FOOD AND DRUG ADMINISTRATION

Public Meeting

Over-The-Counter Monograph User Fees

Friday, June 10, 2016

9:00 a.m. to 1:52 p.m.

FDA White Oak Campus

10903 New Hampshire Avenue

Building 31 Conference Center

The Great Room (Rm. 1503A)

Silver Spring, Maryland

Meeting Roster

Cynthia Bens

Alliance for Aging Research

David Bromberg

American Academy of Pediatrics

Sally Greenburg

National Consumers League

Randy Juhl

University of Pittsburgh School of Pharmacy

Barbara Kochanowski

Consumer Healthcare Products Association

Stacie Maass

American Pharmacists Association

Karen Mahoney

Food and Drug Administration

Donal Parks

Food and Drug Administration

Mark Pollack

Personal Care Products Council

Chris Shreeve

Food and Drug Administration

Cornell Stamoran

Pharma and Bio-Pharma Outsourcing Association

Michael Wolf

Scientific Community Perspectives

Janet Woodcock

Food and Drug Administration

Priscilla Zawislak

International Pharmaceutical Excipients Council of the Americas

Diana Zuckerman

National Center for Health Research

C O N T E N T S

C O N T E N T S (continued)

P R O C E E D I N G S

(9:00 a.m.)

Welcome

MS. SHREEVE: Good morning. We're going to get started. I'd like to welcome you all to the FDA's first public meeting to gather input on the OTC monograph process and the impact of a user-fee program.

I'm Chris Shreeve. I'm CDER's director of the Office of Communications, and I'll be the moderator for today's meeting. Thank you for coming today and thank you for those of us who are joining us by WebEx.

We look forward to hearing from our public stakeholders today. But I'd especially like to thank the speakers and organizations you're going to hear from who will be participating today as panelists.

Before we get started, a couple of housekeeping details. Remember to put your cell phones on vibrate, please, and if you're going to take a call, please step outside because we can

hear you in here.

There's a café -- you probably saw it -- just outside here at the hall. We'll have a short break in the morning and a lunch break as well. And you can get all your refreshments there. If you leave this area, you'll have to enter through security again. And finally, the restrooms are located in the hallway behind the little café out there on the right.

So quickly, to review today's agenda, we'll kick off shortly with three brief FDA presentations, first to welcome CDER director Dr. Janet Woodcock; followed by an overview of the state of the OTC monograph review process from Dr. Karen Mahoney. She is CDER deputy director of the Non-Prescription Drugs Division. And then we'll have a look at user-fee programs by Donal Parks. He is CDER director of the Division of User Fee Management and Budget Formulation.

After Donal's presentation, we'll begin to hear from our public stakeholders. We invited a wide variety of stakeholders to comment today.

Some will be speaking on panels here. Others have chosen to place their comments in the public docket.

Our four panels today are drawn from consumer, industry, healthcare professional, and the scientific communities. After each panel, we'll open up the microphone there in the center for questions from the audience. Feel free to come forward if you have a question and step up and we'll take the questions in order.

At the conclusion of the panel presentations, the fourth one and the Q&A from the audience, we'll open up the microphone for public comments from the audience.

If you'd like to speak during that period and you haven't already signed up outside of the desk, we'd ask you to please sign up and be sure when you come up to the mic to give us your name and affiliation before you ask a question of the panelists. You can follow today's session, which will be tweeted live, hashtag #OMUF.

Now, I'd like to introduce CDER director,

Dr. Janet Woodcock, to welcome you and kick off the day's meeting.

Opening Remarks – Janet Woodcock

DR. WOODCOCK: Thank you, Chris, and good morning, everyone. Thank you for being here bright and early to talk about this really important topic.

As you heard from Chris, in a few minutes, you'll hear overviews of the OTC monograph system that we have right now in place and how user fees are used in other parts of CDER's programs and across the agency.

OTC drugs are regulated in two ways. The drugs that you see on the drug store shelf get there through two different pathways. One is the new drug application system, and that's for new entrants into the OTC market. And they have a new drug application just like prescription drugs do.

But many of the older drugs use a system called the monograph system, which was instituted really many, many decades ago, and we've been trying to implement it since.

The system was a good idea when it was instituted because it was a response to the efficacy requirements that were put in place in the '60s, and yet we had millions -- we had a large number; Karen will tell you how many -- of OTC drugs on the market, all of which had unknown effectiveness. So we had to deal with that somehow.

But this old rulemaking that was good in its time and allowed marketing of safe and effective drugs over the counter over the decades has really become administratively very burdensome. And because of changes to the laws and the procedures on how regulations have to be done, getting regulations out has been slow across the federal government, not just at FDA. And that was really response to the massive amount of regulations that different parts of the federal government pumped out, so many people thought a brake should be put on that.

Unfortunately, these regulations were different. These regulations actually enabled

drugs to get on the market. They were like an approval of sorts, as you'll hear. So this has set up a problem. We even find inside the federal government, people don't understand this and think we're trying to add to regulatory burden by passing regulations when really what we're trying to do is still basically implement the 62 Amendments for old over-the-counter drugs.

We're working to reform the system, but what we're talking about today is not that part of it. We are working on that. But even whether we keep the current system or reform it, we don't have the resources to implement a robust program.

What is most painful to me is that we can't keep up with evolving knowledge and science. So when things come to the forefront that we need to react to quickly, safety concerns, new knowledge about these products, we have to do regulations. And we really don't have the resources to turn quickly and get those out in a timely manner. Even if the system were changed to allow us to do so, we still wouldn't be able to with our resource

constraints.

So this has been a matter personally to me of great concern for at least the past 10 or 15 years, is that we do learn new things.

It's very interesting, back when we put in the monograph system and I think when many laws were passed, for example, Hatch-Waxman, we really believed drugs would get on the market, and then that's all we'd know about them. Then they remain the same forever, our understanding in them.

But now we know even Digitalis, our understanding how to use Digitalis, which has been around for hundreds of years, has changed over the past decade, and we use it differently. We should've expected that but we didn't really fully take that into account.

So right now, we have over 100,000 products marketed under the monograph system in the United States on the drug store shelves to which our population is exposed. And that's a good thing because these products enable self-care, enable people to not have to burden the healthcare system

with minor complaints that they can deal with themselves. But we only have a handful of people funded to look after these products and make sure they continue to be safe and effective.

Millions of people use these drugs every day. All of us in this room use these drugs every day, probably things like acetaminophen; antacids; cough and cold products, that's the winter; sunscreens, that's the summer hopefully; different antiseptics, washes and so forth.

So there's a chance that everyone in the audience has a monograph drug or many of them in their medicine cabinets or in their home somewhere right now.

So the impact -- and that's why I think the consumer groups are very important -- the impact of these for the consumers, it's a very high rate of exposure. Healthy people are using these, as well as patients, and it's a very profound exposure to the public.

With 100,000 marketed products, to put the current OTC monograph budget in perspective as far

as people's expenditures, Montgomery County, where we're meeting today, they spend over three times as much money a year on their libraries as the entire budget for the OTC monograph product oversight. And Donal will have more information on the exact budget.

While I think Montgomery County is very well-known for its educational system, and it's great that it has these libraries and so forth, you could see that the investment that we have available to put into the oversight of these 100,000 monograph products with millions of people exposed to them is very, very limited.

Now, people often ask, "Well, why can't you use your other money to spend on the monographs and beef up the program, Dr. Woodcock?" Well, each of the user-fee programs we have has a base attributed to it of appropriated dollars. And those dollars, according to the way the statutes are set up -- and Donal, you can correct me if I'm wrong. But basically, they have to be spent before we can expend the user-fee funds. They're called

triggers, or bases, or whatever.

So we have to spend on those programs the appropriated dollars before we can really spend the user-fee dollars at all. And we can't have user-fee dollars if we don't spend those appropriated dollars.

The reason for that was that these have to be a fee-for-service, all these user fees. It can't be a tax. They're not a tax. And that's how they're scored in Congress. So we have to keep spending the base that was spent on them, then the fee-for-service is what is paid by various industries over that for additional kinds of services that wouldn't be available from the appropriated based.

Then, of course, I have other programs that have to be run such as compounding, which there are many threats to the public health that have been going on with the compounding over the past several years. We can't let that program down. Inspections of facilities around the world, for example, for the new drug's program is paid out of

based appropriation, and so on. So there are other critical programs that must continue to be funded by the Center, and we simply don't have dollars available to beef up the OTC program as much as we would like to do that with appropriated dollars.

So there are user-fee programs for other kinds of drugs, PDUFA program, generics and biosimilars. But the monograph review, of course, is still funded by the taxpayer, by our base appropriations that come from taxpayer dollars.

Now, I think the PDUFA program has been the longest user-fee program, and I think there is general agreement -- although, of course, there's never unanimity about anything in the public. But most people would agree that PDUFA has brought benefits not only to industry but to the public and certainly to the agency, as well as allowing us to build up our scientific staff and have these scientific resources to conduct the reviews and inspections and other things that we need to do.

So we feel that's been a very beneficial program to us, and we feel the other two programs,

the biosimilars and the generic drug user-fee programs will likewise show benefits, both to the FDA and the public, as well as the industry.

So the OTC program needs stable predictable funding to support the continued assurance of the safety and effectiveness of the monograph drugs to make sure we can respond rapidly when safety issues arise, to make sure we can finish these programs and have these products on a stable footing.

I think if we would get a user-fee program, industry could benefit because FDA would have the resources to review innovations that might be put into these old products, and that could also benefit the public.

There's been a public discussion, for example, about sunscreens and couldn't we have some additional sunscreen ingredients, and that that would benefit the public, and that would benefit the industry, and so forth. Of course, that delay was driven by problems with resources that we simply couldn't to get to those addition sunscreens that were from outside the U.S. and wanted to enter

into this monograph program.

So I believe that it's possible that there would be a win-win-win for the public, for the agency, and for the industry in having a user-fee program. Of course, the FDA is certainly not averse to having additional resources for our program provided in any way possible. It's really too small to regulate this industry in a way that needs to be done.

But this is a pathway, user fees, that we've used in other settings successfully, so we are seeking input from you, from the public, about feasibility of this and what are the upsides and downsides to establish a program in this area.

Having executed user-fee programs for 20 years, we're well aware of how to manage these and some of the downsides and upsides. But we do think it can be successful and result in that triple win for the public, for the agency, for the industry, and we are seeking to see if we can also achieve that in this space.

Thank you very much, and I think the next

two presentations will really provide a lot of illumination about what we're facing right now. Thanks.

MS. SHREEVE: Thank you, Dr. Woodcock.

Next, we'll hear from Karen Mahoney. She's going to give us an overview on the over-the-counter monograph process.

Presentation – Karen Mahoney

DR. MAHONEY: Good morning. My name is Karen Mahoney, and I'm the deputy director of the Division of Non-Prescription Drug Products. I'll be giving you a brief overview of the over-the-counter drug monograph process.

After going over the purpose of this public meeting, I'll begin with a brief overview of FDA history regarding the over-the-counter drug review. This is often called the OTC monograph, and that's how I'll refer to it throughout the talk.

I'll then explain a bit about what the monograph is, and then I'll talk about some of the potential benefits of additional resources for monograph review activities.

Why are we having this public meeting? As you know, user-fee programs exist for non-monograph drug products and for devices. The Prescription Drug User Fee Act, abbreviated PDUFA, and other FDA and other user-fee programs, have provided vital resources in terms of scientific review staff and technology that have enabled FDA to evaluate the safety and efficacy of many drugs, biologics, and devices in a much more timely manner than was possible before PDUFA existed.

However, there are no user-fee resources for the OTC monograph, and funds from other user-fee programs cannot be used for monograph work. And the monograph is very large. There are over 100,000 marketed monograph drug products. This dwarfs the number of drug products in other categories.

These products are used by millions of Americans every year, and as Dr. Woodcock just pointed out, I would imagine that every one of you has at least one monograph drug product in your medicine cabinet right now.

However, despite the enormous size of this drug category, FDA has very few resources allocatable to review of these products. The responsibility for the assurance of the safety and effectiveness of this huge number of products currently falls to a very small group of scientific review staff. Therefore, FDA is seeking public input regarding a possible user-fee program as a way to provide stable, predictable funding for this critical review area.

Today, we are only considering the user-fee question. Monograph policy reform is not a topic of today's meeting. FDA is addressing policy reform as a separate process. For this meeting, FDA is in listening mode. We want to receive public input on the possibility of a monograph user-fee system.

A quick overview of FDA history and how the OTC monograph fits in there. There are many time points one could talk about in the history of the FDA, but I'll only hit a few of the highlights en route to the OTC monograph and en route to the

development of user-fee systems.

The FDA is the oldest comprehensive consumer protection agency in the U.S. federal government. Prior to the late 1800s, there was no federal protection for consumers from bad drugs. There was only a hodgepodge of state laws.

When did regulation of medicines occur? False claims of efficacy and lack of information on the purity and safety of ingredients were the norm. Consumers had no way to know what medicines were effective or even safe.

These are a couple of images from patent medicine advertising. On the left is an ad for something called Outlook Tonic. The resolution isn't great, but you could perhaps see that there's a gentleman up there who is literally on the bandwagon and literally banging the drum for his product. And the flag that's hanging off at the back of the bandwagon is hard to see but it says "Outlook Tonic, nature's remedy for all ailments."

On the right is an ad for Kickapoo Indian Prairie Plant, and that was intended for a

condition called female weakness.

Now, I learned something from this ad. I learned that the womb is held in place by cords that are attached to the spinal column. And if you get disease in the womb, you end up with all kinds of problems like dark circles under your eyes, and headaches, and often insanity. And it literally says "and often insanity."

(Laughter.)

DR. MAHONEY: This whole syndrome, again, is called female weakness. In quote, "There's but one way to cure it." And you can guess that it's Kickapoo Indian Prairie Plant.

So that was what consumers had to contend with when they were trying to get information then about the safety and efficacy of medicines. Then in 1862, President Abraham Lincoln appointed a chemist to serve in the newly formed Department of Agriculture. This was the beginning of the Bureau of Chemistry, the predecessor of the Food and Drug Administration.

Here are a few gentlemen who served in the

Bureau of Chemistry in the late 1800s. These chemists began to examine the adulteration of food products, and over the ensuing years recognized the need for federal regulation of food and drugs.

In the late 1800s and early 1900s, shocking disclosures occurred regarding insanitary conditions in meatpacking plants famously presented in Upton Sinclair's novel, The Jungle. Simultaneously, reports accumulated regarding poisonous preservatives and dyes in foods and cure-all claims for ineffective and often unsafe patent medicines.

In 1906, Congress passed The Pure Food and Drug Act, and President Theodore Roosevelt signed it into law. This law prohibited interstate commerce in adulterated and misbranded food and drugs.

The Bureau of Chemistry began to make progress in this area, and in 1930, the Food and Drug Administration was named as a separate entity. However, drug manufacturers did not have to show that their products were safe. The law just said

that products couldn't be adulterated or misbranded. The FDA recognized the need to be able to require testing of drugs for safety, but drug law did not require it at that time.

Then came the Elixir Sulfanilamide tragedy. In 1937, a pharmaceutical company made an antibacterial solution containing sulfanilamide. Sulfanilamide is hard to dissolve and has a foul taste, so they added some raspberry flavoring and dissolved it in diethylene glycol, which itself has a sweet taste. The sulfanilamide dissolved well in this, but diethylene glycol is similar to the chemical used in antifreeze.

Drug laws, at the time, did not require any testing for safety. Hundreds of shipments of the drug went out. The drug caused renal failure and seizures and resulted in over a hundred deaths, many in children.

FDA's only authority was over the misbranding in this case. The product was a solution, but the drug company was calling it an elixir. An elixir was supposed to have ethanol in

it. But this product didn't have ethanol, so it really was a solution, not an elixir. FDA was able to seize much of the product under this misbranding authority, but this tragedy and several serious safety issues with other drugs led to public pressure for safety testing of drugs.

