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EXAMINING IMPLEMENTATION OF

THE COMPOUNDING QUALITY ACT

TUESDAY, JANUARY 30, 2018

House of Representatives

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 11:00 a.m., in Room 2123 Rayburn House Office Building, Hon. Michael Burgess [chairman of the subcommittee] presiding.

Members present: Representatives Burgess, Guthrie, Barton, Upton, Shimkus, Latta, McMorris Rodgers, Lance, Griffith, Bilirakis, Long, Bucshon, Mullin, Hudson, Collins, Carter, Green, Schakowsky, Matsui, Sarbanes, Schrader, Eshoo, DeGette, and Pallone (ex officio).

Staff present: Adam Buckalew, Professional Staff Member,

Health; Karen Christian, General Counsel; Kelly Collins, Staff Assistant; Zachary Dareshori, Staff Assistant; Paul Eddatel, Chief Counsel, Health; Margaret Tucker Fogarty, Staff Assistant; Adam Fromm, Director of Outreach and Coalitions; Ali Fulling, Legislative Clerk, Oversight & Investigations, Digital Commerce and Consumer Protection; Jay Gulshen, Legislative Clerk, Health; Ed Kim, Policy Coordinator, Health; Bijan Koohmaraie, Counsel, Digital Commerce and Consumer Protection; Katie McKeogh, Press Assistant; Mark Ratner, Policy Coordinator; Jennifer Sherman, Press Secretary; Danielle Steele, Counsel, Health; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Samantha Satchell, Minority Policy Analyst; Kimberlee Trzeciak, Minority Senior Health Policy Advisor; and C.J. Young, Minority Press Secretary.

Mr. Burgess. [presiding] I would like to call the subcommittee to order.

And I recognize myself for an opening statement.

Today's hearing marks the Health Subcommittee's first look at the Compounding Quality Act, which passed under Title I of the Drug Quality and Security Act nearly 5 years ago. Prior to then, the last time Congress examined the drug compounding issue was in 1997, when it passed the Food and Drug Administration Modernization Act, touching upon the Food and Drug Administration's authority to regulate compounded drugs and establishing Section 503A in the Federal Food, Drug, and Cosmetic Act.

A tragic outbreak of fungal meningitis in 2012, when the New England Compounding Center shipped over 17,000 contaminated vials of a compounded steroid medication throughout the country, resulted in one of the worst and most fatal drug safety incidents in the history of the United States, where more than 750 people developed fungal infections in 20 states and, subsequently, 60 people lost their lives. This outbreak prompted Congress to act, with the Energy and Commerce Committee taking the lead in the House, through a series of investigations and a series of hearings on the issue.

Today we will convene two panels of witnesses. And I do want to welcome back Dr. Gottlieb, Commissioner of the Food and Drug

Administration. Thank you for coming back to our subcommittee this morning.

The agency has been very active over the last several months on drug compounding, most recently, releasing the 2018 Compounding Policy Priorities Plan. Your insights today, Dr. Gottlieb, are certainly appreciated.

Later in our second panel, we will hear directly from representatives of the pharmacies, physicians, patients, and manufacturers who will share their perspective on the implementation of Title I under the DQSA. We will also have a patient of the New England Compounding Center to share her personal story from the 2012 incidents and her experience since that time. All of the testimony from today's hearing are critical in our understanding of the compounding issue as the Food and Drug Administration works to strike the proper balance that would continue to advance patient safety while ensuring patients access to compounded medication.

Being a physician who has worked with compounding pharmacists during my time in practice, I know the important role and the value that these individuals serve in the delivery of patient care. Compounded drugs serve a unique need of patients that cannot utilize an FDA-approved product due to, for example, an allergy to one of the product's ingredients or the primary route of the product's administration. Many of us remember the swine

flu epidemic of 5 years when compounding for the anti-flu medications in an elixir form was absolutely critical to protect children who had been recently infected.

Because of the process involved in creating a compounded medication, we all acknowledge the fact that proper oversight is necessary, whether by the Food and Drug Administration itself or a state's regulatory body, such as its board of pharmacy. Preventing poor compounding practices that can lead to contamination or erroneous product strength, quality, and purity is the goal we all aspire to, so that another New England Compounding Center does not happen. Thinking back to that fungal meningitis outbreak, I was not only heartbroken by the patients' lives lost or harmed, but I was also troubled by what seemed to be missed opportunities that could have prevented the tragedy.

Title I of the DQSA accomplished two things. First, the law further clarified the Food and Drug Administration's authority to regulate traditional pharmacy compounding practices under Section 503A, which had seen several court challenges. Second, it added Section 503B to the Federal Food, Drug, and Cosmetics Act, creating a new category of drug compounders known as outsourcing facilities. These outsourcing facilities engage in larger-scale, national distribution of sterile drugs in bulk quantities and have, thus, heightened statutory requirements, such as complying with good manufacturing processes and being

subject to certain registration, reporting, and inspection requirements.

Over the last 4 years, the Food and Drug Administration has issued numerous draft and final guidance documents, proposed and final rules, and a draft memorandum of understanding to implement the Title I provisions. There has been discussion and debate over the manner that the agency has used to implement Title I.

In my home state of Texas, there already exists in statute the framework and manner in which a compounding pharmacy should conduct its practice. Other stakeholders have also expressed concern around office-use compounding and the prescription requirement. I hope these and other issues in the drug compounding space will be discussed today.

So, I am encouraged by the interest of all the stakeholders involved in this important debate, many of whom are represented today. I am certainly encouraged by the commitment of the Food and Drug Administration with Dr. Gottlieb's commitment to work with Congress in ensuring that patients have access to products that are tailored to their clinical needs while equipping agency officials with the requisite tools to protect public health.

Again, I want to welcome our witnesses and thank you for being here.

And I will recognize Mr. Green, 5 minutes, for an opening statement.

Mr. Green. Thank you, Mr. Chairman, for having this hearing.

In 2012, the interstate distribution of contaminated compounded drug products led to an outbreak of fungal meningitis in 20 states, which tragically resulted in 64 deaths and left 750 people with infections that were often severe and cause long-term damage. The New England Compounding Center, the NECC, the entity responsible for the compounding and shipping of the contaminated drugs, had been the subject of prior complaints and had been investigated by both the FDA and the Massachusetts State Board of Pharmacy. However, in part, because of uncertainty over the validity of Section 503A of the Food, Drug, and Cosmetics Act, it was not clear which copy, the FDA or the state, was on the beat, and the NECC continued to operate.

Unfortunately, while it was the most fatal incident to date, the NECC outbreak was not a one-off event. It certainly wasn't the first tragedy and hasn't proven to be the last. Just last year, we learned that at least 43 patients were left with diminished vision from a steroid antibiotic injection compounded by a Texas pharmacy. FDA studies have found quality problems with drugs compounded in other pharmacies, including sub- and super-potent drugs and contamination. According to one report, from 1990 to 2005, FDA became aware of almost 240 serious illnesses and deaths associated with improperly compounding products, with

the actual number likely to be greater since pharmacies are not required to report adverse events to the FDA. The Pew Charitable Trust published a report in 2014 that identified more than 25 reported compounding errors or potential errors linked to more than a thousand adverse events between 2001 and 2013.

Following that NECC outbreak, Congress finally took action with the Compounding Quality Act, CQA, and the Drug Quality and Security Act, DQSA, was signed into law in 2013. In a sideline, I want to thank my colleagues Congressman Griffith and Congresswoman DeGette because we worked together on a bipartisan basis to solve this problem. It sound to protect patients and provide industry with clarity for drawing a distinct line between the authority between state boards of pharmacy and the FDA. CQA made two key changes in reestablishing the FDA role regarding traditional compounding under Section 503A, creating a new category of drug compounders deemed outsourcing facilities under Section 503B.

The NECC outbreak and other adverse events underscored the need to establish a strong legal framework to provide for safe compounded medications that meet patients' needs while clarifying and strengthening oversight of such drugs to protect public health. There was an obvious need to address the growing number of enterprises that had cropped up during the time of legal uncertainty between the states and the FDA. Many of these

enterprises had come to act like drug manufacturers operating outside FDA's standard oversight, often failing to meet current good manufacturing practices and skirting oversight by inappropriately operating under the guise of 503A pharmacy.

DQSA was not perfect, and like all compromises, not every problem was solved to everyone's satisfaction, and not everyone got exactly what they wanted. During bipartisan, bicameral negotiations, we tried to address as many discrepancies as we could and satisfy the needs of patients, providers, pharmacists, and manufacturers. What is ultimately important is that DQSA fixed the problems that led to the deadly fungal meningitis outbreak and required the FDA to succeed where in the past it had not.

Compounded medications fill an important role in our healthcare system, offer patients an option when an approved drug does not fit their needs. Patients' ability to timely access safe compound drugs is vital, and pursuit of this goal is something I believe we all share. I understand questions remain about the office stock, bulk lists, the memorandum of understanding, the interstate distribution, and copies of FDA-approved products, and other issues. More needs to be done to foster a robust 503B sector, support traditional pharmacists, ensure patient access to needed medications, and inform providers on how they can get the drugs they need when they need them, so they can successfully

treat their patients.

As the FDA and stakeholders continue to work on the implementation of DQSA, and the agency, patients, providers, and industry continue to learn and adjust, I hope we can work together to refine the rules of the road, so patient access isn't unduly diminished and patient safety is upheld.

Thank you, Mr. Chairman. I yield back my time.

Mr. Burgess. The Chair thanks the gentleman. The gentleman yields back.

Pending the arrival of the full committee chairman, Mr. Walden, let me recognize the gentleman from New Jersey, 5 minutes for an opening statement.

Mr. Pallone. Thank you, Mr. Chairman.

I would like to submit to the record a joint statement from the Association for Accessible Medicine's Biotechnology Innovation Organization, the National Association of County and City Health Officials, Pew Charitable Trusts, Pharmaceutical Research and Manufacturers of America, PharMEDium, and Trust for America's Health. If I could ask unanimous consent to have a copy of it --

Mr. Burgess. Without objection, so ordered.

Mr. Pallone. Thank you.

[The information follows:]

231 ********** COMMITTEE INSERT 1**********

Mr. Pallone. Mr. Chairman, thanks for holding today's hearing on the Compounding Quality Act, which passed with broad support from stakeholders and bipartisan, bicameral support in Congress in 2013. Passage of the Compounding Quality act was about patient safety. Congress came together in response to the horrible tragedy of actions by the New England Compounding Center, or NECC, that led to 64 people losing their lives. And despite a history of complaints and investigations by both the FDA and the Massachusetts State Board of Pharmacy, NECC was allowed to continue compounding products given to patients on a scale and in a manner that should never have been allowed. The new law was meant to clarify drug compounding laws. It was also supposed to make clear the lines and requirements for traditional pharmacies that want to compound and those pharmacies that compound on a larger scale.

I think we all agree and support maintaining patient access to compounded drug products. Undoubtedly, there are patients with unique medical needs for which a traditional prescription drug product is not appropriate, whether for pediatric patients, seniors, or those with allergies. However, we must all remember that compounded drug products are not without risk. Compounded drug products are not reviewed by FDA prior to coming to the market for safety and effectiveness. Traditional compounding pharmacies are also not required to report on the compounded drug

products they produce or report adverse events.

While this law was intended to prevent another tragedy like the one at NECC, adverse events associated with compounded drug products are still occurring. Since passage of the law, there have been more than 140 recalls associated with compounded drugs. We have also seen reports of serious health events. For example, just last summer, 43 patients suffered vision impairment after receiving compounded eye injections of a drug containing a combination of a steroid and an anti-infective agent. Also, last year three infants received a compounded morphine preparation that was 25 times the strength that was indicated on the label, resulting in at least one hospitalization. These are just two examples of why clearly identified standards and requirements must be maintained if we are going to protect patient health.

Recently, FDA released the agency's 2018 Compounding Policy Priorities Plan identifying next steps the agency will be pursuing in regards to implementing the Compounding Quality Act, including revisions to current guidance. As FDA moves forward, I would caution the agency to ensure that any revisions that it makes do not enable an environment that could allow for another NECC to occur. We must maintain appropriate patient safeguards and clear lines between what activities are permissible for traditional pharmacies and what activities are permissible for outsourcing facilities. Patient safety and the protection of public health

must be at the forefront of any guidance revisions that the FDA considers, and the American people deserve confidence that the drug products they receive are safe and held to strong quality standards.

So, I want to thank Commissioner Gottlieb and all of our witnesses for being here today. I want to go beyond just today's hearing, Commissioner, and mention that you have been really great at trying to reach out to Members of Congress, much more so than most of the agency leaders. So, thank you for that. And I look forward to a robust discussion about the implementation of the Compounding Act.

I yield back, Mr. Chairman.

Mr. Burgess. The Chair thanks the gentleman. The gentleman yields back.

The Chair now recognizes the gentleman from Michigan, Mr. Upton, 5 minutes for an opening statement.

Mr. Upton. Well, thank you, Mr. Chairman, and I would ask unanimous consent to put Chairman Walden's full statement into the record.

Mr. Burgess. Without objection, so ordered.

[The prepared statement of the chairman follows:]

********** COMMITTEE INSERT 2**********

Mr. Upton. And also, a letter from our colleague, Mr. Bishop, enter the letter into the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

********** COMMITTEE INSERT 3**********

Mr. Upton. So, Mr. Chairman, the 2012 outbreak of the fungal meningitis resulting from contaminated steroid injections manufactured by the New England Compounding Center, NECC, was certainly a failure of epic proportions. Of the 753 people that were sickened by the outbreak, 264 called Michigan their home. Yes, we were the largest state hit. Nineteen of the 64 deaths caused by the tragedy were from Michigan, and three of them were constituents of mine.

I was chairman of the full Energy and Commerce Committee at the time that this happened, and we immediately launched a bipartisan investigation to find out what went wrong. I am not going to go through the full history of what happened then, but I will say that those at the NECC who were responsible were, in fact, brought to justice. And this committee crafted legislation to empower the FDA to ensure that the heinous acts of negligence like this one would never happen again. We wanted to fix the problem.

That legislation, the Drug Quality and Security Act, DQSA, is currently being implemented by the FDA, and it takes a number of measures to ensure safety, not the least of which are much-needed restrictions on the use of bulk compounded material as opposed to FDA-approved products when there is not a clinical need to do so.

I am pleased to see the new Commissioner here to update us

on how DQSA implementation is going and what we in Congress can do to help move the process along. We appreciate cooperation, and again, the cooperation of Members on both sides of the aisle.

And I will yield back the balance of my time.

Mr. Burgess. The Chair thanks the gentleman. The gentleman yields back.

And we do want to thank all of our witnesses for taking time to be here today and taking time to testify before the subcommittee. Each witness will have the opportunity to give an opening statement, followed by questions from members. We will have two panels today.

The first panel, we will hear from Dr. Scott Gottlieb, the Commissioner of the United States Food and Drug Administration.

Dr. Gottlieb, once again, we appreciate your being here today, and you are recognized for 5 minutes for your opening statement, please.

STATEMENT OF SCOTT GOTTLIEB, COMMISSIONER, UNITED STATES FOOD AND DRUG ADMINISTRATION

Dr. Gottlieb. Thank you, Chairman Burgess, Ranking Member Green, members of the subcommittee. I appreciate the invitation to testify at today's hearing on implementation of Title I of the Drug Quality and Security Act.

We are all here together today because, more than 5 years ago, we grappled with the devastating consequences of the 2012 outbreak of fungal meningitis caused by the manufacturer that was compounding under the guise of a state-licensed pharmacy that shipped contaminated compounded drugs throughout the country. It led to more than 750 illnesses and 60 deaths in 20 states.

Because of this tragedy, Congress acted to ensure that something like this would never happen again. No one wants to see another such outbreak occur, and I am personally committed to ensuring that FDA does its part to help prevent future deaths from poor quality compounded drugs.

The 2012 outbreak as well as other issues we have seen through our compounding oversight underscore the need to improve compounding practices and more robust oversight of compounders, supported by close federal and state collaboration. It also highlighted the need for a clear legal framework that would provide for compounding to meet patients' needs while also

equipping the FDA with authorities to address unlawful practices that threaten the public health.

Unfortunately, since enactment of DQSA, there have been other tragedies and cases of serious and unnecessary patient harm which reinforce why our work is so critical. The FDA's compounding program is a priority for the FDA, given its profound public health implications, and we are committed to implementing the DQSA framework.

We have issued 24 draft guidances and final guidances, a final rule, and three proposed rules, and a draft MOU with the states. We have held eight meetings with the Pharmacy Compounding Advisory Committee to discuss 48 bulk drug substances nominated for use in compounding, as well as six categories of drug products nominated for the list of drugs that present demonstrable difficulties for compounding.

On the oversight and enforcement front, since enactment of the DQSA, the FDA has conducted nearly 500 inspections and we have issued more than 180 warning letters advising compounders of significant violations of federal law. We have overseen more than 150 recalls involving compounded drugs, and we have worked with DOJ on multiple civil and criminal enforcement actions and set up a joint task force with them.

But I know there is still a lot left to be done, and I know that there are some who say we haven't implemented certain aspects

of DQSA with the speed you had hoped. We have had our own challenges addressing certain aspects of this complex framework, including our constant challenge to make sure we are striking the right balance between safety and access, and addressing the oftentimes very divergent views on these issues. I want you to know I am personally committed and involved in these efforts and committed to getting these things right, to making sure that we strike a careful balance and take measure of your concerns.

In implementing the DQSA over the years, FDA has aimed to develop policies that support the growth of the outsourcing facility sector. Compounding pharmacies and outsourcing facilities can help meet the legitimate patient needs when an FDA-approved drug is not available to meet such medical needs. We know that we must balance the critical role that compounding plays in helping patients and providers advance public health while ensuring that compounders do so in a manner that protects patients from poor quality compounded drugs and does not undermine the drug approval process.

And so, our actions to date, as well as the comprehensive 2018 Compounding Policy Priorities that we unveiled a few weeks ago, focus squarely on protecting patients from harm and establishing regulatory clarity, so our outsourcing facilities can meet important protections in Section 503B and our quality standards.

One of my key goals is to make it more feasible and lower cost for a large swath of pharmacies to transition to becoming outsourcing facilities, which are subject to greater FDA oversight. We are also working to help ensure patient access to compounded drugs when they need them. For instance, we are taking steps to help providers identify outsourcing facilities that make, or would be willing to make, compounded drugs for office stock to treat patients who have medical need for them.

Let me be clear on one thing. I am committed to getting the things we have committed to done. All of the commitments made under the plan I released two weeks ago will be completed in 2018.

I would like to just close by briefly mentioning another critical public health matter. Today we took new action to address the epidemic of opioid addiction. We took steps to limit the dispensing of Loperamide, an OTC drug, that is increasingly being abused for its opioid-like qualities when it is taken at very high doses and dangerous doses. I hope you will take the time to look at the statement we issued, as we continue to work together to address this critical public health crisis. There is no magic bullet to solving this crisis. It is only going to be through continued and vigilant steps, like the one we took today, that I can hope we can start to reverse some devastating trends.

