American Pharmacists Association®
Improving medication use. Advancing patient care.
APhA

September 13, 2013

Division of Dockets Management (HFA–305)
Food and Drug Administration
5630 Fishers Lane, Rm.1061
Rockville, MD 20852

[Submitted electronically to www.regulations.gov]

Re: Standardizing and Evaluating Risk Evaluation and Mitigation Strategies; Notice of Public Meeting; Request for Comments [Docket No. FDA–2013-N-0502]

Dear Sir/Madam:

APhA is pleased to submit these comments regarding the standardization and evaluation of REMS strategies. Founded in 1852 as the American Pharmaceutical Association, APhA represents more than 62,000 pharmacists, pharmaceutical scientists, student pharmacists, pharmacy technicians, and others interested in improving medication use and advancing patient care. APhA members provide care in all practice settings, including community pharmacies, hospitals, long-term care facilities, community health centers, managed care organizations, hospice settings, and the uniformed services.

APhA greatly appreciates FDA's ongoing efforts to gather input from stakeholders on issues related to REMS, especially the opportunity to comment publicly at the July 2013 public meeting. Based on the presentations at the public meeting, it is apparent that the FDA's investment in stakeholder discussions is leading to progress in standardizing and streamlining REMS programs. APhA's goal is to be a resource for FDA and manufacturers in designing effective REMS programs that protect patient health, increase efficiency in the health care system, and recognize the important role of pharmacists as the "medication experts" of the health care team.

I. Standardization of REMS Programs (Part D)

APhA continues to support efforts to standardize REMS. With hundreds of REMS programs, each with its own unique administrative nuances and components, compliance can be daunting for health care professionals and patients. Standardization will contribute to more effective and efficient REMS programs by ensuring that patients, aided by health care professionals, not only have access to medications, but take those medications safely, and by reducing the administrative burden on prescribers and pharmacists (hereinafter, "providers").

A. Leveraging Existing Information Technology Systems

Specifically, REMS should be incorporated into existing prescriber and pharmacist patient care work flows to the greatest extent possible. Leveraging existing electronic technologies and infrastructures, including electronic health records systems, e-prescribing systems, pharmacy management systems, and claims communications technologies creates the possibility of interoperability and enhances information sharing among providers without the necessity of expensive new IT. For example, enrolling patients in a registry at the pharmacy rather than a physician's office is more efficient because pharmacists already enter pertinent information into their pharmacy management systems and can communicate that information to appropriate entities through claims processing, independent of payment systems. This process could be managed in an essentially workflow neutral (i.e., behind the scenes) way and would add great value to the process. Requiring registration at the prescriber's office and then re-entry of the patient's information at the pharmacy doubles the work while increasing the risks of data entry error. Similarly, existing databases could be used to document, maintain, and report eligible and active provider registries for REMS programs, thereby decreasing the administrative burden on both prescribers and pharmacists.

By integrating the REMS processes into regular operations, prescribers, pharmacists, and patients are able to maximize communication and improve patient experiences, reduce adverse events, and limit administrative burdens. We suggest that stakeholders continue to meet to discuss streamlining and standardization options that will work for the full spectrum of REMS participants.

B. Front-Line Provider Input and Pilot Programs

Front-line providers, including prescribers and pharmacists, should be involved in the early phases of development of new REMS program protocols, particularly for those REMS programs that task providers with intervention, registration, or verification elements. A proactive approach decreases the risk that the protocols will have to be modified after implementation begins. New options for integration should be evaluated in pilot programs, allowing front-line providers to troubleshoot technical and/or logistical issues and to offer suggestions for improvement before rolling out the most successful programs with sufficient time for providers to prepare for, and adapt to, changes.

C. Improved System Communication

As the entire health system becomes more coordinated, the options for effectively sharing information and centralizing REMS increase. A first step in improving REMS is to improve communication among providers. Currently, providers rely on communication plans, which may include Dear Healthcare Professional letters or REMS orientation packets. APhA suggests that instead of providing disparate materials, manufacturers begin the REMS education process with a packet that includes all relevant information about the REMS program requirements and logistics and that clearly identifies which provider is responsible for each requirement. The breakdown of responsibilities among prescribers, pharmacists, wholesalers, and patients is vital to pharmacists, as pharmacists often serve as the default REMS monitor. Pharmacists regularly coordinate implementation activities conducted in different settings, including community pharmacies, health system pharmacies and long-term care pharmacies. Clear delineation of activities, including something as simple as a checklist (ideally in electronic form and maintained

in the drug file in pharmacy management systems), could assist providers in ensuring that all REMS elements to assure safe use are satisfied.

