

**Comments of
The Healthcare Distribution Management Association (HDMA)
On the Food and Drug Administration's (FDA)
Anti-Counterfeit Drug Initiative
Docket No. 2005N-0510, 71 Federal Register 1759 (January 11, 2006)**

HDMA appreciates the opportunity to share with the Food and Drug Administration (FDA or the Agency) our members views on the Agency's final regulations implementing the Prescription Drug Marketing Act (PDMA) rule that was finalized on December 3, 1999 (Final Rule). We also take the opportunity to expand upon the comments we provided at the public Workshop with regard to Electronic Product Code/Radiofrequency Identification (EPC/RFID).

HDMA and its members have played a leadership role in the effort to develop both technology and policy approaches designed to meet the threat of counterfeit drugs head on. As shown in Attachment 2, HDMA has established an extensive record of such efforts, not the least of which has been our ongoing work with the states to enact stricter licensure and enforcement laws, development of a set of best business practices, i.e. *HDMA's Recommended Guidelines for Pharmaceutical Distribution System Integrity* and ongoing participation in RFID research and standards development activities.

HDMA is optimistic that efforts to prevent the entry of counterfeit drugs into the supply chain by the distribution industry and other stakeholders have begun to show success. As noted by Randall Lutter in FDA's testimony Before the House Subcommittee on Criminal Justice, Drug Policy and Human Resources, (November 1, 2005) the number of counterfeit drug investigations in fiscal year 2004 fell in fiscal year 2005, and we agree with FDA that the decline may be due in part to successful deterrents. While optimistic, HDMA believes that all members of the prescription drug supply chain, government entities and other stakeholders, must continue to seek additional deterrents if this positive trend is to continue.

1. The Primary Supply Channel

As HDMA noted in our testimony on February 8th and 9th, the drug distribution channel has evolved dramatically over the past 20 years in order to meet the ever changing needs of the nation's pharmaceutical manufacturing and health care delivery systems. Even since promulgation of the Final Rule in 1999, and enactment of the Prescription Drug Marketing Act in 1988, the pharmaceutical marketplace has grown exponentially with new manufacturers, new products, many with special handling requirements, and new healthcare delivery models.

The form, nature, and mechanisms by which patients receive these products have expanded as well. No longer does a patient receive his or her drugs exclusively from the corner drug store. Points of distribution of these products include a national network of clinics, hospitals, long term care facilities, physician offices, and mail-order pharmacies to name a few. Within these categories, a significant number of permutations have evolved to address special manufacturer and healthcare provider requirements. Many of the healthcare provider specifications for the drugs distributed to them exist to support individualized patient treatment needs or advances in standards of care. The distribution industry must accommodate these continuous changes in requirements of our suppliers and customers.

Today's principal drug distribution system consists of legitimate healthcare distributors maintaining one primary supply channel with a variety of routes, tailored to meet manufacturers and healthcare providers' requirements, by which prescription drugs may reach the dispenser or administrator on behalf of the final patient. These frequent, routine distribution routes are as much a part of today's primary supply chain as the traditional routes of the past in which the drug traveled directly from a manufacturer to a distributor to a dispenser. Without maintaining these primary supply channel routes, there is a significant risk that distributor's ability to provide prescription drugs when and where they are needed will be compromised.

To illustrate, below we provide examples of the routes that are maintained by the legitimate primary supply channel and which represent standard business transactions.

- a prescription drug may travel from a manufacturer, to that manufacturer's third party logistics provider or that manufacturer's exclusive distributor to a wholesale distributor to a pharmacy or other persons authorized to dispense or administer prescription drugs to a patient;
- a prescription drug may travel from a manufacturer, to that manufacturer's third party logistics provider or that manufacturer's exclusive distributor, to a wholesale distributor, to a chain pharmacy warehouse to an intracompany pharmacy to a patient;
- a prescription drug may travel from a manufacturer, to that manufacturer's third party logistics provider or that manufacturer's exclusive distributor, to a manufacturer's Authorized Distributor of Record (ADR) to a wholesale distributor, to a pharmacy or other persons authorized under law to dispense or administer prescription drugs to a patient;
- a prescription drug may travel from a manufacturer, to that manufacturer's third party logistics provider or that manufacturer's exclusive distributor to a wholesale distributor to a cooperative pharmacy warehouse to a pharmacy that is a member of the pharmacy buying cooperative or GPO, to a patient;
- a prescription drug may travel from a manufacturer through to a wholesale drug distributor, to a pharmacy (or other person authorized under law to dispense or administer prescription drugs) that receives delivery of the drug purchased from a wholesale drug

distributor as a drop shipment directly from the manufacturer, and to a pharmacy or other persons authorized under law to dispense or administer prescription drugs to a patient;

- a prescription drug may travel from a manufacturer, to a manufacturer's Authorized Distributor of Record (ADR), to a wholesale drug distributor, to a pharmacy that receives delivery of the drug purchased from the wholesale drug distributor as a drop shipment directly from the manufacturer's ADR, and to a pharmacy or other person authorized under law to dispense or administer prescription drugs, to a patient;
- a prescription drug may travel from a manufacturer, to that manufacturer's third party logistics provider or that manufacturer's exclusive distributor, to a specialty or other distributor wherein the prescription drug is delivered to (and received exclusively by) a hospital, individual practitioner, or other person authorized to dispense or administer prescription drugs, to a patient.

