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October 2010

Letter From The Editor: Champagne Wishes & Caviar Dreams – Why Whistleblower Prevention Steps Are Essential In The Wake of Healthcare Reform and Dodd-Frank

by Jamie L. Ghen, Esq., CIS Director of Compliance, Ethics & Legal Affairs

In 2009, after a six year legal battle against Pfizer Inc., former sales representative John Kopchinski became a millionaire as a result of his lawsuit against the world's biggest drugmaker and the record penalty. Kopchinski, along with five other whistleblowers, will earn more than $102 million in payments from the U.S. government under the False Claims Act through which individuals can reap rewards for exposing corporate wrongdoing. As if this headline alone does not peak whistleblower interest, the passage of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care Education Reconciliation Act of 2010 (Healthcare Reform), and the Dood-Frank Wall Street Reform and Consumer Protection Act of 2010 (Dodd-Frank) further incentivize employees to turn into whistleblowers.

In This Issue

1 Letter From The Editor: Champagne Wishes & Caviar Dreams – Why Whistleblower Prevention Steps Are Essential In The Wake of Healthcare Reform and Dodd-Frank
3 It's Time To Take a Stand On AMP
6 Better Late Than Never: CMS Finally Addresses Product Dates In DDR
7 SNHPA is Striving to Improve IPAPs
9 "What if..." Compliant or Non-Compliant, Are You Comfortable Making the Call?
11 FDAAA, Clinical Trial Disclosure, and Clinical SOP Tips

Prior to Healthcare Reform, the False Claims Act contained a "public disclosure" jurisdictional element that required dismissal of a whistleblower (qui tam) suit pursued by the private citizen (relator) where the allegations had been publicly disclosed in a criminal, civil, or administrative proceeding; a congressional, administrative, or GAO report, hearing, audit, or investigation; or in the news media. The scope of this bar had been judicially extended to include state proceedings. Now, the jurisdictional bar is lifted and the False Claims Act is amended to provide that the public disclosure bar is not jurisdictional and does not require dismissal if the government opposes dismissal.

Public disclosure is also now limited to federal criminal, civil, and administrative proceedings in which the government or its agent is a party; and federal reports, hearings, audits, or investigations. State proceedings and private litigation are not qualifying public disclosures. Notably, news media reports, including social media, remain a qualified public disclosure. Where there has been a public disclosure, the relator may only proceed with the action if he or she is the original source of the information.

Prior to the Healthcare Reform amendments, to qualify as an original source, the relator had to have direct and independent knowledge of the allegations. The original source exception is now amended to eliminate the direct knowledge requirement and provides that to qualify as an original source (1) the relator must provide the information to the government prior to the public disclosure, and (2) the information must be independent of and materially add to the publicly disclosed allegations.

Dodd-Frank, recently signed into legislation, covers a wide range of topics in an effort to address the causes of the recent turmoil in the financial markets. It includes significant new whistleblower protections, including the creation of the Securities and Exchange Commission (SEC) and Commodities Futures Trading Commission (CFTC) whistleblower programs, a dramatic expansion of current whistleblower protections under the Sarbanes-Oxley Act of 2002, and a new whistleblower cause of action for employees performing tasks related to consumer financial products or services. Significantly, the legislation creates alternative paths for whistleblowers to assert their rights, often with different and conflicting rights, procedures and remedies.

Dodd-Frank also provides powerful monetary incentives for whistleblowers to report securities and commodities law violations to the SEC and CTFC, as well as strong protections for doing so. Like the False Claims Act, Dodd-Frank provides for whistleblowers that provide the respective Commissions with original information about violations of securities or commodities laws to be awarded a share of between 10 and 30 percent of monetary sanctions ultimately imposed by the Commissions that exceed $1 million.

Healthcare Reform and Dodd-Frank will undoubtedly require companies to be more vigilant in their compliance program efforts as the new law raises the bar for healthcare compliance measures. A failure to implement whistleblower prevention steps will likely subject companies to increased whistleblower-related government investigations as many good employees who turn into whistleblowers strive to follow protocols, and respect and follow the chain of command. Moreover, those companies with existing internal whistleblower policies and procedures should review them to ensure that they require internal reporting and the maximum opportunity to address compliance concerns before employees provide information to federal agencies to materialize their champagne wishes and caviar dreams.

