

provisions of section 911 of the Tobacco Control Act (21 U.S.C. 387k) regarding modified risk claims.

(Response) Thank you for this suggestion. However, this comment is outside the scope of the present study as it is about the implementation of the

public displays of HPHCs and not about testing the display.
 FDA estimates the burden of this collection of information as follows:

TABLE 1—ESTIMATED ANNUAL REPORTING BURDEN ¹

Type of respondent	Number of respondents	Number of responses per respondent	Total annual responses	Average burden per response	Total hours
Youth Screener	1,800	1	1,800	0.05	90
Youth Survey	1,500	1	1,500	0.33	500
Total Youth Hours					590
Adult Screener	3,400	1	3,400	0.05	170
Adult Survey	3,000	1	3,000	0.33	1,000
Total Adult Hours					1,170
Total Burden Hours					1,760

¹ There are no capital costs or operating and maintenance costs associated with this collection of information.

For this study, potential participants will be recruited by a market research firm that maintains an internet panel, and information will be collected through self-administered, online screening tests and surveys of youth aged 13 to 17 and adults aged 18 and older. Approximately 5,200 respondents (1,800 youth and 3,400 adults) will be requested to complete a screening test to determine eligibility for participation in the study, estimated to take approximately 3 minutes (0.05 hour) per screening test, for a total of 260 hours for screening activities. Respondents who qualify for the study will be directed to the survey. Approximately 4,500 participants (1,500 youth and 3,000 adults) will complete the survey, estimated to take 20 minutes (0.33 hour) per survey, for a total of 1,500 hours for completion of both adult and adolescent samples. The length of time to complete the screening test and survey are based on the research firm's experience that panel members answer approximately 2.5 questions per minute. This data collection will take place one time in 2019. Thus, the total estimated burden is estimated to be 1,760 hours.

II. References

The following references marked with an asterisk (*) are on display at the Dockets Management Staff (HFA-305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852 and are available for viewing by interested persons between 9 a.m. and 4 p.m., Monday through Friday; they also are available electronically at <https://www.regulations.gov>. References without asterisks are not on public display at <https://www.regulations.gov> because they have copyright restriction.

Some may be available at the website address, if listed. References without asterisks are available for viewing only at the Dockets Management Staff.

1. Byron, M.J., A.J. Lazard, E. Peters, et al. (2018). "Effective Formats for Communicating Risks from Cigarette Smoke Chemicals." *Tobacco Regulatory Science*, 4(2), 16–29. doi:10.18001/TRS.4.2.2.
- * 2. O'Brien, E.K., A. Persoskie, and J. Tam (2019). "Multi-Item Measures of Tobacco Health Perceptions: A Review," *American Journal of Health Behavior*, 43(2), 266–278. doi:10.5993/AJHB.43.2.4.
3. Brewer, N.T., J.C. Morgan, S.A. Baig, et al. (2017). "Public Understanding of Cigarette Smoke Constituents: Three US Surveys." *Tobacco Control*, 26(5), 592–599.
- * 4. Nadler, J.T., R. Weston, and E.C. Voyles (2015). "Stuck in the Middle: The Use and Interpretation of Mid-Points in Items on Questionnaires," *The Journal of General Psychology*, 142(2), 71–89.

Dated: June 24, 2019.
Lowell J. Schiller,
Principal Associate Commissioner for Policy.
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BILLING CODE 4164-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA-2018-N-3516]

Agency Information Collection Activities; Submission for Office of Management and Budget Review; Comment Request; Disease Awareness and Prescription Drug Promotion on Television

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that a proposed collection of information has been submitted to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995 (PRA).

DATES: Fax written comments on the collection of information by July 29, 2019.

ADDRESSES: To ensure that comments on the information collection are received, OMB recommends that written comments be faxed to the Office of Information and Regulatory Affairs, OMB, Attn: FDA Desk Officer, Fax: 202-395-7285, or emailed to oir_submission@omb.eop.gov. All comments should be identified with the OMB control number 0910-NEW and title "Disease Awareness and Prescription Drug Promotion on Television." Also include the FDA docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Ila S. Mizrahi, Office of Operations, Food and Drug Administration, Three White Flint North, 10A-12M, 11601 Landsdown St., North Bethesda, MD 20852, 301-796-7726, PRAStaff@fda.hhs.gov. For copies of the questionnaire contact: Office of Prescription Drug Promotion (OPDP) Research Team, DTCresearch@fda.hhs.gov.

