



January 24, 2018

The Honorable Dr. Michael Burgess
Chairman, Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Gene Green
Ranking Member, Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

RE: Testimony Submitted for Health Subcommittee Hearing on DQSA Implementation

Dear Chairman Burgess, Ranking Member Green and Members of the Health Subcommittee:

On behalf of the IACP Board and our members, we thank you for holding this subcommittee hearing on the important issues surrounding the Drug Quality and Security Act of 2013 (DQSA), and for the opportunity to submit our organization's input.

IACP is an association representing more than 4000 pharmacists, technicians, students, and members of the compounding community who focus on the specialty practice of pharmacy compounding. Compounding pharmacists work directly with prescribers including physicians, nurse practitioners and veterinarians to create customized medication solutions for patients and animals whose health care needs cannot be met by manufactured medications.

Every day, compounding pharmacists serve patients in a variety of areas including: autism, oncology, dermatology and pediatrics, in a variety of practice settings including hospice in-patient units, emergency rooms, surgical centers, physician clinics, and even Federal Facilities like the VA. Compounding pharmacists also have served patients such as pre-term infants who require parenteral nutrition (PN). PN provides intravenous lifesaving therapy for patients whose gastrointestinal (GI) tracts are not functioning or cannot be accessed, or where nutritional needs cannot be met with oral or enteral diets. These are just a few examples of how compounding pharmacists are working with physicians to provide life-saving medications for patients.

Again, we thank you for including IACP in this important hearing and for the opportunity to provide the subcommittee with our input. We look forward to working with you on compounding pharmacy policies that protect both patient safety and patient access to critical medications.

Sincerely,

Erik Tosh, D.Pharm, FIACP, FACA
IACP President

Executive Summary:

For over three years, IACP has worked with a coalition of over 30 prescriber and pharmacy organizations (the “DQSA Coalition”) on issues related to the Food and Drug Administration’s implementation and enforcement of the Drug Quality and Security Act of 2013. IACP and the other member organizations of the DQSA Coalition have worked to provide stakeholder input directly to the FDA and through Congress to improve patient safety and patient access to compounded medications. In certain areas, we believe the FDA is overstepping the regulatory authority given to the agency by Congress in the Federal Food, Drug and Cosmetic Act as amended by the DQSA and infringing upon the traditional role of state boards of pharmacy in the regulation of the practice of pharmacy. We strongly endorse bipartisan legislation, HR2871, the *Preserving Patient Access to Compounded Medications Act*, by Rep. Griffith (R-VA) and Rep. Cuellar (D-TX) as a needed clarification of the DQSA that will better delineate the practice of pharmacy from drug manufacturing.

While encouraged by some of the intended policy changes announced in the “2018 Compounding Policy Priorities Plan” released by the FDA, IACP is hopeful that this hearing will result in improved dialogue between the FDA and stakeholders, and that future FDA compounding policies will better reflect the input the Agency has received from prescribers and pharmacists. Our written testimony for this hearing of the Health Subcommittee is focused on the following policy areas:

- Office-use compounding pursuant to state pharmacy laws and regulations;
- The draft sample MOU between FDA and states on interstate distributions;
- Appropriate inspection standards for compounding pharmacies;
- Compounding with dietary supplements;
- Policymaking through Guidance for Industry instead of rulemaking;
- The Pharmacy Compounding Advisory Committee (PCAC).

Introduction:

IACP understands and supports the need to protect public health and safety through strong laws and regulations that provide appropriate oversight over both drug manufacturing and the practice of compounding pharmacy. It is also critical that those laws establish clear and definitive lines between compounding and manufacturing and whether state boards of pharmacy or the Food and Drug Administration (FDA) are the appropriate regulators over those distinct activities. Although it was a goal of Congress in passing the DQSA to better brighten this line and improve patient safety and access to compounded medications, in many ways the law has unfortunately had the unintended consequence of providing less clarity to pharmacists, state boards of pharmacy and medical providers, and in addition jeopardizing patient access to critical, often life-saving compounded medications.

Rather than working with stakeholders through the formal rulemaking process to implement the DQSA and establish compounding policies that balance public safety with patient access and adhere to the law's statutory language and congressional intent, the FDA has instead issued draft guidance for industry (GFI) documents that are often in conflict with the statute and congressional intent, and then finalized without any reflection of the stakeholder input received from providers and pharmacists. These GFI documents are treated by the FDA as though they have the weight of law or regulation, which they do not, and are used by the FDA to establish federal violations that lead to state licensed and compliant "503A" pharmacies being inspected under drug manufacturer standards rather than standards established by state pharmacy laws and regulations.

IACP was hopeful that a new Administration and new FDA Commissioner would lead to a reset of the agency's policies that stress the importance of compounding a high-quality preparation, rather than displacing the role of state boards of pharmacy in regulating the practice of compounding. Unfortunately, we have yet to see any significant movement away from the policies of the last Administration, nor have we seen a willingness to work with stakeholders towards improving the FDA's compounding policies to better reflect the practice of medicine and pharmacy in the real world, and the state laws and regulations that regulate those professions.