I look forward to answering your questions today and

continuing to share more with you during the year ahead, as we build on our past efforts as part of our public health mission.

[The prepared statement of Dr. Gottlieb follows:]

********** INSERT 4**********

Mr. Burgess. The Chair thanks the gentleman for his testimony, and we will move into the question portion of the hearing. I will begin with questioning and recognize myself for 5 minutes.

Commissioner, in the information you provided us, you had a list of adverse events associated with drugs prepared by compounding facilities in the past 5 years. Presumably, that is the lifetime of the DQSA. The one at the top of the list has been mentioned by a couple of people on the dais this morning, in Texas, some steroid antibiotic eye injections that caused problems with vision loss. Is there something more that could have been done in DQSA to prevent this or was the problem found more rapidly because of the tools that you were given in the DQSA? Help us sort of understand. Here is something that happened in my backyard. Is it something that we should have worked harder to prevent or was, in fact, the outbreak less than it would have been because you had tools to use?

Dr. Gottlieb. Well, thank you for the question, Congressman.

I think, as we start to exercise these new authorities, we are learning a lot. The scope of the kind of enforcement activities we take have also changed. In the early days of implementation and historically, a lot of the focus has been on issues of sterility with things like eye drops or things that are

used intravenously or intramuscular injections.

I think what we are seeing more and more, and where we are starting to focus more of our inspectional activities, is on formulations that are compounded in ways where they might be super-potent. The challenge is that, when the pharmacies make potency errors, it is usually a logarithmic, log error, so thereby a factor of 10 or 20. So, you can get potencies that can cause significant harm.

I think this underscores the need to make sure that, when drugs are being compounded on a wide basis and distributed on a wide basis, it is done in facilities where we can apply GMP standards to them. And this is, in part, why I think Congress contemplated the whole creation of the 503B structure, where drugs that would be used on a wider scale would be compounded under that kind of supervision.

Mr. Burgess. Let me ask you a question. Obviously, it was before your tenure when we had the hearings after the New England Compounding Center problems. But it was clear to some of us during the course of those investigations and the work that the committee did -- and Chairman Upton was correct to reference it; this committee, the full committee took the leadership on this issue. But there were places where the FDA clearly fell short of its responsibility to protect public health, despite what appeared retrospectively to be clear warnings that the New England

Compounding Center was engaged in dangerous activities. So, are you confident that the FDA now has the clear authority it needs to ensure that we don't see a repeat of those things that happened in 2012?

Dr. Gottlieb. I testified at those hearings as a private citizen in 2013 here in Washington. I was working at a think tank at the time and weighed in at the time. I think I felt what Congress contemplated was a framework that gave the FDA the proper tools to provide oversight over this industry. But I think we need to keep in mind that we are now implementing a framework on an industry that is vast, that grew up, that was allowed to grow up largely outside regulatory purview for a long period of time, and retrofitting a regulatory framework back onto an already existing industry is always a difficult task.

Do I believe the authorities and the tools that we are able to exercise are robust? I do. I think that it is going to take time to get them fully implemented and get the kinds of tools and practices we want applied over that industry. And it is superimposed on an environment where, admittedly -- and people have good arguments on both sides of this debate -- there has been some discussion around how FDA is using those authorities and whether they are using them in an appropriate fashion. I believe we are and I believe we need to continue to move forward.

Mr. Burgess. Yes, I expect we may hear about that this

morning in our second panel. I guess that is the concern. Or what I would like to ask is the efforts that you and the agency have taken to engage the physician community, patient community, other stakeholders, where they may have perhaps the feeling that things have tightened up too much.

Dr. Gottlieb. Well, this isn't going to work unless we are working closely with the providers and the state authorities. This law, Congress contemplated a framework that very much was envisioned where FDA would have close collaboration with medical societies and state authorities, and there was a lot of shared jurisdiction between the federal and the state framework around both the 503A and the 503B facilities. States dually inspect a lot of the 503B facilities.

So, I think it is going to be very important for us to continue to work closely with the state communities and the provider groups. I believe we have. I think that there is more alignment there than perhaps is widely perceived, as obviously some 503A pharmacies that want to engage in certain practices where there is a line that we need to draw to make sure that we are providing the proper oversight, and I think we are going to hear about that tension today. I think that is a large place where we still have some area of disagreement.

Mr. Burgess. Very well. I want to be respectful of everyone's time because we do have a long hearing today. I am

going to recognize Mr. Green for 5 minutes for questions.

Mr. Green. Thank you, Mr. Chairman.

Thank you, Dr. Gottlieb, for being here this morning, but also the good work you are doing at the FDA.

I appreciate the continued emphasis the FDA has put on the issue of compounding drugs and hope to keep working with the agency on implementation in our shared goal of striking the right balance, so we can promote patient access without compromising patient safety. I am encouraged to see the FDA is actively working to implement the patient safety measures that are included in the DQSA.

In particular, I am pleased to see that FDA is taking steps to encourage registration of 503B outsourcing facilities. In your 2018 Compounding Policy Priorities Plan you suggested the FDA will be taking a more risk-based approach to the development and implementation of current good manufacturing practices, or CGMPs. I understand FDA is working on revising the 2014 draft guidance to apply CGMP requirements in a way that is tailored to the nature of the specific operations conducted by an outsourcing facility and move away from one-size-fits-all. I appreciate the agency's goal of improving patient safety by making the regulatory framework more flexible by recognizing volume as a factor in its risk-based evaluation.

Can you elaborate more about the agency's thinking around

what has been referred to as "503B-light"?

Dr. Gottlieb. Thanks for the question, Congressman.

What I am envisioning is a framework where -- the GMP standards are not a fixed standard. It is a risk-based standard. We want to try to devise that framework in a way where we could titrate the level of the regulatory touch to what the facility is doing, the size of the facility, how many drugs they are developing, how they are shipping them, whether the drugs are oral drugs or they are parenteral drugs that are going to be injected, which would be sterile drugs and have higher risk.

The idea is that, by trying to adjust the level of the regulatory oversight to the level of risk, we could potentially allow more 503A facilities to make the conversion into being 503B facilities. That is why we are taking the time to revise that guidance.

There are things where we have some flexibility, like retention of samples, lot release, the stability studies that we require, where if it is a pharmacy doing something on a small scale, not shipping widely, compounding drugs that are relatively low-risk, we might be able to dial back some of that level of regulatory oversight versus someone who is engaging in larger-scale manufacturing. But, again, with the goal of seeing more 503A pharmacies become 503B pharmacies where they are able to engage in the kinds of things that some pharmacies want to do.

We want to bring down the cost of doing that. We have done some economic analysis around what it would cost. I think it is still a little bit too expensive to see some of the small 503A pharmacies opting into that. So, we are trying to take another crack at that.

Mr. Green. Okay. Thank you.

And I do have concerns about the possibility of creating a two-tiered system. In the pursuit of flexibility, I am concerned of the impact this may have on 503B facilities that compound biologics, which are especially vulnerable to degradation.

How would you respond to these concerns? Can you tell me how you plan to ensure that CGMPs that apply to 503Bs will hold these facilities to the highest standards of sterility and stability?

Maybe I didn't understand that language.

[Laughter.]

Dr. Gottlieb. I understand your concerns. I share them. The first thing I am going to do is come up with a better name for it than "503B-light," before that takes hold.

But I will tell you that we are very mindful of that. So, for example, you reference biological products. They are particularly vulnerable to contamination and to bacterial growth. That would be something that would be higher-risk, where we would apply more oversight.

We are talking about trying to create a standard that is flexible, as is all our GMP oversight. It is a risk-based framework. If a pharmacy is engaging in small-scale manufacturing of relatively low-risk products, they wouldn't be subject to all of the same requirements that someone who is engaging in large-scale manufacturing of higher-risk sterile products would be. As they move through the continuum of risk, our level of oversight would increase. It needs to be a flexible standard. It is a flexible standard in every other realm of our regulation. It ought to be here. But you are absolutely right that there is a continuum of risk, and we need to be very mindful that we are matching our regulatory touch appropriately to that level of risk.

Mr. Green. Could you provide, submit your economic analysis for the record, for the committee?

Dr. Gottlieb. I can provide it just off the cuff right here. I mean, when we looked at it -- and again, this was very preliminary work and it is in draft form -- but when we looked at it, we estimated that it would cost a large manufacturer about a million dollars to become a 503B facility, a large pharmacy, and a medium-sized pharmacy, about $600,000. We think that there are things we can do to further titrate the level of regulatory touch, that there are more buckets. Because, again, a 503A pharmacy that wants to engage in relatively low-risk compounding but still ship,

but they are developing low-risk products on a small scale in small batches, there are ways, I think, to adjust the level of regulation to more appropriately match the level of risk that they are creating.

Mr. Green. Well, I understand you want to use resources where the problem is.

Dr. Gottlieb. Exactly.

Mr. Green. And I appreciate that.

Dr. Gottlieb. We want to be efficient.

Mr. Green. Thank you, Mr. Chairman. I know I am out of my time.

Mr. Burgess. The Chair thanks the gentleman. The gentleman yields back.

The Chair recognizes the gentleman from Texas, the vice chairman of the committee, full committee, Mr. Barton, 5 minutes.

Mr. Barton. Thank you, Mr. Chairman.

And, Commissioner, thank you for being here. I want to echo what Mr. Pallone said. You have been accessible, and we appreciate your personal availability to the members of the subcommittee.

I have been on this committee for 32 years. We have got an ongoing sense of friction or tension between the FDA and the compounding pharmacist. It is kind of a love-hate relationship.

A lot of my compounding pharmacists in Texas are fairly

active in the national compounding associations. They have a feeling that the big, old bad federal FDA picks on them. How would you respond to that? Do you think your FDA picks on compounding pharmacists? Or do you think that they are being a little bit too sensitive?

Dr. Gottlieb. Well, I am not going to comment on their feelings and their motives. I am certainly sensitive to the concerns; I would say that, Congressman. This is an important reason why we want to make sure we are working closely with the states. Because I think if we are working cooperatively with the states, and the states are able to assert their responsibilities and obligations under DQSA, but in concert with us, I think that the more that we can rely on local regulation, the more that local pharmacies are going to feel that they have a closer continuity to the nexus of the oversight, if you will.

Mr. Barton. Okay. Well, that leads to my next question. It is almost like you and I coordinated. I was going to ask this; you were going to answer that; then, I would follow up.

What is the current relationship in terms of a working relationship or a cooperative relationship between the FDA and the state regulatory authorities that oversee compounding pharmacists? Do you think it has improved? When we had the problem back in 2010-2011 that led to the bill that you have talked about, Massachusetts and the federal FDA didn't seem to get along

at all. They didn't talk to each other, didn't share information. Today would you say that that relationship has improved, is good? How would you characterize it?

Dr. Gottlieb. Well, I will tell you the relationship is a lot better today and gets better with time. I think it is continuing to expand in terms of the scope of the collaboration and just through the contact we are having with state authorities. Those relationships are important to sound regulation being built. We invite states to join us on inspections. We hold monthly meetings with the National Association of Boards of Pharmacy. We provide training to state compliance officers. There are frequent telecons with state officials.

You don't have to take my word for it. You could look at the GAO report in 2016 that looked at this very question of what the perception was of the states of FDA's communication with the states, and 60 percent said very or somewhat satisfied. They were very or somewhat satisfied with the communication. Now a "D" usually doesn't sound good, but in this context I think it was. It was supportive of my contention that the relationships are much improved from where they were when I was at FDA the last time, prior to NECC. Twenty-three percent reported they were dissatisfied. We want to work on that. I think, hopefully, if I come back here a year from now and we are talking about this, we are going to be able to talk about an even more cooperative

environment.

Mr. Barton. With respect to the opioid crisis, are there some special task forces, special programs, extra effort being utilized right now between the FDA and the state regulatory authorities? And kind of as a secondary question, would you consider the opioid crisis more of a federal issue or a state issue, or is it about 50/50?

Dr. Gottlieb. Well, I think it is an everything issue. I have said before that I think that this is beyond the scope, certainly, of any one agency, but even the federal government, to try to tackle it. We are going to need to work closely with local officials to try to address this crisis. And we have been doing that. We have had a lot of conversations with local officials, state AGs, on different things that we could be doing in collaboration with the states around various aspects of this crisis.

I would say that the one thing that I am still very concerned about is the level of federal oversight in the IMFs, in the international mail facilities. I have spoken with some of the Members about this, and trying to get more resources into those facilities, particularly FDA resources. We play an important role in those facilities doing track and trace and analysis on some of the synthetic fentanyl coming in and doing investigations to trace them back to their source. And that is a big concern

of mine.

Mr. Barton. The last question, the Pharmacy Compounding Advisory Committee currently has no one on it who is a compounding pharmacist. Don't you think there should be at least one voting member who is an actual compounding pharmacist on that committee?

Dr. Gottlieb. I am going to be, we are going to be issuing a solicitation probably within days -- the FR notice is with my office -- to solicit a new member or members on that committee. So, there will be an opportunity to expand the composition of that committee. As you know, there are 12 members on that committee. One is appointed by the NABP, one by USP. It leaves 10 members. Of those, seven are licensed pharmacists. I think five are physicians in total. So, there is good clinical representation. To the extent that someone with a business perspective of being a pharmacist can add to the composition of that committee in a thoughtful way, that is something we would certainly think about.

There is one compounding pharmacist on the committee. He is the industry rep.

Mr. Barton. But he doesn't get to vote.

Dr. Gottlieb. He doesn't get to vote, you are right. We will certainly take this into consideration. I have heard the concerns of Members on this. We will certainly take it into consideration as we think about the new solicitation.

Mr. Barton. I would encourage that.

And I yield back.

Mr. Burgess. The gentleman yields back. The Chair thanks the gentleman.

The Chair recognizes the gentlelady from California, Ms. Eshoo, for 5 minutes, please.

Ms. Eshoo. Thank you, Mr. Chairman, for holding this hearing.

And, Commissioner Gottlieb, it is good to see you, and thank you for your testimony and your work on this issue.

We spoke, I think it was last summer, about -- at that point, there was a recent incident of patients being harmed by compounded products. Specifically, there were 50 patients, some of whom went blind after receiving a compounded antibiotic during cataract surgery last July.

I was talking to a doctor friend this last week. I said, "What's the most common surgery in the country?" And he said cataracts. So, that really broadens this out when you think of 50 patients, some of whom went blind during their cataract surgery. It wasn't too regular for them.

Obviously, we need to do everything we can to protect patient safety, so that these incidents stop happening, including, I think, following up on the warning letters.

There are two areas that I have always thought that are absolutely fundamental to what we do, both when I was in county

786 government and here in the House of Representatives. That is
787 public health and public safety. The two are combined in this
788 issue.
789 So, what I want to ask you is, of the dozens of warning letters
790 posted by FDA, how often have you pursued enforcement action? And
791 what else can the agency do with its enforcement resources to
792 ensure that compounded drugs are safe?
793 Dr. Gottlieb. I appreciate the question. It gets at
794 something that we are trying to work, which is to improve our
795 collaboration with DOJ to try to make sure that we can bring
796 enforcement action when we see something particularly egregious,
797 so we issue a warning letter and a firm is non-compliant. That
798 was the genesis of the task force that we formed with DOJ. It
799 is early days; I think it is yielding dividends in terms of our
800 ability to work cooperatively. But this is something that we are
801 looking at, pushing on, trying to do more of.
802 Ms. Eshoo. Have there been any enforcement actions?
803 Dr. Gottlieb. There has absolutely been enforcement
804 actions, and there is activity that we have in progress.
805 Obviously, we are always working on various activities. But I
806 am hopeful that we will be able to continue to work effectively
807 with DOJ in this regard.
808 Ms. Eshoo. In the two sections of the Compounding Quality
809 Act -- you know, let me say something, because I listened to the

conversation earlier about the FDA, what Congress did, what happened, and then, what Congress did. I think it is important for all of us to recall that the FDA had not been given authority by the Congress in this very area when the tragedy that took place out of Massachusetts, that spread out over the country, took place. So, I know there are a lot of questions to be raised, but the FDA did not have the authority. In my book, I think that the Congress didn't maybe on a proactive basis examine the issue and give the agency the authority.

At any rate, in the two sections of the Compounding Quality Act, it defines that drugs may only be compounded from bulk drug substances when FDA-approved drugs are in shortage. Now, recently, the agency announced enforcement discretion related to an interim list of substances that include more than a hundred approved drugs.

So, what specific steps are you going to take to ensure that there is a legitimate clinical need for the bulk drug substances currently being used by compounders and how are you going to enforce this?

Dr. Gottlieb. I think you are referring to the 503B bulk drugs list, right?

Ms. Eshoo. Right. Right.

Dr. Gottlieb. So, as you know, we received about a thousand nominations for different drugs to be on that list. We have

selected 200 that we allowed onto that list under what we call Category I drugs. Now what we need to do is go through and reexamine all 200 to make sure they belong on that list. And we believe some of them are going to fall off and perhaps many will fall off. Some might be added, but probably many are going to fall off.

We are going to issue in March a guidance document that I outlined in the 2018 plan we put out that is going to define the parameters in which we are going to do those assessments. And then, we need to go through and assess each drug individually, which, as you know, is a resource-intensive process. Each evaluation is between 20 and 80 pages long.

Probably the first complement of drugs that we will render a decision on will be this fall. It is probably going to be a small number. It may be five drugs. But we need to go through that entire list.

But it is important to put in perspective where that 200 came from. Those were drugs that were currently being compounded off of bulk substance at the time that this law was implemented. So, what we effectively did was freeze the market. What we said was we don't want to create more compounding, but we also don't want to start pulling things out of the marketplace and create access issues, especially with respect to the outsources, because we want to see this industry grow up, for one. And on the second hand,

we have now new regulatory tools to assert good manufacturing practices. So, we can provide more oversight. So, the idea was to freeze the market while we, then, did those assessments, which is what we are doing now.

Ms. Eshoo. Thank you very much, Commissioner. I couldn't mean that more. You are in such an important role in the life of our country. So, thank you very much.

Thank you, Mr. Chairman.

Mr. Burgess. The Chair now would like to recognize the gentleman from Kentucky, the vice chairman of the Health Subcommittee, Mr. Guthrie.

Mr. Guthrie. Thank you, and thank you, Mr. Chairman.

Thank you, Commissioner, for being here today.

I kind of want to follow up on what was just said. Five years ago there was a judge in Kentucky, a very prominent citizen, Eddie Lovelace of Albany, Kentucky, who went in for a routine procedure and was contaminated with medicine from the New England Compounding Center and died just shortly after what was going to be a routine procedure. Obviously, his family and the whole community is devastated, and Dr. Lovelace is just one person who was affected by this awful outbreak. And this was tragic and it is the reason I believe we must ensure compounded drugs are safe while striking a good balance of access to compounded drugs.