This led to the 1938 Federal Food, Drug, and Cosmetic Act. This law mandated premarket review of the safety of all new drugs. It banned false therapeutic claims in drug labeling and no longer required the FDA to prove fraudulent intent that had previously been required, and it was a prohibitive hurdle.

The 1938 act authorized factory inspections and added enforcement authorities. This act remains the foundation of FDA regulatory authority today and has been amended over the years as science has progressed.

So how did over-the-counter drugs come into being as a separate class of drugs? In 1951, the Durham-Humphrey amendment created this class. This amendment was sponsored by two senators who are

also pharmacists. Hubert Humphrey was vice-president of the United States under President Johnson. Before that, he served two terms in the Senate representing Minnesota. He was a pharmacist and had a special interest in drug safety. And the co-sponsor of this amendment was Carl Durham, representing North Carolina, and he was also a pharmacist.

Before 1951, prescription and non-prescription drugs didn't really exist as separate classes. Doctors prescribed the most drugs. Durham-Humphrey established two drug classes: "Rx legend" or prescription drugs were those that required practitioner supervision because of, quote, "toxicity or potentiality for harmful effect of method of use." Everything else is non-prescription, commonly referred to as OTC.

Then that created the class of OTC drug products and what are the general characteristics of these drugs, First, you have to be able to label them so that the consumer can self-diagnose, self-treat, and self-manage the condition that the

drug is intended to treat.

Second, the consumer has to be able to understand how to use the drug correctly without any help from a healthcare provider. The drug needs to have a low potential for misuse and abuse. And it needs to have a wide safety margin such that the benefits of having an available OTC outweigh the risks.

So we're continuing to move along in FDA history. Now, you've heard that in 1938, FDA received the authority to require premarket evaluation of safety for drugs. However, FDA did not yet have clear authority to require a premarket evaluation of efficacy. Paradoxically, a safety tragedy, outside the U.S., led to FDA receiving the authority to require premarket evaluation of efficacy of drugs.

Thalidomide was a medication prescribed as a morning sickness treatment in the United Kingdom and other countries. The drug was widely marketed in other countries before the association between the drug and unusual limb malformations was noted.

Despite pressure on the U.S. to approve the drug, after other countries had approved it but before the congenital malformation association was known, FDA did not approve the drug. Publicity over the tragedy led to U.S. public support for stronger drug regulation.

That led to the 1962 Kefauver Harris Amendment, and along with that, the OTC monograph. With Kefauver Harris, in addition to premarket evaluation of safety, manufacturers now also have to demonstrate efficacy. This was the basis for the current new drug application system. However, this created the dilemma for what to do about OTC drug products.

At that time, there were an estimated 100,000 to 300,000 OTC drug products on the market. We couldn't just call them all misbranded and take them off the market, and we couldn't possibly review 100,000 NDAs. So in 1972, by regulation, the monograph process was established to address the safety and efficacy of all these products without requiring each to have a separate new drug

application.

So now, OTC drugs can enter the market in one of two ways. They can come in and do a new drug application or they can come on the market by conforming to a monograph. Both paths involve a scientific decision by the FDA. In the case of NDAs, FDA reviews the safety and effectiveness of a product. For the monograph, FDA reviews the safety and effectiveness of an ingredient.

How did the OTC drug review, which created the OTC monograph, work? In the 1970s, FDA convened expert advisory review panels, and they were charged with putting OTC products into one of three categories: Category 1, generally recognized as safe and effective, abbreviated as GRASE; Category 2, not GRASE; and Category 3, insufficient data available to determine if safe and effective.

Of importance, Category 3 ingredient-containing monograph products could continue to be marketed, pending finalization of their GRASE determination.

The panelists made recommendations about

what the conditions of use might be for ingredients for a given therapeutic use. Examples of conditions of use, which are sometimes called GRASE conditions, include the active ingredient; for a given therapeutic area, what ingredients might be included in OTC treatments for these symptoms; dosage strength, the dose needs to be high enough to be effective but low enough to be safe in the OTC setting.

What dosage forms? For example, tablet, capsule, suspension. What patient population? Can children use it? Is it only for one gender? What's the indication? Is it for headache, diarrhea, dandruff? What labeling is required? How often do you take it? What warnings are needed?

So the panels made their recommendations over several years, and then FDA began to write monographs based on these recommendations.

Now, what is a monograph? It's a sort of rulebook for the marketing requirements for a drug. It lists and explains those GRASE conditions of

which we just spoke. If a sponsor follows the rulebook exactly, it can market a monograph drug without coming to FDA for premarketing approval.

All monograph drug products are still subject to inspection and compliance requirements. Many of these monographs are finished but not all of them. Once final, monographs are published in the Code of Federal Regulations. Drug products that don't meet the conditions of the monograph can still apply for approval under the NDA path.

This is a slide that compares some of the characteristics of the NDA process and those of the monograph. I won't read them all, but I'll just point out a few.

First, the NDA process is product-specific, including final formulation-specific. The monograph, on the other hand, is ingredient and therapeutic category-specific. The NDA process is confidential until an approval decision is reached. The monograph, on the other hand, is public, and there is no data confidentiality.

As just described, for NDAs, an application

is submitted for approval prior to marketing. The monograph relies upon adequate data being submitted, but as long as the sponsor is conforming to the monograph, they may market the drug without premarket review.

NDA review is supported in part by user fees. And, of course, today's meeting relates to the fact that there are no user fees for monograph products. Under PDUFA, FDA commits to review timelines. For the monograph, there are currently no mandated timelines.

Here are some examples of monograph drug categories. When you go to the drug store or any place where OTC drugs are sold, the vast majority of them are going to be monograph products, not NDA products. Again, almost every one of you probably has at least one in your medicine cabinet.

How does monograph get into the Code of Federal of Regulations? Well, right now, it's a complex and lengthy process involving a three-step public notice and comment rulemaking system. This process takes many years.

When the monograph first came into being, it was not as burdensome. But over the years, the federal rulemaking system in general has become more complex and difficult. This is true throughout the federal government, not just with FDA.

For the monograph, the usual route begins with an advanced notice of proposed rulemaking, which publishes the expert panel's recommendation. That's followed by a comment period, and then publication of what's called a tentative final monograph or TFM. And that's what FDA has written based on the panel recommendations. There's then another comment period, and then a final monograph, and then finally, inclusion in the Code of the Federal Regulations.

As mentioned earlier, FDA is hoping that this system can be replaced with a more efficient system, but those reforms are not a topic of today's meeting.

So where does the OTC monograph stand today? Well, it remains one of the largest and most

complex regulatory programs ever undertaken at FDA. There are approximately 88 simultaneous rulemakings in 26 broad therapeutic categories encompassing over 100,000 OTC drug products. There are over 800 active ingredients for over 1400 different uses. This is a massive effort, and FDA needs additional resources to continue.

Beyond final GRASE determinations, the OTC monograph is a living document. Science continues to evolve, new safety issues emerge, and industry has ideas for innovations that they would like to bring forth. But considerations of those innovations would require resources that FDA simple does not have.

So you've just heard that this is a massive drug program. However, as you'll soon hear in Donal Park's presentation, the staff charged with ensuring the safety and efficacy of this enormous number of drugs is tiny. An unfortunate accompanying reality is the fact that even that small pool of resources is often entirely consumed by external mandates with no ability to

make progress on basic review responsibilities.

Recent examples of these all-consuming external mandates include special statutes such as the Sunscreen Innovation Act and a recent consent decree for antiseptic rulemaking.

Mandates for just these two individual types of products are currently consuming essentially all of FDA's monograph review resources. Even without these current external mandates and even with the desired monograph reforms, it would still take many decades to finalize the GRASE determinations for pending monographs if resources remain at current levels.

We don't have adequate resources to make it feasible to consider proposed innovations to the monograph. With current staffing, we find it extremely challenging even to address pressing safety issues. And we must be able to prioritize our work by public health importance. The monograph review program needs sufficient resources to give priority to matters of high public health importance while still meeting other mandates.

So earlier, I presented some FDA history leading up to the monograph, and I'll resume that history now. In 1992, the Prescription Drug User Fee Act was passed. This act allows FDA to collect fees from drug manufacturers. Those fees support a portion of the drug review process.

PDUFA has had an enormously positive effect. Review times were significantly shortened and the number of innovative drugs coming into the U.S. market increased. Before PDUFA, innovative drugs often became available in other countries before coming to the U.S. That turn reversed, and now innovative drugs become available in the U.S. first.

Subsequently, user-fee programs were established for generic drugs, biosimilar drugs, and medical devices. These user-fee programs are reauthorized every five years based on negotiated agreements between FDA and industry. User fees do not affect approvability of drugs and devices. All decisions are based on science.

While these user-fee programs have had great

benefits to public health, their funds cannot be used for review of OTC monograph products. The limited funds for OTC monograph reviews still come entirely from budget authority from what many people think of as ordinary taxpayers' dollars, not from the regulated industry as with other drugs.

There are numerous ways that additional monograph review resources might benefit the public health and might benefit industry. Very importantly, it will enable FDA to address safety issues in a timely manner.

This has an obvious public health benefit, but it also benefits industry from a liability standpoint. Industry often wants to have important safety information added to labeling.

Additional resources would enable timely determination on the safety and efficacy of the many thousands of drug products that are being marketed under non-final monographs. You may recall my statement earlier that Category 3 products, those without adequate evidence of safety and/or efficacy, can continue to be marketed while

their GRASE determination is pending.

Industry wants to innovate, but FDA doesn't have the resources to consider innovations. Science has progressed and new testing methods are available, but we don't have sufficient resources to evaluate these methods and determine if they could replace older methods specified in current monographs. Some of these newer methods could reduce the need for animal testing and many could simplify and speed product development.

We do not have an IT platform to support submission and review of monograph data or to archive our work. Resources for technology under PDUFA revolutionized new drug review.

The monograph progress is a public process, and we need a modern, useful, transparent Web interface to make that a reality. Again, this is a public process and additional resources would allow us to hold more public meetings on important monograph issues.

We want to be able to be responsive to monograph-related concerns from the public and from

industry. In general, added resources could help to establish additional infrastructure for the efficient continued conduct of monograph review activities in the longer term.

Coupled with process reforms, we envision that the monograph will be a living document that can expand consumers' ability to care for themselves, to reduce the overall cost of healthcare in the U.S., to increase consumer confidence in our OTC drug supply, and to improve the public health.

Thank you. And I now like to introduce Donal Parks, director of the Division of User Fee Management and Budget Formulation, who will speak more specifically on the topic of user fees.

Presentation – Donal Parks

MR. PARKS: Thank you, Karen, and good morning, everyone. That's not something I often say in these forums, because I often get stuck after lunch trying to keep people awake, so that makes it challenging for me.

One thing I do is I move around a lot, so I

apologize if I move off camera accidentally. I also try to make my presentations interactive, so what I'd like to do is start by talking a little bit about the current resourcing for the monograph program. I'll then give you a bit of an overview about what a user-fee program is and how these programs work, and then just reiterate the input we're looking for from you today.

So I'm going to give you a little bit of a pop quiz. In some situations, I would toss out candy for the right answer, but I'm not going to do that here. But I'm going to give you a couple of things, and I'd like you to think about what you think costs the most.

The wastewater treatment system for Concord, New Hampshire, a city of about 46,000 people; the dogcatcher in Albuquerque; producing one episode of the Game of Thrones; or regulating the nations over-the-counter drug supply.

Everybody has their answer, right? Wastewater treatment in Concord costs $7.4 million last year. All this is available publicly. The

dogcatcher spent about $11.1 million. One episode -- this is the second to last episode, I think, of the second season -- was $8 million. And oversight of the nation's over-the-counter drug product, $8.2 million. So this gives you some context for the limited resources that Dr. Woodcock had talked about earlier.

The amount that we currently spend at the agency for overseeing this massive effort, as it's been called, is about 30 people, which costs this year about $8.2 million. So there's not a lot of money and not a lot of people going into a very big effort.

This does cover FDA oversight of this really complex and widespread class of products. And as people have pointed out before, many people, sometimes on a daily basis, consume these products across the country.

So describing a little bit about what a user-fee program is, a lot of you in this room have experience with this, but it is not a tax. A tax is generally something you have to pay whether you

do something or not. It's not something for which you necessarily get a particular benefit. But a user-fee program is intended to provide a benefit or a set of benefits to those who wind up having to pay the user fee. And there's generally direct relationship between how much is paid into the program and the sorts of benefits and stuff that come out of it.

It also is not something the government can make a profit it on. So it's not like we sit here and have extra money. These dollars come in, and they supplement the resources that we put into it from budget authority. So we don't stop spending budget authority on this process. We just spend more because we have resources from the user-fee program.

Other examples here, most of you are familiar with the PDUFA that was discussed earlier. GDUFA and BsUFA were implemented a couple of years ago. Outside the drugs area, we have a device program from MDUFA. But you've probably paid user fees elsewhere. The government imposes them on

things like going into the Yosemite Park. If you've traveled recently, some of you probably traveled to get here this morning, you had to pay some fees associated with using the airlines.

Big farmers will have crop insurance programs, and those are considered user fees. And if you throw stuff out at the dump, you may have to pay a tipping fee. So user-fee programs are all around us.

So what does a good user-fee program look like? You can design them badly, but that's not what we're here for. A good user-fee program has a couple of key characteristics. At the end of my talk, I'll get to some of the things we're looking for from you. But I'd like you to keep these in mind.

Government is not known for being nimble, so having a revenue base that's relatively stable from year-to-year helps us in planning. A good program charges those fees to people who benefit from those programs. The beneficiaries will pay something that seems to be a fair share of those liabilities.

In other words, it's not unduly imposed on one part of the industry or on people who don't think that they benefit from it.

You don't want to have a program that costs 90 cents out of every dollar to administer. So you don't want something that's horribly complex. You want something that's relatively straightforward and easy to administer so that the resources are available for the purpose of the program, not for administering the collection of the fee.

I'm going to violate a rule of probably several best practices for PowerPoint slides in a minute. So in order to make sure I don't violate them too badly, I want to walk you through some expectations about that slide.

A reasonable person could well ask, as Dr. Woodcock alluded to earlier, why doesn't Dr. Woodcock or the commissioner simply put more money into this program? And I'd like to expand on the points that she made earlier.

The budget overall has been relatively flat. The slide I'm about to show you will demonstrate

this. For several years, we haven't had an increase in funding. In fact, in one year, we had a decrease due to the sequestration efforts that the government went through fairly recently.

So the reasonable person might say, well, not? But one reason is that we haven't had a much bigger pie to play with. So that's been one constraint that we've had to deal with.

We've also had more things that require spending. So we've had Sunscreen innovation come up. We've had compounding crises with meningitis outbreaks. We've had Zika that popped up. We've had changing priorities coming down from the administration or Congress, all of which, of course, are valid needs for public health purposes. But each one of them requires resources. And the money that we have available has not been growing. The needs for those dollars have been growing, so the competition has been stepping up as it were.

Then going back to the trigger concept that Dr. Woodcock mentioned earlier, when a user-fee program comes into play, the expectation is not

that those funds will replace the dollars that the agency has been spending, but they will supplant them.

If industry is paying a user fee, they want to have a guarantee that the dollars the government had been spending don't go to something else, and that's codified in in statute by something called a trigger. The government has to spend a certain amount in order to access the user-fee funds that were collected in any particular year, and those dollars have to come from budget authority. So it's sort of a matching program.

When you have triggers, they set aside or reserve portions of that budget authority based that Dr. Woodcock and the commissioner have to meet all of their requirements for public health. But that means that those dollars then cannot be spent on something else.