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed collection of information to OMB for review and clearance.

Disease Awareness and Prescription Drug Promotion on Television

OMB Control Number 0910–NEW

I. Background

Section 1701(a)(4) of the Public Health Service Act (42 U.S.C. 300u(a)(4)) authorizes FDA to conduct research relating to health information. Section 1003(d)(2)(C) of the Federal Food, Drug, and Cosmetic Act (FD&C Act) (21 U.S.C. 393(d)(2)(C)) authorizes FDA to conduct research relating to drugs and other FDA regulated products in carrying out the provisions of the FD&C Act.

FDA's Center for Drug Evaluation and Research (CDER), Office of Prescription Drug Promotion (OPDP) is responsible for ensuring that prescription drug promotional materials are truthful, balanced, and accurately communicated. This project is being proposed as part of the research program of OPDP. OPDP's research program provides scientific evidence to help ensure that our policies related to prescription drug promotion will have the greatest benefit to public health. Toward that end, we have consistently conducted research to evaluate the aspects of prescription drug promotion that we believe are most central to our mission, focusing in particular on three main topic areas: Advertising features, including content and format; target populations; and research quality. Through the evaluation of advertising features we assess how elements such as graphics, format, and disease and product characteristics impact the communication and understanding of prescription drug risks and benefits; focusing on target populations allows us to evaluate how understanding of prescription drug risks and benefits may vary as a function of audience; and our focus on research quality aims at maximizing the quality of research data through analytical methodology development and investigation of sampling and response issues. This study falls under the topic of both target populations and advertising features.

Because we recognize the strength of data and the confidence in the robust nature of the findings is improved through the results of multiple converging studies, we continue to develop evidence to inform our thinking. We evaluate the results from our studies within the broader context of research and findings from other sources, and this larger body of knowledge collectively informs our policies as well as our research program. Our research is documented on our homepage, which can be found at:

<https://www.fda.gov/about-fda/center-drug-evaluation-and-research/office-prescription-drug-promotion-opdp-research>. The website includes links to the latest **Federal Register** notices and peer-reviewed publications produced by our office. The website maintains information on studies we have conducted, dating back to a direct-to-consumer (DTC) survey conducted in 1999.

The present research concerns disease awareness and prescription drug promotion communications on television. When pharmaceutical companies market a new drug, they often also release disease awareness communications about the medical condition the new drug is intended to treat (Refs. 1 and 2). FDA is interested in whether and to what extent this practice may result in consumers confusing or otherwise misinterpreting the different information and claims presented in disease awareness communications and prescription drug promotion. Prior research has documented that in both print (Ref. 3) and online (Ref. 4) contexts, consumers tend to conflate the information presented in prescription drug promotional materials with information presented in disease awareness communications. Specifically, the results of these studies suggest consumers incorrectly ascribe benefits to a prescription drug as a result of being exposed to information in a disease awareness communication that broadly describes the symptoms and negative consequences of the disease. There are ways in which this effect can be attenuated. For example, prior research has indicated that greater visual distinctiveness between the two ad types can ameliorate such confusion (Ref. 3). The present research seeks to extend previous studies of print and online promotion to the context of television promotion, and broadly examine the extent to which perceptual similarity between the two communication types, as well as their temporal proximity and exposure frequency, may lead to viewer confusion and the nature of that confusion.

This research is being conducted to determine how the similarity, temporal positioning, and frequency of exposure to disease awareness communications and prescription drug television promotion impact consumer perception and understanding of the benefits and risks of a prescription drug product. These objectives will be achieved using two experimental studies. The first study will explore the impact on consumer perception and comprehension of different levels of

temporal separation between the disease awareness communication and prescription drug promotion within a single period of television programming, as well as the level of similarity versus distinctiveness between these communication types. Temporal separation is defined as the spacing or proximity between the disease awareness communication and prescription drug promotion in the hour-long programming, for example, if they are shown back-to-back or if they are separated by other ads or television programming. Similarity/distinctiveness is defined by variations between the disease awareness communication and prescription drug promotion, including visual and presentation elements such as the setting, actors, and colors. The second study will experimentally examine the impact of disease awareness communication temporal separation and exposure frequency on consumer perception and comprehension. Temporal separation in this second study again refers to the spacing or proximity between the disease awareness communication and prescription drug promotion but is operationally defined as either 1 day or 1 week. Exposure frequency is defined as the number of times that participants will view the disease awareness communication, either one, three, or six times. The results of this latter study will examine the practice of "seeding the market," in which pharmaceutical companies release disease awareness communications before releasing product promotion communications. Similarity versus distinctiveness will also be examined in this study.