It is kind of the theme of what you have said this morning,

but I thought I would just give you kind of a more open-ended look at it. Because in your testimony you mention the balance that is needed. And so, I just want to give you the floor to, how are you ensuring that Americans have access to lawfully-marketed compounded drugs while ensuring safety? You have kind of addressed that just earlier, but I just kind of give you the time.

Dr. Gottlieb. I think the way to ensure that, to be very direct, is to make sure this law gets implemented. I think that this was a good vision by Congress and it is a good framework that provides FDA with the tools that it needs to provide proper oversight. We need to now make sure it gets implemented.

I think where we are going to be able to continue to improve sort of the posture of the industry, and the ability of this industry to provide the critical products that patients need and access to drugs, is going to be to try to see the 503B outsourcing sector become more viable. I think many of us, when this law was first implemented, envisioned that that sector would grow much more quickly than it has. And I think if there are things that we can do through regulation, and I think that they are, to help that industry continue to expand, that is going to be important because, ultimately, that is going to provide more access to the kinds of sterile drugs that some people need on a wider scale and need to be distributed to institutions. The 503A facilities provide a critical function on a local level, giving patients

differentiated products through the practice of pharmacy, so that they can get products that are individualized, tailored to their clinical needs.

Mr. Guthrie. Do you think 503A should report adverse outcomes to the FDA?

Dr. Gottlieb. As you know, the bulk of the adverse events that are reported by 503 facilities are typically either not reported or reported to the states. The states do share that information with us. They are not directly reported to FDA.

Would it help FDA target its inspections better if they had access to that information more readily? I would have to say it would. It would make it more efficient. A lot of our inspections of 503A facilities are for-cause inspections, are on the basis of information. But I think that this is also an area where, through our cooperation with the states, we are going to get access to that information where we need it. Because if we are working closely with the states, they are going to help guide us where we should be inspecting. Because, for example, a 503A facility might be engaging in activities that tip it over into being a 503B and subject to the federal scheme.

Mr. Guthrie. Thank you. Thank you for those answers.

And if I could change the subject just for about a minute or so left, I had an oncologist that contacted my office. Her daughter is an intern in the office. I know her pretty well. And

she was stating concern on the shortage of saline, so to change it a little bit. She said it has been exasperated by the flu epidemic this year. We see these shortages in just basic medicines. And so, can you please provide the most recent FDA developments of the saline shortage?

Dr. Gottlieb. There are two different components to this, or, actually, three different components to this. There were these small bags that were in shortage prior to the hurricane that struck Puerto Rico, the 100-milliliter bags that are typically used to dilute drugs and, then, administer drugs to patients. That shortage was exacerbated by the hurricane because one of the primary manufacturers of those bags is located in Puerto Rico and was knocked out of production. That facility is now back in full production. In fact, all the facilities that we have concerns about in Puerto Rico are now back on grid power and most of them are at full production.

And we have brought in additional supply from additional facilities out of manufacturing sites, ex-U.S. manufacturing sites, to make up for that shortfall. So, there should be much more supply coming into the market.

There is also a shortage of the larger-volume bags. While we haven't declared a shortage, there's spot shortages of the 1-liter bags that are used for volume repletion, and those are also being strained by the flu, the flu outbreak. We have taken

additional steps to bring in additional supply of the 1-liter bags as well.

There is also some tight supply of the empty 1-liter bags because a lot of compounding pharmacies and hospitals, when they can't get access to filled bags, they buy empty bags and fill them themselves in a compounding-type facility.

We have taken additional steps. We are going to have more to say about this on Thursday. I was going to put it out today, but we were delayed in getting our information out. We are going to be putting out a statement on Thursday talking about the steps we are taking to get more of those empty bags onto the market. Some of those were manufactured in Puerto Rico.

I will just close by saying that the time it takes for a bag to go from the manufacturing line to your hand in the hospital as a clinician is about six weeks. I don't know this isn't a more efficient supply chain, but that is what I have been quoted. It takes weeks for it to make its way to the provider setting. And so, the additional supply that we have brought on -- and it is substantial -- is going to take some time to flow through the market.

Mr. Guthrie. Thank you for your attention to that. You all have been really good to work with.

Thank you.

Mr. Burgess. The Chair thanks the gentleman. The

gentleman yields back.

The Chair recognizes the gentlelady from Illinois, 5 minutes for questions, please.

Ms. Schakowsky. Thank you, Dr. Gottlieb. But I want to apologize that I missed much of your testimony. We have a number of hearings going on that I had to be at.

I also wanted to thank you for meeting with some of us about Essure, the contraceptive device that I know has harmed many women, from meeting with some of those women. So, I hope we can continue that conversation because I am very concerned about it.

Most people presume that the prescription that the doctor writes for them, and they fill it, is safe and effective. This is true because the FDA is considered the absolutely gold standard in drug review.

We have all talked about now the 64 people who tragically died because of this drug at the New England Compounding Center. So, obviously, that was an impetus for passing the Compounding Quality Act to improve safety.

And so, I wanted to just say that drugs that enter the bloodstream, the eye, the spine, are supposed to be sterile, but the FDA has received adverse events reports that these compounded products were contaminated, reminiscent of the problems at the NECC.

There have also been reports of sub-/super-potent drug

products in 2016. Three babies received compounded morphine that was 20 times stronger than the label indicated. One of those infants had to be rushed by helicopter to a nearby children's hospital.

So, here's my first question: Commissioner Gottlieb, the FDA has been active in implementing the Drug Quality and Security Act. There have been over two dozen guidance documents issued, four rules, numerous public engagements focused on proper implementation of this law. While these are meaningful steps, what more can we do to reduce the number of adverse events associated with compounded drug products?

Dr. Gottlieb. I will just start out by echoing your concerns, Congresswoman. All drugs have risks. We know that. But I don't think anyone should be put at risk because a drug was improperly manufactured. At the very least, we should guarantee that a drug that purports to be manufactured in a certain way and purports to be sterile is actually a sterile product. That is the bedrock and the essence of what we are trying to achieve with respect to the authorities under this law.

I think that there are things that we can do going forward, including continued implementation. We have heard the concerns of Congress that certain aspects of how we have implemented this have been slower than Congress expected. I think we didn't fully appreciate the complexity of this law. But I think, as we

continue to implement this framework, we are going to be able to exert even better and more efficient oversight. And that is going to increase the level of safety and assuredness that the public can have.

I think there is more that we can do on the enforcement side as well, getting back to the other question. That is going to be an area that we continue to look at, both in terms of what we are doing, how we target our inspections based on what we are learning, looking at issues like potency now because we see those coming up more, as well as what additional resources we can put against it.

This is a program -- and I don't want to get too deep into the resource question; I will save it for an appropriations hearing, but --

Ms. Schakowsky. Feel free. Feel free.

[Laughter.]

Dr. Gottlieb. But this is a program where we do operate by in some cases begging, borrowing, and stealing from other aspects of the agency, other parts of the agency. For example, the team that I have, the policy team in the Drug Center that is working on the guidance development that you referenced and a lot of this policy development, is four people. They borrow resources from the review divisions, but, remember, those reviewers that they are tapping have PDUFA goals and BsUFA goals and GDUFA goals.

They have user fee goals against their time that they have to prioritize their time in certain ways.

So, I think that there is certainly an opportunity to think about how we can grow this program in ways that could better address some of those safety issues.

Ms. Schakowsky. What more do you think the FDA could and should do to ensure safety at 503A compounding pharmacies?

Dr. Gottlieb. I think getting in place the MOU is going to be an important step. The MOU will provide for adverse event reporting back to FDA through the states. And so, I think that as we get that framework in place, I think that there is going to be a lot more we could do to better target our inspectional resources in areas of risk, in areas where the 503A facilities might be crossing into being a 503B facility that would be subject to GMP standards.

So, I am hopeful. We are making good progress on that. We are going to have it out this year. I am hopeful that, as we get that agreement in place with the states, that is going to increase our level of oversight.

Ms. Schakowsky. Well, we will be looking at that. Thank you very much.

I yield back.

Mr. Burgess. The gentlelady yields back. The Chair thanks the gentlelady.

The Chair recognizes the gentleman from Michigan, 5 minutes for questions, please.

Mr. Upton. Thank you, Mr. Chairman.

And, Dr. Gottlieb, it is good to see you here again. We appreciate your go-to attitude in trying to get things right. We understand that and we are with you every step. We appreciate your work on opioids, something that impacts every one of our districts.

And I have to say, as we worked on the Cures legislation out of this committee, the $500 million extra that we added to the FDA budget was almost a no-brainer. So, we appreciate the work of your crew, and we want to make sure that you have the resources to make sure that things, in fact, are safe and that you are not missing any steps.

I have got a couple of specific questions for you. Hopefully, I can get through all three.

It is critical that, until the clinical need list is issued, the FDA not permit bulk drug substances to be used in compounding, absent a final determination of clinical need, once all statutory criteria have been satisfied. Can you confirm that, once the FDA has identified its criteria for clinical need, that bulk drug substances, including those that the FDA has currently placed in Category I, would not be permitted to be used in compounding, absent such a determination?

Dr. Gottlieb. Well, we have put out the essential copies of this, which you know, the essential copies guidance. We are going to have the criteria for the development of the bulk drugs list for the 503B facilities, which is what I believe you are referring to, because we are further along on the bulk drugs lists for the 503B facilities, we will have that criteria out in March. And by the end of the year, we will have specified some bulk drugs that should either come on or off that list. There could be some that fall out pretty quickly from that list, based on safety considerations or a clear lack of clinical need. And so, we are going to do those assessments.

Then, we are going to also have to contemplate how we change our inspectional priorities to prioritize inspecting or taking action on the basis of 503B facilities compounding drugs that might not be on that list. Right now, under our risk-based framework, we need to change some protocols in terms of how we go about looking for some of those other questions, to your point.

Mr. Upton. Is the President's budget going to include more money for inspections?

Dr. Gottlieb. Well, I don't want to get ahead of the President. So, I am not fully aware of what is going to end up in the budget. It is probably a question best put to OMB at this point.

Mr. Upton. It was never Congress' intent that small tweaks

to approve drugs, like minor changes in concentration or inactive ingredients, would satisfy the criteria for clinical need and open the door to compounding from bulk substances under the DQSA. Would you agree that a clinical need can only be found where there exists a genuine patient need unable to be addressed by approved drug products requiring a significant change from the approved drug?

Dr. Gottlieb. Well, again, Congressman, I don't want to get ahead of my career officials who right now are drafting guidance to define that very question. But the type of definition that you put forward would certainly seem to comport with a reasonable interpretation of what a final standard would be.

Keep in mind, also, that we articulated in the essential copies guidance, and we are going to re-articulate in the guidance that we put out in March, that if there is an FDA-approved product available that you can compound from, you have to compound from that product. So, if a 503B facility is compounding from bulk, but they can otherwise be compounding from an FDA-approved product, for example, diluting it down if they are providing a more dilute formulation to satisfy a certain clinical need, they have to start with that FDA-approved product. That is a principle that we have put forward. I think that is going to address some of the issues that have been raised with respect to what is on and not on the 503B bulks list at this time.

Mr. Upton. And when do you think that order will be made?

Dr. Gottlieb. That is a principle that I believe we put forward. I believe that is articulated in the copies guidance that we just put out, but it is going to be re-articulated in the March guidance that we put out. The question will, then, become, well, when are you going to take enforcement action solely on the basis of that issue? Because it is one thing for us to put out a guidance. If people don't follow our guidance, we have to take enforcement action. And that is where I mentioned that we are going to relook at protocols and how we prioritize our enforcement activity, on the basis of those kinds of considerations as well.

But, as you know, we have a risk-based framework. We prioritize our limited inspectional resources and enforcement resources in places where we believe there is direct patient risk. And we are still in a realm where we are dealing with a lot of direct patient risk before we just look at, for example, economic harm, although that certainly is within the criteria that we look at and will be within our protocols.

Mr. Upton. Thank you. I yield back.

Mr. Burgess. The Chair thanks the gentleman. The gentleman yields back.

The Chair recognizes the gentlelady from Colorado, Ms. DeGette, 5 minutes for questions, please.

Ms. DeGette. Thank you, Mr. Chairman.

As Mr. Green mentioned, he and Congressman Griffith and I worked really hard after that terrible tragedy of the New England Compounding Center to come up with our Compounding Quality Act, which was subsequently folded into the Drug Quality and Security Act. We are really proud of that bipartisan work. But, as we are seeing today, it takes constant tweaking and review to make sure that these pieces of legislation are working.

Commissioner Gottlieb, one of the things that I am hearing from a lot of stakeholders about is what to do about office use. A lot of providers are saying that people are having difficulty accessing types of medication because of the requirement that we have for prescription. Now what they say is that these medicines are not lucrative enough to use 503B outsourcing facilities, but that the patients need them. And so, there are shortages.

I want to be clear. I have got strong reservations about undermining or loosening the DQSA's prescription requirement in any way, given the consideration that any move in that direction could have an impact on patient safety. But I do want to make sure that patients with unique needs that cannot be met by FDA-approved medications can get the treatment that they need. It is really a balancing test.

And so, I wanted to ask you if you think there are ways that we can resolve these potential access problems without undermining the prescription requirement and exposing patients

to unnecessary risk.

Dr. Gottlieb. I appreciate the question, Congresswoman. To your point, this is one of the tensions that we are grappling with, because we care very much about these access issues that you have highlighted and need to preserve the practice of medicine. And we need to preserve the ability of physicians to get access to these drugs to use in their offices.

We have seen an environment where we see more of the 503Bs doing small batches. About one-third of registered 503Bs do small batches. We are trying to take steps to better match clinicians with 503Bs that either are currently manufacturing drugs they might need, but also historically have manufactured drugs that would be needed, and are willing to run small batches. So, we are starting to post that information prospectively on our website.

I think, as we also try to look at how we can create a more flexible framework for how we apply GMP standards to the 503Bs and see more smaller pharmacies that might want to make a business in doing small batches become 503B facilities, where they are still subject to GMP standards, I think that is going to also help address this.

I made the comment earlier that the 503B sector has not grown as quickly as we had envisioned and had hoped at the time, including myself when I testified before this committee. But I

think that it is still early days, and I still think we are going to see a robust industry take shape here.

Ms. DeGette. Do you think it would be helpful to work more on giving timely and transparent information for providers about which of these facilities are making these compounded medications?

Dr. Gottlieb. I absolutely do. We are doing that. We do it now prospectively. We are just starting to really do it, because we are starting to get those reports electronically. One of the things we are considering is, can we go back and do it retrospectively, because we have the histories on what the facilities used to produce. That could be helpful as well.

Ms. DeGette. It would help those facilities, too.

Dr. Gottlieb. It would help the facilities.

We are also going to be issuing either an FR notice to create a docket to solicit from provider groups input, in a more systematic way solicit input on where they are seeing access issues around certain products, so that we could, then, see what steps we could take to try to help provide more efficiency to 503Bs that might want to make those products. Because, right now, a lot of what we know is anecdotal.

Ms. DeGette. Right. Right.

Dr. Gottlieb. We want to develop that information on a more systematic basis.

Ms. DeGette. In a systemic way.

Now one last thing about drug pricing. Some people say that compounded alternatives to expensive medicines could actually provide financial relief to patients. But I think there is a real risk, in that marketing unapproved bulk compounded drugs could be really risky to patients. I am concerned that some press reports are already saying this is going on. I just wondered, I don't think that, certainly, the policies that this committee has endorsed are meant to be using compounded drugs to lower prescription drug prices if it is at the expense of patient safety. I am wondering if you can comment very briefly on that.

Dr. Gottlieb. We believe that, if there is an FDA-approved option available, that is always the best option for the patient because it is going to provide the greatest assurance of safety and efficacy for the patient and to the provider. And I also believe, as you have seen me try to demonstrate through the actions we have been taking, that there are a lot of avenues we can go down to try to address the issues of cost and competition in the marketplace. And we will continue to do that.

Ms. DeGette. So, it is not one or the other really?

Dr. Gottlieb. It is not one or the other.

Ms. DeGette. I thank you.

Thank you, Mr. Chairman. I yield back.

Mr. Burgess. The Chair thanks the gentlelady. The

gentlelady yields back.

The Chair recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. Shimkus. Thank you, Mr. Chairman.

And, Scott, it is great to have you here. I appreciate the testimony.

This is a tough issue we have wrestled with for a long time. I think my colleague, Congresswoman DeGette, just actually kind of wove the story and the concerns that I have, and when we talk to some of our folks in different congressional districts.

So, the 503A and the 503B issue, for me, it always comes down to the small-town, rural compounder and the way these rules will be etched or the memorandum of understanding or the batch size and the mileage distance, especially when you have got a rural district -- for me, it is 33 counties, five hours north and south drive, a three-hour east-to-west drive. It is a little different environment than a metropolitan area and a different area of the return on investment based upon what you are producing. You are not really going to manufacture for a large group, but in a small batch. And then, you might have across-state-line issues, especially in a rural area on the Illinois-Indiana border. I see my colleague, Mr. Griffith, nodding his head.

So, can you kind of weave for the small pharmacist compounder, who I haven't had personally any problems as far as

I have represented that area -- he is trying to address this being able to provide what is being requested of him. Sometimes it is even these issues with the -- I am not a doctor -- you know, the eye drop issue for the optometrist who doesn't have the shots in the doctor's office, although it is something they need immediately, in essence. And there is not a prescription because the person hasn't come in yet to be able to get the prescription. And then, you have a delay of providing the medicine.

So, for that small compounder, what should he take home from my vague question?

[Laughter.]

And what assurances can you give him that we are trying to allow him to continue the work he has been doing?

And I know we have got our veterinarian here, too. These guys also use their compounding ability in veterinarian medicine. So, a veterinarian would ask the compounder in rural America. So, he needs to be there for not just humans, but also for the animal health that he also is able to provide for the veterinarian.

Dr. Gottlieb. I can go a lot of different ways with this question.

Mr. Shimkus. Well, I went a lot of ways with the questions.

[Laughter.]

Dr. Gottlieb. But I will go right to where I think you are going, which is the question of the prescription requirement and

whether or not that small-town pharmacist who is providing drugs over a large geographic area still needs to have a prescription in hand in order to provide a drug back and the difficulty of doing it over a large geographic expanse I think is the essence of what you are asking.

The bottom line is that we believe that the line of demarcation for what constitutes the practice of pharmacy versus what constitutes drug manufacturing has to remain the prescription. I mean, the practice pharmacy, if you go and look at the bylaws of states and how they define a practice pharmacy, I did that before coming to the hearing. I spent my weekend looking at that. Embedded in the bylaws of state boards of pharmacies is the idea of the prescription and the named patient. That is the essence of what it means to be practicing pharmacy.

We also understand that Congress contemplated other thresholds and struggled with it, and arrived back at the prescription being the line of demarcation, both 20 years ago when 503 was originally drafted, as well as when it was recodified in DQSA. Because other kinds of schemes that were contemplated, volume-based schemes, for example, didn't provide the kind of delineation that you could apply a regulatory structure to. We can't regulate against "we'll know it when we see it." We need a clear line that we can force against and we can enforce against with our limited resources.