It's Time To Take a Stand On AMP

by Chris Cobourn, CIS Vice President, Regulatory Compliance
Published September 21, 2010 to PharmaComplianceBlog.com

The implementation of Average Manufacturer Price (AMP) changes from the Patient Protection and Affordable Care Act (PPACA) are right around the corner, starting with October's AMP that is due at the end of November.

There have been a lot of questions, a lot of noise, and a serious lack of substantive guidance.

I would like to give some thoughts on where we are today, and some considerations to think about for October's AMPs if no additional guidance is published by CMS. These are my own personal opinions, and are not intended to provide any legal advice or interpretation of guidance.

Bottom Line
I believe that in lieu of any additional guidance being published, we will have no choice but to establish and document the best assumptions we can in October and use them consistently until guidance is published by CMS. There has been a lot of discussion about approaches, including the dramatic approach of completely changing our models, switching from a top-down approach where we start with gross sales and remove sales to non-retail entities, to a bottom-up methodology where we build AMP up based upon what we know to be a sale to the Retail Community Pharmacy (RCP) Class of Trade (COT).

I do not recommend this approach at this time, as it is a very dramatic change, in terms of methodology, systems and tools, and I would hesitate to make such a dramatic change prior to CMS publishing substantive guidance. So, my basic recommendations for consideration are:

> *Establish and document the most reasonable assumptions you can for your October methodology and calculations, to serve as "interim" methodologies until substantive guidance is issued.*
>
> *Use your existing model and approach as the starting point for this interim methodology. For most of us, this starting with gross sales and excluding by COT (which would mean that you would focus on changes to inclusions and exclusions) (Note: this also minimizes the significant system changes until more substantive guidance is published).*
>
> *Document very well what your methodologies will be and the basis for your rationale.*
>
> *Apply the methodology consistently.*
>
> *Wait until there is more substantive guidance from CMS, and then determine whether you may need to perform a recalculation back to October.*

There is no perfect approach, and this approach has its issues as well. But I believe that the ball is in CMS' court to publish guidance. If the guidance is regulatory, that process takes time. In the meantime, we will have October calculations due in November and we have to feel comfortable with our calculations and certification. So we will have to take a stand and make reasonable assumptions.

With that said, I would like to provide some additional background and rationale, starting with looking at things from the guidance perspective.

The Guidance Perspective
What Guidance will be available in October?

CMS has published a Proposed Rule, 42 CFR Part 447 (see CIS' blog on this article), which would remove section 447.504, the definition of AMP, from the CMS Final Rule, as published July 17, 2007. Let's remember, first, that this is a proposed rule, so it cannot be considered guidance at this time, but it does provide indications of where CMS is going. CMS' action with the proposed rule could be seen in part as a response to the retail industry's recent communications, including a letter to CMS requesting that they promulgate full regulations on AMP (see CIS' blog on this) to ensure that the CMS guidance aligns with the intent and direction of the PPACA in the new definition of AMP, and also aligns with the focus on the injunction, which is to have AMP more reflective of the actual price at RCPs, since it will be used in the federal upper limits (FUL) calculation.

So, the first step in this process was to remove the definition of AMP from the Final Rule. In its proposed rule, CMS indicates that manufacturers should calculate AMP according to the legislative language in the PPACA (the

definitions of AMP, RCP and wholesaler), and as modified last month by the addition of the alternative, or non-RCP, AMP.

If the proposed rule goes in to effect as is, the guidance we would be left with is the legislative language in the PPACA, including amendments to add the alternative AMP for products that are "5i" and not "generally" sold to the retail COT (see CIS' blog on this).

That leaves us with legislative-level language, which is very high level. CMS announced in the recent proposed rule that they would issue additional guidance in the future. If this guidance is to be in form of regulation, meaning in the Code of Federal Regulations, it has to go through a process starting with proposed rules and a comment period. I just don't see how that can happen before November. CMS has issued "sub-regulatory guidance" related to PPACA provisions over the past few months, including emails and letters to manufacturers. It is certainly possible that guidance of this nature could be issued before November, but it would seem unlikely that this guidance would be as broad and deep as would be required to be as complete and substantive as the Final Rule was in 2007.

