New REMS Guidelines Raise Fears In Hospitals and Pharmacies

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The FDA’s upcoming publication of first-time guidance for a Risk Evaluation and Mitigation Strategies (REMS) program is likely to complicate life for hospitals and their pharmacists. A REMS program involves restrictions on drug use and documentation requirements that the FDA imposes on new drugs (and sometimes older ones) with unusually serious risk profiles but whose benefits are equally strong. The REMS program outlines steps that manufacturers, wholesalers, pharmacists, and others must take before and after they dispense these drugs to a patient. Congress gave the FDA authority to require these REMS programs in 2007, when it passed the FDA Amendments Act (FDAAA). The FDA published the draft guidance on September 30, 2009.

In terms of what a REMS program can include, one item is mandated: a timetable for an assessment of the REMS, whatever its components. Other optional ingredients might include a Medication Guide (MedGuide), a patient package insert, a specific plan for communication to health care providers, and any of six enumerated restrictions on the drug’s use and distribution, a portion called Elements to Assure Safe Use (ETASU).

It is plausible that the ETASU could (1) require drug companies to audit a pharmacy’s adherence to the special terms of a particular REMS program, (2) confirm that pharmacists have special training, (3) ensure that a physician performed a required patient test or counseled patients about a specific drug, or (4) play a role in managing drug therapy.

Jeffrey K. Francer, Assistant General Counsel of Pharmaceutical Research and Manufacturers of America (PhRMA), says that his group is very concerned about the draft guidance’s endorsement of REMS auditing by drug companies. He commented:

“If the FDA requires biopharmaceutical companies to audit health care professionals such as pharmacists, it can lead to an inappropriate intrusion into health care delivery.”

He suggests that any auditing requirement could force drug companies to look at patient records, which would open a whole privacy-related can of worms. Moreover, it is possible, for example, for a REMS to require that a drug be dispensed only for inpatient use at a specially certified hospital.

So far, according to the FDA’s Web site, few of the 90 or so REMSs that have been approved contain ETASUs. For those REMSs that are presented, the FDA does not describe them, so it is impossible to know whether they have restrictions on distribution. Almost all of the REMS programs require drug companies to prepare, and pharmacists to distribute, MedGuides. According to Dr. Francer, in requiring some of these MedGuides, the FDA has charged the drug companies with monitoring the transfer of MedGuides from pharmacist to patient; thus, auditing requirements of a sort are affixed to some REMS programs already.

These kinds of monitoring agreements, as well as some of the other features of the ETASUs (which could become more common after the FDA publishes its final guidance), take up a pharmacist’s administrative attention and time.

Russell C. Ring, Senior Vice President of Government Affairs at CVS Caremark, comments:

An individual pharmacy easily could become overwhelmed with activities related to collecting data for multiple REMS assessments during the same time period, taking valuable time away from patients. We do not want pharmacists to end up in a position in which they have to choose between neglecting their professional responsibilities and duty of care to patients and failing to comply with the requirements of an approved REMS.

Publication of the REMS guidance is important because the 2007 FDAAA that created the REMS authority also gave the FDA new responsibilities for penalties. Fines would be set at $250,000 per violation, not to exceed $1 million in a single proceeding. They would increase if the violation continued for more than 30 days after the FDA notifies the responsible offender of the violation. The fines would double for the second 30-day period and then would continue to double for subsequent 30-day periods, up to $1 million per period and $10 million per proceeding.

Despite those draconian penalties on the “back side,” hospitals and their pharmacies do not have a say on the “front side,” the point at which the FDA and the drug company negotiate the specific terms of a particular REMS. One suggestion is that the FDA create a pharmacy advisory committee that would have input into the development of individual REMS programs.

Since late 2007, when Congress gave the FDA authority to issue REMS programs, the agency has published about 90 of them, more than the pharmaceutical industry expected or is happy with; this is because drug companies believe that REMSs should be used only in very narrow instances. In addition, last April the FDA proposed a REMS program for an entire category—opioids—and a de facto classwide REMS program for tumor necrosis factor (TNF)–alpha blockers. Both the number of REMSs and the number of category-wide proposals have created concern that the FDA is using the 2007 congressional authority too broadly. In fact, the 2007 FDAAA doesn’t clearly state the conditions that must exist for a new drug’s profile before the FDA can insist on a REMS. This is a point of contention with PhRMA.

“The draft guidance fails to describe, however, how the FDA will determine
when a REMS should be required or amended," PhRMA stated in its written comments.

Any new REMS guidance could end up costing hospital pharmacies time and money. No one disputes that improved patient safety is worth paying for—but pharmacies will object if they must pay administrative costs associated with REMS programs imposed by the FDA as the price of approving a new drug. Some pharmacy advocates argue that the pharmaceutical companies should pay those costs, not the pharmacies.