DRUG LEGISLATION

HEARINGS

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST SESSION

ON

DRUG LABELING AND ADVERTISING

H.R. 1554

NEW DRUG APPLICATION

H.R. 3605

JULY 25, 1983

DRUG ABUSE: QUAALUDES

H.R. 1055, H.R. 1097

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DRUG LEGISLATION

MONDAY, JULY 25, 1983

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, D.C.

The subcommittee met, pursuant to call, at 9:23 a.m., in room 2322, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will please come to order.

This morning the subcommittee is considering two bills which amend the Federal Food, Drug, and Cosmetic Act, H.R. 3605. The Drug Price Competition Act will make available more low cost generic equivalent drugs by allowing the FDA to approve generic versions of drugs approved after 1962. Under current law, FDA generally approves generic versions only if the original drug was approved before 1962. This bill applies the same procedures used by FDA to approve generic versions of drugs originally approved before 1962 to drugs originally approved after 1962.

Approximately 84 percent of our citizens pay their drug bill without any form of Government subsidy. By providing competition in pricing of drugs approved after 1962, all consumers will benefit from lower drug prices.

This is because the only real difference between a brand name and generic version is price. Generic drugs are between 300 and 1,500 percent cheaper than the brand name version. The lower cost drugs that become available as a result of this legislation are particularly important to the elderly. Senior citizens require more medication than any other segment of our society. Tragically they are often those least able to afford the high cost of medicine.

For these older Americans this bill will ease the Hobson's choice between spending fixed incomes on pharmaceuticals or other necessities.

The bill will also save the Federal Government money. For example, the Department of Defense buys hundreds of drugs each year from the lowest bidder. However, for most drugs approved after 1962, there is only one bidder. That company is not only the lowest bidder but also the highest. By introducing competition, both brand name and generic drugmakers can bid for these Department contracts. This assures the Federal Government is getting the best possible price for drugs.

The second bill before us today is H.R. 1554, the FDA Approval Labeling Act. Similar to legislation requested by FDA, this bill

would permit drugmakers to make accurate statements regarding FDA approval in their labeling and advertising.

The subcommittee has heard numerous complaints from pharmacists about the difficulty of determining whether a drug has FDA approval. Unfortunately, section 301(l) of the Federal Food, Drug, and Cosmetic Act prohibits a drugmaker from stating on its label whether the drug is approved by FDA.

Not only are there practical problems associated with section 301(l) but there are constitutional questions. Recent Supreme Court decisions have extended first amendment protection to various forms of commercial speech. While the Court's decisions have not fully delineated the extent of first amendment application, it is clear that accurate and nonmisleading statements such as whether a drug has FDA approval, are constitutionally protected.

Our first panel of witnesses to discuss these bills includes Dr. Mark Novitch, Deputy Commissioner of FDA; Dr. Marvin Seife, Director of Division of Generic Drug Monographs, National Center for Drugs; Thomas Scarlett, Chief Counsel of the Food and Drug Division in the Office of the General Counsel; and James Morrison, Assistant Director for Regulatory Affairs, National Center for Drugs and Biologics.

Gentlemen, we want to welcome you to our hearing today. Your complete statements will be made a part of the record. We would like you to summarize your views.

Before I recognize you, let me call on my colleague if he has any opening statements.

Mr. NIELSON. No, Mr. Chairman.

Mr. WAXMAN. Thank you very much.

[The text of H.R. 3605 and H.R. 1554 follow:

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98TH CONGRESS
1ST SESSION

H. R. 1554

To amend the Federal Food, Drug, and Cosmetic Act to remove the prohibition against the labeling and advertising of a drug concerning its approval under that Act.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 17, 1983

Mr. WAXMAN (for himself and Mr. MADIGAN) introduced the following bill; which was referred to the Committee on Energy and Commerce

---

A BILL

To amend the Federal Food, Drug, and Cosmetic Act to remove the prohibition against the labeling and advertising of a drug concerning its approval under that Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 301(l) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331(l)) is amended (1) by striking out "drug or" each place it occurs, and (2) by striking out "505, 515," and inserting in lieu thereof "515".

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98TH CONGRESS
1ST SESSION

H. R. 3605

To amend the Federal Food, Drug, and Cosmetic Act to authorize an abbreviated new drug application under section 505 of that Act for generic new drugs equivalent to approved new drugs.

IN THE HOUSE OF REPRESENTATIVES

JULY 19, 1983

Mr. WAXMAN (for himself, Mr. MADIGAN, Mr. WYDEN, Mr. SIKORSKI, Mr. WIRTH, Mr. LELAND, Mr. MARKEY, Mr. SWIFT, Mr. BRYANT, and Mr. WEISS) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend the Federal Food, Drug, and Cosmetic Act to authorize an abbreviated new drug application under section 505 of that Act for generic new drugs equivalent to approved new drugs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Drug Price Competition Act of 1983".

SEC. 2. Section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)) is amended by adding at the end the following new sentence: "Clause (1) of the previous

sentence shall not apply in the case of an application for a drug for which a previous application has been approved in accordance with subsection (c), if the drug with respect to which such subsequent application is filed meets appropriate standards of identity, strength, quality, purity, stability, bioavailability, and bioequivalence in relation to the drug approved in the previous application.".

○

STATEMENT OF MARK NOVITCH, M.D., DEPUTY COMMISSIONER, FOOD AND DRUG ADMINISTRATION, OFFICE OF ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY MARVIN SEIFE, M.D., DIRECTOR, DIVISION OF GENERIC DRUG MONOGRAPHS, NATIONAL CENTER FOR DRUGS AND BIOLOGICS; AND TOM SCARLET, CHIEF COUNSEL, FOOD AND DRUG DIVISION, OFFICE OF GENERAL COUNSEL

Dr. NOVITCH. Thank you, Mr. Chairman. I appreciate the opportunity to discuss the extension of the new abbreviated new drug application [ANDA] procedure to drugs first approved after 1962, post-1962 drugs.

You have proposed legislation that would authorize ANDA's for post-1962 drugs. As you know, ANDA's were first used by the Food and Drug Administration [FDA] under the Drug Efficacy Study Implementation [DESI] program for the approval of generic versions of drugs first approved only for safety between 1938 and 1962, the year in which Congress amended the Federal Food, Drug, and Cosmetic Act to require that drugs be shown to be effective as well as safe.

A similar procedure has not been established for post-1962 drugs. In recent years, however, patents have begun to expire for many post-1962 drugs. As a result, generic drug manufacturers have become increasingly interested in changing FDA's drug approval system to eliminate the current requirement for the submission of full reports of safety and effectiveness studies for duplicate versions of drugs already approved in accordance with a full new drug approval [NDA] submitted by the pioneer manufacturer.

FDA, too, is interested in streamlining its approval system for post-1962 drugs so as to reduce requirements for duplicative testing, which wastes resources and causes unnecessary human testing. For this reason, FDA is actively engaged in developing a proposal for an ANDA system for post-1962 drugs and to establish such a system through rulemaking.

A post-1962 ANDA procedure would be consistent with a number of FDA programs that have aided the marketing of generic drugs. In addition to the pre-1962 ANDA procedure, FDA has permitted generic applicants for post-1962 drug products to rely on reports of studies published in the open scientific literature. This has become known as the paper NDA policy. It eliminates the need to duplicate the expensive clinical and animal testing for safety and effectiveness, but it is limited by the availability of published literature.

In addition, the agency in the mid-1970's developed a vigorous program to review and assure the bioequivalence of generically available drugs. In 1980, we began to publish a list of all approved drugs with therapeutic equivalence evaluations to aid States and purchasers of generic drugs to substitute such drugs with confidence.

The development of a post-1962 ANDA procedure raises a number of important and difficult issues. Because we are currently in the process internally of reaching a position on proposed rulemaking that would address these issues, I am not in a position to comment specifically either on FDA's internal working drafts or on

the specific amendment contained in your bill. I can, however, identify and discuss some of the issues that must be dealt with before a post-1962 ANDA system can be instituted.

First, should there be a minimum preeligibility period to assure maximum protection of the public health? When a new drug is first approved for marketing, that does not mean that there is nothing further to be learned about its safety or effectiveness. Approval is based on carefully evaluated evidence in numbers of patients sufficient for us to conclude that the risk of unanticipated side effects is small and justified in comparison to the drug's benefits.

What makes the initial marketing period so important is that it gives us an opportunity for the first time to look for reactions of low incidence, especially serious ones, that could not reasonably be expected to appear in clinical trials. In most cases, due to patent protection, the innovator's drug is the only one on the market for the first several years after FDA approval.

For this reason, any adverse drug effects will be used only by that manufacturer's drug and will be reported only to that manufacturer. Because the innovator manufacturer is familiar with the preapproval testing, it is in a good position to evaluate the adverse reactions.

There will, however, be drugs that have no patent protection after FDA approval, and which may therefore be immediately marketed by both the innovator firm and by generic manufacturers. We therefore believe that it is important to consider whether there should be a preeligibility period, on the order of a few years, during which ANDA's would not be permitted. One may argue that generic drug firms are required to report adverse drug reactions to FDA, and that FDA can therefore evaluate their significance.

But most adverse drug reaction reports are to some extent evaluated by the firm receiving them, and the quality and timeliness of that review is important to the process.

FDA regulations require that only unexpected adverse reactions or clinical failures be reported by the firm to FDA within 15 working days. The others are submitted quarterly during the first year. If adverse reaction reports were received by firms unfamiliar with the clinical trials, and, because of the nature of their business, lacking ties with the research community, we are concerned about the adequacy of the reports we would receive. The holder of the pioneer NDA is frequently of considerable help to FDA in identifying adverse reaction trends and other drug effects bearing on the safe and effective use of a newly developed drug therapy.

Second, should there be a lengthier preeligibility period before ANDA's are permitted to avoid disincentives to drug innovation? This is a controversial issue on which many people have expressed strong views, and we believe it is a legitimate subject for debate. Those who oppose establishing a preeligibility period to preserve incentives for drug innovation argue that Congress has established a patent system for the specific purpose of encouraging invention and that FDA should not impose requirements designed to achieve the same objective.

Others argue that, as a public health agency, FDA cannot ignore the effects of changes in the drug approval system on the incentive

to develop new drug therapies. That will improve the health of the American people. They also note that some drugs cannot be patented, and that others have little patent life remaining after FDA approval.

If one assumes that there should be a preeligibility period to preserve incentives for innovation, at least for some drugs, one must then address the question of how long such a period should be. Should it track the patent period, on the assumption that it is intended primarily for drugs for which patents are unavailable; or should it be some shorter period that is still regarded as adequate to encourage innovation but that would allow competitive products to enter the market sooner?

The third issue is, what kind of transitional provisions should be included in any post-1962 ANDA system to assure that FDA's administrative capacity is not overwhelmed by an early flood of ANDA's and that the agency can concentrate its resources on those drugs most likely to be marketable without patent restrictions assuming that ANDA is approved? We believe that a phased implementation period is essential to avoid being inundated by more applications than we can reasonably handle.

Although these are not the only issues that must be considered in determining what kind of post-1962 ANDA system best serves the public interest, I think they illustrate that we are not dealing with a simple subject that lends itself to an easy solution. Although we believe that we have the legal authority to implement a post-1962 ANDA system and that we should continue to pursue our efforts to establish such a system through rulemaking, we stand ready to work with the committee on the problems associated with developing appropriate procedures for the approval of generic versions of drugs first approved after 1962.

At this point, Mr. Chairman, I would like to express our views on H.R.1554, a bill to eliminate the statutory prohibition in section 301(l) of the Federal Food, Drug, and Cosmetic Act which prevents a drug manufacturer from making representations regarding FDA approval in labeling or advertising of any drug.

As you know, this bill is identical to our proposal which was introduced during the last Congress except that it would retain the prohibitions as they apply to medical devices. Our proposal was motivated in part by growing concerns that pharmacists and other health professionals could unknowingly dispense drugs which did not meet current FDA standards for safety and efficacy.

We continue to believe, as you do, that facilitating pharmacists' ability to determine the approval status of prescription drugs would help safeguard the public health. For that purpose, the necessary information would be provided to pharmacists if the new drug application number or ANDA could be included on the labeling of prescription drugs. We have not identified a need to revise section 301(l) except to provide information to pharmacists with respect to prescription drugs, and we are concerned that a full repeal of the drug provisions of the section would not benefit pharmacists or the public.

We recommend, therefore, that you reconsider a full repeal of the prohibition in favor of an exemption which would permit manufacturers to include the approved new drug application number

on the labeling of prescription drugs. We believe that such an exemption would satisfy the concern of pharmacists while retaining the protections provided by the other provisions of the section.

Mr. Chairman, that concludes my formal statement. We will be happy to attempt to address any questions you or other members of the committee may have.

Mr. WAXMAN. Thank you very much.

I understand FDA has been considering an ANDA procedure for post-1962 drugs since the mid-1970's and sought public comment as long ago as September 1978. Is that correct?

Dr. NOVITCH. Well, I am not sure about September 1978 except as part of legislation that was introduced to reform the entire drug laws. It was our early view that an ANDA provision ought to be included as part of a rather global revision, a complete rewrite of the drug safety and efficacy laws, and that was the first emergence as a specific proposal for a post-1962 ANDA system.

As you know, hearings were held and a version of that act passed the Senate but not the House.

I am not sure, I can ask my colleagues whether there was any other public proposal. I don't believe there was any.

Mr. WAXMAN. Since legislation was not adopted at that time even though FDA had an ANDA procedure, has FDA looked at adopting a regulation to implement an ANDA procedure for post-1962 drugs?

Dr. NOVITCH. Yes; when the legislation failed we again took up the idea of doing it by regulation, first adopting a paper NDA policy that I referred to but saying at that time we would continue to work on a post-1962 ANDA system completely.

All of that occurred at a transition of administrations and there was some delay while the new administration could be brought fully up to date on the history and on the prospects for such a regulation. We have worked now closely with the Department, the Secretary's staff but not the Secretary, they have had several discussions with us. We are now very close to a specific proposal for transmittal to the Secretary.

Mr. WAXMAN. You say very close. How soon can we expect that proposal to be finalized?

Dr. NOVITCH. I believe we can have a proposal to the Department within weeks. As you know, that requires full review by the Secretary and her staff and also clearance by the OMB.

Mr. WAXMAN. If that regulation is challenged in court, how long could that take litigation to resolve?

Dr. NOVITCH. I have no idea, Mr. Chairman. We hope, of course, that the proposal will be reasonable. It will, I can tell you, be flexible enough to accommodate a full range of views on the issues. We hope that informed comment will lead us to a system that is seen as workable by all segments of the industry and by the public and that we will have no litigation on it.

Mr. WAXMAN. How likely is that?

Dr. NOVITCH. I think it is possible, indeed probable.

Mr. WAXMAN. You suggest that an eligibility period is necessary because "most adverse drug reaction reports are to some extent evaluated" by the NDA holder. Has FDA imposed such an eligi-

bility period on paper NDA's which are currently used to approve generic version of post-1962 drugs?

Dr. NOVITCH. Paper NDA's are full NDA's. They are not an abbreviated form of an NDA. They are full NDA in which the manufacturer submits a full report that would otherwise have to be developed.

The paper NDA system I have to tell you is limited. It is not a substitute for the NDA—for the ANDA system. Therefore, I don't think it has been used enough to say whether an eligibility system is useful or not.

Certainly most of the drugs for which paper NDA's have been submitted are drugs that have been on the market for some time and in effect there has been a preeligibility period.

Mr. WAXMAN. My question again and the point I wanted to evaluate was your statement that we needed an eligibility period because most drug reaction reports are to some extent evaluated by the holder. How do you handle that when you have a paper NDA?

Dr. NOVITCH. I was talking about an early period after marketing during which we are trying to learn about reactions of low incidence that can only be found when the population at exposure is larger than in the clinical trials. By the time a paper NDA has been submitted, at least it has been our experience, that brief period is well over. Most of the paper NDA's occur on drugs that are outside of patent protection. The patent protection has expired.

That early period we are talking about is over, that concern is over.

Mr. WAXMAN. Isn't that also true for generic drugs, most of whom have——

Dr. NOVITCH. It is probably true for most generic drugs as well. My concern is that, for those that lack patent protection or for which there is so little protection remaining after marketing that everyone could come straight to market.

Mr. WAXMAN. Let's put that issue aside for a second and go back to the question of adverse drug reactions. When FDA receives an adverse drug reaction report does FDA evaluate it?

Dr. NOVITCH. Yes.

Mr. WAXMAN. Does FDA rely upon the evaluation of the NDA holder or does it also evaluate the reports received by the ANDA holder?

Mr. NOVITCH. Both.

Mr. WAXMAN. If, in other words, you evaluate with the company's assistance?

Dr. NOVITCH. That is right.

Mr. WAXMAN. What does the NDA holder contribute to the evaluation of adverse drug reactions that FDA cannot do itself if a generic company reports adverse reactions?

Dr. NOVITCH. I think the difference between the handling of adverse reactions by a generic company and a major research-based company—I think you have to understand and you do understand that the nature of the business is different. The generic companies are production oriented, the research-based companies are research oriented and if I were in a generic firm collecting adverse experience I would bundle it all together and send it in. I would send everything for fear of not wanting to omit anything.

