Data Standards Plan Version 1.0." The draft plan is intended to communicate FDA's approach for establishing a comprehensive data standards program at CDER and ensuring the development and successful use of data standards for all key data needed to make regulatory decisions. FDA will consider comments received in developing future versions of the plan.

II. Comments

Interested persons may submit to the Division of Dockets Management (see **ADDRESSES**) either electronic or written comments regarding this document. It is only necessary to send one set of comments. It is no longer necessary to send two copies of mailed comments. Identify comments with the docket number found in brackets in the heading of this document. Received comments may be seen in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday.

III. Electronic Access

Persons with access to the Internet may obtain the document at *http://www.regulations.gov* or http://www.fda.gov/downloads/Drugs/DevelopmentApprovalProcess/FormsSubmissionRequirements/ElectronicSubmissions/UCM214120.pdf.

Dated: June 11, 2010.

Leslie Kux,

Acting Assistant Commissioner for Policy.

[FR Doc. 2010–14637 Filed 6–16–10; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket Nos. FDA–2010–N–0284 and FDA–2009–D–0461]

Risk Evaluation and Mitigation Strategies; Notice of Public Meeting; Reopening of Comment Period

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice of public meeting; reopening of comment period.

SUMMARY: The Food and Drug Administration (FDA) is announcing a 2-day public meeting to obtain input on issues and challenges associated with the development and implementation of risk evaluation and mitigation strategies (REMS) for drugs and biological products. As FDA has taken steps to implement the REMS provisions of the Federal Food, Drug, and Cosmetic Act (FDCA), some stakeholders have raised concerns about the impact of various REMS, and the growing number of REMS on the health care system, as well as on individual prescribers, pharmacists, distributors, and other affected stakeholders. To obtain public input about the REMS program and its impact, and to gather additional input on a draft guidance for industry issued on October 1, 2009 entitled "Format and Content of Proposed Risk Evaluation and Mitigation Strategies (REMS), REMS Assessments, and Proposed REMS Modifications," FDA has decided to hold this public meeting. FDA wishes to give a wide range of stakeholders the opportunity to provide input in this area, and will take the information it obtains from the meeting into account in its implementation of the REMS program and in the development of the final guidance and future REMS guidances.

DATES: The meeting will be held on July 27 and 28, 2010, from 8:30 a.m. to 4:30 p.m. Individuals who wish to present at the meeting must register by July 6, 2010. The comment period for the draft guidance for industry on "Format and Content of Proposed Risk Evaluation and Mitigation Strategies (REMS), REMS Assessments, and Proposed REMS Modifications" has been reopened until August 31, 2010.

ADDRESSES: The public meeting will be held at FDA's White Oak Campus, 10903 New Hampshire Ave., Bldg. 31, rm. 1503, Silver Spring, MD 20993. Submit written comments to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. Submit electronic comments to *http://www.regulations.gov*. Identify each set of comments with the corresponding docket number for either the public meeting or the draft guidance as follows: Docket No. FDA–2010–N–0284, "Risk Assessment and Mitigation Strategies; Public Meeting," and Docket No. FDA–2009–D–0461, Draft guidance for industry on "Format and Content of Proposed Risk Evaluation and Mitigation Strategies (REMS), REMS Assessments, and Proposed REMS Modifications."

FOR FURTHER INFORMATION CONTACT: Kristen Everett, Food and Drug Administration, Center for Drug Evaluation and Research, 10903 New Hampshire Ave., Bldg. 51, rm. 6228, Silver Spring, MD 20993, 301–796–0453, FAX: 301–847–8440, Email: *REMSpublicmeeting@fda.hhs.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

On September 27, 2007, the President signed into law the Food and Drug Administration Amendments Act of 2007 (FDAAA) (Public Law 110–85). Title IX, subtitle A, section 901 of FDAAA created new section 505–1 of the FDCA, which authorizes FDA to require persons submitting new drug applications (NDAs) or abbreviated new drug applications (ANDAs) for prescription products, or biologics license applications (BLAs), to submit and implement a REMS if FDA determines that a REMS is necessary to ensure the benefits of a drug outweigh the risks of the drug. To require a REMS for an already approved drug, FDA must have new safety information as defined in the statute.

