device -- information on medical devices. But
2 sometimes understanding the processes that FDA has,
3 sometimes understanding the advisory panels that exist,
4 where the patient has the full understanding of the
5 structure and the processes that are in place to protect
6 the consumers I think is an important education that FDA
7 can do, and have been doing very effectively in some
8 areas.

9 And through the good offices of Audrey
10 Shepherd and the Office of Women's Health at the FDA, we
11 have seen a lot of good consumer education materials,
12 like that office has translated mammography and Pap
13 tests in, I think, over eight different Asian languages,
14 and we have been very aggressively disseminating that to
15 our members and to the doctors that we work with who
16 serve the population.

17 And so I think there is some opportunity for
18 the FDA to sort of step in and say, "Okay, we've done
19 this thus far," in terms of educating, off-label use --
20 I mean, what is off-label use? And I think that what
21 we're advocating is very basic, simple information and
22 processes that are set up at the FDA to protect the
23 consumers. And I hope that clarifies.

24 DR. SIEGEL: Question for Dr. Miller. I'm
25 not sure exactly what you were advocating for patient

1 testimonials. You indicated the necessity for their
2 role, but their potential to be emotionally overpowering
3 in some way has a negative effect by implication. I
4 don't want to put words in your mouth, but what are you
5 recommending or advising in that regard?

6 DR. MILLER: Thank you for your question.
7 I'm not sure what the ideal way is for incorporating
8 this into the process. I wanted to raise this as a
9 concern, both in terms that the ALS experts have come
10 into the advisory meetings and have been lumped into the
11 patient time. Both are important services for the
12 advisory panel.

13 To some extent, the charge that is given to
14 the advisory panel prior to the open mike has a great
15 deal to do with how the panel interprets what they are
16 hearing. And the charge that I have heard that has been
17 given to the panel basically cautions them not to listen
18 too much to their emotions, because this is, after all,
19 a scientific process.

20 I think it's very important that we hear from
21 patients who are struggling with the disease, and that
22 we take their testimony into account when we evaluate an
23 agent. I think it is also important, when we hear from
24 experts who are grappling with the disease full-time in
25 their clinical careers, in their clinical care of

1 patients, they have a perspective that is also
2 important. I'd like to see both of these areas of input
3 given more value than they are now.

4 MR. ELENGOLD: Anything else? I want to
5 thank this panel for taking the time on their own. You
6 can see, by the fact that I'm not asking any questions,
7 this is out of my field of expertise. I rely on Jay and
8 his colleagues for review of this type of information.
9 Thank you very much.

10 And we'll move on to the last phase of this
11 meeting, which is the open public mike for anyone who
12 would like to make remarks prior to the conclusion. Do
13 we have anyone?

14 I'll ask again that you please identify
15 yourself, your affiliation, and at the conclusion, just
16 make sure that the stenographer and Ms. Groover in the
17 back have an idea who you are.

18 MS. MORGAN-GANNON: Hello. My name is Sally
19 Morgan-Gannon. I'm a compliance officer for Sacramento
20 Medical Foundation Blood Centers. We serve a large
21 geographic area of patients in Northern California with
22 a lot of different clinical services, as well as many,
23 many different types of blood products.

24 I have one comment and a question. I wanted
25 to give you feedback from the people in my network that

1 the guidance documents that CBER is now issuing to go
2 along with new regulations are very helpful. I think
3 for many years we've been struggling, trying to
4 understand and know what it is you had in mind, when we
5 look at the wording of various things, and we scrutinize
6 every word trying to really see how to apply it. So
7 they're very helpful, and I think that they should
8 continue, and I think it's been very useful.

9 I also wanted to ask if it would be possible
10 to consider -- and I've been to other forums with the
11 FDA where this has been brought up, but I think it bears
12 repeating -- that many of the regulations, when they're
13 written in the broad umbrella of biologics, really get
14 lost in translation, when you try to apply those broad
15 concepts to the blood and blood-components application.
16 Sometimes they don't translate, and sometimes they don't
17 apply at all, and sometimes there are large sections
18 that don't apply, and you go through page after page
19 looking for the few things that would apply.

20 I think it would be very useful if those
21 could either be put into a section or -- of a particular
22 document, or put in separate documents. It's very hard
23 to struggle through and figure out which things apply to
24 us.

