



NATIONAL ASSOCIATION OF
CHAIN DRUG STORES

By Electronic Submission via www.regulations.gov

March 9, 2020

The Honorable Dr. Stephen M. Hahn
Commissioner of Food and Drugs
Food and Drug Administration
10903 New Hampshire Ave
Silver Spring, MD 20993-0002

Re: Docket No. FDA-2019-D-5711 for "Importation of Prescription Drugs"

Dear Commissioner Hahn:

I. Introduction

The National Association of Chain Drug Stores (NACDS) thanks the Food and Drug Administration (FDA) for the opportunity to comment on proposed rules to allow importation of certain prescription drugs from Canada. NACDS represents traditional drug stores, supermarkets and mass merchants with pharmacies. Chains operate over 40,000 pharmacies, and NACDS' over 80 chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ nearly 3 million individuals, including 157,000 pharmacists. They fill over 3 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and health care affordability.

On December 18, 2019, FDA issued a notice of proposed rulemaking (NPRM) that, if finalized, would allow for the commercial importation of certain prescription drugs from Canada. Specifically, the NPRM would allow states and certain other non-federal government entities to submit time-limited (2-year) importation program proposals (called Section 804 Importation Programs or "SIPs") to FDA for approval.

As we have frequently communicated to the Administration, and more specifically HHS and FDA, we wholeheartedly support efforts to lower prescription drug costs for our patients, and actively work to support policies that further this laudable goal. Unfortunately, due to international pricing practices, U.S. patients and their pharmacies are forced to pay higher prices for prescription drugs. As we pursue efforts to make prescription medications more affordable, the nation must not compromise patient safety. FDA must be careful to ensure that over one hundred years of public policies enacted to protect Americans from unsafe or ineffective medications are not undone as we reduce prescription drug costs.

NACDS has serious safety and operational concerns about commercial importation of pharmaceuticals. Multiple outstanding issues relating to cost, quality, and efficiency must be resolved before a commercial importation scheme could be successful. In our comments

below, we outline numerous concerns that must be addressed before FDA could finalize the proposed rule.

II. Background

Federal law, 21 U.S.C. § 384(l)(1), allows commercial importation programs only if the United States Secretary of Health and Human Services certifies that the program poses “no additional risk to the public’s health and safety [and would] result in a significant reduction in the cost of covered products to the American consumer.” We question whether FDA’s proposal could meet the threshold requirements of no additional public risk and significant cost savings.

Throughout the past 15 years, through speeches, testimony, letters, and other consumer resources, FDA has repeatedly sounded the alarm as to the risk to patient safety posed by foreign drug importation.¹ Former FDA commissioner, Dr. Scott Gottlieb, and his four predecessors, have issued statements opposing drug importation, noting that broad drug importation exposes the U.S. supply chain to foreign counterfeit drugs.^{2,3} In an open letter to Congress, four former FDA commissioners stated:

We believe that such importation represents a complex and risky approach—one that the evidence shows will not achieve the aim, and that is likely to harm patients and consumers and compromise the carefully constructed system that guards the safety of our nation’s medical products.⁴

With regard to cost savings, Dr. Gottlieb stated in March 2016 that, having studied the issue, safe regulation of foreign drugs “would have added so much cost to the imported drugs, they wouldn’t be much cheaper than drugs sold inside our closed American system.”⁵

Commercial importation proposals also raise conflicts with federal law, namely the Drug Supply Chain Security Act (DSCSA). The DSCSA was designed to track and trace prescription medications from point of manufacture to receipt by the pharmacy. Through tracking prescription medications, the law aims to prevent counterfeit drugs from entering the United States supply chain. Most prescription drugs within the United States supply

¹ Food and Drug Administration; Importing Prescription Drugs; available at:

<https://www.fda.gov/Drugs/DrugSafety/ucm170594.htm>; last accessed May 16, 2017.

² Gottlieb, S. (2016); What Trump Should Have Said on Drug Prices; *Forbes*; available at: <https://www.forbes.com/sites/scottgottlieb/2016/03/04/why-trump-is-wrong-on-drug-prices/#540c85a92e74>; last accessed: March 15, 2017.

³ Califf, R.M., Hamburg, M.B., McClellan, M. & Von Eschenbach, A. (March 2017); Open letter to members of Congress.