Therefore, to summarize my point, with only legislative-level guidance in place, I think it is important to make reasonable assumptions for October, keep your changes as simple as possible (such as not completely changing your models), and stay consistent with your interim approach until substantive guidance is issued.

The Exclusion vs. Inclusion Model

As stated earlier, there has been a lot of discussion recently about changing from a top-down "exclusion" approach to a bottom up "inclusion" approach. The PPACA does have language about including in AMP those sales that you know are sales to the RCP COT. There has been some discussion about using 867 data to do this. The 867 data, in its current state, would be very difficult to utilize for calculating AMP in this way. The data is considered by many to be inconsistent and incomplete, with transactions for certain customers obscured, and you would still have to assign COT to every customer on every transaction.

The top-down approach has been used for years, and is actually referenced in the Final Rule as the Default Rule, (in section 504):

> *…AMP shall be calculated to include all sales and associated discounts and other price concessions provided by the manufacturer for drugs distributed to the retail pharmacy class of trade unless the sale, discount, or other price concession is specifically excluded by statute or regulation or is provided to an entity specifically excluded by statute or regulation.*

This method has also been utilized since the beginning of our AMP calculations, I think largely because it was the only way we could do it. We had our direct sales, which were primarily to wholesalers, and we had chargeback data, where we could identify transactions to specifically exclude based upon COT. We did not have insight into non-contracted sales (i.e., direct sales to wholesalers that did not result in a chargeback). So, we started with gross sales, we reconciled the data to the general ledger to show that it was complete and accurate, and we removed transactions for customers with an excluded COT. I don't know that there is any practical way at this point of time to completely switch that model to a build up model. The 867 data is certainly not the answer, given the challenges inherent in that data and the impossibility of reconciling the data to the general ledger. Additionally, as this is such a dramatic change impacting methodologies and systems, I would hesitate to make such a change prior to CMS issuing more substantive guidance. I also think that there is merit in calculating AMP in a consistent manner with ASP and Non-FAMP, which also utilize the top-down exclusion approach.

AMP Methodology Considerations

Each manufacturer may have to establish multiple AMP methodologies (and interim methodologies of each, in lieu of substantive guidance):

> Standard RCP – The standard RCP AMP, using the RCP COT, the updated definitions of includable and excludable payments, and the updated definition of wholesalers.
>
> Alternative 5i – The Alternative AMP, which could be applied at a product level, for products that meet both requirements of being a 5i drug and generally sold to retail
>
> Non-Retail, Non-5i Products that are not a 5i, but may have few or no retail sales.

Note: This would not be actually a separate methodology, but the result of applying the standard methodology to products with few or no retail sales.

There are quite a few factors to evaluate, and a lot of gray areas. At CIS we are making reasonable assumptions based upon limited high level legislative language. I know for a fact that the law firms that work in this space have various perspectives and opinions, which may also vary based upon each business scenario. If you have external counsel that points you in a certain direction with your reasonable assumptions, make sure that you clearly document them.

Key methodology considerations:

1. The RCP AMP
   - A Class of Trade review for includable and excludable classes of trade. Determination of includable rebates to RCP, as well as to wholesalers, and the application of the Bona Fide Fee for Services test from the Final Rule.
   - Evaluation of the new definition of wholesalers, and assumptions on treatment of Authorized Generics under the new definition. (This is a very gray area, and merits legal evaluation. At this point I am concerned about making a significant change such as including AG sales in the branded manufacturer's -AMP without substantive guidance from CMS on the treatment of AG sales).
   - Smoothing of data for lagged rebate price concessions for October's AMP calculation (as October's AMP will be using data from the previous year using the pre-October methodologies).

2. The Alternative AMP
   - Making a product determination of which products may require the alternative AMP calculation, including who to develop relational for what would constitute "generally." There has been some discussion of using the VA 90/10 rule, using the ASP standard, and developing a reasonable percentage between them to apply.

3. The Non-Retail AMP
   - What methodology to employ for those products that are not a 5i drug, but have little or no retail sales. If you use the top down exclusion approach, you would have products with AMP values close to WAC. As stated earlier, this is not really a separate methodology, but the results of applying the standard RCP methodology to products with limited retail sales

     It is also worth noting that I have heard some discussion about using the Alternative AMP for non retail products that are not 5i, such as a pill type product that is not sold to retail. I see the definition of the alternative AMP as meaning it has to meet both criteria, be a 5i drug AND not generally sold to retail. I am not a lawyer, and am taking the current position of only using the alternative AMP for products that meet both criteria. You may have opinion from outside counsel that suggests you do otherwise, so it is important to understand and document their rationale.