So even if Zika happens, we can't take the PDUFA trigger budget authority and spend it on that without jeopardizing the dollars that are collected in the user-fee program for PDUFA. And that's just

not a good return on investment.

Again, keep in mind, there's a lot of things that keep coming up. We have the over-the-counter monograph program. The regulation of that has been funded by budget authority because we don't have user-fee dollars for it. And that's one of many, many things that are competing for those dollars.

So I'm going to transition to this slide that'll probably get kicked out of the PowerPoint club, and I'm going to describe a couple of things here to help you understand it.

So you'll notice that there are 6 bars on here representing fiscal years, from fiscal 2011 through 2016. And each bar shows the amount of budget authority. This is non-user-fee dollars. None of this represents user-fee dollars.

This is strictly budget authority that the Center only has had available to it for those years. So this does not include money spent by ORA or the Commissioner's Office. This is just the Center's budget.

The first thing you'll notice is that all

six of those lines are fairly flat. There's really not a lot of variation. 2013 is the year that I referred to earlier where sequestration hit, and we had a drop that year. So that year, we had even fewer budget authority dollars available to us.

Each bar is divided into two parts. The upper level, the darker sort of hatched line refers to the BA that's available for non-user-fee programs. This is over and above the trigger.

The solid color at the bottom of each bar is the trigger amount; that is the amount, the minimum amount of budget authority that's required for the user-fee programs that's in effect that year for the Center.

So you'll notice in 2011 and 2012, that number hovers around $140 million or so. Those are for PDUFA because in those years, we only had PDUFA. Starting in 2013 though, you'll notice that shaded area jumped up. So not only did the total bar drop, but the amount required to be set aside for triggers jumped up.

You'll see that the amount of available for

non-user-fee programs, the budget authority that Dr. Woodcock can shift around or something, shrank dramatically. It went from whatever that number is to something much smaller. So $117 million in additional BA was required in 2013 because of GDUFA and BsUFA starting in those years. So that further constrained the agency's, the Center's flexibility to deal with non-user-fee program areas.

Over on the right, in that box, I've got a couple of other examples of non-user-fee programs. You'll see that the OTC monograph is one of them, but there are others. There's a Sentinel program, which looks at public safety from an epidemiological aspect. There are drug safety contracts. We have DQSA, which is the track and trace and the pharmacy compounding work.

So there's a lot of things that didn't fit. I only had a little bit of real estate here, but there's a lot more things that could go into this box. All of these things have to have some attention from the agency, and it's a delicate balancing act that Dr. Woodcock has to do. She has

some balls that she juggles, and these are many of them.

The things that we're asking for your input on today, keeping in mind these things about what makes a good program and what sorts of things we have to keep in mind, we'd like to get your input on some questions as we think about going to forward in potentially developing a user-fee program for OTC work.

Some user-fee programs have fees for products. Some of them have them for applications, for facilities, for different things. So one thing that we have to figure out is if we were to move forward with a user-fee program in the OTC context, what sorts of things would we want to have them paid by essentially?

Because the OTC system is different from, say, PDUFA, which is driven by applications, OTC being driven by ingredients, some of these typical bases for which we assess user fees may not apply. It might be difficult to have an application fee in this context or something like that. So we'd like

to get your thoughts on those.

We also would like to understand if -- well, let me back up. A user-fee program, because it incurs or implies a cost, will change behavior, will affect behavior. There may be desirable things that industry dose now or non-desirable things it does now, which would be affected by the imposition of a user fee. If there's a fee associated with something, people generally do less of it. So a user-fee program may have impacts on what industry does, on what consumers do, whatever, so we'd like your thoughts on those.

Then as I mentioned earlier, the stability of the funding is important, too, because if we have wild swings in the revenue coming in, which may happen if a user-fee program is only event-driven like application-based or something like that, it can be very difficult for the government to plan and to react and to be nimble.

So we'd like you to keep those things in mind as well. Other user-fee programs tend to have a certain amount that's sort of stable funding from

products or facilities and some for application, those things like that.

In conjunction with receiving user-fee dollars, there's generally a commitment letter or some sort of performance expectation. And we would like your thoughts on what sort of performance goals might be helpful to keep in mind as we consider a user-fee program.

Are there certain things that, from a public health perspective or from an industry perspective, would be important to measure, cycle time, for example or time to approval, or whatever? Those are things that might be helpful as performance goals.

Finally, how would you judge three years down the road, five years down the road, that the program was successful or not? So what your thoughts on whether this particular program, if we do come up with one, would be evaluated down the road, so we can understand objectively whether it was successful or not? So those are some of the things that we'd like to get your thoughts on as

well.

With that, I will turn it back over Chris Shreeve for next steps. Thank you.

MS. SHREEVE: Thank you, Donal.

We'll switch now over to our panels, and if I could ask the first panelists, the consumer panel, to come forward to the front up here. Please remember to bring your card, your tent card that identifies your organization.

We're going to be joined now by the Alliance for Aging Research, the National Center for Health Research, and the National Consumers' League. Thank you.

While they're coming up, I'd just like to mention that everyone today who will be speaking on the panel, their remarks have been looked at by the FDA. We're here for public input, so they're speaking for their organizations.

I'll ask each of the panels to come up and speak, and then when the panels are finished, then folks can come up to the microphones -- there's two now in the center aisle -- and ask questions of the

panelists if they would like to.

I notice that Diana Zuckerman isn't here yet. She did call and said she was having issues with traffic, but she would hope to be here before this panel is concluded. So we hope she makes it.

We'll start first with -- let me introduce the panel that we have right here. On my left, I have Cynthia Bens from the Alliance for Aging Research and Sally Greenburg for National Consumers League. Thank you, both.

So Cynthia, do you want to start?

Presentation – Cynthia Bens

MS. BENS: Good morning, everyone. My name is Cynthia Bens, and I serve as vice-president of public policy for the Alliance for Aging Research. I'd really just like to start off by thanking FDA for inviting me to speak today and share some of our insights on the importance of OTC products in the care of older adults and also provide our views on the creation of a new user-fee program for monograph activities as they relate to OTC products.

For those of you who aren't familiar with the Alliance for Aging Research, we're a nonprofit organization based here in Washington, DC. We were founded 30 years ago. And since then, our mission has largely been to support research and application of research to improve the experience of aging and health.

In the very early days of the Alliance for Aging Research, our focus was largely on advocacy for increased funding for aging research at the National Institutes of Health. It's still a really core issue for us, but over the years, we've expanded our focus to include FDA regulatory issues as they impact the development and review of products that are used in the care of older adults.

So through our experience in the last decade with FDA, we've really come to recognize the important role that the agency plays in encouraging innovation and also to enable access to safe and effective products for seniors.

The Alliance for Aging Research also maintains a really robust health education program.

Through that program, we provide health education materials for patients, caregivers, healthcare professionals on diseases and conditions that disproportionally affect older adults.

In the last year, we've developed materials on the safe use of OTC pain medications by seniors, as well as information on the use of OTC dietary supplements to improve health. And all those materials, if you're interested in seeing them, are available on our website. That's www.agingresearch.org.

Most of us are keenly aware that our population is aging at a really unprecedented rate. There are 10,000 baby boomers turning 65 every day, and this is up from 6,000 a day just five years ago. People age 80 and older now make up the largest growing segment of our population. Right now, about 10 percent of the U.S. population is over the age of 80, and it's going to triple; that number is going to triple by the middle of the century.

The good news is that many people are living

healthier as they age, but the unfortunate truth is that most people do still experience long periods of illness and disability later in life. They experience forms of cardiovascular disease, cancer, diabetes, bone and joint degeneration, muscle wasting, vision and hearing loss, neurological diseases, persistent pain, as well as things like incontinence.

Many of these ailments are treated with prescription drugs and medical devices and lifestyle interventions, but many older adults rely heavily on non-prescription OTC medications as part of their regular care.

While FDA decides whether or not a medication is safe enough for use to sell over the counter, taking OTC medications come with risks, and these risks are constantly changing, and we fully recognize that.

As you heard earlier today, there are approximately 100,000 OTC products available on the market today. U.S. consumers spend as much as $32 billion on these products. Older adults use

more of these medications than any other demographic group, and older Americans actually account for about 30 percent of all OTC medications used.

Primarily older adults use non-prescription medications to relieve pain, reduce GI disturbance, help with sleep, and maintain things like their oral health. Proper use of these products represents substantial cost savings to individuals and to the healthcare system.

The Consumer Healthcare Products Association estimates that OTC products save as much as $102 billion in value to the healthcare system. $77 billion are saved in unnecessary office visits and diagnostic tests, and about $25 billion in savings on prescription drug costs.

But many of the OTC non-prescription medications in routine use by seniors are monograph products. They're marketed this way because they contain ingredients that were generally determined to be safe and effective in self-treatment.

OTC monographs are continually updated by

the FDA to add, change, or remove ingredients, alter labeling, or include other pertinent information. Despite the significant role OTC monograph products play in routine care, FDA review ingredients included for and proposed for inclusion in OTC monographs are unfunded. And I now have updated numbers based on the last presentation.

With less than 30 FTEs and $8 million devoted to these activities, the lack of funding has contributed to things like unfinished monographs and the delayed labeling changes. And for us, we fear that this could have negative consequences for public health and safety, and that's why we're here today.

The Alliance for Aging Research has observed the success of user-fee programs in other areas at expediting access to safe and effective prescription drugs and medical devices for seniors.

The prescription drug and medical device user-fee programs, they came about to improve the speed and predictability of the drug and device review processes. PDUFA and MDUFA allow FDA to

maintain adequate staffing levels for timely product reviews and establish transparent metrics to hold the agency accountable for meeting certain performance goals.

While we recognize that not all OTC products go through the same premarket review process as drugs and devices, we feel that the same principles of these programs can benefit the regulation of OTC products by expanding FDA's capacity in targeted ways, allowing the agency to fill highly skilled vacancies and scoping on other defined areas where fees would have the greatest impact.

OTC products will play an increasingly important role in self-care as our population continues to age. Recognizing the benefits of safe and effective OTC products will only be possible if FDA has access to the necessary resources to evaluate them.

Our organization continues to engage in the user-fee discussions because we understand that user fees play an essential role in maintaining regulatory processes that efficiently deliver safe

and effective products to people who need them. We're generally supportive of FDA's desire to institute a user-fee program for OTC monograph activities.

Our first recommendation is that the user-fee program be developed through monthly consultation with patient groups, consumer groups, and industry. We've seen this type of multi-stakeholder engagement process work well in both the inception and reauthorization of the current user-fee programs. We actually participate regularly in monthly stakeholder meetings in both PDUFA and MDUFA.

We believe that those types of engagement on the front end can really ensure that an OTC monograph user-fee program has the intended consequence of providing more certainty and timeliness in the monograph process.

The second recommendation that we have is that the proposed user-fee program not exceed the amount of appropriated resources devoted to the OTC monograph activities.

The Alliance for Aging Research is actually the leaders of the Alliance for a Stronger FDA, which advocate solely for appropriated funding for the FDA, with a strong emphasis on finding a balance between user fees and appropriated funding.

We believe that this balance is critical because FDA, at its core, is a public health agency, and its intent is to serve the American public's health. If the user-fee program does move forward, we believe that it should start small and its purpose should be very clearly defined.

Finally, while the prescription drug user-fee program has been successful in many ways, we offer a note of caution. The amount of PDUFA fees increases with each reauthorization, and user fees now account for between 60 and 70 percent of all human drug review activities at the agency.

The Alliance for Aging Research feels strongly that fees should not replace appropriated dollars or become a dominant funding source for the agency in any particular area because, as you've heard a little bit earlier, they're targeted in

nature, and they're defined for a very specific purpose.

We think that FDA really does need the flexibility to adapt [indiscernible] science, and also as their needs and priorities change, to be able to adjust accordingly. We'd recommend that the agency and industry agree to a period of time to reevaluate the need for the OTC monograph user-fee program.

I'll just close by saying that we know that this is the start of the process. I look forward to giving input as we receive feedback from other stakeholder groups. Thank you all for your attention today, and thanks to FDA again for allowing me to be here.

MS. SHREEVE: Thank you for your remarks, Cynthia.

Sally Greenburg, National Consumers League.

Presentation – Sally Greenburg

MS. GREENBURG: Thanks so much, Chris.

Good morning, everyone. It's great to be here, and we so appreciate your inviting consumer

input into this proposed new regime for funding OTC drug approvals.

The National Consumers League is an organization that's been established and around since 1899. I am the executive director of the organization. We have, one, been concerned with the issue of ensuring the safety of food and drugs. And Karen, I really appreciated your history lesson because that history lesson really tracks the history of the National Consumers League.

We, in fact, were very involved in passage of the Safe Food and Drugs Act in 1906, which was signed into law, as you noted, by President Teddy Roosevelt, along with the Meat Inspection Act.

We're not at the USDA. The Safe Food and Drugs Act really was the precursor to the creation of the FDA. But the Meat Inspection Act was the precursor after Upton Sinclair's book came out of the USDA, and they're really important milestones in the whole area of consumer safety and product safety for organizations like ours.

So I think it's really important that we

keep that history in mind because we have a regime to ensure safety and efficacy, and it's very important. And many countries do not have the benefit of that very robust system.

So the NCL's top priorities in this area had been ensuring the safety and effectiveness and appropriate use of both prescription and over-the-counter drugs and medication adherence, which we have been in the forefront of through our Script Your Future Campaign.

The FDA's Federal Register notice states that the OTC market, there are approximately 800 active ingredients for more than 1400 different therapeutic uses. In addition, about 32 billion in OTC medicines were sold in the U.S. last year according to the Consumer Healthcare Products Association, which is the industry group representing the producers of over-the-counter drugs. And that's up 4.5 percent since 2010.

For more than 240 million Americans who use the OTC medicines every year, these drugs probably play a vital role in keeping consumers healthy and

helping them to feel better when they're sick and treat the kind of ailments, minor ailments, that all of us experience on a regular basis, especially those in the older population, which I count myself a part of. And it keeps us out of the doctor's office, and that's actually very, very helpful and useful, I think.

However, it appears with the burgeoning OTC marketplace, the FDA is seriously under-resourced with only 18 full-time employees assigned to oversee the entire OTC market. This is the same number of FTEs it takes to review one novel prescription drug application.

So while the FDA has made determinations about the safety and efficacy of active ingredients in thousands of products for the OTC monograph review process, we know from presentations from this morning, and certainly the history of the OTC review process, that there are still many pending monographs for which ingredients have not been determined to be generally regarded as safe and effective for their intended uses or GRASE.

FDA estimates that at the current funding level, it would take decades to review and finalize the spectrum of OTC monographs that are currently in non-final status. So the agency is asking for additional resources to finalize pending OTC monographs and address safety issues faster and more efficiently.

Finalizing FDA review of these ingredients, as well as devoting additional resources to expeditiously modify labels for new safety concerns would better serve the public. In addition, a user-fee program would benefit both consumers and industry by allowing more timely review of innovations and new ingredients, ultimately leading to the availability of new and improved OTC options. Indeed, we support any processes that reduce the need for animal testing.

For these reasons, NCL agrees that it makes sense to create a pathway for the FDA to have additional resources to manage the growing number of OTC products.

With regard to implementation of OTC user

fees, NCL recognizes that the ingredient-based OTC monograph review process may not always lend itself to user-fee assessment, so we think the FDA should consider implementing set user fees such as product and establishment fees that would generate a steady predictable source of funds for the agency.

That said, we do have a few concerns if the agency moves forward with this proposal. First, we would like to ensure that the FDA take care not to impose burdensome fees on newer or smaller innovative firms that may find it difficult to absorb the fees. Perhaps a tiered system should be contemplated for such firms.