FDAAA specifies the criteria FDA must consider in determining when to require a REMS, the elements of a REMS that FDA must and may require, and additional considerations when requiring a REMS with elements to assure safe use. FDAAA also contains provisions that are specifically directed to REMS for ANDAs and describes enforcement actions for failure to comply with REMS. FDAAA contains provisions that require the FDA to seek input from patients, physicians, pharmacists, and other health care providers about how the elements to assure safe use may be standardized to (1) not be unduly burdensome on patient access to the drug and (2) to the extent practicable, minimize the burden on the health care delivery system. A webinar will be available on the agency's Web site at *http://www.fda.gov/Drugs/NewsEvents/ucm210201.htm* 2 weeks before the meeting, describing in more detail the statutory requirements for REMS.

II. REMS Draft Guidance and Comment Period

FDA has been implementing the REMS FDAAA provisions for more than 2 years. On October 1, 2009, the Agency published in the **Federal Register** (74 FR 80801) a notice of availability of a draft guidance for industry entitled, "Format and Content of Proposed Risk Evaluation and Mitigation Strategies (REMS), REMS Assessments, and Proposed REMS Modifications." Although comments on Agency guidances are welcome at any time (see 21 CFR 10.115(g)(5)), to ensure that comments could be considered as the Agency worked on the final version of the guidance, interested persons were invited to comment on the draft guidance by December 30, 2009. The draft guidance provides information

regarding FDA's current thinking on the format and content that should be used for submissions of proposed REMS, including the availability of templates for REMS and REMS supporting documents. It also includes preliminary information on the content of assessments and proposed modifications to approved REMS.

In comments on the guidance, as well as in various other contexts, stakeholders have raised concerns with the Agency about the use of REMS, and the impact of both the variety of REMS and the growing number of REMS on the health care system and on affected prescribers, pharmacists, distributors, patients, and other affected stakeholders. For example, some stakeholders have expressed concern regarding the cumulative burden of REMS on the health care delivery system. Others have raised concerns about prescribers' and pharmacists' costs of implementing REMS, and some have raised questions about the impact of REMS on patient access to therapies. FDA has decided to hold a public meeting to hear from stakeholders about their opinions on how REMS are working, and the effects of REMS on prescribers, pharmacists, distributors, patients, and other stakeholders, and on the overall health care system. At the same time, FDA is reopening the comment period on the draft guidance for industry on "Format and Content of Proposed Risk Evaluation and Mitigation Strategies (REMS), REMS Assessments, and Proposed REMS Modifications" until August 31, 2010. FDA will take into account the input it receives through comments and at the public meeting in its implementation of the FDAAA REMS provisions when it finalizes the above guidance, and in the development of future guidances regarding REMS for drugs and biological products.

III. FDA Actions Under FDAAA

Section 901 of FDAAA became effective March 25, 2008. Between March 25, 2008, and March 25, 2010, FDA approved 110 new REMS for NDAs and BLAs, and two deemed REMS.[1] Table 1 shows the various types of approved REMS.

TABLE 1. NEW REMS APPROVED BETWEEN MARCH 25, 2008, AND MARCH 25, 2010[1]

REMS Elements (in addition to a timetable for submission of assessments of the REMS)	No. Approved
Medication Guide (MG) Only	75
Communication plan (CP) alone or with a MG	25
Elements to assure safe use alone or with CP and/or MG	10
Total new REMS approved	110

[1] "New REMS" means REMS approved since FDAAA took effect for drugs that did not previously have risk management plans in place.

As shown in Table 1, 68 percent of the newly approved REMS contained only a Medication Guide and a timetable for submission of assessments of the REMS (the only element required in all REMS). Before FDAAA, a drug with only a Medication Guide would not have been considered to have a risk management plan. Instead, Medication Guides were considered part of labeling.

Less than 10 percent of the new REMS contain elements to assure safe use; however, these new REMS are in addition to the 16 previously approved risk management plans with elements to assure safe use that have been deemed to be REMS.

In each case where a REMS was required, FDA made the finding that a REMS was necessary to ensure that the benefits of the drug outweighed the risks. In the case of REMS with elements to assure safe use, the types of REMS that place the greatest burden on participants in the program and on the health care system, FDA determined that without these elements to assure safe use, the drug could not be approved, or if previously approved, would need to be withdrawn from the market. It is these types of REMS that seem to be of most concern to stakeholders who have communicated concerns about the REMS program.