It is important to submit comments to CMS
As you can see from the points above, there is a lot of gray area still, as we are working with legislative level language. CMS is encouraging manufactures to submit comments, thoughts and suggestions. The due date for comments, according to their proposed rule, is October 2nd. They encourage comments outside just the proposed rule, meaning removing sections 504 from the Final Rule, and would like to hear from manufacturers on their thoughts on the challenges and operational aspects of the language in the PPACA. CIS will be submitting comments, as we encourage you to submit them as well. The more manufacture comments the better, especially when CMS sees consistency in the comments and concerns across a large number of manufactures, and across types of manufactures.

Key Considerations for Next Steps
CIS is providing a wide range of services to our clients.

<u>Develop "interim" AMP methodology assumptions.</u>
Based upon the legislative language available, we

will work with you to develop and document an AMP methodology that you can start using for October's calculations. This would include the retail, or RCP AMP, the alternative non-RCP AMP, and possibly an AMP for products that are not retail based but do not meet the criteria for the alternative AMP.

Develop your Product Master and evaluate your products for the "Alternative AMP."
Develop and document assumptions on your product master, and AMP methodology treatment.

Retail Community Pharmacy (RCP) and Customer Class of Trade designation, and AMP inclusion/exclusion matrix.
Evaluate your current class of trade schema and customer master, and develop an inclusion/exclusion matrix for your statutory pricing calculations under ACA.

AMP, URA and PHS Price Modeling.
Evaluate the potential price points for Medicaid and PHS under the ACA.

Base AMP Analysis.
Evaluate the potential Medicaid AMP and UR impact so that you are aware of the potential price impact should CMS issue guidance to allow for a restatement of Base AMP.

PPACA impact analysis.
An evaluation of the potential impact of the PPACA and other Healthcare Reform measures on your specific product and business, as well as providing an executive summary for senior management.

Healthcare Reform and GP 101 Training.
Provide an overview to management of the Federal Programs, as well as the key changes that may impact your company from healthcare reform.

Excise Tax (Annual Fee) Analysis.
Assist with the evaluation of and accruals for the excise tax, to be implemented in 2011 based upon your 2010 branded/AG sales.

Better Late Than Never: CMS Finally Addresses Product Dates In DDR

by Lauren Pellicciotti, CIS Government Pricing Project Manager

In August 2010, The Centers for Medicare and Medicaid (CMS) added two additional data fields to the Drug Data Reporting (DDR) website, Purchased Product Date (PPD) and Package Size Intro Date. These were additional that industry has been hoping and waiting for. The DDR website was designed to assist manufacturers to comply with the Medicaid Drug Rebate Agreement by ensuring all required labeler information was complete and accurate on a monthly and quarterly basis. According to Release 78, PPD will be optional field for labelers.

"This field will allow labelers to input a date on which they purchased a product so that DDR will not require pricing from periods earlier than that date. Currently, pricing owed by a labeler is tracked from the Market Date of the NDC, which does not consider products purchased from another labeler. "

On another note, the Package Size Intro Date is very similar field to PPD; however, it does have slightly a different purpose. "This date will be required when a new package size is added so that the labeler will not be shown as out of compliance for monthly periods prior to a package size's introduction to the market. "

On both, new features will be for ongoing new product additions. CMS has also updated their DDR User's Guide for manufacturers to update their product file text files to reflect these recent changes.

Stayed tuned for further blog articles regarding this topic.

SNHPA is Striving to Improve IPAPs

By Judy Fox, CIS Director, US Commercial Compliance

I recently had the pleasure of interviewing Rita Baskett, Director of Pharmacy and Educational Services of Safety Net Hospitals for Pharmaceutical Access (SNHPA) and a member of their Patient Assistance Programs (PAP) and Institutional PAPs (IPAPs) Advisory Committee. SNHPA is an organization of over five hundred (500) public and private hospitals and health systems throughout the United States that participate in the Public Health Service 340B discount program. SNPA monitors, educates, and serves as an advocate on federal legislative and regulatory issues related to drug pricing and other pharmacy matters affecting member providers. SNHPA is dedicated to creating new opportunities for members to save on pharmaceuticals and improve access to pharmaceutical care. Individual application PAPs require each patient to be approved prior to the hospital receiving the medications. IPAPs allow a hospital to receive the drugs through bulk replacement programs and administer them to eligible patients. Rita, who oversaw the PAP program at Carolinas Healthcare System for 6 years, shared the Committee's concerns regarding the future of IPAPs in SNHPA hospitals across the country.