Secondly, we are mindful of concerns expressed by some that because industry pays user fees, industry thereby controls the agency's agenda and process. We, too, are members of the Alliance for a Stronger FDA, and we are very mindful of that need for balance between user fees and science, controlling what drugs get approved.

We urge the FDA to make it abundantly clear that it will act independent of industry influence

and always work to advance the public's access to safe and effective OTC products. Karen, I appreciate your noting that it's all about the science, so that's critically important for us and for consumers.

As for performance goals as per the OTC user program, NCL would like to see the FDA commit to initiating a certain number of OTC monograph finalizations per year and recommend the publication of an annual report progress in addressing OTC monograph backlog, including highlighting the approval of new and innovative treatments that are made possible as a result of a user-fee program.

We commend the FDA for soliciting the views of the many stakeholders who will be affected by this program, and we particularly appreciate you're giving consumer organizations the opportunity to share our views.

I agree with Janet Woodcock that this could be a win-win-win, a win for industry, a win for the FDA, and a win for consumers. We look forward to

working with the FDA and with the OTC industry as appropriate to design a balanced and fair user program for OTC drugs.

Thank you very much.

MS. SHREEVE: Thank you, Sally.

Diana Zuckerman, I don't believe has arrived. And I think I can safely say she's not the first person to be held captive by DC traffic. If she shows up a little bit later, we'll try to find a spot for her so she can speak as well.

At this point, if anyone in the audience has questions, we really invite you to come up and ask them of the panelists. And while I'm waiting for someone to show up, I just want to apologize for the fact that the lights are out in the front and they're lit in the back. Apparently, they're out. We can't do anything about that. I'm straining to read myself.

So questions? Anyone?

(No response.)

Okay. I think we will move to a brief break, and maybe Diana will have arrived right

after that, and we can let her talk as well.

Thank you so much, Cynthia and Sally.

(Whereupon, at 10:08 a.m., a recess was taken.)

MS. SHREEVE: So I think we'll get started with the next -- well, actually, before we start with the next panel, Diana Zuckerman who was foiled by the Beltway but managed to come, we'll give her opportunity to speak and questions, if you'd want to ask them. And then we'll move on to the second panel.

Diana Zuckerman, from the National Center for Health Research, the president. Thank you.

Presentation – Diana Zuckerman

DR. ZUCKERMAN: Thank you very much. It's either Metro or the Beltway. It's always something, right?

I'm very glad to be here. I am president of the National Center for Health Research. We're a think tank that focuses on -- we do research, we analyze other research, and we synthesize information from various research sources and other

credible sources to try to figure out what are the safety and efficacy issues for all kinds of medical treatments and how best to use that information to promote the public health.

This issue is one that's really important to us because, as you know, over-the-counter medications are very, very frequently taken by a public that assumes they're all safe for all purposes, and how can we best provide information to them that will be accurate and understandable, and how best can FDA keep up with all the new information that becomes available.

I should just say that while our center would prefer that the Congress provided adequate appropriations for the FDA for all its important and essential work, we know that isn't happening, and it hasn't happened for quite some time and that user fees have become essential.

Because of that, the prescription drugs user fees and the medical device user fees, for example, have added important resources for those centers, and the centers that get user fees have more

resources than the offices and centers that don't have them. That's why these OTC user fees are so essential.

Four decades after the OTC drug review process was established, as you know, the monograph process still hasn't been completed for all ingredients and all conditions of use. Many products containing Category 3 ingredients without GRASE determination continue to be marketed, and that's not really acceptable.

You've already heard and you know that a staff of 18 people just isn't enough to regulate 800 active ingredients for more than 1400 different therapeutic uses. As a result of inadequate resources, there are warnings that patients would benefit from that they're not getting in a timely manner, and they're not getting all the information they need to make the best choices for themselves.

Unfortunately, the prescription drug user fees and the medical device user fees have really focused on speed of getting products to market more than safety and efficacy. Obviously, the OTC user

fee is a different situation because these products are not reviewed prior to going on the market and that the focus is on those that are already on the market or will soon be on the market.

As a result, in addition to the monograph completion, it is absolutely essential that these user fees enable the FDA to look at new information as it becomes available, both in terms of safety and efficacy.

I'm still having trouble with these glasses and looking at you and reading. Age is not for ninnies.

(Laughter.)

DR. ZUCKERMAN: Another very important issue is that when the monographs were first developed in the 1970s, it didn't really have a lot of information on children and infants. They used a way of looking at it by extrapolating information from adults to children as if children were just really small adults.

We now know that's not the best way to do things. It's often not accurate. So one of the

very important things that we would want these OTC user fees to be used for would be to really examine a vast array of products that are used by children to make sure that the dosing and other information is appropriate for them. Obviously, that came up in recent years on a very popular children's medication for colds and pain.

The OTC user fee should also help pay for the development of product formulation standards. The monographs have set forth the conditions under which a specific active ingredient used in a drug product is not misbranded, but they don't usually specify the non-active ingredients that can be added and can have an impact as well.

In addition, many product formulation variables affect the dose that's delivered. And for that reason, we recommend that development of standards for drug products not just be for the drug product, not just for the ingredients. So we strongly urge the FDA to include funding for that in the user fees.

Since the monograph system is based on

ingredients and since sponsors of monograph drugs are not required to obtain FDA approval prior to marketing, the fee structure must be different than it is for prescription drugs.

These user fees should be structured as a product-listing fee based on a sliding scale proportionate to the complexity and FDA resources required for the review. This would provide the agency with a stable and predictable source of funding for the OTC division, and that's obviously absolutely essential.

We should avoid structuring the fee as a facility fee since it could easily inspire sponsors to consolidate operations into as few facilities as possible; in addition to reducing the user fees that would or could cause OTC drug shortages if one facility is removed from operation and there aren't other facilities to make up for it.

Just in summary, the OTC user fees are urgently need to finalize the monographs, but they're also urgently needed to review the emerging safety and effectiveness issues. These are issues

that are always going to come up. That's just the nature of science, that we'll gather more information. And in this time of big data, perhaps gather even more information than we ever thought was possible.

Between those emerging issues and a particular focus on the OTC product used by children and infants, we think are really essential and should be part of the performance goals, and finding a way for the user fees to have performance goals that really benefit patients and consumers by providing the information they need on safety and effectiveness so that they can make the best decisions and continue to enjoy the vast array of products that are available to them.

Thank you very much. And I'm happy to answer any questions.

(No response.)

DR. ZUCKERMAN: Okay. Thank you.

MS. SHREEVE: Thank you very much, Diana.

We're fine on time. The next panel will be the healthcare professionals' perspectives. If we

could ask Dr. Bromberg to come up and Stacie Maass. Thank you. You've got your cards up here.

I'd like to introduce Dr. Bromberg from the American Academy of Pediatrics who is a member on the board of directors, and Stacie Maass from the American Pharmacists Association, senior vice-president.

Dr. Bromberg, do you want to go first? Go ahead. Thank you.

Presentation – David Bromberg

DR. BROMBERG: Thank you. Good morning. Thank you for the opportunity to be here and to represent the kids. I want to thank Dr. Zuckerman for her comments relative to pediatrics as well.

My name is Dr. David Bromberg, and I'm a pediatrician with over 35 years of clinical experience treating children in a private practice in Frederick, Maryland. I also serve as a member of the American Academy of Pediatrics Board of Directors, and I'm here today officially representing the academy.

As a primary care pediatrician, I'm

frequently asked to discuss with parents the risks and benefits of using over-the-counter, OTC, medicines to treat common pediatric ailments. Because parents often rely on these drugs to treat their children, it's absolutely essential that the process is set up to regulate them is responsive to the best and most recent medical science.

I want to spend a minute reviewing one monograph, specifically the cough, cold, allergy, bronchodilator and anti-asthmatic product monograph. Just the monograph's name is a mouthful.

In 2007, I spoke on behalf of the AAP at an FDA advisory committee meeting called to consider the safety and efficacy of cough and cold products for children. The meeting was held in response to a citizen petition, signed by numerous pediatric experts, that highlighted not only safety concerns related to these monograph drugs, but also in the case of some products a demonstrated lack of efficacy in the pediatric population.

The committee voted unanimously that adult

add-on cough and cold products should not be extrapolated to establish efficacy of the drugs in children under 12. They also voted to recommend that cough and cold drugs not be used on children under 6 years of age, consistent with the AAP recommendations at that time.

About a year later, in 2008, I had the opportunity to address FDA again for the AAP on the same issue, this time at a Part 15 hearing called to commence the process of revising the pediatric cough and cold monograph, as recommended by the advisory committee, to better reflect the current state of the evidence.

Sadly, it's now 2016, and the FDA has yet to publish, even draft changes to this monograph despite pleas from Congress, pediatricians, and the public. We're convinced that this is not a lack of progress -- it's not for lack of effort on the part of the FDA. Rather, progress has not been realized because the monograph process simply does not work. It's cumbersome and slow, and therefore, the FDA cannot act quickly to respond to development and

the science, public health concerns, and product innovation.

The process is resource-intensive while being significantly underfunded. It does not serve the needs of children, and for that matter does not serve the needs of the general public.

Parents deserve to walk into their pharmacy and expect that the medication on the shelves labeled for children are not only safe and effective for children but have been tested and labeled appropriately for their use. The only way to ensure that consumers are afforded reliable, safe, and quality medicines is to change how the monograph system works and provide significant new resources to the endeavor.

For this reason, the AAP supports reforms to the current OTC monograph system and the creation of a user-fee program to fund FDA's monograph work, provided that such a fee program meets the needs of patients and healthcare providers. The AAP has adopted and recommends five principles to guide the development of such a user-fee system and the

accompanying reforms to the OTC monograph process. They're as follows:

Principle 1. FDA must have the ability to quickly respond to new evidence about the safety of drugs regulated under the monograph system. The monographs detail allowable dosages, indications, and warnings for active ingredients in the Code of Federal Regulations, the CFR.

For FDA to change a warning in a monograph, it must go through a lengthy notice and comment rulemaking process to modify the CFR. This unwieldy process comes with numerous bureaucratic steps and layers of review. The process is unfortunately incompatible with modern medical research that moves quickly and precisely than ever and can identify important drug safety concerns.

In the case of cough and cold medicines for children, FDA was unable to act decisively in the face of mounting evidence that these products were resulting in thousands of pediatric overdose-related emergency department visits each year, all for products with modest or non-existent

efficacy in children. FDA's only recourse was to initiate a rulemaking process that has never concluded.

If FDA identifies safety issues associated with the monograph drug, it must have the authority to require prompt label changes without going through a lengthy and burdensome regulatory process, including the lengthy Office of Management and Budget review.

Additionally, any monograph reform efforts must ensure the agency is provided resources to conduct safety surveillance for monograph products and allow quick action when safety issues arise.

Principle 2. The monograph system must allow industry to make innovations to improve patient health. While the new drug application process is the gold standard for the approval of new and innovative drugs, there are certainly instances where industry-related changes to the monograph are appropriate. Such changes can lead to improved drug formulations, increased safety, and other benefits for patients.

For instance, industry has, for years, been requesting that the monograph be amended to provide acetaminophen dosing instructions for children under the age of 2. Even though there is well accepted guidelines for acetaminophen dosing for children age 6 to 24 months, the label of infant and children's acetaminophen will still ask parents for children under 2 to ask a doctor for dosing directions. Parents unable to quickly reach a physician may be tempted to make a guess at the appropriate dosing, putting the infant at risk for either over or under-dosing the medication.

The AAP supports such a change in labeling. And if the monograph process worked better, surely that change would've happened years ago. The existing backlog of industry-requested monograph changes currently languishing under the FDA review is unacceptable. The uncertainty and complexity of the review process likely also reduces industry's incentive to invest research in development and resources in to monograph products. A reform monograph system must add certainty to the

evaluation of industry-initiated monograph revisions.

Principle 3. FDA must have the ability to address monograph products that lack sufficient evidence to justify their use. The OTC drug review, the process FDA use to review grandfathered OTC products on the market prior to the enactment of FDA's modern standards for safety and efficacy, was a massive and complicated undertaking as we heard this morning.

While FDA reviewers did their best to evaluate the safety and efficacy of these products, the data available to them was often extremely limited. And in the case of drugs for children, much has changed in the area of pediatric therapeutics since the 1970s. We've moved from an era where drugs were seldom studied in children and pediatric drug studies were considered to be unethical, to today where failure to study drugs in children is considered unethical.

The data that led FDA to label cough and cold medicines for children does not come close to

meeting today's standards for pediatric data. Not only that, but additional data gathered since that time has clearly shown certain cough and cold products to be completely ineffective in the pediatric population.

Nevertheless, these products are still commonly marketed to children and often in combination with other products that can increase the safety risks.

The monograph process is proven ineffective in ensuring that OTC drugs marketed to children and families have data to justify their use. FDA needs the authority and resources necessary to identify monograph products that lack appropriate data.

Using a risk-based approach, FDA should be able to either require products to immediately come off the shelves or to give manufacturers a period of time during which they must submit new efficacy data to FDA to justify their continued marketing, after which a product lacking such data would be removed from the monograph.

Today's monograph process is ill-equipped to

handle this task. A reformed system must ensure FDA's ability to address products that do not meet appropriate efficacy standards.

Principle 4. The monograph process must be streamlined to allow FDA to take action without unnecessary regulatory burdens and maintain FDA as the final public health decision-maker.

The existing monograph process is a failure in large part because of the unreasonable length of time it takes to respond to new information. We must be careful not throw out one cumbersome process only to replace it with another one.

While monograph changes should always be approached by FDA in thoughtful and careful manner, a reformed OTC system should not be overwhelmed by new and different process requirements.

Reasonable opportunities to industry, provider, and consumer groups' input to propose changes must be offered but must not delay the needed changes that enhance access to patients as quickly as possible. Additionally, any new process reforms must ensure the FDA remains the final

arbiter of safety and efficacy.

Principle 5. User fees must support the ability of FDA to address public health needs related to monograph products. Certainly, a reasonable element of any user-fee program is in expectation that the resulting resources will be used to provide regulated industry with predictable and timely agency decisions.

However, we strongly believe that any monograph user-fee program must also provide FDA sufficient and stable resources to address issues that it determines are important to public health even if not directly were tied to industry-initiated request.

A modernized system must be set up to receive requests for monograph changes from both industry and the public. There must be a mechanism for consumers, researchers, and providers to share data with FDA about monograph-regulated products and request appropriate action by FDA in response to this information.

Thank you for the opportunity to speak today

about the importance of safe and effective over-the-counter medications for children. We look forward to working with the FDA and other stakeholders as the process moves forward.

MS. SHREEVE: Thank you, Dr. Bromberg.

Next, we'll hear from Stacie Maass, senior vice-president, Pharmacy Practice and Government Affairs with the American Pharmacist Association.

Stacie?

Presentation – Stacie Maass

DR. MAASS: I think I'd like to first start thanking FDA for the dim lighting. As someone who's on the camera right now, I appreciate the dim lighting up here.

Good morning. As was said, I represent the American Pharmacists Association. Our members, we represent over 60,000 pharmacists, pharmacist technicians, pharmaceutical scientists. We represent pharmacists and pharmacy technicians in all practice setting: hospital setting, community setting, as well as managed care organizations, physician offices.

I'd like to, again, thank FDA, as others have, for holding this public meeting to gather input on the potential development of a user-fee program for OTC monograph drug ingredients as the desire to support a timely and efficient FDA review of the efficacy and safety of these products' ingredients. I think it's a shared goal by many in this room, if not everyone in this room, and the impact that that also has on innovation as well as patient health outcomes.

APhA, unfortunately, does not have a position or official policy with regard to user fees or establishment of some kind of system to support additional funding beyond congressional appropriations. However, we wanted to make sure we spoke today because of the impact that it has on pharmacists.

