The Greater Metropolitan Clinical Taskforce

Blood and Marrow Transplant Network N.S.W.

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12 February 2010

Blood and Tissues Unit
Standards and Code of GMP
Office of Devices Blood and Tissues
Therapeutic Goods Administration
PO Box 100
WODEN, ACT 2606

To whom it may concern,

Re: Consultation on proposed standards and Code of GMP for human blood and blood components, human tissues and human cellular therapies (December 2009)

The following comments are made on behalf of the Blood and Marrow Transplant (BMT) Network NSW.

1. Comments on the draft code of GMP for Human Blood and Blood Components, Human Tissues and Human Cellular Therapies

The new draft document is based heavily on the Code of GMP for Blood and Tissues (2000). The new document has been restructured into a more logical order and sections that were specific for blood and blood components have been written to be more general and hence applicable to a wider range of cellular therapies. Sections on screening and testing donors for transmission of infectious diseases have been moved to a separate document, "Therapeutic Goods Order No. XX".

Specific issues in the Code of GMP:

300	It is not clear when clauses in Annex 1 of the mandated Code of GMP for Medicinal Products would be applicable.
702 – 704	The clauses regarding product recall seem irrelevant to the HPC sector where products are infused without delay after release.
818	Equipment used in collection is rarely required to be sterile and hence this sentence should be removed.
905	The definition of "competent" is not indicated in the document. It is assumed that a NATA-accredited diagnostic laboratory would be deemed as "competent".

It is still uncertain whether the draft Code of GMP will apply to the majority of non-cord blood HPC collection and processing facilities. This largely depends on how facilities are classified and whether any exemptions continue to be applied. The draft Code of GMP is a very generic document that lacks specific requirements that are applicable to the HPC sector and hence it is unlikely that it would be used as the sole standard in this area. The use of an additional, more prescriptive standard adds complexity and potential for conflict.

The following prescriptive standards were written for the HPC sector, contain much more detailed and specific requirements, and contain the same quality management requirements as the Code of GMP:

- NPAAC Requirements for procedures related to the collection, processing, storage and issue of human haemopoietic progenitor cells (3rd edition 2009).

- FACT-JACIE International standards for cellular therapy product collection, processing, and administration (4th Edition 2008).

Hence the BMT Network strongly urges the TGA to use either of the above standards for regulation of HPC in Australia.

2. Comments on Therapeutic Goods Order No. XX – Standards for minimising infectious disease transmission via therapeutic goods that are human blood and blood components, human tissues and human cellular therapies

This draft TGO details the requirements for screening and testing donors for infectious disease transmission. It applies to autologous and allogeneic donors of blood, HPC and other therapeutic cells, with tables that clearly list the donor groups and applicable requirements.

Comments regarding specific sections of the TGO relevant to the HPC sector:

General	The term "ineligible" is used in the document, but is not defined. The BMT Network would support the use of this term if used in the same context as the FACT standards and the FDA "Guidance for Industry: Eligibility Determination for Donors of Human cells, Tissues, and cellular and Tissue-Based Products (HCT/Ps), where an ineligible donor can be used in certain defined circumstances.
4. Interpretation, (2):	It is recommended that this document use abbreviations that conform to the ISBT 128 nomenclature, i.e.: • HPC, Apheresis • HPC, Marrow • HPC, Cord Blood
Schedule 2, (1b):	This clause excludes the use of allogeneic donors who have (i) resided in the UK for more than 6 months between 1980 and 1996, or (ii) have received a blood transfusion or blood components in the UK after 1980. Although such a clause is relevant to blood and blood components, its relevance to the HPC sector is questionable. We would advocate that information on donors that do not meet these requirements be provided to the Transplant Physician who should be able to proceed to using such a donor after performing a risk/benefit analysis and informing the recipient of the potential risks.
Schedule 4, (9) & (10):	These clauses require storage of donor serum/plasma to facilitate retesting or additional testing at the time of cell infusion (clause 9) and a minimum of 2 years after the product expiry date (clause 10). Although the BMT Network generally supports this clause, it must be recognised that the additional storage equipment and space that will be required to meet this clause will have a significant impact on NSW Health budgets.
Schedule 5, (1a):	Mandates the use of NAT for HIV, HCV and (when approved), HIV for all autologous and allogeneic HPC donors. Although tests using NAT have the ability to significantly reduce the time window for detection of infectious disease markers, it must be recognised that the additional testing required to meet this clause will have a significant impact on NSW Health budgets.
Schedule 5, (1 c ii):	States that a physical examination be performed to determine suitability of the donor within 7 days of collecting the cells. Mandating that this examination occur within 7 days of collecting cells from an allogeneic donor could have morbid consequences for a recipient that has already commenced conditioning therapy. Hence it is suggested that the requirement be changed to performing the physical assessment within 30 days of collecting HPC.
Schedule 6, (2 a iii):	This clause states that supplies & reagents that come in contact with the HPC must, "if required by the Act", be approved for an

equivalent purpose and entered on the ARTG. It is unknown at this stage which items this clause would apply to, but would be problematic if applied to items such as DMSO and Dextran-40 since the suppliers do not sell enough in Australia to warrant getting the item listed on the ARTG. Inability to use such products could severely compromise HPC transplant programs.

It would be appreciated if receipt of these comments were acknowledged together with feedback regarding our comments.

Yours sincerely

V. Antonenas

VA on behalf of Anthony Dodds.

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