The PAP Advisory Committee reached out to pharmaceutical manufacturers through one of the industry's primary IPAP auditors ("vendor") earlier this year in an effort to address the concerns over IPAP requirements and audit practices. The goal was to bring members' concerns to the attention of manufacturers in the hopes of reaching an amicable solution to what the Committee sees as a cause for action.

SNHPA members have voiced concern over the methodology for the requirements for hospitals to participate in IPAPs, and specifically IPAP audits. The current requirements for participation are not standardized among drug manufacturers and member hospitals are experiencing a wide range of audit activities that prove to be onerous and difficult to accommodate. The audit requirements are especially taxing, given the fact that hospitals do not have dedicated resources available for audits. As a result, as hospitals question the value of participating in IPAPs, they are withdrawing from the programs and are relying on the individual PAPs to bring medications to needy patients.

"Hospitals really need the IPAP programs to become more manageable," Rita pointed out as she outlined some of the concerns, "SNHPA believes the two sides can reach an amicable solution that will satisfy the drug manufacturers and their regulatory responsibilities without taxing the hospital resources." She provided insight into some of the challenges as well as recommended solutions to the audit process:

Concerns:

- The documents being requested during an audit include documentation that is repetitive to the same information hospitals have to submit in order to qualify for IPAPs. As an example, in order to qualify for IPAP participation, a hospital has to submit its relevant policies and procedures for managing the program and provide updates whenever the documents are revised. Auditors are requesting the same documents during an audit. SNHPA members feel that their submitted documents should be retained and reviewed prior to the on-site audit as a means to facilitate a more efficient audit process.
- The document requests during an audit are not consistent. In some cases, hospitals are permitted to submit documents electronically prior to the on-site audit, and others require hospitals to present documents to the auditors on-site, adding inefficiencies to the process, and still others require information such as dispensing records to be viewed on the hospital computer screens and do not permit the hospitals to provide printouts for the audit review. In addition, hospitals feel that some documents requested are not relevant to the audit or managing an IPAP. When document requests extend beyond the management of the IPAP, hospital members must obtain it from other resources within the hospital, increasing the burden. As an example, the following documents have been reported as requested during an IPAP audit: hospital floor plans and security systems; individual pharmacist's license; and hospital financial statements.
- Auditors have increased the number of patient files to be tested during an audit, yet the increase in the sample size is not directly related to the volume of patients.
- The length of an audit varies from two (2) days to a full week, without the timing of the audit aligning to the IPAP activities or patient volume. Since

hospitals have limited resources and space for audits, the audit scope should reflect a reasonable rationale behind the need for a week long audit.
- Drug manufacturers require specific IPAP policies and procedures, some drug specific policies and procedures, rather than policies generally applicable to all IPAPs.
- The IPAP renewal process is becoming increasingly difficult, including submission of the same policies and procedures submitted during the application and audit processes. Additionally, the eligibility period is very short while the renewal process is very long, resulting in a renewal cycle that is extremely inefficient and time consuming.

Suggestions for improving the audit process:
- Standardize the audit process, specifically, the methodology for document review should allow auditors to confirm that documents have not been revised, and are up to date. Document collection should not be required for policies and procedures that have not changed.
- Extend the time between scheduled audits for hospitals with successful audits and satisfactory processes.
- Allow hospitals to produce state board of pharmacy examination results as documentation of compliance with state pharmacy laws.

Suggestions for improving the IPAP process:
- Provide member hospitals with regular updates of drugs added or deleted from an IPAP.
- Eliminate the requirement that an insurance investigation be performed at the time of each refill and substitute annual updates.
- Deliver drugs only to the pharmacy or the attending physician as a means to effectively track drug disbursements as opposed to delivering drugs directly to a patient.
- Accept email or on-line submissions of documentation related to applications, renewals and audits.
- Standardize federal poverty level (FPL) eligibility requirements.