We propose the following hypotheses for this research:

A. Study 1

H1: Increased perceptual similarity between a disease awareness communication and a prescription drug promotion will result in significantly more conflation of the information presented in both pieces.

H2: Increased temporal proximity between a disease awareness communication and a prescription drug promotion will result in significantly more conflation of the information presented in both pieces.

B. Study 2

H1: Increased frequency of exposure to a disease awareness communication before exposure to a prescription drug promotion will result in significantly more conflation of the information presented in both pieces.

H2: Increased temporal proximity between a disease awareness

TABLE 4—STUDY 2 SEQUENCE—Continued

Three Exposures	1 day	similar				x	x	x	x						
		distinct				x	x	x	x						
	1 week	similar				x	x	x							x
		distinct				x	x	x							x
One Exposure	1 day	similar						x	x						
		distinct						x	x						
	1 week	similar						x							x
		distinct						x							x

Study 1 and 2 Sample. The targeted voluntary sample for both studies will comprise adults who self-report a current asthma diagnosis, a lifetime incidence of asthma, or experience a large number of asthma symptoms. These groups are believed to be very likely to be targeted by disease awareness and product promotion communications for asthma. The combined incidence rate of these groups is 22.2 percent (Refs. 5 and 6). In addition, several exclusion criteria are specified. These include: (1) Training or employment as a healthcare professional, (2) employment with a pharmaceutical company, an advertising agency, a market research company, or the Department of Health and Human Services, and (3) participation in market research within the past 3 months on the topic of prescription drugs. Pretest participants will also be ineligible for the main study.

Pretesting. Pretesting will take place before the main studies to evaluate the procedures used in the main studies. Each of the two pretests will have the same design as its respective main study (pretest 1 for Study 1 and pretest 2 for Study 2). The purpose of both pretests will be to: (1) Ensure that the mock stimuli are understandable, viewable, and delivering intended messages; (2) identify and eliminate any challenges to embedding the mock stimuli within the online survey; (3) ensure that survey questions are appropriate and meet the analytical goals of the research; and (4) pilot test the methods, including examining response rates and timing of survey. The two pretests will be conducted simultaneously.¹ Based on pretest findings, we will refine the mock stimuli, survey questions, and data collection process, as necessary, to optimize the full-scale study conditions.

Measurement. Our planned analyses are designed to address the key hypotheses. For both Study 1 and Study

2, we anticipate that the primary analysis will be analysis of variance to compare the main and interaction effects of the experimental factors.

The focal dependent variable will be *conflation*—a measure of memory and perceptions regarding the promoted drug relative to the information presented in the disease awareness communication. Conflation will be measured by using the number of benefits that are incorrectly attributed to the prescription drug product based on responses to a number of both open-ended and closed-ended items.

Other key dependent variables will reflect perceptions and attitudes toward the product ad. These include measures of:

1. Perception of product promotion effectiveness;
2. Behavioral intentions toward the drug;
3. Perceived efficacy of the drug; and
4. Perceived risks of the drug.

In addition to the primary variables of interest, we have also identified potential covariates that will be included in the analyses:

1. Knowledge about asthma;
2. Health literacy; and
3. Perceived ad effectiveness.

We expect that knowledge about asthma and increased health literacy may moderate any conflation that results from ad similarity, temporal proximity, and frequency of exposure. Perceptions of promotion effectiveness, on the other hand, can be examined both as an outcome/dependent variable but also as a covariate that examines involvement with the product promotion. Greater involvement may attenuate conflation in that it directs more in-depth processing of both the disease awareness communication and product promotion, and therefore more correct understanding of the claims in each (Refs. 7 to 9).

In the **Federal Register** of October 17, 2018 (83 FR 52472), FDA published a 60-day notice requesting public comment on the proposed collection of information. FDA received six comments that were PRA related. Within those submissions, FDA

received multiple comments that the Agency has addressed. Two additional comments were received that were not responsive to the four collection of information topics solicited and therefore are not discussed in this document.