⁴https://healthpolicy.duke.edu/sites/default/files/atoms/files/2017_03_16_commissioners_letter_final_signed.pdf (accessed March 3, 2020)

⁵ <https://www.forbes.com/sites/scottgottlieb/2016/03/04/why-trump-is-wrong-on-drug-prices/#79721f022e74> (accessed March 3, 2020).

chain, from the point of manufacture to the point of receipt by the pharmacy, must comply with the DSCSA product tracing requirements. Tracking and tracing of drugs can help prevent counterfeit drugs from entering the U.S. supply chain only if tracking and tracing begins with the manufacturer long before the drugs arrive in the United States. Given the complexities of tracking and tracing, full alignment between the DSCSA and federal or state importation schemes is highly unlikely, as the United States government cannot enforce the provisions of the DSCSA over drugs not manufactured for the United States supply chain.

Even if HHS does certify an importation program, such certification could undermine the DSCSA's goal to protect consumers from exposure to counterfeit, dangerous drugs by creating loopholes within the DSCSA regulatory framework, easily allowing counterfeit drugs to slip into the United States supply chain. As a result, we are concerned that any pharmacy receiving a drug from a foreign source could be at risk for violating DSCSA if it takes ownership of such a drug product.

III. Canadian Government Concerns

The Canadian government shares these concerns. Diane C. Gorman, Assistant Deputy Minister of Health Canada, stated that "Health Canada does not assure that products being sold to U.S. citizens are safe, effective, and of high quality, and does not intend to do so in the future."⁶ According to Gorman, "The Government of Canada has never stated that it would be responsible for the safety and quality of prescription drugs exported from Canada into the United States, or any other country for that matter."⁷ More recently, the Canadian federal government led by Justin Trudeau, healthcare professionals, and patient communities have said they don't want us raiding their drug supply. Widespread drug shortages already plague their country,⁸ and because they import 70 percent of their own medicine, they have no way to increase production to accommodate bulk purchases from the United States.⁹

We support continued, strong FDA oversight over the drug supply chain. As such, we maintain serious concern for how enforcement and oversight related to importation of prescription drugs would occur. It would be difficult or impossible for the federal government to provide adequate safety assurances if the government of Canada is not an eager and fully engaged partner in such an endeavor. Otherwise, how would one verify any participating Canadian entity which either is, or claims to be, a pharmacy in compliance with U.S. law? U.S. citizens simply cannot rely on the Canadian government and its

⁶ HHS Task Force Report citing Letter from Diane C. Gorman, Assistant Deputy Minister, Health Canada, to Richard H. Carmona, U.S. Surgeon General, pg. 60-61. June 1, 2004.

⁷ Letter to The Washington Post, Diane Gorman, Assistant Deputy Minister, Health Canada, May 9, 2003.

⁸ Summary Report, *Drug Shortages Canada*, <http://bit.ly/2EeXnW3>.

⁹ "Readout of Acting Ambassador Kirsten Hillman's meeting with Joe Grogan Assistant to the President for Domestic Policy," *Connect2Canada*, November 1, 2019, <http://bit.ly/2tZfAVg>.

provinces to provide such oversight when they do not have any responsibility or desire to do so.

Canada's prescription drug supply is designed and carefully managed to serve its population of approximately 36 million and is subject to national price negotiation and regulation. Drug shortages present a challenge to Canada's health system, and jurisdictions around the world.¹⁰ Canada routinely experiences a shortage of 700 to 1000 medicines at any given time.¹¹ Should the FDA proceed with the proposed rule, there is great concern that the Canadian supply will quickly be at risk of significant depletion and the ability of Canadian patients to access needed medication will no longer be a guarantee. The Canadian prescription drug market is designed to serve the Canadian public. It is not equipped to support to the needs of a population ten times its size without creating important access or quality issues. We are concerned that the supply does not, and would not, exist within Canada to meet U.S. demands.