I would send all those reactions and in those early phases of marketing where you are trying to learn what you can about the drug, what we could get is everything with no initial separation, no attempt by the firm who is getting the reactions in the first place to say, hey, that is one we didn't see before, we ought to really pay closer attention to that one.

A generic firm wanting to obey the law and our regulations, lacking the research base that an innovator firm has, would send everything in. Our concern is that we would be inundated with reports with no attempt to self-sort them. It would impose a burden on us to sort them out.

Mr. ECKART. Would the gentleman yield?

Mr. WAXMAN. Yes.

Mr. ECKART. I am not sure exactly how it works—a physician who experiences an adverse reaction after having prescribed a specific drug does not report to the FDA, but just reports to the drug——

Dr. NOVITCH. Reports it to the firm. He may also report it to FDA. We encourage that but the firm has a greater obligation to receive those data. There is no obligation on the part of the physician to report that to FDA.

Mr. ECKART. Could you give an indication of what percentage of the reports you get come from physicians and what from the firms?

Dr. NOVITCH. Overwhelmingly from the firms.

Mr. ECKART. Thank you.

Mr. WAXMAN. FDA has a responsibility of making a determination of safety and efficacy of drugs. Sounds to me like you rely on a company with a substantial financial interest in the sale of a drug.

Dr. NOVITCH. The consequences of not detecting an early and unexpected reaction by the firm are serious to the firm. I cannot say that there haven't been derelictions on all sides, but I think that overwhelmingly firms have a very strong interest in detecting early any adverse effect to prevent later trouble for patients.

Mr. WAXMAN. I assume the generic drug manufacturers would have the same responsibility?

Dr. NOVITCH. Yes, sir, but the generic firm unless it transforms into a research-based organization—and I think this is a question you should put to them really—I think that they would have an inclination to strictly obey the law and send everything they receive straight in.

Mr. Chairman, I am not saying it is an insurmountable problem. What I am saying is that it poses a problem during an early and sensitive time in the marketing of a drug. We are not talking about the second kind of preeligibility period in which the main concern is incentives for innovation but rather a much more public health oriented period, and we feel it would be safer to have that drug—most are under patent anyway so we may be talking about an academic issue—we are talking about a very sensitive period in the life of the drug in which a narrower marketing base happens naturally and probably ought to be continued.

Mr. ECKART. PMA figures show an average patent life of 7 years after FDA approval. What percent of all drugs have no patent protection, including use or process patent protection, after FDA approval?

Dr. NOVITCH. If I recall the figures correctly about 18 percent of drugs that first come to market have 5 years or less of patent life remaining. About 5 to 7 percent have no patent protection. They were patented but have no protection. But 2 percent have never had patents in the first place.

If you extend that question to say the first 5 years after marketing, fully a fifth of the drugs lack more than 5 years of patent protection.

Mr. WAXMAN. What is your source for these figures?

Dr. NOVITCH. Our staff. I can submit this for the record with the citations of the source.

Mr. WAXMAN. We would like to receive that.

[The information referred to follows:]

LENGTH OF PATENT PROTECTION FOR POST-62 DRUG PRODUCTS

Between 1962 and 1978 FDA approved over 350 new drug products for the first time. Approximately 205 of these products are considered products which will be candidates for ANDAs under a post-1962 ANDA policy. The remaining post-1962 approved products are not considered ANDA candidates for one of the following reasons. The product is: (1) an antibiotic and is covered under the "form 6" procedures; (2) in a class of products not covered by the ANDA policy, e.g., insulin, radiopharmaceuticals, LVPs, medical devices, etc.; (3) no longer marketed (either FDA has withdrawn approval or the sponsor has discontinued marketing). Between 1979 and 1982, FDA estimates that another 40-50 products were approved which would be suitable ANDA candidates.

FDA examined the patent status of the 205 1962-1978 candidate products and found that the effective patent life of these products averaged about 12.5 years. However, for products approved in the late 1970s, the effective patent life has averaged only 9 to 10 years. These estimates do not necessarily include all applicable patents, since relevant process or use patents may extend patent protection. In addition, a number of these products had no, or very little, patent protection following approval. A breakdown and list of these products is provided below.

27-934 O—83——2

For the 205 drug products approved between 1962-1978, 15 products or 8 percent of the drugs had no effective patent life at the time of approval. Another 36 products, or 18 percent, had comparatively little protection. See table below:

Status Patent	No. Products	Percent of Total
Never patented	3	2
Off-patent before approval	12	6
Less than 7 years patent protection	36	18
TOTAL	51	25

Present data for these drug entities were obtained from the following sources:

1. The Merck Index, Ninth Edition, Published by Merck & Co.
2. 1976 Basic Patents for Major Drugs, Noyes Development Co., 1969.
3. The U.S. Generic Drug Market, Frost & Sullivan, 1976 and 1980.
4. Innovation in the Pharmaceutical Industry, David Schwartzman, The Johns Hopkins University Press, 1976.
5. Dr. Martin Eisman, Center for the Study of Drug Development, the University of Rochester, School of Medicine and Dentistry, Rochester, N.Y.
6. Telephone queries with individual drug sponsors.

POST-1962 ANDA-CANDIDATE PRODUCTS WITH
LESS THAN 7 YEARS EFFECTIVE PATENT LIFE*

Products With No Effective Patent Life After Approval Date

- Natural Substances/Never Patented (3)

Approval Date	Chemical/"Generic" Name	Trade Name
1970	Lypression	Diapid
1970	Lithium Carbonate	Lithonate
1978	Lithium Citrate	Lithonate-S

- "Old Chemicals"/Patents Expired Before Approval Date (12)

Approval Date	Chemical/"Generic" Name	Trade Name
1964	Sulisobenzone	Uval
1966	Piprobromain	Vercyte
1967	Clofibrate	Atromid-S
1967	Dextrothyroxine	Choloxin
1970	Mitotane	Lysodren
1974	Dopamine	Intropin
1974	Sodium Nitroprusside	Nipride
1975	Calcitronin-Salmon	Calcimar
1975	Dacarbazine	DITC
1976	Lactulose	Cephulac
1976	Lomustine	Ceenu
1977	Carmustine	Bicnu

* Covers only ANDA-candidate products approved between 1962 and 1978; 205 products were approved during this time period. Includes expiration date of "chemical" or "product" patent only; does not cover "use" or "process" patents.

Products With Less Than 7 Years Effective Patent Life After Approval (36)

Approval Date	Chemical/"Generic" Name	Trade Name
1964	Orphenadrine Citrate	Norgesic
1964	Mestranol & Norethynodrel	Enovid-E
1967	Nonoxynol & Idophor	IO Prep
1967	Diphenidol HCl	Vontrol
1968	Lidocaine HCl & Dextrose	Xylocaine HCl w/Dextrose
1969	Testolactone	Teslac
1970	Flavoxate HCl	Urispas
1970	Floxuridine	FUDR
1971	Propoxyphene Napsylate	Darvon-N
1971	Tretenoin	Retin-A
1971	Flucytosine	Ancobon
1971	Propoxyphene Napasaylate & Acetaminophen	Darvon-N w/ASA
1971	Megestrol Acetate	Megace
1972	Bupivacaine HCl	Marcaine HCl
1972	Bupivacaine HCl w/ Epinephrine	Marcaine HCl w/Epinephrine
1972	Desonide	Tridesilon
1972	Dexamethasone Sodium Phospate & Xylocaine	Decadron w/Xylocaine
1973	Betamethaseone-17-Benzoate	Benisone
1973	Dexamethasone Acetate	Decadron-LA
1974	Halcinonide	Halog
1975	Oxybutynin Chloride	Ditropan
1975	Betamethasone Dipropionate	Diprosone
1975	Clotrimazole	Lotrimin
1975	Clonazepam	Clonopin
1976	Prazepam	Verstran
1976	Naproxen	Naprosyn
1976	Danazol	Danocrine
1976	Beclomethasone Dipropionate	Vanceril
1977	Clemastine Fumarate	Tavist
1977	Disopyramide Phosphate	Norpace
1977	Azatadine Maleate	Optimine
1977	Lorazepam	Ativan
1977	Desoximetasone	Topicort
1977	Chlordiazepoxide & Amitriptyline	Limbitrol
1978	Sodium Valproate	Depakene
1978	Hydrocortisone Valerate	Westcort

Mr. WAXMAN. Let's assume there are some drugs with no patent protection after approval and it is important to have the NDA holder receive adverse reaction reports. Generics made by non-PMA members average only 4 percent of the markets for all drugs. That is the figure we have anyway.

Given that fact won't the overwhelming majority of adverse drug reactions be reported to the NDA holder?

Dr. NOVITCH. I cannot speak to the 4 percent figure. I do know that when competition opens for a drug, when previously single source drugs become multiple source, the percentage of the market held by the innovator drops sharply. I would think that more than 4 percent of a drug coming on to the generic market would be occupied by multiple source drugs. I could look further into that.

Mr. WAXMAN. We would like any other information you have to answer that question.

[The following information was submitted for the record:]

Based on drug sales data provided by IMS-America, FDA has estimated the generic share of pre-1962 ANDA-eligible drugs products (excluding antibotics). These data show that the innovator loses an increasing share of the market over time—an average of 30 percent of its market by the 10th year after generic competition begins. Most of this market loss (80 percent) accrues to non-PMA, or usually generic firms, while the remainder (20 percent) shifts to competing PMA firms with a generic line.

Mr. WAXMAN. I have other questions but I want to recognize my colleagues.

Mr. Nielson.

Mr. NIELSON. I have a couple questions.

Dr. Novitch, you mentioned that quite often the firm will find a problem and refer it to you. Do you ever have a case where the firm finds the problem and does not disclose it to you and you find out by other means?

Dr. NOVITCH. That happens.

Mr. NIELSON. How often?

Dr. NOVITCH. Very rarely.

Mr. NIELSON. If it happens what do you do about it?

Dr. NOVITCH. If the firm has violated the law by doing that and violation can be shown then we would—if it is a minor defect and one that is not willful, we may take regulatory action. If it is more severe we would take legal action against the firm.

Mr. NIELSON. Does that same apply to the generic firms?

Dr. NOVITCH. Yes.

Mr. NIELSON. Do you have that same situation with generic firms as well?

Dr. NOVITCH. I don't know.

Mr. NIELSON. DR. SEIFE.

Dr. SEIFE. That they failed to report?

Mr. NIELSON. Yes.

Dr. SEIFE. The tendency in recent years is they are reporting more than ever. I think the fright from Selacryn, Oraflex, Zomax, and so on, has resulted in our being inundated with reports from the generic firms. They want to cover themselves. They send in everything rather than omit anything.

Mr. NIELSON. In your opinion it is self-policing then, with both firms?

Dr. SEIFE. In my opinion, yes.

Mr. NIELSON. As I recall years ago, Thalidomide was one that seemed like you had information on that for some time before it was disclosed publicly. There were a lot of individuals who had monstrosities and things of this nature because they didn't know the danger of the drug.

Have you had any recurrence of that kind of scandal in the last 20 years?

Dr. NOVITCH. I wouldn't say anything of that order, no.

Mr. NIELSON. That is all I have, Mr. Chairman.

Mr. WAXMAN. Thank you very much.

Mr. Eckart.

Mr. ECKART. To what extent are the major pharmaceutical manufacturers involved in the manufacture and distribution of generics?

Dr. NOVITCH. I think they are widely involved. Many major firms also make drugs for the generic market.

Mr. ECKART. What percentage of the generic market do the top 20 pharmaceutical manufacturers have?

Dr. NOVITCH. What percentage of the generics—could you answer, Dr. Seife?

Dr. SEIFE. A large number. I can name—almost all firms have a generic line to some degree. Even Lilly has one of the largest lines; Parke-Davis; Lederle; Smith-Kline; and on and on. They are all involved to some degree, and if they are not involved, they are getting involved. If they develop another marketing name other than their own name, for example, Lilly has Dista, et cetera, et cetera, so we are occupied with the major firms, up to 30 percent of our workload. More in the antibiotic area than the nonantibiotic area.

Mr. ECKART. So the big boys are playing both sides of the field on this?

Dr. NOVITCH. Yes, we can supply that for the record.

Mr. ECKART. I would be interested in that because it seems to me that there has to be some in-house struggle as they seek to gain a larger share of the generic market which this legislation may facilitate.

That is the only question I have. Thank you, Mr. Chairman.

[The following information was submitted for the record:]

Currently, the generic drug market is dominated by antibiotic generics, with over half of the generic prescriptions written for antibiotics. The remaining generic market consists primarily of generics for products approved for the first time before 1962. Based on drug sales data provided by IMS America, FDA has estimated that approximately 80 percent of these generic prescriptions were manufactured by small generic firms.

Mr. WAXMAN. Dr. Novitch, taking your figures, 82 percent of the drugs have at least 5 years or more patent protection after they are approved by FDA. Is there any reason why for those 82 percent of the drugs there ought to be a waiting period?

Dr. NOVITCH. I don't think it is as important that there be a waiting period. I suppose one possible problem that arises if you accept ANDA's during that period is that you may be accepting applications that cannot result in marketing because there is patent protection. I doubt that any manufacturers would apply so long before they are eligible to apply that it doesn't make good business sense.

But I suppose that is possible.

Mr. WAXMAN. Your major argument is that there ought to be an eligibility period to be sure we get all the adverse reactions that go to the NDA holder?

Dr. NOVITCH. On that we feel quite strongly. On a period of pre-eligiblity so that we can learn what needs to be learned about the drugs. As far as a period of eligiblity for incentives to innovate is concerned, that is an open question on which there should be public comment.

Mr. WAXMAN. You suggested an eligiblity period providing patent-like protection is necessary to encourage innovation. Yet in the Federal Register of October 31, 1980, FDA stated:

> The patent laws do not have any bearing on enforcement of the Federal Food, Drug and Cosmetic Act and the agency does not consider these laws when reviewing new drug applications and making drug product approval decisions.

Does FDA consider patents in administering the law?

Dr. NOVITCH. No, it does not. Our concerns don't go to patents. But as a public health agency, we want to be certain that our regulations and our enforcement of the laws entrusted to us are not inhibiting incentives to innovate.

If we were to say that data submitted to us is immediately available to others for the same purpose, for applications, then one has to be concerned that research-based firms would have less incentive to develop new products.

Mr. WAXMAN. Is that the job of FDA?

Dr. NOVITCH. I think it is a job of an agency concerned with the public health and of wanting to see agents delivered for therapy, yes.

Mr. WAXMAN. We all have concerns about broader public issues but my question to you is does FDA consider patents in administering the law?

Dr. NOVITCH. No, it does not.

Mr. WAXMAN. If you don't consider patents how do you consider encouraging innovation in administering the law?

Dr. NOVITCH. In the manner that I just outlined, Mr. Chairman. I think that we have to be concerned that our regulations, neither inhibit the entry, the legitimate entry of new agents, nor reduce opportunities for people to come forward with new drugs.

Mr. WAXMAN. The memo on post-1962 ANDA's to Secretary Heckler, I understand, Commissioner Hayes made the following statement, "We have initially selected 15 years because that period plus the 2 years usually required for a firm to develop a generic product totals 17 years, the statutory patent period."

If there is a concern regarding inadequate incentives to innovate, shouldn't that problem be addressed in the patent laws and not in the Federal Food, Drug, and Cosmetic Act?

Dr. NOVITCH. We don't administer the patent law, we administer the Food and Drug Act. As I said earlier, we just are very concerned about an administration of the law that would have the effect of reducing useful applications for new drugs. I think that can be seen apart from the Patent Act.

Mr. WAXMAN. Well, we have a patent law for that very purpose. Do we have an FDA law for that purpose?

Dr. NOVITCH. We have an FDA law—we have an FDA policy, we have——

Mr. WAXMAN. What does the law say? Does the law say we have a Federal Food and Drug Administration Act to give incentives to industry for all sorts of purposes; or do we say you are obligated to protect the public for drugs to be safe and effective?

Dr. NOVITCH. Our law says, and obligates us to clear drugs for safety and effectiveness, Mr. Chairman.

Mr. WAXMAN. What is the statutory authority for FDA to consider patents in the administration of the act?

Dr. NOVITCH. There is no statutory authority.

Mr. WAXMAN. If you——

Dr. NOVITCH. Would you add to that.

Mr. SCARLETT. The statement you read earlier concerning FDA's not taking patents into account was, I think, directed toward a more technical issue. That is, FDA does not directly consider patents in any of its decisions, it regards its own approval system as independent of the patent system but that doesn't mean FDA doesn't take into account or cannot take into account incentives to innovate to the extent that any such incentives have been built into the current drug approval system.

Our concern is not that we are authorized by statute to create a system in which there are incentives to innovate. Our concern is that the present post-1962 approval system has, intentionally or not, entered into the investment-backed decisions of research-oriented drug companies and has operated to create incentives for them to develop new drug therapies.

Our concern now is that in revising the post-1962 approval system that we not create disincentives to innovation, thereby detracting from our ultimate objective which is to protect the public health as best we can.

Mr. WAXMAN. You are talking about a policy question and if the administration wants to accomplish certain policy objectives, that is legitimate, but does the FDA have authority now to make decisions in supervising the approval of drugs to take into consideration those areas generally considered protected by patents and for which incentives are adjusted based on the patent?

Mr. SCARLETT. I think we do have such authorities.

Mr. WAXMAN. Where?

