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Sent by e-mail

Declaratory Order: Resolution of Shortages of Semaglutide Injection Products (Ozempic and Wegovy)

Semaglutide injection products were first added to Food and Drug Administration's (FDA's) drug shortage list in March 2022 for Wegovy and August 2022 for Ozempic.[1] For the reasons below, FDA has determined that the semaglutide injection product shortage is resolved.

This order has been prepared to allow for its public disclosure. It does not include any of the confidential commercial information and/or trade secret information provided by Novo Nordisk Inc. (Novo Nordisk) that FDA analyzed for the purpose of making the shortage determination.

I. Determination

FDA has determined that the semaglutide injection product shortage is resolved. This determination is based on the analysis set forth in FDA's decision memorandum dated February 21, 2025, "Resolution of Semaglutide Injection Product Shortage and Supply Status" (Decision Memorandum") and summarized below.

FDA is required by statute to "maintain an up-to-date list of drugs that are determined by [FDA] to be in shortage in the United States,"[2] and a "shortage" is defined as "a period of time when the demand or projected demand for the drug within the United States exceeds the supply of the drug."[3] In order to ensure the list remains "up-to-date," FDA has reviewed information provided to FDA by Novo Nordisk, the manufacturer of the relevant semaglutide injection drug products. Novo Nordisk's submissions include detailed information and data regarding Novo Nordisk's production and inventory of these drug products, such as quantities supplied and demanded, and inventory held in stock, for all strengths of these drug products; projected supply and demand in

[1] https://dps.fda.gov/drugshortages/activeingredient/semaglutide-injection

[2] Section 506E(a) of the FD&C Act.

[3] Section 506C(h)(2) of the FD&C Act; 21 CFR 314.81(b)(3)(iii)(*f*).

future months; and wholesaler inventory data. FDA also considered information from multiple sources other than Novo Nordisk, including telehealth companies, pharmacy compounders, associations representing pharmacy compounders and outsourcing facilities, and individuals.

As a result of this review, we conclude that the information and data Novo Nordisk has provided to FDA demonstrate that Novo Nordisk's supply is currently meeting or exceeding demand for its semaglutide injection products, and that Novo Nordisk has developed reserves that it now holds in its finished product inventory in addition to significant units of semi-finished product, such that supply will meet or exceed projected demand. After carefully evaluating the information from sources other than Novo Nordisk, we find that it has important limitations. We conclude that this information does not undermine or outweigh the evidence demonstrating that Novo Nordisk's supply is currently meeting or exceeding demand and that, based on our best judgment, it will meet or exceed projected demand.

FDA has received reports that some patients and pharmacists are not able to obtain the approved drugs, and that a substantial amount of semaglutide compounding is occurring. The information provided by Novo Nordisk, however, demonstrates that the company is currently meeting or exceeding demand for Ozempic and Wegovy. That is not inconsistent with some, or even many, individuals having had some trouble getting prescriptions for the affected drugs filled over the course of the shortage. Some individuals may encounter challenges getting prescriptions for the affected drugs filled even though Novo Nordisk's supply is now meeting or exceeding demand nationally. In our assessment, intermittent challenges of this kind are most likely explained not by a continuing national shortage of supply, but by the practical dynamics of the part of the supply chain between Novo Nordisk and the firm's customers, including wholesale distributors and pharmacies. We recognize that significant compounding of semaglutide injection products is occurring, and that some number of patients currently receiving those products can be expected to seek Novo Nordisk's approved products when compounding is curtailed. However, the additional information provided by patients, healthcare providers, and others, including compounders, does not demonstrate that Novo Nordisk will be unable to meet projected demand, especially when weighed against the Novo Nordisk-provided data.

For all these reasons and as explained further in the Decision Memorandum, we determine that the semaglutide injection shortage is resolved. Our determination is based on our conclusions that supply meets or exceeds current demand, and that, based on our best judgment looking at the available information with its limitations, supply will meet or exceed projected demand.

FDA will continue to monitor supply and demand for these products and consider whether any semaglutide injection products should be included on the drug shortage list in the future, as appropriate.

This order also explains that FDA does not intend to take action against compounders for violations of the Federal Food, Drug, and Cosmetic Act (FD&C Act) arising from conditions that depend on semaglutide injection products' inclusion on the FDA drug shortage list (see section 506E of the FD&C Act) [section 503A(b)(1)(D) (compounded drugs that are essentially a copy of a commercially available drug product) or sections 503B(a)(2)(A) (bulk drug substances used

in compounding) and (a)(5) (compounded drugs that are essentially a copy of an FDA-approved drug product)] for the following time periods from the date of this order:

- For state-licensed pharmacists or physicians compounding under section 503A of the FD&C Act, 60 calendar days from the date of this order, until April 22, 2025; and
- For outsourcing facilities under section 503B of the FD&C Act, 90 calendar days from the date of this order, until May 22, 2025.