Furthermore, we urge the FDA to consider centralizing all REMS information—making educational material (including, but not limited to, MedGuides), training, and patient and provider registration information available through one FDA-based link or clearinghouse that may easily route providers to the appropriate sponsor's tools and information while not requiring providers to remember where each manufacturer's REMS website is located. This site could then serve as a foundation for future add-on functionality, including the integration of the claims transaction process and the patient registration process. At present, providers in practice settings that do not use the prescription claims transaction process must visit multiple Internet sites to complete these tasks and duplicative log in and patient information actions must be completed. From a clearinghouse, providers could use a unique identifier, such as their National Provider Identifier ("NPI"), to manage REMS logistics and compliance activities through connectivity with the appropriate REMS administrator databases. If provider and patient data were captured in a single registry, the tool could be accessed by providers implementing REMS programs in various practice settings, and also within an institution (e.g., in a community pharmacy setting, when a pharmacist verifies that a physician is certified to dispense a REMS medication) or health system. Continuing with the current fragmented, siloed system that centers on the REMS sponsor rather than the patient wastes an opportunity to take advantage of technological solutions that can improve compliance and increase system efficiencies.

A user-friendly integrated electronic network could make REMS implementation easier to execute, increase awareness of, and access to, information, and improve flexibility in implementing programs across various practice settings using different standards. A more manageable system also could better ensure successful delivery and compliance with REMS programs, thereby improving overall patient safety.

D. Tiered REMS System

APhA suggests that the FDA organize REMS programs based on tiers or levels, perhaps similar to the schedules for controlled substances. A similar approach has worked well for Transmucosal Immediate Release Fentanyl ("TIRF") drugs, and we believe that it could be extended successfully to other medications. Each level could include a standard set of components that may be applied based on the level of risk associated with the medication. Such an approach would offer manufacturers some flexibility in constructing REMS programs, but would also provide baseline consistency that would make management of numerous REMS programs easier in a variety of pharmacy settings, decreasing the burden on prescribers and pharmacists.

II. Educational Tools and Patient Outreach (Part B)

A. Simplification of MedGuides and Patient Information

APhA appreciates the FDA's ongoing efforts to improve patient education and outreach regarding REMS programs. In a perfect world, all discussion of REMS medications would involve prescriber and pharmacist intervention to assure safe and effective use as a covered benefit for patients. REMS sponsors and the FDA would have to work out how coverage for these services would be provided. At present, as required by law, providers distribute a large

volume of educational materials to patients. Many patients derive little benefit from the massive amounts of information provided and would be better served with simpler materials. As such, we support the simplification of educational materials, so that patients are not confronted with overwhelming amounts of information.

In the past, the FDA has considered streamlining educational materials so that patients receive only a single informational sheet regarding their REMS medication. As per previous suggestions, to improve the odds of patient adherence, the materials should explain the benefits of the medications in tandem with the discussion of the risks. For instance, each REMS medication could have a one-page risks/benefits discussion, with additional inserts (and/or electronic links) with supplementary technical or scientific information for those patients who can benefit from the higher-level information.

Further, to combat patient" fatigue," which can result when a patient repeatedly receives the same information in the same format, technological and iterative solutions should be considered. Online learning modules that guide patients through the medication information or smart-phone apps that push safety reminders along with reminders to take medication provide an alternative to the standard paper information. However, these innovations cannot completely supplant provider communication because not all patients currently have access to such technology.

B. Patient Interaction and Medication Therapy Management

Patients, like most people, have a limited capacity for taking in and retaining highly technical, dry information. In many instances, medication discussion comes at the end of an appointment, by which point the patient may have already reached his/her medical information saturation limit. Thus, APhA recommends that the FDA and stakeholders consider solutions that incorporate face-to-face and tele-health consultations as key elements of REMS programs. Incorporating human interaction into the REMS process improves patient safety and allows a provider to gauge patient comprehension. Further, it creates flexibility to customize risk communication to meet patients' changing needs as their long-term or chronic therapy evolves. Thus, because these consultations can have an invaluable impact on patient safety and long-term costs, they should be a covered benefit to patients.