For over three years, IACP has been working with a coalition of more than 30 pharmacy and provider organizations (the “DQSA Coalition”) on the issues our members and their patients are having with FDA’s implementation and enforcement of the DQSA. The DQSA Coalition was pleased and encouraged when bipartisan legislation, HR2871, *The Preserving Patient Access to Compounded Medications Act*, was introduced by Rep. Morgan Griffith (R-VA) and Rep. Henry Cuellar (D-TX) in June of last year. This legislation, which now has 43 cosponsors, would address several of these issues and amend the DQSA in a way that would better clarify state and federal regulatory authority over compounding, and better balance patient safety and patient access to critical medications. HR2871 has been endorsed by 50 national and state pharmacy and medical provider organizations.

IACP strongly recommends that HR2871 be voted out of this committee and the full House and Senate this year and we look forward to working with you on that process. In the meantime, and for purposes of this subcommittee hearing, we appreciate the opportunity to provide our input on several specific policies the FDA has adopted in implementing and enforcing the DQSA that we and other organizations believe is contrary to the language of the law and its congressional intent, and that is unnecessarily jeopardizing patient access to critical medications.

Office-Use Compounding:

“Office-Use Compounding” refers to a pharmacist, pursuant to state pharmacy laws that authorize the practice, compounding a limited quantity of a medication that medical necessity requires be administered in an office or clinical setting by the prescribing physician and transferring the drug to the physician for administration to the patient. The majority of state pharmacy practice acts and related state regulations authorize some form of office-use compounding, usually as an exception to the prescription requirement under state law. IACP and multiple other organizations representing pharmacists and the providers who prescribe and treat their patients with compounded medications have provided the FDA with input as to the medical necessity of the administration of compounded medications by providers in office or clinical settings. The Congress has

weighed in on multiple occasions and in multiple ways (including statements in the congressional record, letters, and directives in appropriations bills that are enclosed in this submission) to remind the FDA that the DQSA was not intended to prohibit office-use compounding and does not preempt state laws that authorize office-use compounding. Indeed, appropriators have been very clear with the FDA in asserting congressional intent on the issue of office use. Relevant language in the House Reports accompanying the FY2016 and FY2017 Omnibus Appropriations Acts, as well as House Report language in the FY2018 FDA/Ag Appropriations Act is as follows:

Omnibus Appropriations Act: House Report 114-205, FY 2016:

The Committee is concerned that, since passage of the Drug Quality and Security Act (DQSA) of 2013, the FDA has interpreted provisions of Section 503A of the FDCA in a manner inconsistent with its legislative intent and with the agency's own previous positions. Specifically, the FDA has taken the position that under 503A, a pharmacist may not compound medications prior to receipt of a prescription and transfer the drugs to a requesting physician or other authorized agent of the prescriber for administration to his or her patients without a patient-specific prescription accompanying the medication. This practice, which is often referred to as 'office-use' compounding, is authorized in the vast majority of states and was intended to be allowable under DQSA. The Committee is aware that in 2012, prior to passage of the DQSA, FDA was working on a draft compliance policy guide for 503A of the FDCA that provided guidance on how 'office-use' compounding could be done consistent with the provisions of 503A. The Committee understands the intent of the DQSA was not to prohibit compounding pharmacists 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 before the receipt of a patient-specific prescription consistent with the provisions of 503A within 90 days after the enactment of this Act. (P.67)

Omnibus Appropriations Act: House Report 114-531, FY 2017:

The Committee believes patient access to the right drug at the right time is of utmost importance. In instances where a commercially manufactured drug is not appropriate for a patient for a specific reason, a compounded drug may be the difference between life and death. Since passage of the Drug Quality and Security Act (DQSA) of 2013, the Committee has had concerns that the FDA interpreted provisions of Section 503A of the FDCA in a manner that might jeopardize the availability of compounded medications for “office use”. The practice of “office use” occurs when a compounder will compound a batch of drugs in anticipation of receiving patient-specific prescriptions at a later time. It may also be the case of a doctor in his or her office maintaining compounded drugs on site because it is unsafe or impractical to issue a traditional prescription. This practice is authorized in the vast majority of states and was intended to be allowable under DQSA. The Committee is aware that on April 15, 2016, FDA released a new Draft Guidance on the issue of “office-use” compounding. The Committee directs the FDA to issue a Final Guidance that provides for “office-use” compounding of drugs, in appropriate circumstances as well as including drugs compounded in anticipation of a prescription for an identified individual patient. Such “anticipatory” compounded drugs must be based on the history of previous valid compound prescription orders, and on an established history between the prescriber and the patient and the compounder. (p 68-69)

House Committee Report to FY 2018 FDA/Ag Appropriations Bill:

The Committee continues to believe that patient access to the right drug at the right time is of utmost importance. In instances where a commercially manufactured drug is not appropriate for a patient for a specific reason, a compounded drug may be the difference between life and death. Since passage of the Drug Quality and Security Act (DQSA) of 2013, the Committee has had concerns that the FDA interpreted provisions of Section 503A of the FDCA in a manner that might jeopardize the availability of compounded medications for “office use”. The practice of “office use” occurs when a compounder will compound a batch of drugs in anticipation of receiving patient-specific prescriptions