No other healthcare professional has more interactions with medications than the pharmacists, and that includes OTC medications. Medications are the cornerstone of what pharmacists do, and as the most accessible healthcare professional with

86 percent of Americans living within 5 miles of a pharmacy, we clearly are the healthcare professional that many patients seek first with regard to these products.

While OTC product ingredients are reviewed by FDA with the intention that healthcare professionals' involvement isn't required prior to their use, the reality is every day in every pharmacy in the U.S., pharmacists are asked questions about OTC products.

Therefore, it's not only the millions of American consumers but other healthcare professionals, especially pharmacists, who rely on FDA's review of OTC ingredients and the accuracy of these products' labeling in order to make recommendations with regard to OTC products, especially given the vast number of OTC products on the market and many with multiple ingredients within those products.

In addition, it's important to remember that OTC medications can interact with other OTC medications, as well as prescription medications,

so a timely review of these products' ingredients have far-reaching impact beyond just the OTC market.

Given that access of hundreds of millions of consumers have to the OTC medications and the large number of products on the market, it's not lost on anyone in this room the fact that FDA is underfunded with regard to the OTC monograph review process, a process which it's important is augmented by the fact that these products are intended to be used without the supervision of another healthcare professional.

I'd like to close by thanking FDA and the other stakeholders for their interest in improving the OTC monograph drug review process, its timeliness, and its impact on innovation. While APhA, as I said, has no specific recommendations regarding the establishment of a user-fee program, APhA has had long policy supporting the need for patient access to safe and affordable medications.

So any potential system or mechanism needs to consider the patient cost and access, as well as

any meaningful reform should be tied to the user-fee program just to make sure, as others have stated, that the program just doesn't focus on the timeliness of review but also address real reform within the program.

APhA looks forward to being part of future discussions on this topic, and thank you for your time.

MS. SHREEVE: Thank you, Stacie.

We have an opportunity now, if you'd like, the audience, to ask questions. You can come to any of the mics. I believe they're turned on.

(No response.)

It doesn't look like we have anyone. All right. Thank you so much, Dr. Bromberg, Stacie Maass, really appreciate it.

Now, we'll go right into the third panel on industry perspectives. We could ask the panelists to come forward; if you can remember your table tent.

Today, on the industry perspectives panel, we have right here on my left Barbara Kochanowski

from the Consumer Healthcare Product Association. She's vice-president of Regulatory and Scientific affairs.

Next to her is Priscilla Zawislak from the International Pharmaceutical Excipients Council of the Americas. She's the global regulatory affairs manager.

Next to her is Mark Pollack, Personal Care and Product Council. He's the senior executive vice-president, strategic initiatives, and assistant secretary. We all have such long titles.

Finally, we have Cornell Stamoran from the Pharma and Bio-Pharma Outsourcing Association. He's vice-president of corporate strategy. And we'll start with Barbara. Thank you.

Presentation – Barbara Kochanowski

DR. KOCHANOWSKI: Thank you very much, and good morning, everyone. As Chris said, I'm head of regulatory and scientific affairs at the Consumer Healthcare Products Association. Our members, the manufacturers of non-prescription medicines, have a strong interest in the topic here today and are

pleased to offer our comments. My comments will be divided into three topics: FDA resources, the need for OTC monograph reform, and user fees for non-prescription medicines.

For over 40 years, the vast majority of non-prescription medicines have been marketed under the OTC monograph system, which provides consumers with access to safe and effective treatment options for a variety of conditions. In fact, the majority of pharmaceuticals used in the United States, approximately 60 percent by volume, are actually non-prescription pharmaceuticals.

The prevalence of OTC medicines in our healthcare system is widespread. Because of the importance of these medicines to public health, consumers, stakeholders, and the regulated industry need to know that these products are marketed under a safe and adequately-funded regulatory system.

Currently, FDA is under-resourced for regulating non-prescription medicines under the monograph system. We've all heard the numbers this morning, less than 30 full-time equivalents,

$8 million, is simply insufficient to cover 400 active ingredients on the market today for over 700 therapeutic uses. That is the OTC market today.

While the monograph system has served our nation well, it has become cumbersome and outdated and needs to be modernized. The rulemaking process upon which it is based is stalled, and that's a bigger issue than just for the monograph process.

FDA needs the ability to protect the public health by completing unfinished monographs and making labeling updates in a timely fashion. In addition, industry desires the ability to innovate and provide consumers with modern technology. That technology can support, safety, efficacy, and compliance. CHPA submitted comments on the monograph reform back in 2014 at that public meeting.

As we heard a little from Donal, there are now several examples of user-fee programs under FDA's jurisdiction. In each case, the regulated industry supported user fees. When added to

baseline appropriations, they enable FDA to accomplish very specific goals agreed with the users paying the fees.

For example, in the case of new prescription drugs, in order to make the drug review process more efficient and get medicines to patients quicker, Congress worked on a bipartisan basis with FDA, patient organizations, industry, and other stakeholders to craft a remedy to supplement FDA resources while preserving agency fiscal and management discipline and independence.

The remedy was a framework for user fees paid for by drug sponsors with funds dedicated to enlarging the FDA workforce committed to new drug reviews.

At the same time, FDA agreed to performance review goals and maintenance at baseline appropriations. More recently in the case of generic drugs, a lack of FDA resources to manage a backlog of ANDAs resulted in agreement by industry to pay user fees. In these cases, there were incentives for both industry and FDA to develop

user-fee programs.

A user-fee program for non-prescription medicines will need thorough discussion and study. Unlike other drugs subjected to user fees, non-prescription drugs under the monograph system are not subject to FDA approval prior to marketing. Many of these ingredients have been marketed for more than 40 years with a long history of safe use. There is no backlog of applications. Therefore, we must define value differently than the industry subject to FDA approval prior to marketing.

As FDA correctly identifies in the meeting notice, assessment of fees can create certain incentives or disincentives for activities that are the subject of these fees. So neither we nor FDA, nor the public, want to discourage activities that could benefit the public health.

Fees for non-prescription medicines under the monograph could be a disincentive for innovation or they could incentivize innovation depending on how they're applied.

For example, today, very few manufacturers

are filing new drug applications and paying the PDUFA fee to innovate with monograph ingredients. Discussion of a potential user-fee program should include identifying mechanisms to support innovation.

In terms of fees in general, we would expect fees to be justified and spending transparent. Fees should not be disproportionately targeted to rebuilding and maintaining capability. We'd expect to see a balance in the application of fees between long-standing needed actions under the monographs and acting on innovation.

So in summary, our members are supportive of a robust monograph system to regulate non-prescription medicines. The current system needs to be modernized, and we welcome the opportunity to discuss reforms, and in that context how a user-fee program may fit.

Thank you for the opportunity to share our comments.

MS. SHREEVE: Thank you, Barbara.

Priscilla Zawislak?

Presentation – Priscilla Zawislak

MS. ZAWISLAK: I'd like to thank the FDA for inviting us to speak today. I'm Priscilla Zawislak, and I'm with Ashland, an excipient manufacturer. But today, I'm representing IPEC Americas as the chair-elect.

IPEC Americas is a nonprofit trade association representing many excipient makers and users, as well as distributors. Just to give you some idea, our ingredients are used in all different types of drugs, not just OTCs but also branded and generic drugs.

IPEC very strongly supports the OTC monograph user-fee concept, and we definitely support improvements in the OTC monograph system to provide sufficient FDA resources to facilitate a more expeditious review of the process. We also support a user-fee system that might enable FDA to gather better quality data on OTC manufacturers because the facilities would need to be identified and registered.

A user-fee system, we believe, would be a

viable means to fund the necessary resources at FDA, but careful consideration should be given to the types of fees and which parties would be responsible for paying for them.

Some of the concerns that we have are just questions. Who would be responsible for paying these user fees? Would it be the finished OTC drug manufacturer or supplier or their facility fee, or would it be the ingredient supplier and their manufacturing facility?

Under GDUFA, API manufacturers are subject to fees. But what would the impact of setting fees for excipients, APIs, or ingredients used as atypical actives be in the OTC drug products if the user fees were applied to those?

The fees applied to an ingredient manufacturer or supplier could be prohibitive to those companies. It could lead to shortages or withdrawal of ingredients from this market by suppliers who would not be able to justify the cost.

IPEC Americas would support user fees for

resources to review OTC monographs, as well as resources to evaluate OTC finished drug manufacturing facilities, for example, GMPs, including foreign facilities as similar to some of the provisions within GDUFA.

Since many OTC drug products contain atypical actives, a different user-fee approach regarding active ingredients than is used with GDUFA is needed. So I'd like to take just a minute to explain to those in the audience and to clarify with FDA what do we mean by an atypical active.

This is a material that may be an excipient, a food additive, or a cosmetic ingredient that is being used as the active ingredient in a drug formulation. Unlike traditional APIs, atypical actives usually have a physical rather than a purely pharmacological effect. These are very commonly used in OTC products.

Most OTC drug formulations existed long before the ICH Q7 GMP guideline was developed for APIs, although atypical actives have a very long history of safe use. These have been used for not

only decades but in some cases a hundred years or more. In some cases, it is the only ingredient in the drug product.

Some examples of OTCs containing atypical actives other people have mentioned this morning, so I won't go over those. But you can see that there's a lot of different types of ingredients that you might not think of as being an active in that drug, but in fact, they're actually manufactured as excipients, food additives, or cosmetic ingredients, and sometimes even industrial products.

The potential consequences for user fees, if we talk about the OTC ingredients -- and we heard earlier that OTCs are very much about the ingredients -- if fees were imposed on API manufacturers and suppliers, and they were required to register and comply with the appropriate GMPs for APIs such as ICH Q7, many ingredients may no longer be available.

If fees were imposed on the ingredients, withdrawal of OTC drug products from the market

could result in a potential adverse impact to patients and consumers because the drugs they're used to buying may no longer be available, and it could also lead to possible drug shortages for very common OTC drugs.

Due to the nature of the manufacturing processes and distribution channels, it would be very difficult and sometimes impossible to apply this level of GMPs for APIs to manufacturing of atypical actives.

Not only would the cost to apply these GMPs rarely be justified from a business perspective due to limited profit margins and market size relative to other applications, but these are materials that were never intended to be used as APIs, and the manufacturing plants are not built to those standards.

I might also add that when we talk about volume of products used as atypical actives, if you look at a typical chemical company that manufactures these, the amount of time that it takes to produce, for example, a one-year supply

for some of these ingredients used as actives might be a matter of a few minutes a year because these are large chemical plants with continuous production processes.

So the cost impact of a user fee on something that you might make for 20 minutes or a couple of hours a year could be very prohibitive for companies.

So IPEC Americas' recommendations regarding the user fees for OTC monographs are that we do support user fees, including facility registration, but they should not be imposed on ingredients used in OTC drug products but rather on the finished OTC drug product itself.

The user fees for OTC active ingredients or facilities could have an adverse impact on availability of many OTC medicines. Many suppliers of ingredients used in these OTC drug products are not always aware of how their products are being used and would not be willing to pay fees based on their use in OTC drug products.

This is something that has come up under

GDUFA as well. A lot of times, as I mentioned, the chemical companies that make these ingredients as excipients or food additives are not even aware that their products are being used as actives in drugs. So when they find out that they're subject to user fees, it sometimes comes as a surprise to them.

Any user-fee system should also have an FDA commitment for completing the pending OTC monographs. Thank you.

MS. SHREEVE: Thank you, Priscilla.

Mark Pollack now from Personal Care Products Council.

Presentation – Mark Pollack

MR. POLLACK: Good morning. I'm Mark Pollack, senior executive vice-president for strategic initiatives of the Personal Care Products Council. Our member companies manufacture and/or distribute cosmetics, toiletries, fragrances, and personal care products, as well as supply ingredients to the industry, and we are very interested in the subject of this hearing.

PCPC acknowledges that the OTC monograph system could be modernized. Non-prescription OTC drugs under the monograph system are not subject to approval by FDA prior to marketing, so there are thousands of such products currently on the market.

Our members feel strongly that any monograph reform needs to avoid any disruption of the market for these existing products. Reform also must be balanced so as not to impair the industry's ability to innovate.

The current rulemaking process is slow. We believe that FDA can better protect the public health by completing monographs in tentative status and making necessary labeling changes in a timely fashion. Consumers need assurance that the regulatory system works for them and continues to allow them access to OTC drug products that they use on a regular basis.

PCPC recognizes that FDA is critically under-resourced for regulating non-prescription OTC drugs under the monograph system and that user fees are one possible funding mechanism FDA is

considering for mitigating the shortfalls. The funding mechanism should be a mix of appropriation and fees so that tentative monographs can be finalized and, in addition, the fees are used to support innovation.

We are open to a thorough discussion and study of a user-fee program for non-prescription OTC drugs. It is important that any program avoids double fees for cosmetic drug products since the proposed Feinstein-Collins legislation contains provisions for user fees for cosmetic products, and it would be unfair to require fees from companies twice for the same product.

We acknowledge that additional resources for FDA could result in potential benefits to the public health and that user fees can create incentives or disincentives for certain activities. However, any fee proposal must be fair and balanced, must establish clear identification of products subject to the program, and be tailored to the unique needs of this discreet set of products.

The focus of fees should not target

longstanding actions that FDA has yet to complete such as monographs that are not yet finalized. With regard to user fees in general, FDA's application of fees must be transparent so it is clear what they are spent on and trackable, that is measurable, transparent, and understood by industry.

In conclusion, FDA and industry must work together to establish specific goals and metrics tied to the collection of any fees. Any user fee should target innovation while the appropriations budget should cover longstanding actions such as monograph finalization and maintaining capabilities.

Thank you for the opportunity to share our comments.

MS. SHREEVE: Thank you, Mark.

Now, we'll hear from Cornell Stamoran, vice-president of corporate strategy from Pharma and Bio-Pharma Outsourcing Association.

Presentation – Cornell Stamoran

DR. STAMORAN: Good morning. Thank you to

the FDA for allowing our association to present here. I'm Cornell Stamoran. I serve as head of strategy for Catalent, and today, I'm in here in my capacity as a trustee of the Pharma and Bio-Pharma Outsourcing Association or PBOA for short.

Very briefly, as we're a new trade association, for clarity, we're an association representing the interest of contract development manufacturing, developers and manufacturers serving the pharmaceutical, biotech and consumer health industry.

To be clear, our customers typically help other companies develop and manufacture finished drug products or dose forms. Those companies typically own the filings such as NDAs or ANDAs and are the ones whose names you'll see on boxes of consumer health products, not ours.

Generally, there are some company names you'll recognize, but again, generally, you won't find most of these companies' names on boxes of products, on consumer health products or prescription drugs.

One point here, we do play an integral role supporting the prescription and consumer health industry. We produce about 200 billion doses, which represents about 1 in every 7 doses globally taken of Rx in consumer health products. So that's where we fit, if you will, in the industry.

So with that, moving on to our comments here for why we're here. We definitely strongly support the OTC monograph model in place in the U.S. OTC products play a critical role in supporting the health of consumers; often are for the primary available means of treatment for economically-disadvantaged segments of the population, and broad availability of safe and effective products, taken properly by patients, help reduce the country's overall healthcare cost.

We have this broad and diverse range of consumer health products that are safe and efficacious directly as a result of the monograph-driven system in place in the U.S., which, despite its shortcomings, remains a model for OTC medicine product regulation worldwide.

Our members provide consumer health products in many countries around the world, so we're familiar with the regulatory systems in place, both monograph-driven systems and under advanced filing-based ones. And we strongly believe the U.S. model drives consumer-centric new products and dose form innovation and increases competition, both of which are very much in the public and the consumers' interest.

We also agree that the FDA is critically under-resourced for the OTC area given the role and importance of a monograph process to a vibrant and consumer-centric OTC market.