For example, Medicare and many states have embraced medication therapy management programs (or "MTM") as an essential tool in medication adherence and safe use of medication. MTM is a distinct service (or group of services) that optimizes therapeutic outcomes for individual patients. As part of a model framework for MTM services and personal interactions with the patient, pharmacists assess and evaluate a patient's complete medication therapy regimen and then work with the patient and others on the health care team to focus on medication use and patient safety. The interaction between pharmacist and patient provides a unique opportunity to educate, identify problems, monitor drug therapy effectiveness, and follow up with other health care professionals. Use of MTM would also align more closely with the integrated models of care, such as patient-centered medical homes, that have proliferated following health reform. We suggest that, when possible, REMS patient education be folded into these MTM programs to enhance standardization and increase opportunities for full understanding and effective use. As noted above, REMS sponsors and the FDA would have to

negotiate coverage issues for these services. Not every state has an MTM program[1] and a viable compensation model would be required to make such a REMS requirement sustainable.

In addition to the benefits to patients, the use of MTM programs to provide patient education presents an opportunity to collect relevant data regarding REMS and medication use issues. MTM programs allow patient monitoring and the gathering of data on patient medication usage and adverse events, which could be highly beneficial in assessing the relative effectiveness and impact of REMS programs on patient medication usage. Additionally, when incorporated as an element of REMS, MTM programs could provide a method to independently monitor adverse reactions to specific medication if built around health IT standards. We encourage the FDA to become familiar with the work of the Pharmacy HIT Collaborative, which has made great strides in creating SNOMED codes to allow pharmacists to document their services in electronic health records. APhA believes with the appropriate application of time and resources, a direct intervention REMS element would allow pharmacists to improve program effectiveness, patient safety and education, and public health.

III. REMS Tool in Dispensing Settings (Part C)

A. Incorporating REMS Programs Into Existing Workflows

APhA appreciates the FDA's ongoing efforts to work with dispensers to design REMS programs that meet the needs of health care personnel and patients. As previously mentioned, for pharmacists, one of the most important aspects of REMS is the integration into daily workflow. Thus, the more integrated REMS programs can be into existing systems, be they electronic health records systems or pharmacy management systems, the easier it will be to comply with REMS requirements. For example, REMS training could be incorporated into required provider education, such as Continuing Education ("CE") courses (that meet all FDA requirements regarding conflict of interest, etc.), so that providers can access REMS-related education while fulfilling requirements related to licensure. Because there are a number of organizations that already create CE programs, this would not create additional work for either the FDA or REMS sponsors. APhA supports FDA-approved CE programs that provide unbiased information on the systems and procedures to safely use a medication, as presented by their sponsor manufacturers. This information is not to be confused with drug information produced by manufacturers related to their medications. We understand that the FDA has had previous discussions with the Accreditation Council for Pharmacy Education ("ACPE") regarding this issue.

Additionally, we believe that the integration of electronic verification for REMS requirements into existing pharmacy systems will also cut down on administrative work for pharmacists and improve communication across the whole of the health care "team." This has worked well for TIRF products, and it could be translated to additional medications. Electronic prescribing platforms, electronic health records ("EHRs"), and prescription claims adjudication processing currently in place could be used to accommodate REMS requirements. For prescription claims adjudication, the technology and National Council for Prescription Drug Programs ("NCPDP") standards supporting this process could be used to verify REMS-related data requests. Standards could be populated with data fields to transmit prescription data

[1] We have attached as Exhibit A APhA's 2013 MTM Digest, which provides an overview of current MTM programs.

elements to a REMS administrator database that would store REMS-required information for a specific REMS program. Using this system, a real-time messaging system could alert providers to unfulfilled REMS requirements such as patient registry enrollment or the need for provider education. Administrative burden could be further reduced by establishing patient registries using demographic data created from electronic prescribing systems to create the patient entries for a REMS registry rather than filling out a separate paper form and faxing it to a third party, as is the case for some programs.