Most of the REMS with elements to assure safe use require prescriber education and certification about the specific risks of the drug covered by the REMS and the drug's appropriate use. In some cases, prescribers are required to counsel patients about the risks of the drug. They also may be required to enroll patients in the REMS, and they may be asked to have the patient sign a prescriber/patient agreement. All of these actions are intended to promote informed, appropriate prescribing of the particular drug, and provide information to the patient about the risks and appropriate use of the drug. However, FDA has heard from prescribers who are concerned about having to enroll in many different programs, obtain different certifications, and comply with various requirements for counseling their patients. They are concerned that these restrictive programs interfere with the practice of medicine and are costly to implement without any reimbursement for the costs incurred. Patients have expressed the concern individually and through patient advocacy groups that prescribers may refuse to participate in the REMS, so they may be deprived of access to necessary drugs.

Many of the REMS with elements to assure safe use require pharmacists or pharmacies to be certified, and in several REMS with elements to assure safe use, pharmacists are required to determine whether the prescription presented by the patient was written by a certified prescriber or whether the patient is authorized to receive the drug. Sometimes pharmacists are also provided educational materials so that they can counsel patients on the safe and appropriate use of the drug. FDA has heard from pharmacy organizations that complying with these requirements can cause a disruption in usual workflow, and these organizations have expressed concern that there is no additional compensation for pharmacists complying with REMS requirements. In addition, pharmacists have said that the multiplicity of programs requiring separate enrollment and certification are unduly burdensome on the pharmacy, as is the lack of a single source for information on all REMS requirements.

In some REMS, to help ensure that the REMS is appropriately implemented, the sponsor will elect to distribute only through a central pharmacy or pharmacies that agree to abide by the terms of the REMS. Some health care organizations have expressed the concern that these arrangements disrupt their ability to provide drugs to patients in their system, and are anticompetitive in nature. (See the citizen petition filed under 21 CFR 10.30 by Kaiser Foundation Health Plan, Inc., Docket No. FDA–2009–P–0602, available on the Internet at *http://www.regulations.gov*.)

A few REMS with elements to assure safe use require that drugs be dispensed only in particular settings, such as hospitals. Some require patients to be monitored for the development of undesirable reactions to the drug or, in the case of drugs that can adversely affect a fetus, require pregnancy testing to prevent fetal exposure to the drug. Stakeholders have expressed concerns

[1] Section 909 of FDAAA provides that drugs approved with elements to assure safe use before FDAAA was enacted were deemed to have REMS. Sponsors of these products were required to submit proposed REMS by September 21, 2008.

about these types of restrictions, citing burden and cost.

Several of the REMS with elements to assure safe use require that the drug be dispensed only with documentation of conditions to assure safe use. For example, patient enrollment may be required in a program designed to make sure the patient is educated about the risks of the drug, the importance of follow-up, monitoring, if applicable, and reporting of adverse events. Stakeholders have raised concerns about the effect of such restrictions on patient access to medications and about the costs to prescribers and pharmacists to implement such a program.

All REMS include a timetable for submission of assessments. The timing for assessments is at a minimum 18 months, 3 years, and 7 years, but for drugs that have REMS with elements to assure safe use, the assessments can be more frequent. Sponsors must assess the REMS and determine whether the goals of the REMS are being met. REMS assessment reports generally summarize surveys of patients and prescribers, data on compliance with the REMS processes, drug use, and information on certain outcomes.

Because FDA regulates the holders of approved applications to market drugs, the REMS requirements are imposed on sponsors, not directly on other participants in the health care system. Thus, sponsors must establish the education and certification programs and the monitoring systems, and implement the REMS requirements. Yet sponsors do not control the other participants in the health care system, and it may be difficult to get the participants to comply with the REMS requirements. Furthermore, because in most cases the REMS programs are established by individual sponsors and are tailored to the characteristics of the drug, the population using the drug, and the way the drug is prescribed and distributed, it can be difficult to standardize the elements of REMS to reduce their burden. Finally, it may be difficult to determine whether a REMS is working effectively and, if so, which specific elements of the REMS are working well.