It should be reemphasized that the above list is not comprehensive and we may find that new routes are necessary in the future as manufacturer, dispenser, and patient requirements and needs evolve.

In the absence of a uniform electronic track and trace capability, requiring a comprehensive pedigree for any of these primary supply chain routes would result in difficulties with continuing to efficiently and reliably ensure that the dispenser/administrator receives the products they need for their patients in a timely manner. To illustrate, we explore below one of these routes, drop shipments, in order to explain why it is imperative to allow a supply chain with varying, highly secure routes to continue.

Drop shipments may be ordered, for example, because of manufacturer requirements, due to product shortages, short shelf life, special handling needs, or for other emergencies in order to get prescription drugs to customers in crisis situations in which time is of the essence. Although the distributor may be financially involved in the transaction, for example, by handling customer invoicing, they never have physical custody of the product.

Since a distributor typically is not notified of the transaction until an invoice is received from the manufacturer (or the manufacturer's third party logistics provider or exclusive distributor), it would be almost impossible for distributors to support efficient distribution in this manner because they would not be able to provide a pedigree "before the completion of any wholesale distribution." (21 CFR § 203.50(a)) Often, notification occurs only after the product has been delivered to the customer and dispensed to the patient.

We do not believe a simple solution, such as an exemption from the pedigree requirements or by eliminating the distributor's role in drop shipments, would effectively resolve this problem. There will likely be emergencies that cannot be defined or foreseen; if required, time consuming documentation of an emergency would defeat the purpose of rapid distribution of a potentially life saving drug; and eliminating the invoicing role of the distributor likewise reduces efficiencies or may fail to meet a manufacturer's requirements.

Although we have elaborated only on the difficulties of imposing the pedigree requirements in the context of a single route of the legitimate primary supply channel, each of the other routes listed above, as well as other legitimate routes that may currently exist or may be developed in the future to meet the evolving needs of dispensers, administrators, and patients, would face similar, and highly significant, constraints if required to meet the final rule's pedigree requirements. In section 4 below, we describe some of the practical difficulties associated with creating a pedigree.

Also note that the final rule's pedigree requirements would affect ADRs almost as dramatically as it would affect other wholesale drug distributors. That is, in each of the legitimate drug distribution routes described above in which an ADR sells drug to another distributor, even though the ADR is exempt from passing an actual pedigree, it would have to pass the equivalent information (a so-called "De Facto Pedigree") so that its customer could create an actual pedigree for its subsequent sale. The far reaching implications of the final rule's pedigree requirements must be well understood.

HDMA urges FDA to amend the Final Rule to recognize these primary supply channel routes which are based on dispenser, administrator and patient needs, as standard, legitimate and necessary models for drug distribution under the primary supply chain. With such recognition, HDMA would then urge the FDA to amend the Final Rule to permit distributors that provide products using these routes, to do so without having to pass a pedigree which would only increase costs and delay, rather than secure, the product's delivery.

HDMA also points out that since the rule was finalized in 1999, and FDA prepared its report to Congress in 2000, the United States has had considerable experience with sweeping disasters and emergencies. Most recently, Hurricanes Katrina and Rita have resulted in difficulties with communications and transportation systems, as well as dislocation of dispensing sites. Distributors acted quickly to do their part in responding to the emergency needs of the populations in affected areas. If distributors must change their primary supply channel routes to meet the FDA and/or varying state requirements, they may not have in place the business, operational, and other structures needed to respond as rapidly and effectively to future such incidents. We encourage FDA to recognize these realities when evaluating the final rule.

HDMA believes that when coupled with stronger license and enforcement regulations we also advocate, these business models help facilitate the timely and efficient distribution of drugs within a tighter, stronger supply chain.

2. Product Returns

As HDMA noted in our Workshop testimony, we believe that closer scrutiny of some of the Final Rule's requirements would aid in our mutual goal of creating a more secure supply chain. Product returns is another issue that bears closer scrutiny.