As far as veterinary medicine is concerned, as you know, we recently pulled the guidance that sought to define what our regulation was going to look like in that realm. And we pulled that for a variety of reasons, but, largely, because we don't think we got it right. I will say we will be reissuing that this year. But I will say that the issues around compounding in the veterinary space are different than issues around compounding in the human space. The practice of pharmacy in the veterinary space is a different kind of practice of medicine than it is in the human space. And so, our framework will also look different. It will be reflective of the practice of veterinary medicine.

Mr. Shimkus. All right. Thank you.

Mr. Burgess. The Chair thanks the gentleman. The gentleman yields back.

The Chair recognizes the gentleman from Oregon, Dr. Schrader, 5 minutes for questions, please.

Mr. Schrader. Well, thank you.

And I thank my colleague for asking some good questions about veterinary medicine. That is near and dear to our heart.

We use compounders a lot in our practice, I don't think inappropriately, but, as you alluded to, the size of the animal, the different metabolism of an animal, the lack of a particular drug that has worked historically that is affordable for my patients, I mean that is a different beast to some degree. I

appreciate the thoughtfulness that USDA under your guidance and FDA is actually approaching the whole veterinary guideline issue. So, I want to thank you for that.

While I have had a lot of experience in using compounders in smaller communities to make sure my patients get the best medication possible, I am new to the regulatory framework with all this. I don't profess to be knowledgeable. So, my questions might be a little arcane and pretty obvious.

But the whole 503B opens up a potential, as I think you have alluded to and some of the questions have alluded to, problem for circumventing a lot of the regulatory framework that our generic manufacturers, for instance, have to apply. What are the major differences -- well, first, I will say I fully support the continued definition of pharmacy prescription. It has to have a prescription to be able to do that. I think that is for the safety of any patient, human or animal. That is critical, and I urge you to continue to use that as a very bright line.

But, having said that, then what do you see as the big demarcation between your 503B regulatory framework versus your generic regulatory framework? How do you see that as different, and what constitutes the guidelines there?

Dr. Gottlieb. Right. By generic, I think you mean 503A, traditional pharmacy compounding, 503B being the outsourcing facility. And the difference is the prescription, whether or not

that the drug is being compounded on the basis of a named patient in response to a lawful prescription from a provider. That is the traditional practice of pharmacy. That is a 503A compounder.

A 503B compounder is engaging in manufacturing. They are manufacturing either in small batches or on a larger scale, not in response to individual prescriptions that they have received from a provider, but in anticipation of orders, and they are doing advanced shipping. They might be doing what we all office stock. They might be shipping to providers to allow those products to be stocked inside the offices.

That is traditional manufacturing. There is no way around it. Whether you do it with 10 units or you do it with 100 units, you are engaging in manufacturing, and those circumstances, instead of applying the traditional regulatory framework where they would be subject to regulations around the sanitary conditions, which is what you would apply to 503A pharmacy, in the context of the 503B setting you are applying GMP standards, some form of GMP, not GMP-light, but some form of GMP. I don't want to call it "GMP-light".

Mr. Schrader. So, similar to the generic manufacturing that would go on?

Dr. Gottlieb. Subject to good manufacturing practices, I mean, good manufacturing practices, as I said at the outset, are not a fixed standard. They are risk-based. And so, they look

different depending on the manufacturer that you are evaluating. But it would be some form of GMP standards that you would be applying. You would be doing lot release, sterility testing, batch testing. You would be retaining samples. You would provide for the compounding in a sterile environment if you are compounding a sterile product. So, you would be applying the GMP standards, traditional GMP standards.

Mr. Schrader. Whatever level you are approaching that manufacturer?

Dr. Gottlieb. There are basic principles of regulation with respect to the good manufacturing practices. So, when we say "level," I think that there are things you can do to make it less expensive if you are doing it on a smaller scale. So, for example, you require a lot of small batches. If you are only going to be making a small batch, if you are only shipping a small amount, you would require that facility to retain a lot of samples. There are ways that you can apply the GMP standards in fashion that comports with the level of the volume and the level risk you are creating. And that is what we are seeking to do in the more flexible framework that we are contemplating.

Mr. Schrader. So, I guess the last question: what do you see as the role with the state regulatory framework versus the federal regulatory framework. The interstate commerce piece would, obviously, be a federal purview. How do you juxtapose the

state regulatory framework on these 503A and, more importantly, the 503B pharmacies?

Dr. Gottlieb. The MOU is going to define sort of the interplay between the state and the federal scheme and the level of activity that a 503A can engage in that might cross it into being subject to federal oversight because it is engaging in interstate commerce, interstate activity. And we have talked about various thresholds, about how much product can cross a state line before a compounder should or ought to be subject to at least our attention, to make a decision on whether or not it is subject to, should be subject to FDA oversight.

Here again, this is not going to be a fixed standard when we are contemplating this. It is not going to be, if you ship 31 products, you are subject to the federal scheme, but if you had only shipped 30, you would be fine. We are going to try to take a risk-based approach here as well, and it is going to be based on volume, percentage of products you are shipping across the state line, the kinds of products you are shipping across the state line, the manner in which you are doing it. And so, we are going to have a threshold in which we want notification by the states, but, then, we are still going to make an independent decision whether or not it should be subject to a federal inspection because of the activity.

And the essence is, if I could just close, the essence is

that, if a pharmacy is engaging -- if a pharmacy is subject to state regulation, but is shipping most of its product out of state, it can't be subject to state regulation anymore. Because if you are in New Jersey and you are subject to the New Jersey Board of Pharmacy and New Jersey inspectors, but most of your products are going to New York, the New York inspectors don't know. Then, they can't provide the oversight that they need to in a trace-back. So, it is important that the states be aware of what is going on within their states.

Mr. Schrader. Very good. Thank you.

And I yield back.

Mr. Burgess. The Chair thanks the gentleman.

The Chair recognizes the gentleman from New Jersey, Mr. Lance, 5 minutes for questions.

Mr. Lance. Thank you very much, Mr. Chairman.

And thank you for being here, Commissioner.

The district I serve provides innovative medicines for patients across the country. Protecting these patients is, of course, a top priority for all of us, and so is protecting the FDA's gold standard. As the Drug Quality and Security Act is implemented, we need to ensure that we provide the incentive for innovator and generic manufacturers to go through the FDA process. To do this, we need to make sure that commercially-available drug products cannot be copied. How is the agency protecting patients

and the gold standard as you implement the Drug Quality and Security Act?

Dr. Gottlieb. Well, Congressman, thanks for the question. I would like to assert that we are protecting the interest of patients by implementing this statute and making sure that we continue to move through the regulatory steps to, for example, finalize the 503B bulks list, finalize the guidance on sanitary conditions, finalize the list on bulk substances that the 503A facilities can compound from, make sure we get the MOU in place, so we can provide proper oversight of 503B and 503A facilities, in concert with the states, and work closely with our state partners. And so, we are going to continue to work through that.

With respect to the first part of your question about just the sort of economic issues inherent in situations where a compounder might be copying a drug that is otherwise an FDA-approved product, we have asserted in the copies guidance certain activities that we would believe fall outside the scheme contemplated by DQDA. We are going to reassert those in the guidance that we issue in March with respect to the criteria for what should and shouldn't be on the bulk drugs list. Then, it is going to be a question of taking enforcement action where we see companies or compounders engaging in activity that falls outside that scheme that we both articulated in our guidance as well as Congress contemplated in the statute. That is what we

are going to be focused on doing.

I will say, thought, our enforcement activities will be, as they should be, guided by patient risk, first and foremost. But we will be baking into our protocols in terms of how we take enforcement action the kinds of considerations that you talked about, because that is what Congress has asked us to do.

Mr. Lance. Thank you.

I was pleased to see that the agency's 2018 Compounding Policy Priorities Plan -- and I am interested to hear more about the forthcoming flexible risk-based approach to current good manufacturing practices. Recognizing the agency's goal to increase the number of 503B outsourcing facilities, recognizing the compliance costs for larger 503B facilities and the investment necessary to satisfy the statute, is the agency concerned that the multi-tiered 503B regulatory approach may affect incentives for these facilities?

Dr. Gottlieb. Well, quite the opposite, we feel that we hope that by taking a tiered approach based on risk, we might provide the opportunity for more 503A pharmacies to step across the line into being 503B pharmacies and consider it worth the economic investment. Becoming a 503B pharmacy is not without some investment in cost for most 503A facilities. They don't have the kinds of facilities to be subject to GMP oversight. And so, it is going to require some investment. But we are hoping that we

could provide a framework where more facilities can find it, have the ability to make the capital investments and raise the capital necessary to make those investments because they see a better opportunity on the other side of that in terms of trying to increase their volume and increase the kind of activity that they are engaged in. We think by having more 503A facilities converting to being 503B facilities, it is going to facilitate access and, also, give them the ability to grow.

A 503A facility that is trying to engage in some low level of manufacturing, even if they can do it under the radar of regulators, if they grow to a certain proportion, eventually, they are going to pop up. And so, they are basically capped under this legislation. If they step across that threshold and become a 503B, they have much more latitude to engage in broader manufacturing.

Mr. Lance. Thank you, Commissioner.

And, Mr. Chairman, I yield back 27 seconds.

Mr. Burgess. The Chair thanks the gentleman.

The Chair recognizes the other gentleman from New Jersey, the ranking member of the full committee, Mr. Pallone, 5 minutes for questions.

Mr. Pallone. Thank you, Mr. Chairman.

I wanted to ask you about this issue of distribution versus dispensing. Section 503A of the law prohibits a pharmacist,

pharmacy, or healthcare provider from distributing compounded drug products across state lines that exceed 5 percent of the total prescriptions distributed or dispensed unless the product is compounded in a state that has entered into a memorandum of understanding with FDA that addresses the distribution of inordinate amounts of compounded drug products and provides for investigation by the state into complaints associated with compounded drug products that are distributed interstate. And FDA released a draft MOU in February 2015 that proposed defining inordinate amounts for purposes of interstate distribution to no greater than 30 percent of all products distributed or dispensed.

So, in terms of this distribution versus dispensing, Commissioner, some have suggested that the MOU is only intended to apply to drugs that are distributed without a prescription. What is your view about the purpose of the MOU and the public health purpose it serves? Are there some drugs, such as those dispensed directly to patients, which could be excluded consistent with that purpose?

Dr. Gottlieb. Well, in my weekend reading of pharmacy bylaws, the other observation that I had is that the bylaws make specific reference to the word "dispense" as part of their definition of what constitutes the practice of pharmacy. It is our view, and we feel strongly, that the practice of pharmacy always contemplates the dispensing of the drug. Now in certain

circumstances the drug is going to be dispensed and, then, distributed across state lines, and that is where the MOU comes into play. The MOU contemplates drugs that are dispensed and shipped across state lines, and shipping is a form of distribution, as I think you all agree. But we think that dispensing is part and parcel of the activity of practicing pharmacy, and no drug, no compounded drug can be distributed without first being dispensed, because dispensing is the act of creating that patient-specific prescription.

And I will just say, and sort of to address the elephant in the room, because this has been contemplated as one of the sort of beliefs in terms of why DQSA might have contemplated something different with respect to office stock than FDA's current interpretation of how we perceive the law to have been written, I don't think that defining, redefining the practice of pharmacy, which involves the activity of dispensing a product to a patient, is a good way to try to create a framework for office stock. I am open to the debate about office stock and the merits of it. I think we have been clear from the agency's standpoint the risks that we feel it creates if a 503A facility is getting engaged in it. But I would hate to see the practice of pharmacy redefined as a sort of backdoor into that. I think if we are going to have a discussion about the merits of 503A facilities engaging in some level of manufacturing and shipping, we ought to just do that

directly.

Mr. Pallone. All right. Then, let me get to my second question. Recently, you announced the agency's intention to modify the allowable percentage of compounded drug product distributed into a state to effectively eliminate the 30-percent threshold and, instead, implement certain reporting requirements that will be triggered at a 50-percent threshold. And this strikes me as a weakening of an important patient protection and in contrast to what you have noted in your testimony is the stated goal of this provision in the statute, which says, and I quote, "Preventing compounders reportedly operating under the exemptions in Section 503A from growing into conventional manufacturing operations making unapproved drugs and operating a substantial portion of their business interstate without adhering to current good manufacturing practice requirements and other provisions intended to ensure the manufacture of quality drugs." So, would you explain how increasing the allowable threshold for interstate distribution to 50 percent is consistent with the goal of the statute of preventing compounders from making unapproved drugs and operating a substantial portion of their business interstate without adhering to the CGMPs?

Dr. Gottlieb. Well, I appreciate the question, Mr. Chairman. I don't see it as a weakening. I see it as a strengthening, because we are going from a hard threshold of 30

percent to a risk-based threshold of 50 percent. It is not 50 percent -- it is not 49 percent and you are all good, and 51 percent and you are now subject to a different scheme. There are going to be other tests that we apply to make assessments about what the appropriate scheme is for a particular facility.

It is the case, though, that there are facilities -- for example, a border-state pharmacy that develops TPN, total parenteral nutrition; a home infusion company that provides patient-specific, named patient products on a prescription basis and might ship more widely that are engaging in the traditional practice of pharmacy; they are doing it on the basis of named patients in response to an individual prescription, but they might be shipping more of those products. They might be lower-risk, too, depending on what they are doing.

And so, the reality is that there is a lot of different kinds of pharmacies situated across the spectrum in terms of the activity that they are engaged in. And we don't think a sort of fixed standard where there is a fixed line based just on volume makes the most sense. We want a volume-based standard, but also a standard that allows us to make an assessment about what the kind of activity is. And it is another effort on our part to be risk-based. I think, ultimately, our enforcement is stronger when we are taking a risk-based approach.

Mr. Pallone. All right. Thanks a lot.

Thank you, Mr. Chairman.

Mr. Burgess. The Chair thanks the gentleman. The gentleman yields back.

The Chair recognizes the gentleman from Virginia, 5 minutes for questions, please.

Mr. Griffith. Thank you very much, Mr. Chairman. I appreciate it greatly.

Let me get the record a little bit straight because I think it was confused a little bit earlier. While we had criminal conduct by NECC, we also had timid lawyers at the FDA. Ohio had warned the FDA there was a problem. Colorado had outright banned NECC from putting products into their state. And FDA was aware of it and didn't even bother to seek a warrant to go in and see what was going on. So, as we move forward, let's continue on that.

Also, I think in the next panel there will be some question about the intent, and you touched on that in your testimony with Mr. Shimkus a little bit earlier. But I want to go back to when the bill passed in September of 2013. At that time, now-Ranking Member Green said, in part, "While I believe the FDA dropped the ball with regards to the NECC, with this law they must succeed where in the past they failed." And I know you are working hard on that.

This bill still lacks clarity in many important areas: office use, how nuclear pharmacies are regulated, and repackaging

of sterile products. I look forward to working with my colleagues to provide meaningful oversight of the FDA to make sure another NECC-type outbreak never happens again, and make sure they are using the type of enforcement discretion necessary to preserve patients' access to critical medicine.

In that same press release -- because it was a bipartisan effort, as you heard earlier, Mr. Green, myself, and Ms. DeGette worked hard on trying to get this portion of the DQSA right, and to the best of our ability, although we had some disagreements with our Senate colleagues. I said on that occasion that, "The Drug Quality and Security Act leaves a large portion of existing law intact. It also leaves many areas of practice where clarification may still be needed, particularly as it relates to office use, repackaging, and nuclear pharmacies. Along with my colleagues, I will continue working to oversee the FDA's interpretation and implementation of this law."

And I think that is what we are doing today. Some folks have characterized this, because I am leading the push for office use, as wanting to undo everything that DQSA stood for. Obviously, I wouldn't have drafted it and fought hard along with my colleagues to get it, if that was my intent.

But I do have questions. And one of those was raised by your testimony to Mr. Shimkus in answering his questions where you indicated that twice they had decided that you had to have a

prescription in order to issue a drug, and that Congress had made that decision. But I am looking at 503A, little "a" to big "A", and it says, as one of the things, it says, "or is by a licensed pharmacist or a licensed physician in limited quantities before" -- before -- "the receipt of a valid prescription order for such individual patient."

Obviously, the law -- and that was the old law, which was not changed and which we were assured that the practices weren't going to change at the times we were negotiating this by folks in the Senate saying they didn't want to do this because the FDA wasn't going to change anything. It clearly anticipates that in some cases you won't have a prescription until afterwards. We had debated making sure that a prescription was written within seven days at the time that we were negotiating it. But this seemed acceptable at the time, and the reason that I put that into my statement -- and others may have put it into their statement -- and the statement on the Floor was we were given the assurance that office use was going to remain pretty much the same, and for 503A pharmacies I think that is important.

So, how do you rectify that you think there needs to be a prescription with the actual wording of the law? There are also other references, future-looking references, in the next section.

Dr. Gottlieb. Yes, thank you, Congressman, for the question. I appreciate your longstanding dedication to this

issue and your longstanding work on it. And you and I have had the time to talk about this on many occasions.

With respect to the nuclear pharmacies, I will just say we will be putting out a guidance that will specifically address radiopharmaceuticals.

But, in respect to your specific question about the language you quoted, I believe that that language and we believe that language was contemplating anticipatory compounding, basically, compounding on an expectation that you were going to receive a certain volume of prescriptions. Because we know, with the 503A pharmacies -- and I know you are very familiar with the practice of pharmacy -- sometimes when you mix up one batch, when you are mixing up a batch, you can't just mix up one drug. You mix up 10 at a time or 15 at a time. And you can do that if there is an expectation that you know you get 30 prescriptions a month or 40 prescriptions a month. So, we allow for that.

What we have said in guidance is that you can mix up a level of volume in anticipation of what you your prescriptions might be over the course of a 30-day period to provide that kind of flexibility. That is what I believe the statutory language that you referenced was anticipating and that we have allowed for.

Mr. Griffith. And I disagree, just based on the debate that we had when we were doing this a number of years ago in 2013, because we anticipated there would be continued office use. That

is why we were looking at putting in the seven-day requirement. And as Ms. DeGette said, there has got to be a balance. As Mr. Shimkus said, we are worried about rural areas.

I do appreciate that you are concerned about the state lines because, having now been made famous by the GEICO commercial where the lizard jumps from Tennessee to Virginia and back and forth, and back and forth, that is my district. And so, you have got a pharmacy on either side of that state line. I mean, you just turn around and you cross the state line.

The other day I was traveling in my district and I went from Virginia to West Virginia, to Virginia, to West Virginia, back to Virginia, then ended up the day going from Virginia to Tennessee, back into Virginia, and back into Tennessee, and then, back home in Virginia, just to try to talk to my constituents and do what I needed to do.

So, I appreciate you paying attention to that as you look at the flexibility side, but I really believe that the existing law allows for some office use from the smaller folks. We were trying to get to the big guys and the larger guys because of the NECC problem, which was shipping into all the states, not just across the Tennessee line or the Virginia line.