Mr. SCARLETT. I think it implicit in the act. I think it is implicit in our authority to interpret the drug data submission requirements of section 505. You will have to understand that the current system which is also based on 505 does require the duplication of studies and therefore stands as a barrier to entry of generic drug firms into the drug market. That fact, which has been a fact of life for 15 or more years, may have created incentives to innovate. We have to deal with that fact because that fact emerges from our own administration of 505. Conversely, when we go to change the interpretation of section 505, I think we are authorized to take into consideration the consequences that that interepretation has had on incentives to innovate and to avoid creating disincentives to innovation.

Mr. WAXMAN. Let me react to that. There is no place in the law where there is a statement that the FDA has authority over pat-

ents. Your FDA statement of October 31, 1980, said the patent laws do not have any bearing on the enforcement of the Federal Food, Drug, and Cosmetic Act and the agency does not consider these laws in reviewing new drug applications and making drug product approval decisions.

Do you disagree with that statement in the Federal Register of 1980?

Mr. SCARLETT. No, but I don't think it is on point.

Mr. WAXMAN. Explain to me why you don't think it is on point.

Mr. SCARLETT. When we receive a new drug application or an ANDA, we do not ask ourselves whether the submitter holds a patent on that product. We can well be reviewing and have found ourselves in the position of reviewing applications for products that are under patent to other manufacturers. That statement merely says that we do not take the patent status of a product into account in operating our new drug approval system.

I do not think that that statement was intended to say that FDA is foreclosed from consideration of the same types of issues as the patent system deals with in connection with its regulatory decisions concerning the shape and content of a post-1962 approval system.

Mr. WAXMAN. If FDA determined that those drug manufacturers that had the most money or most likely to do the most good for the public and therefore wanted to benefit those drug manufacturers by approving their drugs first, would FDA have the authority to do that because it wanted to encourage incentives in the drug you thought appropriate?

Mr. SCARLETT. No, I think you are postulating a much more activist role in this than we want to assume.

Mr. WAXMAN. It seems to me you are assuming a much more activist role than the statute permits.

Mr. SCARLETT. We simply want to avoid diminishing incentives to innovate to the extent we can.

Mr. WAXMAN. Your determination of what is diminishing incentives is taking upon yourselves a responsibility that Congress has and that the patent laws are set forth to address.

Mr. SCARLETT. Well, we would say that we have corresponding authority within the very limited area that we are dealing with.

Mr. WAXMAN. And again your authority is based on inferences from the statute? Not specific reference of authority?

Mr. SCARLETT. You will not find in the statute anything that specifically says that FDA is authorized to take into account incentives to innovation. I am not saying that there are words to that effect in the statute.

Mr. WAXMAN. Now, Dr. Novitch, you suggest that an eligibility period is necessary so that FDA will not be buried in ANDA applications. Yet, a December 1982 memorandum prepared by your staff concluded that increased ANDA submissions as a result of a post-1962 policy will be offset by decreases in other types of drug approval applications.

Dr. Seife, your division will be responsible for approval of ANDA's for post-1962 drugs. What will be the additional workload and will you need additional staff and office space?

Dr. SEIFE. At this point we would probably—our workload has not diminished as projected over the period of years. We had expected the number of submissions to gradually taper off. But that has not happened.

Let me explain that. We have up to 50 applications a month including the antibiotics and several years ago we projected a gradual diminution and therefore if the post-1962 factor came in, we projected the ability to take care of that workload.

This is not happening because of the post-1962 policy was not forthcoming. What happened with our firms, or the firms we deal with, they took a second look at the list of eligible products and filed for many products that they had overlooked the first go-around. Also, we have had additional Federal Register publications upgrading or saying additional drug products were effective and they required abbreviated new drug applications so the process has been ongoing and the workload has been steady.

Now, we hope in the next period of time that there would be a dropoff.

At this point, if we were faced with a post-1962 drug application, I assume at first we would put them in line. We process abbreviated new drug applications including antibiotics on a first-come, first-served basis. In other words, these products queue up. We don't rate them as being one more important than the other. At first, we probably would be able to handle the workload. As time goes on I know I would need increased space for storage.

The handling of abbreviated new drug applications—the way we do it is to very carefully process the paper so that it will flow steadily. Otherwise we would be drowning in paper.

So the first thing I would need would be increased document room space. I have two rooms at this point, one for antibiotics and one for the nonantibiotic ANDA. It would be the nonantibiotics ANDA room that would have to be enlarged. I can foresee doubling the room in the future. We retire the records when a firm no longer has any interest in that particular application.

Initially we could probably handle some of the workload. Then I foresee us requesting one or two additional reviewers, plus support personnel.

I have always felt that a small staff is the best type of staff to do this kind of work, a small, well-motivated group of people.

I would rather not have a larger corps of people. I find that most ineffective.

So immediately we probably would take a bit of the load. Thereafter, I would request additional space, additional support staff, additional reviewers.

Ideally in the foreseeable future when this—if this act is implemented or if our regulation is implemented or some sort of post-1962 regulation comes about, in order to keep the flow steady, in order not to be overwhelmed by the work, I would foresee our needing five more reviewing chemists, a supervisor, another consumer safety officer, a physician or a very well-trained pharmacist, support people meaning at least one secretary and at least one additional person for the record room.

So I am talking about when fully implemented, about 10 people, 11 people maximum.

Also, concomitantly, because every one of those drugs would require a bioavailability study, the Division of Biopharmaceutics would need—I think it is projected—three additional reviewers and one secretary. So we are talking about 14 or 15 people overall.

Mr. WAXMAN. How many ANDA's for pre-1962 drugs has the agency approved?

Dr. SEIFE. 3,677 of the approximately 6,700 received since the first one at the end of 1969.

Mr. WAXMAN. What is the average time for approval?

Dr. SEIFE. Anywhere from 3 months to a year.

Mr. WAXMAN. Three months to a year.

Dr. SEIFE. Yes.

Mr. WAXMAN. According to a March 1983 preliminary regulatory impact analysis on ANDA policy, H.R. 3605 would result in consumer savings of $920 million over the next 12 years, yet, a 15-year eligibility period such as FDA is considering would afford consumer savings of only $500 million, a reduction of over $400 million. Is that correct?

Dr. NOVITCH. I don't know. I could review the figures and respond for the record, Mr. Chairman.

Mr. WAXMAN. We would like to get that response. It seems to me that—while Dr. Seife is talking about the number of people that would be required and the cost required to implement this—the savings to the consumers is incredible.

[The following information was received for the record:]

FDA has not completed a preliminary regulatory impact analysis of the ANDA policy, however, an early working draft of this analysis, publicized in March 1982, did estimate annual consumer savings through 1995 for a variety of implementation options. The option most similar to H.R. 3605 permitted ANDA's for products approved between 1962 and 1978. The undiscounted sum of consumer savings from 1983 through 1995 was $921 million. Comparable undiscounted savings for the option approximating a 15 year pre-eligibility period was $506 million.

Mr. WAXMAN. That is justifiable, not only to the consumers but to the Federal Government as I indicated in my opening remarks since the Federal Government purchases drugs at the lowest possible price and if we don't allow competition, the lowest possible price is whatever the highest price would be.

FDA originally proposed to repeal secton 301(l) and now you are proposing the use of NDA numbers. Why wouldn't the repeal of section 301(l) benefit the pharmacists and the public? What are the protections of the section 301(l) that should be retained?

Dr. NOVITCH. The concern of the pharmacists is limited. The pharmacists want to know whether a drug they purchase—this is also true of States and other large purchasers—whether that drug has been approved for safety and effectiveness by the FDA. The only information they need for that purpose is the NDA number and we are concerned that if that section of the statute is repealed outright it would allow the advertising of OTC approval—which may or may not be beneficial—and much more information than pharmacists really are needing and apparently asking for would be there.

So we feel that the repeal of it should be limited to that which is needed to meet the purpose.

Mr. WAXMAN. Do the numbers assigned an NDA and ANDA signify FDA approval or merely filing of drug approval application?

Dr. NOVITCH. The number is assigned at the time of application but we would permit it to be used only where the drug has been approved for safety and effectiveness. The number would not be permitted to appear on the label simply because application had been filed, only after approval for safety and effectiveness.

Mr. WAXMAN. Should the manufacturers of pre-1938 drugs and drugs for which the DESI review has not been completed be permitted to label the product as FDA-approved and are such products on the FDA-approved products list?

Dr. NOVITCH. They are not on the approved products list because they don't have approved applications. But it wouldn't cause any particular inequity among the manufacturers of those pre-1938 products because none of them has approval. It is on a class basis. If a drug doesn't require NDA approval, a pharmacist wouldn't pick one up and say, "That is the one I will use because it has approval. Here is the number on it."

They either all have approval or none have. We believe it is a fair system and one that meets their needs without raising other possibilities that need not be addressed by legislation.

Mr. WAXMAN. The Supreme Court issued a number of decisions affording first amendment protections to accurate and nonmisleading commercial speech. Is 301(l) of the Federal Food, Drug, and Cosmetic Act constitutional given that it bans truthful statements by FDA in advertising?

Mr. SCARLETT. I wouldn't want to anticipate a court decision should 301(l) ever be challenged in its present form.

I don't think it is unconstitutional. I think that the prohibition represents a legislative judgment that the fact of NDA approval or PMA approval for medical devices, when used in isolation as it would most likely be in labeling or advertising, would be inherently misleading most of the time.

You can argue that the first amendment does not allow a generalization of that sort to be translated into a flat ban but I think that the problem that Congress probably had in mind was a real one. If all you say in an advertisement is "This drug has been approved by FDA under an NDA," and nothing more, you have put into the listener's mind a very attractive sounding fact but which has very little meaningful content in the consumer's mind because the consumer or listener does not understand what it means for FDA to approve a drug under a new drug application.

Our position here before you today, Mr. Chairman, is not based on any belief that 301(l) is or is not constitutional, it is simply that we don't see any particular public purpose to be gained by repealing 301(l) at this time, particularly considering that the only problem that we have identified with it is the problem of pharmacists not knowing whether a particular drug has been approved by FDA.

Mr. WAXMAN. There is no advertising to the public at the present time, is that correct? We are talking about statements to pharmacists.

Mr. SCARLETT. If you are referring to prescription drug advertising to consumers—first of all, there can be NDA numbers for OTC drugs which are advertised to consumers. Second, we are facing in-

creasing demands for permission, if that is the right word, people might dispute me on that, for manufacturers to advertise prescription drugs directly to consumers. The ability to say that a product has been approved by the Federal Government I think is peculiarly subject to abuse.

As you know, there are special provisions of law regarding what you can say about the registration of a securities offering with the Securities and Exchange Commission. In fact, you have to disclaim that there is any signifiance at all to registration or approval of an issuance by the SEC.

Mr. WAXMAN. Back to my original question to you, as you look at the Supreme Court decisions and you evaluate what is now protected speech and what is not, your advice to your client aside from the policy questions which I will leave aside for the moment because I want to know your legal opinion, your legal opinion is that 301(l) is constitutional?

Mr. SCARLETT. Yes.

Mr. WAXMAN. And they can go ahead and continue to administer the law restricting the statements under 301(l)?

Mr. SCARLETT. That is correct.

Mr. WAXMAN. Well, that completes the questions that I have which were quite extensive. We look forward to the additional information that you indicated you would make available. I appreciate you being with us.

Our second panel of witnesses includes Kenneth Larsen, chairman of the board, Generic Pharmaceutical Industry Association; and Milton A. Bass, general counsel, National Association of Pharmaceutical Manufacturers, accompanied by Burton Greenblatt, president, National Association of Pharmaceutical Manufacturers.

STATEMENTS OF MILTON A. BASS, GENERAL COUNSEL, NATIONAL ASSOCIATION OF PHARMACEUTICAL MANUFACTURERS; AND KENNETH N. LARSEN, CHAIRMAN, GENERIC PHARMACEUTICAL INDUSTRY ASSOCIATION, AND PRESIDENT, ZENITH LABORATORIES, INC., ACCOMPANIED BY BILL HADDAD, EXECUTIVE OFFICER AND PRESIDENT (GPIA)

Mr. BASS. Mr. Chairman, I first want to thank you on behalf of the association for introducing this bill. We are pleased that we have this kind of a move afoot.

I would like to mention, you asked Dr. Novitch the first question as to whether in September 1978 there had been any notice by the FDA about a post-1962 ANDA policy, and he did not recall. I would like to just answer the question if I may, Mr. Chairman.

There was, you are correct, on September 1, 1978, in the Federal Register, page 39126, specifically on 39128, such a notice by the FDA.

I would like to note this, Mr. Chairman, in answer to that very same appropriate question, on page 8 of a memorandum from Commissioner Hayes to Secretary Heckler, on March 14, 1983, he said as follows: "In addition, our intent to establish this procedure has been mentioned publicly numerous times. As early as September 1978, FDA invited comments. The Department's agenda of signifi-

cant regulations under development as well as the calendar of Federal regulations have included this proposal."

So that there is no question that since September 1978 we have had continued notices that something would be done and invitations for comments of all kinds.

One of the things that appears rather strange and difficult to me, is that you, Mr. Chairman, introduced a bill which basically says that there is no difference between pre-1962 and post-1962 ANDA's.

We at NAPM, Mr. Chairman, introduced a case, we filed a case in the Federal court asking for a declaratory judgment in part saying the same thing. There is no difference between pre- and post-1962 ANDA's, that is, the statute.

What I find difficult to understand, strangely enough, is the FDA has consistently agreed with the bill basically you introduced and our case that the statute authorizes it. There is no difference between pre- and post-1962 ANDA's, yet they have done nothing about it all these years. And I might note though, I won't take the time to quote it, I will submit to the committee; there is the statement, particularly in the February 8 internal memorandum of the FDA signed by Dr. Crout then Director of the Bureau of Drugs with an appendix which sets forth in detail, Mr. Chairman, that statutory authority that they have the authority and it clearly says, Mr. Chairman, if I might, that "with respect to the legality of the proposed regulation"—that refers to the post-1962 ANDA's—"it is our position that it is current FDA policy not any statutory impediment that has prevented our accepting ANDA's for post-1962's."

That is what is really, I think, something that has been difficult to understand. The agency agrees the statute does not present any obstacle, it is the agency which has. They have not done anything for all these years.

If I might, rather than read my statement, Mr. Chairman, I would like to address some of the comments that the FDA made this morning. Now they are telling us there are reasons why they are not doing anything, why we need more time since 1978. There are three reasons: First, we heard talk about an eligibility period and we were told this morning that the agency would like a period for marketing surveillance, to check a drug after it is introduced. Now, I agree 100 percent, Mr. Chairman, the FDA should have a very good postmarketing surveillance program for drugs but I respectfully suggest that has nothing to do whatever with post-1962 ANDA's.

Now, you, Mr. Chairman, mentioned paper NDA, you say how about those. I would like to go a step further, take any NDA. If the legitimate concern is postmarketing surveillance and if I introduce a drug with a full NDA today, what is the difference if somebody comes in tomorrow with another full NDA? We still want the postmarketing surveillance. It has nothing to do with post-1962 ANDA's. So I will suggest we address the problem of postmarketing surveillance but the remedy is not to give a monopoly outside the patent laws for post-1962 products.

We are not going to burn down the house to roast the pig. We should address the problem on target. Now Congressman Neilson, I

think, appropo the substance of the question, I think you addressed perhaps the relevant question, though it has nothing to do with post-1962 ANDA's. We heard they were concerned about how they would get information, how the surveillance would work and that the generic companies were giving too many reports. Inherent in the question you asked, I think, our problem has not been too many reports, I mean according to the recent newspaper reports like Oraflex. Our problem is too little reports. We don't have to go back to Thalidomide. There have been enough recent ones.

If it comes to that problem, let's address it in the proper forum. But we are missing the entire point in discussing that question, Mr. Chairman. It has nothing to do with how many drugs are on or off patent. It has nothing to do with this problem. The simple answer is, Mr. Chairman, we have an ANDA procedure for pre-1962's. That procedure could and should be used for post-1962's, no reason whatsoever. There is nothing under the law to prevent that.

We were told the second reason is to provide incentives. Here, too, Mr. Chairman, I am 100 percent in agreement. We should provide incentives for innovation and we should provide that incentive where it belongs, with patent laws. Where we evaluate public interest and competition, the public interest and innovation. That is the function of the patent laws where Congress decided it, not the FDA law.

I was troubled when I heard the discussion, Mr. Chairman, this morning and we were told that—I note this is not an exact quote because I just heard the statement a short while ago—that the FDA is stating they have the power or the right to consider incentives relative to questions of monopoly or patent laws, inherent in their right to interpret the data under the Food and Drug Act.

I suggest to you, Mr. Chairman, the Food and Drug Act is clear and precise. What does 505 say? Section 505 specifies, 505(d), as to what the Food and Drug must do, it must evaluate drugs for safety and efficacy. That is one. Express direction; nothing else. No incentives, no competitive advantages to one company as against another. No monopolies.

Even more significant, 505(d) (4) and (5) of the statute goes further and it expressly says that the Food and Drug in studying whether it accepts or rejects an NDA must consider not only the material that the applicant submits, it must consider all information it has so this goes to the whole question of other information, other studies, the question of duplicate studies. So there is no ambiguity in the statute as far as their power.