at a later time. It may also be the case of a doctor in his or her office maintaining compounded drugs on site because it is unsafe or impractical to issue a traditional prescription. This practice is authorized in the vast majority of states and was intended to be allowable under DQSA. The Committee directed the FDA to issue a Final Guidance that provides for “office-use” compounding of drugs, in appropriate circumstances as well as including drugs compounded in anticipation of a prescription for an identified individual patient. Such “anticipatory” compounded drugs is based on the history of previous valid compound prescription orders, and on an established history between prescriber, patient and compounder. Despite clear directives in previous reports accompanying FDA’s appropriations bills for the agency to finalize guidance that authorizes office-use compounding, in December of 2016, the FDA finalized a Guidance for Industry (GFI) entitled “Prescription Requirement Under Section 503A of the FDCA,” which expressly prohibits office-use compounding. The Committee directs the FDA to rescind this GFI and issue a proposed rule, subject to the notice and comment provisions in the Administrative Procedure Act. The proposed rule should be consistent with Congressional intent as stated in both Appropriations Reports and the DQSA, and that also allows for office-use compounding as authorized by state law. In the proposed rule, FDA should lay out the means by which office use is permissible while addressing such critical safety matters, such as maintaining controls on quantity and safety issues such as those related to office stock shelf life. Lastly, FDA’s clarification on the line between traditional compounding and outsourced compounding will support state regulators, outsourcing facilities, and traditional compounders in their efforts to ensure that patients have access to safe compounded drugs while reducing the risks associated with sterile drugs produced in bulk. (page 67)

Yet, the FDA continues to ignore stakeholders and the Congress and substitute the agency’s desired regulatory authority over compounding pharmacies for the authority actually given to the agency under the law. Stakeholders and the Congress have repeatedly reminded the FDA that in 2012, prior to passage of the DQSA,

the agency circulated a draft compliance policy guidance that would have allowed for office-use compounding under 503A of the FDCA, with some restrictions. The relevant statutory language of 503A was not changed by the DQSA, yet the agency now takes the position that the same statutory language prohibits office-use compounding by 503A pharmacies under all circumstances, even where expressly authorized by state law.

Similar to most, if not all, state and federal statutes governing the practice of pharmacy, the statutory language of Section 503A of the FDCA requires that drug products compounded by pharmacies must be “*for an identified individual patient based on the unsolicited receipt of a valid prescription order...*” However, this language does not speak to the timing of the prescription, and there are always statutory and regulatory exceptions to the prescription requirement based on the realities of medical practice and the needs of patients.

Indeed, Section 503A also clearly allows for “anticipatory” compounding “*in limited quantities before the receipt of a valid prescription order for such individual patient.*” Additionally, Section 503A gives the FDA regulatory authority over the “*distribution of inordinate amounts of compounded drug products interstate...*” in the form of an FDA-developed MOU between states, or a default cap on interstate distributions equal to 5% of the “*total prescription orders dispensed or distributed by such pharmacy or physician.*” Notwithstanding FDA’s attempt to redefine the terms in Footnote 7 of the GFI on the Prescription Requirement Under FDCA 503A, it is clear from the plain language of the statute that Congress intended for the terms “distributed” and “dispensed” to be treated as the distinct activities they are in law and in medical/pharmacy practice, and that Congress recognized there are limited instances where it is appropriate and medically necessary for a pharmacist to “distribute” compounded medications to a physician or other prescriber prior to the receipt of a valid prescription order, including for administration to patients in an office or clinical setting.^{4,5}

Given this context and the statute’s plain language, together with the fact Congress did not in Section 503A of the FDCA expressly preempt state pharmacy laws and regulations that allow for limited quantity office-use compounding, we believe FDA has misinterpreted the law to prohibit office-use compounding. When inspecting 503A compounding pharmacies, FDA continues to use the fact that a pharmacy is doing office-use

compounding prior to receipt of a prescription, including where expressly authorized by state law, to remove the exemptions provided to pharmacies in the law and inspect them under current Good Manufacturing Practices (cGMPs) rather than under standards adopted by state pharmacy boards under state law. This is drastically reducing patient access to vital, and often life-saving, compounded medications.

FDA, Pew and others have asserted that leaving the issue of 503A office-use compounding to state laws and regulations will mean that pharmacies will be able to do unlimited compounding without safety and recordkeeping requirements. However, a look at the laws and regulations of the states that still allow office-use compounding, shows that the vast majority of them have quantity limitations, sterility requirements, and recordkeeping requirements that state lawmakers and boards of pharmacy have determined are appropriate to balance the interests of patient safety and patient access to critical compounded medications. Unfortunately, FDA has worked diligently to convince several states who previously allowed office-use compounding to repeal their laws and regulations in this space due to FDA's assertion that these laws and regulations are now in conflict with or preempted by the FDCA as amended by the DQSA. However, a majority of the states still authorize some form of office-use compounding by 503A traditional pharmacies, a clear recognition of the medical needs of patients in those states. Below are some examples of states that still allow some form of office-use compounding under restrictions and requirements determined to be appropriate in those states by state lawmakers and boards of pharmacy.

Texas:

Office-Use Compounding Authorized: Yes

Sterile: Yes

Non-Sterile: Yes

Statutory Reference: TX Occupations Code §562.152

Rule or Policy Reference: TAC §291.131

Prescription Requirement: No

Quantity Limitation: Yes

Comments: Texas statutes and Board regulations specifically authorize the compounding of a “reasonable quantity” of sterile and non-sterile drugs by pharmacies for office administration. The regulations further define reasonable quantity, require a written agreement between pharmacist and prescriber, and have strong recordkeeping and labeling requirements.