As FDA continues to require and approve REMS for drugs, it is important to hear more from stakeholders about their concerns. Therefore, FDA has decided to hold this public meeting.

IV. Purpose and Scope of Meeting

The purpose of this meeting is to receive information and comments on issues with REMS from a broad group of stakeholders including interested prescribers, pharmacists, patients, third party payers, application holders, and the public.

Although any comments are welcome, FDA is particularly interested in obtaining information and public comment on the following issues:

A. Requirement for a REMS

In each case where a REMS was required, FDA made the statutorily required finding that a REMS was necessary to ensure that the benefits of the drug outweighed the risks. Section 505–1 lists the factors FDA must consider in determining whether to require a REMS as follows:

- The estimated size of the population likely to use the drug
- The seriousness of the disease or condition that is to be treated with the drug
- The expected benefit of the drug with respect to the disease or condition
- The expected or actual duration of treatment with the drug
- The seriousness of any known or potential adverse events that may be related to the drug and the background incidence of such events in the population likely to use the drug
- Whether the drug is a new molecular entity

In addition, for REMS with elements to assure safe use, the elements to assure safe use must:

- Be commensurate with the specific serious risk listed in the labeling of the drug
- Not be unduly burdensome on patient access to the drug, considering the risk and, in particular, patients with serious or life-threatening diseases or conditions and patients who have difficulty accessing health care (such as patients in rural or medically underserved areas)
- To the extent practicable, conform with elements to assure safe use for other drugs with similar serious risks, and
- Be designed to be compatible with established distribution, procurement, and dispensing systems for drug.

1. How should these factors be evaluated individually and in relation to each other to determine whether a REMS is appropriate?

2. How should the factors be evaluated individually and in relation to each other to determine what type of REMS is appropriate (i.e., what elements should be included in the REMS: Medication Guide, communication plan, elements to assure safe use, implementation system)?

3. Are there other factors that FDA should consider besides the statutorily enumerated factors in deciding whether to require a REMS, and if FDA believes a REMS is necessary, what type of REMS should be required?

B. Establishing the Goals of A REMS

1. When FDA requires a REMS, how should the goals be expressed? For example:

a. Should the goal be to reduce the risk to zero (e.g., zero fetal exposures or cases of agranulocytosis), even if it is recognized as an aspirational and not an achievable goal?

b. Should the goal be expressed in terms of risk reduction either to some minimum level (e.g., not more than 100 fetal exposures) or as compared to a baseline, assuming there is a known baseline from which risk reduction can be measured (e.g., reduce fetal exposures by 90 percent)?

c. What factors should FDA consider in establishing the goals of a REMS?

d. What criteria might be considered for modifying a REMS (increasing or decreasing elements, or eliminating it all together)?

C. Issues Regarding Elements to Assure Safe Use

1. Is there evidence that REMS with elements to assure safe use have adversely affected appropriate patient access to approved drugs?

a. What features of a REMS with elements to assure safe use are most likely to adversely affect appropriate patient access to approved drugs?

b. What design features or safeguards could be incorporated into elements to assure safe use to reduce any negative impact on appropriate patient access?

2. Is there evidence that REMS with elements to assure safe use have improved patient safety?

3. Is there evidence that REMS with elements to assure safe use have adversely affected patient safety?

4. How have REMS with elements to assure safe use affected the health care delivery system?

a. What features of a REMS with elements to assure safe use are most likely to adversely affect the health care delivery system?

b. What design features could be incorporated into elements to assure safe use to reduce any negative impact on the health care delivery system? For example, can training and certification of health care providers be streamlined? If so, how?

c. How should REMS with elements to assure safe use be made compatible with established distribution systems so as to minimize the burden on the health care delivery system?

5. Some REMS are implemented by distribution of drugs through a central pharmacy system, and some are

implemented through a retail pharmacy system.

a. What are the advantages and disadvantages of the various models of drug distribution under a REMS?

b. Should sponsors be permitted to choose the drug distribution system they prefer to manage the risks, or should a common distribution system be employed for REMS?

6. Can implementation of elements to assure safe use be standardized (e.g., could uniform systems for providing prescriber and pharmacist education or certification be developed)?

a. Is there a preferred way to standardize the elements to assure safe use (e.g., based on the nature of the risk, across a class of drugs with common risks, or around certain elements such as prescriber education or pharmacy certification)?

b. What are the advantages and disadvantages of standardizing the way elements to assure safe use are implemented on:

i. Patient safety?

ii. Patient access?