I agree and I agree with your comment, Mr. Chairman, that if the FDA has some concerns, they are interested, they should tell us of their interest, but they cannot exercise a legislative power. The Congress has to decide when there should be a monopoly, how long, and under what circumstances.

Now I would also suggest in this regard, Mr. Chairman, that if we use the Food and Drug Act to grant monopolies, it is not only the wrong place, it is not only the place that Congress did not decide to do it, I would say it is the worst place because you are not getting the evaluations that are ostensibly the ones Congress took into account in deciding whether it will grant a patent, when it will or won't. In other words, the FDA can say they can wipe out

the patent laws, you get a 17-year period by filing a NDA, should the FDA be able to do that?

I suggest it is not the function of the agency and contrary to what Congress has done and has decided should be done.

Now we have a third reason, Mr. Chairman, being inundated with work.

Here, too, I am in 100-percent accord with the FDA, Mr. Chairman. I don't want them inundated with work. But I am not that worried about it for this reason: No. 1, on March 14, 1983, the Commissioner of the Food and Drug Administration sent a memorandum to the Secretary of the Department of Health and Human Services. On page 6 of that memorandum, I would like to call your attention to a certain statement which says as follows:

> Since ANDA's are reviewed by a different division within the National Center for Drugs and Biologics, and NDA's, the proposal would not significantly affect the NDA review process.

So that at least as of March 14, 1983, we apparently were not overly concerned about inundations or floods.

However, here again I would like to suggest, of course there can be problems but let's meet the problem with the answer that is called for. The answer to a problem of workload, and we don't know what it will be now, it is purely conjectural, should be by steps to meet that.

It is not for granting a monopoly for all time. What about the workload with NDA's, do we know how many we will have next year or 6 years from now? How about paper NDA, pre-1962 NDA's? Do we know how many we will have tomorrow or next month?

Why post-1962 ANDA's? Strange. But I think what we will find if we look at the three reasons, Mr. Chairman, is that unfortunately over the years we have had different reasons given at different times in justification for inaction. I suggest, Mr. Chairman, the statute is clear, the agency has admitted that the statute does not draw this distinction between pre- and post-1962 NDA's and the statute does not.

It should follow what the statute says, "Without further delay."

Now, what troubles me, Mr. Chairman, and here is what I am afraid of, we have had a reference to notice and comment proceedings, administrative proceedings. I think this is the nub of our problem today. The real heart of the problem is time, Mr. Chairman, delay, and every device and every method I am afraid is going to be used and has been used as you mentioned from 1978.

I can go back further than that.

I can mention meetings where we have sat and discussed it time and again.

Now, why notice and comment? What is there to notice and comment about? No. 1, the Commissioner told us as I note in this memo, we have been having invitations for notice and comment since 1978. We had a public notice even as recently as January 13, 1982. We have had continued notice and comment. We have had discussions with industry, with consumer groups, we have had written submissions, we have had a lot of notice and comment.

No. 2, we don't need it. What is the issue? The only issue mentioned is a preeligibility period which isn't in the statute. It is a

nonissue. So if you remove the nonissue there is nothing to sit and spend years about.

You asked, Mr. Chairman, How long will it take? If we go through these administrative proceedings, court review and all these actions, this is going to take years and years in addition to the 5 years since 1978, it can go another 7, 8 years. That is the name of this game, Mr. Chairman. Time. That is what we are all talking about. There is nothing for notice and comment proceedings.

Now, I suggest that we have a pre-1962 NDA procedure and there is no reason the same cannot be used for post-1962. It is in place, it is working, we have a division, the head of the division was sitting here and he could handle post-1962's the same as pre-1962's, what is the difference? There is nothing to talk about.

If there are other problems, let's address them together. But not as an excuse for unwarranted monopoly, not as an excuse for years of delay.

Thank you, Mr. Chairman.

[Testimony resumes on p. 42.]

[The statement of Mr. Bass follows:]

STATEMENT OF THE NATIONAL ASSOCIATION
OF PHARMACEUTICAL MANUFACTURERS,
BEFORE THE HOUSE HEALTH AND
ENVIRONMENT SUBCOMMITTEE

I am Milton A. Bass, general counsel to the National Association of Pharmaceutical Manufacturers.

The National Association of Pharmaceutical Manufacturers is a non-profit trade association of manufacturers and distributors engaged in the sale of drug products to wholesalers, retail pharmacies, physicians, hospitals and to federal, state and city institutions. The NAPM represents a cross-section of the many hundreds of generic drug companies which provide low-cost pharmaceutical products to the public.

The NAPM fully supports the legislation under consideration which would dispense with the necessity for wasteful, duplicative testing for drugs which have previously been approved by the FDA as safe and effective under §505 of the Food, Drug and Cosmetic Act.

Approval of so-called post-1962 ANDA's has been suspended in administrative limbo for over a decade, despite repeated promises of action and concessions by the Food and Drug Administration that its current policy is unjustified from any perspective: legal, moral, social and economic.

The FDA recently observed in an internal memorandum that "[t]he current data requirements for duplicate drug product approval have tended to perpetuate exclusive marketing by pioneer firms long beyond the expiration of patents for their drugs." Memorandum of J. Richard Crout, Director of the Bureau of Drugs, to the Commissioner, February 8, 1982, page 2. As a result of FDA inaction, the large drug manufacturers have been

permitted to exploit the public protection features of the Food, Drug and Cosmetic Act for secondary economic protection against competition in addition to, and far in excess of, that already granted them by the patent laws.

As a direct result, generic drug companies have been effectively precluded from offering moderately priced generic versions of many drugs for sale to the public. The generic drug companies, which have fulfilled a vital national interest in dispensing lower cost drug products, are thus unable to provide to the public some of the most necessary and widely-used medications in recent history, while the large drug companies continue to reap the disproportionate profits generated by this lack of competition.

More importantly, and of greatest concern to the public and to its lawmakers is the economic cost to the consumer of the high drug prices supported by the FDA's inaction. The burgeoning health care burden of this country is a much publicized national concern and need not be belabored. The high cost of pharmaceutical products is one of the chief components of high health care costs. These costs affect every segment of the economy, beginning with the consumer, particularly the elderly, who are retired and on a fixed income. These drug costs are then passed on to the public treasury through medicaid and medicare.

The FDA itself has repeatedly stressed the need for breaking this economic logjam. Yet pronouncements have been

followed only by procrastination. During the past five years, the agency, in meetings with myself and industry representatives, promised early action. Nothing was done. On January 13, 1982, the FDA published a Federal Register announcement stating that a proposal would be issued in March, 1982. Nothing happened. Now, we are advised that the FDA is planning to derail a simple policy correction into an elaborate, legally unjustifiable rulemaking enterprise which promises only more years of delay.

Further the FDA is now threatening to enact into the Food and Drug law a patent-type economic protection period for large drug companies, the very evil which the FDA had for a decade professed a wish to inhibit. In a March 14, 1983 Memorandum, the Commissioner of the Food and Drug Administration proposed a post-approval exclusive marketing period of up to 15 years for the pioneer NDA applicant. In 1975, however, the FDA took the opposite position, that "it was not the intention of Congress that Section 505 of the Act would be used as an economic trade barrier." 40 FR 26142 (June 20, 1975).

There is, we submit, no reason for blatant economic protectionism in the Food and Drug law, which was designed exclusively to insure the public safety. Moreover, this attempted tampering with the Food and Drug law is but the "second front" in the traditional effort by the large drug manufacturers to gain an ever greater economic windfall. Their primary campaign is now being waged in its proper legal form, the so-

called patent-extension hearings, in which Congress has been deliberating the wisdom of extending the patent period beyond its seventeen year statutory limit. The post-1962 NDA area is simply a ruse by these companies to accomplish indirectly what they are simultaneously attempting to accomplish directly in another forum.

There is no difference between pre- and post-1962 drugs. The same statute applies.

The "Post-1962" ANDA problem is a simple question of logical and equitable statutory construction. It concerns drugs approved by the FDA as safe and effective for public consumption, per the statutory directive of the Food, Drug and Cosmetic Act, §505. Pursuant to §505, any drug for which approval is sought, whether pre- or post-1962, must be determined by the FDA to be safe and effective based upon all information submitted in the application and all other information which the agency has as §505(d) specifically provides.

The FDA's current practice is to require unnecessary and wasteful duplicative testing for most generic drug applications of drugs approved after 1962, although it dispenses with the testing requirement for pre-1962 drugs.

The statute, however makes no such distinction; it requires no duplicative testing where such testing would merely show what the FDA already knows with respect to the safety and efficacy of a given drug.

Pursuant to §505(d), the FDA must consider all information available in approving a drug for safety and efficacy. See, also FDA regulations in this regard, 21 C.F.R. §314 et seq.

Thus, neither the statute nor its attendant regulations require duplicative clinical studies. In the paper NDA litigation, the FDA, expressly rejecting any such contention, noted "[a]ll that is required is the submission of reports upon which it can be fairly and responsibly concluded that the drug is safe and effective." Memorandum of Law submitted by the Food and Drug Administration in Hoffman-La Roche, Inc. v. Harris, (D.C. 79-1650, 2318, 2516), page 30.

Under §505, therefore, the FDA must make a determination that sufficient or insufficient evidence of safety and efficacy exists on the basis of all information before it. Safety and efficacy may be indicated by any evidentiary source, including reports of pertinent studies, no matter who performs them -- the applicant or any other person. Thus, when the FDA receives an application by a manufacturer for a generic duplicate of a previously approved drug which the FDA -- by virtue of the prior approval -- knows to be safe and effective, the FDA must, by statute, utilize that knowledge to approve the safety and efficacy requirement of the generic duplicate.

The FDA, conceding the legal unjustifiability in requiring wasteful duplicative clinical testing, agrees. In a recent internal memorandum, the FDA notes, "with respect to the

legality of the proposed regulation, it is our position, stated in the proposal, that it is current FDA policy, not any statutory impediment, that has prevented our accepting ANDA's for post-1962 drugs." J. Richard Crout Memorandum, supra, page 4.

Because their basic safety and efficacy has already been established, there is no legal or scientific necessity for generic companies' reproving their safety and efficacy by duplicating the extensive costly and risky clinical testing submitted with the original NDA. The FDA has repeatedly recognized the wastefulness of such a requirement, noting that:

> "[i]t is common for a widely prescribed non-patented drug to be marketed in a dozen or more products made by individual firms. A requirement for duplicative testing would, thus, require not merely 1 or 2 firms but as many as 10 or 20 or more firms to conduct repetitive, scientifically useless and ethically questionable human studies."

FDA Memorandum of Law, supra, page 13. Generic manufacturers already conduct proper tests and studies such as bioavailability, bioequivalence, stability, and dissolution. Our only objection is to conducting concededly unnecessary duplicative studies.

The distinction between pre- and post-1962 drugs is thus completely irrational. If the safety and efficacy of pre-1962 approved drugs need not be repeatedly reproven by costly and unjustifiable duplicative testing, this applies no less to post-1962 approved drugs.

To require unnecessary duplicative tests is unconscionable. It is morally wrong, it is socially wrong, it is economically wrong. The FDA has long conceded the ethical questionability of requiring scientifically unnecesary clinical re-testing. Tests of safety and efficacy typically present risks to human test subjects in such crucial areas of investigation as toxicity, contraindications and placebo effects. To subject human test subjects to more testing than that necessary for the initial showing of safety and efficacy is thus morally unjustifiable.

Moreover, such large scale testing would severely tax the limited research and testing facilities available, and divert enormous effort from more socially useful projects. The FDA noted in a recent internal memorandum:

> "The reasonableness of the extension of the ANDA concept to post-1962 drugs has been apparent not only to FDA but to many outside the agency as well. To require each duplicate version of an approved drug product to undergo the same testing for safety and effectiveness as the pioneer product, in animals and in humans, is not in the best interest of the public, of investigators who are needed for newer products, or of those subjects who would be exposed to the rigors of clinical trials."

FDA Memorandum, supra, page 2

The first manufacturer to obtain an NDA approval is free to market its product protected from competition by its patent. During this period of patent protection, the

manufacturer may price drugs to recoup not only its research and development costs, but to generate substantial profits for itself as well. Currently, some of the most vital and widely-prescribed drugs are under patent protection and sell for huge multiples of their basic manufacturing costs. These drugs include such multi-hundred million dollar drugs as Valium, Aldomet, Motrim, Keflex and Clineril.

Upon expiration of the patent period, other companies may market generic duplicates of the drug. However, for post-1962 drugs, the FDA requires that the generic company duplicate all studies of safety and efficacy which the FDA already has in its possession.

The FDA had attempted to remedy this problem with its so-called paper NDA policy. Pursuant to this policy, a subsequent NDA applicant may substitute published reports of safety and efficacy for performing duplicate clinical testing.

As a practical matter, the paper NDA policy is of extremely limited utility, and fails to solve the duplicative testing problem. According to the FDA itself, the paper NDA policy cannot be used for over two-thirds of post-1962 drugs because they do not have adequate published literature. Even with respect to those drugs for which published literature is available, the policy is a mere "paper chase" in that it simply provides the FDA with literature already in its possession. This process is merely a paper game because the second applicant can simply submit a Freedom of Information Act request to the FDA

and obtain the necessary published reports. These reports may then be resubmitted to the FDA in the application. The paper NDA policy is thus but a limited aid, not a solution for the post-1962 ANDA problem.

Clinical testing for safety and efficacy, involving great financial investment, is an insurmountable obstacle to the ability of smaller, generic drug companies to market drugs for which patent protection has expired.

The FDA recently estimated in its Federal Register notice of January 13, 1982 that safety and effectiveness evidence accounts for about 95% of a firm's costs for a duplicate NDA. Thus, requiring unnecessary, duplicate clinical testing for post-1962 generic drugs effectively forecloses a major portion of the drug market from generic competition. That the originating manufacturer could utilize this procedure to obtain patent-like protection, was recognized by the FDA in 1975:

> "The Commissioner is aware that the manufacturer who holds the 'pioneer' NDA for a drug may well have an economic interest in retaining the new drug status of that drug. As long as either a full or an abbreviated NDA is required, entry into the market place, and thus increased competition, will be impeded."

40 F.R. 26142, supra.

This outcome, the FDA continued, was inconsistent with the purposes of §505:

> "The Commissioner concludes that it was not the intention of Congress that §505 of the act would be used as an economic trade barrier. It is in the public interest, and consistent with the purpose of the act, to permit the marketing of drugs with the least restrictions necessary to assure their safety and effectiveness."

40 F.R. 26142, supra.

The FDA rejected the timeworn contention of the large drug manufacturers that additional economic protection was necessary to recoup their development costs. In the paper NDA litigation, the FDA declared in response:

> "For the protection plaintiffs seek in recouping research and development costs, plaintiffs should look to the patent laws, not to the Federal Food, Drug, and Cosmetic Act which was never intended to be used as a sword to cut down competition. As incident to insuring the safety and effectiveness of drug products, the FD&C Act does erect certain barriers to competition. Nevertheless, plaintiffs' argument they are entitled to maintain and extend those barriers is without merit. Plaintiffs have had an adequate legal remedy all along to avoid the possible injury they fear -- they are free to obtain patents for their products."

FDA Memorandum of Law, supra, page 46.

Nevertheless, despite its longstanding, unequivocal stance, it is precisely this secondary economic protection, wholly unrelated to safety concerns, which the large drug companies have succeeded in perpetuating, abetted by FDA diffidence and procrastination.

After repeatedly conceding the need for post-1962 NDA reform and emphasizing the imminence of a published policy change, the FDA has recently shifted its position. According to its recent pronouncements, the FDA will now attempt to magnify a simple statutory procedure into a full-scale rulemaking process, with notice and comment, solely to enact a special patent-like economic protection period for the large companies.

Such rulemaking is legally unjustified. There exists no issue for which notice and comment is required. Bringing post-1962 ANDA policy into line with pre-1962 policy is a mere policy change which, like the paper NDA and the original ANDA policies, does not require lengthy and arduous notice and comment proceedings. The sole issue for notice and comment is the artificial issue of a protective patent-like period which the FDA now proposes to implant in the drug approval process. The FDA, in fact, solicited comments on its anticipated post-1962 proposals, in September, 1978 and in January, 1982. Its contemplated policy has long been published in the Department's agenda of significant regulations under development as well as in the calendar of Federal Regulations.

The corrective agency ANDA policy has been extensively discussed and explained in lengthy Federal Register notices in 1975, 1978, 1982 and in numerous public and quasi-public meetings with industry officials and their representatives. Although FDA repeatedly noted that no legal justification existed for

its current post-1962 policy, that a full proposal was extant and its publication imminent, no proposal was ever issued.

We submit that this procrastination, which aids those who seeks only further delay and greater economic rewards at the expense of smaller companies and the consuming public, is alien to the public safety goal of the Food and Drug Law, and should not be tolerated by this lawmaking body.

An economically non-discriminatory post-1962 ANDA policy is critical to the continued viability of the generic drug industry. Currently, fifteen of the 50 most frequently sold branded prescription drugs are off patent. By 1990, an additional 24 of those patents will expire. Over the next four years, 48 different branded drugs will come off patent which have current annual sales of over $1.5 billion. The ability of generic companies to market these essential, widely prescribed drugs upon the expiration of their patent periods is thus a significant national interest and should be facilitated.