The SNHPA committee recognized the fact that all of the responsibilities cannot be the burden of drug manufacturers and as such presented what I found as one of their most compelling suggestions. The committee would develop a set of best practices, covering key criteria for managing an IPAP which would in turn be high risk areas in an audit. Once suggested policies have been established, member hospitals would be able to adopt the appropriate documents and implement processes that are both compliant and efficient.

"We sent [the vendor] a document in an effort to start a dialogue." said Rita. "With the tough economic climate and growing numbers of uninsured patients, we are anxious to start a dialogue with the drug manufacturers so our member hospitals can maximize the use of IPAPs." The vendor responded by saying that they are reviewing the concerns and suggestions with drug manufacturers, but that no immediate response from the manufacturers should be expected due to the complicated process for business rules.

While CIS would agree that change cannot be expected overnight, we would suggest that the fact that the committee is willing to proactively address their concerns by establishing standardized policies is the best place to begin the process. Multiple drug manufacturers are involved in IPAPs; however, the common denominator of SNHPA membership and a single vendor handling most of the IPAP compliance audits provide a head start in implementation. From the perspective of CIS' auditors, such standardization would allow for the audit process to be more efficient, allowing more time for transactional testing of patient records and dispensing activities that are so crucial to IPAP audits.

As the SNHPA advisory committee moves forward with any initiatives, they welcome feedback and suggestions from drug manufacturers. Manufacturer representatives can contact Rita Baskett at 202-552-5857 or rita.baskett@snhpa.org with comments or questions.

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[1] Release 78: Medicaid Drug Rebate Program, Centers of Medicare & Medicaid Services

[2] Release 78: Medicaid Drug Rebate Program, Centers of Medicare & Medicaid Services

"What if..." Compliant or Non-Compliant, Are You Comfortable Making the Call?

by Judy Fox CIS Director, US Commercial Compliance

The recent Vermont (VT) state legislation requires manufacturers to report disbursements of samples, coupons, vouchers, and starter doses and the Healthcare Reform Law requiring reports for sample disbursements. As a result, manufacturers are justifiably anxious to conduct program assessments and vendor audits to ensure that their programs are robust enough to stand up to the laws. Some of the time, it only takes one person to shake things up before a gap in your program is realized. Hopefully, by sharing some of these stories, you will not have to wait for that to happen in order to make improvements that can proactively address the laws.

The following are some scenarios that I have actually witnessed in my experience auditing and monitoring sampling programs and sales representatives. Names have been changed to protect the not so innocent and in many cases, the not so bright. The idea is to get you thinking about your program in ways that you may have never considered before.

Situation #1
A sales representative with ABC Pharmaceuticals samples a Rx cough/cold product. The rep is allocated 10 samples per doctor once every 2 weeks. The rep gets request from a practitioner's office requesting samples. The rep has a good relationship with everyone in the doctor's office, and does not want to jeopardize the relationship so he visits the doctor and brings the 10 allocated samples.

The rep and the doctor chat for a while and the doctor asks the rep if he can spare some additional samples. The rep has 100 samples in his car and gives the office all of them. To thank the sales representative, the doctor gives the representative two tickets for Sunday's football game. The rep is a big fan and is thrilled with the tickets.

Does this transaction require compliance consideration?

Situation #2
Emily is a Texas sales representative for a pharmaceutical manufacturer. She begins sampling in January after completing training. When she receives her first quarterly reconciliation report in early April she has a sample variance of over 1000 samples, well beyond the acceptable threshold.

Emily is confused by the reconciliation process and is brought into the home office for reconciliation mitigation. Emily continually says that she does not know what happened. It is discovered that Emily has never conducted the required monthly inventory and many of her documents are missing, so there is little that can be done to help her. Emily is reported to the FDA for a significant loss.

In fear of being terminated, Emily resigns. Her manager conducts a closeout and transfers the samples in her storage unit to other representatives. When the transactions are completed, Emily and her manager sign the closeout document, stating that she has zero samples in her possession.

In May, the pharmaceutical manufacturer receives a phone call from a storage facility in Texas. The facility went in to confiscate the contents of a storage unit for auction and discovered drug samples. It turns out that Emily had rented a storage unit in March, never informed the pharmaceutical manufacturer and never paid the rent.