II. Background

FDA maintains an up-to-date list of drugs that are determined by the Agency to be in shortage in the United States.[4] FDA's drug shortage list is publicly available on the Agency's website.[5] FDA's drug shortage list includes the names and National Drug Code (NDC) numbers for such drugs; the name of each applicant for such drugs, the reason for the shortage as determined by FDA, and the estimated duration of the shortage.[6]

In this context, the term "drug shortage" or "shortage" means "a period of time when the demand or projected demand for the drug within the United States exceeds the supply of the drug."[7] As such, in determining whether a drug is in shortage for purposes of the FD&C Act, FDA evaluates the supply and demand or projected demand of the drug on a nationwide level, across the entire market, not at the local level.[8] The Agency acknowledges that even when a shortage is considered resolved, patients and prescribers may still see intermittent localized supply disruptions as products move through the supply chain from the manufacturer, to wholesalers and distributors, and to local pharmacies.

FDA receives input regarding drug shortages and potential drug shortages from numerous stakeholders, including manufacturers, patients, healthcare providers, and others, including compounders.[9] In particular, manufacturers are required to notify FDA about discontinuances and manufacturing interruptions pertaining to certain drugs pursuant to statutory and regulatory

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[4] See section 506E(a) of the FD&C Act (21 U.S.C. 356e) and 21 CFR 314.81(b)(3)(iii)(*d*)(*1*).

[5] https://dps.fda.gov/drugshortages. See section 506E(c) of the FD&C Act and 21 CFR 314.81(b)(3)(iii)(*d*)(*1*).

[6] See section 506E(b) of the FD&C Act and 21 CFR 314.81(b)(3)(iii)(*d*)(*1*). FDA cannot disclose trade secret or commercial or financial information that is considered confidential or privileged. See sections 506C(d) and 506E(c)(2) of the FD&C Act and 21 CFR 314.81(b)(3)(iii)(*d*)(*2*). Additionally, FDA may choose not to make drug shortage information publicly available if FDA determines that disclosure of such information would adversely affect the public health (such as by increasing the possibility of hoarding or other disruption of the availability of drug products to patients). See section 506E(c)(3) of the FD&C Act and 21 CFR 314.81(b)(3)(iii)(*d*)(*2*).

[7] Section 506C(h)(2) (21 U.S.C. 356c) of the FD&C Act; see 21 CFR 314.81(b)(3)(iii)(*f*).

[8] See FDA Strategic Plan for Preventing and Mitigating Drug Shortages at 9 (October 2013), available at https://www.fda.gov/media/86907/download. See also CDER's manual of policies and procedures on drug shortage management at 11, 16 (MAPP 4190.1 Rev. 4), available at https://www.fda.gov/media/72447/download.

[9] FDA's website includes information about drug shortage notifications for industry and a public portal for patients, healthcare providers, and organizations to report new shortages, available at https://www.fda.gov/drugs/drug-safety-and-availability/drug-shortages.

requirements,[10] and they may voluntarily provide additional information as relevant about quality issues, increases in demand, recalls, or other events (such as relevant supply and demand conditions).

Semaglutide is a glucagon-like peptide-1 (GLP-1) receptor agonist. Ozempic and Wegovy are the only FDA-approved semaglutide injection products.[11]

Ozempic (semaglutide) injection, for subcutaneous use is indicated as (1) an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus, (2) to reduce the risk of major adverse cardiovascular events in adults with type 2 diabetes mellitus and established cardiovascular disease, and (3) to reduce the risk of sustained estimated glomerular filtration rate (eGFR) decline, end-stage kidney disease and cardiovascular death in adults with type 2 diabetes mellitus and chronic kidney disease. Ozempic is approved as prefilled pens in several strengths (2 mg/3 mL (0.68 mg/mL; 4 doses of 0.25 mg and 2 doses of 0.5 mg, or 4 doses of 0.5 mg), 4 mg/3mL (1.34 mg/mL; 4 doses of 1 mg), 8 mg/3mL (2.68 mg/mL; 4 doses of 2 mg), and 2 mg/1.5 mL (1.34 mg/mL)).[12] Ozempic was approved by FDA in December 2017 (NDA 209637) and added to FDA's drug shortage list on August 23, 2022.

