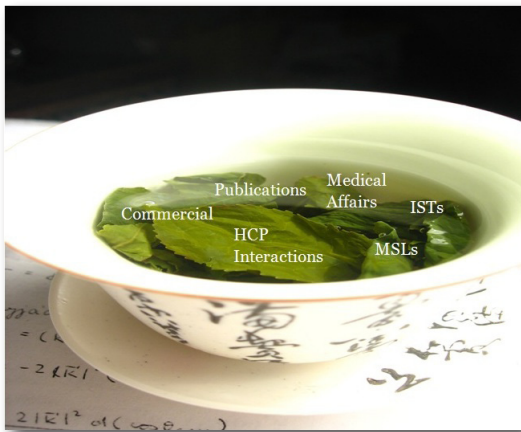


Letter From The Editor: CIAs Serve As Intelligible “Tea Leaves” As the Government’s Focus on Commercial-Related Activities Continues to Lead to Medical Affairs Activity Scrutiny

by Jamie L. Ghen, Esq., Director of Compliance, Ethics & Legal Affairs, and Kerri McCutchin, Healthcare Compliance Associate



Who would have thought that the Corporate Integrity Agreements (CIAs) executed over the past several years related to commercial activities should be construed as putting the pharmaceutical industry on notice that the government would soon shift its focus to include medical and scientific affairs activities. As the rise of recent off-label investigations and subsequent CIAs continue to become public, it is clear that the industry does not have to try to read the “tea leaves” because the terms of the CIAs clearly indicate that the government will continue to scrutinize medical affairs departmental activities.

For those of you unaware, a CIA is an agreement made between a company and the OIG as a settlement due to a variety of civil false claims statutes violations. These violations usually include allegations that a company submitted false claims to government agencies such as Medicare and Medicaid. Once executed, a CIA typically lasts between three and five years. The OIG agrees that the company will not be excluded from

participating in Medicare, Medicaid and other Federal health programs while each company agrees to be bound to extensive compliance and reporting requirements. By imposing various compliance criteria that must be met by a pharmaceutical manufacturer, a CIA aims to ensure that claims submitted to Medicare, Medicaid and other Federal health care programs agencies by the manufacturer are complete and accurate.[1]

Although CIAs have commonalities, each is tailored to address company-specific conduct that is in question. [2]

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Over the past ten years, pharmaceutical CIAs have typically focused upon commercial-related activities such as off-label promotion. However, if recent CIAs are any indication of where the OIG is now rearing its ugly head, investigations into activities associated with medical and scientific affairs departments will continue and most likely increase. These departments are critical components as research, clinical development, external scientific communications, medical communications, scientific publications and many other areas are pertinent to the development of scientific medicine and the overall growth of a pharmaceutical company. Indeed, medical affairs departments aim to increase a company's scientific reputation which includes on-going communications with Healthcare Professionals (HCPs) to increase the value and appropriate use of a company's product.[3] However, it is no secret that commercial activities and medical affairs activities sometimes overlap. This activity overlap was first discussed in the seminal case *U.S. ex rel. Franklin v. Parke-Davis*.[4]

In 2003, Parke-Davis, a division of Warner Lambert Company and Pfizer Inc., was accused of promoting the drug Neurontin for uses not approved by the Food and Drug Administration (FDA) resulting in federal reimbursement payments for Neurontin prescriptions that were ineligible under Medicaid.[5] Investigation into the allegations suggested that Neurontin was aggressively marketed for unapproved uses such as bipolar disorder, several pain disorders, Amyotrophic Lateral Sclerosis (ALS), attention deficit disorder, migraines, drug and alcohol withdrawal seizures, restless leg syndrome, and epilepsy. Moreover, evidence also suggested that various aggressive marketing methods were used to illegally promote Neurontin. Notably, many of the allegations in this case related to Warner-Lambert and its "Medical Liaisons"[6] (also known as "medical science liaisons" or "MSLs") who were allegedly promoting Neurontin for off label uses. The Medical Liaisons allegedly presented themselves to HCPs as scientific experts, when in fact they were not. An investigation into these allegations began when Dr. David Franklin, an MSL, filed a lawsuit against Warner Lambert on behalf of the government. Warner Lambert ultimately pled guilty and agreed to pay more than \$430 million in addition to executing a CIA with the OIG.[7]

Fast forward to September 2010 where Novartis pled guilty to accusations that in 2000 and 2001 the company marketed Trileptal for unapproved uses such as neuropathic pain and

bipolar disorder. Novartis agreed to pay \$422.5 million and executed a CIA with the OIG.[8] Novartis' CIA, among other things, narrowly targeted several areas of Novartis' medical and scientific affairs department. Indeed, Novartis was required to agree to develop (to the extent that none existed) and implement written policies and procedures related to:

- Materials and Information that may be distributed by Medical Information Communication (MIC) and the mechanisms through, and manner in which, MIC receives and responds to requests for information from an HCP or a managed markets customer about off-label uses; the form and content of information disseminated in response to such requests; and the internal review process for the information disseminated;
- The inclusion of a requirement that MIC develop a database(s) ("Inquiries Database") to track all requests for information about Novartis' products to MIC. The Inquiries Database shall include the following items of information for each unique inquiry received about products: (a) Date of Inquiry; (b) Form of inquiry (i.e. fax, phone); (c) Name of the requesting HCP, management markets customer, or healthcare institution in accordance with applicable privacy laws; (d) Nature and topic of request (including exact language of the inquiry if made in writing); (e) Nature/form of the response from Novartis (Including a record of the materials provided to the HCP or HCI in response to the request); and (f) Name of the representative who called on or interacted with the HCP, customer, etc. if known;
- Manner and circumstances under which medical personnel from Medical Affairs interact with or participate in meetings or events with HCPs (alone or with sales representatives or account executives) and the role of the medical personnel at such meetings or events, as well as how they handle responses to unsolicited requests about off label indications of products;
- Consultant or other fee-for-service arrangements

entered into with HCPs (Including but not limited to speaker programs, speaker training programs, presentations, consultant task force meetings, advisory boards, and ad hoc advisory activities, and any other financial engagement or arrangement with an HCP) and all events and expenses relating to such engagements or arrangements. These policies and procedures shall be designed to ensure that the arrangements and related events are used for legitimate and lawful purposes in accordance with applicable Federal health care program and FDA requirements. The policies and procedures shall include requirements about the content and circumstances of such arrangements and events;

- Review of promotional materials and information intended to be disseminated outside Novartis by appropriate quality personnel (i.e. regulatory, medical, legal) in a manner designed to ensure that legal, regulatory and medical concerns are properly addressed during Novartis' review and approval process are evaluated when appropriate. The policies and procedures should ensure that such materials and information comply with all Federal health care program and FDA requirements. Policies and procedures should require that: (a) Applicable review committees review all promotional materials prior to the distribution or use of such materials; and (b) Deviations from the standard review committee practices and protocols shall be documented and referred for appropriate follow up;
- Sponsorship of post-marketing research and investigator sponsored trials (ISTs) including the decision to provide financial or other support for ISTs; the manner in which support is provided; and support for publication of information about the ISTs, including the publication of information about the trial outcomes and results and the uses made of publications relating to ISTs; and
- Authorship of any articles or other publications about products or about therapeutic areas or disease states that may be treated with products, including, but not limited to, the disclosure of any and all relationships between the author and Novartis, the identification of all authors or contributors



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(including professional writers) associated with a given publication, and the scope and breadth of research results made available to each author or contributor;[9]

Further, the recent Pfizer CIA demonstrates the government's specific focus upon MSLs. MSLs act as field counterparts to office-based medical affairs staff. MSLs primarily address the scientific needs of HCPs by fostering truthful, non-misleading scientific communications. MSL interactions include responding to unsolicited inquiries that are medical and/or scientific in nature and facilitating scientific interactions with HCPs through the exchange of product and disease state information. Other roles of an MSL include but are not limited to speaking engagements regarding on-label uses of products and scientific data related to development projects, products and therapeutic areas.[10] However, MSL activities can overlap with commercial activities causing discussions with HCPs to be considered a risk area as a potential improper promotional forum. Because of this, one of the provisions in Pfizer's CIA specifically addresses MSL activities. Pfizer agreed to develop (to the extent that none existed already) and implement written policies and procedures related to:

Systems, processes, policies, and procedures relating to the manner and circumstances under which medical personnel (such as Medical Science Liaisons) participate in meetings or, events with HCPs or HCIs (either alone or with sales representatives or account executives) and the role of the medical personnel at such meetings or events, as well as how they handle responses to unsolicited requests about off-label indications of Pfizer's Government Reimbursed Products.[11]

Still further, at least three pharmaceutical manufacturers have agreements with the OIG that address Investigator Sponsored Trials (ISTs): AstraZeneca, Novartis and Allergan. All three company CIA's use nearly the exact same language throughout the IST section, changing only the name of the company and the amount of days each company is given to complete their contractual obligations. Each CIA states in pertinent part that HCPs who are engaged by pharmaceutical companies to perform ISTs or other research should be referred to as "Researchers." [12] Manufacturers are required to "enter written agreements describing the scope of the clinical research or other work

to be performed, the fees to be paid, and compliance obligations for the Researchers." [13] Each CIA requires Researchers be paid according to a centrally managed, pre-set rate structure that is determined based on a fair-market value analysis conducted by the pharmaceutical company. The CIAs also require:

Each company to establish annual budget procedures that identify the scientific or business need for the Researchers, how many will be required and what types of activities they will be doing and how much will be spent on those activities. Compliance personnel should be involved in reviewing the budget for researchers to ensure they are being used for legitimate means.[14]

Each CIA also requires a "needs assessment" to be completed prior to obtaining Researchers. Indeed, the AstraZeneca CIA states in pertinent part:

The needs assessment shall identify the business or scientific need for the information to be provided by the Researcher and provide specific details about the research arrangement (including, for example, information about the numbers and qualifications of the HCPs or HCIs to be engaged, a description of the proposed research to be done (including the research protocol) and type of work product to be generated). Any deviations from the Researcher budgeting plans shall be documented in the needs assessment form (or elsewhere, as appropriate) and shall be subject to review and approval by AstraZeneca U.S. compliance personnel.[15]

An establishment of a Research Monitoring Program which conducts audits on at least 30 Research Arrangements with HCPs (at least 20 of which must be ISTs) is also required. Results of such audits are required to be reported to the U.S. Compliance department who may follow up if the Program finds that there are arrangements inconsistent with the policies and procedures set forth in the CIA.[16] AstraZeneca's CIA also provides provisions related to ISTs which is similar to similar sections in the company CIAs which establish monitoring programs and reporting structures for others business divisions within each company. For example, all of the CIAs require the establishment of a field force monitoring program to

monitor and evaluate sales representative interactions with HCPs.[17]

Recent trends within the industry provide for a period of unprecedented change. The increase in high profile government investigations leaves little room for mistakes within the commercial and medical and scientific affairs arenas, as well as within the pharmaceutical industry in general. As CIA provisions serve as “tea leaves,” all companies within the industry are on notice that proper proactive compliance initiatives across all business units are essential.

Resources:

- [1] <http://oig.hhs.gov/fraud/cias.asp>
 [2] Id.
 [3] <http://www.best-in-class.com/bestp/domrep.nsf/pages/EEA6BDD9096ACC6385256E7D006A865A>
 [4] 147 F. Supp.2d 39 (D. Mass. 2001)
 [5] http://ma.findacase.com/research/wfrmDocViewer.aspx/xq/fac.%5CDCT%5CDMA%5C2003%5C20030822_0000266.DMA.htm/qx
 [6] http://www.justice.gov/opa/pr/2004/May/04_civ_322.htm
 [7] Id.
 [8] <http://www.businessweek.com/news/2010-09-30/novartis-to-pay-422-5-million-to-end-trileptal-probes.html>
 [9] http://oig.hhs.gov/fraud/cia/agreements/Novartis_Pharmaceuticals_Corporation_09292010.pdf
 [10] <https://secure.web.emory.edu/biomed/.../MSL%20role%2004-2009.ppt>
 [11] http://oig.hhs.gov/fraud/cia/agreements/pfizer_inc_08312009.pdf
 [12] http://oig.hhs.gov/fraud/cia/agreements/astrazeneca_04272010.pdf
 [13] Id.
 [14] See *Corporate Integrity Agreement between the Office of the Inspector General of the Department of Health and Human Services and AstraZeneca Pharmaceuticals LP and AstraZeneca LP, (AstraZeneca), April 2010* http://www.justice.gov/usao/pae/News/Pr/2010/apr/astrazeneca_cia.pdf (last visited January 12, 2011); See Also *Corporate Integrity Agreement between the Office of the Inspector General of the Department of Health and Human Services and Novartis Pharmaceutical Corporation, (Novartis), September 2010*, http://www.justice.gov/usao/pae/News/Pr/2010/Sept/novartis_cia.pdf (last visited January 12, 2011); See Also *Corporate Integrity Agreement between the Office of the Inspector General of the Department of Health and Human Services and Allergan Inc., (Allergan), September 2010*, http://oig.hhs.gov/fraud/cia/agreements/Allerga_Executed_CIA_with_Appendices.pdf (last visited January 12, 2011).
 [15] Id.
 [16] Id.
 [17] http://oig.hhs.gov/fraud/cia/agreements/astrazeneca_04272010.pdf



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Obama Takes a Look at PHS Pricing

by Chris Cobourn, Vice President of Regulatory Affairs

Published January 12, 2011 to PharmaComplianceBlog.com

An article in the New York Times yesterday shed an interesting light on the Public Health Service (PHS) Program,

“...The Obama administration, following a lengthy internal debate, has unexpectedly come down on the side of pharmaceutical companies that are accused of overcharging public hospitals and clinics that care for large numbers of poor people.”