25 Then Mr. Elengold, I had a question. One of

1 your successes that you listed was updating biological
2 regulations. And I wondered if you could share what's
3 been happening. We feel that there are certain areas of
4 the CFRs where scientifically, the information is very
5 outdated, needs to be revised, new information is not
6 even represented. And I was just curious what that
7 process is, and where you are.

8 MR. ELEGOLD: Sure.

9 MS. MORGAN-GANNON: Thank you.

10 MR. ELEGOLD: Anything to do with
11 regulations is a long-term process. They go from the
12 FDA to the Department, in many cases to OMB, and then
13 are published as proposals.

14 Some of the ones we've published in the
15 relatively recent past are the elimination of the
16 additional standards for certain biological products,
17 elimination of the ELPA process, and there are many more
18 specific to the blood industry that are in the pipeline.

19 The blood organizations have formed a
20 coalition for regulatory reform, CFRR, and they
21 testified at the meeting we had back in Washington. And
22 they have been very active in identifying the
23 regulations they believe need to be changed or
24 eliminated.

25 As to the other comments you made, believe it

1 or not, the rest of the biologics industry tells us that
2 there are so many things in our regulations that only
3 apply to blood, that they don't understand them, and why
4 do they apply to them? We are grappling with that as
5 part of our review of all of our regulations, as well as
6 our modernization efforts. And we hope, through things
7 like the monograph system we're going to be
8 experimenting with for blood, to try and segment that a
9 little better. But thank you for bringing that up. It
10 will be in the record, and we'll discuss it as part of
11 our blood initiatives.

12 The other thing is, if you see a regulation,
13 when it's proposed, that you believe specifically should
14 not apply, or doesn't make sense, it's the appropriate
15 time to submit a comment suggesting that it be bracketed
16 with "for products other than blood components" or
17 something like that to make it very clear, and that we
18 don't expect it to apply. That's, you know, one of the
19 reasons that the process takes so long, but it's one of
20 the strengths of the process, in that people make
21 constructive suggestions. Thank you.

22 Next.

23 MS. LYON: My name is Mary Lyon, and I'm
24 representing the ALS Association, and I bring to you
25 comments from patients that have come to us since

1 Dr. Miller's testimony was put together.

2 Thank you for the chance to address you and
3 to speak on behalf of the 30,000 stakeholders and their
4 family members who are struggling with ALS today, and we
5 appreciate the difficulty of the job CBER and the other
6 centers within the FDA have in evaluating, in your case,
7 biologic therapies in a manner and within a time frame
8 that assures your center's mission of enhancing the
9 public health.

10 Relative to the implementation of the
11 Modernization and Accountability Act, ALS patients and
12 their family members make the following recommendations
13 to increase the Agency's focus on ALS. First of all,
14 biologic products for ALS absolutely must be managed on
15 a fast track with published deadlines that are met. ALS
16 has certainly been in the medical -- recognized in the
17 medical literature for hundreds of years, yet to date we
18 only have one FDA-approved therapy, and we need your
19 help.

20 Secondly, some patients want to participate
21 in more than one clinical trial at any one time.
22 Understanding the challenge that this presents to the
23 scientific design review and analysis, we ask that the
24 FDA work with the pharmaceutical industry to design
25 trials that can include, in certain situations, patients

1 who are in more than one clinical trial. Given the
2 horrific nature of this disease, and the alternatives
3 that these patients face, we stress the importance of
4 expanded access programs, and encourage the FDA to
5 continue to make this program option available without
6 always requiring data collection.

7 The efficacy threshold for approval of ALS
8 therapies should be set within the context of the time
9 urgency of this disease and the lack of therapies. Some
10 patients would like to see, wherever possible, a
11 minimizing of the number of patients who receive
12 placebos, and an elimination of placebos at whatever
13 point in trials that they are not absolutely necessary.

14 We understand and we want to make sure that
15 the FDA does not think that these points of view are
16 driven by irresponsibility, or a cavalier disregard for
17 the scientific method, or a lack of interest in safety
18 and efficacy in high standards, but rather, they're
19 driven by a lack of any significant process; that we
20 suggest that we all share in, would want to partner with
21 you and the industry in trying to overcome some of these
22 barriers.

23 The last two recommendations are, we
24 encourage the FDA to increase the effectiveness and
25 openness of the dialogue between the Agency and patients

1 on an ongoing and timely basis. And I would underscore
2 Web site comments that have been made earlier as
3 certainly a good way to do that for our patient
4 population.