Washington:

Office-Use Compounding Authorized: Yes

Sterile: Yes

Non-Sterile: Yes

Statutory Reference: RCW 18.64.270

Rule or Policy Reference: WAC 246-878-020

Prescription Requirement: No

Quantity Limitation: Yes

Comments: The statute and the Board rules authorize distribution of limited quantities of compounded medications to licensed practitioners for office administration. Distribution of inordinate quantities is considered manufacturing.

Oregon:

Office-Use Compounding Authorized: Yes

Sterile: Yes

Non-Sterile: Yes

Statutory Reference: No

Rule or Policy Reference: OAR 855-045-0200

Prescription Requirement: No

Quantity Limitation: Yes

Comments: Oregon pharmacies may provide non-patient specific, non-controlled compounded drugs to OR practitioners under a Shared Service arrangement with the Oregon Board of Pharmacy.

Colorado:

Office-Use Compounding Authorized: Yes

Sterile: Yes

Non-Sterile: Yes

Statutory Reference: CO Code 12-42.5-118(6)(b)

Rule or Policy Reference: Colorado BOP Rule 21.00.20

Prescription Requirement: No

Quantity Limitation: Yes

Comments: Colorado resident pharmacies can compound and distribute to CO prescribers for office administration up to a 10% cap. Any compounding for out of state must be patient specific. An accredited compounding pharmacy can register as such with the board and then dispense and distribute compounded meds in unlimited quantities to CO prescribers and other pharmacies.

The FDA's assertion that the creation of 503B "outsourcing facilities" that are authorized to compound without receipt of a patient-specific prescription eliminates the need for 503A office-use compounding is inaccurate. 503B outsourcing facilities simply do not have the flexibility to meet these needs. These new entities must meet current good manufacturing practices (cGMP), which are designed for making large amounts of a limited variety of medications. To compound an order for a particular formula, extensive testing and validation must be done that can take a minimum of 90 to 120 days before the medication can be made available to either a healthcare provider or a medical professional. In addition, there must be a need for large quantities of the medication in order to make the business practice sustainable given the cost of standardizing of processes as required by cGMP. On the other hand, traditional compounding pharmacies, also known as 503A pharmacies, can provide necessary medication in a matter of days or even hours. In many cases, medications need to be prepared within hours to ensure a patient can transition from one site of care to another. Their flexibility allows them to quickly respond to the needs of patients and medical professionals for specialized medications that are not commercially available. For example, the majority of parenteral nutrition patients, especially those needing long-term therapy, need individualized formulations that are adjusted frequently. Customized parenteral nutrition compounds cannot be provided by 503B outsourcing facilities due to the lag time of dispensing created by the end-product testing requirements.

503B outsourcing facilities are restricted in the range of medications they can provide. They are able to compound medications that are on FDA's drug shortage list that is still under development, and can repackage finished product to customize dosage and delivery systems. However, when compounding from bulk ingredients (the most common form of compounding), they are limited by statute to a positive list developed by FDA. FDA has yet to develop the positive list and has been using enforcement discretion to allow 503B facilities to compound from bulk ingredients without the limitations of a list. But as soon as the agency develops the positive list, most bulk ingredients are likely to be excluded from what is allowed. Further, FDA is interpreting the statute authorizing outsourcing facilities as requiring an extensive documentation of clinical need before compounding of a medication is allowed. If FDA enforces this interpretation, a simple prescription

or medical order will no longer suffice and the required medication could not be obtained from a 503B outsourcing facility.

FDA claims that the demand for office use of compounded medications, which medical professionals depend on for emergency situations and other appropriate uses as allowed under most state laws, can be met by outsourcing facilities. With the prospects of a limited positive list, a requirement for documented clinical need, and a limited demand of many of these medications, outsourcing facilities simply will not and cannot meet the needs of patients and medical professionals. Furthermore, the greatest demand for office use is for non-sterile compounds (capsules, creams, tablets, powders, etc.). Establishing an outsourcing facility requires meeting extensive and costly sterile compounding regulations, and only a small number of outsourcing facilities are doing non-sterile compounding.

503B facilities will play an important role in our health care system, and are designed to meet the needs of hospitals and others in dealing with drug shortages. This should help alleviate some of the patient access problems in those settings; however, the requirements and cost of complying with cGMP prevents the compounding of small batches and limits the role they can play in meeting the needs of patients for compounded drugs in smaller office and clinical settings. This gap in patient access to compounded medications for office administration has been experienced by prescribers in a broad range of practice areas, but has had a particularly negative impact on the patients of dermatologists and ophthalmologists. Enclosed in our submission is a chart showing compounded medications needed by prescribers that they report they are unable to obtain from 503B facilities.

On Friday, January 19, FDA released a “2018 Compounding Policy Priorities Plan” that describes the agency’s intention to issue a revised draft guidance document with a “new flexible, risk-based approach to requirements for outsourcing facilities.” The policy is intended to make it easier for smaller pharmacies to register with the FDA as outsourcing facilities, and compound with or without patient specific prescriptions, including for office administration. While IACP will wait to see the actual language of the revised GFI and eventual proposed rule

before commenting in detail on this new policy proposal, we do have strong concerns about any proposal that could negatively impact patient access to compounded medications and are wary of FDA policies that would lead to the further federalization of the regulation of the practice of pharmacy, and weaken the traditional role of state boards of pharmacy as the appropriate regulatory authority over the profession.