(Comment 1) Four comments suggested that FDA provide copies of stimuli in the **Federal Register** for public comment. Relatedly, one comment requested a copy of the participant consent documents.

(Response) We have described the purpose of the study, the design, the population of interest, and have provided the questionnaire to numerous individuals upon request. Our full stimuli are under development during the PRA process. We do not make draft stimuli public during this time because of concerns that this may contaminate our participant pool and compromise the research. The consent form is available as part of the information collection submission to OMB.

(Comment 2) Three comments expressed support for FDA's determination to take an evidence-informed approach to its regulation of sponsor communications.

(Response) We appreciate this support.

(Comment 3) Three comments suggested that selecting asthma sufferers as the target population limits the applicability of the results, or that asthma sufferers' prior knowledge regarding asthma may bias their responses.

(Response) Researching each medical condition, or general population sample, requires significant resources. We are committed to conducting this research using our available resources while ensuring the integrity of the research by collecting data on a high prevalence condition (*i.e.*, >20% incidence rate) for which participants might be thought of as sufficiently representative of the average consumer, thus allowing us to draw conclusions about broad perceptual and cognitive processing outcomes.

(Comment 4) Three comments suggested that use of mock

¹Pretesting will be preceded by cognitive interviewing, not described here. Cognitive interviews are used to probe a small sample of participants on how and why they responded to various questions as they did, resulting in strong measurement instruments.

advertisements, products, and environments do not represent what happens in the real world.

(Response) In response to **Federal Register** notices for prior research under our research program, commenters have suggested the opposite, which is that use of real materials (*i.e.*, existing drug ads) could have confounding results due to consumer familiarity with medicines and drug classes used to treat their existing condition. We sought to address this concern by utilizing realistic mock materials. Additionally, utilizing mock materials allows for precise manipulation of the stimuli fitting with our research questions and is the most common practice in the field.

(Comment 5) Two comments expressed concern about use of “conflation” as a dependent variable.

(Response) The present research seeks to extend previous studies of print and online promotion to the context of television promotion and as such utilizes many of the same dependent measures, including the key dependent measure of “conflation.” Conflation as defined in this notice reflects the key outcome of interest given the research questions posed and therefore has been retained.

(Comment 6) Two comments suggested that the open-ended response questions are open to interpretation and data variability and encouraged FDA to revise these to close-ended questions.

(Response) The purpose of the open-ended items is to measure unaided participant recall of claims made in the prescription drug promotion. These responses will be content coded using an inductive approach and numeric codes will be assigned to the open-ended responses. Quantifying open-ended responses provides structure and reduces the interpretation associated with a qualitative coding scheme. After sanitizing open-ended comments (removing obscenities, proper names, and any case-specific information), two reviewers will read the responses and develop a coding scheme to establish theme descriptions, numeric codes, and coding rules. Two coders will receive training and will code 25 percent of the responses. After achieving high inter-coder reliability (*e.g.*, kappa = .75), the remaining responses will be divided between the coders. Open-ended coding will then be merged with the data set for analysis. Additionally, we have tested these response options in cognitive interviewing and found them to be effective for their intended purpose. We have also received positive feedback on these measures from our consultations with expert peer reviewers. These measures have therefore been retained.

(Comment 7) Two comments suggested adding a control condition to Study 2 whereby participants only see the prescription drug product ad before completing the survey.

(Response) For Study 2, the primary questions are related to both frequency of exposure and delay. A control condition that features no disease awareness communications makes the delay factor redundant, and comparisons can be made between no exposure and repeated exposure. Therefore, a control condition for Study 2 is unnecessary given the current design.

(Comment 8) Two comments suggested that Studies 1 and 2 are highly similar and thus only one study needs to be conducted. One of these comments suggested dropping Study 2 and utilizing the resources that would have been allotted to instead create different iterations of temporal separation for Study 1.

(Response) Studies 1 and 2 include overlap in their independent and dependent variables. However, they are unique in that Study 1 will explore outcomes within a single period of television programming, whereas Study 2 will examine outcomes over time mirroring the practice of “seeding the market,” in which pharmaceutical companies release disease awareness communications before releasing product promotion communications. Both studies offer significant and unique value to FDA and therefore both studies have been retained.

(Comment 9) One comment suggested separating recall of the ad from recall of the product into separate questions.