5 And lastly, the ALS community needs the FDA
6 to commit to conducting research in ALS. The human
7 effect and toll of this illness is significant and
8 deserves this attention. Thank you.

9 MR. ELENGOLD: Thank you. Jay, you have a
10 question?

11 DR. SIEGEL: Yes, I have a question. I'm a
12 little perplexed by one comment I think I understood you
13 to make. We would anticipate in ALS, given that it's
14 not a terribly common disease, and that the products
15 certainly ought to be reviewed and made available in the
16 marketplace as soon as adequate data are available, that
17 at the time of marketing, there will be adequate but not
18 always as much data as one would want, particularly
19 regarding safety.

20 And I'm wondering, therefore, what is your
21 perspective in calling for expanded access to have noted
22 that we should also be permitting expanded access
23 without data collection? What is the advantage of not
24 collecting data in the premarketing period?

25 MS. LYON: I'm not an expert in this field.

1 What we in the patient advocacy group would like to have
2 is companies, as they go through drug approval process,
3 at the appropriate time, feel that they can offer
4 expanded access programs that would not burden them with
5 the cost of collecting other data.

6 We leave that really to the FDA to determine
7 where, in the interest of protecting safety issues and
8 efficacy, where it's absolutely required to continue the
9 data collection. But we ask that that be done with a
10 mind that, if it's not absolutely necessary, and it may
11 be a financial burden, and the industry may decide not
12 to offer it, that may have an impact on our patients.
13 Did that help?

14 DR. SIEGEL: Yes.

15 MR. ELENGOLD: Thanks very much. Next?

16 MR. CALANDRA: My name is Tony Calandra, I'm
17 from Amgen. I just wanted to provide some clarification
18 on the remarks regarding two of the drugs that were
19 mentioned by Dr. Miller. One is BDNF, and the other
20 GDNF.

21 First of all, GDNF is in the Phase I trial.
22 So the totality of the data collected on GDNF, it is
23 really too early to tell you how much data we'll gather
24 on that, because we are still in Phase I.

25 With regard to BDNF, although it is correct

1 to say that the Phase III trial would provide the
2 pivotal data for that, the registration package would
3 have involved many more trials than one trial. And in
4 terms of the comments made on fast-tracking, in our
5 experience, we've had very good speed with the ALS drugs
6 that we're trying to develop.

7 MR. ELENGOLD: Thanks very much. Any
8 questions? No.

9 Next, please.

10 MS. HORNBAKER: Hi. Good morning. My name's
11 Nancy Hornbaker. I'm the Director of Regulatory Affairs
12 for Chiron Diagnostics, which is the business of Chiron
13 Corporation. I'm here representing HIMA. HIMA is a
14 Washington, D.C.-based trade association and the largest
15 medical technology association in the world. Our member
16 companies number around 800 or more, and they work in
17 the area of medical devices, diagnostic products, and
18 medical information systems. This CBER stakeholders'
19 meeting is of great interest to our members.

20 HIMA is encouraged by the Agency's efforts to
21 gain input from the regulated industry, consumers, and
22 academia on how the FDA can meet its statutory
23 obligations under the Food, Drug, and Cosmetic Act. And
24 we believe that this dialogue with all of these
25 constituencies is very important as FDA, in particular

1 CBER, makes attempts and tries to meet the challenges
2 that will meet us all in the future.

3 We appreciate the opportunity to be here
4 today and to be part of these discussions, and we will
5 be submitting more extensive comments to the docket. In
6 the comments you've asked us to identify six major
7 areas, so we are going to have very brief comments on
8 the six areas.

9 First is additional objectives. FDAMA covers
10 a broad range of Agency activities, and the Agency
11 should be complimented for attempting to determine
12 whether there are other objectives or issues that lie
13 ahead and challenge them and could be added to the plan.
14 If FDA accomplishes all of the objectives outlined by
15 FDAMA in the time frames that are specified, we in
16 industry will be more than willing to look at ways that
17 we can help to work within that system and tweak it, if
18 necessary, to gain even greater efficiencies.

19 The one thing we might add is a reminder that
20 FDA's mission has now been broadened. The focus is not
21 only protection of public health, but promotion of
22 public health. We believe the change in focus results
23 in delicate balancing of risks and benefits in an
24 environment that is essentially risk-averse. We hope
25 there is a way to develop a reasonable approach to its

1 revised mission, and that revised approach will direct
2 future Agency activities.