We join the 65 Members of Congress who wrote to the FDA in May of 2017 asking that the final GFI on the 503A prescription requirement be rescinded, and that the agency work with stakeholders to develop a proposed rule that authorizes office-use compounding by 503A compounding pharmacies where authorized by state law in a way that protects both patient safety and patient access to the compounded medications they need.¹

Definitions of the terms “Distribute” and “Dispense”:

Section 503A of the Food, Drug and Cosmetic Act (FDCA) gives the FDA limited regulatory authority over the “distribution” of “inordinate quantities” of compounded medications across state lines in the form of a sample MOU between states to be established by the FDA in consultation with the National Association of State Boards of Pharmacy, or a default cap contained in the FDCA. The relevant section of the FDCA (21 U.S.C. §353a (b)(3)(B)) establishing the default cap on compounded medications shipped interstate, says that it applies to pharmacies in a state “(ii) that has not entered into the memorandum of understanding described in clause (i) and the licensed pharmacist, licensed pharmacy, or licensed physician distributes (or causes to be distributed) compounded drug products out of the State in which they are compounded in quantities that do not exceed 5 percent of the total prescription orders *dispensed or distributed* by such pharmacy or physician.” (emphasis added). This section of the FDCA was not amended by the DQSA and was part of the 1997 Food and Drug Modernization Act that established Section 503A of the FDCA.

The draft MOU, in its Appendix, defines “distribution” to include the dispensing of compounding medications directly to a patient for the patient’s use. In December of 2016, the FDA issued a Final Guidance for Industry (GFI) entitled “Prescription Requirement under 503A of the Federal Food, Drug and Cosmetic Act” that, in a footnote, also defines “distribution” to include dispensing a drug directly to a patient. The terms

“distribution/distributed” and “dispensing/dispensed” are clearly distinct and commonly understood terms in both medical practice as well as throughout federal and state law.⁴

The “dispensing” of medications, commonly understood to mean the transfer of a drug product to a patient or an agent of the patient for that patient’s use, is the very essence of the practice of pharmacy, something appropriately regulated by state boards of pharmacy under laws established by state legislatures. The term “distribution” is commonly understood in medical practice and defined throughout federal and state law to mean the sale, transfer or storage of a drug product that does not include “dispensing” to a specific patient.

The very section of the FDCA (21 U.S.C. §353a(b)(3)(B)) giving the FDA regulatory authority over the “distribution of inordinate quantities of compounded medications” clearly distinguishes distribution and dispensing as the distinct activities they are by creating a default cap on interstate *distributions* that is based on a percentage (5%) of the total amount of prescriptions “*dispensed or distributed*” by the pharmacy or physician. (emphasis added). By redefining these key terms in the sample draft MOU and in a GFI, the FDA is asserting regulatory authority over the “dispensing” of compounded medications over state lines in a way that Congress never intended and that will jeopardize patient access to critical compounded medications. The FDCA was not intended to give FDA the authority to limit the patient specific “dispensing” of compounded medications, only the “distribution” of “inordinate quantities” of compounded medications shipped over state lines.

It is highly unusual and inappropriate for the FDA to, in a GFI and a sample MOU, attempt to redefine key statutory terms to meet their policy interpretation of the statute, especially those that are defined elsewhere in federal state laws and regulations and with clearly understood meanings in practice. FDA, in the Notice of Availability for the MOU acknowledges the fact that these terms are defined elsewhere in federal law. In the notice the FDA asserts that because Congress did not provide a definition of “distribution” in this section of the FDCA that does not specifically exclude “dispensing”. Congress intended for FDA to ignore the multiple federal and state statutory and regulatory definitions of these terms, as well and the medical and pharmacy

communities' common understanding of those terms, and instead use the "ordinary meaning" of those terms, which they analogize to manufacturers of other goods distributing those goods to their customers.

Congress has, through multiple letters to the FDA and in report language in the last two FDA appropriations bills (FY16 and FY17) told FDA their re-defining of these terms in a sample MOU and in a GFI is an "overreach," and is "unprecedented" and inconsistent with congressional intent of the statute. A copy of the congressional letter referenced above and dated May 23, 2017, is enclosed as an attachment to this testimony and the relevant report language is quoted below, including language from the House Report accompanying the FY 2018 bill. However, FDA continues to move forward with implementing compounding policies in a way that is inconsistent with the statutory language of this section of the FDCA and the definitions of these terms throughout federal and state law and congressional intent, which will threaten patient access to critical compounded medications. The access problem will be especially felt by patients served by compounding pharmacies near state lines that would, under FDA's interpretation of the FDCA, be subject to an arbitrary cap on the compounded medications they can "dispense" to specific patients across state lines.

Examples of definitions of the key terms "distribution" and "dispensing" can be found throughout state and federal health care and pharmacy law. For FDA to redefine these key terms in the MOU and GFI would not only expand the agency's regulatory authority over patient specific dispensing of compounded medications in a way Congress never intended, it would conflict with the commonly understood medical and legal definitions of those terms throughout state and federal health care statutes causing unnecessary confusion and legal uncertainty at both the state and federal levels. Below are some examples of how these key terms are currently defined in state and federal law:

Federal Law Definitions:

21 CFR 208.3

Specifically, in 21 CFR §208.3,

§208.3 Definitions.