(Response) The question reads, “Do you recall seeing a commercial for [Drug X], a prescription product for asthma?” This question is intended to assess recall of the commercial for [Drug X] and is not intended to assess recall for this fictitious product beyond this commercial. We hope this clarification is helpful for understanding why we intend to retain the present version of this question.

(Comment 10) One comment suggested that pretesting be conducted to ensure that stimuli reflect the intended manipulations.

(Response) FDA intends to conduct both cognitive interviewing and pretesting to ensure the stimuli reflect the intended manipulations.

(Comment 11) One comment suggests that the proposed research overlooks the positive aspects of disease awareness campaigns, and to address this, steps can be taken such as adding questions about behavioral intentions to the questionnaire.

(Response) FDA acknowledges that there are positive aspects of disease awareness campaigns. This research is intended to evaluate specific research questions as outlined in the 60-day **Federal Register** notice and therefore dependent measures align with these research questions. As an overall strategy to reduce participant burden, we do not intend to ask questions that do not inform these research questions.

(Comment 12) One comment suggested relocating non-terminating screening questions to the end of the questionnaire to reduce participant fatigue.

(Response) The purpose of including the screening items at the beginning of the questionnaire is to ensure a diverse sample using predetermined quotas, and for required statistical analyses following completion of the data collection. Retaining the screening items at the beginning of the questionnaire will allow for comparisons between non-respondents and respondents.

(Comment 13) One comment suggested adding a “Don’t know” response option wherever applicable.

(Response) We understand the value of providing such responses for items of a factual nature. The drawback to providing such response options to these questions, however, is that we may lose information by allowing respondents to choose an easy response instead of giving the item some thought. Research has demonstrated that providing “no opinion” options likely results in the loss of data without any corresponding increase in the quality of the data. Thus, we prefer not to add these options to the survey.

(Comment 14) One comment suggested that FDA develop a clear, overarching research agenda and provide a comprehensive list of its prescription drug promotion studies.

(Response) The 60-day **Federal Register** notice for this study describes OPDP’s research agenda, how this study fits into that agenda, and provides the web address of OPDP’s research page, which includes links to the latest **Federal Register** notices and peer-reviewed publications produced by our office. The website maintains information on studies we have conducted, dating back to a DTC survey conducted in 1999.

(Comment 15) One comment suggested that the current research duplicates prior work conducted in online and print contexts.

(Response) The present research seeks to extend previous studies of print and online promotion to the context of television promotion. In previous **Federal Register** notices under our

research program, we have been advised by commenters that findings for one form of advertising should not be assumed to broadly apply to other forms of advertising. Additionally, we note that the present research includes unique elements beyond advertising format that have not previously been studied. An example of this is assessment of “seeding the market” in Study 2 whereby sponsors initially release a disease awareness ad for a period of time, followed by release of a product promotion ad.

(Comment 16) One comment suggested that the time commitment required for participation may result in a self-selected sample of individuals with more time available (e.g., students).

(Response) Participants will be recruited through online panels, which include a diverse range of participants in regard to age, race/ethnicity, income, education, and employment. We also have proposed the use of soft quotas to further ensure that we will recruit a diverse sample. Finally, we were able to recruit a diverse sample for cognitive interviewing and although a smaller sample size than will be recruited for the pretests and main studies, the sample was not overrepresented in any demographic categories.

(Comment 17) One comment suggested that the calculated burden is appropriate but requested additional detail about other requirements that may add to burden in addition to the time in the study itself.

(Response) Data collection will occur online, so the burden estimate reflects time spent answering the screener, stimuli viewing, survey completion, thus reflecting overall study time and requirements.

(Comment 18) One comment identified errors in the questionnaire.

(Response) Thank you for noting these errors. All identified errors have been fixed.

(Comment 19) One comment suggested adding intermediate response values to questions that omitted them (e.g., 1 = no improvement, to 6 = substantial improvement).

(Response) These questions were developed through scale validation research. We did not encounter any confusion on the part of respondents during cognitive testing of the questionnaire. We will retain these questions in their original form.

(Comment 20) One comment suggested that because “prescription drug information” has become a political topic in recent years, the introduction to the questionnaire should be revised to avoid saying that “[w]e will use your feedback to . . . improve prescription drug information for people like you.” The concern is that this information may bias responses depending on participant views of “prescription drug information.”