Wegovy (semaglutide) injection, for subcutaneous use is indicated in combination with a reduced calorie diet and increased physical activity (1) to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease and either obesity or overweight; and (2) to reduce excess body weight and maintain weight reduction long term in adults and pediatric patients aged 12 years and older with obesity, and adults with overweight in the presence of at least one weight-related comorbid condition. Wegovy is approved as prefilled, single-dose pen-injectors with an integrated needle in several strengths (0.25 mg/0.5 mL (0.25mg/0.5 mL), 0.5 mg/0.5 mL (0.5 mg/0.5 mL), 1 mg/0.5 mL (1 mg/0.5 mL), 1.7 mg/0.75 mL (1.7 mg/0.75 mL), and 2.4 mg/0.75 mL (2.4 mg/0.75 mL)). Wegovy was approved by FDA in June 2021 (NDA 215256) and added to FDA's drug shortage list on March 31, 2022.

FDA has provided public updates about the status of GLP-1 shortages on its website.[13] On October 2, 2024, FDA noted that semaglutide injection products were in shortage, but that Novo Nordisk had "reported all but one of the presentations are available."[14] On December 19, 2024, FDA noted that semaglutide injection products were in shortage, but that Novo Nordisk had "reported all presentations are available," and FDA was "actively monitor[ing] drug availability"

[10] Section 506C of the FD&C Act; 21 CFR 314.81(b)(3)(iii).

[11] Rybelsus (semaglutide) tablets are approved for oral use and are not currently in shortage.

[12] The 2 mg/1.5 mL (1.34 mg/mL) strength is not currently marketed by Novo Nordisk.

[13] FDA clarifies policies for compounders as national GLP-1 supply begins to stabilize, available at https://www.fda.gov/drugs/drug-safety-and-availability/fda-clarifies-policies-compounders-national-glp-1-supply-begins-stabilize

[14] Id.

and "working to determine whether the demand or projected demand for each drug in shortage exceeds the available supply."[15]

III. Procedural Considerations

This declaratory order is the product of an informal adjudication in which FDA evaluated the information available to the agency to make a determination of the relevant facts regarding the affected drug products, and applied the statutory standard for drug shortages to those facts. Under 5 U.S.C. § 554(e) (section 5(d) of the Administrative Procedure Act (APA)), an agency, "in its sound discretion, may issue a declaratory order to terminate a controversy or remove uncertainty." The APA defines "order" as "the whole or a part of a final disposition, whether affirmative, negative, injunctive, or declaratory in form, of an agency in a matter other than rulemaking but including licensing." 5 U.S.C. § 551(6). The APA defines "adjudication" as "agency process for the formulation of an order." 5 U.S.C. § 551(7). FDA's regulations, consistent with the APA, define "order" to mean "the final agency disposition, other than the issuance of a regulation, in a proceeding concerning any matter . . . ." 21 C.F.R. 10.3(a). Our regulations also define "proceeding and administrative proceeding" to mean "any undertaking to issue, amend, or revoke a regulation or order, or to take or not to take any other form of administrative action, under the laws administered by the Food and Drug Administration." 21 C.F.R. 10.3(a). Moreover, our regulations establish that the Commissioner may initiate an administrative proceeding to issue, amend, or revoke an order. 21 C.F.R. 10.25(b).

The statute does not explicitly provide the procedure FDA must use to make a determination regarding whether a drug product is in shortage, or whether such a shortage has resolved. As explained below, FDA has determined that its drug shortage authority is more compatible with adjudication than with rulemaking, and, consistent with the agency's past practice, FDA continues to implement this authority through adjudication. "The choice between rule-making or declaratory order is primarily one for the agency regardless of whether the decision may affect policy and have general prospective application." *Viacom v. FCC*, 672 F.2d 1034, 1042 (2d Cir. 1982). *See also SEC v. Chenery*, 332 U.S. 194, 203 (1947); *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969); *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 294 (1974); *United States v. Undetermined Quantities of All Articles of Finished and In-Process Foods*, 936 F.3d 1341, 1351 (11th Cir. 2019); *Almy v. Sebelius*, 679 F.3d 297, 303 (4th Cir. 2012); *City of Arlington, Tex. v. FCC*, 569 U.S. 290, 306 (2013); *Beazer East, Inc. v. EPA*, 963 F.2d 603, 609 (3d Cir. 1992); *Qwest Servs. Corp. v. FCC*, 509 F.3d 531, 536–37 (D.C. Cir. 2007) ("Most norms that emerge from a rulemaking are equally capable of emerging (legitimately) from an adjudication, and accordingly agencies have very broad discretion whether to proceed by way of adjudication or rulemaking" (internal citations and quotations omitted)). Courts "accord significant deference to an agency's characterization of its own action" when determining whether it is a rule or an order for APA purposes. *City of Arlington, Tex. v. FCC*, 668 F.3d 229, 241 (5th Cir. 2012) (aff'd *City of Arlington, Tex. v. FCC*, 569 U.S. 290 (2013)); *Am. Airlines, Inc. v. Dep't of Transp.*, 202 F.3d 788, 797–98 (5th Cir. 2000) (citing and quoting *British Caledonian Airways, Ltd. v. Civil*

[15] Id.

