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July 18, 2016

Robert Califf, MD, MACC

Commissioner

Food and Drug Administration

5630 Fishers Lane, Rm. 1061

Rockville, MD 20852

RE: Hospital and Health System Compounding under the Federal Food, Drug and Cosmetic Act

Dear Commissioner Califf;

Established in 1943, the AAAAI is a professional organization with more than 6,700 members in the United States, Canada and 72 other countries. This membership includes allergist/immunologists, other medical specialists, allied health and related healthcare professionals—all with a special interest in the research and treatment of patients with allergic and immunologic diseases. We appreciate the opportunity to comment on the FDA Guidance entitled "Hospital and Health System Compounding under the Federal Food, Drug and Cosmetic Act," which we believe could affect beneficiary access to allergy, asthma, and immunology care and treatment.

A physician affiliated with a system or a hospital that provides a compounding pharmacy, such as is the case with a number of academic medical centers, may provide allergy diagnostic testing and treatment in clinics in various locations in the communities they serve. In some cases, those centers require that compounded materials be provided by the system or hospital pharmacy.

Material compounded for use in skin testing is for the purpose of diagnosing allergies, so the testing material itself is not individually prescribed. Once the physician conducts and reviews the results of the skin tests, then a prescription is developed for personalized compounded allergen extract. Therefore both unprescribed extract to be used for testing and extract developed according to a prescription may be provided by a system or hospital pharmacy.

Allergen immunotherapy is a highly personalized treatment regimen requiring frequent office visits. Each patient's response to the previous injection is reviewed with clinic staff at the beginning of the next visit, and before every injection is given. Patients are kept under observation after every injection, so they know that clinic staff are looking for any reaction to the injection.

(more)

Therefore any infectious event or post discharge allergic complication would be reported at the next visit if not sooner. So long as the patient is within the same system and/or being seen under the supervision of the same physician, this provides ample opportunity for signaling and reporting if there is any problem with the safety of the extract.

In regards to the length of use of the compounded product, prescribed allergen extract has specific FDA regulations that allow it to be used until the soonest expiration date of any single component of the compounded extract. However many physicians maintain stricter rules and discard extract as of some sooner set date, generally six months to one year from the mix date. This is because these mixes may also have to be modified to take into account the patients response to therapy, again reflecting the very personalized nature and frequent contact required of allergen immunotherapy treatment.

In combination, these factors of a highly personalized method of care that requires frequent visits, and facilitating an ongoing communication between patient and clinic to consistently review symptoms, would result in reports of any infectious adverse events. Patients are kept for 30 minutes after their shots and it is reinforced after each visit that they should report any untoward adverse event that could be related to the treatment. Therefore a rule that requires that extract be available only to those clinics within a mile of the system's or hospital's pharmacy is duplicative and unnecessary for this particular treatment modality.

Such a rule could, however, become a barrier to treatment. Because of the frequent visits allergen immunotherapy requires, making patients travel further for these visits could be a significant barrier to treatment, particularly in areas and for patients for whom transportation is challenging. Many of these clinics associated with academic medical centers are located in socio-economically disadvantaged areas where patients would lose access to this care if they are not able to have treatment available nearby. Particularly in congested urban areas, reduced access to allergen immunotherapy for treatment for allergic asthma may threaten the wellbeing of fragile patients, particularly children. Allergists provide care that can be not only life changing but also life-saving in the case of patients with highly anaphylactic allergies, such as to stinging insects. Therefore any regulation that reduces access to allergen immunotherapy potentially does more harm than good.

In addition, it is unclear how this rule change would assure better safety and less possibility of a theoretical complication of a localized or systemic infection following an intra-cutaneous or subcutaneous injection of materials diluted in preservatives that prevent microbial growth.

In general, we sincerely appreciate and support the endeavor to protect patient safety with compounded drugs and products. However, this must be undertaken in balance with a commitment to protect patient access to evidence-based treatments. We know that some experts suggest that although there are no reported incidents of infectious complications, that this just reflects a lack of reporting. However, we do have accumulated scientific data and significant provider feedback that supports that there is no evidence that compounded allergen extracts following current USP <797> guidelines cause any infections complication. Further, there is zero data that show underreporting of infectious complications from allergen immunotherapy exists. Therefore, in regards to allergen immunotherapy specifically, we believe the totality of the treatment method needs to be taken into consideration. This treatment is a highly personalized, high-touch modality with frequent patient feedback. And yet in more than 100 years of this treatment, there are no reports of infectious adverse events.

While the care provision scenario provided above, in which physicians in systems with hospital pharmacies treat their patients more than one mile from the pharmacy facility, is an important consideration, this description fits a small albeit important segment of our specialty. Allergists are also practicing in small and solo clinics in rural settings, and small to medium-sized cities, as well as urban centers, all over the country. The geography of their practices and the setting in which our members are providing this treatment may vary, but what they share is the significant impact this proven effective and safe treatment has in the lives of our patients. Therefore any regulation of physician compounding that has the potential to result in reduced patient access to this treatment needs to put patients first; meaning their health outcomes should take priority over a risk that, as it pertains specifically to allergen immunotherapy, remains merely hypothetical.

We appreciate the opportunity to submit these comments and would certainly be happy to discuss these concerns with you at any time.

Sincerely,

A handwritten signature in black ink that reads "Thomas B. Casale". The signature is written in a cursive, flowing style.

Thomas B. Casale
Executive Vice President, AAAAI