Right to Try Legislation Should Focus on Patients, Not Politics

To the Editor:

There were many good points raised in Steven Barlas’ recent article, “Right to Try’ Legislation Moving Through Congress,” published in the December 2017 issue of P&T.1 However, I believe that some points need clarification.

The opening paragraph asserts that state Right to Try (RTT) laws are putting pressure on Congress to enact federal law to “remove some of the obstacles erected by the Food and Drug Administration (FDA) that RTT advocates say prevent pharmaceutical companies from initiating or expanding compassionate care programs.” Yet it does not indicate what those obstacles are.

Given that the FDA allows more than 99% of the requests for expanded access2—the use of investigational agents outside of the clinical trial setting for the purpose of treatment—that come to the agency, I don’t think a reasonable argument can be made that the agency creates obstacles to access. In fact, the FDA sometimes works with companies to encourage them to provide access outside of clinical trials when trial data is promising.

In contrast, the FDA actually adds value to expanded access through its experience with investigational agents and access to data that is unavailable to treating physicians and patients.3 Agency oversight of expanded access can result in safer use of investigational products based on consideration of the patient’s medical history and current health status. The agency sometimes suggests more appropriate dosing and/or closer monitoring based on factors such as renal or hepatic sufficiency, comorbidities, and/or concomitant medications.

Institutional review board review, required by the FDA before treatment begins, ensures that patients receive adequate informed consent that clearly describes the investigational nature of the treatment, what is known about the drug’s effectiveness so far from clinical investigation, and what side effects and risks might be associated with investigational products.

It is worth noting that in Josh Hardy’s case, mentioned in the article as a “kick-start to new pressures for RTT,” Chimerix, Inc., was unable to provide expanded access to its drug brincidofovir. The FDA’s Division of Antiviral Products, working with the company, suggested creating, instead, a research protocol to study a new secondary indication: adenovirus. This was an elegant solution that allowed not only Josh Hardy to have promising therapy, but others who also might benefit from the therapy. And, if successful, the study has the potential to lead to an approved labeled indication, providing the broadest possible access to patients with adenovirus infection.

The article also repeats, without challenge, a quote from Naomi Lopez Bauman, Director of Healthcare Policy for the Goldwater Institute, who says, “When fewer than one-half of 1% of terminal patients can access the system, the system is clearly not working.”

This is a very questionable statistic. Where does the number come from, and exactly what does it represent? The total global population with a potentially fatal illness? It seems like a number capriciously pulled from the air.

Not all terminal patients are candidates for “the system,” if “system” refers to expanded access. Not all diseases and conditions have products in development. Not all patients are willing to tolerate the risks involved with investigational products, which can also rob patients of life or quality of life during their remaining time. Not all patients seek to take “heroic actions.”

I also question the motivation behind the statement. There are many people in the U.S. who cannot access therapies already shown to be safe and effective for their condition because they are uninsured or underinsured. Neither the Goldwater Institute nor any of these RTT bills serve those patients, many of whom cannot get access to approved therapeutics.

Another unsupported statement from the Goldwater Institute says, “These state laws not only restore patient autonomy, but make the system more equitable so that more patients—not just a select few who are wealthy, well-connected, or lucky enough to get into a trial—can try to save their own lives.” This is a specious argument at best. No evidence is offered to support the assertion that those who receive access to unapproved drugs for the purpose of treatment are wealthy or well connected, or how RTT legislation could prevent that from happening. Has anyone seen or collected the data that supports this allegation?

And without outcome data, why are those who receive access characterized as “lucky?” The fact is that, while some investigational therapies prove to be effective, many expanded access outcomes, like many clinical trials, are not positive. There are not sufficient data to meaningfully track outcomes, including survival.

A commonly cited deterrent to expanded access, repeated in the article, is the perceived threat that any adverse event experienced by patients will negatively affect future development of the drug. The Government Accountability Office report is quoted: “However, several stakeholders we spoke with, including the selected manufacturers we interviewed, raised concerns that FDA is not clear about how it uses expanded access adverse events data in its review of drugs being considered for sale and marketing in the United States.”

Adverse reaction reports must be considered in the context of the patient in whom the drug was used. It is impossible to define exactly how adverse reaction data will be treated because there is no way to predict what kind of adverse reaction might occur, whether it was associated with the drug, and importantly, whether it might be preventable with adequate monitoring or precautions in place. The FDA addresses the question in its Expanded Access Guidance for Industry.4

Recording and assessing these adverse reactions should actually be seen as a potential benefit, revealing what adverse reactions might result from the use of an investigational drug in patients outside of the carefully controlled population in the trial, and possibly more representative of the patient population that might ultimately be exposed to the drug if approved.

The underlying message of the article is that patient advocacy groups and the FDA oppose the Right to Try legislation pending in Congress. Patient advocacy groups are very much aware of the potential benefits and the possible risks that are an integral part of expanded access. They think critically about how it is used and the guardrails that exist under FDA jurisdiction. They also recognize that, while expanded access may offer direct benefit to some patients and hope to others,
it is well-studied and characterized approved medical products that offer the best option and the broadest availability of meaningful therapeutics to patients.

The voices of patient advocates should ring louder than the political interests that appear to be driving this legislation.

Richard Klein
Former Director, FDA Patient Liaison Program

REFERENCES

