DEPARTMENT OF HEALTH AND HUMAN SERVICES
FOOD AND DRUG ADMINISTRATION

DISTRICT ADDRESS AND PHONE NUMBER	DATE(S) OF INSPECTION
6751 Steger Drive Cincinnati, OH 45237-3097 (513)679-2700 Fax:(513)679-2772	7/11/2017-8/8/2017*
	FEI NUMBER 3011509553

NAME AND TITLE OF INDIVIDUAL TO WHOM REPORT ISSUED
Edward J. Zatta , Managing Partner

FIRM NAME	STREET ADDRESS
RXQ Compounding LLC	340 W State St Unit 9
CITY, STATE, ZIP CODE, COUNTRY Athens, OH 45701-1564	TYPE ESTABLISHMENT INSPECTED 503B Outsourcing Facility

This document lists observations made by the FDA representative(s) during the inspection of your facility. They are inspectional observations, and do not represent a final Agency determination regarding your compliance. If you have an objection regarding an observation, or have implemented, or plan to implement, corrective action in response to an observation, you may discuss the objection or action with the FDA representative(s) during the inspection or submit this information to FDA at the address above. If you have any questions, please contact FDA at the phone number and address above.

The observations noted in this Form FDA-483 are not an exhaustive listing of objectionable conditions. Under the law, your firm is responsible for conducting internal self-audits to identify and correct any and all violations of the quality system requirements.

DURING AN INSPECTION OF YOUR FIRM I OBSERVED:

OBSERVATION 1

Time limits are not established when appropriate for the completion of each production phase to assure the quality of the drug product.

Specifically,

It was observed that the (b) (4) parameters have been changed from the manufactures settings (b) (4) to the following settings: (b) (4) Your firm has failed to validate the changed parameters used on all (b) (4) (room (b) (4), room (b) (4) and room (b) (4)). In addition, it was observed that the parameters for sterilization were not always met. For example,

- Methylprednisolone Acetate 40 mg/ml injection suspension lot 04252017@1 was sterilized in (b) (4) loads using the (b) (4) in (b) (4) It was observed that (b) (4) of the (b) (4) loads only sterilized at (b) (4) with a (b) (4) ranging from (b) (4) (b) (4)

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- The (b) (4) in room (b) (4) was observed three times from 1/1/2017 – present to sterilize (wrapped) stoppers, (wrapped) goggles and (wrapped) general laboratory supplies at (b) (4) (b) (4) with (b) (4) In addition, it was observed (b) (4) sterilization cycles were ran at (b) (4) temperature with a sterilization time of (b) (4) and (b) (4) minutes.
- The (b) (4) in room (b) (4) was observed eighteen times from 1/1/2017 – present to sterilize (wrapped) stoppers and (wrapped) general laboratory supplies at (b) (4) for (b) (4) minutes with (b) (4)

The (b) (4) parameters were stated by the QA Head and not written in a procedure.

OBSERVATION 2

Testing and release of drug product for distribution do not include appropriate laboratory determination of satisfactory conformance to the identity and strength of each active ingredient prior to release.

Specifically,

Your firm released three lots of Vitamin B Complex 100 and three lots of Betamethasone Acetate 2.5 mg/ml / Betamethasone Sodium Phosphate 4 mg/ml (6.5 mg/ml) Injection Suspension based on an average of the active ingredients and not each individual specification. For example,

- Vitamin B Complex 100, lot 03302017@1 – The test results obtained from your contract testing laboratory show the potency for Pyridoxine HCl (Vit B6 HCl) to be 120% and Riboflavin to be 84.3%. This is out of specification but the product was released and distributed based on overall evaluation. No out of specification investigation was opened.

OBSERVATION 3

Procedures designed to prevent microbiological contamination of drug products purporting to be sterile are not written and followed.

Specifically,

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(a) SOP 015 – Sterile Compounding Process Qualification (Media Fills) requires all media fills operations to be documented on Log 021 and Log 29. It was observed that no media fills have been documented using this form. Also, no documentation could be provided for the following media fills: Operator (b) (6) third qualification and Operator (b) (6) 2017 (b) (4) qualification. During this inspection Operator (b) (6) was overdue for (b) (4) qualification; last qualification was done on (b) (4) In addition, the firm allows a maximum of two operators in the clean room (b) (4) at one time; however, no media fill has been conducted to represent this worst-case scenario situation.