“The administration has told the Supreme Court that the hospitals and clinics cannot sue drug companies to enforce their right to deep discounts on drugs or to obtain reimbursement from companies that overcharge.” [1]

Knowing what I know about the way that PHS pricing works, I think that this is fair and reasonable, although the politics and court actions behind it all probably have little to do with what we all know about the complexities of compliance with the program. What those of us who work in the industry know, that in most cases, where there may be an “overcharging” of PHS entities, it is related to mistakes, corrections, or restatements of Medicaid Pricing. Manufacturers struggle with the complexities of government programs (GP), but I think it is fair to say that most are doing their best to get it right. I have personally never seen a case where a company was intentionally overcharging PHS entities.

The public does not usually get much exposure to the true inner workings of GP, such as Medicaid, Veterans Affairs and PHS. Even within the industry itself, there is very little understanding of how the programs actually work, given the significant requirements for pharmaceutical manufacturers who report statutory pricing calculations to the government under those programs. Those of us who work directly in the space know the complexities of the programs. The PHS price itself is a pretty simple calculation, using Medicaid Average Manufacturer Price (AMP) minus the Medicaid Unit Rebate Amount (URA). Therefore, the complexity of PHS pricing comes in the complexity of calculating AMP. This becomes more complex and challenging as Medicaid AMP changed in October under the Patient Protection and Affordable Care Act (PPACA), and we are currently in a “sub-regulatory environment,” lacking substantive and

consistent regulations to implement the new definitions in the PPACA (<http://www.pharmacomplianceblog.com/blog/?p=2812>)

Having worked with manufacturers for years, what I have consistently seen is that the people who work in GP are trying their best to understand the complex requirements and ensure that they are calculating accurately. However, there can be occasional data related errors, or restatements due to things like Best Price “True-Ups” (Best Price is reported quarterly, but must be reported before all rebate payments are invoiced and processed, so manufacturers often have to estimate Best Price and true it up at a later date). Given that, CMS allows manufacturers to update their Medicaid Pricing for a period of three (3) years in their DDR system without any prior approval. When mistakes are identified and corrected, or when there are BP true-ups that create a change to the reported AMP and URA, the manufacture makes the update and must also identify whether the new resulting PHS price is lower than the previously reported price. If this is the case, the standard practice is that they correct the pricing differential with individual entities to make them whole. (There is currently insufficient guidance, which would require this, but it is generally understood that the Office of Pharmacy Affairs expects manufacturers to do this). This is often done at a significant cost and burden to the manufacturer, as they have to work directly with each individual entity to make them whole.

Articles in the press can portray pharmaceutical manufactures in a negative light, suggesting at times that companies may be purposefully trying to overcharge entities or the government. There may be cases where this has happened; I just don't think it is the norm. On the contrary, from my professional experience working with GP professionals for many years, the intent is to understand the requirements and get it right. Therefore, I think that in cases where there may be “overcharging” of entities, that it is rare, and it would be critical to get the facts before assuming any intent. Chances are, the manufacturer can show what they calculated and how. This will all be a moot point when the Office of Pharmacy Affairs publishes regulations on formal dispute resolution between manufacturers and entities. That may take a while.

Resources:

[1] http://www.nytimes.com/2011/01/10/us/politics/10drug.html?_r=1&scp=4&sq=health%20reform&st=cse

Managed Care Claims Update

by Jessica Ebert, CIS Senior Associate

Published January 26, 2011 to PharmaComplianceBlog.com

Since there is still a lot of ambiguity and unanswered questions surrounding the expansion of Medicaid to managed care organizations (MCOs), we like to keep everyone informed as we receive updates on how states are planning to incorporate managed care into their fee for service (FFS) claims, as we've either heard from state representatives or our clients. Below is a quick update on Minnesota, California and New York regarding format, anticipated first billings, and whether or not we can expect retroactive invoices.

It was recently brought to our attention that a Minnesota-based HMO had communicated to manufacturers that Minnesota was not planning to add the Medicaid managed care claims to their FFS claims, but would still continue to have the Pharmacy Benefit Managers (PBMs) bill for the Medicaid managed care organization (MMCO) utilization. Since this is a little different from the MMCO claims that we have seen so far, we followed up with Drug Rebate Coordinators for Minnesota to find out what they were planning to do. We are able to confirm that Minnesota will be collecting claims data from the MCOs and the Department of Human Services will bill the manufacturers. There will be a separate invoice for managed care utilization, like many of the other programs that we've seen, but otherwise the process will be the same as it is now for FFS Medicaid. We should see the first billing for Minnesota managed care claims occurring in the late spring.

