1 May 2017

Reforms and Operations Section
Pharmacovigilance and Special Access Branch
Therapeutic Goods Administration
PO Box 100
WODEN ACT 2606
Submitted via online submission

Dear Sir/Madam,

Response to Consultation: Strengthening monitoring of medicines in Australia

ASMI (Australian Self Medication Industry) is the peak body representing companies involved in the manufacture and distribution of consumer health care products (non-prescription medicines) in Australia. ASMI also represents related businesses providing support services to manufacturers, including advertising, public relations, legal, statistical and regulatory consultants. Further information about ASMI and ASMI members is available on our website (www.asmi.com.au).

Thank you for the opportunity to provide feedback to this consultation on enhancing medicines monitoring, a project predominantly designed to address the elements of recommendation 27 of the Review of Medicines and Medical Devices (MMDR). We note that R27.2 will be deferred until other work is undertaken.

Recommendation 27, where the Expert Panel proposed that the Government undertake:
1. Better integration and timely analysis of available datasets, including analysis of matched de-identified data from the Pharmaceutical Benefits Scheme, Medical Benefits Scheme, eHealth records, hospital records, private health insurance records and device and other relevant registries and datasets;
2. Establishment and maintenance of registries for all high-risk implantable devices;
3. Implementation of a scheme to alert practitioners and consumers that a drug is newly registered and to encourage reporting of any adverse events;
4. Provision for electronic reporting of adverse events; and
5. Enhanced collaboration with overseas National Regulatory Authorities to share information relating to safety or efficacy.

ASMI are supportive of this recommendation in principle dependent on the detail of the plans for implementation. In this consultation we are pleased to see the incorporation of work conducted under previous consultations, undertaken as part of the TGA’s Blueprint for reform and the ANZTPA B2B projects, along with a strong commitment to IT resource to improve AE reporting and signal detection.

ASMI’s responses to each of the proposals to implement R27 and to the questions asked in the consultation paper follow.

In summary of the key points of our response are:

Advancing consumer health through responsible self care
The purpose of the Black triangle scheme (the Scheme) should be clear and not confused with other post-market monitoring communications. The terminology used to describe the criteria for a product’s inclusion should be consistent with the Scheme’s purpose. Non-prescription medicines (complementary and OTC medicines, unscheduled, Schedule 2 and Schedule 3 medicines) are by definition not “newly available” and should be clearly excluded from the Scheme.

We support adoption of the European SmPC format for Product Information (PI). This will allow for trans-Tasman convergence and for common PI/Data Sheets for joint Australian and New Zealand products. While transition details were not provided in the consultation paper, ASMI were reassured by the transition proposals provided in the ARCS hosted TGA webinar on this consultation, held on Wednesday 26th April, 2017. We support these proposals to quickly and with minimal regulatory burden deliver product information for health professionals in a more useful order for ease of prescribing.

Transparency and clarity of the Pharmacovigilance inspection program (PVIP) process will need to be provided in the form of guidance that outlines the details of the process. ASMI would be please to participate in the development of the process details and the drafting of guidance via review and feedback. ASMI also suggests an initial investment in sector specific roadshows which would provide an opportunity for sponsors to confirm their understanding of the guidance and TGA to share the observations of common deficiencies/misunderstandings from the pilot. ASMI support the proposal for statistical reporting of the program.

In principle ASMI would have no issue with Risk Management Plans (RMPs) being subject to compliance monitoring. ASMI would like to be kept informed and involved in the development of compliance monitoring processes, with potential for application of RMPs as a tool to manage the change in risk profile and the new safety concerns for certain switch applications from Schedule 4 to Schedule 3.

ASMI welcome the investment in implementing a new IT system (replacing ADRS) to improve and streamline the submission of adverse event reports electronically to the TGA. We request sponsor training and user guidance for the new system.

ASMI welcome the new functionality of AEMS and the capacity enhancement it provides the TGA to make a stronger contribution to international information sharing and collaboration.

We remain committed to working with the TGA to ensure and effective and comprehensive notification change process is implemented.

Yours faithfully
Adverse event reporting

Black triangle scheme

| Do the proposed criteria for inclusion in the Black Triangle Scheme appropriately target new medicines for which adverse event reports should be sought? |
| What information, communication and education activities would assist health professionals and consumers to understand the Black Triangle Scheme and the importance of reporting adverse events for these medicines? |

Criteria for inclusion in the Black Triangle Scheme

ASMI trust that the TGA’s intent is that the Scheme will apply to prescription medicines. ASMI believe the Scheme should overtly exclude non-prescription medicines; namely those medicines that are complementary and OTC medicines, and either unscheduled, or in Schedules 2 or 3 of the Poisons Standard.