IV. Patient Safety Concerns

As FDA works on importation policy, FDA should address the likelihood that the final rule could lead to consumers' personally importing prescription drugs by purchasing drugs online from websites that falsely purport to be "Canadian pharmacies." When they do, Americans will find dozens, if not hundreds, of sellers offering promises of safe Canadian products. FDA itself recognizes this risk in the proposed rule: "Consumers go to these websites believing they are buying safe and effective medications, but often they are being deceived and put at risk by individuals who put financial gain above patient safety."¹²

It is common knowledge that the internet is replete with illegal online pharmacies posing as "Canadian" and claiming to be selling safe U.S. Food and Drug Administration (FDA)- or Health Canada-approved medicines.¹³ At any given time, there are up to 35,000 active online pharmacy websites operating on the open web, of which about 94.8% are operating out of compliance with U.S. state and federal law and relevant pharmacy practice standards.¹⁴ U.S. consumers buying medications from alleged "Canadian online pharmacies" rarely, if ever, receive the same regulator-approved products provided to Canadian consumers. Indeed, FDA has found that 85% of the drugs being promoted as "Canadian" came from 27 other countries around the globe.¹⁵

Moreover, mass quantities of counterfeit pills – many of which have been laced with deadly fentanyl and other synthetic opioids – from foreign sources commonly slip into the U.S. illegally through international mail. It is estimated that FDA is only able to inspect less than .018% of the packages assumed to contain drug products that are shipped through the

¹⁰ www.drugshortagescanada.ca

¹¹ <https://www.cbc.ca/news/health/second-opinion-drug-shortages180908-1.4815355>

¹² "Importation of Prescription Drugs," *Federal Register* 84, no. 286, (December 13, 2019): 70800.

¹³ *Id.*

¹⁴ Alliance for Safe Online Pharmacies; <https://buysaferx.pharmacy/>

¹⁵ *Id.*

international mail. FDA estimates that of the packages that it does screen 87% contain illegal, unapproved, counterfeit and potentially dangerous drugs.¹⁶

We urge FDA to address these real and potentially grave safety concerns regarding personal importation before, or contemporaneous with, issuing a final rule on commercial importation.

V. Specific Policy Concerns

1. Adequacy, Consistency, and Integrity of Supply Issues

It is doubtful that sourcing prescription drugs from Canada would offer a supply of prescription drugs that is adequate and consistently reliable. SIP sponsors may be able to obtain sufficient Canadian drug products at one time, but inadequate product supply at another. This could lead to higher prices for consumers, or different quality of drug or different drugs altogether, when consumers return for medication refills. Pharmacies must have access to consistent, reliable, and quality sources of medication supply.

Moreover, pharmacies must be assured that medications are not counterfeit or diverted. According to the World Health Organization, 10% of drugs worldwide are counterfeit. The best way to prevent the infiltration of counterfeit drugs into the drug supply is to restrict and regulate access to the medication supply, such as is done in the United States. As mentioned above and discussed below, additional safeguards are currently being implemented through the DSCSA, which will require the creation of an electronic interoperable system to track and trace prescription medications to prevent the introduction of counterfeit and/or dangerous products into the supply chain. Consequently, permitting importation schemes weakens the security of the supply chain by circumventing these protections.

Even if products are thought to be sourced from a particular country that has high manufacturing and quality standards, the products may in fact be diverted from countries that do not. Commercial importation could likely generate “black markets” or “gray markets” for prescription drugs, raising serious questions about the safety of these drugs.

2. Quality and Safety Issues; Testing Requirements

Many pharmaceutical products sold in other countries—albeit containing the same active pharmaceutical ingredients as those sold here—may have different shapes, sizes, colors, and even trade names. Canadian drugs do not always align with FDA on characteristics like colors, preservatives, starches, and sweeteners. These different inactive ingredients could lead to unexpected allergic and deadly anaphylactic reactions to American patients or could exacerbate existing patient health sensitivities. The imported products could have ingredients not approved by FDA or in fact banned, like the sweetener sodium cyclamate.

¹⁶ <https://www.fda.gov/media/111980/download>

Some products are sold in different doses because the patients in other countries have different dose-response relationships. This could lead to dangerous under-dosing or overdosing of American patients. At a minimum, introducing different-looking foreign pharmaceutical products into the U.S. system will certainly confuse patients and health professionals. Performing assays to determine all of the specific elements of an imported drug, versus the active ingredients alone, are complex and very expensive. It is likely that doing so would consume much if not all of the projected drug savings. Pharmacies and pharmacists cannot be expected to perform these functions or bear these costs.

