BIO
BIOTECHNOLOGY
INDUSTRY ORGANIZATION

December 6, 2007

BY ELECTRONIC DELIVERY

Attention: Deborah Perfetto
United States Pharmacopeia
Model Guidelines Submissions
Department of Information Development
12601 Twinbrook Parkway
Rockville, MD 20852-1790

Re: Comments on the USP Draft Medicare Model Guidelines Version 4.0

Dear Dr. Perfetto:

The Biotechnology Industry Organization (BIO) appreciates this opportunity to comment on the United States Pharmacopeia's (USP) Draft Medicare Model Guidelines Version 4.0 (Revised Guidelines). BIO is the largest trade organization to serve the biotechnology industry in the United States and worldwide, and represents more than 1,100 biotechnology companies, academic institutions, state biotechnology centers, and related organizations. Our members are involved in the research and development of health care, agriculture, industrial and environmental biotechnology products, with biotech drugs in clinical development addressing cancer, heart disease, Parkinson's, Alzheimer's and other intractable diseases.

BIO appreciates the time and effort that the USP and the Model Guidelines Expert Committee (MGEC) have devoted to maintaining the Model Guidelines. BIO notes that this year's Revised Guidelines contain fewer proposed changes to the therapeutic categories, pharmacologic classes, and formulary key drug types (FKDTs) than previous annual updates. While BIO appreciates the stability achieved by avoiding large fluctuations in the number of categories and classes each year, we continue to stress that increased specificity is critical to ensuring that Medicare beneficiaries have access to the prescription therapies they need most.

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BIO has reviewed and considered the Revised Guidelines and has identified several areas of concern related to both the update process and Revised Guidelines themselves. Specifically, BIO recommends that: (i) USP continue to establish single-drug classes in the Model Guidelines, as appropriate, to accommodate first-in-class drugs and biologicals; (ii) USP continue to implement a timely and responsive review process to ensure that beneficiaries have access to new therapies and new indications and to provide increased transparency as to the rationale supporting USP's revisions to the Model Guidelines; (iii) USP provide additional clarity and consistency regarding the listing of drugs and biologicals that could be covered under Part B or Part D; and (iv) USP continue to expand the classes and categories in the Revised Guidelines in certain instances to ensure full access to Part D drugs and biologicals by beneficiaries. BIO requests that USP consider these recommendations as it finalizes the Revised Guidelines.

I. USP Should Continue to Establish Single-Drug Classes in the Model Guidelines for First-in-Class Drugs and Biologicals.

BIO strongly believes that assuring beneficiary access to the drugs and biologicals they require under Part D should be paramount to the Model Guidelines update process, and take precedence over maintaining a static number of therapeutic categories and pharmacologic classes each year. Based on USP's elimination of a number of single-drug classes in Model Guidelines Final Version 3.0, as well as the minutes of MGEC meetings, it appears that USP has adopted a new policy that discourages the creation and/or continued existence of drug classes that include only one drug.

BIO encourages USP to reconsider this proposed policy. In implementing a policy that does not allow pharmacologic classes with only one drug, USP may facilitate the creation of Part D formularies that discriminate against patients that could benefit from new, unique, first-in-class drug and biological products. First-in-class drugs are the first in a new, unique class of drugs to reach the market. They are considered first-in-class precisely because they do not fit into existing classes. They are new and different, and thus patients who need a first-in-class drug may not have a therapeutic alternative.

The Medicare Part D Final Rule expressly acknowledges that a category or class may contain only one drug. Because a single drug

category or class clearly is permissible, there is no reason for USP to eliminate these categories or classes. CMS' policy change to use FKDTs as a formulary "outlier" test, rather than a comprehensive FKDT-level review, makes it even more critical that the Model Guidelines reflect the most accurate and specific classifications to ensure continued adequate beneficiary access to needed therapies.

II. USP Should Improve the Process for Updating the Model Guidelines to Incorporate New Therapies and Indications Throughout the Year.