Aeronautics Bd., 584 F.2d 982, 992 (D.C. Cir. 1978) ("In the present case we have, moreover, the Board's own assertion that its order is purely interpretive, and this contention in itself is entitled to a significant degree of credence. . . . While declaratory orders differ in some respects from interpretive rules, the same rationale should apply equally to an agency's characterization of one of its rulings as a declaratory order.")).

Making a determination regarding drug shortage status in a declaratory order issued as a product of informal adjudication is well within FDA's discretion under the FD&C Act and the APA. Whether an affected drug product is (or is no longer) in shortage is a "concrete and narrow question[]"—in this case involving drug products manufactured by a single pharmaceutical company—"the resolution[] of which would have an immediate and determinable impact on specific factual scenarios." *City of Arlington,* 668 F.3d at 243; *see also ITServe Alliance, Inc. v. DHS,* 71 F.4th 1028, 1035 (D.C. Cir. 2023) ("adjudication involves case-specific determinations"), *Qwest Servs.*, 509 F.3d at 536–37; *Chisholm v. FCC*, 538 F.2d 349, 364–66 (D.C. Cir. 1976). FDA is issuing this declaratory order to remove uncertainty as to the status of the shortages of semaglutide injection drug products, specifically, Ozempic prefilled pens in 2 mg/3 mL (0.68 mg/mL; 4 doses of 0.25 mg and 2 doses of 0.5 mg, or 4 doses of 0.5 mg), 4 mg/3mL (1.34 mg/mL; 4 doses of 1 mg), 8 mg/3mL (2.68 mg/mL; 4 doses of 2 mg), and 2 mg/1.5 mL (1.34 mg/mL) and Wegovy prefilled pens in 0.25 mg/0.5 mL (0.25mg/0.5 mL), 0.5 mg/0.5 mL (0.5 mg/0.5 mL), 1 mg/0.5 mL (1 mg/0.5 mL), 1.7 mg/0.75 mL (1.7 mg/0.75 mL), and 2.4 mg/0.75 mL (2.4 mg/0.75 mL).

This adjudication requires FDA to make determinations about the relevant facts, using the information available to the agency, and apply the statutory standard for drug shortages to those facts. Such applications of law to facts do not create new law and accordingly do not require FDA to engage in rulemaking, even if they include some amount of interpretation. "The feature which distinguishes declaratory orders and other interpretative rulings from those legislative rules which must conform with the procedures established by the APA for rulemaking is not the extent of their effect, but rather that the order or ruling *instead of creating new law serves only to clarify and state an agency's interpretation of an existing statute or regulation*." *British Caledonian Airways v. Civil Aeronautics Board*, 584 F.2d 982, 990 (D.C. Cir. 1978) (emphasis added); *see also Trans Int'l Airlines v. Civil Aeronautics Board*, 432 F.2d 607, 612 n.9 (D.C. Cir. 1970) ("an interpretation of . . . regulations by . . . declaratory ruling . . . [is] well within the scope of the familiar power of an agency to interpret the regulations within the framework of an adjudicatory proceeding"). In addition, the temporary nature of a shortage determination is consistent with adjudication rather than rulemaking. *See Goodman v. FCC*, 182 F.3d 987, 994-5 (D.C. Cir. 1999) (upholding an order granting temporary waivers to companies who were not named parties in the proceeding, and contrasting the temporary nature of the waivers with a "general, prospective amendment" to existing rules as "a strong reason to conclude the proceeding was not a rulemaking").