We've also received an update from California on how they are planning to incorporate their managed care invoices, and they're still in the process of figuring this out and determining how they will be submitted. California's Drug Rebate Branch said they are currently working internally on this initiative, along with the managed Medicaid health plans to develop a uniform data submission format, as well as how dispute resolution and other processes and procedures will be handled. They are putting a lot of thought into this and as a result, they won't be able to provide a specific timeline or format for when the managed care claims will be included with FFS invoices, but confirmed that they will likely NOT be sending any invoices that include managed Medicaid prior to 2Q2011. Any companies that have recommendations or preferences for consideration are welcomed to submit them to the State. We

will keep you updated as we receive additional information, but for now we most likely won't be seeing any managed Medicaid invoices from California until after 2Q2011.

New York has also given an update that their Drug Rebate Work Group is currently in the process of identifying MCO physician-administered drug utilization for invoicing drug rebates. They are hoping to begin invoicing for these drugs starting with 1Q2011. Although not yet clear on whether the MCO utilization will be included with the FFS claims or on a separate invoice, they have confirmed that they are planning to make the utilization retroactive back to the March 23, 2010.

We'll continue to keep you updated as we receive additional information on these programs, as well as others. If you have any questions, or are looking for information on a specific state or program, please feel free to reach out to us!



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The CIS commercial compliance experts speak at a variety of industry events and are often available to discuss current issues affecting government programs professionals. Be sure to stop by our booth to meet them!

The New Era of Sample Accountability has Arrived: Are You Prepared?

by Clarissa Crain, CIS Compliance Director

Published January 17, 2011 to PharmaComplianceBlog.com

On January 1, 2011 the first sample tracking period for Federal transparency requirements defined under section 6004 of the Patient Protection and Affordable Care Act (PPACA) began.[i] On the same day the amendments to Vermont's State Disclosure of Allowable Expenditures and Gifts by Manufacturers of Prescribed Products went into effect requiring tracking of drug sample disbursements within the state of Vermont.[ii] Both sample tracking periods close December 31, 2011 and will be reportable to the respective government agencies on April 1, 2012.

The requirements for tracking of disbursements at the Federal and Vermont levels vary in a few key areas including, but not limited to, the definition of a sample and the data to be compiled and reported for such samples. To add to the complexity of ensuring that your sample accountability program is, and will continue to be, compliant with Federal and Vermont requirements, guidance for implementation has come late in the game, if at all. Vermont delivered a holiday treat, issuing the "2011 Guide to Vermont's Law on Disclosure of Samples" on December 27, 2010, while the Federal government leaves manufacturers in suspense.[iii]

Ensuring that your company is appropriately prepared to maintain compliance with regulation, while also being prepared to adjust as necessary to other potential legislative changes or updates to guidance is a challenge. However, there are some key steps that all manufacturers should consider in assessing the company's preparedness. The mini assessment below details five major tasks manufacturers should have in place currently to ensure ongoing compliance and reporting preparedness.

Sample Accountability Mini Assessment

- All necessary data elements have been defined, identified, tracked, and captured for purposes of sample disbursement tracking reports
- Updates to internal policies, procedures, systems,

and training relevant to the new reporting requirements for sample tracking and reporting are complete

- Updates to vendor contracts are confirmed and the vendors ability to meet compliance and reporting requirements has been evaluated (as appropriate)
- Penalties related to non-compliance have been communicated, and are clearly understood throughout the organization
- An Auditing and Monitoring program has been developed to ensure ongoing data integrity and the accuracy of data and reports compiled for Vermont and the Federal government

Many may quickly review these assessment topics and consider their sample accountability programs equipped to meet 2011 sample tracking requirements, however it is the detail behind these major points of consideration that is where the potential risk lies for manufacturers. With sample tracking requirements defined differently by Vermont and Federal law, the assessment topics must be considered separately for each set of requirements. Using system setup as an example:

- Have systems been developed in such a way internally and/or at the vendor to allow for the capture of data required by Vermont law, but not required under Federal law?
- Will the systems allow for the report out of data specific to program requirements? For example:
 - Does the system allow for inclusion of coupon, voucher, and appropriate PAP disbursements in Vermont reports, while excluding these same disbursements from Federal reports?
 - Is data for Vermont stored in such a way that it allows for input/upload of necessary disbursement data to the soon to come Vermont Samples Access database (VT Attorney General is projecting release in March 2011)?
 - Does the system setup allow for the flexibility to respond to any Federal reporting guidance which may come from Health and Human Services prior to the first report of data on April 1, 2012?
 - Has appropriate testing been completed on systems and are ongoing data integrity

monitors in place to ensure that data is retained appropriately within systems?