BIO appreciates the changes USP has made to the process for monitoring and updating the Model Guidelines to incorporate newly approved therapies, and we applaud USP for adding two new FKDTs to accommodate new therapies approved by the Food and Drug Administration (FDA) in 2007. Ensuring that the categories, classes, FKDTs, and drug listings for the Model Guidelines remain current is critical to maintaining appropriate beneficiary access under Part D. As such, BIO again asks USP, prior to finalizing version 4.0, to review the latest FDA approvals of drugs and biologicals and assess the need for changes to the Revised Guidelines.

While BIO also recognizes and appreciates the increased transparency USP has provided on the methodology for updating the Model Guidelines, we continue to believe that additional steps can be taken to improve this process. Our members have found the explanatory synopses that detail the MGEC's rationale for classification decisions that are released with the final versions of the Model Guidelines to be very helpful. BIO requests that USP issue such explanatory documents along with the release of the draft Model Guidelines each November, as this would allow stakeholders an opportunity to develop more meaningful comments.

In addition, BIO again requests that USP publish materials along with the release of the Revised Guidelines explaining what information it has examined and considered in reviewing new drugs and biologicals and its rationale for determining a new treatment's therapeutic category, pharmacological class or classification, or for not including a particular therapy at all. Currently, the Model Guidelines Web site only contains minutes from MGEC meetings that occurred during the year that list the newly approved drugs and biologicals that the committee reviewed and voted on during that particular meeting. No additional information is

provided to the public—or to our knowledge to any individual stakeholders—that explains how the committee arrived at its decision regarding these newly approved therapies. Releasing such information along with the Revised Guidelines in November would be extremely helpful, and would improve the dialogue between the MGEC and manufacturers, resulting in more informed public comments.

III. The Model Guidelines Should Serve Their Intended Purpose of Ensuring That Beneficiaries Have Access to Needed Therapies.

The Model Guidelines are intended to promote beneficiary access to Part D covered therapies, and inclusion in the Model Guidelines is significant in terms of providing some assurance that CMS' formulary requirements are met. Accordingly, USP's focus in revising the Model Guidelines should be to ensure that the categories and classes will prevent a plan from discouraging enrollment of certain types of beneficiaries with particular conditions or diseases.

To that end, BIO seeks greater clarity around the MGEC's decision-making process for drugs and biologicals that could be covered under either Medicare Part B or Part D, depending upon the specific circumstances. If Part B does not cover a particular drug or biological "as prescribed and dispensed or administered" to an individual patient, then it is eligible for coverage under Part D. According to USP's own description of its approach and methodology to developing the Model Guidelines Version 3.0, the MGEC views the concept of self-administration as a "useful framework" for helping to determine which therapies are most appropriate for the Part D benefit, noting that therapies that are usually self-administered more than 50 percent of the time are most likely to be covered under Part D, while those therapies that are not usually self-administered would most likely fall under Part B.[1]

However, as USP also points out, there are exceptions to the self-administration concept. BIO notes that Part B versus Part D coverage determinations are often complex, and applying the self-administration threshold is just one of several different methods for making such distinctions. Certain therapies that meet CMS' "usually self-administered"

[1] United States Pharmacopeia, "Summary of USP Approach and Methodology to the Model Guidelines Version 3.0," accessed at: http://www.usp.org/pdf/EN/mmg/modelGuidelinesApproachMethodology.pdf.

criteria can be covered under Part D. For example, drugs and biologicals that are usually administered or infused in the physician's office and covered under Part B as "incident to" a physician's service could be covered under Part D if the drug or biological is dispensed by a pharmacy. Part D regularly covers these drugs or biologicals when a patient self-injects, the drug or biological is administered in a long-term care facility, by home infusion or other means not covered under Part B. BIO urges USP to make determinations regarding the Model Formulary Guidelines that protect beneficiary access to medically necessary drugs and biologicals and take into consideration that patients may require therapies in various settings of care and under different circumstances. We look forward to working with both CMS and USP to ensure that Part B versus Part D decisions related to the Model Guidelines do not deny access to medically necessary therapies under Part D.