3 The second point is improving review process.
4 We believe CBER has made significant strides to
5 improving its licensure processes, and we think the BLA
6 is an example of that improvement. We believe that will
7 make licensing much more efficient, and we look forward
8 to efforts being directed to additional improvements in
9 the approval processes, including regulation of devices
10 and premarket approval processes.

11 CBER's focus, however, on the PDUFA products
12 has left the devices in trouble. Sometimes our
13 applications are put aside, because the resources have
14 to be directed to the PDUFA products. In some places
15 some products have been under review for more than 18
16 months, some others for 24 months. CBER reviewers have
17 made comments that they were required to put
18 applications aside and work on other items.

19 We don't necessarily have a total fix for
20 this, but we do believe that this is not a great way to
21 win friends and influence people. So we're suggesting
22 some of the following at least to try and mitigate that.
23 We believe that -- and this is an opinion that seems to
24 be contrary to much of what we've heard today -- that
25 CBER needs to redirect some of its research towards the

1 review process and cleaning up the backlog of device
2 reviews. We believe CDRH did this a while ago, and
3 successfully.

4 There probably can be additional
5 harmonization with CDRH, especially with instrumentation
6 and other devices, where the same device can be used in
7 blood screening or diagnosis will not require dual
8 license applications. We would suggest that CDRH take
9 the lead and, when necessary, then incorporate CBER
10 concerns.

11 We also believe that if there were more
12 templates available for submission work, that
13 submissions preparation and review would be simplified.

14 We think, too, that there should be an
15 evaluation of current processes to determine which items
16 add little to no value, and that those things should be
17 dropped.

18 We think it would be a wise idea if we could
19 publish flow charts or some sort of checklist of
20 internal process so that everyone can understand them,
21 and they really become quite transparent.

22 And we again urge everyone to remember that
23 promotion of public health is equally important to
24 protection of public health, and promotion includes
25 getting good products to the market as soon as possible.

1 The next idea was product quality, and we
2 share the concern with CBER that product quality is very
3 important, and we think that the shared concern may be
4 often overlooked. We believe that the manufacturers in
5 our organization have responsibility to ensure that
6 their products meet the highest quality possible, and we
7 also believe that their goal is to design quality in.

8 We think that CBER now has at its disposal a
9 large arsenal of tools to help in the area of product
10 quality. And that includes the opportunity for early
11 and frequent conversations with industry, and we have to
12 say that CBER's always been very good about doing that.
13 We discuss study protocols, there can be discussions of
14 technical review, and how we might be able to manage the
15 review process. We also believe that application of the
16 quality systems regulations and specially designed
17 control for products or devices regulated by CBER is
18 another important tool.

19 In light of the design control requirements,
20 in fact we are suggesting that CBER reevaluate the
21 current lot release program for devices. We believe
22 that the lot release program implies or suggests that
23 there is an element of being able to test quality into a
24 product. We think efficiencies in this process may be
25 gained in looking at other countries' programs they have

1 for monitoring product quality.

2 Another area was communications, and we
3 believe that on certain levels, the CBER communications
4 have improved. There have been a number of published
5 guidance documents coming out, and those have given
6 industry the opportunity to comment. We believe more
7 are needed. The device industry, however, has not been
8 given great opportunity for meaningful participation in
9 the guidance development process, and again, using CDRH
10 as an example, CDRH has been working together with
11 industry to provide guidance documents, and industry has
12 provided the straw man documents for the industry to
13 review, modify and adapt, and take forward to comment.
14 We believe CBER could benefit with that kind of
15 documentation.

16 We believe that CBER should make even more
17 use of scientific workshops to gain a broader
18 perspective on issues. We have heard a lot about
19 advisory committees, and we believe the current advisory
20 committee is often looked at as a rubber stamp for CBER
21 activities. Workshops, on the other hand, are much more
22 open. They provide a mechanism for dialogue and sharing
23 of ideas.

24 An example that is effective, and we know
25 another is on the way, is a workshop that addresses

1 implementation of nucleic acid testing for HIV-1, and
2 another is planned for hepatitis and other viral
3 markers. We understand, however, that doing these
4 workshops is very labor- or resource-intensive. So we
5 suggest that CBER might be able to work with industry or
6 trade associations to help sponsor these workshops.