(Response) The proposed research concerns prescription drug information and so we need to provide this context to participants to orient them to the questions that follow. Moreover, institutional review boards typically require transparency about the topic of the research. We have therefore retained this language in our study materials.

(Comment 21) One comment noted that “[p]erceptions of promotion effectiveness” is described as both a dependent variable and a covariate, and to avoid distortion in the model, recommends selection of a different covariate.

(Response) Perception of promotion effectiveness is described as a dependent variable, differing from perceived ad effectiveness, which

measures perception of the disease awareness communications. The purpose of including perceived ad effectiveness as a covariate is that perception of the disease awareness communications may directly affect conflation, which could require statistical adjustment.

(Comment 22) One comment suggested expanding the participant exclusion criteria to include individuals studying health fields and product marketing (beyond pharmaceuticals).

(Response) We currently exclude individuals who work for a pharmaceutical company, an advertising agency, a market research company, or the Department of Health and Human Services. These criteria exclude individuals working in advertising or market research beyond pharmaceuticals, but do not necessarily exclude students studying these fields. To ensure a diverse sample, we generally aim to limit our exclusion criteria. However, please note that random assignment to experimental condition should ensure that these individuals are approximately evenly distributed across conditions.

(Comment 23) One comment requested information about how learning effects would be controlled for given the multiple exposures.

(Response) For Study 2, learning effects are accounted for by the exposure frequency manipulation. Participants are randomly assigned to see the disease awareness ad once, three times, or six times. For Study 1, all participants see the ads the same number of times, except participants randomly assigned to the control condition who do not see the disease awareness ad.

FDA estimates the burden of this collection of information as follows:

TABLE 5—ESTIMATED ANNUAL REPORTING BURDEN ¹

Activity	Number of respondents	Number of responses per respondent	Total annual responses	Average burden per response	Total hours
Study 1 Pretest screener	385	1	385	0.08 (~5 minutes)	31
Study 2 Pretest screener	329	1	329	0.08 (~5 minutes)	26
Study 1 screener	3,007	1	3,007	0.08 (~5 minutes)	241
Study 2 screener	2,643	1	2,643	0.08 (~5 minutes)	211
Study 1 Pretest	270	1	270	1.33 (~1 hour 20 minutes)	360
Study 2 Pretest	158	1	158	0.53 (~32 minutes)	84
Study 1	2,105	1	2,105	1.33 (~1 hour 20 minutes)	2,800
Study 2	1,269	1	1,269	0.53 (~32 minutes)	673
Total					4,426

¹ There are no capital costs or operating and maintenance costs associated with this collection of information.

II. References

The following references marked with an asterisk (*) are on display at the Dockets Management Staff (HFA-305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852, and are available for viewing by interested persons between 9 a.m. and 4 p.m., Monday through Friday; they also are available electronically at <https://www.regulations.gov>. References without asterisks are not on public display at <https://www.regulations.gov> because they have copyright restriction. Some may be available at the website address, if listed. References without asterisks are available for viewing only at the Dockets Management Staff. FDA has verified the website addresses, as of the date this document publishes in the **Federal Register**, but websites are subject to change over time.

1. Bulik, B.S. (March 11, 2018). "Unbranded Pharma Ads—What Are They Good For? Actually Quite a Bit, Marketing Panelists Say." Available at https://www.fiercepharma.com/marketing/unbranded-pharma-ad-what-are-they-good-for-actually-quite-a-bit-marketer-panelists-say?mkt_tok=eyJpLjoiWkRnelpUSmlORFpoWkdNMSIsInQiOiPaENIUERpT0tnUmt6Y1BPMk9LTnpreUI3bUtPOVRzRnh1RzNuWUtYQmp0cWJhcW05UFhlcllwTzI3V0RJSndjVkJZLR3NGUHBLaWJmZmJkZmZlVWtVXczeFRFcmE0NFaVdCSjArUmx4dU1RVHZpUzFFOWIVY0dNb1RzOU9XayJ9&mrkid=20932234. Accessed on April 12th, 2019.
2. Bulik, B.S. (December 21, 2016). "Avanir Shelves Danny Glover PBA Awareness Ad in Favor of Branded Nuedexta Effort." Available at <https://www.fiercepharma.com/marketing/avanir-launches-nuedexta-brand-campaign-retires-danny-glover-pba-disease-awareness-ad>. Accessed on April 12, 2019.
3. * Aikin, K.J., H.W. Sullivan, and K.R. Betts, "Disease Information in Direct-to-Consumer Prescription Drug Print Ads." *Journal of Health Communication*, 21:228–239, 2016.
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5. * Centers for Disease Control and Prevention. (2018a, May 18). "2016 National Health Interview Survey (NHIS) Data." Retrieved from <https://www.cdc.gov/asthma/nhis/2016/table2-1.htm>.
6. * Centers for Disease Control and Prevention. (2018b, May 15). "Most Recent Asthma Data." Retrieved from https://www.cdc.gov/asthma/most_recent_data.htm.
7. Petty, R.E. and J.T. Cacioppo, "Issue Involvement Can Increase or Decrease