D. Evaluating the Effectiveness of REMS

1. How should REMS be monitored and assessed to determine their effectiveness, considering the different types of REMS elements (e.g., Medication Guides, communication plans, elements to assure safe use)?

2. How should the overall burden on the health care system of a REMS with elements to assure safe use be monitored and assessed, considering the different types of elements to assure safe use (e.g., training or certification of prescribers and pharmacists, implementation of patient registries)?

3. Should metrics for determining the effectiveness of a REMS be specified at the time the REMS is approved? How should the appropriate metrics be determined?

4. Are surveys the optimal method to assess patient and health care provider understanding of the serious risks and safe use of the drug? Are there alternative methods that should be considered?

E. Effects of REMS on Generic Drugs

1. Section 505–1(f)(8) states that no holder of an approved application shall use any element to assure safe use required by the Secretary to block or delay approval of an application under section 505(b)(2) or (j) or to prevent application of an element to assure safe use to a drug that is the subject of an abbreviated new drug application. What steps should FDA take to ensure that REMS are not used to block or delay generic competition?

2. FDAAA requires that innovator and generic sponsors use a single shared system to provide a REMS with elements to assure safe use, unless a waiver is granted. What design or process features should be taken into account when designing an innovator REMS to facilitate use of a single shared system when generics are approved?

F. Protection of Patient Information

1. Some REMS with elements to assure safe use require enrollment of patients and health care providers in a program, or require a patient registry as a condition of prescribing or dispensing a drug.

a. What, if any, privacy concerns are raised by these programs?

b. Does enrollment in a REMS program or a patient registry without requiring a specific collection of health information raise the same privacy concerns?

2. What steps should FDA take to reduce concerns about patient privacy when REMS with such elements to assure safe use are determined to be necessary to ensure the benefits of a drug outweigh its risks?

V. Attendance and Registration

The FDA Conference Center at the White Oak location is a Federal facility with security procedures and limited seating. Attendance is free and will be on a first come, first served basis. Individuals who wish to present at the public meeting must register by email to *REMSpublicmeeting@fda.hhs.gov* on or before June 30, 2010, and provide complete contact information, including name, title, affiliation, address, email, and phone number. In section IV of this document, FDA has included questions for comment. You should identify by number each question you wish to address in your presentation, so that FDA can consider that in organizing the presentations. FDA will do its best to accommodate requests to speak, and will determine the amount of time allotted to each presenter and the approximate time that each oral presentation is scheduled to begin. An agenda will be available approximately 2 weeks before the meeting on the Agency Web site at *http://www.fda.gov/Drugs/NewsEvents/ucm210201.htm.*

If you need special accommodations because of disability, please contact Kristen Everett (see **FOR FURTHER INFORMATION CONTACT**) at least 7 days before the meeting.

A live Web cast of this meeting will be available on the Agency Web site at *http://www.fda.gov/Drugs/NewsEvents/ucm210201.htm* on the day of the meeting. A video record of the meeting will be available at the same Web address for 1 year.

VI. Comments

Regardless of attendance at the public meeting, interested persons may submit written or electronic comments to the Division of Dockets Management (see **ADDRESSES**). Submit a single copy of electronic comments or two paper copies of any mailed comments, except that individuals may submit one paper copy. Comments are to be identified with the docket number found in brackets in the heading of this document. To ensure consideration, submit comments by August 31, 2010. Received comments may be seen in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday.

VII. Transcripts

Transcripts of the meeting will be available for review at the Division of Dockets Management and on the Internet at *http://www.regulations.gov* approximately 30 days after the meeting. A transcript will also be made available in either hard copy or on CD-ROM, upon submission of a Freedom of Information request. Written requests are to be sent to Division of Freedom of Information (HFI–35), Office of Management Programs, Food and Drug Administration, 5600 Fishers Lane, rm. 6–30, Rockville, MD 20857.

Dated: June 11, 2010.

Leslie Kux,

Acting Assistant Commissioner for Policy.

[FR Doc. 2010–14547 Filed 6–11–10; 4:15 pm]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.