The applicable statutory authorities are more consistent with adjudication than with rulemaking in part because "adjudicatory decisions are not subject to the APA's notice-and-comment requirements." *Blanca Tel. Co. v. FCC*, 743 F.3d 860 (D.C. Cir. 2014)). In rulemaking, however,

the APA typically requires agencies to "give interested persons an opportunity to participate . . . through submission of written data, views, or arguments." 5 U.S.C. § 553(c). Notice to interested parties of their opportunity to do so requires the agency to "reveal[] for public evaluation" the "'technical studies and data' upon which the agency relies." *Chamber of Commerce v. SEC*, 443 F.3d 890, 899 (D.C. Cir. 2006) (quoting *Solite Corp. v. EPA*, 952 F.2d 473, 484 (D.C. Cir. 1991)). Under the APA, therefore, "[a]n agency commits serious procedural error when it fails to reveal portions of the technical basis for a proposed rule in time to allow for meaningful commentary." *Solite Corp.*, 952 F.2d at 484 (quoting *Connecticut Light and Power Co. v. NRC*, 673 F.2d 525, 530–31 (D.C. Cir. 1982)). Put another way, rulemaking generally requires an agency to "afford interested parties an opportunity to challenge the underlying factual data relied on by the agency." *Chemical Mfrs. Ass'n v. EPA*, 870 F.2d 177, 200 (5th Cir. 1989) (citing *Air Products & Chemicals, Inc. v. FERC*, 650 F.2d 687, 700 n.17 (5th Cir. 1981)).

These notice-and-comment requirements are impossible to reconcile with the statutory provisions governing a drug shortage determination. To begin, take the statutory section titled "Public Availability," 21 U.S.C. § 356e(c). First, section 356e(c)(3) explicitly provides FDA with discretion not to make *the very existence of a shortage* public. It states that FDA "may choose not to make information collected under this section [356e] publicly available . . . if [FDA] determines that disclosure of such information would adversely affect the public health (such as by increasing the possibility of hoarding or other disruption of the availability of drug products to patients)." The existence of a shortage itself, as well as factual information supporting the determination of its existence, is "information collected" under section 356e, and the fact of a shortage's existence (rather than any particular factual detail supporting the determination of a shortage) is the most obvious type of information that would be likely to cause hoarding when publicly announced. Knowledge that a shortage exists may foreseeably incentivize people to, for example, hoard product for their own or others' use (thereby avoiding disruption for some patients, but at the possible expense of other patients), or for financial gain (such as by selling the product at increased prices due to scarcity). The statutory provision giving FDA discretion to choose whether to make a shortage public based on these types of concerns is impossible to reconcile with a requirement that FDA conduct notice-and-comment rulemaking. In such a circumstance there could be no notice, no comment, and no public announcement of the decision itself. By contrast, FDA could act consistently with the provision through an adjudication process in which the agency made the necessary information available only to affected entities in the product's supply chain.

Second, a large amount of the information that FDA analyzes to determine the status of a drug shortage is the drug manufacturer's trade secret and/or confidential commercial information which FDA may not publicly disclose under applicable laws and regulations. This includes detailed information about current and future production, inventory, sales, and distribution. Such information is, in most cases, closely held by the submitting company, which considers the information privileged and confidential business information. Such information is exempt from the public disclosure provisions of the Freedom of Information Act (FOIA) by exemption 4, *see* 5 U.S.C. § 552(b)(4), and may not be disclosed by FDA because of protections in the Trade Secrets Act, see 18 U.S.C. § 1905, and FDA's regulations. *See*, *e.g.*, 21 C.F.R. 20.111(d)(3)

(identifying "production, sales, distribution, and similar data and information" submitted voluntarily to FDA as "not available for public disclosure" subject to certain exceptions); 10.20(j)(2)(i)(d) (similar); and 20.61 (further detailing FDA's treatment of such information). In some cases, most, or even all, of the factual materials that FDA considers, and which therefore make up the administrative record, will be subject to disclosure-law protections. The statute's "public availability" section recognizes this reality and underscores that the requirement to publish the drug shortage list does not alter or amend the disclosure restrictions in 18 U.S.C. § 1905 or 5 U.S.C. § 552(b)(4); *see also* 21 U.S.C. § 356e(c)(2); *Food Marketing Institute v. Argus Leader Media*, 588 U.S. 427, 440 (discussing sales data, and concluding that "where commercial or financial information is both customarily and actually treated as private by its owner and provided to the government under an assurance of privacy, the information is 'confidential' within the meaning of [5 U.S.C. § 552(b)(4)]"). Because, absent the drug manufacturer's consent, FDA typically cannot proactively publish confidential information about a drug's current and future production, inventory, sales, and distribution, notice and comment rulemaking is incompatible with drug shortage decisions.