The statutory language is seldom more clear than in the safety and efficacy provisions of the Food and Drug Act, and for good reason: because the safety of the public is the aim. We are witness to a sorry spectacle indeed when, after a decade of public and private promises and pronouncements, the FDA remains unable or unwilling to implement the safety and efficacy provisions in their simple, pure form.

Mr. WAXMAN. Thank you very much, Mr. Bass.
Mr. Larsen.

STATEMENT OF KENNETH N. LARSEN

Mr. LARSEN. Thank you very much, Mr. Chairman. I am chairman of the Generic Pharmaceutical Industry Association which represents 80 percent of the commodity prescription generic pharmaceuticals manufactured in this country.

I am also president of Zenith Laboratories, a publicly-traded generic drug company. The 30 years prior to my joining Zenith were spent with a major international pharmaceutical company. During that period I was privileged to work in more different areas of the company than anyone else in the 100-year history of the company, including regulatory affairs, so I have insight into that area.

Before proceeding with my remarks, Mr. Chairman, I would like to express my personal appreciation to you, which I have not had the opportunity to do, for your position on the Orphan Drug Act. This comes from a company that is presently supporting three different orphan drugs.

We support H.R. 3605 because it removes major barriers to competition in the pharmaceutical industry. The harsh fact is that, for drugs which entered the market after 1962 on which the patents have expired, we are prevented from competing on a timely basis because the FDA has failed to develop an efficient procedure for the approval of duplicate versions of approved post-1962 drugs.

For prescription drugs which entered the market prior to 1962, there is an efficient, effective proven procedure. The lack of a similar procedure for post-1962 drugs provides the patent holders a period of extended monopoly. For the consumer and the Government, it is an extended period of higher prices.

The Chinese Wall between pre-1962 and post-1962 drugs resulted from the Kefauver-Harris amendments to the Food, Drug, and Cosmetic Act of 1962. The Thalidomide crisis alerted Congress to the realization there was a need to establish that drugs were both safe and effective. Kefauver-Harris required all drugs entering the market after 1962 be proven both safe and effective. All drugs in the market were subject to review to determine if they were safe and effective.

Pre-1962 drugs submitted to the FDA for approval were, and are, reviewed for safety, effectiveness, and manufacturers' compliance with the FDA's Good Manufacturing Practices requirements. Those satisfying the requirements are approved for marketing under the abbreviated new drug application [ANDA] procedure. Dr. Marvin Seife, who directs this area of the FDA, and who you heard this morning, has reported, and I quote, "To my knowledge, no mishap, no untoward or tragic experience has occurred in relation to or as a result" of these ANDA's which were awarded to both trade name and generic companies.

In short, for a drug which entered the market prior to 1962, there is a procedure for approval. For a drug which entered the market after 1962, the procedures are insensitive to the fact a duplicate version of a proven drug requires less rigorous procedures than a totally new drug.

Mr. Lewis Engman, president, Pharmaceutical Manufacturers Association, recognized the need for change when he stated to a Subcommittee on Science, Research and Technology—

> There should be a sense of urgency in bringing the drug approval system to higher levels of efficiency if the needs of the American public are to be met adequately. Our health care system is under constant siege. It must become more efficient, more cost-effective, more attuned to consumer and medical demands. We believe that we should do something, but that we ought to keep in mind that the goal is how to help consumers in this country who have illness and how to help them get drugs that are safe and efficacious in the best possible, most efficient manner.

In earlier years, this was not as great a problem but, as the number of products coming off patent has increased, it has become more important to have an efficient procedure. Extending this period because of the absence of a sensitive procedure creates a real catch-22 problem with real life consequences. It should be easier to approve a duplicate version of a post-1962 drug, which has been proven safe and effective at its introduction and marketed for a period of years, than to approve a pre-1962 drug which might not have been proven effective at the outset.

The FDA itself, in a draft proposal for post-1962 regulations, recommended the pre-1962 procedure be used as the post-1962 procedure. We agree. Your legislation would establish that procedure as a matter of law, expediting the change rather than delaying the implementation because of all the hearings and administrative reviews that would be required if implemented through the FDA.

As Dr. Novitch noted, he could not even project what that would be. The consequences of delay are severe. For just 10 of the top selling 51 drugs which are due to come off patent by 1986, annual retail sales are $1.34 billion. This is 14 percent of all retail prescription drug sales. Without your legislation, it is clear there would be inordinate delays in finalizing an administrative change in procedures extending the market monopoly despite the fact the drugs should be legally subject to competition as their patents expire.

Competition means lower prices for consumers and the Government. Let me give you some examples of what has happened to prices for pre-1962 drugs where there is competition. You have these in my statement and I would only cite, spironolactone with hydrochlorothiazide, $22.57, the brand price, $8.19 the generic price, brand percent greater, 176 percent.

Meprobomate (equanil), $11.33, $3.63, 212 percent.

Hydrochlorothiazide, $7.47 for the brand, generic is $2.82, and that is 165 percent higher.

Tolbutamide (orinase), $14.63 is the brand price, $4.18 is the generic price, and that is 250 percent higher. This list could go on and on. (Exhibit A.)

Further, there are many post-1962 drugs that are off patent for which there is no generic competition. Drugs in this category, taken from a list of the top 100 prescribed drugs, have a drugstore market value of $500 million. Included in this group of dyazide, indocin, darvocet, and others.

Who is hurt by delay? The elderly, the 11 percent of the population who purchase 25 percent of all drugs. Recently Bill Haddad, president of our association, was on the "Larry King Show" to talk

about generics. He received almost 8,000 letters—all handwritten—almost all from the elderly, revealing in stark human terms what it means to pay high prices for drugs, when FDA approved identical generics could be available at a fraction of the price.

We were tempted to present all the letters to you but it would be a burden to give them to you. But if you did read over them you would find the story of the importance of generics.

The choice, for them, is horrendous. Do you stop taking drugs at the end of the month, or do you skip some meals, or do you fail to heat your house and wait out the month in the cold? Those are the realities. Unless Congress provides an effective procedure for approving post-1962 drugs, consumers, particularly the elderly, are left with the hard choices.

The chronically ill and young couples with growing families have need for your help.

Control of third party health care costs can be substantially effected by a procedure that provides for the timely review and approval of generic post-1962 drugs.

In closing, let me illustrate how important your legislation is to reducing the Government's health care costs by citing just one product example. This is a comparison we made taken from the U.S. Department of Defense procurement because it shows the impact to the Government. The product is Metronidazole, in bottles of 250, 250 milligram. The record goes back to 1965 but we looked at it only from April 1980 forward when the contract was awarded to G. D. Searle as a price per bottle of $53.24. There were no other bidders at the time as there were no other manufacturers approved.

In September 1981 G. D. Searle received the award again at $53.24.

In the summer of 1981 the Department of Defense learned that there was a generic company that was about to receive approval. At that time Searle had entered a bid for $69.74 per bottle.

The Department of Defense did not award the bid at that time. They held it back.

Then in May 1982, Zenith Labs bid $32 per bottle, G. D. Searle's bid was $69.74.

In September 1982, Zenith Labs bid $28, G. D. Searle, $69.74.

In February 1983, G. D. Searle bid $26.40, and Zenith labs $26.60. Searle won the award.

Then the most recent bid, April 1983, Cord Laboratories bid $19.67 and received the award.

As a result of generic competition beginning in May 1982, the Department of Defense has saved $1,161,774 using G. D. Searle's price of $69.74 as a base. Had there not been competition, I don't believe the price would have dropped.

The price the Department of Defense would have paid, that $69.74, if it had not been for the introduction of generics. (Exhibit B.)

If you think now about the one statement that was made by Dr. Novitch and Dr. Seife, they are asking for 15 people. If they assume 15 people with a price of $30,000 each let's say, that is $450,000. On just one product we have paid for those people for several years.

I, too, would like to comment on this adverse reaction issue that was brought up. I can speak as a manufacturer and for two other generic companies in whose representatives are in attendance that are sensitive to the importance of looking at adverse reactions. We are sensitive and responsible. The generic manufacturers of today will respond to those needs. As far as I know we have been not remiss in that responsibility. If it demands a higher level of knowledge on our part we are prepared to meet and respond to the need.

Certainly the recent history does not speak well to the PMA's companies reporting adverse reactions.

Patent life has been brought up as an issue. I don't believe that this is an issue that the FDA should concern itself with as I don't believe that it is in its charter. There are too many things that influence patent life of drugs that companies have the ability to control including when they issue. Companies have the ability to make decisions as to the rate drugs will be developed providing opportunities for extensions under the proposed legislation.

I can think of an example of two drugs where, both drugs came out of research at the same time, the one drug entered the market and enjoyed an extensive period of patent life protection; the other drug was held back and the manufacturer subsequently pushed the drug through. By the time it entered the marketplace it only had 2.5 years of protection. This was a decision of the company and it had nothing to do with the FDA process.

I think when we hear this 7-year statement of product life, that was brought up, you have to compare that to the 18.5 years which we have determined to be the average patent-protected life of products in the marketplace.

The reason for the difference? The overlapping of patents, the overlapping by the process patents and use patent.

Certainly this is not an area where FDA should concern itself. I cannot help but comment that Dr. Novitch says the market share dropped sharply. I sure wish it did because our market share does not come close at all to what the major companies enjoy. Our market share is 20 percent of the generic market. You can find many estimates but I believe it is probably an 80–20 ratio branded to commodity generics.

We encourage and support you in this effort to bring this legislation forward. We thank you for this opportunity.

[The exhibits to Mr. Larsen's statement follow:]

EXHIBIT A

Chain Store Price June 1983

Package Size 100

Generic	Brand Price	Generic Price	Brand % Greater
Spironolactone with Hydrochlorothiazide (Aldactazide) 25 mg.	$22.57	$8.19	176%
Meprobamate (Equanil) 400 mg.	$11.33	$3.63	212%
Hydrochlorothiazide (Hydro-Diuril) 50 mg.	$ 7.47	$2.82	165%
Tolbutamide (Orinase) 500 mg.	$14.63	$4.18	250%

EXHIBIT B

U.S. DEPARTMENT OF DEFENSE PROCUREMENT
Metronidazole 250 mg. Bottles of 250
Procurement History

	AWARD		OTHER BIDS	
Date	Contractor	Price/Bottle	Bidder	Price/Bottle
April 1980	G.D. Searle	$53.24		
Sept. 1981	G.D. Searle	53.24		
May 1982	Zenith Labs	32.00	G.D. Searle	$69.74
Sept. 1982	Zenith Labs	28.00	G.D. Searle	69.74
Feb. 1983	G.D. Searle	26.40	Zenith Labs	26.60
April 1983	Cord Labs	19.67		

Mr. WAXMAN. Thank you very much, Mr. Larsen. FDA estimates there were 125 drugs approved after 1962 which are off-patent and for which generic verions could be approved if H.R. 3605 were enacted. FDA suggested an eligibility period that would not permit generic versions to be approved for some of those off-patent drugs.

Are there health and safety justifications for an eligibility period? For example, are your firms subject to the same legal requirements regarding the reporting of adverse drug reactions?

Mr. LARSEN. The answer is yes.

Mr. BASS. Not only yes, Mr. Chairman, but they should be.

If they are not they should change them. But it has nothing to do with this proceeding or this question.

Mr. WAXMAN. What assistance to the FDA on evaluation of NDA's do NDA holders render that a generic company cannot render?

Mr. BASS. I cannot conceive of any, Mr. Chairman. In fact, I would say the problem is that the FDA must and should assume more of the burden. I think they should not rely too much on a company other than to report it and have a duty to report it.

I think the evaluations from my point of view and the public point of view would be best performed by the FDA in terms of whether there is a problem, whether a drug should be taken off the market. But the duty of the company should be to give the reports and that applies to all companies. The statute does not break down into parts for large companies or small companies. There is no division. It is one statute for all companies as to manufacturing requirements, GMP's, NDA requirements, in fact you know we say ANDA, Mr. Chairman, that is just a word to communicate.

The statute says NDA and that really is what an ANDA is. As I mentioned, if you look at 505(d) (4) and (5) all it is telling the FDA is that every company doesn't have to redo these studies when you know it is safe and effective. They may do bioavailability studies, they may have to do bioequivalence studies, they may have to do stability studies, they may have to do dissolution studies, but they don't have to redo unnecessary tests. That is what the statute says, period, "NDA"—that is what it is.

Mr. WAXMAN. Dr. Novitch testified that when there is an adverse drug reaction report that the NDA holder, if it is a company that does research, they are better able to understand what is going on and to correct the problem than presumably a generic company that is producing for sale the drug without investing in research itself.

Can you respond to that concern of his?

Mr. BASS. Do you want to first?

Mr. LARSEN. I would say this, there is no question that the major pharmaceutical companies that have performed the basic research on a drug are going to have more intimate knowledge of that drug.

However, if we present the drug to the FDA we have an obligation and responsibility to understand the drug under the paper NDA procedure. For example, we are expected to know what the drug is and know what the literature says, we are expected to be able to respond to the regulatory requirements.

I can state for my company as well as I think I can state for the other generic companies that produce these products, that we will

do and provide whatever is required to be performed to meet the regulatory requirement to provide for the safety and well-being of those that are using the drug, this is our role and responsibility. This is an obligation to be in this business.

Mr. BASS. If I may comment on that question, Mr. Chairman, it would seem to me once again that the question is not relevant to the issue. In other words, if that fact was so, assume certain companies can do a better job than others on reporting or evaluating the reports, what is the solution? The solution is to set standards and requirements for reporting, not to say I will give a monopoly across the board to certain companies to give them an economic advantage, No. 1.

No. 2, I question whether the facts support that statement. It seems to me that from the reports we have seen and heard that there has been a real question about the evaluation process by some companies of what they deem to be serious or not serious.

Mr. NIELSON. Mr. Chairman.

Mr. WAXMAN. Yes, Mr. Nielson.

Mr. NIELSON. I was interested in that comment. The question was, can the pharmaceuticals do a better job of research than the generic firms and should they be protected? You seem to be taking off on a different track.

Mr. BASS. I misundertsood the question from the chairman. I thought he was asking about the ability of one company to do a better job on reviewing adverse reactions after the drug is out. If you are asking me about research, I will address that question.

Mr. NIELSON. Mainly misunderstood. I was thinking that was the question. It involved the research and can you do as good a job as they can do?

Mr. BASS. Well, I will address that.

Mr. WAXMAN. Let me reclaim my time. I will have you respond on my time. My question dealt with after the drug had been approved and FDA, having the responsibility for protecting the public from drugs that are not safe and effective, after the drug has been approved by the research company, or the company that discovers the drug, and after the period of time there is a generic manufacturer who wants to come in and produce the drug, the concern that I raised is whether the difference between the companies in their orientation would make a difference as to tracking adverse reactions so that we do know what adverse reactions——

Mr. BASS. My answer to that question is, if you have a problem of checking adverse reactions, put in requirements what you want. If they can't comply, put them out of business. Don't penalize the companies that do a good job, like Zenith here, just because you say somebody doesn't do a good job.

What I am suggesting is meet the problem by giving the solution to that problem, not as a reason or excuse to monopolize across the board against everyone.

Mr. WAXMAN. Go ahead.

Mr. NIELSON. My contention is there is an awful lot of money saved by FDA because there are these research firms who do a lot of work they cannot do themselves. Generic firms do not have that advantage, therefore, I think there is a natural bias of the FDA

toward the research firms, and you alluded to that yourself saying that they are giving monopolies a special consideration.

Do you think it is fair for a research firm, who has a patent on a particular drug, to use up most of the time of the patent in the time it takes to get it approved and, therefore, only have 5 or 7 years left rather than the original 17?

Mr. LARSEN. I think if you review the statistics on it, we have found in reviewing the prescription drugs, the actual market protected life is 18.5 years. I think you have to take a look at the patent system in itself. The patent system provides basically for three kinds of patents.

There is a manner in which one can have evergreen effect on patent life. There is a product patent. I am sure the 7 years they are addressing has to do with the product patent, but does not reflect the process patent or the use patent.

As an example, there is a drug, chloropropamide. When its patent finally expires it will have had 26 years of protected market life. If you compare this to the patent life overseas in other sophisticated countries, most of the top prescribed drugs in this country have been off patent overseas for somewhere between 5 and 8 years. The U.S. companies enjoy the overseas markets. If you look at equity return on development you have to consider all aspects.

Mr. NIELSON. Should there be a set length of time after the drug has received approval for a patent, or whatever that term should be, should there be a guaranteed certain period of time?

Mr. LARSEN. I have my own personal opinion on it which may not be shared by all members of the generic industry, but my personal opinion is one that I have stated before congressional committees some 3 or more years ago. I find now the Washington Post shares that opinion. I am sure they didn't go back and read the record, they came to the same conclusion, and that is that if one is to provide patent extension, it should begin at the date of the filing of the NDA, not date of initial testing.

Initial testing, as provided in the Senate bill is a mysterious kind of thing. It is a date that is nonspecific because at a point of time when something is initially tested, one doesn't know whether it is going to be a drug or anything else like that and there are all forms of manipulation that can take place.

If one takes the date of filing of NDA as a date specific, a time specific, there are two things that occur. One, that the manufacturer, because of the investment that they will have made, as of that point in time, will be more inclined to make sure their filing is full and complete, and should make the job as easy as possible for the FDA.