The criteria for inclusion in the Scheme should be clear and consistent with the stated purpose. We were concerned at the terminology used in the consultation paper to list the circumstances where “Other types of registered medicines” [emphasis added] may be included in the Scheme if determined by the TGA. Use of the term ‘registered medicines’ broadens the scope for inclusion in the Scheme from truly new, high risk, prescription medicines to all registered medicines and introduces the potential for subjectivity of the decision for the requirement for priority monitoring. If the black triangle symbol is to be a successful communication tool it should be applied consistent with its purpose, clearly standing for newly available medicine and triggering the need to be alert to possible unidentified adverse events. The value of the symbol will be diminished in health professional’s minds and trigger doubt if it is applied to well characterised, established registered medicines as a means to alert them to a new safety concern. It could also undermine the other existing mechanisms for communicating new or suspected safety concerns - the Medicine Safety Update or the Early Warning System.

Non-prescription medicines (Complementary and OTC medicines) generally have a favourable safety profile. OTC medicines typically have a long history of use in self-limiting conditions or minor conditions which are able to be managed by the consumer. Schedule 3 medicines, which are not available for self-selection, generally have a history of use as a prescription medicine prior to being rescheduled to Schedule 3. Applications for rescheduling are required to provide data on benefits and risks associated with the medicine, the extent of use, safety data, and must demonstrate a low potential for toxicity or misuse. Applications undergo evaluation and consideration by the Advisory Committee on Medicines Scheduling (ACMS) in order to be rescheduled from prescription only medicine (Schedule 4) to OTC status.

Similarly, the majority of complementary medicines are non-prescription medicines, are low-risk and include vitamins, minerals and some herbal products. Very few registered complementary medicines are entirely novel.

If during the registration evaluation process there are suspected concerns about the safety profile of a ‘new’ OTC or complementary medicine we suggest that this would trigger consideration of the appropriateness of the scheduling of the active ingredient rather than consideration of inclusion in the Scheme, which is dependent on the supervision of the medicine’s use by a health professional.
Product Information (PI) reformat

Are the proposed changes to the Product Information (PI) leaflet useful for health professionals?

What support will sponsors need to comply with the new format and what are achievable timelines for implementation of the new format?

ASMI members are impacted by the proposal to reformat the PI, being sponsors of schedule 3 medicines and/or restricted medicines. The ASMI secretariat and members look forward to being included in the work TGA intends to undertake with sponsors to reformat the PI.

In this regard, harmonisation is a key principle to be applied, in particular with New Zealand. Sponsors attempt to ensure economic viability of products by harmonising the product labelling and PI and CMI. Medsafe conducted a consultation of the format of Data Sheets¹ in the first quarter of 2016 and has decided to adopt the EU SmPC format. They allowed for a 2 year period to update existing datasheets and set a window after which the existing format would not be accepted. All new medicine applications currently in evaluation were required to be approved with a data sheet in the SmPC format. Other allowances were made for the practicality of the initial updating of format within this timeframe.

We understand that the TGA similarly proposes to adopt the European SmPC format. ASMI would be very supportive of this proposal as it would accommodate a common PI/Data Sheet for joint Australian and New Zealand products.

While transition details were not provided in the consultation paper, ASMI were reassured by the advice provided in the ARCS hosted TGA webinar on this consultation held on Wednesday 26th April, 2017, where the TGA presenter advised that:

- A 2 year transition period was envisaged with a planned implementation from January 2018 for full implementation by January 2020, and
- An optional soft implementation commencement mechanism may be considered to allow sponsors to commence transition earlier than January 2018.
- It was envisaged the change would be a re-ordering of the existing approved information under the SmPC format headings, rather than a complete rewriting of all PIs,
- As most applications would in effect be a reformatting of blocks of text – no variation fee would apply. For older products – TGA advised that they would look at how they move to the new format – and they may audit them to assess no change to the text, just change to the order.

ASMI support all of these proposals to quickly and with minimal regulatory burden deliver product information for health professionals in a more useful order for ease of prescribing.

¹ Medsafe Consultation on proposed changes to the data sheet format
Compliance

Pharmacovigilance (PV) inspection program

What activities could TGA undertake to assist sponsors in complying with their pharmacovigilance requirements?

Some ASMI members participated in the PV inspection trial conducted in 2015. All members who participated indicated that they had learned significantly from the experience and would recommend that TGA run some specific non-prescription (registered and listed) medicine workshops to provide feedback from the TGA’s learnings from the pilot, give an overview of the TGA’s approach to a PV inspection and the expectations during and after the inspection. ASMI suggest an initial investment in sector specific roadshows on the new inspection process. This will assist the industry to self-assess their processes for readiness for an inspection. For the non-prescription sector it will particularly assist those sponsors without the reassurance of a multinational company’s corporate pharmacovigilance system support and oversight.