Third, section 356e(c)(1)'s directive only that the agency "shall make the information in such list publicly available" (subject to the significant exceptions discussed immediately above) is more consistent with adjudication than rulemaking. The statute does not provide that the agency must use rulemaking, or that it must publish its determination in the Federal Register. The APA requires agencies to "make available for public inspection and copying" any "final opinions, . . . as well as orders, made in the adjudication of cases," 5 U.S.C. § 552(a)(2)(A), and if an order contains "statements of general policy or interpretations of general applicability," the agency may need to publish the order in the Federal Register, 5 U.S.C. § 552(a)(1)(D). But the Federal Register publication requirement does not apply to "interpretations of general applicability [made] in the course of issuing adjudicatory opinions" in light of section 552(a)(2), which requires only "public inspection and copying" of orders. *See*, *e.g.*, *Cheshire Hosp. v. New Hampshire-Vermont Hospitalization Serv.*, 689 F.2d 1112, 1123 (1st Cir. 1982) ("Courts which have been forced to harmonize these two provisions [§ 552(a)(1)(D) and § 552(a)(2)(D)] have held that an agency may formulate interpretations of general applicability in the course of issuing adjudicatory opinions without publishing such opinions in the Federal Register. The agency need only make such opinions available to the public as provided for by 5 U.S.C. § 552(a)(2)(A).") (internal citations omitted).

Beyond the "public availability" statutory section, the requirement in 21 U.S.C. § 356e(a) that the Secretary maintain an "up-to-date" drug shortage list also, at a minimum, strongly suggests that the authority is more consistent with adjudication than with rulemaking. Even if notice and comment rulemaking were done expeditiously, that procedure plus a 30-day delayed effective date, *see* 5 U.S.C. § 553(b–d), would not result in a drug shortage list that could fairly be characterized as "up-to-date," thereby potentially preventing the agency from fulfilling its statutory mandate. While the APA contains a "good cause" exception to the notice-and-comment and 30-day delayed effective date requirements, 5 U.S.C. § 553(b)(B), (d)(3), the exception's requirements have been stringently interpreted, which could introduce uncertainty about whether a court will agree with the agency that good cause exists in a particular circumstance. *See, e.g.,*

State of N. J., Dep't of Env't Prot. v. U.S. Env't Prot. Agency, 626 F.2d 1038, 1045 (D.C. Cir. 1980) ("exceptions to the notice-and-comment provisions of section 553 will be narrowly construed and only reluctantly countenanced"). And even assuming that drug shortage decisions would routinely qualify for the good cause exception, the most straightforward interpretation is that Congress did not intend such decisions to be subject to notice-and-comment requirements at all, rather than that Congress intended such decisions to be subject to, but routinely exempt from, those requirements.

For all these reasons, FDA considers the drug shortage list authority in 21 U.S.C. § 356e to be much more compatible with adjudication than rulemaking, and consistent with its approach to date, the agency continues to choose to implement this authority through adjudication.

Finally, FDA notes that this order is a product of an informal adjudication that included notice to affected parties via publication of the shortage determination on FDA's website, and an opportunity for affected parties to be heard by submitting information to the Agency for consideration. On October 2, 2024, FDA noted on its website that semaglutide injection products were in shortage, but that Novo Nordisk had "reported all but one of the presentations are available."[16] On December 19, 2024, FDA noted that semaglutide injection products were in shortage, but that Novo Nordisk had "reported all presentations are available," and FDA was "actively monitor[ing] drug availability" and "working to determine whether the demand or projected demand for each drug in shortage exceeds the available supply."[17] The APA gives agencies discretion to determine the appropriate level of public participation in agency decisions. *See* 5 U.S.C. § 555(b) ("So far as the orderly conduct of public business permits, an interested person may appear before an agency. . . for the . . . determination of an issue"). Multiple interested parties, including the manufacturer of the affected drug products, individual patients, pharmacy compounders, outsourcing facilities, associations representing pharmacy compounders and outsourcing facilities, and telehealth companies, did in fact submit information to the Agency, and the agency considered those submissions in formulating this order. Such procedures are appropriate for the formulation of declaratory orders and avoid the problems that would be presented by notice-and-comment rulemaking, as described above. *See*, *e.g.*, *National Labor Relations Board v. Bell Aerospace*, 416 U.S. 267, 295 (1975) (no procedural error where the parties "most immediately affected" by the order were "accorded a full opportunity to be heard").