Further, it puts an onus on the FDA because it is a time specific, and if the filer who has that patent wants prompt approval, then they are going to be on FDA's back and FDA is going to be more accountable. The FDA should be able to act more promptly and be held accountable for unreasonable delays.

Personally, my personal view—it does not necessarily represent the views of the association representative——

Mr. NIELSON. I was wondering if there should be some rule or some definite length of time so you are not hurt by excessive lengths of time that stretch out things, and also that the firm

which produces the drug is also protected for a reasonable length of time. I think there is a middle ground that protects them and doesn't stretch it out to hurt you.

Mr. WAXMAN. If I can respond. The witness can respond further on it. Of course, the gentleman is correct, there should be a period of time in which a drug ought to be protected by a patent. That is the way we give incentive to discoveries. We say that we are going to reward those people who are researchers and innovative, come up with breakthroughs, but after that period of time is up, whatever that period of time is, we ought to allow competition. It seems to me the issue at stake is when that time is up we are allowing competition.

Mr. BASS. I agree, Congressman, that it is only fair there should be a period of monopoly, of protection to create an incentive for innovation. I am in accord with that. What I wanted to note, No. 1, this is not the place for it—the Food and Drug Act. I think Congress has to weigh all factors. You have a balance, there is a public interest in creating incentive to give monopoly and a public interest in competition. There are many public interests to be weighed under the patent laws to decide that question.

I would agree with Mr. Larsen, Congressman. There most certainly should not be any credit for time for studies, because—I would suggest this. Assuming there was no Food and Drug Act, assuming there aren't any laws, would any company come out with a drug without testing it, give it to the public without conducting tests? I think it has nothing to do with the food and drug laws.

Now, second, as to what should be done, a specific time period, I would say there we would have to get the facts. We have a numbers game. Somebody says 18 years they have an effective life, others say 7 or 5. Is there an incentive? I just received in the mail, one company for 6 months, Congressman, showed $1 billion of sales at $125 million of earnings, likely $125 million in incentives for innovation.

I don't know what all the bottom lines look like. I think for that question we need all the facts. Let Hoffman-LaRouch give us their statement. Let's see what is involved. Let's see if they need help, whether they are going bankrupt or whether this is the most profitable industry in America. I don't know. We have to evaluate all the facts in the proper place but not here, not the Food and Drug Act.

Mr. HADDAD. Could I take a crack at your question? I think I listened carefully to the FDA statement about adverse reaction and the word that went through my head was red herring. It is not accurate, and there is a track record. Pre-1962 drugs, 3,000 of them have been tested, and there is a history, and for those 3,000 drugs the generic company reported adverse reactions and we heard what Dr. Seife said. To my knowledge no mishap, no untoward or tragic experience, so there is a procedure in place right now for adverse reaction.

Second, there seems to be a misconception about what generic companies—yes, we are better manufacturers than maybe some of the big companies because we put our efforts into technology. We also put our money into research. Every single generic drug company that I know has a large research staff. It not only researches

the drug that they are copying, or bringing into the market but it researches new drugs, researches adverse reaction.

I think that the idea that we cannot do as well is not founded on fact. The track record within the FDA speaks against it and I think this is an issue raised in such a way as to put a cloud over what you are trying to do.

Mr. NIELSON. I have a couple of questions. Would you oppose or support patent term restoration legislation?

Mr. BASS. I believe, as I mentioned a moment ago, Congressman, at this point from what I have seen, I would oppose it. I have not been shown any facts to justify patent extension nor have I seen a public interest or public need as against a public interest of competition of high drug prices for the——

Mr. NIELSON. The reason I asked the question is because you said it should not be in the FDA.

Mr. BASS. If it is done at all, at this point, if it could be shown by the companies, Congressman, any valid reason, if there is a problem about incentive, they are not doing adequately, not getting adequate return, I think that should be considered. I would like to see the facts. I haven't been shown them as of this date.

Mr. LARSEN. I don't believe that the bill as presented is a bill that serves the interest of the consumer. I don't believe the bill serves the interests of the Government. It doesn't take into account all the matters that should be considered. The bill as presented is a broad generalized statement that needs to be quantified more specifically and the facts need to be presented and aired. The bill as it stands isn't adequate. I feel personally that that period of time that I specifically mentioned is a reasonable period of time, and it is the appropriate and right period of time.

Mr. HADDAD. Our association has a position on that. We said if patent life has been retarded by Government regulations, it should be restored. We have said that. If it is retarded, it should be restored.

The information to prove or disprove that case is in the hands of the PMA. The 1 year that they turned over to the Congress—1980—demonstrated, according to the OTA, in testimony under oath before the House, that patent life was lost not by government regulation but by the companies themselves.

Congressman Gore, who happened to chair that committee, asked PMA to provide the years 1962 to 1982. If patent life has lost in those years it should be restored. We are still waiting for that information to arrive.

Mr. NIELSON. You said you have a lot of R&D in your company?

Mr. HADDAD. Yes sir.

Mr. NIELSON. Do you have any idea what percentage that may be of your total sales?

Mr. HADDAD. Yes, it has been in the three public companies, it has been running to 6 percent. I estimated from reports that I have seen, that for the entire industry it will probably jump to 9 percent, which is an appreciable number compared to the House's. You have to recognize obviously volume when you have a Hoffman-LaRouch Zenith. There is a difference in dollars, but the percentages are mounting.

Mr. NIELSON. Now, any of you can answer this: You have benefit from the NDA, you don't have to go back and do the basic research, you can do simply yourselves as good as or the equivalent to what you are replacing, is that correct?

Mr. HADDAD. Yes, sir.

Mr. NIELSON. You would like to keep the NDA process. You have no quarrel with the 1962 pre-NDA?

Mr. HADDAD. We do, like any businessman about the Government, say they can speed it up. You have to show the drugs are the same and conform to good manufacturing processes. It is not only us, Lilly, Hoffman-LaRouch, the big companies do the same thing. You have a drug comes off patent subject to competition. We compete, and the big companies, we all go through the identical procedures.

Mr. BASS. In answer to your question, yes, we can use the same procedure tomorrow morning as the pre-1962. They split it. The FDA doesn't have to change a dot.

Mr. NIELSON. Would you say then we don't need legislation, they can have the authority right now?

Mr. BASS. That is correct. I admit it, everybody admits it.

Mr. NIELSON. We don't need the legislation or do we need the legislation?

Mr. BASS. We need the legislation to force them to follow the statute which they agree provides for the authority for these post-1962's. They have admitted that in document after document which we will submit and send to you.

Mr. NIELSON. I wish they had stayed to listen to your comments.

Mr. BASS. They have admitted it, Congressman. I can show you the February 1982 statement, by the agency. I can show you the September 13, 1982, the March 14, 1983 by the Commissioner. In fact, I think one of the most important documents before committee—I will provide copies for you, Congressman—and the other is this complete document of February 8, 1982, and in that document, Congressman, there is a very extensive analysis by the Food and Drug Administration, explaining why the statute provides for ANDA's for postpost-1962.

Right now, in the statute they take every argument that has been discussed. If you look at the appendix beginning on page 31, you will have the answer to all those questions that they admit the statutory powers. It is in this document and they have not done it all these years.

Mr. NIELSON. Would you supply that document to the committee?

Mr. BASS. Yes, sir, Congressman, we will make copies for your entire committee.

Mr. LARSEN. I think the real facts are nothing has happened since the midseventies. It has been in the pipelines since the seventies, and when and if it came out of the pipeline, there is the unknown period of how long is it going to be deliberated, how many hearings and so forth. The issue is, that it is something that should happen, it hasn't happened, Congress can make it happen.

Mr. NIELSON. How come you have been so patient to wait 20 years?

Mr. BASS. We haven't been that patient and the real issue has come of late as more post-1962 drugs have come off patent. Prior to

that, there wasn't the incentive, if you will, there wasn't the drive. Now that more and more drugs are coming off patent, such as this year, the market value of drugs coming off patent——

Mr. NIELSON. That was perhaps not a very fair question.

Mr. LARSEN. It is very relevant. Just listen to some of the facts as to what happened. The level of drugs coming off patent, what are they? In 1983, $245 million. In 1984, $1 billion. And then in 1985, I believe it was around $700,000. So we are talking a totally different magnitude.

What happens to some of the drugs that have been off patent for 3 years? Take one of the drugs that was mentioned—dyazide. It has been off patent for 3 years. It is still down in the FDA. It is still being considered, there is still discussion on it. Hopefully, that under the procedure that is before the committee that action on an item like that could take place much more expeditiously. It is important to look at $1 million, $161,000 for one drug.

Mr. NIELSON. I am new to Congress. I wonder why this wasn't brought up in 1964-65?

Mr. BASS. We weren't patient. We have been talking continuously for years. In fact, I can remember one meeting when in fact Dr. Novitch; the Commissioner at that time—about 12 of the FDA people were at one meeting with us and they said within a couple of months—in fact it was a holiday which occurred last month, religious holiday which was coming up. They said by that holiday you are going to have it. There have been four of those holidays since this meeting, so we have been going through this, Congressman, year after year. We have not been patient but we have waited and finally were forced to take other action.

Mr. NIELSON. I would like to thank you and return it to you, Mr. Chairman.

Mr. WAXMAN. As I understand it, prayer, penitence and fasting will bring about this?

Mr. BASS. That would make a good film.

Mr. WAXMAN. Let me question you about something. Let's say FDA wanted to do what Mr. Nielson suggested. FDA said they can go ahead and adopt a policy for treating post-1962 drugs. Couldn't that be subject to litigation?

Mr. BASS. Of course, but all they have to do right now under the law is to do what they did with the pre-1962. All they have to do is publish a notice saying our policy is—our pre-1962 NDA policy applies to post-1962 NDA. That is all the law requires.

Mr. WAXMAN. If they did that, would you expect there would be litigation?

Mr. BASS. Yes. In the meantime we would be going ahead with ANDA's. They are going to proceed to put obstacles in our path forever. There is a big difference between our being in the business, getting into the marketplace, while they bring cases, and as against our being held back all these years, and continuing now and not being able to be in business, not getting drugs into the marketplace.

Mr. HADDAD. Two points. One, in the paper NDA suggested policy went through the court for many, many years, and finally was passed and then was blocked administratively. As you know, paper NDA is not working, so we have a track record right there.

Second, there is no indication that FDA is going to do this. We have been talking about this, beating around this bush—I am sorry the Congressman left—we have been talking but nobody has been listening. We followed administrative procedure, we have been down to the FDA, we have talked to them, they have agreed with us. They say it is off patent, it is equitable, but nothing happens. The only way this is going to be solved is by your legislation. If we are going to have those savings immediately it is going to be by legislation.

Mr. WAXMAN. FDA has proposed the drugmakers be permitted to include the number assigned to an NDA or ANDA in their labeling or advertising to indicate that the drug has been approved. Is that an acceptable alternative to H.R. 1554?

Mr. HADDAD. Again, this is an ingenious way of preventing the information. I really rankle at that, because I have been to the FDA for years. Last year, they told me that twice, they had recommended a policy and twice it had been turned down by OMB. They present the question in a different way than it really exists. Let me give you a little bit of background.

The major impediment of the sale of generic drugs is the doctor who signs the prescription. He is the one that is reached with a multibillion advertising campaign. For example in New York, you have the so-called Haddad law, which makes it easy for a doctor to prescribe a generic drug. He writes out the trade names, signs it on the right, and is paid a buck from the approved list.

First, 1980 statement first set up by New York, the doctor signs the left, you pay $8. Two out of every three doctors in New York sign on the left. They do it from habit and advertising. How would you stop that? What did you say to the FDA, what did they agree to? If I could put it on the air, add some word which meets their requirements and didn't stimulate undue impressions—"approved by the FDA," whatever their phrase is, that one enhances generic prescriptions immediately.

If you do it with the pharmacist—he doesn't write the prescription, it is the doctor. We need 301(l) removed so that we can advertise not to the consumer, but to the doctor, what he apparently does not now know.

Mr. WAXMAN. Are there any policy reasons that you see why a drugmaker should not be able to label its product "FDA approved?"

Mr. HADDAD. No, they may want to play with the language. We told the FDA, look, find the language that is legally suitable to you, that doesn't create a lot of false impressions, we will live with it. If it is a clause, if it is a sentence, that doesn't bother us. I would like to see—if they wanted two sentences, that is fine, so we don't have any problem with that and they did not have a problem when we visited them and when they were preparing testimony before you 4 months ago, there was no problem. Senator Hatch and yourself laid it out and it was a situation that was agreeable to them. Something happened between your hearing and their appearance.

Mr. BASS. I would say that the problem really is we have to undo the fear that has been engendered. In other words, it is a competitive question again. This has been part of the problem, that they

have created fear that the product is not the same or is not acceptable by prohibiting this advertising or this statement, and I think we should have the right to state the facts completely, to obviate that kind of a problem, and I believe you are correct in your earlier question that there is a constitutional problem under commercial free speech.

I don't think we can have an absolute bar or absolute ban under the case decision by the Supreme Court in *Virginia State Pharmacy*. I think we can make regulations or limitations of how it is done, where it is placed and what it says, which is reasonable, but we cannot have a complete ban, I would say, constitutionally.

Mr. WAXMAN. Well, that completes the questions that I have had. I want to thank you very much for being with us today and we will look forward to working with you on this legislation.

Mr. BASS. Thank you, Mr. Chairman.

Mr. WAXMAN. Our third panel of witnesses includes representatives of senior citizens, Fred Wegner, pharmaceutical specialist, National Association of Retired Persons; Sam Brightman, assistant executive director, National Council of Senior Citizens; and Bill Schultz is an attorney with the Public Citizen Litigation Group. We have your prepared statements and we will make them part of the record in full. Without objection, we will make the previous panel's full statements part of the record as well.

STATEMENTS OF WILLIAM B. SCHULTZ, PUBLIC CITIZEN LITIGATION GROUP; FRED WEGNER, PHARMACEUTICAL SPECIALIST, AMERICAN ASSOCIATION OF RETIRED PERSONS; AND SAMUEL BRIGHTMAN, ASSISTANT TO EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. SCHULTZ. Thank you, Congressman Waxman.

I will try not to repeat the arguments that have been made previously, but I wish to raise a few points.

We strongly support H.R. 3605, the Drug Price Competition Act. The bill would correct what we think is an anomaly at FDA, which under its current regulations divides drugs into two somewhat artifically categories. If a company wants to copy a drug that happens to have been marketed first before 1962, it is very easy to gain approval, but if the drug was first marketed after 1962, it is more difficult. The company can either rely on scientific studies or submit full clinical trials.

In our view, the current system makes absolutely no sense and it also raises serious ethical problems. The problem comes from the requirement that a generic company duplicate testing that has already been done. In other words, if a generic company wants to sell a drug that was first marketed after 1962, and there aren't sufficient scientific studies, the only way it can market that drug is to redo the clinical study showing safety and efficiency. This is unnecessary use of scientific resources, it also subjects humans to testing that is absolutely unnecessary.

We are requiring the generic companies to undergo testing and to pay for it even though we already know what the answer is going to be.

In addition to this ethical concern, there are four other policies that your bill would promote, and all of these are policies that the Reagan administration claims to endorse. I would like to mention each of these briefly.

First of all, it means less Government regulation. Instead of requiring full clinical tests, in a lengthy new drug application, your bill would limit the requirement to what is absolutely essential. Essentially you would require the generic company to show it can make a good copy of the drug that has already been shown to be safe and effective.

Second, your bill would allow the free market to operate without artificial barriers that the current policy creates. This means more competition. This is the kind of economic system that we are supposed to have, and that the Reagan administration claims to favor.

Third, the bill is good for small business. The generic drug industry is going to grow, because some other barriers have been removed, and it is certainly appropriate for the Federal Government to eliminate the barriers that it has created to the generic drug industry.

And finally, your bill would save the Federal Government money. The Federal Government is a large purchaser of drugs, at VA hospitals and also through medicaid. In fact, the purchases through medicaid approached $1 billion in recent years, and so to the extent that you make lower price generic drugs available to consumers, that is going to save the Federal Government money, because it also is a large consumer of generic drugs.

The question has been asked many times, does the FDA have the authority to extend the abbreviated new drug application procedures to post-1962 drugs? We think FDA has authority to adopt this policy, but we don't think we can count on the Government to do it. The FDA has been considering this issue for years. I don't believe it has been delayed simply because of the agency's inability to get the regulation out, but there is a lot of pressure on the current administration not to issue that regulation. The administration has been very hostile to generic drugs, and as has been pointed out, even if the FDA issued the regulation, it could be delayed for many years by court battles.

The PMA is not here testifying today, but it is on record as taking a position on this issue and I would like to close by reminding the committee of what PMA's position is. The PMA is the trade association for the pharmaceutical industry for the so-called research firms. On April 1, 1981, over 2 years ago, this committee held hearings on the patent extension, and at that time, Dr. Louis Sarett, who is a vice President of Merck, one of the big research firms, testified, and in closing his testimony he stated that he would like to make a comment about this ANDA issue.

He stated that he supported ANDA policy, and the reason he gave was, "I would like to say that as a scientist, I feel that duplication of all that elaborate clinical study in terms of efficiency and safety is not necessary, that it is not even desirable."