For the purposes of this part, the following definitions shall apply:

- (a) Authorized dispenser means an individual licensed, registered, or otherwise permitted by the jurisdiction in which the individual practices to provide drug products on prescription in the course of professional practice.*
- (b) Dispense to patients means the act of delivering a prescription drug product to a patient or an agent of the patient either:*
 - (1) By a licensed practitioner or an agent of a licensed practitioner, either directly or indirectly, for self-administration by the patient, or the patient's agent, or outside the licensed practitioner's direct supervision; or*
 - (2) By an authorized dispenser or an agent of an authorized dispenser under a lawful prescription of a licensed practitioner.*
- (c) Distribute means the act of delivering, other than by dispensing, a drug product to any person.*
- (d) Distributor means a person who distributes a drug product.*

21 U.S.C. §802(10)-(11)

In addition, the Controlled Substances Act defines “dispense” and “distribute” to mean two different things, and expressly excludes “distribute” from the act of dispensing. Specifically, the CSA states that a pharmacy which is:

registered to dispense a controlled substance may distribute (without being registered to distribute) a quantity of such substance to...another practitioner for the purpose of general dispensing by the practitioner to patients” unless the pharmacy’s “total number of dosage units of all controlled substances which will be distributed by him” does not “exceed 5 percent of this total number of dosage units of all controlled substances distributed and dispensed by him during that calendar year.”

21 U.S.C. 581

In section 581 of the FDCA, the term “distribute or distribution” is defined:

§581 Definitions.

In this subchapter:

...

(5) Distribute or distribution.--The term `distribute' or `distribution' means the sale, purchase, trade, delivery, handling, storage, or receipt of a product, and does not include the dispensing of a product pursuant to a prescription executed in accordance with section 503(b)(1) or the dispensing of a product approved under section 512(b).

State Law Definitions:

Indiana:

IC 25-26-13-2

Definitions

Sec. 2. As used in this chapter:

...

"Dispensing" means issuing one (1) or more doses of a drug in a suitable container with appropriate labeling for subsequent administration to or use by a patient.

IC 25-26-14-4.7

"Distribute" defined

Sec. 4.7. As used in this chapter, "distribute" means to sell, offer to sell, deliver, offer to deliver, broker, give away, or transfer a legend drug, whether by passage of title or physical movement, or both. The term does not include the following:

(1) Dispensing or administering a legend drug.

(2) Delivering or offering to deliver a legend drug by a common carrier in the usual course of business as a common carrier.

(3) The provision of a legend drug sample to a patient by a:

(A) practitioner;

(B) health care professional acting at the direction and under the supervision of a practitioner; or

(C) hospital's or other health care entity's pharmacy that received the drug sample in accordance with this chapter and other applicable law to administer or dispense and that is acting at the direction of a practitioner; licensed to prescribe the legend drug,

Wisconsin:

Statute 450.01

(7) "Dispense" means to deliver a prescribed drug or device to an ultimate user or research subject by or pursuant to the prescription order of a practitioner, including the compounding, packaging or labeling necessary to prepare the prescribed drug or device for delivery.

(8) "Distribute" means to deliver, other than by administering or dispensing.

The Congress has been clear that its intent on this issue is for these terms to be treated as the separate and distinct activities that they are and has expressed that intent in the reports accompanying the final versions of

the FDA's appropriations legislation for FY2016 and 2017, as well as the House Report for the 2018 bill. Below is the language in each of those House reports.

Omnibus Appropriations Act: House Report 114-205, FY 2016:

The Committee is very concerned with the draft MOU that the FDA has proposed under Section 503A of the FDCA. The proposed MOU would complicate patient and prescriber access to compounded medications, and may have a deleterious effect on small pharmacies. Under the draft MOU, the FDA attempts to describe "distribution" as occurring when "a compounded human drug product has left the facility in which the drug was compounded." In the DQSA, Congress only allowed the FDA to regulate "distribution." But the MOU appears to exceed the authority granted in the statute by redefining "distribution" in a manner that includes dispensing—something unprecedented. This overreach could generate exactly the kind of costly and confusing litigation that Congress intended to avoid when it amended and rein- stated Section 503A. The Committee expects that, when a final MOU is proposed as a model agreement for the states to consider, that distribution and dispensing are treated as the different and separate activities that they actually are.

Omnibus Appropriations Act: House Report 114-531, FY 2017:

The agreement remains concerned with the draft MOU that the FDA proposed under Section 503A of the FDCA. Section 503A distinguishes between "distribution" and "dispensing" for the purposes of the MOU. In the DQSA, Congress only allowed the FDA to regulate "distribution." The MOU appears to exceed the authority granted in the statute by redefining "distribution" in a manner that includes dispensing. Congress did not intend to include dispensing of compounded drugs over state lines within the scope of the MOU. The MOU should not address dispensing of compounded drugs to a patient over state lines if all other requirements of 503A are met.