The Final Rule clearly defines the circumstances under which a pharmacy must be provided with a pedigree, yet it is silent on how the pedigree requirement would apply, if at all, in the event that a pharmacy returns a product. On the other hand, the Final Rule does contain specific requirements for returns by hospitals or health care entities. Specifically, the returning hospital or health care entity must provide:

...a credit memo specifying: (1) The name and address of the hospital, health care entity, or charitable institution; (2) The name and address of the manufacturer or wholesale distributor from which it was acquired; (3) The product name and lot or control number; (4) The quantity returned; and (5) The date of the return... (21 CFR § 203.23(a))

Further, section 203.23(b) requires that the health care entity forward a copy of the credit memo with this information to the manufacturer and section 203.23(c) requires the returning entity to provide the manufacturer or distributor with written documentation that the drug was stored and handled appropriately.

These requirements were intended primarily to prevent financial or other abuses, as noted in the preamble to the Final Rule:

The notice and documentation requirements... are necessary to help ensure that the returning entity or entities do not profit unfairly by the return and that diversion of returned drugs does not occur. (64 Fed. Reg. 67730)

However, given today's concern over the potential for counterfeit drugs to enter the supply chain at any point, these documentation requirements should have broader application. Specifically, we believe that the distributor accepting the return should receive this documentation, or equivalent information such as a return authorization, from all parties returning drug products, not just hospitals, health care entities or charitable institutions. We suggest that the FDA consider amending the Final Rule accordingly. With this information, the return recipient would be provided with documentation that they are receiving the same product that they supplied to the pharmacy or other customer, or an indication of the previous owner, in the event that they must supply a pedigree to another purchaser. (HDMA notes that exceptions to this requirement could be made for products unsuitable for use, such as damaged or expired product returns.)

3. Pedigree Requirements – Lot Number and Transaction Dates

Since the FDA first proposed its implementing regulations, HDMA and others in the distribution industry have provided to the Agency examples of the difficulties with meeting the various pedigree requirements and why these requirements would result in slowing, or even halting in some cases, the distribution process. We would like to take the opportunity to further explain the reasons why this still holds true. Certain pedigree data elements, specifically, lot numbers and transaction dates, present particular difficulties for distributors to include on pedigrees.

Manufacturers do not provide product lot numbers in an automated system with their product shipments at the item level. Therefore, there is no automated means by which distributors may track lot numbers from those shipments. (Although distributors do maintain this information as required under the PDMA's recordkeeping requirements.) Further, should distributors resort to manual systems to track lot numbers as the products arrive in their warehouses, a number of significant hurdles would have to be overcome before such systems could be implemented.

For example, the lot number is not always included on invoices or shipment documents. They are currently placed on each individual product package/bottle, in different locations on each package/bottle for different products. Due to the limited available space on the package/bottle, it is also typically written in very small, varying type font and of varying and/or limited visual clarity. To require distribution center employees to stop each shipment as it enters the warehouse, individually open each one, visually scan and manually record each product's lot number, would involve such time consuming efforts as to result in a substantial slow down of the tens of thousands of products that are shipped each day through a typical distribution center.

As the products are placed on the warehouse shelves, they would have to be segregated by lot number and purchase date in order for the distributor to then create a pedigree upon the drugs' sale to the distributor's customers. Such segregation by itself poses an almost insurmountable logistical challenge not to mention the delay associated with manually creating pedigrees.

Even placing bar codes on the products is not a viable solution, since there is no standard format for lot numbers. Each of the hundreds of manufacturers have their own lot number configurations, which may differ *by product*. Today's distribution centers often carry over 25,000 – 30,000 stock keeping units (SKUs) and bar coding technologies have not been developed that can address differing standards and formats.

Issues with recording transaction dates are similar to those involving lot numbers. Even if the problems with tracking lot numbers noted above could be overcome, the lot number cannot be used as the product identifier because a distributor may purchase product from the same lot on multiple days due to the large number of units within each lot. Therefore, lot numbers cannot be used to individually identify the product and link that product with a transaction date. It is critical to have the individual unit identifier placed on the product at the point of manufacture through serialization if the transaction date is going to be recorded for each unit.

Clearly, providing a pedigree, regardless of whether it is paper or electronic, without a means to automate the tracking and individual identity of each product, is not feasible under the conditions necessary to support large volume, efficient distribution systems. The ideal solution would be based on the following: 1) manufacturers serialize all product units with a unique ID number, 2) the ID number could be read and transmitted using a non line-of-sight technology, 3) the technology is based on a single, industry-wide standard.

4. Strengthening the Requirements for Wholesale Distributor Licensure

In HDMA's comments on the FDA's Anti-Counterfeit Task Force Interim Report (November 25, 2003), and in our recent Workshop testimony, HDMA stressed that adoption of stronger, consistent wholesale distribution licensure requirements is a vital step to address the threat of counterfeit drugs. We cannot emphasize enough that there is no better way to prevent the entry of counterfeit drugs into the system than by preventing the entry of criminals into the system.