I yield back.

Dr. Gottlieb. I understand and appreciate concerns, Congressman, the impact on small pharmacies.

Mr. Griffith. And I yield back. Thank you, Mr. Chairman.

Mr. Burgess. The Chair thanks the gentleman.

And the Chair recognizes the gentleman from a similar small state, Maryland, for 5 minutes.

Mr. Sarbanes. Small, but powerful, and home to the FDA.

Welcome, Commissioner.

People have touched on kind of the partnership, regulatory partnership between your agency and what happens at the state level. I wanted to explore that a little bit more.

I was looking at your testimony on page 3, where you talked about the 500 inspections that have been conducted, 503A and B facilities, since the passage of the new law and the end of the last fiscal year; how you have observed problematic conditions during the vast majority of these inspections, overseeing more than 150 recalls of compounded drugs, issued more than 180 warning letters. You have also worked in close coordination with our federal and state partners, sending more than 70 referral letters to state regulatory authorities for followup on certain inspectional findings.

So, I am just curious how that is going. I mean, there must be some states that are better partners than others. Obviously, you have to rely to a certain degree on those followup inspections. And maybe without naming specific states, you could give me an example of a state that is engaged in this partnership in a very

productive and efficient way, and why that is the case, what you would point to as indicating kind of a high standard in terms of the partnership, and the followup, and all the rest of it. And then, maybe give me an example, again without naming the state, of a place where that is not going so well. And what does the agency do, either because it is required to in some element or just because you regard it as your responsibility to help states to get to where they can be the best possible partners in this effort at oversight?

Dr. Gottlieb. Congressman, thanks for the question. To your point, there is a fair degree of variability. I think it would be risky of me to try to characterize a good state and a not-so-good state, because it is not something I have actually asked the question of my folks, and I would want to contemplate it in concert with them. Because the field people, the field team that is engaged in these efforts are going to have the best perspective. We could certainly get you that perspective, but I wouldn't want to mischaracterize the state.

I will say, though, broadly, that what we are seeing directionally is that the states are starting to conform more to DQSA now. And so, there has been discussion, for example, of states' pharmacy bylaws that might allow for certain practices that DQSA we don't believe contemplates. We starting to see more of the states conform their practices, their inspectional

activity, as well as their laws, to be compliant with the DQSA, be consistent with the principles of the DQSA.

For the states that might be moving in a different direction or not moving as quickly in the direction that was envisioned by DQSA, I think what it creates for us is more of a resource burden. Those are the states that we might have to put more resources into to make sure that we are providing the same level of oversight that we would be to a state that is sharing information with us very cooperatively and reporting to us, so we can target our inspections better.

A lot of our inspections are for-cause inspections. A lot of them are based on information we derive from the states. If the states aren't reporting to us as efficiently, then we need to do more work to try to derive that information on our own. It is just a more resource-intensive process.

Mr. Sarbanes. Is there an opportunity to provide, I don't know, technical assistance or other support to the states, as they are trying to come into compliance with this effort?

Dr. Gottlieb. We do that. As the scheme contemplates, we provide a lot of resources or technical assistance within the context of the resources we have available to do this in terms of training to state inspectors, training around inspectional issues that they might need to be aware of as they start to inspect, for example, 503B facilities and do their own GMP inspections.

We do dual inspections with the states. We invite the states in on our inspections, so that they can both learn alongside of us as well as dually inspect some of these facilities and share information. So, there is a lot of stuff that we are trying to do in concert with the states.

As I sunk deeper into this and understanding how we were applying this framework when I re-arrived at FDA 10 months ago, there were a lot of aspects of this that looked very similar to FISMA, the framework envisioned in FISMA, where the regulatory scheme is very much dependent upon a close federal/state partnership.

Mr. Sarbanes. Thank you. I yield back.

Mr. Burgess. The Chair thanks the gentleman. The gentleman yields back.

The Chair recognizes the gentleman from Georgia, 5 minutes for questions, please.

Mr. Carter. Thank you, Mr. Chairman.

And thank you, Dr. Gottlieb, for being here. I want to commend you and thank you for your adherence to safety, and I think it is very important.

It has been mentioned more than once during this hearing that there has to be a balance between accessibility and safety. I think that is perhaps one of the areas that I struggle with. And you and I have had many conversations.

I want to ask you, first of all, about the rulemaking process, because that is of great interest to me, being a relatively-new Member of Congress, only in my second term, my third -- I guess I am starting my fourth year now. So, I am getting older, but I am still learning about the rulemaking process.

I noticed that, since the passage of DQSA, that you have used oversight guidance documents to really enforce this and to really enforce what you want the agency to see out there. Although we probably disagree, and we do disagree, you say it is with stakeholder input; I say it has not been with stakeholder input. And I am just wondering how you can justify that, particularly in light of the fact that just recently the Office of the Associate Attorney General issued a new policy to DOJ that guidance policies will not be converted into rulemaking. So, how are you justifying this, that you are going to use guidance policy for rulemaking here?

Dr. Gottlieb. Thank you, Congressman.

We have a long history of issuing non-binding guidance in many contexts. And our guidance practice -- and this question has come up in other contexts well outside this context -- our guidance practices, generally, have been used as a model for other agencies and for OIRA as well in terms of what we do, how we issue guidance, what we use guidance for under the Administrative Procedures Act.

So, I feel confident that, on the whole -- and we can have a debate around any individual guidance -- but I feel confident that, on the whole, we have adhered to good practices in terms of how we promulgated guidance in multiple --

Mr. Carter. I don't mean to interrupt, but you even answered Mr. Upton's, Representative Upton's question about the guidance, that you expected it and that you were using the guidance for enforcement. I mean, you are, essentially, saying that this guidance is going to be enforced.

Dr. Gottlieb. There is --

Mr. Carter. Even though the DOJ has been told that, no, it cannot be converted into rulemaking. Quite honestly, I have not read this from the Associate Attorney General. Perhaps they said this is going to apply to the DOJ, but not to the FDA. I don't suspect that was the case; maybe it is.

Dr. Gottlieb. Well, we could take enforcement action now. We don't need the guidance document in order to take the enforcement action. The guidance document is a way to provide public discussion around how we intend to take our enforcement action. So, we can both inform the public as well as learn from the public. The guidance document itself isn't the basis for the enforcement action, you are absolutely right. We have regulatory authority that has been given to us by Congress.

Mr. Carter. Well, what about stakeholder input? Because

that is something that is very concerning to me, that I don't feel like we have had stakeholder input. I know that you are coming out with a new MOU. My hope is that you are going to have more stakeholder input into that. The existing MOU, although I was not here at the time, I don't think there was sufficient stakeholder input into that.

One thing, in particular, about this is the difference between dispensing and distributing. As you know, the DEA has said that distributing is going to be overseen by the FDA, but the dispensing is going to be overseen by the state boards of pharmacies. Yet, you seem to want to oversee dispensing as well through the FDA.

Dr. Gottlieb. I am not familiar with the particular definition of dispensing and distributing, probably under the Controlled Substances Act, that you have derived from -- I don't know, is it a regulation or a guidance document? So, I can't speak to how the DEA might have defined something in a certain context, again under the Controlled Substances Act, which is my presumption.

We believe that, under this law and under the practice of pharmacy, with products that we regulate, and outside of the context of controlled substances, the practice of pharmacy involves the dispensing of a product, just like the practice of pharmacy involves a patient --

Mr. Carter. But why is it that the FDA thinks that they have to intercede the state boards of pharmacy? That has always been something that the state boards of pharmacies --

Dr. Gottlieb. We need to work with them.

Mr. Carter. Okay. I have got just a few minutes left, just a few seconds left. Now I want to ask you about something that has been brought up by Ms. DeGette, by Mr. Griffith, and that is office use. And that is something that I think you have absolutely got wrong here.

But I want to ask you just from a perspective of a Member of Congress. It is my understanding that not once, not twice, but three times, through appropriations language, that the FDA has been instructed to revisit this and to look at this. In fact, in 2016, it said, "The committee understands the intent of the DQSA was not to prohibit compounding pharmacies from operation under existing 503A exemptions. Therefore, the committee directs the FDA to issue a guidance document on how compounding pharmacists can continue to engage in office-use compounding."

Why do you ignore these? Why have you not ignored it once, not twice, but three times? I don't get it.

Dr. Gottlieb. Congressman, those appropriation riders I believe preceded my arrival at FDA. I would be happy to work with this committee, or anyone in Congress, to contemplate if they want to have a discussion around the statute and what we can do to

continue to improve this on this legislation.

But we have to keep patients in mind and make sure patient safety drives the decision we make. And remember why we are here. We are here because pharmacies were engaging in manufacturing without any standards in place.

Mr. Carter. Dr. Gottlieb, I could not agree with you more. I commend you on your dedication to safety. Again, we get back to the balance between access and safety. And that is just you and I live in different worlds. I mean, you are in a different world than what I previously was in my career in pharmacy, and I saw firsthand the access issue and how people struggled with it. That is just a difference that we have and that I hope that you will take into consideration in the future.

Thank you very much.

Dr. Gottlieb. Thank you, Congressman.

Mr. Burgess. The gentleman yields back.

So, Dr. Gottlieb, once again, I think we have gotten everyone on the committee. I will just ask, Mr. Green, do you have a followup question before we leave?

Mr. Green. No. Oh, I guess we do, Mr. Chairman.

[Laughter.]

Mr. Burgess. I could intuit that.

Mr. Green. Okay. Commissioner, one of the most important ways FDA is conducting oversight and ensuring compliance with the

DQSA has been through inspections. Since the enactment of the Drug Quality and Security Act, FDA has conducted nearly 500 inspections, issued more than 180 warning letters identifying significant violations of compounding pharmacies, issued more than 70 letters referring to inspectional findings to state regulatory bodies, and overseen more than 120 recalls of compounded products.

Commissioner Gottlieb, as I noted, FDA has conducted hundreds of inspections in compounding pharmacies and identified numerous violations. Will you describe briefly for us some of the violations and conditions FDA found when they were inspecting both 503A compounding pharmacies or 503B outsourcing facilities?

Dr. Gottlieb. I brought some slides with me, if the chairman would let me use them, of some of the things that we found. So, we can close on this, if that is okay. I don't know if we have them teed up.

Thank you, Mr. Chairman.

This is visible microbial contamination on a ceiling tile in a clean room.

If we go to the next slide, this is a HEPA filter located immediately above an ISO5 workbench that was observed to have a stained surface. The stain was due to a drug product which had exploded due to excessive pressure when forcing non-sterile product through a sterilizing filter, a device used to force the

product sterilizing, in other words, a stainless steel caulking gun that was not sterilized.

Next slide. This is a sleeve used in the aseptic glovebox for aseptic manipulation. You can see it is damaged where it is circled.

Next slide. This is a toaster oven that was used to dry heat sterilize glassware. The oven wasn't capable, as we can probably presume, of reaching high enough temperature to be effective for that purpose.

Next slide. This is a ceiling above the doorway to a clean room with exposed insulation. This was supposed to be a clean room that would store products manufactured.

Next slide is a kitchen dishwasher that was actually being supplied with tap water and home detergent and used to clean equipment, equipment and the utensils that come in contact with products that were intended to be sterile.

And they jumped my bug. This was a bug.

But, you know, we also saw things like coffee filters being used to filter particulate matters. We find things that are deeply concerning. And these are sterile, these are facilities that are manufacturing sterile products, or at least intended to be sterile products.

I appreciate the question.

Mr. Green. Thank you.

Mr. Burgess. The Chair observes that debate on the Floor has proceeded to the point where Mr. McGovern is making some fairly significant gestures, which usually means he is concluding and we will be voting shortly. So, I will advise the committee that we will recess upon the votes that are called on the Floor.

But we thought Ms. McMorris Rodgers was coming back, and she is. So, I will recognize her.

Mrs. McMorris Rodgers. Thank you, Mr. Chairman.

Mr. Burgess. But, again, I observe that the vote on the Floor is probably very close. Mr. McGovern is making smaller and smaller circles with his hands, and that usually means we are getting there.

[Laughter.]

Mrs. McMorris Rodgers. Okay. Very good. Okay.

Well, Commissioner, thanks for being here.

I wanted to ask about the 503As and the 503Bs, and just what the intent is moving forward as far as preserving them separately, or what your thoughts are.

Dr. Gottlieb. Well, thank you, Congresswoman, for the question. On the 503A, are you talking about the bulks list or just the different facilities?

Mrs. McMorris Rodgers. Well, I understand that you have issued some guidelines related to 503As, 503Bs, and I wanted just to understand better what you think the future is for the 503As.

Dr. Gottlieb. Well, I mean, the general question with respect to the 503As is we believe that the 503As, which is a traditional practice of pharmacy, should continue to flourish. We believe it provides an important product for patients, the practice of pharmacy being able to individualize products on the basis of a prescription for an individual patient.

On the 503Bs, we do hope, and we always envisioned, that there would be more facilities converting into being outsourcing facilities. We also believe that more 503A facilities would opt to become 503B facilities. Now, in full disclosure, we have not seen the industry grow up the way we had hoped. We still believe it is early. And we intend to try to promulgate a set of policies that we believe that will, hopefully, provide a flexible regulatory framework based on risk that is going to allow more pharmacies to contemplate becoming 503B facilities. Because there is an argument to be made that, when a pharmacy can become a 503B facility and engage in larger-scale manufacturing, under GMP compliance standards, we are able to apply a level of oversight that ensures the sterility of the products that are being manufactured. That could, hopefully, provide for more patient access.

But, with respect to the 503A facilities that were contemplated in the statute, and always enshrined in statute, that is the traditional practice of pharmacy that we believe should

be preserved and protected, and provides an important opportunity for patients to get products that are tailored to their unique clinical needs.

Mrs. McMorris Rodgers. So, you anticipate that they will be preserved as you move forward, the 503A --

Dr. Gottlieb. Well, they are. They are being preserved. The question becomes the scope of the activity and whether or not 503A facilities can and should be engaging in larger-scale manufacturing, and manufacturing and distributing products. And we believe that DQSA contemplated a scheme where that kind of activity would move into the 503B facilities that would be subject to GMP standards, if you were engaging in manufacturing and wider-spread distribution.

That is what brought us here. I mean, it was the fact of pharmacies like NECC engaging in manufacturing under the guise of a pharmacy license, not subject to standards that ensure the sterility of those products, that created the risks that brought Congress to contemplate this new framework.

Mrs. McMorris Rodgers. Okay. Well, I look forward to talking further about this with you.

Dr. Gottlieb. Thank you.

Mr. Griffith. Will the gentlelady yield?

Mrs. McMorris Rodgers. Yes. Yes, I would be happy to yield.

Mr. Griffith. And I would just ask, in relationship to 503A, because we were talking about it earlier, if that didn't contemplate office use, then why has FDA allowed it up until this point in time? Because that is existing law and was existing law before DQSA, and it was allowed.

Dr. Gottlieb. Yes, I mean, it is a good question, Congressman. And I was at FDA over part of the time that we struggled with the 503A statute. As you know, after the Western States case vacated certain aspects of that law, FDA was on shaky legal ground with respect to trying to contain and implement that statute --

Mr. Griffith. We know.

Dr. Gottlieb. -- with the division in it.

Mr. Griffith. I know, and, yes, that was, again, timid lawyering, because that just dealt with advertising. It didn't have anything to do with anything else, and it was not ruled, the question of severability was not ruled on by the Supreme Court.

Dr. Gottlieb. Right. I think what the agency would have said at the time was that it had a difficult time bringing cases under that statute, and we also at the time faced a lot of pressure from Congress on the implementation of 503A. I think DQSA was not only a clarification of the statute and removed the offending provision, but was a clear declaration from Congress that you wanted the agency to be vigilant with respect to these --

Mr. Griffith. No question about being vigilant. Just we didn't anticipate eliminating something that had been in practice under the existing law that we left as the existing law.

But, that being said, also, you showed the pictures of things you found as problems in compounding pharmacies, but you also found problems, which is why you do your job, in large manufacturers as well from time to time. Isn't that correct?

Dr. Gottlieb. Absolutely right.

Mr. Griffith. Thank you very much. I yield back.

Mr. Burgess. The gentleman yields back.

The Chair recognizes the gentleman from Texas for a unanimous consent request.

Mr. Green. Mr. Chairman, I would also like to ask the Commissioner to submit those slides for the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

********** COMMITTEE INSERT 5**********

Mr. Burgess. I do have one followup question that I feel compelled to ask. Because we are going to hear from a patient in the next panel, and Mr. Guthrie referenced -- I think it was Mr. Whitfield's constituent in several Congresses ago who came and talked to us about losing a spouse after the Exserohilum infection that they acquired.

Does the agency have an opinion on when it is the duty of a physician or a surgery center or a hospital to inform a patient that they are receiving a medication from a compounding pharmacy as opposed to one of the other pharmacies?

Dr. Gottlieb. I don't have a view on that, Congressman. I have seen survey data with respect to that, I think including data that was developed by Pew. So, I know you have a witness who can speak to that, the development of that data, on the next panel.

As you know, there are labeling requirements for the products that are produced by the 503B facilities that provide warning information and certain disclosures, but not necessarily that it was a compounded product.

Mr. Burgess. It doesn't escape me that the witness we had several Congresses ago, and likely the one we are going to hear from today, may very well tell us that they never had any idea what a compounding pharmacy was; they never heard of it before. And now, their lives have been seriously affected by --

Dr. Gottlieb. Well, I would say that, here again, I think

this gets to the question of the prescription as a line of demarcation. Because if the prescription is the line of demarcation, if you are going into a 503A facility and getting a compounded product, you know that. If you are going into a doctor's office and you are getting a product from that doctor's office, and that was produced by a compounding pharmacy, not subject to sterility standards, you don't know that. That is why it is important, we believe, to have a mechanism in place to make sure that, when those products are being provided in that sort of de-identified way, because you no longer have that relationship to the pharmacist and understand where and how that product was manufactured, that there are standards applied for sterility to how that product was developed.

Mr. Burgess. I also appreciate your comments that this is all about patient safety, and that is why we all want to get it right. We may not agree on everything on the dias here, one side or the other, but we do want to get it right. And we appreciate your efforts in trying to help us get that right.

That will conclude the testimony from the first panel.

Again, we are very close to a series of votes on the Floor. So, I am going to ask that we actually not take a break between panels. We will let Dr. Gottlieb gather his papers up and leave, and just take a second to put the nameplates out. But we probably better proceed directly into the second panel.

I call the subcommittee back to order.

Once again, as we transition to our second panel of witnesses, I do want to thank all of our witnesses for being here and taking time to testify before the subcommittee. Each witness will have the opportunity to give an opening statement, followed by questions from members.

Again, I will advise that we will recess when votes are called on the Floor.