(b) The procedure for media fills, SOP 015 – Sterile Compounding Process Qualification (Media Fills), lacks details for frequency and required challenges during media fills.

(c) Proper aseptic technique was not practiced by personnel engaged in manufacturing drug products. For example,

- On 7/11/2017, I observed the Operator lean against the wall in the ISO 8 clean room with her sterile gown while putting on her sterile boot covers.
- On 7/11/2017, I observed the operator pick up trash that had fallen to the floor in the clean room with her sterile gloves. Afterwards the operator did not change her sterile gloves. The operator was producing Glutathione 200mg/ml, lot 07112017@1.
- During the production of Hydroxocobalamin 100 mcg/ml, lot 07112017@3 on 07/11/2017, I observed the following:
  - On multiple occasions, the sterile gowned operator would go from ISO 7 clean room to the ISO 8 ante room to get empty sterile vials and return full vials to the ante room. In doing so, the sterile gowned operator crossed paths with the non-sterilely gowned operators who had entered the ante room. The sterile gowned operator never changed her gloves or gowning throughout this process.
  - On two occasions, the sterile gowned operator was observed in the ante room using her sterile glove to wipe the inside of her goggles to remove condensation. Afterwards she returned to the clean room without changing her sterile gloves.

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- On two occasions, while obtaining additional sterile vials, the operator did not remove the outer layer of foil before entering the clean room.

OBSERVATION 4

The batch production and control records are deficient in that they do not include documentation of the accomplishment of each significant step in processing.

Specifically,

The (b) (4) in room (b) (4) does not generate a printout documenting the sterilization cycle (b) (4) (b) (4) Your firm failed to maintain a use log for the (b) (4) in room (b) (4) so the use is unknown; however, it was stated that this (b) (4) serves as the backup and was the primary (b) (4) used in June and July 2017. In (b) (4) lots of product were observed without the (b) (4) printout documenting the parameters for the run. For example,

- Betamethasone Acetate 2.5 mg/ml / Betamethasone Sodium Phosphate 4 mg/ml (6.5 mg/ml) Injection Suspension, lot 01032017@4 – according to the use log for the (b) (4) in room (b) (4) the sterilization cycle for this lot failed due to (b) (4) However, there is no print out for the sterilization run or documentation of a rerun. This lot was released and distributed.
- Hyaluronic Acid Sodium 11 mg/ml injection, lot 01052017@5 – This lot is not documented on the use log for the (b) (4) in room (b) (4) or (b) (4) therefore was most likely (b) (4) using the (b) (4) in room (b) (4) There is no print out for the sterilization cycle for this lot. This lot was released and distributed.
- Betamethasone 6.5 mg/ml injection solution, lot 04132017@2 – This lot was not documented on the use log for room (b) (4) or room (b) (4) According to the QA Head both (b) (4) were not in use during this time as they were down for maintenance and that your firm was using the (b) (4) in room (b) (4) There is no print out for the sterilization cycle for this lot. This lot was released and distributed.

OBSERVATION 5

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Athens, OH 45701-1564	503B Outsourcing Facility

Aseptic processing areas are deficient regarding the system for monitoring environmental conditions.

Specifically,
(a) Active viable air monitoring is not being conducted each day that sterile production is performed.
(b) Pressure gauges monitoring the pressure differential of the processing rooms are not continuously monitored.
(c) Your firm has no rationale to support the alert and action limits for environmental monitoring surface and settling plates established.

OBSERVATION 6

There is a failure to thoroughly review any unexplained discrepancy and the failure of a batch or any of its components to meet any of its specifications whether or not the batch has been already distributed.