Finally, we note that many good ideas about enhancing the monograph process were proposed by organizations during the 2014 hearing that's been referenced a couple of times. We believe that some of those considerations are relevant as user-fee deliberations move forward.

Our members are currently involved in most of the FDA user-fee programs that are currently in place, so we bring some perhaps different

perspective on what works and what doesn't on design principles here.

We've developed some key principles for user-fee design that may seem basic but can be quite difficult to implement in practice. First, the party who receives the economic benefit from the program should pay the fees. While this seems obvious, with a complex nature of industry and certainly even more so with a complex nature of the go-to-market process for consumer health products, it doesn't always play out like you'd expect.

For example, under GDUFA 1, if a generic product is outsourced to a CDMO, the CDMO will, in general, capture about 1 percent of the economic value over a 10-year generic life. Yet, we'll pay about 90 percent of the GDUFA fees over that same period.

Two, the fee should fully recover the cost of services provided unless there's a public policy reason to do otherwise, and we can discuss that offline.

Number three, there are certain things which

we've learned that make user fees more implementable from an FDA standpoint. If the fees are based on data, they FDA already has in a structured way, it's much easier to implement, such as NDCs, or SPLs, or some other data set for OTC products, for example, rather than in creating a new reporting requirement in order to drive a basis to assess fees.

Getting this right is crucial. Again, with GDUFA 1, our members and other CDMOs ended up paying about 15 percent or $45 million of the total initial bill, annual bill, for virtually no incremental volume or resulting, then, value versus pre-GDUFA 1. This led some of our members to have to reduce employment, to lay off people, and others to reduce capacity available to generics, or potentially to reduce the ability to invest in innovation.

Before progressing too far on user fees, we do again recommend the FDA and other stakeholders revisit the process improvement opportunities identified in 2014, many of which we believe are

readily implementable and would improve the efficiency and effectiveness of the monograph process.

Once that's done and the remaining gap to a full support is understood, only then do we believe can effective conversations about user fees take place: how much, for how long, what type, who pays, et cetera.

Once that point is reached, we currently would recommend consideration of either or both of, first, a one-time licensed-type fee associated with future substantive updates to final monographs, potentially including addition of new ingredients or technologies, as well as creation of new monographs.

A license model, perhaps combined with some advanced market access, as is in place with other areas in the U.S., could create some real economic incentive for companies to make the leading investments required to support these while providing a corporate accounting-friendly vehicle that would make it more feasible.

Second, annual product fees for active products using the FDA's existing data sets to define that could be used to support enhanced safety surveillance, timely label updating, and monograph process management. Due to the broad number of products in the market, we believe this would likely prove to be a relatively small fee to support these activities.

Finally, we do not support facility fees for this initiative based on the incremental degree of work required for the FDA to implement that system and what we see as inadequate alignment of fees with benefits.

Finally, we do request that the FDA aggressively continue to progress turning TFMs to final while these deliberations are ongoing. Consumers have need and will benefit.

We have some preliminary thoughts on performance goals largely around adherence to plans for monograph updating, and development timeliness of safety-related label revisions, and pace of additions of new ingredients, dose forms, and

technologies to existing monographs. As program specifics become clearer, these will evolve.

Though the lowest-hanging fruits will improve the monograph systems as related to current active ingredients and uses, there is significant value to all to CMC development topics such as those covered USP monograph and ICH.

One other comment, certainly, many of the ANDA-based ingredients contribute to the backlog and the resource issues that OGD faces as well, so the introduction of some of those ingredients to monographs might reduce stress points in other parts of the FDA.

In closing, PBOA supports consideration of an OTC monograph user-fee system that aligns payment of fees with those that will realize the greatest value. In the end, both the U.S. healthcare system and consumers will significantly benefit from a strong up-to-date and vibrant OTC monograph process. Thank you.

Audience Questions to the Panel

MS. SHREEVE: I really want to thank the

panel for your really helpful input.

Do we have any questions? We have a question coming up. Just to remind you to state your name and affiliation, if you would, and whoever you're directing your questions to.

MR. SMITH: Sure. I'll break the ice and be the first question-asker today.

My name is Greg Smith, and I'm with Reckitt Benckiser. I have question for Dr. Stamoran. I'd like to thank you and thank the panel for your presentations today.

Dr. Stamoran, in your slides, you made mention of the party who will benefit should pay the fee. I'm just wondering are you talking about benefit from a period of exclusivity based upon the changes to the monograph or can you just expand upon that a little bit?

DR. STAMORAN: From a design standpoint, conceptually, thinking about other fee programs, you have facility fees and whatnot that don't necessarily align with the people receiving the economic benefit of marketing the product.

I think that's where we were thinking here, those people that actually are receiving essentially the gross margin or the contribution margin from end market sale of that product.

That doesn't necessarily mean it's just consumer health companies. It may be private label companies going directly to retail pharmacy or other things. The channels are very different here than other parts of the market. But we're definitely talking about the people that are earning economic value by sale of those products.

Now, it's also probably -- there are multiple parties earning economic value, and we're not suggesting that every one of those in the chain: a consumer health company or a retail pharmacy, a wholesaler. It's very definitely the people that own the product and are taking it to market. So that's our intention.

MR. SMITH: Okay. Thank you.

MS. SHREEVE: Thank you. Anyone else in the audience? Anymore questions?

(No response.)

MS. SHREEVE: Okay. If not, it looks like there aren't, then we'll thank the panel again, and we can break for lunch. Given that we're a little bit ahead of schedule, I'd like to say to that we will start back again at -- instead of at 1: 00 maybe 12:45. So that gives you a little bit more than hour for break. Thank you.

(Whereupon, at 11:35 a.m., a lunch recess was taken.)

A F T E R N O O N S E S S I O N

(12:46 p.m.)

MS. SHREEVE: Good afternoon. We'll get started for the afternoon session. Get a minute to take your seats.

So we'll start with Panel 4, which is our scientific community perspectives first. We're going to invite Michael Wolf from Northwestern University, professor of medicine and learning sciences to come up, and also, Dr. Randy Juhl, University of Pittsburgh, School of Pharmacy.

If you could just come up. You can bring your cards with so people who you are, or not.

This is Dr. Michael Wolf. Thank you.

Presentation – Michael Wolf

DR. WOLF: Good afternoon. So I'm hoping this is not too much of a tangent from the morning conversations, but I think it might provide some backdrop as to I think what are some of the critical points that underlie a lot of the need for safety in over-the-counter products.

So I'm going to just give a quick

background. A lot of the research that we do in the lab at Northwestern Health Literacy and Learning Program is mostly focused on medication safety and adherence.

This is kind of our disclosures. We do quite a bit or work with industry and also private foundations, but also have a healthy federal research portfolio as well. But a lot the work does focus on how patients, or in this case, healthcare consumers, think about medications, understand the information that they get in support of their safe use of the medications, and the problems that kind of come to play that might actually affect the need for some of the considerations for expanding the resources at the FDA to properly review a lot of these products that patients have to self-select and use.

I'm just going to walk through what I think are maybe at least -- I was trying to, for this conversation -- and it's very short talk, but I wanted to kind of at least frame some general thoughts I had based on about 18 years of research

focused on prescription and non-prescription products and how patients actually use the medications outside of a learned intermediary or in their own home where they assume a role of quality control 99 percent of the time when they're not engaged with a provider.

Just kind of the underlying thought -- and I apologize if a lot of this is redundant to you and you may know a lot about this. But some thoughts I think probably is the backdrop for today's conversation is that OTC products, yes, offer a great deal of public health benefit with the caveat that patients are properly self-selecting and safely using them.

Specifically, when I was kind of looking at some of the information that is the background for this meeting, the monograph products receive the GRASE determination with an assumption that these products, the labeling of these products ensure a consumer's appropriate use when self-treating. That, we have shown, is not always the case, and I'll get to that in a moment.

Understanding that piece that the labeling can guide patients through proper self-use of these medications, the proper use of these medications for self-treatment, is the notion to a lot of the research that we focus on in the context of health literacy research, which is really the backdrop for my talk, is that people vary quite a bit. Individual differences exist in the general population, and this is something that we've learned in about 2600 plus studies in health literacy research when we look at people and how they engaged in self-care.

They vary by educational level, literacy skills, self-care experience, and that includes their experience with the products that you would all be -- for those that are in industry making, the culture and the beliefs, belief specific to how they should engage with the products, the safety of the products compared to a prescription product, and also the symptom tolerance, which in many cases, especially for analgesic products where the symptom itself may determine how they use the

medication or if they choose to kind of abide or not abide to the instructions and safe use information that they receive with it.

How consumers actually use or, again, misuse the OTC monograph-covered products may not be as expected when receiving the GRASE determination. Yes, the product may be generally safe and effective, but in the hands, when you shift into the actual use world when people are self-selecting and choosing how to use these medications without a learned intermediary, things are often different.

Some unique OTC challenges that I think just kind of set the stage for why over-the-counter products can actually have considerable problems -- I think, again that require great review and careful consideration of how people use them to determine their safety and how labeling might have to be modified as we go along -- is that because there's that no learned intermediary, we have consumers who have to walk into and choose products safely.

That, I'm going to get to in another point

how in industry, solution has also actually worked well to support the self-selection task, which has also set up a potential for harm as a result by patients being inadequately prepared to understand their medication in terms with how they use it with other medications for drug-drug interactions.

Also, there's a lot of product choices, so patients, in general, have to choose and also try to differentiate between a range of consumer products, which can be actually challenging in itself. Single-, multi-ingredient products also leave patients to oftentimes over-treat.

Problematic labeling has been well-published in the academic literature showing that there's a lack of clarity and understandability of a lot of information, including the drug facts label itself, which is the standard, and seeking different ways that we can actually improve upon that so people can safely use these products and not make errors is pretty important at this point.

Just as an aside, kind of in context, where the level of difficulty of taking an

over-the-counter product actually resides in terms of everything that one has to do to manage health.

This was the National Assessment of Adult Health Literacy done in 2003 among, I believe, 17 or 18,000 adults throughout the United States, where they are giving objective tasks where they had to kind of perform.

Here, you probably can't see because the font is too small, but in the middle of the pack, what you see is one of the tasks that people were given was to identify three substances that may interact with an over-the-counter drug that causes side effect, and to use the information given to them on an over-the-counter label to actually make proper decision-making with that product.

This score of 228 basically is situated that people that were in the basic or below basic levels of literacy skills, in that group of 18 or 19,000, adults could not perform that task.

What does that translate to? It translates to 43 percent of the adult population struggled to do this OTC task in this large national assessment.

That group, the basic or below basic categories that you see on the side, are actually groups that we would recognize in the literature as being limited-health literate or low-literate populations.

So again, to say such a large amount of people would struggle with some basic common tasks with OTCs, I think underscores the need to make sure that everything we do is very much consumer-centered and we do monitor their safety.

Point number 3 is that the marketing practices for over-the-counter products, as I mentioned earlier, focus consumers on symptom targets, so not active ingredients. Again, this has come out quite a bit.

So in the context of thinking about how we have to safely support patients and their safe use of the products, we do recognize time and time again that consumers may probably self-select the product, that they've matched it because it says on the product "for migraine," "for back pain," "treatment of cold or severe flu," yet, they don't

know what they're taking. And this creates great potential for drug-drug interactions, patients double dipping with pain products. We've seen this and reported on this many times before.

The term that I really, really hate that oftentimes is used in the prescription world -- it's almost a way of suggesting that it's fun, a "therapeutic misadventure," happens with OTC products as well. And again, this shouldn't come as a surprise. I just went on PubMed real quick just to kind of get an update. The number of times you see articles pop up are in the thousands in terms of studies that actually showed that some specific non-prescription product might be associated with some sort of misuse or medication error.

Consumers intentionally or unintentionally misuse over-the-counter products. In specific, some of our research that we published over the past few years, with not just over-the-counter pain analgesics but cold medications as well, has looked at how patients exceed maximum daily dose, double

dip, incorrectly self-titrate dosing intervals, taking medications if it's supposed to be every 4, every 6 or 8 hours, over-medicate with multi-ingredient product, hearing people say that I take Tylenol PM just because I want to go to sleep.

These are the kind of products that we we've been kind of investigating with people, realizing that they could be taking a single-ingredient product instead. And again, in a lot of these studies, we've identified that the labeling itself is the root cause of the problem.

Here are some of the statistics that we've shown in recent literature. Mick Miller [ph] just recently just showed that over half of adults lack awareness of over-the-counter risks. One in 4 patients from our studies have shown that patients would take more than a recommended max dose for over-the-counter products, and that nearly half of adults misuse over-the-counter products by concomitant use, the double dipping that I mentioned earlier.

So kind of getting to a culminating point

here with my time running out, better OTC surveillance is really necessary at this point, and that includes having a more detailed and more frequent safety review and the responses to how we can actually think about handling some of these issues with labeling, improving better safety, making sure patients are aware of the risks, all of these things. Innovation is greatly needed in these areas at this time.

The timeliness of this I think is very, very important as well because, again, there is not learned intermediary, and it's a challenging thing to get a lot of the messages out when we can't rely on healthcare system or even, oftentimes, a pharmacy that may not have the capability or part of their workflow, a means to kind of capture patients to support their decision-making.

Just one other piece on the surveillance that makes it so challenging for non-prescription medications is the fact that, again, not only do we not require a healthcare professional to be involved in the decision-making for use of these

products, but oftentimes not only do patients perceive them to be of lesser risk and safer medications to take, but so, in some cases, do healthcare providers.

What we've shown in the study is two things. One, in a study that we published in 2013, 86 percent of patients believe their doctor is aware of all the over-the-counter medications they're taking regularly. But only 46 percent reported what routine OTC medications they take. It's kind of like there's omnipotence. I just assumed that physician knows what I'm taking. I don't have to tell him because he's got this wonderful electronic health record.

That said, one thing that we have shown with medication reconciliation with electronic health records and part of doing a comprehensive medication review, when patients do self-report over-the-counter medication use on a regular basis, their provider rarely recognizes that omission and puts that information into the medication list because their beliefs also are that, I don't need

to worry about that; it's not one of the prescription medications.

So again, I know I'm over here. Just my final points for this, mainly the context for this meeting today is that I think the justification for OTC versus prescriptions based on labeling is about the ability for consumers to self-care, so making sure that patients are able to get directly through all of these products that are reviewed through the monograph are updated and are accurate. And especially when you recognize how people misuse medications, it's important, especially with non-prescription medications, to have that review intensely.

Consumers also presently have inadequate support for OTC decision-making and safe use, and disparities actually exist in the patients who are most at harm. Reasons for an FDA expanded review program are well-defined. I think through the FDA register, I would agree with all of the points why there could great benefit to have more resources directed in this area.

I'll stop there. Thank you.

MS. SHREEVE: Thank you, Dr. Wolf.

Dr. Juhl, you want to join us now? Dr. Wolf [sic] is from the University of Pittsburgh School of Pharmacy.

Presentation – Randy Juhl

DR. JUHL: And that's Pittsburgh with an H on the end.

Good afternoon. I'm Randy Juhl. I recently retired from the University of Pittsburgh and now holding the title of dean emeritus of pharmacy and distinguished service professor emeritus.

More germane to today's agenda, I had the pleasure of serving as the initial chair of FDA's Non-Prescription Drug Advisory Committee from 1992 to 1996. There I am.

In the interest of full disclosure, I am not part of any current grant or contract with pharmaceutical industry or device companies. However, my wife has worked for Pfizer and currently for Mylan, so I have those interests.

First, my thanks to the FDA for the

invitation to appear here today. It's good to be back. Let me start by providing my perspective on what's wrong with the FDA.

(Laughter.)

DR. JUHL: There are basically two big problems that are illustrated by this Washington Post article. The first big problem is that the FDA is too slow and conservative in its actions, and people are dying.

The second big problem, the FDA is too quick and careless in its decisions, and people are dying.