But today we are going to hear from Dr. George Williams, President-Elect of the American Academy of Ophthalmology; Dr. Bruce Brod, the Chairman of the Congressional Policy Committee for the American Academy of Dermatologists; Shawn Hodges, Vice President, International Academy of Compounding Pharmacists; Jacob Olson, the President and CEO of Skywalk Pharmacy, on behalf of the National Community Pharmacists Association; Jenn Adams, Senior Vice President, Clinical Product Solutions, PharMEDium Services; Molly Ventrelli, Vice President, Regulatory Affairs, Fresenius Kabi; Elizabeth Jungman, Director of Public Health of the Pew Charitable Trusts, and Nancy Dargan, a former patient of the New England Compounding Center.

We appreciate all of you being here today.

Dr. Williams, you are now recognized for 5 minutes for a summary of your opening statement.

STATEMENTS OF GEORGE WILLIAMS, PRESIDENT-ELECT, AMERICAN ACADEMY OF OPHTHALMOLOGY; BRUCE BROD, CHAIRMAN, CONGRESSIONAL POLICY COMMITTEE, AMERICAN ACADEMY OF DERMATOLOGISTS; SHAWN HODGES, VICE PRESIDENT, INTERNATIONAL ACADEMY OF COMPOUNDING PHARMACISTS; JACOB OLSON, PRESIDENT AND CEO, SKYWALK PHARMACY, ON BEHALF OF THE NATIONAL COMMUNITY PHARMACISTS ASSOCIATION; JENN ADAMS, SENIOR VICE PRESIDENT, CLINICAL PRODUCT SOLUTIONS, PHARMEDIUM SERVICES; MOLLY VENTRELLI, VICE PRESIDENT, REGULATORY AFFAIRS, FRESENIUS KABI; ELIZABETH JUNGMAN, DIRECTOR OF PUBLIC HEALTH, THE PEW CHARITABLE TRUSTS, AND NANCY DARGAN, FORMER PATIENT OF THE NEW ENGLAND COMPOUNDING CENTER

STATEMENT OF GEORGE WILLIAMS

Dr. Williams. Chairman Burgess, Ranking Member Green, and members of --

Mr. Burgess. And do be sure your microphone is on and pull it close.

Dr. Williams. Is it working?

Chairman Burgess, Ranking Member Green, and members of the committee, I am honored to be testifying to you on behalf of the American Academy of Ophthalmology on a topic critical to the practice of ophthalmology.

My name is George Williams. I am a practicing retina specialist from Michigan. I am also the Immediate Past Secretary

of the American Academy of Ophthalmology; Secretary of Federal Affairs, and current President-Elect for the Academy.

As the world's largest association of eye physicians and surgeons, the Academy seeks to protect sight and empower lives by setting standards for ophthalmic education, advocating for our patients and the public.

Access to safe and effective compounded repackaged drugs is vitally important to the practice of ophthalmology. This is due in large part to the uniqueness of our specialty, as we utilize drugs in dosage forms that differ from other areas of medicine. Effective treatment often requires that drugs be compounded or repackaged in concentrations or doses that are tailored to a patient's specific needs and unusual route of administration to the eye. These drugs are used in the successful treatment of several ophthalmological treatments, including diseases that threaten sight such as age-related macular degeneration.

Ophthalmology's treatment of patients facing sight-threatening diseases such as AMD requires access to drugs known as vascular endothelial growth factor inhibitors, or VEGF inhibitors. These include the FDA-approved anti-VEGF treatments ranibizumab and aflibercept, as well as repackaged bevacizumab, or Avastin. The Academy has long advocated for access to all three treatments, as individual patients may respond differently and have better outcomes with one treatment versus another.

Since the passage of the DQSA, the Academy's advocacy efforts have included focus on protecting access to repackaged Avastin. The Academy is aware of adverse event clusters associated with intravitreal injections of repackaged bevacizumab, including events in Georgia and Florida. Events like these, along with the passage of the DQSA, have led to the necessary changes at compounding pharmacies and improvements in the safety of this treatment.

Because of our efforts since 2013 to track outcomes of patients who receive anti-VEGF therapies, we have been able to gather data on effectiveness and safety of these treatments. The American Academy of Ophthalmology utilized our IRIS registry, which is the nation's largest comprehensive eye disease clinical registry, to track adverse events associated with the use of these products from January of 2013 to June of 2016. These data clearly showed no statistically-significant difference in adverse events among different anti-VEGF agents, including repackaged Avastin.

Today repackaged Avastin remains a safe and effective treatment option for patients facing sight-threatening disease, and Academy efforts to protect access are ongoing. The new guidance from FDA, which represented a step in the right direction, was recently finalized by the agency. The Academy will continue to engage with the agency, Congress, and compounding facilities to ensure patient access to repackaged bevacizumab.

The Academy is also concerned about continued access to other non-biologic compounds or drugs for office use. The FDA has issued final guidance on office use that we believe threatens access to compounded drugs for such use, requiring patient-specific prescriptions before a compounded drug can be distributed by a traditional compounding pharmacy. We are concerned that policy outlined in the final guidance forces practitioners to rely solely on outsourcing facilities to meet all of their needs for office-use drugs.

I would like to share a few examples of how implementation of the DQSA is having some unintended consequences, is impacting access to compounded and repackaged drugs. This is why the Academy is supporting policy that ensures access to drugs for office space use, such H.R. 2871, the Preserving Patient Access to Compounded Medications Act, introduced by Congressman Morgan Griffith.

I would like to discuss a patient from my state of Michigan. She is a 31-year-old lady who wears soft contact lenses and developed an infection in her eye. She was eventually determined to have a serious infection known as acanthamoeba keratitis. The standard treatment for this is the use of a drug called polyhexylmethyl biguanide. Essentially, this is pool cleaner. This was prescribed, but, unfortunately, it was not available in the state of Michigan. As a result, the patient's

ophthalmologist in Michigan was forced to contact doctors at the University of Illinois-Chicago and to obtain the drug from Chicago. However, Chicago was unable to provide the drug in Michigan, and the patient, suffering from severe eye pain, was forced to drive 225 miles from Michigan to Chicago in order to obtain this therapy. Fortunately, she responded well. But this is an example of the type of problems we have when patients cannot access immediately important therapies.

The Academy has other examples of this involving the use of autologous serum drops that are given topically and have been used for more than three decades. These drugs are critical to the management of severe dry eye. However, due to compounding regulations, many compounding facilities have stopped producing these drops.

In closing, ophthalmology strongly believes that compounded drugs must be produced safely and be subject to critically important testing. We do believe that regulatory policy in this arena can become restrictive and, in turn, negatively impact physicians' ability to properly and effectively treatment patients. It is important that, as implementation efforts move forward, the FDA strives to find a more balanced approach. We believe that increased direct engagement with the physician community is a strong path forward, and we look forward to future opportunities with FDA, Congress, and other stakeholders on these

2339 important issues.

2340 Thank you.

2341 [The prepared statement of Dr. Williams follows:]

2342

2343 ********** INSERT 6**********

Mr. Burgess. Thank you, Dr. Williams.

Dr. Brod, 5 minutes for an opening statement, please.

STATEMENT OF BRUCE BROD

Dr. Brod. Thank you, Chairman Burgess, Ranking Member Green, and members of the Health Subcommittee.

I am Dr. Bruce Brod. I am pleased to share with you my perspective as a dermatologist, a view that is shared by the American Academy of Dermatology Association.

Dermatologists rely heavily on compounded medications that are medically necessary and life-changing. We safely and effectively prepare and administer low-risk topical and intralesional compounded medications to a wide range of patients, including individuals presenting with special and emergent needs and persons suffering from rare diseases, including children.

Current policy adversely affects the practice of medicine in two significant ways, the first being with respect to maintaining a small supply of office-use compounded medications for administration to patients in our offices. Dermatologists have historically obtained compounded medications from 503A compounding pharmacies for immediate use in the office without the need for a patient-specific prescription. However, current policy now restricts this. While we understand the FDA intended 503B outsourcing facilities to be a meaningful resource for providing physicians with office-use stock, not all office-use compounded medications used by dermatologists are produced by

503Bs, including non-sterile topicals as well as sterile intralesional drugs used for injection in the skin.

The FDA's website reflects a partial list of drugs that registered outsourcing facilities have reported producing, starting December 2016, but ending May 2017. So, the list is retrospective and it is incomplete, and it doesn't indicate if these drugs will be produced in the future. Furthermore, we have no indication that 503Bs will provide flexibility in the various concentrations that we use in our offices.

The FDA lists only the facilities that are registered. Yet, it doesn't contain any contact information, real-time product availability information, or price listing. So, physician practices literally must go on a scavenger hunt for these needed compounds. In addition, dermatologists have reported that the outsourcing facilities have quoted prices that are cost-prohibitive.

If a compounded drug is not available from an outsourcing facility, a patient now requires, first, a trip to the physician office for evaluation and diagnosis, then a trip to the pharmacy to obtain the prescription, and then, thirdly, a followup visit back to the physician to finally have the treatment administered. Those two additional steps impose new burdens on the patient, delayed treatment, and create inefficiencies in our practices.

When compounded medications are handled outside of a

provider's control, there are also major safety concerns regarding proper storage, handling, and application. When the dermatologist cannot be sure how it has been stored between patient pickup at the pharmacy and administration in the office, it calls into question the integrity of the medication.

An additional safety concern is the risk that patients may be tempted to self-administer the drugs prior to returning to the physician's office. Many of the powerful compounds in dermatology are used to destroy unwanted malignant and benign skin lesions. And so, if they are spilled on the skin by patients, they will cause scarring and disfigurement.

The second way current policy adversely affects the practice of medicine pertains to dermatologists' preparation of low-risk sterile and non-sterile medications in the office setting. Because of the FDA's broad definition of compounding, many simple in-office preparations are considered compounding. Buffering lidocaine, for example, is a widely-used local anesthetic in dermatologic procedures. Without our ability to buffer lidocaine with sterile sodium bicarbonate, patients, including children, will endure painful injections of lidocaine. Using the buffered lidocaine allows us to perform very extensive skin cancer surgeries in an outpatient office setting without the risks and costs of sedation.

Because the FDA considers reconstituting certain

FDA-approved neurotoxins with sterile saline to be compounding, the FDA's proposed guidelines imply that physician offices are compounding facilities, subject to the same equipment and process requirements as high-volume compounders. Many of those requirements are simply unworkable for dermatology offices, both structurally and financially.

Accordingly, we are encouraged that the FDA mentions routine clinical practice and negligible patient risk in its 2018 Compounding Policy Priorities Plan, which states that providers would not be subject to the same compliance policy in certain cases. The manner in which we routinely buffer and dilute our injectable medications in dermatology is really part of our normal practice of medicine.

While we greatly appreciate the FDA and U.S. Pharmacopeia are working with medical specialties to explore an urgent-use exemption, we have real concerns that an exemption based on a restrictive timeframe will negatively affect patient access. The well-being of our patients is our primary concern and responsibility. On behalf of the American Academy of Dermatology Association, I want to thank you for holding this hearing, and I am happy to address any questions.

[The prepared statement of Dr. Brod follows:]

********** INSERT 7**********

Mr. Burgess. Thank you, Dr. Brod.

Mr. Hodges, you are recognized for 5 minutes, please.

STATEMENT OF SHAWN HODGES

Mr. Hodges. Yes, sir. Yes, sir. Good afternoon, committee members.

Mr. Chairman and members of the subcommittee, my name is Shawn Hodges, a pharmacist and owner of Innovation Compounding, a compounding-only pharmacy located in Kennesaw, Georgia, just outside of Atlanta. I also serve as the Vice President of the International Academy of Compounding Pharmacists, IACP, an organization that represents more than 4,000 pharmacists, technicians, students, and members of the compounding community who focus on the specialty of pharmacy compounding. I would like to express my gratitude and appreciate to the Health Subcommittee for taking the time to understand compounding pharmacy and patient access issues from a pharmacist's perspective with the implementation of DQSA.

In 2012, a pharmacy owner who lost sight of his moral compass and violated his oath as a practicing pharmacist violated both state and federal laws and regulations related to quality and safety. As a result, more than 60 lives were lost and hundreds more fell ill, some to this day, nearly five-and-a-half years later. As compounders, our top priority is adhering to the highest-quality compounding standards to prevent something like this from happening again.

Since NECC, all regulatory bodies have made a concerted effort to improve the practice of pharmacy. In November of 2013, the DQSA was signed into law, somewhat clarifying the FDA's joint authority with the state boards of pharmacy, to monitor the quality of pharmacy compounding. State boards of pharmacy also updated pharmacy regulations and hired additional state inspectors to monitor and inspect compounding pharmacies. USP, the organization that sets the standards for governing compounding pharmacies, is revising its standards to continue to ensure best practices of pharmacy compounding, which can reduce the risk of harm to patients and compounding pharmacy employees.

As DQSA is well into its fourth year, I would also like to share with the committee what the professional compounding pharmacy has experienced and provide suggestions on how all pharmacies, state boards, and the FDA can actually strengthen DQSA while protecting access to lifesaving compounded preparations. As I rely the suggestions of IACP and other key pharmacy stakeholders, please note that our overall goal is to encourage an open, transparent dialog with all stakeholders, public and private. We strive to work closely with FDA in developing an appropriate balance between regulating quality and safety without eliminating patient access.

Pharmacies which are compliant and meet USP guidelines and state board of pharmacy rules fear that FDA overreach will impact

patient care. This fear has been substantiated by actions of FDA investigators. My pharmacy team experienced this firsthand in an FDA inspection that lasted for 11 days over a period of 4 months.

It is important to acknowledge that the FDA investigations were fulfilling their assigned duties and expressed a keen interest in the quality of our preparations. For that, I had the utmost respect for them. However, many requests about our pharmacy had little to do with the quality of our compounded preparations, but were, rather, in how we operated our pharmacy practice that is regulated by the boards of pharmacy. Luckily, our pharmacy team employed attorneys who are knowledgeable of both state and federal pharmacy laws and regulations to advise FDA that they were inspecting outside the scope given to them under the law. Many of our fellow compounding pharmacists have had similar experiences.

I would also like to share IACP's concerns as it relates to the memorandum of understanding between FDA and the states, which could limit patient access for preparations that are only available across state lines. Last week we were encouraged by Commissioner Gottlieb's 2108 Compounding Policy Priorities Plan that states he would rescind the current draft MOU and prepare a new draft for public comment. However, we still remain concerned that the FDA proposes to define distributing and dispensing as one and the same. As noted in all other federal

and state regulations, these are two distinct activities. If this is not corrected, the impact on patient access to medications will be detrimental, particularly for patients near state borders who rely on compounded medications from neighboring states.

Another of our primary considerations for review is the role of office-use compounding. I regularly hear from prescribers who need compounded medications for office use that they cannot obtain from outsourcing facilities in small dosages necessary to expeditiously meet patients' needs. The fundamental concept of office use from 503A pharmacies offers solutions to prescribers who are faced with unique challenges, whether a dentist needs a fast-acting, liquid anti-anxiety drug on hand in case an autistic child may have a panic attack or a hospice nurse that suddenly needs a compounded nausea medication because she has terminally-ill patient who is not responding to a manufactured product. The purpose of office use is to support prescribers who otherwise do not have access to a GMP product.

In closing, we at IACP want to be clear that our goal isn't to interfere with FDA's inspections on quality, but to ensure that FDA investigators who inspect compounding pharmacies are aware of and spec within the boundaries of FDCA. They also must have a working knowledge of USP standards and relevant state regulations. Likewise, we don't seek to weaken the DQSA in a way that will allow pharmacies to operate as drug manufacturers. Our

goal is to have an open and consistent dialog with Congress and the FDA to establish policies that more effectively balance patient safety with patient access, because patient access is a patient safety issue.

We thank you for the opportunity to appear here today and provide our input, and we do look forward to continuing to work with you on these common goals.

[The prepared statement of Mr. Hodges follows:]

********** INSERT 8**********

Mr. Burgess. Thank you, Mr. Hodges.

Mr. Olson, you are recognized for 5 minutes. And because a vote has been called, we will take your testimony, and then, we will have to recess until after the votes. So, you may proceed.

STATEMENT OF JACOB OLSON

Mr. Olson. Thank you. Thank you, Chairman Burgess, Ranking Member Green, and members of the subcommittee. Thank you for conducting this hearing on compounding.

My name is Jake Olson, and I am the pharmacist and owner of Skywalk Pharmacy. We have four locations in the greater Milwaukee area, serving patients of Children's Hospital of Wisconsin and clinics. I am testifying on behalf of the National Community Pharmacists Association. NCPA represents America's community pharmacists, including the owners of more than 22,000 independent community pharmacies that dispense nearly half of the nation's prescriptions.

In 2003, I had the unique opportunity to open Skywalk Pharmacy as an independently-owned community pharmacy which would serve as the outpatient pharmacy for the Children's Hospital of Wisconsin, the first of its kind in the United States. My pharmacies specialize in treating pediatric patients with routine ear infections to cystic fibrosis, cancer, and organ transplants. I compound only non-sterile preparations and I am compliant with USP 795 standards. I am licensed only in Wisconsin. I do not ship compounded medications across state lines, and compounding comprises 20 percent of my business.

Many of my pediatric patients have health conditions that

require medications that have not undergone FDA approval. In many cases drug manufacturers do not produce a commercially-available product in the necessary dosage form or strength for these patients' needs. Physicians call on me to help under these circumstances when compounding is the only option for their patients.

I am here today as a healthcare provider and small business owner to present some of my experiences and those of my fellow independent pharmacists regarding the FDA's implementation of the Compounding Quality Act.

First, it is imperative the state boards of pharmacy retain oversight of pharmacy compounding. I am not eligible to register as an outsourcing facility, nor would it make sense for me to do so. The dispensing of custom-made medications should continue to be regulated by the boards of pharmacy, as all other medical license profession practices are.

Second, physician office-use compounding needs are not being met. We used to provide compounds for dentists to treat pediatric patients who would present with urgent issues. However, we stopped doing this in 2013 due to the uncertainty caused by DQSA and conflicting Wisconsin state law. Dentists still request this compounded medication to be on hand in the event that a patient needs this treatment. Because I am no longer providing dentists with this office-use compound, the dentist now has to close up

the tooth, have the patient leave, come down to my pharmacy, pick up a prescription, and then, return to the dentist. This cannot happen in the same day. So, the child will continue with an infected tooth until the dentist can reschedule an appointment. Most of these patients are innercity children with Medicaid. Transportation is a huge issue, and sometimes it will take a week or longer to get them to come back. All the while, the child is suffering.

Third, not all office-use compounding needs can be met by outsourcing facilities. 503B outsourcing facilities provide an important function in meeting the needs of healthcare providers and patients. However, outsourcing facilities are not able to meet the entire office-use market, nor are they able to replace the role of the traditional compounding pharmacies.

Because of the requirements placed on outsourcing facilities and the costs of complying with CGMP, they are not able to compound in small batches; thus, limiting the role they can play in meeting the immediate patient needs for compounds. By prohibiting 503A pharmacies to compound for office use, the FDA is severely limiting access.