3. Problems with Dual Inventories

Pharmacies will likely have to maintain dual inventories of prescription drugs to assure that products that have not been imported, and those that have been imported, are tracked and billed appropriately. However, space limitations in pharmacies, carrying costs, and other considerations could make it virtually impossible to maintain separate inventories. Moreover, if American pharmacies do maintain dual inventories, it is unclear as to who decides which patients get domestic versus imported drugs.

4. Cost of Establishing System

Establishing the infrastructure necessary to effectively and efficiently operate an importation program – coupled with potential testing and other regulatory requirements – could result in significant start-up and operational costs. Given the unstable political environment surrounding importation, SIP sponsors would not be guaranteed the ability to recover their costs.

5. Liability for Injury Caused by Commercially Imported Prescription Drugs

There are serious questions regarding who will bear liability if imported drugs result in harm to American patients. For example, manufacturers currently bear potential liability resulting from harm for a properly dispensed prescription drug sold to an American pharmacy through established, licensed domestic distribution channels. It is unclear how liability would be affected if a drug that caused injury was made for a foreign country but was imported by and dispensed in a domestic pharmacy. This is an even greater concern for pharmacies due to the likelihood that any possible recourse against the foreign supplier of a harmful drug may be lost due to a waiver or subject to foreign courts and foreign law.

6. DSCSA Concerns

a) General DSCSA Concerns

In 2013, Congress passed the DSCSA, which requires the tracking and tracing of prescription drugs from manufacturer to receipt by the dispenser. Through tracking prescription drugs, the law aims to prevent counterfeit drugs from entering the U.S. supply chain. We are concerned that the proposed rule would allow circumvention of the DSCSA

and the subsequent dangerous lowering of safety standards. From the point of manufacture to the point of arrival in the U.S., there would be no U.S. oversight over the supply chain of prescription drugs. The patient would be at the mercy of whatever supply chain protections might be afforded in Canada.

The proposed rule would introduce inconsistencies that pharmacies would have to work with to ensure safety in the products being dispensed. Currently the process is uniform and the ability of the pharmacy to check the pedigree is straightforward. With additional inputs and no uniformity concerning how they would have to present information required by DSCSA, a pharmacy would be challenged to know the product is safe and effective. This undermines the DSCSA's goal to protect consumers from exposure to dangerous counterfeit drugs.

Finally, in the proposed rule, FDA proposes a number of exemptions to DSCSA provisions. We question FDA's authority to allow such exemptions through rulemaking, as the provisions have been established by Congress through statute.

b) Technical DSCSA Concerns

In addition to general concerns about the proposed rule weakening DSCSA patient protections, there are also technical concerns that must be addressed. Data standards for exchanging the serialized information of the imported product would have to be universal (i.e., should be in English and follow the GS1 data standards for capturing, sharing and informing trading partners of serialized pharmaceutical products). There would have to be a requirement for sharing data electronically following specific forms (i.e., T3 and EPCIS data messages). Master data files of the imported drug products would have to be uploaded into routing systems to allow for traceability of product, validating product lineage, and authentication. Finally, there would have to be clear guidance for the logistics and compliance procedures if an imported drug product arrives within the U.S. and doesn't have the proper labeling.

VI. Recommendations Should FDA Move Forward

In the event that FDA is able to address our concerns outlined above and the Agency decides to finalize the proposed rule, we have provided specific recommendations below for how FDA should proceed within the scope of the language of the proposed rule.

1. SIP Sponsors/ SIP Proposal

Under the proposed rule, SIPs could be sponsored by a State, tribal, or territorial governmental entity; and a SIP could be co-sponsored by a pharmacist, wholesaler, or another State or other non-federal governmental entity. In the proposed rule, FDA inquires whether a "pharmacy," instead of or in addition to a "pharmacist," should be allowed as a co-sponsor. Although 21 U.S.C. 384 authorizes FDA to allow importation by "pharmacists"

and “wholesalers,” we note that pharmacists dispense prescription drugs through licensed pharmacies. Therefore, a “pharmacy” should be allowed to serve as a co-sponsor.