These specific considerations represent only a drop in the flood of details that are challenging Compliance and Sample Accountability teams as they seek to gain assurance that with the arrival of the new era of accountability, their compliance is not compromised. When you add to the complexities of ensuring the completeness and accuracy of data reported, to the penalties associated with noncompliance, sample disbursement tracking should not be taken lightly. Furthered by the personal accountabilities created through the Vermont requirement for disclosure of the person responsible for sample compliance, and the existing Federal expectations for company management oversight of compliance, organizations must be equipped to proactively identify risks and ensure ongoing compliance.

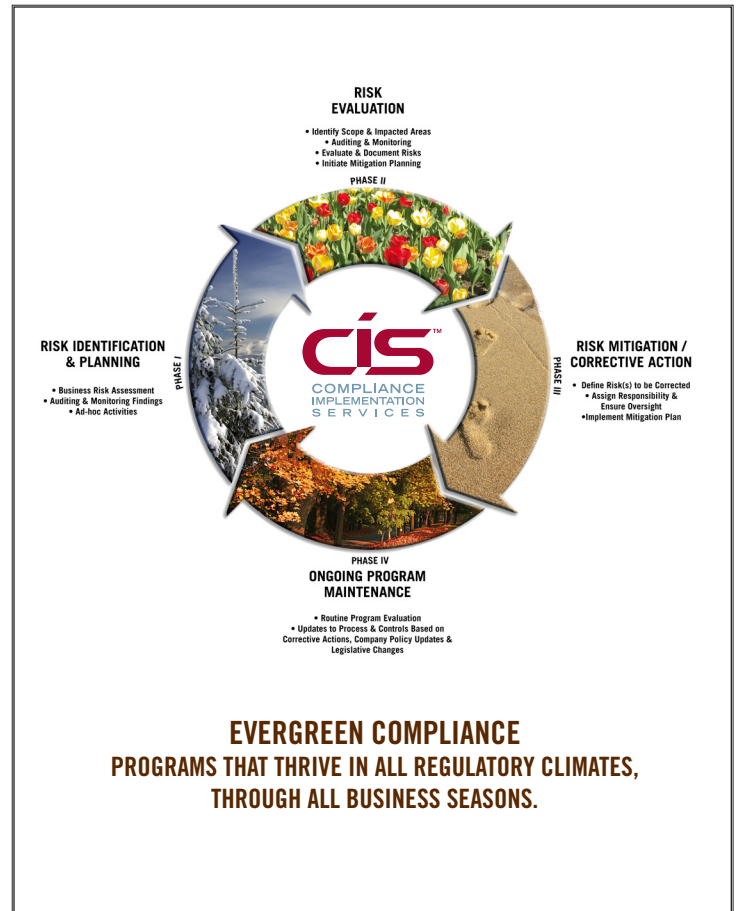
If assessing your Sample Accountability and Tracking program to ensure preparedness and compliance in the new era of sample accountability is of interest to you, please attend my presentation at the upcoming Pharmaceutical Compliance Congress. The presentation, “The New Era of Sample Accountability,” will explore the hidden risks for 2011 sample disbursement data capture in much more detail. Also, please look for CIS’ other subject matter experts in attendance at the event. If you are unable to attend the event, stay tuned to the blog for additional updates on sample disbursement.

Resources:

[i] <http://thomas.loc.gov/cgi-bin/query/F?c111:1:./temp/~c111C1pa6n:e1828080>:

[ii] Vt. Stat. Ann. tit. 18, § 4631a, Vt. Stat. Ann. tit. 18, § 4632

[iii] Vermont Guidance. <http://www.atg.state.vt.us/issues/pharmaceutical-manufacturer-payment-disclosure.php>



Is a Sample by Any Other Name Still a Sample? The State of Vermont Redefines “Sample”

by Judy Fox, CIS Commercial Compliance Director
Published January 19, 2011 to PharmaComplianceBlog.com

Excerpt from 2011 Guide to Vermont’s Law on Disclosure of Sample of Prescribed Products, published by the Vermont Office of the Attorney General – December 27, 2010.

“Effective January 1, 2011, Vermont law requires disclosure to the Attorney General, on an annual basis, of distribution of samples of prescribed products to Vermont health care providers. Under Vermont Law, “sample” includes starter packs, coupons, and vouchers that enable an individual to receive a prescribed product free of charge or at a discounted price. The disclosure must be made on or before April 1 for the previous calendar year.”¹

“Patient Assistance Programs: If prescribed product is sent to a health care provider for a patient, it must be reported as a sample. If the product is sent directly to a patient, it need not be reported. Thus, prescribed products distributed under a patient assistance program through an HCP (including a pharmacist) must be reported as a product sample, even if the HCP is acting only as a conduit for the patient and has no obligation under federal law to log the sample in or out of the HCP’s practice.”²

“The statutory definition of “sample” is: ‘a unit of a prescription drug, biological product, or medical device that is not intended to be sold and is intended to promote the sale of the drug product or device. The term includes starter packs and coupons or other vouchers that enable an individual to receive a prescribed product free of charge or at a discounted price.’ Samples distributed through clinical trials should not be included in the Samples Access database or Samples Disclosure Form [for reporting to the state], but will need to be reported with disclosures of allowable expenditures and permitted gifts.”³

If we dissect the language in the Guide, the challenges start to unravel. A manufacturer has to delegate someone to have responsibility for the reported data. Responsibility has to include confidence in the processes and systems used to capture the data in order to ensure that the integrity of the data are protected.