7 One example that worked very well in CDRH is
8 something called vendor day. We suggest it being
9 expanded to include CBER. We believe it could include
10 better understanding of technology, in the technology
11 that they're really reviewing applications for.

12 Outreach efforts, we think the outreach
13 programs for the blood community are important, and they
14 need to be continued. And we think the Web site and
15 professional organization provide another avenue for
16 dissemination. As far as information on new products,
17 from our standpoint, we think posting approvals and
18 information on the CBER Web site or in the "Federal
19 Register" is adequate for our needs.

20 And in closing, HIMA would like to thank FDA
21 for this opportunity to provide input. And again, we
22 will submit written comments to the docket, and we look
23 forward to working with you in improving the process.

24 MR. ELEGOLD: I have to apologize. Linda
25 had to leave. Her plane doesn't have much flexibility,

1 and getting from here to D.C. is not the easiest job as
2 it used to be. It used to be there were a fair number
3 of nonstop direct flights. So she was pretty much
4 locked into having to leave. She will review the
5 transcript in total, but also, specifically to the
6 portion that she missed.

7 Are there any other people who wish to speak?

8 MS. BINKO: Hello. I'm Bridget Binko from
9 Cell Genesys. We are a small biotech company located
10 here in the Bay Area involved in cellular and gene
11 therapies. And I have two comments I'll try to be brief
12 on.

13 The first one relates to challenges that I've
14 encountered over the years involved in intra-CBER
15 discussions where, for example, a particular product
16 falls clearly within one specific type of area, like a
17 gene therapy, but for example, in its manufacturing
18 process, involved review by other groups because, for
19 example, monoclonal antibodies or cytokines may be used.

20 And in my experience, there have been
21 breakdowns within those communications, and a serious
22 problem in getting something to spin out of CBER, to get
23 a final resolution, to get the groups internally talking
24 together. And for example, if an IND has been put on
25 hold, it can drag on waiting for the two review centers

1 to get on the same page about what are the issues, and
2 getting them resolved. And I think there has possibly
3 been some improvement in that.

4 But I think my suggestion there is that the
5 lead center -- or I'm sorry -- the lead division really
6 needs to be an advocate for the application that comes
7 to them, and they need to push the process through.
8 They need to get the consulting divisions to respond, to
9 respond in a clear way that can be understood, and to
10 make the thing move, instead of letting it get stuck in
11 what seems to us like quicksand. So my recommendation
12 there is to have the lead reviewing division really be
13 an advocate for an application that comes to them.

14 And then changing to cover another topic, and
15 that topic would be what I would call efficiency and
16 value-added. And there have been some comments from
17 previous speakers regarding that. But what I would like
18 to say here is that I think all of the organizations
19 that have been represented here today could do more if
20 they had more money. But the reality is, we all have
21 what we have, and that includes FDA.

22 And so while I think some changes have been
23 made recently that are helpful, for example, the changes
24 in supplements to -- for manufacturing changes for
25 marketed drugs, for example, or biologics, I think I

1 would encourage that you continue to look internally at
2 your processes, and ask yourselves what are the value-
3 added elements to the things that you do.

4 One area that I would bring up as an example
5 is, for biological INDs, we need to submit the lot
6 release results or protocol for every lot that's made.
7 Now, in the last ten years I've worked for two companies
8 where we have done autologous therapies, meaning we make
9 a lot for every patient that's being treated. So in
10 those years, I've submitted a lot of lot release
11 protocols. I can tell you I have not received a comment
12 on any single one. Why would there be a question to
13 begin with?

14 So my question is, if you're reviewing those,
15 why? And if you're not reviewing them, why are you
16 making us submit them? So that's just one example of
17 what I would encourage you to continue to look at
18 internally in your processes, just as we do within our
19 organization, about what is the value-added aspect of
20 the thing I'm doing today? And if it's not valuable,
21 then stop doing it. If it requires the regulations be
22 changed, then I know it takes a long time, but get it
23 started. There's no time like today to start doing
24 things like that.

25 So thanks for the opportunity to comment.

1 MR. ELENGOLD: Thank you. Jay, do you have
2 any questions or comments?

3 DR. SIEGEL: No. Those are very helpful. I
4 guess I would comment briefly that under the, under
5 PDUFA II, we are increasingly obligated to meet a 30-day
6 deadline in responding in complete responses to items on
7 hold, all the groups you mentioned monoclonal
8 antibodies, cytokine, gene therapy are in my office.
9 And so I'll certainly look into your suggestions, and
10 where there might be problems in coordinating, we're
11 working hard to make sure we have the processes to meet
12 that deadline.