FDA seeks comment on whether entities other than pharmacists and wholesalers, such as pharmacy benefit managers, or union health and welfare benefit plans, should be permitted to co-sponsor SIPs. Should FDA move forward with finalizing the proposed rule, we believe the only expansion allowed beyond 21 U.S.C. 384 should be for “pharmacies” as doing so would comport with Congressional intent. Since pharmacies employ pharmacists, the intent to have pharmacists perform a key role in the importation would be preserved.

In the proposed rule, FDA presents “Option 2,” in which a SIP could be sponsored by a State, tribal, or territorial governmental entity, *or a wholesaler, or a pharmacist, with or without a co-sponsor*. Again, should FDA move forward with the proposed rule, we believe that *a pharmacist or a pharmacy* could serve the role of a SIP sponsor just as well as a state or similar governmental entity in meeting the requirements for importing prescription drugs.

Finally, we agree that the SIP proposal should be required to include how the proposal would result in significant reduction in cost to American patients and would pose no additional risk to public health and safety.

2. Patient Access and Reimbursement

Should FDA move forward with finalizing the proposed rule, we ask that FDA work within HHS and the Administration to address potential concerns that must be addressed regarding patient access and reimbursement.

Should FDA finalize the proposal, we believe that a SIP sponsor should be required to address in its proposal the applicability of the Medicaid rebate program. State Medicaid programs would likely be interested in utilizing lower-cost prescription drug products as soon as they are available. Without Medicaid rebate applicability being addressed in SIP proposals there is the potential to have imported drugs covered for which manufacturers would not have to pay rebates. This would be a great disadvantage to both the states and HHS.

Moreover, SIP proposals should consider and address the impact on Average Manufacturer Price (AMP), as pharmacy reimbursement for covered outpatient drugs in the Medicaid program is influenced by AMP. Any imported prescription drug products should be excluded from the calculation of AMP unless the products are widely available to all Medicaid beneficiaries nationwide.

In addition to assuring that SIP proposals address the calculation of AMP, HHS/CMS should issue guidance instructing that the prices of prescription drugs imported pursuant to the final rule should not be used as a reference point for calculating the usual and customary (U&C) price for reimbursement of prescription drugs. By rule, U&C prices reflect the costs

of the drugs to the general public at the retail level without the use of insurance and is often referred to as the “cash price” for the general public. Imported prescription drug prices are neither “usual” nor “customary,” since they do not exist in the current U.S. marketplace, and prices for drugs imported through SIPs will not constitute the usual and customary price for prescription drugs in the U.S. Since imported products will cost less than their related counterparts, including imported products as a reference point for calculating U&C prices will result in lower U&C-based pharmacy reimbursement. This will unjustifiably lower pharmacy reimbursement on domestic versions of the same drug when dispensed in the fee-for service program, as access to imported drugs will be inconsistent, unreliable, and not within pharmacy control.

Similarly, we urge FDA to work with HHS counterparts to educate commercial prescription drug plans and programs, Medicaid Parts B and D plans, as well as Affordable Care Act (ACA) exchange prescription drug programs that it would not be appropriate to design their benefit programs and formularies in ways that coerce, steer, or force their beneficiaries to utilize imported products; there is no assurance that such products would be available nationwide, reliably, and/or indefinitely. For example, prescription drug programs should not place imported products in preferred drug classes that also exclude domestic products. Also, pharmacies should not have their reimbursement based on the imported product cost if the patient receives the domestic product. Forcing patients to utilize imported products solely could lead to patient harm if the imported product has different ingredients than a domestic product or is not widely available nationwide and/or on a sustained, reliable basis.

3. Labeling Recommendations

We would urge FDA to address in the final rule issues related to non-proprietary naming and labeling. As FDA is aware, many pharmaceutical products are known by different non-proprietary names worldwide (e.g., acetaminophen vs. paracetamol) including biosimilars, for which the United States has a unique suffix nomenclature not found in any other world market. To avoid potential patient harm, we would urge FDA to develop policies that would help ensure American patients are not confused by dissimilar or unique non-proprietary names. We understand FDA is well aware of the dangers of overdoses caused by labeling that may be confusing, such as the confusion among different label presentations of acetaminophen (e.g., “APAP”) or aspirin (e.g., “acetylsalicylic acid,” “ASA”).