ASMI welcome the TGA’s proposal for a risk based approach for scheduling inspections which includes both random inspections as well as targeted inspections determined by established criteria. We agree with the proposed criteria for targeting of inspections based on risk assessed by:

- the types of medicines the sponsor is responsible for, specifically medicines with uncertainty about their risk profile (new medicines and provisionally registered medicines);
- products with known safety concerns;
- evidence that the sponsor is or has been non-compliant with other TGA regulatory requirements – such as, RMP activities;
- data analysis which identifies potential non-compliance with pharmacovigilance requirements under the Therapeutic Goods Act 1989– for example evidence of failure to submit adverse event reports within required timeframes;
- information from prior inspections in Australia and overseas.

We would appreciate the availability of guidance that outlines the process for random and targeted inspections, including:

- the announcement of the inspection,
- the preliminary information necessary to assist identifying the scope of the inspection (e.g. how many sites may be impacted, who will need to be available to the inspectors),
- the closing meeting and summary of the close out steps to finalise the inspection report (which it is assumed would be prepared and provided for the sponsor),
- details of any response required by the sponsor, and
- the anticipated timeframes associated with each stage of the inspection.

It would be useful to understand whether a rating system will implemented given the proposal to publish the statistics of the program. We propose that a final report and a rating system would provide sponsors with clarity of the findings and the areas requiring focus for improvement, along with the ability to benchmark against industry ratings figures.

We are pleased with the consultation paper’s proposal that where deficiencies are identified, the TGA’s initial approach will be to work with sponsors to implement corrective actions by providing education, guidance, tools and examples. Regulatory action should only be considered where: a sponsor has a continuous history of non-compliance, major deficiencies are left unaddressed, or where a critical finding which poses a high risk to public health is detected.

ASMI members will be interested to understand the approach to publishing the statistics of the PV Inspection Program. We are reassured that the proposal is to publish statistics of the program rather than to publish the
outcomes of the inspections. This allows sponsors to gauge their performance and progress. With the opportunity afforded in the design of a new program, consideration should also be given to collecting useful feedback statistics for the industry, such that common or emerging deficiency areas might be reported.

We assume statistical reporting of the PVIP would appear in the TGA Performance statistics report, however we noted the discrepancy in frequency of reporting with this report now to be published annually, where the proposal in this paper is to publish the statistics half yearly. Greater clarity of the proposed approach for publishing the statistics would be welcomed. We suggest that publishing results for the purpose of transparency of individual inspection outcomes, particularly at the outset of this new inspection program, would be inconsistent with the stated approach to deficiencies and regulatory actions.

Risk Management Plan (RMP) compliance monitoring

| Is the information regarding RMP requirements included in the AusPARs sufficient to inform you of the risk minimisation and pharmacovigilance commitments that have been made by the sponsor? |
| What activities could we undertake to assist sponsors in complying with their RMP requirements? |

Until recently ASMI would have had no comment to this part of the consultation, however a recent Scheduling delegate’s final decision\(^2\) indicates the possibility of the application of a RMP as part of the lifecycle of some products to support the change in risk profile and new safety concerns as they change from being prescribed medicines under the supervision of a medical practitioner to being assessed for suitability by a pharmacist as a schedule 3 non-prescription medicine. ASMI are still working to understand the suitability of the RMP format and how the RMP approval process would fit within the Scheduling Policy Framework (SPF).

In principle ASMI would have no issue with RMPs being subject to compliance monitoring. Non-prescription products will not have an AusPAR as a mechanism for making the relevant details of a RMP transparent. However it is not anticipated that when used in support of a down-scheduling application that the details of the RMP would need to be confidential. Indeed they would need to be available for application to other sponsors impacted by the switch of the substance.

Improved collection and use of data

Adverse Events Management System (AEMS)

ASMI welcome the investment in implementing a new IT system (replacing ADRS) to improve and streamline the submission of adverse event reports electronically to the TGA. We appreciate the efforts made to ensure the system will use the same electronic reporting standards used for reporting to other agencies. We would like to note that this should not preclude the need for sponsor training and user guidance for the new system.

International information sharing

ASMI believe it is important for sponsors that TGA are able to stay connected with and actively participate in the international efforts to proactively minimise, detect and address medicine safety-related issues for the safety of patients. ASMI welcome the new functionality of AEMS and the capacity enhancement it provides the TGA.

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\(^2\) [Scheduling delegate's final decisions, March 2017 for Vardenafil](#)