Just scratching the surface, some of the issues our clients are facing include:

1. The Code of Federal Regulations, Title 21, Part 203, Prescription Drug Marketing, defines a sample as: “...a unit of a prescription drug that is not intended to be sold and is intended to promote the sale of the drug.”⁴ With the Federal definition differing from Vermont’s definition, clients are assuming that meeting the requirements in Vermont will mean for one physician, different information will be captured and reported to the state and to the U.S. Department of Health and Human Services (HHS) under HR 3590 (The Patient Protection and Affordable Care Act).
 2. Many manufacturers capture data regarding coupon and voucher redemption, but capturing distribution to practitioners has not been a priority. With Vermont requiring detailed reporting of disbursements of not only the coupons and vouchers, but of the specific benefits to the recipient as part of the reporting, new processes had to be implemented in a very short period of time. Part of the process should include reconciling the distribution of coupons and vouchers as a means to ensure accuracy of the data reported.
- The concern over members of the sales force being burdened with additional administrative tasks in tracking the coupons and vouchers and additional accountability for the manufacturer, has resulted in the realignment of territories and the elimination of targeting Vermont practitioners all together.
3. Drugs distributed under Patient Assistance Programs (PAPs) offer their own set of logistical concerns:

- a. PAPs are often managed through a third party vendor and it is rarely the same vendor as the vendors used in PDMA compliance and sample accountability. The reporting processes and business rules for the management of these programs has to be reviewed and possibly revised to ensure data integrity. This can prove to be quite challenging when the requirements are not within a vendor's normal business processes and not part of their core competencies.
 - b. Patient information is part of the PAP approval process so the processes around gathering and reporting the distribution data for these products has to be compliant to the Health Insurance Portability and Accountability Act (HIPAA).
 - c. Given that drugs distributed through PAP programs are often full therapy and not samples, there has to be due diligence in ensuring that the data allows products distributed under a PAP to be easily distinguished from true samples.
4. The forms used for reporting data are simplified and will not likely pose a challenge for manufacturers with minimal products and voucher programs to report.⁵ Manufacturers with multiple products and programs may find the simplicity of the forms proving to be a compliance challenge. I took a very unsophisticated survey of current clients and those with a limited portfolio of products have ceased activities in Vermont, while those with multiple programs and products are active in the state. Vermont's attempt to simplify things may actually cause confusion with the data collected as various companies interpret the process differently.

I am still struggling with the Vermont definition of "samples," but by including the coupons, vouchers, starter doses and PAP distributions in the definition, the original intent of reporting seems to be getting diluted through the guidance. In the report of the Vermont Attorney General on the Advisability of Requiring Disclosure of Free Samples Distributed by Manufacturers of Prescribed Products to

Vermont Health Care Providers, dated January 15, 2010, it states: "Many samples are provided to patients with insurance coverage and to physicians and their families, groups that do not have impaired access to medications. In such situations, the convenience of samples is outweighed by their potential to undermine evidence-based, cost-effective prescribing. For patients with chronic illnesses who lack the ability to pay for medications, a sample should be a stopgap that is accompanied by referral of the patient to a public or pharmaceutical company assistance program that can provide continuity of treatment. If physicians decide to accept drug samples, they should be given to patients who lack financial access to medications in situations in which appropriate generic alternatives are not available and the medication can be continued at little or no cost to the patient for as long as the patient needs it..."

While prescribing habits can be influenced by the availability of samples, not all therapeutic choices are available through PAPs. Prescribers may be limited in the choices under PAPs and as I mentioned in a recent article, (SNHPA is Striving to Improve IPAPs) hospitals are already struggling to meet the requirements of Institutional Prescription Assistance Program (IPAP) audits. With yet another layer of due diligence, it is any wonder if patients will be able to get the help that they need.