Fourth, FDA needs to end inspection reporting discrepancies between manufacturers and compounding pharmacies. I often hear from my fellow compounders who have been inspected by the FDA about the 483 reports that may be issued post-inspection and posted

publicly, like they were today, on FDA's website. I don't understand why these same reports are not also publicly posted for FDA-registered facilities. While FDA publicizes Form 483s and photographs from compounding pharmacy inspections, there is evidence of several of the same observations from CGMP manufacturers with no corresponding publicity. This treatment suggests there is intent by the FDA to sway the public and undermine the confidence that parents have in my ability to take care of their child's medications.

Fifth, the FDA must make changes to the Pharmacy Compounding Advisory Committee and related activities. I am very concerned that not one of the voting members of the committee compounds for human use on a daily basis, considering the committee is making recommendations that can vastly impact the practice of compounding. The previous FDA PCAC had at least three pharmacists with current experience and expertise in compounding. The FDA should select, at minimum, one practicing human compounder on the committee as a voting member.

Lastly, it is very confusing for me, as a compounder, to understand what I can or cannot compound with today because of some of the conflicting information.

In summary, NCPA is committed to working with members of the Health Subcommittee, the FDA, and other stakeholders regarding these important matters for a balanced approach to ensuring

patient access to safe and effective compounded medications. Thank you.

[The prepared statement of Mr. Olson follows:]

********** INSERT 9**********

Mr. Burgess. Thank you, Mr. Olson.

And I apologize, we were only able to get through half the panel. We will get to the rest of you immediately after this series of votes. It will probably take us 30 minutes to complete that task.

So, the committee stands in recess until immediately after the votes.

[Recess.]

Mr. Burgess. I think to be respectful of everyone's time, I am going to call the subcommittee back to order. We are expecting other members to show up almost immediately.

But as we recessed for votes, we were about to hear from Jenn Adams, the Senior Vice President, Clinical Products Solutions from PharMEDium Services. So, Ms. Adams, you are recognized for 5 minutes.

STATEMENT OF JENN ADAMS

Ms. Adams. Thank you. Chairman Burgess, Ranking Member Green, and members of the subcommittee, thank you for the opportunity to participate in today's hearing.

My name is Jenn Adams, and I am the President of PharMEDium Services. On behalf of PharMEDium, I want to thank you for holding this hearing on the implementation of the Compounding Quality Act, which Congress enacted as a part of the Drug Quality and Security Act of 2013.

PharMEDium, which is a subsidiary of AmerisourceBergen, operates four 503B registered outsourcing facilities. I want to briefly describe, as we begin, what PharMEDium does, as our business models tracks exactly what Congress codified in the Compounding Quality Act. Our four facilities prepare ready-to-administer compounded sterile drugs for hospitals, so that they don't have to prepare these medications at a patient's bedside under conditions that could introduce more risks of contamination.

Many sterile drugs, such as injectables, in their FDA-approved form are not manufactured in ready-to-use doses. Therefore, the drugs have to be prepared by diluting or admixing the FDA-approved drug with diluents or other components to achieve the appropriate dose for patient care. We prepare these sterile

drugs into customized preparations, as ordered by our hospital customers. And this is the primary need that outsourcing facilities fulfill. And PharMEDium exclusively compounds using only FDA-approved sterile drugs obtained from registered drug manufacturers. This practice fills a very different role than that of traditional pharmacy compounding, which involves filling an individual patient prescription as required by law.

Based on our experience in serving the needs of hospitals and healthcare systems, outsourcing facilities anticipate the need for drug preparations. We compound those preparations on behalf of our customers, and then, our customers dispense the medications to their patients. The types of drug preparations that are compounded are, by definition, not available from manufacturers; therefore, requiring these more custom formulations to meet the clinical needs of patients.

Both of these distinct types of compounding, by outsourcing facilities and also by traditional pharmacies, we believe are critical in ensuring that patients have access to safe compounded medications when needed.

PharMEDium was, and remains, an active supporter of DQSA because we felt strongly that more oversight of our industry was needed. The premise of the DQSA is that outsourcing facilities are subject to FDA oversight and more stringent quality requirements. And as our industry shifts more toward

manufacturing quality standards, significant investment has been and is required in our facilities, personnel, and equipment to comply with these heightened standards. At PharMEDium our investment has, indeed, been quite significant, and the enhancements we have made have been challenging to implement, but we are confident that these improvements are in the best interest of patients and we are committed to continuing on this path in cooperation with the FDA.

Unfortunately, the successful implementation of Section 503B is under a separate threat; namely, from the misuse of bulk drug substances. I mentioned earlier that PharMEDium only compounds from FDA-approved drugs, as opposed to starting from bulk drug substances, which are sometimes referred to as bulk active pharmaceutical ingredients, or API powders.

There are, indeed, circumstances in which it is sometimes necessary to compound from bulk drug substances, such as when an individual patient requires a dose that cannot be achieved when using the FDA-approved manufactured drug as a starting point. But using bulk powders and outsourcing facilities should be the rare exception versus the rule, as it requires using a version of the drug that has not gone through the FDA approval and, therefore, has not benefitted from all of the safeguards that are inherent to FDA's drug approval process, which are designed to mitigate the risks of contamination.

As a result, under the law, bulk powders are only to be used when clinically necessary and not simply substituted for the FDA-approved version of the drug. Nevertheless, right now we are witnessing rampant compounding from bulk drug substances in the marketplace, usually lacking any clinical justification, even for sterile drugs. This is particularly concerning because using bulk drug substances is much less expensive for the compounder; therefore, undercutting demand for the actual approved drugs and creating a loophole for compounders to circumvent the drug approval process.

In light of these and other risks, we remain concerned about the rapid uptake of bulk drug substance powders in place of FDA-approved drugs. As we have learned from history, which demonstrated the tragic impact of poor compounding practice, FDA should make every effort to implement the DQSA in a manner that preserves patient access to important compounded medications and that eliminates opportunities to perform an end-run around clear restrictions of the law.

While we commend FDA's overall efforts to implement DQSA, the agency has not tamped down on this rapidly growing abuse of bulks. Its release of an overly broad interim list of permissible drug bulk substances and its final guidance on what amounts to impermissible copies of approved drugs fail to call out these practices and will not curb these abuses. We appreciate,

however, that FDA announced that it would be releasing a separate draft guidance in March clarifying that bulk drug substances may only be used for compounding when there is a clinical need to compound drugs using these substances. FDA conformed that this restriction protects patient health and the drug approval process, for example, by helping to ensure that outsourcing facilities do not compound using a bulk drug substance when an FDA-approved version can be used to meet patient medical needs.

While this acknowledgment is important, it is even more important that FDA follow this statement up with the promised guidance as soon as possible, revise the guidance on copies, communicate this message to providers who may not be aware of the undisclosed use of bulks, and to rigorously enforce these restrictions. In order to ensure that patients have a reliable and safe source of sterile compounded preparations, it is also important that FDA continue to move forward as quickly as possible in finalizing other 503B policies that will provide certainty and clarity to the outsourcing industry providers and patients. In particular, the lack of final GMP standards for outsourcing facilities has exacerbated ongoing confusion among state regulators, many of whom continue to impose expectations that differ from that of FDA's.

Key congressional proponents champion the DQSA as clarifying the role of the states in regulating traditional compounding, and

outsourcing to be regulated at the federal level. That vision has not yet been fully realized.

Again, thank you for the opportunity to contribute to this important dialog. I appreciate it, and I look forward to your questions.

[The prepared statement of Ms. Adams follows:]

********** INSERT 10**********

Mr. Burgess. Thank you, Ms. Adams.

Ms. Ventrelli, you are recognized for 5 minutes, please.

STATEMENT OF MOLLY VENTRELLI

Ms. Ventrelli. Thank you. Chairman Burgess, Ranking Member Green, and members of the subcommittee, thank you for the invitation to testify today.

My name is Molly Ventrelli, and I am Vice President of Regulatory Affairs for Fresenius Kabi USA. Fresenius Kabi is a global healthcare company specializing in lifesaving medicines and technologies for infusion, transfusion, and clinical nutrition. We manufacture most of these medicines in Illinois, New York, and North Carolina, and we employ more than 3,000 people in the U.S. Additionally, Fresenius Kabi operates 18 compounding centers around the world, and we are in the process of launching our first U.S.-based 503B compounding center in a suburb of Boston.

We commend FDA's implementation of the DQSA, and we believe that FDA must continue to enforce the strong protections of the DQSA against illegal or improper compounding activity. Patient safety requires strict FDA oversight on outsourcing facility compounding by pharmacies that do not comply with FDA regulations and do not meet the highest standards for quality and CGMP.

Drug compounding plays an important role in the delivery of health care by allowing a pharmacist, by a patient-specific prescription, to tailor a therapy for an individual's unique

needs. But it is critical to ensure the safety of patients receiving these compounded medications. Congress recognized this in drafting the DQSA and established the two regulatory structures, both 503A and 503B. Pharmacies that operate under 503A are those that compound according to specific prescriptions unique to a patient under state board of pharmacy oversight. They do not compound large quantities in advance of a patient prescription.

However, Congress also recognized that some hospitals and healthcare providers may need supplies of medications not made by pharmaceutical manufacturers or not made in a specific dosage form, combination, or strength that is medically required for patients. These products, which need to be on hand, represent unique safety concerns, as they are typically made in larger volumes. So, if they become contaminated or are produced incorrectly, more patients are exposed to harm. Congress required that these 503B facilities adhere to CGMP, rigorous requirements enforced by the FDA, with a full set of quality standards for the manufacturing, processing, packing, release, testing, and storage of pharmaceutical products.

It is important to note that 503B outsourcing facility compounders may not make a drug that is essentially a copy of an approved medicine except under certain highly limited circumstances like drug shortages. One key reason Congress

included this was to preserve incentives for traditional manufacturers to continue to pursue FDA approval through the current NDA and ANDA review process. This protects patient safety and should be upheld.

We support the FDA's efforts to ensure patient safety by timely inspecting 503B compounders and issuing compliance guidance. Fresenius Kabi is currently addressing this now at our site in Massachusetts.

We also commend the FDA for its continued risk-based inspections of unregistered compounding pharmacies. FDA's enforcement of 503A is also important to ensure that facilities that are essentially acting as outsourcers by selling significant amounts of commercially unavailable compounded sterile drugs in the absence of patient prescriptions should register as 503B outsourcers. In the interest of public health, the safety and manufacturing standards of compounders should be held to rigorous standards to ensure patient safety.

Additionally, to uphold patient safety, Congress sought to ensure that FDA-approved drugs would be used as source material by compounders whenever possible. Under the DQSA, compounders should not use bulk active pharmaceutical ingredients as an alternative to compounding from an FDA-approved medicine unless doing so would produce a clinical difference for an identified patient. Fresenius Kabi believes that there could be instances

where several 503B outsourcing compounders are doing exactly this in contravention of federal law. It is our strong recommendation that the committee support FDA's rigorous oversight of pharmaceutical compounding.

Thank you for holding today's hearing, and I welcome any questions you may have. Thank you.

[The prepared statement of Ms. Ventrelli follows:]

********** INSERT 11**********

Mr. Burgess. Thank you, Ms. Ventrelli.

Ms. Jungman, you are recognized for 5 minutes, please.

STATEMENT OF ELIZABETH JUNGMAN

Ms. Jungman. Good afternoon. I am Elizabeth Jungman, Director of Public Health Programs at the Pew Charitable Trusts. We are an independent, nonpartisan research and public policy organization with a longstanding focus on drug quality, including compounding. I want to thank you for holding this important hearing.

This committee has a long history of working to protect Americans from the risk of substandard compounded drugs. Five years ago, even before we knew the full scope of the fungal meningitis outbreak, your oversight team investigated how the crisis began, and you worked with the Senate and across party lines to pass the DQSA. This legislation is making a difference.

Today I will stress the importance of preserving it. Efforts to weaken the DQSA pose very real risks for patient safety. I will also share some new findings showing that DQSA is spurring better compounding oversight in the states.

I was privileged to be among the Senate committee staff that helped develop the DQSA. We knew then the provisions would be met with resistance, but each round of negotiations started with a new count of illnesses and deaths, and it was a powerful motivator to push past that controversy and get the job done.

The meningitis outbreak is, of course, not the only case of

harm. As we have heard today, just last year 43 people in Texas had contaminated antibiotics injected into their eyes and several suffered vision loss. Also, last year 41 patients received contaminated injections in a New Jersey clinic. They developed joint infections caused by microorganisms that should only be found in human mouths.

Americans expect their government to play a major role in making food and drugs safe. Eighty-seven percent of Americans think that, according to a Pew Research Center survey.

FDA evaluates the safety and effectiveness for most drugs and sets manufacturing quality standards, but compounded drugs are not subject to those protections, and, thus, should only be used when commercial alternatives won't work. There is a big difference between drugs prepared for a single patient who will use it immediately and drugs prepared in bulk quantities for use at some undetermined future date.

Compounding for a single patient is a traditional part of pharmacy practice. The risks of dangerous contamination are relatively low and the impact for errors is contained. States oversee patient-specific compounding and mandate quality standards.

But, if compounded drugs are going to be kept onhand, so-called office stock, the risks are greater. They are often stored for some period of time, increasing the chance that

contaminates like bacteria and fungus can grow. And since they are not tailored to specific patients, they products are frequently produced in bulk, multiplying the consequences of any error.

That is why Congress created outsourcing facilities. In exchange for meeting appropriate manufacturing standards, outsourcing facilities can compound drugs without prescriptions. Congress has decided twice, first 20 years ago and again in 2013, that traditional compounding should require a patient-specific prescription. If compounders want to sell stock supplies, they must invest in the equipment, training, and specialized personnel necessary to mitigate the risk. That dividing line between stock supply and individual prescription creates accountability.

This committee's investigation demonstrated the importance of clear and enforceable lines, so that facilities and their regulators know who is responsible for oversight and what rules apply. The prescription requirement is very clear. Either a patient's name is on the product or it is not.

While FDA regulates outsourcing facilities, states are still the primary regulator of traditional pharmacies, and they play an important role in ensuring the safety of compounded drugs. In 2014, Pew convened an advisory committee of pharmacy regulators, state pharmacy regulators, and other compounding experts to identify best practices for states. Next month, Pew, together

with the National Association of Boards of Pharmacy, will release a 50-state assessment.

I am happy to say that most states now conform to best practices in two key areas. First, states are widely adopting quality standards that have been established by the USP, the United States Pharmacopeia. And second, states are aligning with federal law on the prescription requirement.

However, there is more work to be done. Ideally, states should inspect compounding pharmacies every year, but our study showed that we haven't met this mark. That is why state and federal regulators must prioritize the most risky operations.

To wrap up, since the DQSA became law, states have made important changes, and other stakeholders like outsourcing facilities have made significant investments, too. To avoid undermining that progress, Congress and the FDA must continue to protect, implement, and enforce the DQSA.

Five years ago, this committee acted boldly to draw clear lines that protect patients from another tragedy. This hearing reminds us of why we need that law and what could happen if it is weakened.

I welcome any questions.

[The prepared statement of Ms. Jungman follows:]

********** INSERT 12**********

Mr. Burgess. Thank you, Ms. Jungman.

Ms. Dargan, you are recognized for 5 minutes, please.

STATEMENT OF NANCY DARGAN

Ms. Dargan. Thank you. Good afternoon, and thank you for the opportunity to be here today.

My name is Nancy Dargan and I live in Brighton, Michigan. I am going to tell you how a contaminated compounded medication permanently harmed my health, putting a premature end to my career and ruining my family's finances and plans for our future.

To begin my story, I have to travel back to early 2012. I was experiencing pain from arthritis in my back and hip, and my primary physician referred me to a pain clinic for periodic injections of a steroid called methylprednisolone, which is a compounded product.

The shots gave me some relief and I continued my busy career, my life as a grant-writer, a business consultant. And everything changed that August. I had driven from my home in Michigan to West Virginia to meet with a new client and help them set up a nonprofit organization. During my stay I began to feel sick, but I didn't think very much of it at first. But the symptoms steadily worsened and I realized I had to cut my trip short.

As I drove home, an excruciating burning sensation developed in my right hip spreading down to my knee. The pain became so unbearable that I had to use my left foot for gas and brakes. I arrived in Michigan completely unable to bear weight on my leg,

and my husband took me immediately to the hospital to figure out what was going on.

The doctors ordered x-rays, a spinal tap, a biopsy, and several other tests and expressed that my condition was something they had not seen before. They worked to treat my pain, but, initially, had no clear diagnosis. So, they sent me home.

It was there that I got a call from the pain clinic that had administered my steroid injections. They said I potentially received contaminated drugs and should go to the emergency room immediately.

By this time, the hospital staff were realizing that my case was not an isolated incident. Other patients were showing up at the hospital with infections and pains similar to mine, and like several of them, I was ultimately diagnosed with a fungal infection.

I underwent surgery and spent two weeks in the hospital. I was placed on a maximum dose of a drug called Voriconazole, a very powerful antifungal medicine with severe side effects that seemed nearly as bad as death itself. I took it four times a day for 14 months, even waking in the middle of the night for doses.

After I was discharged, my husband Mike became my caretaker, at great personal expense to him, both mentally and physically. His job was one of the worst a care partner can experience, dealing with the unknown effects of a major medical event. I can't tell

you how many times Mike would come into the room and I would be carrying on a conversation with my daughter, who had died in 1979. That was the result of hallucinations caused by the antifungal medication. I would call out for our pet, and I would get frustrated because he wouldn't respond, and we had had him put down the year before due to cancer.

Through all this nightmare, Mike made sure that I made it to every doctor's appointment, even often three or four per week, on top of other tests, including blood draws every Friday. If something needed to be done, including our household chores, he did it. If something needed to be done around the house, he never left my side unless I was napping and he could get errands run. He was not only my caregiver, but my constant advocate.

Of course, all of this has had a devastating impact on our lives and plans for the future. Financially, we have lost everything to this event. The hospital and doctor bills were astronomical. I lost my ability to maintain self-employment and, regrettably, had to close my business and refer my clients to others.

We had partial ownership in a cabin left to my husband and his sister by his father, but had to sell our interest in this treasured family property which we enjoyed so much and which had such wonderful memories for my husband. I saw the grief in Mike's eyes every time we had to sell something he loved. The financial

toll has threatened our retirement and our independence as we grow older together.

Today, five years after this tragedy began, I still have recurring symptoms and numerous side effects. I walk with a limp and cannot get an orthopedic surgeon to consider replacing my right hip because there are still fungal pockets on my bones. My pain levels are always elevated. My disease and treatment have made me vulnerable to opportunistic infections that have attacked my kidneys and my sinuses, and I still continue to suffer from short-term memory loss, and it is getting worse every year.

Before this happened to me, I had never heard of drug compounding, and I never would have imagined coming to Washington to speak about it. But I feel obligated to do so. Sadly, there are many others who have endured as much suffering and more. I weep for the 60-plus families who lost their loved ones to this deadly and preventable outbreak and for the hundreds of patients who live every day with the lasting consequences of illnesses caused by contaminated compounded drugs. Many of these people are friends and neighbors who live in our community, and I am here to speak up for them, too. I don't want another soul to experience what we have.