13 MR. ELENGOLD: I'll repeat what I said to
14 Dr. Holland, that if you believe there is a problem, we
15 can't help unless somebody brings it to our attention.
16 And there are people and processes to address these
17 kinds of things. And there's really nothing worse in
18 the world, and I suffer this when I deal with companies
19 once in a while as a consumer, to not be able to get an
20 answer from someone when you know there is a simple one.

21 And so I urge you, you know, to please -- we
22 have informal processes, we have a formal ombudsman
23 process, both in CBER and in the FDA. And if there
24 appears to be something that doesn't make sense, please
25 question it, because it probably won't make sense to

1 management either, or there is a good reason for it, and
2 we'll be happy to explain it.

3 So anyone else? No one else. Okay. I'll
4 make some final remarks. Do you have anything you want
5 to say, Jay?

6 I'll repeat what I said a few minutes ago,
7 that if you came in late, and there was nobody at the
8 registration table, please, on the way out, stop and
9 sign the sign-in sheet, so we know you were here, and we
10 can have the record reflect that.

11 If you spoke from the audience, please check
12 in both with the stenographer and Ms. Groover in the
13 back. Let them know your name and title, so the record
14 will reflect that correctly.

15 I remind you of the additional meetings.
16 There is the health professionals meeting September 8th
17 in Bethesda. There is the overall meeting September
18 14th in Bethesda. We are having the grass-roots meeting
19 in Irvine next month, and anything relating to
20 stakeholder interest from that will also be incorporated
21 into the record.

22 The dockets will remain open, both the
23 overall FDA docket, and the specific CBER docket, so you
24 are free to submit to that. The process, as I said in
25 my opening remarks, didn't start here, and it's not

1 going to end here. You know we have a lot of workshops
2 planned. We have one the 2nd on the BLA process. As
3 some other speakers said, there are specific ones in the
4 blood area coming up that, as Team Biologics roll out
5 individual workshops, we had one for the IVD industry a
6 few weeks ago, we will be planning one for the
7 allergenic manufacturers, and then the biotech-derived
8 product manufacturers, and finally the vaccine
9 manufacturers which Team Biologics is developing.
10 Please participate in those, if you see a need for them.

11 You're free to contact our Office of
12 Communications Training Manufacturers Assistance, or in
13 the Pacific Region, Mark Roh is always available to
14 discuss those. If you want to sponsor one, co-sponsor
15 one, be involved in planning one, both offices are
16 available to discuss that with you.

17 The process doesn't end here. We are happy
18 to hear from you. The phones, the mail room, the
19 electronic e-mail gateways are always open. And we
20 invite you to discuss this with us, either on a formal
21 basis or an informal basis. And we want to keep this
22 up.

23 And I want to thank everyone again for taking
24 time out at an inconvenient period of the year, during
25 vacation season. I know several people here have

1 traveled from far away, and we appreciate that.

2 Again, thanks to the Pacific Region people,
3 Mr. Baldwin, Mr. Roh, GSA folks who helped out around
4 here. To our folks, Jay, for taking time from his
5 vacation, for Linda to come here and chair the meeting
6 with us, and specifically to the speakers who, at some
7 inconvenience to themselves, came to help us form a
8 better FDA regulatory process, and thank you very much.
9 And the meeting is adjourned.

10 (Meeting adjourned at 12:12 p.m.)

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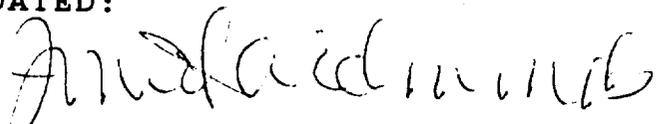
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STATE OF CALIFORNIA)
) ss.
COUNTY OF SAN FRANCISCO)

I hereby certify that the foregoing proceedings in the within-entitled cause took place at the time and place herein stated were real-time reported to the best of my ability, by me, JONIEL A. EDMONDS, a Certified Shorthand Reporter and disinterested person, and were thereafter transcribed into typewriting.

And I further certify that I am not of counsel or attorney for either or any of the parties, nor in any way interested in the outcome of the cause named in said caption.

DATED:



JONIEL A. EDMONDS, CSR No. 2075