If the original intent of the state of Vermont's decision to collect data on sample disbursements was to ensure that the distribution of samples did not outweigh more cost effective prescribing, a true analysis of sampling against prescribing habits will not be possible with the data that are being collected.⁶

Resources:

- 1, 2, 3. <http://www.atg.state.vt.us/assets/files/2011%20Guide%20to%20Vermonts%20Law%20on%20Disclosure%20of%20Samples.pdf>
4. <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?fr=203.3>, Code of Federal Regulations, Title 21, Part 203 §203.3 Definitions (i) Drug Sample
5. <http://www.atg.state.vt.us/assets/files/FY11%20Samples%20Form.pdf>
6. <http://www.atg.state.vt.us/assets/files/Free%20Samples%20Report.pdf>

Informed Consent — More than Just a Form

by Beth Kline, CIS Project Manager

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In early January, the FDA announced that they have adopted final amended informed consent regulations. In all of the efforts that the FDA is making to increase transparencies and awareness around clinical trial conduct, this is one more way that the public will have information available at their fingertips.

For informed consent documents initiated on or after March 7, 2012 (the FDA is allowing a one year grace period from the effective date of March 7, 2011) the following statement must appear: “A description of this clinical trial will be available on <http://www.ClinicalTrials.gov>, as required by U.S. Law. This website will not include information that can identify you. At most, the website will include a summary of the results. You can search this website at anytime.” This rule affects both drug trials as well as medical device trials.

So, what is informed consent and why is it so important? Informed consent is the process of understanding the risks and benefits of treatment. It is important because every individual has the right to make decisions about his or her own health and medical conditions. Informed consent is especially important when considering participation in a clinical trial.

The purpose of informed consent in this setting is to allow a person to learn enough about the trial to decide whether or not to participate. Informed consent for a clinical trial should answer the following questions:

- Why is this clinical trial being conducted?
- What are the researchers hoping to accomplish?
- What exactly will occur during the clinical trial?
- How long is a patient/subject expected to participate?
- What are the risks from participation in the trial?
- What are the benefits from participating in the trial?
- Who will see the patient/subject data collected during the trial?

- What other treatments are available?
- What happens if a patient/subject leaves the trial at any time?
- What standard of care will be provided if a patient/subject chooses to withdraw from the trial?

These questions serve to inform each person about all of the positives and negatives involved in being a part of a clinical trial. Of course, potential participants must have the ability to make the decision to participate for themselves (except for pediatric clinical trials, where the parents are deferred to for consent); they must comprehend all of the information contained in the informed consent (and have the opportunity to ask questions of knowledgeable site staff); and they must grant consent voluntarily, without feeling forced or even threatened.

Although an informed consent document must be signed before participation in a clinical trial can begin, it is important to remember that informed consent is a process that continues throughout the trial. A subject or patient may ask questions of the investigator or site staff at any time before, during, or after the trial. This is also an element of transparency that must be adhered to for the benefit of the patients/subjects who choose to participate in a clinical trial.

Resources:

<http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?fr=50.25>

<http://edocket.access.gpo.gov/2011/pdf/2010-33193.pdf>

FDA Introduces New Websites

by Erica Brooks, Senior Compliance Manager

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In June 2009, Food and Drug Administration (FDA) Commissioner Dr. Margaret Hamburg launched FDA's Transparency Initiative and formed an internal task force to develop recommendations for making useful and understandable information about FDA activities and decision-making more readily available to the public. The goal was to provide this information in a timely manner and in a user-friendly format.¹ The task force developed a three phase approach to implementing the initiative:

- * Phase I: FDA Basics
- * Phase II: Public Disclosure
- * Phase III: Transparency to Regulated Industry

In January of 2010, the FDA launched a new website called FDA Basics. The agency goal is to provide the public with knowledge of the FDA and how the agency works. The site can be accessed from the www.fda.gov homepage. This resource now includes (1) questions and answers about FDA and the products that the Agency regulates, (2) short videos that explain various Agency activities, and (3) conversations with Agency officials about the work of their offices. The site also includes webinars and each month the agency sponsors a topic where the public can participate by asking questions.

In January of 2011, the FDA launched a second website, FDA Basics for Industry. The site serves as information for freshman drug manufactures, oversees companies, and those who need information on the FDA practices. The site includes messages from key FDA staff as well as frequently asked questions. The site is a source for guidance documents, educational resources, databases, and regulatory processes. The site is designed to offer information to the consumer.

Both websites support the FDA's initiative to be more transparent to the public. The sites are specific to the framework of the FDA and the content addresses many frequently asked questions by industry and the general public. It is imperative that the site contains the most current information in order for it to be effective with industry as well as the public. The timely response to question will show that the FDA is committed to educating

their audience. The initial steps taken by the group has opened up dialogue with the agency. As a member of the public and the industry, I find the sites to be helpful in my knowledge quest. I look forward to seeing how the FDA will continue to develop the sites.

Resources:

1. www.fda.gov
2. <http://pharmtech.findpharma.com/pharmtech/FDA-Launches-Industry-Basics-Website/ArticleStandard/Article/detail/703005?ref=25>