As a result of contaminated drugs and a failure to oversee them, I am now a person who will spend the rest of my days dealing with a complex illness. It wasn't easy for Mike and I to get here

today. We hope that by sharing our story we can help prevent this from happening to someone else or anyone else.

Thank you for allowing me to take some of your time, and I welcome any questions you might have.

[The prepared statement of Ms. Dargan follows:]

********** INSERT 13**********

Mr. Burgess. Thank you, Ms. Dargan. We appreciate your testimony, and appreciate all of you for spending so much time with us today.

I am going to yield to Mr. Griffith 5 minutes for questions, since he was the Representative who was instrumental in moving this legislation along several years ago. So, Morgan, you are recognized for 5 minutes.

Mr. Griffith. Thank you, Mr. Chairman. I appreciate it very much, and appreciate all of you being here.

I think sometimes we are talking at cross-purposes because I don't think any of us want to see somebody like NECC coming back, because they were operating in a couple of dozen states, if I remember correctly, in my state and your state, Ms. Dargan --

Ms. Dargan. California.

Mr. Griffith. -- and California. They have been kicked out of Colorado. They were national manufacturers who were lying about what they were doing. They weren't your traditional small pharmacy that was doing even small batches.

And so, what we have to do, as Ms. DeGette says, we have to try to find that balance, because we have situations that, in all fairness, I wasn't aware that one of the solutions to resolve the problem was that we were going to have folks going and picking up drugs. I forget who it was. I think a couple folks were talking about the dentist. Mr. Olson? And I think somebody,

maybe Dr. Brod mentioned it, too, that they are having the patients have to go to pick up the drug from the pharmacist because of the new interpretation on 503A. I think we all think 503B and the new stuff is good stuff. It is a question of that balance.

And so, if you could, first, Mr. Olson, and then, Dr. Brod, just tell me quickly about you and your testimony, but what other situations besides the dentist who has to send somebody in and, then, a child has to go through or an adult has to go through pain for a day or two, until the dentist can get them back in?

Mr. Olson. Thank you for the question, Congressman.

The dentist is the most critical one to my office. We have other dental products that we had provided in the past. But I think the other situation that we have is we are having to teach parents to do this themselves at home, instead of me providing it now. So, it is not necessarily an office-use situation, but because I am not able to compound it -- for example, insulin dilutions, we are having to teach parents to dilute their own insulin at home. We are having to teach patients to draw up their own medications at home because we are not allowed to perform that in our pharmacy. And we are just unsure, if we do that, whether we will be violating anything.

Mr. Griffith. Dr. Brod, you had some other examples?

Dr. Brod. Yes, several instances. So, we use cantharidin quite a bit. It is not commercially available. So, we are

relying upon getting it from a compounding pharmacy. It is used to treat predominantly children and, also, genital warts, too.

So, you can envision a situation where a child comes in. They are a little scared to begin with. We recommend cantharidin. It is painless. Other treatments that we have, such as freezing or burning, to get rid of warts and molluscum, common skin infections, are very painful and intimidating.

The parent took off of work. The child is out of school. We say, "You need a patient-specific prescription." The 503Bs, these are small batches, so we are having trouble getting them at any reasonable cost. So, the parent, then, has to go to the pharmacy, schedule another appointment back into the office.

The other problem, too, is we treat a lot of genital warts which carry oncogenic viruses. Patients with that don't want to come in in the first place. A lot of the other treatment alternatives, especially in patients with skin of color, can cause dyspigmentation and scarring. Things like cantharidin or podophyllin are really good options. And diminishing access creating inefficiencies I think is actually a public health issue.

Mr. Griffith. Do you find that some people, when they find out they have got to go to the pharmacist and, then, make another appointment, that they just don't do the treatment at all?

Dr. Brod. Yes. Sometimes they don't do the treatment at all; they don't come for followup visits, yes.

Mr. Griffith. Does anybody disagree that we all think that the 503B program as it was originally intended for those medium to larger folks is a good thing? Anybody disagree with that?

[No response.]

So, we have got to find that balance. Dr. Williams, do you have examples of where that balance is askew right now?

Dr. Williams. I do, I believe. One of the most devastating conditions that can occur in your eye is an acute bacterial infection. This can either be on the surface of the eye, as I discussed with that patient with a corneal problem, or in the --

Mr. Griffith. I am running out of time. So, if I could get you to cut to the chase?

Dr. Williams. The answer to your question is, yes, we need office-based access to specific antibiotics that are not available through the 503B mechanism.

Mr. Griffith. And you don't need a big batch? You just need a couple of small batches, isn't that correct, from time to time?

Dr. Williams. I just need enough to have on the shelf, so when that one patient a week comes in, I can take care of him.

Mr. Griffith. And I worry about my rural areas and my folks who have a problem, suddenly an emergency late at night or on the weekend, and there is no compounding pharmacy readily available in that small, rural community. Is that a concern for your doctors as well?

Dr. Williams. Absolutely. That is one of the most common scenarios that we hear.

Mr. Griffith. That is what I am hearing, too.

I appreciate all your testimony. I think everybody had some valid points. I figure we have got to figure out a way. Our job is to help work with the FDA and find that proper balance.

And with that, Mr. Chairman, I yield back.

Mr. Burgess. Thank you, Mr. Griffith.

I am going to proceed with my 5 minutes for questions. Mr. Green, I will come to him next. I was going to give him time to collect his thoughts since he just rushed in here.

Dr. Williams, several references have been made to an ophthalmic preparation that was injected after cataract surgery. Now a patient comes in for cataract surgery in an outpatient facility. They are coming in with the expectation that they are either going to need drops or injection after the surgery, is that correct?

Dr. Williams. That is correct.

Mr. Burgess. So, in that instance, could they not come in with the prescription already in hand or having picked it up themselves at a pharmacy? What would prevent that from being the way this would be administered?

Dr. Williams. So, for an elective procedure such as cataract surgery, that would be a possibility. The drug that the

specific episode, it is still not exactly clear what happened. It does not appear to be a contamination in the sense of a microbial or infectious cause. It seems to be that there was a toxicity involved when the two drugs were mixed. And so, it is still not entirely clear exactly what happened. But, even if those patients had had a prescription and brought that in, it probably would not have changed the outcome in this particular case.

Mr. Burgess. Correct. The compounds would have been the same and the doses and the route of administration would have been the same, and the outcome you would predict would be the same. So, I think that is a point well-taken. Just having a prescription does not necessarily protect you in all instances from an untoward event.

In the case of the methylprednisolone acetate -- and I do remember that so vividly from our hearings a couple of years ago -- so, here you have got a compound that has to be preservative-free because it is going into the epidural space and you don't want to damage a nerve with a preservative. And, of course, being a steroid, it reduces the body's ability to fight infection. So, it is like everything culminated in these cases to really create literally one of the worst things that I can recall having ever seen.

In addition to all the sympathy I have for everyone else, the sympathy for the emergency room doctors -- I know we had a

patient here in the previous hearing, and it was so difficult for the attending physicians in the emergency room to really get a grasp of what was going on, similar to other events that have happened in this country. When there was anthrax in the post office here in suburban Washington, the same thing, the emergency room doctors, seeing those patients out of context, it made it very, very difficult for them.

Ms. Adams, you referenced the bulk active pharmaceutical ingredients. Can you give us an idea of which bulk pharmaceutical ingredients you are talking about?

Ms. Adams. Yes, I can. Thank you.

So, when we look at the list, as an example, of the 200 permissible substances in Category I for bulk compounding right now, as we cross-reference that list, we feel that almost half of them have an FDA-approved vial that could be used rather than bulk substances. So, it is a long list that we think needs much revision.

Mr. Burgess. Okay.

Ms. Adams. And I think important to note, revising the list is something that for sure needs to happen. But, in addition to that -- that is not a holistic approach -- we also think that, really, to address the issue beyond just that list of 200 substances, the essentially copy needs to be revised to differentiate between compounding that starts from FDA-approved

vials and compounding that starts from bulk substances.

Mr. Burgess. And are you assisting the agency in revising that list?

Ms. Adams. We are. We have got a good dialog going with the agency. We have got an opinion, which we have documented for them, and we are happy to continue to serve as a resource in that regard.

Mr. Burgess. Very well.

Mr. Olson, again, thank you for being here for the people that you represent. Let me just ask you, on the FDA's draft memorandum of understanding, they decided to rescind the original draft and they are going through significant revisions. States are going to be required at some point, though, to sign onto this memorandum of understanding, is that correct?

Mr. Olson. Yes, Congressman, that is my understanding.

Mr. Burgess. And what will be the consequences if a state decided we are not going to sign onto that memorandum of understanding? How would that leave you?

Mr. Olson. It would leave us very conflicted as to what we are supposed to do. Because if we abide by our state laws, that is what we should be abiding by. But in my situation I am only licensed in Wisconsin, so I wouldn't have to worry about the situation specifically. But I would think it would put pharmacies in bordering towns or bordering areas in a precarious

position to figure out, well, wait, if the state I am in signed it, but the state I am shipping into didn't, then where does that leave me, or vice versa. Even though, to be fair, most of the time if you are shipping into another state, you have to be licensed in that other state as well. So, there is a state license that you would have in both states. It would just be the conflicting memorandum of understanding about whether you can ship and how much you can ship into that state.

Mr. Burgess. Thank you.

And, Dr. Brod, just as an observation, years ago I remember discovering that a little bit of bicarbonate in a vial of lidocaine could make a tremendous difference as to what your patients thought about you. And I didn't realize I was compounding when I was doing that. I just thought I was being a nice guy. But in your testimony you reference that as an episode of compounding, is that correct?

Dr. Brod. A tremendous difference. And in speaking with colleagues who haven't been able to buffer in the office, they say that the patients note a distinctive difference. I mean, we are very reliant on it. We perform extensive surgeries, but we do it in the outpatient setting, Mohs surgery with reconstruction. Having the bicarb to buffer the lidocaine, so that injections in multiple areas of the face are tolerable, it really allows us to do surgery outpatient instead of going into a surgical facility

with sedation and those types of things. So, it is a world of difference and our patients really appreciate it very much.

Mr. Burgess. Let me just echo, before I yield to Mr. Green, let me just echo the comments of Mr. Griffith again. We appreciate so much you all being here. We recognize that there are some issues that we are going to have to work through, and we appreciate your help in getting there.

Mr. Green, you are recognized for 5 minutes, please.

Mr. Green. Thank you, Mr. Chairman.

I apologize to the panel about being late, but I had a medical that I couldn't do. I couldn't have any of my great staff deal with that.

But I want to thank you for being here. And you know that Congressman Griffith and Congressman DeGette and the chairman, we want to fix it because we want to make sure the system works. And that is what we did after the tragedies in Massachusetts with 65 people dying. But we appreciate you all being here and giving your stands on it, so we can actually work through and see what the solutions will be.

Ms. Jungman, I know the Pew Charitable Trust has done a lot of research on compounded drugs and was actively engaged in this issue before the DQSA was signed into law and since. I think it would be helpful to take a step back and get an understanding of why this law was necessary and how we can support its

implementation in a manner that strikes the right balance between access and safety.

Ms. Jungman. I would be delighted to answer that question, and thank you.

So, as you know, the history of compounding has a long and complicated legal history, right? It has been a part of traditional pharmacy practice for as long as pharmacy has existed. But over time businesses grew up; they were compounding at a larger scale. And Congress first tried to tackle that in the nineties, met some legal challenges that Dr. Gottlieb referred to. And NECC I think really brought to the forefront of everyone's mind the scale of the patient risk that was there.

We have done a lot of work trying to capture the adverse events that have happened in all sorts of facilities from compounding pharmacies, but there is really not a comprehensive way to know what the risks, what the scale of the impact is.

And so, what the DQSA does is draw really clear lines that are designed to ensure that patients have access to the highest quality product that meets their clinical need. So, if you can use an FDA-approved product, that is great. If you can't use an FDA-approved product, then you want a product that is made under appropriate quality standards. And so, there is a balance there that is about both ensuring that the quality standards are appropriate, but that the lines are really clear, so that everyone

knows which side of the line they have to be on.

Mr. Green. I was a state legislator in Texas and we worked with our pharmacy board and trusted them. I know, typically, we have these national legislative groups that have standard pieces of legislation from state to state. So, we do have some kind of commonality between Texas and Louisiana, or whatever. But is there anything like that, so we wouldn't have such 50 different? Is there any agency that does that, and say, "This is the standard way you pharmacy boards deal with it."?

Ms. Jungman. The National Association of Boards of Pharmacy does have a model law that does talk about some of these issues. There is, of course, still state variation. But the research that we will publish in about two weeks, not quite in time for this hearing, will show that states are really beginning to align with, really kind of come into compliance with each other and in line with DQSA.

Mr. Green. What is the history of responsibility between the state boards of pharmacy and the FDA? And how did DQSA change that defining line?

Ms. Jungman. At the time that the NECC outbreak happened there was a lot of confusion. And I think we saw that in the hearings that happened at that time, where there was a lack of clarity about who was supposed to be taking charge of these institutions. And so, the DQSA really stressed accountability

and clear lines for that reason. So, it was, of course, about improving the safety of the products, but it was also about making sure that everyone knew who was, to use the phrase that kept being used at the time, "on the flagpole". Which regulatory agency was in charge of any type of activity?

And so, the Congress at the time -- and you gentlemen know this better than anyone -- considered a lot of different ways of drawing those lines. Could you do it based on volume? Could you do it based on geographic reach? But, ultimately, the prescription requirement was the line that was clear and enforceable, and that was considered to be really important for ensuring that the right quality standards were applied.

Mr. Green. When we had the hearings earlier on the tragedy in Massachusetts, I remember we had FDA and the Massachusetts Pharmaceutical Board, and they looked at each other. Here we were sitting up here and saying, somebody has got to be minding the store, and that is what we are looking for.

States are critical partners in the effort to ensure patient access to safe compounded drugs. And I understand Pew will soon release a report with our National Association of Boards of Pharmacy which assesses best practices that are more achievable by the states. Hopefully, we can have that coordination. Again, we just want somebody to make sure, whether it is the state level or across border lines, the FDA, somebody needs to be minding the

store to make sure we don't have an incident like we did in Massachusetts, well, literally countrywide, but it originated there.

Thank you.

Ms. Jungman. Thank you.

Mr. Guthrie. [presiding] Thank you.

And I will now recognize myself for 5 minutes for questions.

Dr. Williams, your testimony has been about the critical need for office use of compounded drugs. How do we ensure office use is allowed while protecting patient safety?

Dr. Williams. Well, I think that is the critical issue we have been discussing all day. We do not think that the patient-specific prescription contributes to safety in any way. It would allow us to track the use of drugs perhaps. But, for the incidents where timely treatment is critical -- and as I mentioned earlier, infections of the eye, even a delay of an hour or two will have adverse effects. So, we need to be able to have these drugs available in office. We can just pull them off the shelf. And it is just absolutely critical.

I alluded earlier to the pool cleaner for this type of infection. And it sounds crazy that we would use a pool cleaner for an infection in the eye, but I can assure you, if you had that infection, you would want immediate access to that treatment.

Mr. Guthrie. Thank you very much.

Ms. Adams, some compounded drugs for ophthalmology are being done only be a single facility. Do you why this is and was this the case before DQSA?

Ms. Adams. Thank you.

I don't have specific knowledge of where ophthalmology drugs are compounded and in what scale. PharMEDium is strictly sterile-to-sterile compounding in our 503B facilities. And as we stand right now, we do not serve the ophthalmology patient population. So, I don't have specific knowledge of that.

Mr. Guthrie. Would you know anything about that, Dr. Williams? Is it done by a single facility and why is that the case? Was it the case before DQSA?

Dr. Williams. So, before the DQSA, it was done by a single facility, so-called traditional or 503As. There are many ophthalmic drugs that are available through 503Bs, and we encourage our members to use those. But it is these relatively rare conditions, but, yet, very potentially catastrophic, where we need immediate access. And simply writing a prescription and, then, having the patient have to go get it, if, in fact, they can get it -- these are drugs that are not typically manufactured or compounded at a high rate. So, for a rural population, it could be literally hundreds of miles, as I stated in my statement.

Mr. Guthrie. Yes, absolutely. Thank you very much.

I am going to yield the time, my remaining time, to Mr.

Griffith of Virginia.

Mr. Griffith. Mr. Hodges, I am going to ask you a question. It is getting down a little deeper in the weeds, and we still want to reach a balance. But the committee has heard, much to their chagrin, all about my family's allergy issues. And some pharmacies specialize in serving patients with specific needs, such as a drug without a particular dye or ingredient for those patients who do have allergies to those particulars. And they do it because they specialize. They do it in multiple states.

If the shipment of a patient-specific compounded prescription is limited by the memorandum of understanding, will patients be able to get all of these medications from local pharmacies?

Mr. Hodges. Thank you, sir.

Simply put, no, they will not. Not all pharmacies make all products for every type of patient population. So, for instance, we engage in allergy immunotherapy. There is only a handful of pharmacies in the country that offer that. And so, it is particularly a concern for us that we cannot meet these patients' needs because we are not able to provide it, in fear of the MOU, if it is implemented.

And so, what we want to do is work closely with the FDA. We have some ideas about what we can do to ensure the quality and access. We have ideas. But we are looking for a sit-down with

the Commissioner. We have requested this year and years prior we have sent letters, and we are not getting a response. And so, what we would like to do is ask that the Commissioner have a sit-down with us. We have some ideas on what we can do.

But, to answer your question, it would be a problem if the MOU went into effect, especially for patients that live across state borders.

Mr. Griffith. All right. I appreciate that.

I will tell you that Commissioner Gottlieb, of all the folks that we have dealt with at that level, is probably the most responsive that the committee has found. And so, we will work towards that. But he is very responsive, tries to listen, tries to pay attention. And so, it is a good working relationship. Hopefully, together we can find a balance to the issues that have been raised by today's hearing.

I appreciate all of you very much.

And I yield back, Mr. Chairman.

Mr. Guthrie. Thank you. The gentleman yields back, and I yield back my time.

Seeing that there are no further members wishing to ask questions, I would like to thank all of our witnesses for being here today.

I would like to submit the statements from the following for the record: American Society of Health System Pharmacists;

American College of Mohs Surgery; Avella; Outsourcing Facilities Association; American Society of Cataract and Refractive Surgery; National Association of Chain Drug Stores; American Pharmacists Association; a joint statement from the American Academy of Allergy, Asthma & Immunology and the American College of Allergy, Asthma and Immunology.

[The prepared statements follow:]

********** COMMITTEE INSERT 14**********

Mr. Guthrie. Pursuant to committee rules, I remind members they have 10 days to submit additional questions for the record, and I ask that the witnesses submit their response within 10 business days upon receipt of the questions.

Without objection, the subcommittee is adjourned.

[Whereupon, at 2:43 p.m., the subcommittee was adjourned.]