We have strongly advocated requiring such measures as:

- Including more complete financial, ownership and product information as part of the license application.
- Posting a performance bond of a sufficient amount to ensure their financial solvency (covering all facilities in all states).
- Conducting criminal and financial background checks of the applicant.
- Conducting a thorough inspection prior to granting an initial license.
- Having the distributor employ a high level staff member within the company (or otherwise retain outside counsel or a consulting specialist) with the authority, knowledge and experience to help ensure compliance.

These recommendations have been built into HDMA's model legislation for state licensure. We encourage FDA to evaluate these licensure requirements and consider incorporating them into their guidelines for the licensure of Wholesale Distributors as found in 21 CFR § 205.

5. Wholesale Distributor and Pedigree Requirement Uniformity

Despite a variety of proposed state models circulating among state legislatures (including model legislation proposed by HDMA, model rules proposed by the National Association of Boards of Pharmacies (NABP) and others), as well as the Verified Accredited Wholesale Distribution (VAWD) program, there is no uniformity among the states' requirements for wholesale distribution.

What exists is a patchwork of state requirements that collectively undercut the consistent application of strict standards nationally and across the supply chain. The varying, and even conflicting, state requirements also may result in even more migration by counterfeiters from state to state, as they seek a "safe haven" in states with weaker regulatory requirements or enforcement capabilities. Even more importantly, the varying requirements have served to divert resources in the supply chain from more effective technological solutions. Time, expertise, and resources that should be dedicated to EPC/RFID implementation, are being siphoned off to develop make-shift, short-term electronic and manual solutions to accommodate varying state requirements.

Attachment 3 contains a chart summarizing the licensure and pedigree requirements for the 11 states that have passed new distribution licensure/pedigree laws to date. Clearly, neither the

requirements for licensure nor the pedigree requirements are consistent between any two of these states, much less among all of them.

Further, as of this writing, another 23 states have had wholesale distribution licensure bills introduced, and/or interpretive rules proposed since this chart was developed, and none is the same as any of the others. Even greater disparities exist regarding the required Pedigree Data Elements, i.e., the information that must be included on a pedigree. Many of these requirements only serve to create delay and additional expenses by duplicating what is already available in the distributors' records, or do little to aid in identifying prior ownership, the PDMA's original intent when establishing the pedigree requirement.

The substantial lack of uniformity that is evident in Attachment 3 highlights the need for a uniform federal standard for wholesale distributor licensure and pedigree requirements, as called for by HDMA.

6. Accreditation

Several of the individuals testifying at the February 8th and 9th Workshop highlighted "accreditation" as a means of ensuring uniformity as well as assuring consistent inspections of wholesale distributors. While HDMA fully supports both goals, we believe any distribution accreditation program must address significant issues.

First, as noted above, the states laws already vary considerably. Thus, it is unclear how overlaying another -- and different -- evaluation process would ensure uniformity. Greater confusion is just as likely to result as greater uniformity. HDMA is also concerned with presenting accreditation programs as a means to achieve consistency among the variety of different state licensure requirements, when the standard to which a company is held must be specific to the laws of the licensing state. If another state adopts an accreditation requirement, but has also adopted different licensure and pedigree requirements, which state standards would the accreditation organization apply? This very real issue calls into question how accreditation, in the absence of a uniform, legal standard, as a condition of licensure can be implemented on a state-by-state basis.

Many questions about the application of accreditation programs to wholesale distribution should be answered before any government entity, whether an individual state or the FDA, proceeds with accreditation requirements.

These questions involve:

- Due process for license applicants
- Lawfully enacted standards for inspection
- Qualifications and capabilities of accreditation organizations
- Protection of proprietary information
- Conflicts of interest

We note that federal accreditation programs address these questions very thoroughly. For example, the Food and Drug Administration's (FDA) Mammography accreditation program has detailed criteria and FDA oversight spelled out in federal regulations. (21 CFR §§ 900.1 – 900.12) FDA has extensive requirements for applicants seeking to become an accrediting body, including requirements for submitting policies and procedures for initiating and performing on-site visits, dispute appeals processes, fee schedules with supporting cost data, data confidentiality provisions, and much more. Further, there are criteria that an applicant must meet after FDA approves an entity as an accrediting body, including adhering to a code of conduct, following review practices, conducting staff training and an annual evaluation.

These elements help assure that the accrediting body is an unbiased, independent party able to fulfill its commitments and to assure the public that its trust is well placed. Should accreditation be further considered for oversight of wholesale distribution, HDMA recommends adopting an approach with structure and clarity comparable to the FDA Mammography example noted above.

Conclusion

HDMA wishes to thank FDA for the opportunity to testify at its Workshop and to provide these written comments. We encourage the Agency's continuous leadership in the effort to prevent prescription drug counterfeiting.