The Committee is also very concerned with the draft MOU issued February 13, 2015, entitled “Draft Memorandum of Understanding Addressing Certain Distributions of Compounded Human Drug Products Between the State of () and the Food and Drug Administration” as it applied to Section 503A of the FDCA. The proposed MOU would complicate patient and prescriber access to compounded medications, and may have a deleterious effect on small pharmacies. Under the draft MOU, the FDA attempts to describe “distribution” as occurring when “a compounded human drug product has left the facility in which the drug was compounded.” In the DQSA, Congress only allowed the FDA to regulate “distribution.” But the MOU appears to exceed the authority granted in the statute by redefining “distribution” in a manner that includes dispensing—something unprecedented. This overreach could generate exactly the kind of costly and confusing litigation that Congress intended to avoid when it amended and reinstated Section 503A. The Committee expects that, when a final MOU is proposed as a model agreement for the states to consider, that distribution and dispensing are treated as the different and separate activities that they actually are. (pages 67-68)

We were encouraged to read in FDA’s “2018 Compounding Policy Priorities Plan” issued Friday, January 19th that the agency, in the coming months, intends to pull down the current draft sample MOU and issue a “significantly revised draft MOU” that is intended to “address many of the concerns (they) have heard” in the thousands of public comments on the current draft sample MOU. The plan states the FDA’s intention to raise the current MOU’s 30% cap on the distribution of inordinate quantities of compounded medications interstate to 50% and indicates the new cap will trigger enhanced reporting requirements and FDCA violations that would lead to pharmacies being regulated like drug manufacturers. The new draft sample MOU will also purportedly relax some of the requirements on the states that sign the MOU. While we are pleased that the FDA has acknowledged the serious deficiencies in the current MOU that we and other stakeholders have been pointing out since its release, IACP will wait to see the actual language of the new draft sample MOU before

commenting in detail. However, we do have strong concerns that as described in the plan, the new draft sample MOU would still apply to interstate patient specific dispensing in violation of the plain language and congressional intent behind the FDCA, and pharmacists in states that do not sign the MOU would still be subject to a true 5% cap on these prescriptions that could lead to pharmacies that go over that arbitrary cap being regulated by the FDA like drug manufacturers.⁵

We join other stakeholders and the Congress in asking that FDA rescind the GFI and issue a proposed rule and final MOU that treats the distribution and dispensing of compounded medications as the distinct activities they actually are in medical and pharmacy practice and under the plain language of the statute.

Inspection Standards for 503A Pharmacies:

IACP would also like to raise the issue of FDA inspecting 503A compounding pharmacies under cGMP standards rather than under USP or other applicable pharmacy inspection standards adopted by state law or regulation. Often, FDA will cite a pharmacy for not obtaining patient-specific prescriptions before compounded medications leave a pharmacy and assert that the pharmacy has therefore lost its exemptions from cGMP standards, even when inspecting pharmacies in states where office-use compounding is specifically authorized by state law and/or regulation. FDA also routinely attempts to deny compounding pharmacies the records exemptions provide in 21 USC 374 (a)(2)(A) without citing any statutory authority to do so.

IACP believes that when inspecting state-licensed 503A pharmacies, the agency should work with state boards of pharmacy and use inspectors trained in USP or other applicable state pharmacy inspection standards. We believe that the FDA should cease using the agency's misinterpretation and misapplication of the prescription requirement under 503A as a pretext to conduct pharmacy inspections under manufacturer standards. As the Congress has attempted to remind the agency on multiple occasions, compounding pharmacies are not drug manufacturers, and should not be inspected under cGMP standards absent a clear showing of violations of 503A of the FDCA. This congressional intent was clearly expressed to the agency in the following House report language from the 2017 Omnibus Appropriations Act.

Omnibus Appropriations Act: House Report 114-531, FY 2017:

The Committee understands that the FDA is interpreting provisions of Section 503A of the FDCA to inspect state-licensed compounding pharmacies under current Good Manufacturing Practices (cGMPs) instead of under the standards contained in the United States Pharmacopeial Convention (USP) for sterile and non-sterile pharmaceutical compounding or other applicable pharmacy inspection standards adopted by state law or regulation. The Committee reminds the FDA that compounding pharmacies are not drug manufacturers, but rather, are state licensed and regulated health care providers that are inspected by state boards of pharmacy pursuant to state laws and regulations that establish sterility and other standards for the pharmacies operating within their states. Compounding pharmacies are more appropriately inspected using USP standards or other pharmacy inspection standards adopted by state law or regulation in the state in which a pharmacy is licensed. (p. 69)

Compounding with Dietary Supplements:

Section 503A of the FDCA authorizes drug compounding by pharmacists and physicians using components of FDA approved drugs, or that appear on a positive list to be established by the FDA. In a June 2016 guidance for industry document on their interim policy on bulk ingredients, and later in the Final GFI on the Prescription Requirement Under 503A issued in December of 2016, FDA formally took the position that only a **drug substance monograph** met this requirement, without citing any statutory authority or legislative intent to back up this interpretation. The FDA's interpretation would eliminate compounding using dietary supplements, including those with USP dietary supplement monographs. This interpretation is inconsistent with the common

meaning attached to the term “monograph” and will limit patient access to compounded preparations using ingredients with a dietary supplement monograph. This interpretation of the law by FDA will mean that patients will have to rely on over the counter dietary supplements rather than allowing the prescribing physician and compounding pharmacist to work together to determine appropriate dosage levels and other medical considerations when dietary supplements are part of the recommended course of treatment. Again, this was done not through formal rulemaking but through a GFI. FDA should rescind the GFI and issue a proposed rule, or alternatively, the statute should be amended to clarify that either a drug substance or a dietary supplement monograph meets the statutory requirement as an ingredient that may be compounded under Section 503A of the FDCA.