4. Recommendations for Risk Evaluation and Mitigation Strategies (REMS)

Excluded from FDA’s importation proposal would be controlled substances, biologicals, infused drugs (including a peritoneal dialysis solution), intravenously injected drugs, drugs inhaled during surgery, and drugs subject to risk evaluation and mitigation strategies (REMS).

NACDS supports the proposal to exclude drugs subject to REMS. Allowing the importation of drugs that are subject to REMS would create significant burdens for healthcare

providers. Especially for REMS medications with ETASU, a single, shared system REMS for all versions is critical to ensure that any associated healthcare provider training, enrollment, and/or authorization requirements are practical and workable for healthcare providers.

Imported drugs would likely have to follow a separate REMS. If numerous REMS programs for the same medication exist, pharmacies would have no way of knowing which manufacturer's program a particular prescriber and patient may have completed, making pharmacy compliance challenging. Subsequently, multiple manufacturers' REMS programs would lead to significant delays in patient care, as pharmacists would need to contact prescribers to determine which manufacturer's REMS would be applicable. Moreover, it is conceivable that prescribing healthcare providers may choose to limit the prescription to only the domestic product to avoid going through the trouble of completing the requirements of separate REMS programs for imported products, thereby undermining what FDA had intended to accomplish through the proposed rule.

5. Labeling; Patient and Provider Education

FDA seeks comments on the content of the disclosure statement, in particular whether such a statement is necessary. We believe that the proposed disclosure statement would be necessary to help patients and providers distinguish imported products from domestic products. Moreover, we support a requirement that the disclosure information be provided clearly on the medication bottle or container so that providers and patients can easily distinguish among imported and domestic medications. We also support including the name of the SIP sponsor in the disclosure information as it would be necessary if there are multiple SIPs importing the same products or NDCs.

Also, with respect to labeling and provider and patient information, we believe the final rule should address the applicability of PI and PPI with respect to imported products.

6. Prescription Drug Recalls

With respect to recalls of imported drugs, in order to facilitate timely responses to recall notices, we believe that the sponsor or importer should be required to notify of recalls and handle recall processes. Logistically, keeping track of different processes for returning a recalled medication could be very challenging, compared to the current process which allows for returns through a reverse distributor who handles the back-end logistics.

In the final rule, FDA should address the obligations of the manufacturer partner to release recall information on product not originally intended for the U.S. market. For example, FDA should address situations in which an importer fails to obtain recall information from the manufacturer despite good faith efforts to obtain it.

Similarly, adverse event reporting would need to be consistent with current adverse event reporting, including having one mechanism for reporting adverse events so that providers don't have to follow different recall procedures for different importers.

7. Miscellaneous Recommendations

Should FDA move forward with the proposed rule, we provide the following recommendations for issues not covered in the proposed rule that should be addressed:

- FDA should provide clarity on the scope of the program from a legal and competitive status perspective. In particular, FDA should clarify whether there will be an exclusion of drugs with external patent protection in the U.S.
- We recommend that FDA impose an assessment phase so that we may fully understand the impact of commercial drug importation on the U.S. pharmaceutical supply chain. The assessment phase should require SIP sponsors to demonstrate adequate supply of imported products. In addition, SIP sponsors should be required to show no negative impact on the Canadian health care system.
- FDA should address how imported drugs would be included in domestic prescription drug databases such as those provided by commercial entities (e.g., Medi-Span, First Databank).

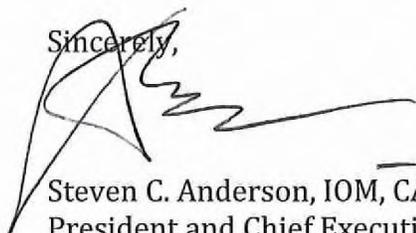
VII. Conclusion

In light of the potential dangers relating to quality and consistency of pharmaceutical supply, potential disruptions to the existing efficient pharmaceutical distribution system, and the likelihood that the distributive and testing functions would add significant costs to the process, NACDS has significant concerns about commercial importation of prescription drugs. We urge FDA to consider and address our concerns detailed above before issuing a final rule.

Moreover, should FDA move forward with issuing a final rule, we urge FDA to adopt our recommendations provided above to help ensure patient safety.

Again, we thank FDA for consideration of our concerns and recommendations.

Sincerely,



Steven C. Anderson, IOM, CAE
President and Chief Executive Officer