

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
FOOD AND DRUG ADMINISTRATION**

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| DISTRICT ADDRESS AND PHONE NUMBER 19701 Fairchild Irvine, CA 92612 (949) 608-2900 Fax: (949) 608-4417 Industry Information: www.fda.gov/oc/industry | DATE(S) OF INSPECTION 02/01/2016 - 02/05/2016 |
| | FEI NUMBER 3006616657 |

NAME AND TITLE OF INDIVIDUAL TO WHOM REPORT ISSUED
TO: Michael A. Koch, Vice President Marketing and Professional Services

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| FIRM NAME Central Admixture Pharmacy Services, Inc. | STREET ADDRESS 16800 Aston Street, Suite 150 |
| CITY, STATE, ZIP CODE, COUNTRY Irvine, CA 92606 | TYPE ESTABLISHMENT INSPECTED Corporate Headquarters |

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.

DURING AN INSPECTION OF YOUR FIRM WE OBSERVED:

OBSERVATION 1

The responsibilities and procedures applicable to the quality control unit are not fully followed.

Specifically,
 During an interview with the Director of Quality Assurance, he stated that he has ultimate authority regarding quality issues at all 24 CAPS sites. The CAPS Operating Procedure, COP-CAPS-4000004, dated 06-03-2014 and entitled: Quality - Upper Management Notification, describes the types of deviations that must be reported to upper management including the Director of Quality Assurance. However, this procedure is insufficient in that it does not fully describe all of the roles and responsibilities of the Quality Control Unit at corporate headquarters over all of the 24 CAPS sites.

OBSERVATION 2

Investigations of an unexplained discrepancy did not extend to other batches of the same drug product.

Specifically,
 In Complaint Investigation 37-150123-015, notification was provided that indicated a cardioplegia drug was not working (did not stop the heart when administered during surgery). The firm's investigation revealed that IV Technician (b) (4), (b) (6) was involved in producing the drugs in all lots in the complaint supplied by the hospital. The Cardioplegia Induction (b) (4) was from lots #37-80463-0-5, #37-80463-0-6, and #37-79031-0-20 made on 1/13/15, 1/13/15, and 1/8/15 respectively. The conclusion was classified as "investigation no issue". Yet, the investigation did not extend into any other batches that may have been produced by the same person or evaluate the quality of the components used. None of the remaining bags from the lot were returned, therefore, further testing could not be completed.

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|---------------------------------|---|---------------------------|
| SEE REVERSE OF THIS PAGE | EMPLOYEE(S) SIGNATURE Stacie A. Woods, Investigator <i>Stacie Woods</i> Djamila Harouaka, Investigator <i>D Harouaka</i> Lance A. Finnical, Investigator <i>L Finnical</i> | DATE ISSUED 02/05/2016 |
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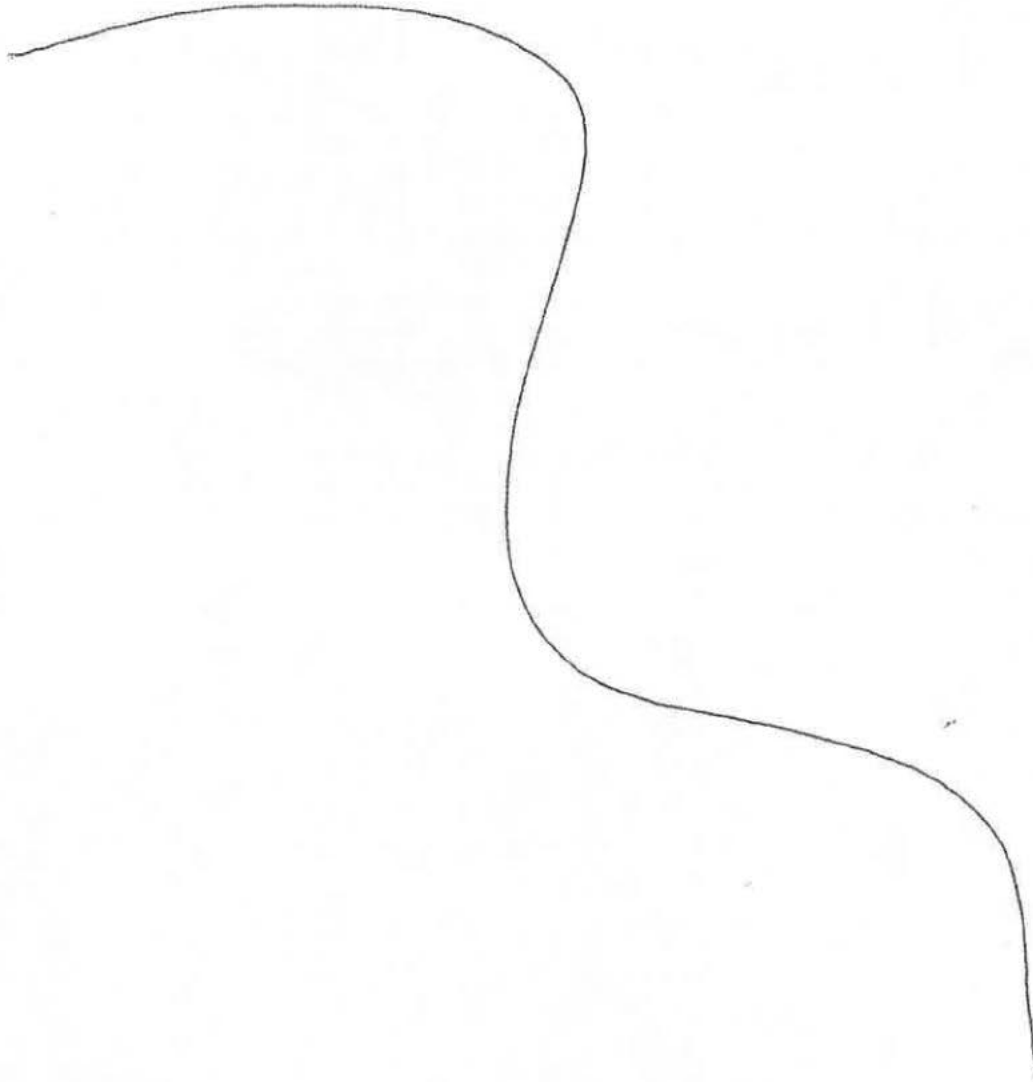
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