Subsequently, the president of the Pharmaceutical Manufacturers Association testified, and during his testimony, Congressman Waxman, you asked the following question:

Mr. Engman, just briefly, very briefly, I want to ask you a question. Dr. Sarett indicated to us that he did not think that after a drug patent had expired, that it was reasonable to ask FDA to have a generic equivalent conduct human clinical trials to prove it is effective. Do you agree with that?

His answer was as follows:

We have two separate issues here, Mr. Chairman. The issue in the legislation that is a subject of this hearing, that is patent term extension, is the economic incentives necessary for innovation. The issue out of FDA and the function of FDA, is to require what scientifically is necessary to ensure safety and efficiency, what is necessary in that sense should be sufficient. In other words, in the opinion of the pharmaceutical industry, FDA has no business, no authority to consider this question of incentives to innovation.

He went on to state,

I would agree with Dr. Sarett's statement, in the sense that we should not need a repetition of all of the studies.

Then he goes on to say,

I would also defer to his scientific judgment that bioequivalence and bioavailability testing should be required.

In light of the fact that we have an issue here on which the generic industry, the Pharmaceutical Manufacturers Association, and consumer groups all agree, we would hope that this bill will be promptly passed by the Congress.

Thank you.

Mr. WAXMAN. Mr. Brightman.

STATEMENT OF SAMUEL BRIGHTMAN

Mr. BRIGHTMAN. I am Samuel Brightman, a member of the Washington staff of the National Council of Senior Citizens, which represents some 4 million members of the affiliated membership groups. The National Council of Senior Citizens supports the Drug Price Competition Act and urges its passage. Our health care experts were occupied last week with our national legislative conference and convention so they have not completed a formal statement of our reasons for this support. I would like to thank the chairman for appearing at our rally last week in LaFayette Park and tell him that all of our members survived the heat there and are still alive and well.

I ask the committee to let me make some brief remarks and supplement them with a written statement to be included in the committee report. As you see, I myself am a senior citizen. I am one of a million elderly who will benefit if this legislation is enacted. And after listening to some of the timeframe talk here, I have written in "in time to help us."

Many of us in my age group have ailments that cannot be cured but can be managed with proper medication. I have perhaps more than my share of such disabilities. I am a consumer. I take medication for emphysema, for chronic bronchitis, for a heart condition and for high blood pressure. The monthly bills for my regular medication have been averaging out over $100. They are going up.

One medication that I recently have begun to take is dyazide. I am informed that this is probably the most widely used diuretic prescribed for persons with high blood pressure and its patent expired in 1980. It is not available as an inexpensive generic drug, and I presume because of condition the bill under discussion seeks

to correct by permitting companies to manufacture and sell the lower cost generic without the human tests that are required for new drugs. At the present time I understand the FDA permits only drugs marketed prior to 1962 to be approved by the abbreviated new drug application route.

The forcing of manufacturers of generic drugs to conduct time consuming and expensive tests, to prove the safety of medicines, whose safety has already been proved many times over, discourages the manufacturing of pioneer drugs by generic manufacturers, and makes the cost of generics higher than necessary.

In addition, there is an ethical problem with the additional human tests that disturbs me greatly. What moral justification is there to supply to human beings who require dyazide, for example, to alleviate high blood pressure, to give them a useless placebo when they believe they are taking medication to treat a serious ailment?

There is another matter that came up earlier today and that is I seem to hear innovation and generic as an either/or thing, that from now until time unimaginable I should keep on paying a high price on drugs to encourage innovation. I am sure there is some other way to encourage innovation. And when I pass the beautiful Johnson and Johnson buildings up in New Jersey, I think innovation is rewarded fairly well.

To continue, as a consumer, I am fortunate because I am employed and until this year when I had two expensive hospital stays, what the doctors eloquently described as cardiac events, I paid far more in taxes than the few hundred dollars I sometimes obtained from medicare. I drew no social security benefits until this year. I am better off than the median citizen, but the cost of medication is a serious problem for me.

Most of the aged find our incomes decreasing as we grow older and our lifestyles change accordingly. This happens for all except the very well to do. Whether you are in the middle class or lower middle class or above the poverty line, most of us have serious changes, notable changes in lifestyle as we get older, so I want to emphasize that the cost of medication is becoming heavier all the time, is a very serious problem to all but the very wealthy among the aged.

Sometimes when I take my dyazide, I think about how much less it could cost me as a generic, and my blood pressure goes up, making the medicine counterproductive. Passage of this legislation will increase the therapeutic effect of my medication.

It is hard to pick up a newspaper or magazine these days without reading about a great national crisis senior citzens like myself are creating by staying alive. It is not pleasant reading. It is not pleasant to hear the aged described as a special interest. The high costs of Federal programs for the elderly are not the fault of the aged. We did not create the health care industry that changed the healing of the sick from an art to a business, we did not create the conditions which caused medicines to sell for hundreds of times more than the cost of production, plus a reasonable profit.

That is why the elderly have a special interest in this bill. Its enactment would relieve our burden. It would also reduce the rising medical bills of Uncle Sam, it would be a step in the right

direction for all Americans, and it would be a special benefit for the elderly who have ailments that will be managed by drugs for the rest of our lives. For many of us, people of my generation, it would help reduce the high cost of living.

Mr. WAXMAN. Thank you.

Mr. Wegner.

STATEMENT OF FRED WEGNER

Mr. WEGNER. Thank you, Mr. Chairman.

I am not on dyazide but I think I will be a candidate for it after working in the pharmaceutical field. The 14 million member Association of Retired Persons strongly supports this bill, H.R. 3605. We think that this little bill has the potential for being the biggest consumer interest piece of legislation in this decade because it will certainly save American consumers hundreds of millions of dollars.

The FDA Chief Counsel admitted to the Chairman that patent law has no part in drug law and the FDA was not operating from that standpoint. But indeed, the agency has because it has, I think, unlawfully been extending the marketing monopolies of brand name manufacturers beyond the time limit of their patent periods, and I will later cite a couple of instances.

This enables these brand name manufacturers to remain the sole sources of their drugs and to raise the prices of their drugs with impunity. Besides the costs to consumers, to hospitals, to the Federal Government, State governments, third party payors, I think there is an element that hasn't been touched on enough today and that is, as drug prices go up, some people are denied access at those prices to those drugs. That is particularly true of older Americans who are not protected from consumer drug pricing increases, nor do they have drug benefit programs under medicare as do elderly in every other advanced country in the world.

The two examples I had in my testimony were Dyazide and Indocin. Let me talk about one of them. Indocin or Indomethacin, the generic name, is a sterile nonsteroidal, anti-inflammatory drug used in treatment of arthritis. It is the 10th highest selling drug in the country by dollar volume. Its patent expired in 1981, as did Dyazide's. A patient for whom Indocin has been prescribed, spent at least $426 in 1981 for a year-long maximum dose therapy. In 1982, the patient expenditure for just this one drug rose to $540 and so far in 1983, the drug is costing the patient $588 at the annual projected rate. That is an increase of $162, 38 percent over the price of Indocin in 1981 when that drug was supposed to have gone off patent, when it did go off patent, but no generic as yet.

This example illustrates that FDA's lack of generic approval is costing some patients hundreds of dollars more per year, for only one drug, in this case, Indocin. If a generic were available, and priced at a 50-percent reduction in price over the brand name, which is not unusual, and it is far lower than some of the figures cited by Ken Larsen today, an Indocin patient could save $294 a year.

I would like to say that in listening to the FDA testimony today, I am a lot more frightened than I was when I came to this hearing. I think millions of Americans believe that the FDA is a consumer

protection agency. All I have heard this morning up until this panel, was industry protection, patent protection, profit protection. I cannot believe the FDA is taking a new tack that I do not believe is in their legal mandate. I think it is incumbent upon this committee and this Congress to enact legislation, in this case on the post-1962 ANDA, to tell FDA what it is supposed to be doing.

It might be necessary to enact further legislation, to tell the FDA what else it is supposed to be doing, remind it what it is supposed to be doing in the area of consumer protection. I cannot believe these pre-eligibility periods that FDA is talking about requiring before it will approve generic drugs. What possible good does prohibiting generics do in the way of protection of the public health which is their first point? How is allowing another version of a chemical entity into the marketplace diminishing the continued post-marketing surveillance of that chemical entity? That is beyond me.

As has been pointed out, it is ridiculous as well as unethical to require clinical studies for a generic drug when much more experience has already been gained from the brand name drug out in the marketplace and with a generic version introduced there would be all that much more experience with adverse drug reactions.

Thank you.

[The statement of Mr. Wegner follows:]

FRED WEGNER

PHARMACEUTICAL SPECIALIST

OF THE

AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman, my name is Fred Wegner and I am a pharmaceutical specialist -- and have been for nearly 13 years -- with the 14 million member American Association of Retired Persons.

It is good to be with you again, and I appreciate the opportunity to testify on the Drug Price Competition Act of 1983.

This brief bill may well turn out to be the most significant consumer-interest legislation of the 1980s. Its enactment can mean the savings of literally hundreds of millions of dollars over the next few years by consumers, by the federal and state governments, and by private third-party payors.

It will correct one of the grossest injustices ever perpetrated by the Food and Drug Administration. For by its failure to approve expeditiously less expensive generic versions of off-patent post-1962 drugs, the FDA is guilty of:

1) unlawfully extending the marketing monopolies of brand name drug manufacturers far beyond the time limits of their periods of patent protection;

2) causing American consumers, hospitals and nursing homes, and public and private drug reimbursement or benefit programs, to pay millions of dollars in overcharges for expensive single-source drugs; and

3) harming public health by contributing to denying access to needed medications by near poor, low income patients.

Those most hurt by the FDA's unconscionable delay in approving post-'62 generic drugs are the elderly and, in particular, those who are chronically ill and uncovered by medicaid or private drug insurance.

The United States is unique among the advanced countries of the world in its neglect of its older citizens' prescription drug needs. Although more affluent than most, our country provides no outpatient drug coverage in its health program for the elderly. The other countries do. The U.S. has no system for controlling the costs of pharmaceuticals. The other countries do.

Americans over age 65 are 11% of total population, yet account for at least 24% of all prescription drugs. Collectively, their drug costs in 1981 amounted to $5.1 billion of total national expenditures of $21.4 billion for drugs and drug sundries. Prescription drugs make up 70% of that category; non prescriptions are 30%.

Some 82% of the elderly's drug costs are paid out-of-pocket. This constitutes their fourth largest self-paid health expenditure.

On average, an older American will buy 18 prescription drugs in a year's time or two-and-one-half times as many as a person under age 65.

As a means to reducing these often burdensome costs, the AARP, during the seventies led efforts which successfully enacted generic drug substiution laws in all of the states except Indiana. At the same time, the federal government implemented its Maximum Allowable Cost, or MAC, program. In both instances, the objective was to realize savings from increased use of less expensive, equivalent generic products.

These efforts were aided and abetted by a predecessor FDA which took seriously its Congressional mandate to serve and to protect consumers. At the present time, we have an FDA which is

effectively denying consumers access to less expensive generic versions of off-patent drugs. And we have an FDA which is considering permitting the drug industry -- which means the major brand name manufacturers -- to advertise their products directly to consumers. Among other dire consequences of such a promotion, if it is allowed, will be higher prices and an anti-generic bias.

Further assaults on generic drugs in this Administration include the termination of the Guide to Prescription Drug Prices, a growing effort to destroy the MAC program, and an industry grab for an extension of patent term protection.

In 1982, prescription prices shot up 12%, a rate three times greater than the increase in the Consumer Price Index for all items. So far in 1983, prescription prices have continued to move steeply higher -- at an annual rate of 11.8%, and once again three times more than the CPI for all items.

Yet, during 1982, Social Security recipients' cost of living increase was only 7.4%, causing them to fall further behind in their struggle to keep up with double-digit increases in prescription prices. In 1983, as you are aware, the elderly will be penalized by a six-month postponement of their cost of living increase in Social Security and, thereby, drop back even further in their attempt to keep up with drug prices that continue their double-digit ascent.

To understand better what the foregoing data mean in human terms, let me cite the examples of two prescription drugs which are among the top 10 largest sellers in the U.S. and among elderly patients.

Dyazide, or Triamterene Hydrochlorothiazide, which is a diuretic/antihypertensive drug, is the number three highest selling drug by dollar volume. Its patent expired in 1981.

Indocin, or indomethacin, which is a non-steroidal anti-inflammatory drug used in the treatment of arthritis, is the 10th highest selling drug by dollar volume. Its patent expired in 1981 as well.

A patient for whom Dyazide has been prescribed spent at least $145.27 in 1981 for year-long, maximum-dose therapy. In 1982, the patient's expenditure for just this one drug rose to $157.68, and so far in 1983 the drug is costing a patient $171.55 at an annually projected rate, an increase of $26.28 or 18%, over 1981.

A patient for whom Indocin has been prescribed spent at least $426.32 in 1981 for year-long, maximum-dose therapy. In 1982, the patient's expenditure for just this one drug rose to $540.20, and so far in 1983 the drug is costing a patient $588.38 at an annually projected rate, an increase if $162.06 or 38%, over 1981.

The first conclusion from this example is that FDA's lack of generic approvals is costing some patients hundreds of dollars more per year for only one drug than they need have spent. Not only do they not have an opportunity to select a less expensive generic product, but they are being forced to pay more and more for the brand name product. Despite the brand name drug being off-patent, FDA's negligence continues to protect the medication's exclusive status by preventing competition.

If a generic were available and priced at a 50% reduction in price -- which is not unusual -- a Dyazide patient could be saving $85.77 per year and an Indocin patient could save $294.19 annually,

just think what this would mean to a low-income person with barely enough to feed and clothe his or her family.

That the FDA, a consumer-protection agency, should be involved with restraint of trade is a tragic situation which demands immediate correction by legislative action.

The second conclusion to be drawn from our example is even more distressful. More than one study has shown high rates among patients of non-compliance with drug therapy. Our own AARP national survey taken within the past year found that nearly 21% of respondents had at least once refused to have a prescription filled. Of those who had not obtained the drug, 6.3% cited cost as the reason. And of that number, 40% were over age 65.

It is therefore reasonable to assume that the price increases in off-patent, post-'62 drugs, aided by FDA's restraint on generic competition, are depriving more and more Americans of access to the drug therapy prescribed for them. It is incredible that a federal agency should thus be contributing to a lowering of public health.

The combined effect of state generic substitution laws and MAC has been to save consumers and government many millions of dollars. Although neither of these initiatives has yet realized its full potential, they have helped those who most needed help.

Sixty percent of the respondents to AARP's national survey proved knowledgeable about generic drugs by correctly answering five true and false questions. Of these, an impressive 41.5% gave an affirmative response to the question of whether they tried to buy generic drugs whenever they could. And 23.5% claimed to have asked their doctors to write their prescriptions generically.

These responses indicate a good knowledge about generic drugs among a large majority of consumers and a significant number of patients -- although a minority -- who do try to buy generic drugs. For them, the FDA's restraint on generics has been counterproductive to their best interests.

The greatest challenge facing this Administration is the financial crisis in health care. It is being called upon to devise new strategies for assuring coverage and accessibility to health care for many millions of our citizens and for containing the costs of health care. Yet the FDA's non-policy for approving post-'62 generic drugs is restraining competition, abetting prescription price increases, and denying more and more patients access to the medication they need.

The Drug Price Competition Act of 1983 will go a long way toward correcting these problems to the extent that they are attributable to the FDA's inaction on generics. This legislation establishes adequate safeguards for consumer protection by requiring that generic versions of a drug product meet "appropriate standards of identity, strength, quality, purity, stability, bioavailability and bioequivalence." These tests in addition to FDA requirements that a company must be in compliance with Good Manufacturing Practices and be regularly inspected are sufficient means to assure the quality and equivalency of generics.

Requiring further clinical studies to ascertain the safety and effectiveness of a chemical entity which has already been in the marketplace for as long as 17 years would be an unwarranted expenditure of time and money. Depriving ill persons in a control group of a drug that is known to alleviate their condition would be unethical and needlessly harmful. The chemical entity already has a history of use and adverse reaction reports from a universe of patients far surpassing those which would participate in any further clinical studies.

AARP fully supports the Drug Price Competition Act of 1983 and urges its expeditious enactment in order to enhance both the health and economic interests of American consumers.

Thank you.

Mr. WAXMAN. Thank you.

Mr. Wegner, you talked about Indocin, which is one drug, and Mr. Brightman was talking about Dyazide, which is another drug. Both of these drugs are off patent. There are 125 drugs that are now off patent. Even if we passed a patent extension law, because we want to give incentives for the future development and research to produce new innovative drugs, these 125 drugs have already gone through their patent period, they were protected for a period of time, and that period of time has ended.

The issue, then is how do we get competition for those 125 drugs so that those people who are buying drugs, particularly the elderly, can have the opportunity to pay a lower price?

The FDA has been hinting around and suggesting that there may be a 15-year waiting period that they will impose themselves before they get around to approving these generic equivalents. Well, if we add on 15 years because FDA wants to take 15 more years on top of the patent period, that would mean 47 of these drugs out of 125 could be made available, but only 47, and it strikes me that we are, for no public purpose, asking the people who buy drugs to pay that higher monopoly price. Now, if FDA tried to move with something, or FDA at one time talked about moving in 1978, that is 5 years now, if we wait another couple of years, all these years mean that there is not going to be competition.