(Laughter.)

DR. JUHL: Now, I love this slide. It's an old one as you can see by the date, but it's still a commonly held view in many circles. Here, the FDA is rushing drugs to market based on shoddy evidence. Here, the FDA sloth is hurting innovation.

But finally, I was relieved, and you should be relieved, too, that there has been finally a sensible and definitive solution that was offered

by Senator Cruz, you remember him, "Congress ought to make the decision any time that there's a problem with the FDA."

(Laughter.)

DR. JUHL: So given that clarity of the FDA's mission as viewed by the public, I have great sympathy and respect for those of you who are charged with carrying out the massive responsibilities of the agency.

Having said that, I believe that the OTC monograph system probably falls squarely in the too-slow category. The process started in 1972 when I received my bachelor of pharmacy degree from the University of Iowa. Here, we are today, no end in sight and I've retired. And likewise, I'm very grateful to see the agency's initiative to get this process back on its feet.

I think it's useful to remind ourselves what an innovative and can-do operation the OTC drug review was during its early years. As stated earlier, there was lots of products on the market, and rather than go product by product, as

ingredient by ingredient, and there were those 17 expert panels, 513 meetings over 10 years with 200 plus outside volunteers and FDA staff, and in retrospect, it was a massive and highly successful operation.

Let me run through some of the events. Hexachlorophene was removed from the prescription market. They're removed from the OTC market to prescription. For those of you that don't recall, that was the old-time Purell, but it was found to be absorbed through the skin of infants, neonates, and caused neurotoxicity.

Zirconium, tribromsilane was removed from the market. Antacid testing procedures, that was really helpful to me as a pharmacist. We used to use antacids for a lot of different things. But nobody knew how good they were.

There was a New England Journal article, it was basically the same kind of thing you did in introduction to chemistry, you titrate with a burette to find the acid neutralizing capacity, and they studied it in vivo as well.

Theophylline was supposed to go over-the-counter. The FDA, in its wisdom, overruled the advice of the panel, and that turned out to be the right thing.

Chloroform was removed from the market. The chlorofluorocarbon situation was started. Daytime sedatives were removed and methylpyroline was removed from the market. SFP, protection factor, was recommended by the panel and voluntarily accepted by the industry.

Phenacetin, a common ingredient in headache remedies, APC, the P stands for phenacetin, it was removed from the market for kidney damage that it tended to cause.

Internal insect repellents were removed from the market. Now, I don't know how people expected those to work. Those tiny little tablets, you couldn't get mosquitos to take those.

(Laughter.)

DR. JUHL: Overindulgence remedies or hangover remedies were removed. Anti-cholinergics were found to have more toxicity than good, and

hair restorers of the day were removed. Last, Reye's syndrome warning list was placed on aspirin.

This last one serves to remind us that not everything OTC is curing up pimples and growing hair on bald guys. Some of these things are life and death issues.

This graph shows a number of cases of Reye's syndrome over time, and you see the marked events where the possible scientific correlation was made, the Surgeon General's Advisory labeling of aspirin products, and the subsequent decline in number of cases.

Two things to say from this chart, first, when science learned of the relationship between Reye's syndrome and aspirin consumption, action by the Surgeon General, the CDC, and the FDA solved the problem, a victory for public health.

The second thing the graph shows is there's considerable morbidity and mortality between the beginning and the end of the protracted story. In retrospect, who wouldn't have hoped for a faster, more efficient regulatory process and a more

cooperative and more public health-minded commercial constituency, not a particularly proud moment for a segment of the OTC industry.

Now, I review this bit of history to reinforce the importance of moving forward, not only finishing the monograph but more importantly to devise and find support for ongoing care and feeding of the monographs so as to encourage innovation, modernization, and to enable, prompt, and enlighten reaction to signal, so safety problems.

Now, on to the questions at hand, the user fees. Conceptually, I'm not a fan of user fees for a variety of reasons, but given current day political realities, the buffalo aren't coming back and user fees are here to say. Though moving away from ideology to reality, yes, I accept the need to implement a user-fee strategy to support the monograph system at the FDA.

Now, we got to the questions, and I have to be truthful, that's where I bogged down for a couple of reasons. There really wasn't enough

information, and I'm not particularly well-qualified to talk about what kinds of user fee should be implemented. But I was puzzled that there was so little information from the FDA about how user fees are going to be implemented, or used, or some qualitative information that would be helpful in that regard.

I'm from a university. We ask for money. We ask for money a lot, and we're actually pretty good at it. Now, let me digress. I'm of Scandinavian decent, and there's an old Viking proverb that speaks to the order of how things should be done. It goes, "Pillage, then burn."

(Laughter.)

DR. JUHL: To do it the other way around doesn't make sense.

(Laughter.)

DR. JUHL: But what I saw in the announcement for this meeting was we're going to ask for money, but we're not going to tell you what we're going to do with it. We're not going to tell you how much we want, and we don't know when we're

going to be done.

So I really encourage the agency to move forward with that kind of thing. And I know there's stuff going on behind the scenes, but you really need to give us more information in order to, two things, one, make the political process work, and two, to inspire confidence that this actually can be done, because there's been a lot of broken promises over the last decades on the monograph system.

The regulatory process always goes better when the public interest and constituencies and the regulated industry are informed, engaged, supportive, and in this case, confident that new money will be invested in a process that will bring measurable success.

The implementation of the OTC monograph user fees will require a formal transparent public quantitative planning process that tells the taxpaying public interests and constituents and the regulated industry what they're being asked to buy, how much, at what cost, and what measurable public

health promoting their protective achievements will be realized, and when. A discussion of the funding of the monograph user fees really seems premature without that information. I'm really supportive of it. I know it's needed. We just need to have a little bit more information.

I close by reading from the summary of the 2014 meeting that has been off topic, I guess, for today. I'm a little rusty, having been retired. The official summary of the 2014 meeting said, "Here are the key themes presented by stakeholders. First one mentioned, the agency should establish clear goals and timelines in order to finish the remaining 20 percent of the TFMs. Number two, there's a need to improve transparency."

So I'd recommend a reread of that over two-year-old document, and let's move forward on this and get the job done. Thank you.

MS. SHREEVE: Thank you, Dr. Juhl.

Are there any questions at this point for the panel?

(No response.)

Open Public Comment

MS. SHREEVE: Okay. It doesn't look like it, so we'll let you go, not too far, I hope.

At this point, we'd like to open up the mics for the public comment. We have about eight speakers who have asked to speak today. For those of you who might want to, if you want to come up after they finish, that would be great.

We'll ask you to sit in your seats. I'll just call the first speaker, if that's all right, and then we'll move on through the list.

Paul Brown?

MR. BROWN: Hi. Good afternoon. My name is Paul Brown. I'm affiliated with the Patients, Consumers, and Public Health Coalition. I also work for the National Center for Health Research Dr. Zuckerman presented earlier.

Thank you for the opportunity to speak today. We support providing the FDA with additional resources through OTC user fees. I think there's been a pretty good case made for the need for the user fees.

We agree with many of the statements that were made today by National Center for Health Research, of course, the National Consumers League, the AAP, the university professor who just spoke here. I'm not going to go into all the history because I think it's pretty well covered, so I'm going to skip that part.

Many OTC products without general recognition of safety and effectiveness determination continue to be marketed leaving millions of Americans vulnerable to potentially unsafe products. As has been pointed out, a staff of 18 cannot effectively regulate 800 active ingredients for over 1400 different therapeutic uses.

We are particularly concerned about how the current process limits FDA's ability to require new warnings or other labeling changes to address emerging safety and effectiveness issues in a timely manner.

We strongly urge the FDA to include funding and user fees to address safety and effectiveness

issues. FDA needs resources to provide ongoing surveillance of marketed products and to move quickly when safety signals arise.

This is especially important, as AAP pointed out, for products used by children. When the monographs were first developed in the '70s, FDA lacked specific data on use in infants and children. So FDA did what was scientifically customary at the time and extrapolated the data by simply reducing the adult dosage by percentage.

Our understanding of pediatric dosing has grown since then, and as a result, data from actual use in the pediatric population is preferred. Many products continue to be given to infants and children without sufficient safety and effectiveness data. The OTC user fees are needed to support the reexamination of the use of these products in children.

OTC product user fees should also support the development of product formulation standards. The monograph set forth the conditions under which a specific active ingredient used in a drug product

is generally recognized as safe and effective and not misbranded.

The monograph, however, generally does not dictate what other non-active ingredients can be added or other aspects of the formulation. For example, we know that many products formulation variables affect how of the tablets medication dose is absorbed.

The regulatory science behind generic drugs has shown us that excipients in manufacture and quality controls must factor into the determination of a products' safety and effectiveness. Therefore, we recommend development of standards for drug products, not just ingredients, and we urge FDA to include funding for this in user fees.

A user-fee system for OTC drugs will have to take into account the way OTC drugs come to market, since the monograph system is ingredients-based, not product-based. And since sponsors of monograph drugs are not required to obtain FDA approval to marketing, the fees structure will have to have important differences as compared to that used by

prescription drug programs.

We recommend that user fees be structured as a product listing fee based on a sliding scale proportionate to the complexity and reviewing resources required. We feel this mechanism will provide the agency with a stable and predictable source of funding for the OTC division.

We would avoid structuring the fee as a facility fee since it may have the unintended consequence of pushing sponsors to consolidate operations into a few facilities. This could impact the supply chain and cause OTC drug shortages.

In summary, we support the establishment of a user-fee program so that the OTC monographs can be finalized. We urge you to include funding and user fees to address emerging safety and effectiveness issues and to reexamine the use of certain OTC products in infants and children. Thank you.

MS. SHREEVE: Thank you, Paul.

Our next speaker is, Greg Collier.

MR. COLLIER: Thanks, Chris.

My name is Greg Collier. I'm the global director for healthcare safety regulatory and analytical chemistry for the Procter & Gamble Company. On behalf of P&G, we appreciate the opportunity to provide some comments on a possible user-fee program to help facilitate a reformed OTC monograph system.

I think I probably speak for everybody here. There's no place we'd rather be on a beautiful June Friday afternoon than talking about this topic. So in the interest of better meeting the needs of U.S. healthcare consumers, if the following criteria can be met, Procter & Gamble is supportive of a user-fee program that would help ensure high quality science, regulatory review, and responsiveness for OTC monograph active ingredients.

The OTC monograph process is very different from other user-fee funded programs. OTC monograph drug products don't require FDA approval. The ingredients under review have been safely marketed

for decades. Therefore, a monograph user-fee program will require careful consideration and design to ensure it provides value for both healthcare consumers and product manufacturers.

In addition, care must be taken that a new fee structure doesn't become a disincentive for manufacturers to request new safety-related product enhancements that could better serve healthcare consumers.

P&G agrees that FDA is critically under-resourced for regulating non-prescription medicines. We agree FDA needs expedited hiring authority to fill critical, high-skill vacancies to prioritize and complete the review of top priority tentative final monographs.

We recommend, as a first step, FDA should consider additional appropriation funding adequate to staff and manage a streamlined monograph review process for completion of these top priority TFMs. With baseline appropriations in place, a new OTC monograph user-fee program could be established to complemented the appropriation budget, further

enabling development of new innovations processes, review capabilities and information management systems to help provide responsiveness and agility to keep OTC monograph drug products state-of-the-science and relevant into the future.

P&G recommends user fees be directed towards measurable deliverables that facilitate new innovation and updated science to improve OTC monograph products so they better meet the needs of our healthcare consumers.

User fees should be transparent and trackable with clearly defined metrics and success criteria. Examples of user-fee targeted deliverables and metrics might include timely scheduling of sponsor-requested meetings, new processes, associated review timelines, and possibly exclusivity to enable new innovations such as updated claims, dose forms or performance tests for existing ingredients, and possibly general recognition of safety and effectiveness for new ingredients; new processes and timelines for sponsor-initiated drugs facts changes, new guidance

documents to facilitate the above processes, and a new dashboard process for transparent FDA communication of monograph priorities and upcoming actions to allow manufacturers' ability for adequate preparation.

Finally, the heterogeneity of current OTC drug monograph manufacturers will make it more difficult to develop a user-fee model that equitably distributes cost. A straight fee for a requested event model may be the most equitable, but P&G understands the FDA's need for a more predictable funding model to facilitate staffing and budget projections.

We, therefore, recommend exploration of a hybrid funding model structured to provide predictable funding to support new capabilities and activities that benefit all manufacturers while also including a fee for requested event component to fund additional FDA review capability and performance targets that enable new innovation and specific sponsor-requested activities. Thank you.

MS. SHREEVE: Thank you, Greg.

Could Paul DeLeo come up next?

MR. DeLEO: Thank you, and good afternoon. I'm Paul DeLeo with the American Cleaning Institute. The American Cleaning Institute is a trade association representing the $30-billion U.S. cleaning products industry.

ACI members include the formulators of soaps, detergents, general cleaning products used in household, commercial, industrial and institutional settings, and the companies that supply ingredients and finished packagings for these products.

More specific to today's public meeting, ACI members manufacture retail consumer antiseptic products, as well as commercial and institutional antiseptic products used in healthcare settings and food handling setting, which are regulated by the FDA under the topical antiseptic product OTC monographs.

We've been engaged in the development of the OTC monograph for topical antiseptic products for four decades as ACI and in our previous incarnation

as the Soap and Detergent Association.

While completion of the topical antiseptic monographs and several other monographs are long overdue, we want to be clear that we continue to support the OTC monograph system and believe it continues to serve public health by bringing safe and effective drugs to the market at affordable prices while permitting some innovation in the market. As such, we would caution against a user-fee system that would jeopardize the cost effective nature of OTC drugs and would, in any way, inhibit innovation.

While we believe it would be useful for FDA to have additional resources to be more effective in handling the OTC workload, FDA needs to more clearly justify those needs and better demonstrate how those additional resources would benefit consumers and the regulated community.

It's not apparent that user fees would be easily applied to every regulatory action that falls under the OTC process. And again, our particular interest is primarily with the

unfinished monographs and the four monographs specific to the topical antimicrobial products.

We do not believe that the user fees for manufacturers of products under those four monographs would be easily assessed or collected without additional burdens being placed on those companies, and we would oppose the establishment of new product registration requirements that might be necessary to collect user fees.

Finally, ACI member companies have committed tremendous resources and are prepared to work for many years, if necessary, to complete four topical antiseptic monographs. In that respect, our members who have come forward to generate safety and efficacy data for active ingredients to satisfy new requirements from FDA should not be punished for doing the right thing.

There are many other companies in the market who appear to be poised to benefit from our members' goodwill. We believe that those who make material contributions in generating safety and efficacy data to complete unfinished monographs

should receive credit for this investment up to and including being exempt from any user fees that might be developed for those monographs.

We appreciate the opportunity to share our thoughts with FDA and wish you the best of luck in addressing this challenging issue. Thank you.

MS. SHREEVE: Thank you, Paul.

Jethro Ekuta?

MR. EKUTA: I have a disclaimer to make, which is that Greg and I did not share our presentation before the meeting, but you will find some parallels.

Good afternoon. My name is Jethro Ekuta. I'm vice-president and head of regulatory affairs, North America, for Johnson & Johnson Consumer Incorporated. First, I would like to state that Johnson & Johnson supports a user-fee program for OTC monograph products.

As a global leader in the development of over-the-counter products, Johnson & Johnson appreciates the opportunity to present its ideas on how to support the OTC monograph process to address

the challenges raised by the FDA.

In short, Johnson & Johnson supports a user-fee program for OTC monograph products and believes that the monograph process should build on the history of safe use and the progress made to-date. We share FDA's mission to protect and promote public health, and we believe in the value of collaborations to help accomplish this.