Specifically,

Deviations and failures are not always fully documented and investigated. For example,

- On 7/11/2017, the Operator failed to place the (b) (4) in the sterile product while producing Hydroxocobalamin 100 mcg/ml lot 07112017@3. The Operator had filled approximately (b) (4) vials out of (b) (4) vials in the lot when this was brought to her attention. This deviation was not documented.
- Hyaluronidase 175 units/ml (MDV) injection solution, lot 03242017@2 failed sterility. No out of specification investigation was opened.
- Betamethasone 6.5 mg/ml injection solution, lot 06192017@1 failed potency. No out of specification investigation was opened.

OBSERVATION 7

Written production and process control procedures are not followed in the execution of production and process control functions and documented at the time of performance.

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On 7/11/2017, it was observed that the Operators are not following the written procedures and not documenting the process control functions contemporaneously. For example,

- SOP 016 – Sterile Compounding Finished Preparation Testing requires (b) (4) (b) (4) On 7/11/2017, the operators were observed quickly moving the vials of Hydroxocobalamin 100 mcg/ml, lot 07112017@3 back and forth and not always moving the vials fully on the (b) (4)
- SOP 002 – Cleaning and Maintenance of the Clean Room and Log 005 requires (b) (4) (b) (4) On 7/11/2017, it was observed that the Operator only cleaned the Laminar Flow Hood using sterile (b) (4)
- On 7/11/2017, the batch record for Moxifloxacin 0.5% Ophth Solution Syringe, lot 07112017@2 was observed to be incomplete for visual inspection and label accountability. When I reviewed the batch record in the general laboratory the product had been already been visually inspected, labeled and moved to quarantine. In addition, at the end of the day when the batch records were being reviewed by the Pharmacist in Charge he noted that the one batch record was incomplete.

OBSERVATION 8

Aseptic processing areas are deficient regarding the system for cleaning and disinfecting the room and equipment to produce aseptic conditions.

Specifically,

The contact time for the sporicidal used in the clean room of (b) (4) is not adequate.

OBSERVATION 9

The number of qualified personnel is inadequate to supervise the manufacture, processing, packing and holding of each drug product.

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The firm's Quality Control Unit is not staffed to meet the demands of the workload. For example,

- Equipment is not properly maintained in that the pressure gauges used to monitor the pressure differential for the clean rooms have not been calibrated since installation (room (b) (4) 2015 and room (b) (4) mid 2016) and the routine maintenance has not been done on the (b) (4) as required by the operation manual and your standard operating procedure, SOP 024 Use and Maintenance of the (b) (4)
- The beyond use date (BUD) of 194 days was assigned to two lots of Hyaluronidase (04102017@2 and 04212017@4) prior to obtaining the data to support the 194 beyond use date. The 194 BUD was assigned to these lots on 4/10/2017 and 4/12/2017. The firm obtained the supporting BUD data on the following dates: 12/28/2016, 06/22/2017 and 07/11/2017.

***DATES OF INSPECTION**

7/11/2017(Tue),7/12/2017(Wed),7/13/2017(Thu),7/14/2017(Fri),7/19/2017(Wed),7/20/2017(Thu),7/21/2017(Fri),8/03/2017(Thu),8/08/2017(Tue)

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FDA U.S. FOOD & DRUG ADMINISTRATION
OFFICE OF REGULATORY AFFAIRS

Date: September 14, 2017

Edward J. Zatta
RXQ Compounding LLC
340 W State St Unit 9
Athens, OH 45701-1564

Subject: System Notification

Dear Edward J. Zatta,

We are notifying you that due to a technical error related to a software update, the FDA Form 483 you received recently inadvertently included a sentence meant only for medical device firms. That statement says, "Under the law, your firm is responsible for conducting internal self-audits to identify and correct any and all violations of the quality system requirements."

This statement refers to quality system requirements applicable only to medical device establishments, but was inadvertently included on certain Form 483's issued to non-device establishments for a brief period of time. Please note that the statement has no bearing on the inspection observations themselves, which remain applicable as of the date that you were issued the Form FDA 483.

Should you have any questions, please send to AskORAIT@fda.hhs.gov.

Sincerely,

Lisa Creason
Director, Office of Information Systems Management
Office of Regulatory Affairs
Food and Drug Administration