Pharmacy Compounding Advisory Committee (PCAC):

The PCAC was originally created in 1997 under the Food & Drug Administration Modernization Act of 1997 (FDAMA); however, due to judicial rulings that held portions of §503A invalid, PCAC was dissolved. The PCAC Charter was re-established in 2012, and referenced in the Drug Quality and Security Act (DQSA) in 2013. PCAC held its first meeting in 2014. The committee is comprised of 14 members - 12 voting and two non-voting - who provide advice on scientific, technical and medical issues concerning drug compounding under sections 503A and 503B of the Federal Food, Drug, and Cosmetic Act. Members and the Chair are selected by the Commissioner or designee from among authorities knowledgeable in the fields of pharmaceutical compounding, pharmaceutical manufacturing, pharmacy, medicine, and related specialties. The statute requires that members will include representatives from the National Association of Boards of Pharmacy (NABP), the United States Pharmacopeia (USP), *pharmacists with current experience and expertise in compounding*, physicians with background and knowledge in compounding, and patient and public health advocacy organizations.

IACP is concerned that although we and other organizations have nominated multiple pharmacists with compounding experience and expertise, none of them have been selected to serve as voting members of the PCAC. There is currently one non-voting member who is a practicing compounding pharmacist. The nominees

are often informed by the FDA that their financial interest in a compounding pharmacy creates a conflict of interest that precludes their service on the PCAC.

By contrast, The Pew Charitable Trusts (Pew), a huge charitable entity with a significant lobbying/advocacy component has an employee who serves as a voting member of PCAC, including making recommendations to FDA on ingredients and medications that can be used in human compounding. These decisions can have a significant effect on competition and the profitability of large pharmaceutical companies that see compounded medications as competition to their commercially available drugs. As a result, recommendations by PCAC can affect the products of drug companies that have billions of dollars at stake for their high priced and market protected medications. It is often these pharmaceutical companies or those associated with them make nominations of ingredients to the PCAC's "difficult to compound" list and oppose nominations to the positive list of bulk ingredients that can be used in pharmacy compounding under 503A of the FDCA.

In addition to the financial conflicts arising from Pew's joint activities with the pharmaceutical industry, Pew has advocated for restrictions on the access of compounded medications that would be difficult - if not impossible - for their employee to ignore. These restrictions benefit the very pharmaceutical companies whose interest Pew lobbies for in jointly signed documents and efforts, and creates a conflict of interest that should preclude their participation in the PCAC. IACP recommends that PEW be removed from the PCAC and replaced with a voting member with experience and expertise in pharmacy compounding.

Guidance For Industry vs. Rulemaking:

IACP and other organizations have expressed concern with the FDA's policy of using Guidance For Industry (GFI) documents to implement and enforce the DQSA, rather than going through notice and comment rulemaking pursuant to the *Administrative Procedures Act*. As has been noted throughout this testimony, IACP has serious concerns that many of the policies that FDA has finalized and is enforcing through GFI do not adhere to the statutory language of the FDCA as amended by the DQSA, nor to its clear congressional intent. IACP believes the FDA should rescind the GFI that have been developed pursuant to the DQSA to date, and

issue proposed rules to be published in the *Federal Register*, seek and incorporate stakeholder input, and then finalize those rules consistent with the underlying statute. Unlike GFI, which do not have the weight of law and are merely FDA's current interpretation of the law, final agency rules are subject to judicial review and must adhere strictly to the laws they are based on. Given the serious consequences on patient safety and access, as well as the economic and regulatory burden the FDA's policies are having, it is appropriate that their policies be developed through the rulemaking process.

Conclusion:

Again, we thank you for holding this important hearing, and for seeking ICAP's input on the many issues surrounding FDA's implementation and enforcement of the DQSA. We strongly support HR2871 as a much-needed clarification and strengthening of the DQSA, and again urge the Congress to pass the bill this year. We stand ready to work with you to establish laws and regulation that protect patient safety, including access to critical compounded medications.

Citations

¹(2017, May). Congressional Support Letter [Letter to Commissioner Gottlieb]. Washington, D.C.

²Representative Griffith (VA), Representative Burgess (TX), and Representative Green (TX). “Drug Quality and Security Act.” Congressional Record p.H5963. Available from: Thomas.gov.

³Representative Griffith (VA). “Preserving Patient Access to Compounded Medications Act of 2017.” Congressional Record p.H2871. Available from: Thomas.gov.

⁴United States. Department of Health and Human Services. Food and Drug Administration. Prescription Requirement Under Section 503A of the Federal Food, Drug, and Cosmetic Act. Final Guidance. Washington, DC: n.p. December 2016. Print.

⁵United States. Department of Health and Human Services. Food and Drug Administration. Draft Memorandum of Understanding Addressing Certain Distributions of Compounded Human Drug Products between the State of [insert State] and the U.S. Food and Drug Administration. Washington, DC: n.p. February 2015. Print.

Accompanying Materials (Attached)

See attached for state office-use laws and chart.

See attached for office-use drug chart.