So in this regard, Johnson & Johnson has been collaborating and will continue to collaborate with other industry members of the Consumer Healthcare Products Association and the Personal Care Products Council to partner closely with the agency through productive conversations that will lead to reform of the OTC monograph process.

This would enable all key stakeholders to realize the full benefits of an effective monograph process in advancing the public health. In the four decades since FDA developed what was then a groundbreaking process to regulate OTC products, the monograph system has provided access to safe and effective products that consumers and

caregivers depend on and that healthcare professionals recommend.

While we believe that appropriations should remain the mainstay of the agency's funding for executing its public health mandates, J&J welcomes and supports this dialogue regarding a potential user-fee program to supplement but not replace the agency's appropriations.

Second, J&J shares the agency's need for stable and predictable sources of adequate funding. The most important sources of a stable and predictable revenue stream from existing user-fee programs for the agency tend to come from product listing and facility fees.

It would seem reasonable that these sources of revenue should also be explored for OTC monograph user fees. It's important to highlight that for the most part, current OTC monograph products generate less revenue than their pharmaceutical counterparts. And this is a factor that the agency should consider in any decision regarding user fees. It will be extremely

difficult to justify an application-based user fee in the absence of any incentive to encourage innovation such as provision for exclusivity.

The current OTC monograph system does not have a provision for exclusivity. Other existing user-fee programs align with some corresponding form of exclusivity. The provision of a reasonable period of exclusivity based on the nature and extent of studies conducted to support developing activities such as new claims, new dosage forms, addition of new ingredients or combination of existing ingredients, is highly likely to encourage innovation and should be considered an important element of any application-based user fee imposed on OTC monograph products.

Third, FDA needs to be clear on what activities of the agency will be supported through user fees. We believe that user fees should be leveraged to address the most important activities that would result in improving the efficiency of the regulatory process and enable innovative OTC products to become more readily available thereby

promoting the public health.

We anticipate the benefits of potential user-fee programs would be to support innovation, predictability and transparency in regulation and the regulatory process. We also anticipate that in conjunction with receiving user fees, FDA will commit to certain performance goals related to the agency's activities with respect to the relevant products.

Finally, FDA should build on progress made to-date and build on long history of safe use regarding OTC monograph products. We're also fully aligned that user fees can help provide the resources needed to allow FDA to finalize those OTC monograph products that have open issues.

The agency should build off of the existing data and decades of robust postmarketing safety and efficacy experience that currently exist for OTC monograph products rather than starting over. In some cases, these products have been used by consumers and patients for many decades.

In conclusion, J&J supports the current

discussion regarding an OTC monograph user-fee program. This program would provide FDA with resources to supplement appropriations and promote predictability in the agency's OTC monograph review process while continuing to promote the development and evaluation of innovative OTC monograph products.

In order to serve the needs of consumers and healthcare providers who have come to rely on these important products for self-care, a reformed and well-funded monograph process could advance the public health.

Thank you again for the opportunity to comment on the OTC monograph user-fee discussion at this public meeting.

MS. SHREEVE: Thank you, Jethro.

Diane McEnroe, coming next.

MS. McENROE: Thank you. My name is Diane McEnroe, and I'm a partner at Sidley Austin in New York. We also take this opportunity to thank FDA for opening up this meeting to hear stakeholders and offer input on the OTC monograph user-fee

program possibilities.

Sidley represents the number of global pharmaceutical and consumer healthcare products who manufacture a wide array of monograph and NDA OTC products. With our input, I offer the following points, which in large part favor user fees when tied to innovative new market entries with the establishment of related performance goals by the agency.

While not the focus of today's hearing, supporting monograph reform legislation is important and is an important backdrop, as the safety and health of consumers can be optimized by improving FDA's ability to promptly communicate safety issues, finalize monographs, and enable innovation.

That said, as we've heard a lot today, the monograph program is critically under-resourced, which has resulted in the backlog of pending monographs we heard about earlier. However, user fees for non-prescription drugs must be carefully and cautiously considered for monograph products so

they're tied to efforts that would move the industry forward and not just play catch-up while ensuring the safe and effective OTC monograph products.

A user-fee program that will encourage much need innovation in the OTC monograph arena makes a lot of sense. Tying OTC user fees to innovation will best serve to jump start the monograph system while providing the FDA the resources to ensure the products that are introduced to the market are safe and effective for the American public.

It's also consistent with the established prescription drug user-fee programs, which FDA has stated are intended to promote innovative therapies and which Dr. Mahoney's presentation this morning indicated is in fact happening.

In the OTC context, user fees should support the timely marketing of novel therapies if they're targeted to, for example, FDA's review of industry initiated Category 3 ingredient safety or efficacy submissions, or FDA's review of a company's position on a new ingredient, a new combination, or

a new dosage form to an existing monograph.

FDA must recognize however that companies are hesitant to initiate the studies to support innovative therapies and to pay user fees if competitors can simply piggyback on that effort. We therefore support congressional establishment of incentives, such as product exclusivity for industry submissions containing data that support innovation to a monographed product.

Ultimately, encouraging innovation in a monograph system will lead to increased value and safe and effective product option for consumers, but there must be some motivation for companies to expand additional resources to move products forward.

The establishment of performance goals related to each activity that triggers a user fee is encouraged, such as the agency on a timely basis reviews and responds to each submission supported by a user fee. Using GDUFA performance goals as a model, FDA could identify specific timelines or target goals for FDA to complete review of a set

percentage of submissions.

Finally, user fees that are tied to product listings, manufacturing to sites, or to industry-specific sales numbers are not supported, as these will act as a disincentive to product introduction and maintenance of products in the United States. User fees should not be used to finalize pending monographs across the board, especially as companies are marketing products in only certain therapeutic categories and typically not all.

As FDA has recognized, there are important differences between the prescription and OTC drug approval process and the OTC monograph system. In particular, the monograph system is ingredient-specific, not product-specific. Imposing user fees simply to finalize an FDA imposed undertaking over four decades in the making raises considerable inequities.

Congressional appropriations rather than user fees are more appropriate method for ensuring a stable and predictable source of adequate funding

to continue that monograph process. To that end, we would support additional congressional appropriations to assist an underfunded FDA in finalizing pending monographs, completing FDA-initiated reviews of Category 3 ingredients, and to develop and maintain a modern monograph system.

In summary, any OTC user fee should be tied to innovation. We recommend the establishment of new pathways for OTC manufacturers to submit data in support of new products. And to stimulate innovations, Congress should provide for incentives such as exclusivity for certain types of submissions.

This proposal adequately serves the agency's goal of increasing monograph flexibility but does not impose inequitable burdens on innovative OTC manufacturers. Thank you.

MS. SHREEVE: Thank you, Diane.

Next, we'll here from Richard Stec.

DR. STEC: My name is Richard Stec, vice-president of global regulatory affairs and

public relations, and I'm from Perrigo Company.

Perrigo would like to thank the Food and Drug Administration for the opportunity to present our thoughts and opinions on extending a user-fee program for regulatory oversight of OTC monograph products.

There are numerous existing user-fee programs within FDA for drugs and devices, each with their own driver. PDUFA, the initial user-fee program signed into law in 1992, was borne out of the agency's inability to keep pace with an increasing volume of NDA submissions.

The pharma industry was willing to pay user fees supplement appropriations for the purpose of clearing the submission backlog and building FDA's review capability to expeditiously review and approve NDAs.

MDUFA was signed into law in 2002 and, similar to PDUFA, provided the agency funding for additional resources to keep pace with an increasing volume of medical device submissions and to significantly improve the timeliness and

predictability of FDA's device reviews.

The most recent user-fee program, GDUFA, signed into law in 2012, was built upon the tenets of transparency, access, and safety. To address the agency's inability to keep pace with a huge influx of ANDA submissions, the generic and API industries agreed to a user-fee program to provide FDA funding, in addition to appropriations, to address the ANDA backlog, to create parity of facility inspections, and to provide predictability of ANDA reviews.

In general, the predicate user-fee programs just described were agreed to by industry to provide FDA with additional resources to A) address the increased submission workload that resulted in a backlog of pending submissions, and B) to provide greater certainty of application reviews, faster approvals, and greater patient access.

In contrast, OTC monograph products do not require FDA approval of a regulatory application to market. Unlike the user-fee programs just described, there is no dramatic increase in new

monograph introductions creating a backlog of products that cannot enter the market. On the contrary, of the 52 OTC monographs that have been issued, only 10 remain pending and have been pending for decades.

The proposal for user fees to clean up decades old tentative monographs has no tether to provide greater access of new products to the public and therefore little incentive for the industry.

Additionally, FDA claims it needs resources from user fees to reengineer and modernize its processes. In our opinion, the current monograph rulemaking process works. FDA, however, has elected not to resource executing the process. The other user-fee programs have funded process improvements to address increased submission volume, certainty of reviews, and greater patient access. Modernizing old processes for existing OTC monographs is the responsibility of appropriations funding.

FDA's earlier presentation today indicated

there are only 30 FTEs overseeing monograph products. In our opinion, FDA quietly has elected not to resource OTC monograph drugs. Previous user-fee programs augmented federal appropriations. The proposed monograph user fees appear not to augment appropriations but rather fund the majority of the monograph program. This simply is not an OTC industry responsibility.

FDA has also stated that a user-fee program is required to address consumer safety by finalizing the review of pending ingredient monographs and modifying labels for new safety concerns.

The drug and device industry has fully supported improved patient safety in other user-fee programs. However, we are a bit confused by the link of pending OTC monographs to consumer safety. It is well-known that FDA prioritizes activities by public health need. Yet, the finalization of tentative monographs is clearly not a high priority, and a manufacturer is not prohibited from marketing products covered by a tentative

monograph. The safety concern raised appears to be a very low-risk issue.

Perrigo agrees in part with the agency that the current monograph rulemaking process is cumbersome, slow, and somewhat prohibitive to allow new innovative products to enter the market. Perrigo would consider support for a user-fee program that focuses on greater consumer access to innovative OTC products. Any change to the current regulatory framework that would involve the submission and review of data by FDA would not be supported.

Perrigo hopes the agency industry dialogue around monograph modernization continues. While pay-to-play user fees might be a mechanism to support this objective, it must be fair to all companies.

We encourage the ongoing dialogue to focus on the following five critical issues: 1) the scope of innovative products and technologies to consider; 2) the goals that support market entry of new innovative products; 3) the overall user-fee

structure; 4) the companies within the industry that would pay the user fees; and 5) the annual program cost.

Perrigo thanks the agency for the opportunity to share our views and opinions, and we look forward to continuing dialogue on this important topic.

MS. SHREEVE: Thank you, Richard.

Now, we're hear from Steven Woolf.

MR. WOOLF: Good afternoon. Good-looking group. I can't believe we're all here on a Friday afternoon. I'm with Greg.

I will make this very brief. My Uber driver says he's six minutes out, so here we go.

First of all, thank you. We appreciate the opportunity to sit in on a forum and speak at a forum such as this, a public forum. My name is Steven Woolf. We're right on that one. I'm representing HUMCO Holding Group. HUMCO is a 144-year-old company that manufactures and distributes in excess of 160 OTC products, most marketed under the FDA's OTC drug review and OTC

monograph system.

As some of you know, not many, but some of you know, and many will figure out, I'm not a scientist; I'm not an attorney. But I am a business owner and chief financial officer.

I come with about four decades of experience in FDA regulated industries, consumer products industries, I should say. Thus, my mission today is to clearly and simply point out that the economic impact of user fees will ultimately be passed through to the consumer. This increased cost to the consumer should be top of mind as we debate and talk about the user-fee issue.

We appreciate the FDA seeking new resources to support OTC drug ingredients under the OTC monograph system. The breadth and complexity of the FDA activity is staggering, ranging from monitoring safety and finalizing pending monographs, to expanding the monograph process, to new OTC products rather than relying on the expensive alternative of a sponsor-specific NDA items.

While we understand the agency's consideration of a user-fee system, we believe such a system is not the appropriate solution to the unfinished and ongoing business of OTC drug review. The OTC drug review is, by nature, a public process, and funding to complete the review should come from public funds appropriated by Congress.

We would, therefore, strongly oppose an FDA appeal to Congress for user fees to fund the monograph-based OTC market. Our position is that products in this market are generally low-priced, low margin, commodity type items without third party reimbursement and with extremely low barriers to entry.

Were we to add a fee to this system, we run the risk of pricing OTC monograph products to the point that they are no longer affordable to typical consumers who rely heavily on these drugs as a critical part of their family's healthcare regimen.

HUMCO is dedicated to producing safe, high quality OTC products. We focus on quality with manufacturing efficiencies in order to bring

low-cost, high quality product to the consumer.

Even seemingly modest cost increases in the form of user fees could have a destabilizing effect on the market, likely giving larger organizations an advantage, driving smaller companies out of business, eliminating competition, and leading to increased prices for the consumer.

Bottom line, the result of placing user fees in this market could have a painful impact on the consumer. This is not the result that any of us want to see. Please take into consideration the ultimate impact on the consumer that a user-fee system would cost.

HUMCO's view is that either congressional appropriations or redirecting existing resources via the regulatory stipulations that were pointed out earlier is a much better way and will provide a much more favorable outcome for the consumer than by implementing a user fee in this market.

Thank you. I appreciate your time. I appreciate the opportunity.

MS. SHREEVE: Thank you, Steven.

Carl Cirrachi?

MR. CIRRACHI: Thank you. First, I got to apologize. I don't have a prepared statement. I just got my name on the list to make sure I got to reiterate some of the points that were made here today.

Again, my name is Carl Cirrachi, regulatory compliance lead with Church & Dwight, consumer packaged goods company. You probably know us better by our brands, Arm & Hammer, Orajel, First Response, and Trojan.

First, understanding that there's going to be a need for fees, the first thing -- and I think it was the good doctor that made the statement that there should be a plan put in place before a fee is imposed to let the public know or the industry know with regards to what they're going to be used for.

I can take this from real life experience. Having served or currently am serving in local government, I've seen public questions put on ballots, asking the taxpayers for spending initiatives. The ones that are well-defined get

approved. The ones that are not well-defined don't get approved. It would be a challenge, I believe, to get this referendum approved without a plan if it was put before the public.

But as far as going forward with the plan, it was stated numerous times here with regards to transparency, some of that should include, with regards to tentative final monographs, what is the plan for that, whether it's going to be all worked on or a timeline simultaneously, or if there will be a prioritization list; because obviously, we're interested in only a handful of those or in that category.

With regards to the fee structure, the GDUFA model wouldn't be the best or appropriate one considering its splitting the deficit amongst all the users doesn't really provide incentive for controlling costs. Again, I can give a real life example of that. Coming from New Jersey and our property taxes, it's pretty much how our property taxes are determined, is a budget is put together, then we split it amongst all the taxpayers.

So what we would be in favor of or we do see as legitimate would be more along the lines of devices, would be a facility fee. I know there were some concerns with regards to supply chain. Being a publicly traded company, the last thing we would be doing is jeopardizing our ability to meet the demands of our retail partners at that. Again, that's only speaking for ourselves.

We could see perhaps product listing fees, but as far as from ease of registration and filing, facility fees would be much easier for us, a little bit of a less of a burden.

Lastly, with application fees, we wouldn't want to see them for those that are currently in process, but just strictly for new ingredients going forward. Thank you.

MS. SHREEVE: Thank you, Carl.

Carl was our last registered speaker. Would anyone else like to come forward?

(No response.)

Closing

MS. SHREEVE: Okay. If not, that concludes

today's agenda. We want to thank, again, all our panelists, public commenters and all of you for attending.

The materials from today's meeting and the recording of the proceedings will be available and posted to the Web. If you would like to comment on today's proceedings, we encourage you to access the public docket. We'd like to hear from as many of you as possible. And I believe we have those Web addresses there for you. Thank you.

(Whereupon, at 1:52 p.m., the meeting was adjourned.)