IV. Status of Compounding Following this Decision

To avoid unnecessary disruption to patient treatment and to help facilitate an orderly transition, FDA does not intend to take action against a compounder that is not registered as an outsourcing facility for compounding, distributing, or dispensing semaglutide injection products that are

[16] FDA clarifies policies for compounders as national GLP-1 supply begins to stabilize, available at https://www.fda.gov/drugs/drug-safety-and-availability/fda-clarifies-policies-compounders-national-glp-1-supply-begins-stabilize

[17] Id.

essentially a copy of a commercially available drug product[18] within 60 days of this decision. In addition, FDA does not intend to take action against an outsourcing facility for use of the bulk drug substance semaglutide to compound, distribute, or dispense a drug product that appeared on FDA's drug shortage list,[19] or for compounding, distributing, or dispensing semaglutide injection products that are essentially a copy of an FDA-approved drug product,[20] within 90 days of this decision. This order does not prevent FDA from taking action for violations of any other statutory or regulatory requirements, such as to address findings that a product may be of substandard quality or otherwise unsafe.

The enforcement discretion described here is based on the following considerations.

First, as explained in FDA's guidance documents, "Compounded Drug Products That Are Essentially Copies of a Commercially Available Drug Product Under Section 503A of the Federal Food, Drug, and Cosmetic Act" and "Compounded Drug Products That Are Essentially Copies of Approved Drug Products Under Section 503B of the Federal Food, Drug, and Cosmetic Act," the FD&C Act generally limits the compounding of drugs that are essentially copies of commercially available and approved drugs, respectively.

Although compounded drug products can provide treatment options for patients during a drug shortage, compounded drugs have not undergone FDA premarket review for safety, effectiveness, and quality, and lack a premarket inspection and finding of manufacturing quality that is part of the drug approval process. Further, drug products that meet the conditions under section 503A are not subject to current good manufacturing practice (CGMP) requirements and are subject to less robust production standards that provide less assurance of quality. Accordingly, the statute includes restrictions on compounding drugs that are essentially copies of commercially available drugs[21] and approved drug products that are not on FDA's drug shortage list. These restrictions help reduce the risk that compounders will prepare these unapproved drug products for patients whose medical needs could be met by an approved product. This helps to protect patients from unnecessary exposure to drugs that have not been shown to be safe and effective, and that offer fewer assurances of manufacturing quality.

The copies restrictions also protect the integrity of the new drug and abbreviated new drug application (ANDA) approval processes by, for example, incentivizing sponsors to invest in and seek approval of innovative, life-saving medications—by limiting the ability of compounders, after a drug is approved, to compound "substitutes" that may be less expensive because they have not had to demonstrate safety and effectiveness or be labeled with adequate directions for

[18] See section 503A(b)(1)(D) of the FD&C Act.

[19] See section 503B(a)(2)(A) of the FD&C Act.

[20] See section 503B(a)(5) of the FD&C Act.

[21] For purposes of section 503A, FDA does not consider a drug on FDA's drug shortage list to be "commercially available."

use, and, for drugs compounded under section 503A, are not produced in accordance with CGMP requirements.[22]

For the above reasons, an indefinite or overly long period of enforcement discretion for continued compounding of drugs that may be essentially copies of an approved drug that is no longer in shortage would not be appropriate.

FDA has also considered public health concerns and reliance interests (as discussed further below), and the enforcement discretion described here takes those concerns into account. FDA considers that the 60/90-day period described here will allow patients a reasonable amount of time to transfer their prescriptions, as needed, to different pharmacies to obtain the FDA-approved drug. Patients who used compounded semaglutide injection products during the shortage may otherwise face gaps in their ability to access treatment.[23] The additional time will allow local pharmacies to adjust their stocking and ordering patterns to adjust to new patterns of patient demand, which should help to minimize local disruptions.[24]

FDA also recognizes that compounded versions of drugs on FDA's drug shortage list can provide an important treatment option to patients during the shortage, and that compounders who prepare such drugs may be holding finished, compounded products, or inputs to compounded drugs, when a shortage resolves and the approved drug is taken off FDA's drug shortage list. For example, the compounder may have compounded drugs that are essentially copies of the approved drug and be waiting for the results of sterility tests before releasing them. FDA is required by statute to maintain an "up-to-date list" of drugs in shortage,[25] and does not give advance notice of its decisions to move drugs on and off the list. In recognition of this fact,

[22] Less directly relevant in this case, involving copies of sterile injectable products, the copies restrictions also help protect FDA's drug monograph process by limiting the ability of compounders to produce drugs without having to comply with monograph standards or CGMP requirements that apply to such products.