BIO also remains concerned that certain additional categories or classes are necessary to account for distinct therapies with clinically relevant differences, such as selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs). In previous versions, the MGEC concluded, based on an understanding of available comparative safety and efficacy information, that these categories were clinically non-distinct. BIO continues to disagree with this determination, and strongly encourages USP to consider the extensive clinical evidence that others have submitted on the differences between SSRIs and SNRIs in the treatment of depression. Creating two separate pharmacological classes for these agents in the Antidepressant therapeutic category will better ensure that beneficiaries suffering from depression have access to the treatment most appropriate for them.

Another example where an additional therapeutic class is necessary to account for distinct therapies with clinically relevant differences is in the Antivirals therapeutic category. The Draft Model Guidelines includes four different pharmacologic classes for anti-human immunodeficiency virus (HIV). FDA currently recognizes seven different types of drugs used in the treatment of HIV, including the category "Multi-class combination products." Although USP added a new "Anti-HIV Agents, Combinations" class to its draft of version 3.0 Model Guidelines, it was removed at the request of CMS, apparently based on the theory that single agent anti-HIV agents are accommodated for in the existing structure of the Model Guidelines. BIO continues to disagree with this determination, and strongly

encourages USP to consider the clinical evidence that others have submitted in this area. Multi-class combination agents are not so accommodated because they do not fit under any of the four pharmacologic classes listed in the final version 3.0 or the draft version 4.0 of the Model Guidelines. Indeed, the FDA includes multi-class combination agents in a category distinct from the four classes in the Revised Guidelines. BIO greatly appreciate CMS' ongoing efforts to ensure appropriate beneficiary access to HIV/AIDS drugs under Part D, including continuing the requirement that Part D plans include "all or substantially all" of these therapies on their formularies and prohibiting the use of restrictive plan utilization management techniques. BIO shares with CMS and USP the goal of enhancing patient access to HIV/AIDS therapies under Part D. Accordingly, we recommend that USP establish a new class within the Antivirals therapeutic category defined as "Anti-HIV Agents, Multi Class Combinations" to bring its classification in line with the most current FDA classifications of HIV drugs, as this would represent an additional protection for beneficiaries who require these important therapies.

Finally, BIO notes that one of the "Recommendations for Future Versions of the Model Guidelines" that was identified at the August 6, 2007 meeting of the MGEC was that with regard to consideration of combination products, "[e]ach drug moiety should be considered separately. The decision to include combination drugs on formularies should be left to the P&T committees." BIO respectfully disagrees with this recommendation. As USP notes in its Summary of USP Approach and Methodology to the Model Guidelines Version 3.0, the Model Guidelines are one of the mechanisms under the Medicare statute "for assuring access of Medicare beneficiaries to the prescription drugs they require." BIO is concerned that excluding combination drugs from the Model Guidelines all together and leaving formulary decisions to individual plans would be inconsistent with USP's mission, as it would inappropriately limit access to important treatment options for beneficiaries under Part D.

USP has previously stated that combination drugs are only included in the Model Guidelines when an exclusive clinical benefit has been established, such as when the individual components of the drug are not commercially available or when the individual components combine to form a unique chemical entity. BIO believes that any combination drug that is the only FDA-approved treatment for a given condition should meet the exclusive clinical benefit test. In this case, a unique patient outcome is

demonstrated when two FDA-approved molecules are taken in the form of a combination drug even though a unique chemical entity is not created. While we understand the drug listing is not intended to be comprehensive, it is reasonable to assume that some Part D plan sponsors may be relatively unfamiliar with select disease states and may assume that the list is complete or reasonably complete. This could result in plans excluding important therapeutic options for debilitating illnesses from their formularies. Thus, BIO respectfully requests that USP begin including in the drug listing any combination drug which is the only FDA-approved treatment for a given condition, as this meets the exclusive clinical benefit test.

IV. Conclusion

BIO appreciates this opportunity to comment on issues of ongoing concern related to the Revised Guidelines. We look forward to continuing to work with the USP and CMS to revise and refine the Model Guidelines to ensure that Medicare beneficiaries have access to critical Part D drugs and biologicals. Please feel free to contact me at 202-312-9281 if you have any questions or if we can be of further assistance.

Respectfully submitted,

/s/

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