A pharmaceutical manufacturer manager visits the storage unit to collect and count the contents. After documenting the additional return of samples, Emily's inventory balances. When contacted, Emily said that she forgot that she had a second storage unit, but is happy that her records balance. She admits that she never really sampled a physician, and that is why she had so few documents. She rented the storage unit to move the samples so that her inventory would appear to be correct if ever inspected. She now wonders if a new report will be filed with the FDA to let them know that her inventory did indeed reconcile and Emily feels she is in the clear.

Do you agree that there is now nothing to report to the FDA?

Situation #3
A pharmaceutical manufacturer uses the ABC Group to handle all of their sample accountability. As part of their agreement, the ABC Group sends the pharmaceutical manufacturer representatives forms for distributing samples to the physicians. The forms are preprinted with

the physician's name, address, license number and other pertinent information to satisfy the PDMA requirements. The ABC Group sends the forms to the reps once a month and prints out 3 forms per doctor with approximately 50 blank forms in the shipments as well.

Steve is a representative for the pharmaceutical manufacturer and he has approximately 200 doctors on his target call list, so he receives 650 forms in his shipment every month. He uses the blank forms to add new doctors and as a back up when he runs out of preprinted forms for his existing doctors.

When Steve wants to sample a new doctor, he has been told that he is allowed to sample the doctor one time and then he must wait for the ABC Group to make sure that the physician has a valid license number and that the address is correct for the license. If the information is valid, the ABC Group will send the forms with the preprinted information for doctor. If the license is not valid, Steve will not receive a preprinted form for the doctor.
If the doctor is not a valid practitioner and Steve continues to distribute samples to the doctor, the ABC Group will send him an email telling him that he should not sample the doctor again.

Does this represent a compliant process?

Situation #4
A pharmaceutical manufacturer has a drug that will go off patent at the end of December. They already know that a generic of the drug is scheduled for launch at the beginning of January. The brand manager for the drug knows that there are a lot of samples with the reps in the field and they will not provide detail or promote the product after the first of the year.

The brand manager wants to avoid the expense of a lot of returns on any un-sampled product because even though it may not be expired, it is company policy to destroy product that has been returned from the field. As a solution, the brand manager instructs the field sales representatives to give out all of their samples of this particular product by the end of the year, in the hopes it will create some brand loyalty after the generic is available. He tells the representatives to find doctors that want to donate the samples to a charity or to just give doctors extra samples so that they can minimize the cost of returns and destruction.

Are you comfortable with this decision?

Situation #5
ABC Pharmaceuticals, Inc. regularly conducts practitioner signature audits as required by the PDMA. One Vermont practitioner responded to the audit that while he knew the sales representative and the signature was genuine, he was concerned over the quantity documented. The practitioner said that he was usually sampled one (1) or at most two (2) units, but this one document showed that he was given 100 units. In the mean time, the sales representative's inventory is off for a quarterly reconciliation. After investigating the issue, it was noted that the sales representative had made an error and inadvertently entered two (2) zeros after the same disbursement of one (1) unit.

ABC's electronic Sales Force Automation (SFA) system does not allow adjustments to a sample disbursement. The vendor handling sample reconciliations for ABC corrects this particular transaction by entering a phantom shipment for ninety nine (99) units to balance the representatives' inventory and "correct" the error. The sales representative's inventory is now within the threshold and the matter is considered resolved since the practitioner acknowledges the signature and the error was detected.

Do you agree that the matter would be considered "resolved"? If you do, did you take into consideration the following?

1. When reporting sample transactions under the Healthcare Reform Act and to the state of Vermont, will this be reported as 100 samples given to the practitioner? If not, how will the data be corrected?
2. Did this method of correcting such disbursement errors go through an approval process?
3. Are you certain that your compliance department does not consider this falsification of records as defined by the PDMA?

At the time of this writing, CIS is exhibiting at the PDMA Alliance Sharing Conference in San Diego, October 4-6 (www.pdmaalliance.org). When I return, I will be certain to share any insight from the conference sessions and my experiences as a member of the vendor panel discussing the impact that state and federal compliance and reporting laws have on sample accountability programs. Please check pharmacomplianceblog.com for those insights.

Contact me at judyfox@cis-partners.com or at 484-445-7185 if you have any compliance questions.