[23] See Nov. 15, 2024 email from Andrew Grossman, Baker & Hostetler LLP, to Valerie Jensen and Gail Bormel, "Semaglutide Shortage," with attachment. See also Oct. 3, 2024 letter from Scott Brunner, APC, to OCQC (docket no. FDA-2015-N-0030, document ID FDA-2015-N-0030-8519), stating that a 60-day transition period "would allow for a smoother transition, giving pharmacies time to contact prescribers for updated prescriptions and to navigate insurance prior authorization processes" and "would prevent abrupt discontinuations in patient care that will undoubtedly result from the sudden unavailability of compounded copies"; and October 7, 2024, letter from Scott Brunner, APC, and Ronna Hauser, SVP, Policy and Pharmacy Affairs, National Community Pharmacists Association, to FDA, DSS, and OCQC (docket no. FDA-2015-N-0030, document ID FDA-2015-N-0030-8520), stating that during a 60-day transition period, "prescriptions can be authorized for the FDA-approved products, coverage determinations made by insurance companies, and the FDA-approved products can be obtained by pharmacies to fill the prescriptions."

[24] FDA recognizes that local and regional conditions can make it difficult for patients to get a drug through their local pharmacies, even if that drug is not in a nationwide shortage. FDA's authorities relating to drug shortages are limited to shortages that exist "in the United States," that is, at the national level. Section 506E(a) of the FD&C Act. Thus, FDA does not treat local or regional supply disruptions the same way as the Agency treats national shortages.

[25] Section 506E(a) of the FD&C Act.

FDA's guidance for outsourcing facilities has previously described a brief period of enforcement discretion at the end of a drug shortage to account for such materials to be sold off.[26]

The above considerations are particularly relevant to the semaglutide injection products shortage. We note that the shortage was ongoing for some time,[27] and compounders and other stakeholders report that a significant amount of compounding has been occurring. Additionally, litigation regarding another FDA shortage decision (*Outsourcing Facilities Ass'n, et al. v. FDA, et al.*, No. 4:24-cv-00953 (N. D. Tex., filed Oct. 7, 2024)) may have caused some uncertainty about whether or when compounded versions of the FDA-approved product would leave the market. A period of enforcement discretion should help facilitate an orderly transition, as the adjustments described above take place. Although the 60/90-day period described here is longer than the period previously described in FDA's guidance documents, we conclude that it is justified in light of the considerations described here, including the information FDA has reviewed in connection with the semaglutide injection products shortage. That this period is relatively brief also mitigates concerns about potential effects on patients, the integrity of the drug approval process, and any reliance interests of the approved drug manufacturer. While the approved drug manufacturer may have an interest in FDA providing only the more limited enforcement discretion stated in the Agency's existing guidances, FDA has considered any such reliance interest and concludes that it is outweighed by the reasons discussed here that otherwise support this brief additional period of enforcement discretion.

The amount of time FDA intends to exercise enforcement discretion is longer for outsourcing facilities (90 days) than for those compounding under 503A (60 days). Drugs compounded in outsourcing facilities under section 503B are subject to more assurances of quality than drugs compounded under section 503A because, in contrast to compounders under section 503A, outsourcing facilities are subject to CGMP requirements, FDA inspections on a risk-based schedule, specific adverse event reporting requirements, and certain other conditions. Additionally, FDA understands that outsourcing facilities need to invest relatively more resources and time before they can produce product during a shortage in order to comply with CGMP requirements.

[26] FDA guidance documents for outsourcing facilities addressing compounded drugs that are essentially copies of approved drugs and bulk drug substances used in compounding provide a period of enforcement discretion of 60 days for certain orders received during a drug shortage. See Guidance for Industry: Compounded Drug Products That Are Essentially Copies of Approved Drug Products Under Section 503B of the Federal Food, Drug, and Cosmetic Act (Jan. 2018), at 8; Guidance for Industry: Interim Policy on Compounding Using Bulk Drug Substances Under Section 503B of the Federal Food, Drug, and Cosmetic Act (Jan. 2017), at 7. FDA's guidance document for section 503A compounders, Compounded Drug Products That Are Essentially Copies of a Commercially Available Drug Product Under Section 503A of the Federal Food, Drug, and Cosmetic Act (January 2018) does not address an enforcement policy at the end of a drug shortage. CDER is currently re-evaluating these policies pertaining to a period of enforcement discretion at the end of a shortage.

[27] Since March 2022 for Wegovy and August 2022 for Ozempic.

V. Conclusion

FDA has determined that the shortage of semaglutide injection products, which first began in March 2022 for Wegovy and August 2022 for Ozempic, is resolved. FDA continues to monitor supply and demand for these products.

Sincerely,

Jacqueline A. Corrigan-curay -S

Digitally signed by Jacqueline A. Corrigan-curay -S
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