Persuasion by Enhancing Message-Relevant Cognitive Responses." *Journal of Personality and Social Psychology*, 37:1915–1926, 1979. doi: 10.1037/0022-3514.37.10.1915.

8. Petty, R.E. and J.T. Cacioppo, "The Elaboration Likelihood Model of Persuasion." *Advances in Experimental Social Psychology*, 19:123–205, 1986. doi: 10.1016/S0065-2601(08)60214-2.
9. Petty, R.E., J.T. Cacioppo, and R. Goldman, "Personal Involvement as a Determinant of Argument-Based Persuasion." *Journal of Personality and Social Psychology*, 41:847–855, 1981. doi: 10.1037/0022-3514.41.5.847.

Dated: June 24, 2019.

Lowell J. Schiller,

Principal Associate Commissioner for Policy.

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BILLING CODE 4164-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA-2019-D-1828]

E19 Optimisation of Safety Data Collection; International Council for Harmonisation; Draft Guidance for Industry; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice of availability.

SUMMARY: The Food and Drug Administration (FDA or Agency) is announcing the availability of a draft guidance for industry entitled "E19 Optimisation of Safety Data Collection." The draft guidance was prepared under the auspices of the International Council for Harmonisation (ICH), formerly the International Conference on Harmonisation. The draft guidance provides recommendations regarding appropriate use of a selective approach to safety data collection in some late-stage pre- or postmarketing studies of drugs where the safety profile, with respect to commonly occurring adverse events, is well understood and documented. The draft guidance is intended to advance important clinical research questions through the conduct of clinical investigations that collect relevant patient data, which will enable an adequate benefit-risk assessment of the drug for its intended use, while reducing the burden to patients from unnecessary tests that may yield limited additional information.

DATES: Submit either electronic or written comments on the draft guidance by September 25, 2019 to ensure that the Agency considers your comment on

this draft guidance before it begins work on the final version of the guidance.

ADDRESSES: You may submit comments on any guidance at any time as follows:

Electronic Submissions

Submit electronic comments in the following way:

- **Federal eRulemaking Portal:** <https://www.regulations.gov>. Follow the instructions for submitting comments. Comments submitted electronically, including attachments, to <https://www.regulations.gov> will be posted to the docket unchanged. Because your comment will be made public, you are solely responsible for ensuring that your comment does not include any confidential information that you or a third party may not wish to be posted, such as medical information, your or anyone else's Social Security number, or confidential business information, such as a manufacturing process. Please note that if you include your name, contact information, or other information that identifies you in the body of your comments, that information will be posted on <https://www.regulations.gov>.

- If you want to submit a comment with confidential information that you do not wish to be made available to the public, submit the comment as a written/paper submission and in the manner detailed (see "Written/Paper Submissions" and "Instructions").

Written/Paper Submissions

Submit written/paper submissions as follows:

- **Mail/Hand Delivery/Courier (for written/paper submissions):** Dockets Management Staff (HFA-305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.

- For written/paper comments submitted to the Dockets Management Staff, FDA will post your comment, as well as any attachments, except for information submitted, marked and identified, as confidential, if submitted as detailed in "Instructions."

Instructions: All submissions received must include the Docket No. FDA-2019-D-1828 for "E19 Optimisation of Safety Data Collection." Received comments will be placed in the docket and, except for those submitted as "Confidential Submissions," publicly viewable at <https://www.regulations.gov> or at the Dockets Management Staff between 9 a.m. and 4 p.m., Monday through Friday.

- **Confidential Submissions—**To submit a comment with confidential information that you do not wish to be made publicly available, submit your comments only as a written/paper submission. You should submit two