FDAAA, Clinical Trial Disclosure, and Clinical SOP Tips

by Annette Horner, CIS Senior Director, Clinical Consulting Services

In the interest of transparency in clinical research, sponsors conducting research in the U.S. are now generally aware they must register clinical trials and disclose trial results on the publicly accessible website, clinicaltrials.gov. Larger companies have dedicated considerable resources to design and implement effective business processes, and have reported on those processes and the supporting organizational and IT systems at industry meetings over the past two years.

Still, small and mid-size sponsor companies struggle to comply with the requirements for Clinical Trial Registration and Results Disclosure (CTR/RD). Some companies report that they do not understand the intricacies of the still evolving Food and Drug Administration Amendments Act (FDAAA) requirements. Others report they don't have adequate resources to maintain a consistent and timely disclosure effort. We think both issues can be addressed by creating or updating Clinical SOPs to structure a "right-sized" internal process that works with available resources.

Here are a few CTR/RD SOP tips, shaped mostly for the small to mid-size company, gathered from our consulting experience with sponsors and other industry experts:

1. Begin with a corporate CTR/RD policy: Should you follow the letter of the law OR exceed current requirements?

a. If your company is small with few products, start with the letter of the law to conserve resources and maintain simplicity.

b. If your company is medium to large, exceed current requirements to gain the following benefits:

- Fewer customized decisions
- More efficient process
- Fewer changes in SOPs, templates, training

2. Create an internal central repository of your company clinical trials

a. Make it the authoritative source of your clinical trial information, upon which you base clinicaltrials.gov entries and updates

b. Include studies of co-development partners

c. Make small scale (spreadsheet) or large (database)

d. Keep it accurate, current, and accessible to all internal stakeholders

3. Include procedural steps to evaluate each study for CTR/RD posting; document each disclosure decision

4. Specify information sources and authorizations

a. Include information verification steps at data point level: data subsets are prone to error and need careful quality control

b. Address protocol amendments

5. Select familiar and reliable process milestones to signal release of information

a. e.g., 1st drug shipment to signal release of study registration information on clinicaltrials.gov.

b. Include a quality control step/check to ensure the signal works as intended

6. Review organizationally related SOPs and update to align with CTR/RD SOPs:

Business process or SOP related to CTR/RD SOPs	Check for these alignments
Clinical study protocol development & approval	Include steps that clearly trigger internal release of protocol information for CTR
Internal audits	Make internal auditing SOP broad enough to allow for audits of CTR/RD compliance
Informed consent	Include information that study results will be posted on publicly-accessible website
Clinical study report development & approval	Include steps that clearly trigger internal release of study results for Results Disclosure
IND submission NDA submission	Include steps to complete Certification Form FDA 3674 and submit to FDA with all marketing and clinical investigation applications for drugs, biologics, and devices.
Contracting with alliance partners & CROs	Include mutual review of CTR/RD policies as part of due diligence negotiation, to determine which partner has best access to needed information sources and infrastructure; to define which partner has CTR/RD reporting responsibility; to specify timelines for status reports that allow for CTR/RD updates.

7. Address the complexity of multiple registries world-wide

a. About 30 countries and industry stakeholders have laws, registries, or expectations for clinical trial transparency

b. Beware registry inconsistencies: in the scope of trials, specific data fields, timing of public release, measures of compliance

c. Apply vigilance to routine maintenance complexities: regulatory updates, clinical trial updates, multiple study IDs

8. Overall Challenge: Maintain clinical trial disclosure compliance with an efficient business process and SOPs appropriate to the company size, product portfolio, number of business units and geographic reach.

Clearly, even small and mid-size sponsors will need to allocate resources to this issue and create effective and efficient business processes and reliable SOPs that make CTR/RD compliance a routine part of doing business.

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[3] Food and Drug Administration Amendments Act of 2007. Public Law 110-85. Enacted September 27, 2007.

[4] Teden P. Clinical trial registration and results disclosure: business process considerations. Drug Information Journal. 2010;44:243.

[5] Kishore R, Tabor E. Overview of the FDA Amendments Act of 2007: Its effect on the drug development landscape. Drug Information Journal. 2010;44:469.

[6] Pelletier SM, Strange MA, Godlew BJ. Operational issues in clinical trial disclosure of global trials. Drug Information Journal. 2010;44:253.