In the case of EHRs, medications listed in a patient's EHR should link to corresponding FDA drug and/or REMS program information. Such linkages could improve provider access to labeling and safety information as well as REMS program information. Other information contained in EHRs such as patient demographics, progress notes, problems, medications, past medical history, and laboratory data could be accessed by a REMS program administrator for use in REMS programs through Health Insurance Portability and Accountability Act (HIPAA) and health IT standard-compliant transactions. It is important to note that for this level of interactivity to occur, additional integration of standardized EHR systems into pharmacy management systems will be necessary. APhA suggests that the FDA and stakeholders continue to work cooperatively to identify opportunities for effective integration across provider settings and health systems.

B. REMS Certification

As discussed earlier, the development of standard repository for REMS-related information would greatly benefit pharmacists. A REMS clearinghouse would allow pharmacists to complete certification and education requirements under a single system rather than across multiple program-specific platforms with myriad differences. Because pharmacists operate in a variety of settings, APhA recommends that each pharmacist be certified for REMS programs, as is required for prescribers participating in the REMS program. At the public meeting, two pharmacy organizations commented that there should a health-system level of certification. While we recognize that provider-level certification may require additional work for health systems, when REMS programs are changed or a new program is implemented, each provider needs education regarding that program. Pharmacists are highly educated, but just like physicians, they require additional information or training on new programs in order to ensure patient safety. It should not be too burdensome to spend a few minutes learning the nuances of a REMS program for those pharmacists who dispense and teach patients safe use. Delegating this responsibility to the system or the pharmacist-in-charge increases risks that a knowledge gap will lead to REMS failure. If health-system level certifications became the norm, it may be difficult to ensure that all providers have the requisite knowledge and resources to safely and effectively provide REMS medications to patients.

C. Tracking and Verification Through NPIs

As suggested above, pharmacists could use NPIs to access the REMS clearinghouse, and NPIs could be used to track fulfillment of education requirements. The use of NPIs would simplify the tracking of practitioner-specific REMS requirements (e.g., attestation and verification of education requirements, certification, etc.). However, not all pharmacists have an NPI because prescription claims processing is built on the pharmacy NPI rather than an individual's NPI. If the FDA made the use of the NPI integral to REMS programs, it could help to formalize the use of NPI in pharmacy practice and streamline the tracking of provider activity. While Drug Enforcement Administration ("DEA") registration numbers could theoretically be

used for tracking REMS, they would not reach all REMS programs because REMS are not limited to controlled substances and, in many cases, individual providers do not use individual DEA numbers (prescribers in hospitals may use the hospital's DEA facility number and pharmacists use the pharmacy's DEA number). In addition, the DEA has historically discouraged the use of the DEA number outside of its association with controlled substances. With NPIs, if specific verification of education is required for certification, attestation of the successful completion of the program could be sent electronically for inclusion in a seamless verification process linked to the electronic prescription claims adjudication process.

IV. Assessing the Impact of REMS (Part E)

APhA believes that the ongoing reassessment of REMS programs and tools is vital to both patients and providers. From a patient safety standpoint, assessment measures should be designed to create an iterative feedback loop. Using the same efficacy assessment tools year after year may not provide substantive and actionable insight into poor outcomes and adverse events. Therefore, we urge the FDA to require assessment tools that generate usable data and build on information gleaned from previous assessments. Further, assessment results should be shared with prescribers and pharmacists. To provide manufacturers with the flexibility to create these assessment tools and to respond appropriately to findings, we believe the FDA should streamline the process for making changes to REMS tools when such changes are prompted by assessment data. We also believe that each REMS program assessment process should involve input and guidance from prescribers, pharmacists, and patients.

In closing, we thank the FDA for dedicating time and resources to this important effort, and for acknowledging the essential role of pharmacists and pharmacies in REMS standardization and implementation. While FDA doesn't regulate the practice of pharmacy, FDA's decisions impact the practice of pharmacy daily. If appropriate time and resources are invested, pharmacists can further improve public health and education regarding REMS medications. APhA continues to advocate for a standardized, systems-based approach that utilizes existing technologies and infrastructures to implement and evaluate REMS programs. We look forward to working with the FDA, manufacturers, prescribers, and other stakeholders to identify solutions and evaluate options for REMS standardization and implementation.

Thank you for the opportunity to provide comments on this important issue. If you have any questions or require additional information, please contact Jillanne Schulte, JD, Director of Regulatory Affairs, at jschulte@aphanet.org or by phone at (202) 429-7538.

Sincerely,

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