It seems to me it would be in the interest of the pharmaceutical manufacturer to try to draw this thing out as long as possible. Every year they can block legislation or keep from finally implementing a policy, they stand to gain enormous amounts of money. Is that the way you see it when you talk about your being discouraged about actions not being taken to give the public the opportunity to buy lower priced drugs.

Mr. WEGNER. It certainly is, and I guess I was even shocked to hear the Deputy Commissioner say that the FDA proposal isn't at the department yet. It would be there in a few weeks, then it will be more weeks for OMB to give its approval, and then who knows how much longer.

Mr. WAXMAN. Well, quite likely there would be litigation. After all, just to tie it up in the courts for a while could benefit some party or other finally.

Mr. SCHULTZ. It may not be clear that the only matter at OMB is a proposal. If the FDA issues that proposed regulation, there would be some unlimited period of time before it would be finalized, before it could ever go to court.

Mr. WAXMAN. FDA came out with a 15-year waiting period for these drugs, and that was their recommendation, that we have a period of time in which we have to wait for them to publish the recommendation, for OMB to approve it, then they will issue a notice.

Mr. SCHULTZ. There would then be a period of time for comment, an unknown period of time before they actually issued the regulation, because this is only a proposed regulation that FDA is sending to the Secretary.

Mr. WAXMAN. After they issue the regulation, whatever period of time that could take, that could be tied up in the courts?

Mr. SCHULTZ. Yes, sir.

Mr. WAXMAN. It seems to me that is a major reason in my mind why Congress ought to clarify the public policy and that public policy consideration is that we want patent protection to encourage innovation, when that patent period is up we want competition.

Indocin is an incredible example. A patient for whom indocin has been prescribed, spent $426 in 1981 for the year's dosage, and in 1982, they go up to $540.20. By 1983, $588.38. That is a lot of money for an elderly person and it was increasing over a short period of time $162 or 38 percent over 1981. And if generic were available, it could be priced at 50 percent less. So we are talking about an enormous amount of money that the consumers are being forced to pay after the patent period protection is over.

Let me ask another question. After this patent period and there is a generic equivalent competing, what is the market share of that brand name as opposed to the generic equivalent? Do you have any estimates of that?

Mr. WEGNER. We have a few examples we have used before. It takes quite a while for a generic to make inroads on the pioneer drug. That is why I personally cannot get all that exercised about patent protection. Not that I am against it or anything, the simple fact of the matter is that the innovator drug, the first drug on the market, is the one which commands the market almost in perpetuity, even when that drug goes off patent.

I recall the case of Librium, for example. For a number of years—4 or 5 years or so—after Librium went off patent the generic accounted for less than 10 percent of the total sales.

Mr. WAXMAN. The explanation I have heard for this remarkable statistic, because after all, one would think in a free market system where there is competition there is a product that is lower price there would be a move toward that produce with a lower price. But the explanation is that there have been years of heavy advertising by the pioneer manufacturer, and the conditioning of the physicians to prescribe that brand name drug and not a generic equivalent.

Some people have argued—although we haven't heard it today—generic equivalents are not as effective as brand name drugs. You people at the American Association of Retired Persons, or Mr. Brightman, National Council of Senior Citizens, have you experienced that these generic drugs are not equivalent and not as effective?

Mr. BRIGHTMAN. I am satisfied with the evidence I have heard that generic drugs do do the job. In some cases, I have taken generic drugs and I have not found any difference in the effect of the medication.

Mr. WEGNER. I think what happened as a result of generic drug substitution in the States, the maximum allowable cost program, et cetera, is that generic drugs are even of better quality than, say, a decade ago, and the industry is an advanced, sophisticated industry, putting out quality products. I know of no circumstances where generic drugs have been of inferior quality or created a problem.

Mr. WAXMAN. We have a Food and Drug Administration that is supposed to guarantee to the public that any drug is safe and effective. Of course, that is their job. We hear they may want to talk

about innovative policies and incentives, all that, but their job under the law is to make sure a drug is safe and effective.

Mr. SCHULTZ. Under your bill the FDA would continue to insure that the generic company can make a good copy of the brand name product. The generic company would have to submit tests to show that its product is equivalent to the brand name product. So that protection is retained.

Mr. NIELSON. I would like to ask a question. In hospitals, is it not true that they dispense mostly brand name drugs rather than generic drugs? Is it not true they often don't regard the cost in dispensing drugs in the hospitals, knowing most of the insurance companies will pick up whatever cost there is?

Mr. WEGNER. That is not true.

Mr. NIELSON. It is alleged, at least that the hospitals do not attempt to contain costs, they just give you whatever drug?

Mr. WEGNER. That is a different issue. Hospitals do use generic drugs.

Mr. NIELSON. Hospitals also use drugs without regard to cost in many cases?

Mr. WEGNER. Usually a hospital will have a pharmaceutical and therapeutics committee, comprised of physicians and pharmacists, and they will agree on a formula of drugs that will be used in that hospital. I believe that in some 85 percent of hospitals, or more, the chief pharmacist is permitted to purchase those drug entities at the lowest prices he can get them, and the doctors have agreed that their patients will receive whatever drug happens to be cheapest that month.

Mr. NIELSON. That is very reassuring, because I have heard the opposite.

Mr. WEGNER. That has nothing to do with what the hospital charges the patient for the drug. They are making fantastic markups.

Mr. NIELSON. They buy the generic drug and charge you for the other one?

Mr. WEGNER. Much more than that. That is where they make much of their profit.

Mr. NIELSON. I want to say I am impressed with the testimony we have. I didn't realize we had a vaudeville star, Mr. Brightman. I wish I had been able to hear all your testimony. I like your attitude on life and I appreciate that, and I would like to go on record as supporting the thrust of this legislation, even though I asked some hard questions of Mr. Bass and some others only to bring out what I think is necessary to bring out. We need to have both the protection of the original drug manufacturer, plus a reasonable length of time, but then we have to have it opened up for others and try to get the price down, which I think is the thrust of this legislation.

I simply thank you for coming.

Mr. BRIGHTMAN. Mr. Nielson, thank you for liking my attempt to be humorous, but I would like to urge all of you to think about this thing as people. These are flesh-and-blood people and a lot of them are my age and don't have a lot of time left to support the pharmaceutical industry in the style to which it has become accustomed.

We are doing our best, but please think about this in people, not the pharmaceutical companies' reports at the end of the year.

That is the thing that shocked me the most out of what I think was really a typical bureaucratic reaction of FDA; that is, we don't want to do anything different than the way we have been doing it since the Civil War. But they seem to feel they have no responsibility to the customer, to the consumer, that they work for the pharmaceuticals, the big pharmaceutical research houses, and I hope Congress can jolt them out of that notion.

Thank you.

Mr. SCHULTZ. I would like to respond to your question, if I may, about why this issue has come up only in recent years and why it didn't arise shortly after 1962. What happened is that the drugs approved in 1962 have a 17-year patent and so that the patents did not begin to expire until the late 1970's. So no one really cared what the policy was for post-1962 drugs until about 1977 or 1979, and that was the time when the FDA began considering whether to issue this policy. Since then, everyone has expected the agency to make a prompt decision.

I think that is why Congress didn't look at it until now and that is why there haven't been vigorous complaints, but it is now getting to be a very serious delay.

Mr. WEGNER. I would like to add one other thing, if I may.

I disagree with the FDA thinking on its role in innovation and patent term extension, for this reason: Why should a few million Americans be forced to pay for the drug industry's innovation and research through higher and higher drug prices? I don't think that is good social policy. I don't think it is equitable. Why load on the back of the chronically ill, the sick and elderly, the costs of the drug industry's innovation? Why not spread that cost?

If we are going to subsidize the drug industry—we have already given them a 25-year tax credit on their development costs. You gave them 73 percent, wasn't it, on orphan drugs of their research and development costs, but at least that is an equitable tax expenditure, because all of our society then is contributing to drug innovation. But let's stop giving them longer patent protection, more monopoly, and higher and higher prices. This is denying access to drugs by many marginal low-income people who can't afford those drugs any more.

Mr. WAXMAN. Let me, as well, thank you for your participation in this hearing. I think the testimony has been excellent and we look forward to working with you. Thank you.

Our last panel consists of witnesses on H.R. 1554, FDA Approval Labeling Act. The panel includes Dr. William S. Apple, president of American Pharmaceutical Association; John Rector, director of government affairs, National Association of Retail Druggists; Ty Kelley, vice president of government affairs, National Association of Chain Drug Stores; and Bill Schultz and John Cary Sims, who are attorneys with the Public Citizen Litigation Group.

Welcome to our hearings. We have your prepared statements. They will be made part of the record. Please summarize.

STATEMENTS OF DR. WILLIAM S. APPLE, PRESIDENT, AMERICAN PHARMACEUTICAL ASSOCIATION; BILL SCHULTZ AND JOHN CARY SIMS, COUNSEL, PUBLIC CITIZEN LITIGATION GROUP; JOHN M. RECTOR, DIRECTOR, GOVERNMENT AFFAIRS, NATIONAL ASSOCIATION OF RETAIL DRUGGISTS; AND TY KELLEY, VICE PRESIDENT, GOVERNMENT AFFAIRS, NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Dr. APPLE. Thank you, Mr. Chairman.

As we have indicated in our statement, it became evident after drug product election laws were enacted by the States, that the pharmacist, who is the major medical individual charged with the responsibility of acting as the patient's procurement agent, would need to know whether the drug product has been approved for marketing by the FDA, or the pharmacist would need to know if a particular product was exempted from that requirement. As a result of our discussions with FDA during the late seventies, eventually a hotline for distributing this information was developed.

Mr. Chairman, after reviewing your bill and reviewing the policy of our association, and finding them totally consistent with each other, we are very pleased to have this opportunity to inform you of our support for your legislation.

We feel that the striking of the few words in section 301(l) will make it possible for everyone to learn what action has been taken. Given the opportunity, we believe manufacturers will convey this information without any Federal regulations or laws. We, therefore, wish to assure you of our continuing support for this particular bill, or a similar bill, that accomplishes the same mission, Mr. Chairman.

[Dr. Apple's prepared statement follows:]

Statement of the American Pharmaceutical Association

The National Professional Society of Pharmacists

TESTIMONY OF DR. WILLIAM S. APPLE

ON

H.R. 1554 "FDA APPROVAL LABELING ACT"

BEFORE THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

COMMITTEE ON ENERGY AND COMMERCE

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, D.C.

JULY 25, 1983

American Pharmaceutical Association
2215 Constitution Avenue, N.W.
Washington, D.C. 20037

(202) 628-4410

CHAIRMAN WAXMAN, MEMBERS OF THE SUBCOMMITTEE, AS PRESIDENT OF THE AMERICAN PHARMACEUTICAL ASSOCIATION, THE NATIONAL PROFESSIONAL SOCIETY OF PHARMACISTS, I WELCOME THE OPPORTUNITY TO TESTIFY WITH REGARD TO H.R. 1554, THE "FDA APPROVAL LABELING ACT". I AM PARTICULARLY PLEASED THAT OUR STATEMENT THIS MORNING MIRRORS THE LEGISLATION ITSELF-BRIEF AND TO THE POINT.

APHA IS PLEASED TO VOICE ITS SUPPORT FOR THIS BILL. IT WOULD EFFECTUATE A DRUG PRODUCT INFORMATION GOAL THAT THE ASSOCIATION HAS PURSUED FOR SEVERAL YEARS. IN 1981, BY ACTION OF ITS HOUSE OF DELEGATES, THE ASSOCIATION FORMALLY ADOPTED THE FOLLOWING POLICY:

> "THE AMERICAN PHARMACEUTICAL ASSOCIATION SUPPORTS LEGISLATION TO REQUIRE THAT THE LABELS OF PRESCRIPTION DRUG PRODUCTS DISTRIBUTED TO PHARMACISTS INCLUDE EVIDENCE THAT FDA HAS APPROVED THE MARKETING OF THE PRODUCT OR THAT FDA HAS EXEMPTED THE DRUG FROM APPROVAL REQUIREMENTS."

WHILE H.R. 1554 WOULD NOT REQUIRE A DRUG MANUFACTURER TO INCLUDE SUCH FDA APPROVAL OR EXEMPTION INDICATIONS ON ITS DRUG PRODUCT LABELS, REPEAL OF THE CURRENT PROHIBITION IN SECTION 301(L) OF THE FEDERAL FOOD, DRUG, AND COSMETIC ACT IS CONSISTENT WITH APHA POLICY. THE FACT OF FDA APPROVAL OR EXEMPTION FROM APPROVAL REQUIREMENTS WOULD SEEM TO BE AN IMPORTANT PIECE OF MARKETING INFORMATION FOR DRUG MANUFACTURERS. WE WOULD EXPECT THAT, WITH THE CURRENT PROHIBITION REMOVED, THE INFORMATION WHICH PHARMACISTS DESIRE WILL BE INCLUDED BY DRUG MANUFACTURERS AS A COMPETITIVE FACTOR ON LABELS, AS WELL AS IN LABELING AND ADVERTISING.

IT IS OUR UNDERSTANDING THAT THE CURRENT PROHIBITION IN SECTION 301(L) OF THE ACT WAS INTENDED TO INSULATE THE FOOD AND DRUG ADMINISTRATION FROM ANY SUGGESTION THAT ITS SAFETY AND EFFECTIVENESS APPROVAL OF A PARTICULAR DRUG PRODUCT COULD BE INTERPRETED AS ANY FORM OF COMMERCIAL ENDORSEMENT OF THAT PRODUCT. WHILE THERE WAS APPARENT LOGIC TO THIS STEP, IT DID NOT ANTICIPATE CONTEMPORARY PROBLEMS WHICH NOW WEIGH HEAVILY IN FAVOR OF REMOVING THE PROHIBITION.

LET ME EXPLAIN WHY THE INFORMATION IN QUESTION IS OF SUCH IMPORTANCE TO PHARMACISTS. OUR DIRECT INTEREST IN THIS ISSUE STEMS DIRECTLY FROM EXPERIENCES OF THE EARLY 1970S DURING WHICH APHA WAS SEEKING THE ENACTMENT OF STATE LAWS TO PERMIT PHARMACISTS TO ENGAGE IN DRUG PRODUCT SELECTION. ONE OF THE ARGUMENTS MADE AGAINST SUCH ACTION BY STATE LEGISLATURES WAS THAT MANY DRUG PRODUCTS ON THE MARKET WERE OF QUESTIONABLE QUALITY. IT BECAME APPARENT TO APHA AT THAT TIME THAT THERE HAD TO BE SOME MEANS OF READILY ASSURING PHARMACISTS THAT DRUG PRODUCTS BEING OFFERED TO THEM, HAD "PASSED MUSTER" IN TERMS OF THEIR QUALITY AND RELIABILITY.

IN THE LATE 1970S THE PROBLEM BECAME SEVERE, DUE IN PART TO CONFLICTING COURT DECISIONS REGARDING THE LEGALITY OF CERTAIN MARKETED DRUG PRODUCTS, AS WELL AS CONTINUING FDA DISPUTES WITH CERTAIN MANUFACTURERS OVER THE LEGAL STATUS OF MARKETED DRUG PRODUCTS, PHARMACISTS WERE BEING WARNED BY FDA ABOUT "UNAPPROVED" DRUG PRODUCTS IN THE MARKETPLACE. THEY WERE AGAIN PLACED IN THE POSITION OF HAVING TO SORT OUT CONFLICTING REPRESENTATIONS AS TO

WHETHER OR NOT PARTICULAR DRUG PRODUCTS BEING OFFERED TO THEM WERE LAWFULLY ON THE MARKET. DURING THIS PERIOD, APHA RAISED WITH FDA THE "NDA OR ANDA NUMBER ON THE LABEL" ISSUE AND RAN HEAD-ON INTO SECTION 301(L). FDA WAS SYMPATHETIC TO THIS PROBLEM AND DID GO SO FAR AS TO ESTABLISH A "HOT LINE" TELEPHONE NUMBER WHICH PHARMACISTS COULD CALL TO OBTAIN INFORMATION REGARDING FDA'S RECORDS OF THE LEGAL STATUS OF PARTICULAR DRUG PRODUCTS. NEEDLESS TO SAY, THIS SYSTEM WAS BOTH COSTLY AND BURDENSOME, CERTAINLY MORE BURDENSOME THAN SIMPLY LOOKING AT THE LABEL OF A DRUG PRODUCT TO DETERMINE WHETHER OR NOT IT CARRIED AN FDA APPROVED NDA OR ANDA NUMBER, OR SOME INDICATION THAT SUCH WAS NOT REQUIRED.

IN AN EDITORIAL CARRIED IN THE APRIL 1980 ISSUE OF THE JOURNAL OF PHARMACEUTICAL SCIENCES, PUBLISHED BY APHA, DR. EDWARD G. FELDMANN OF APHA'S STAFF COMMENTED ON THE CONFUSION THAT WOULD BE CREATED IN AN ANALAGOUS SITUATION:

> " IMAGINE FOR A MOMENT THE CONFUSION THAT WOULD REIGN IF THE MILLIONS AND MILLIONS OF AUTOMOBILES IN THIS COUNTRY WERE ALL BEING DRIVEN AROUND WITHOUT LICENSE PLATES. THE VEHICLES THEMSELVES STILL MIGHT BE PROPERLY REGISTERED WITH THE RESPECTIVE STATE VEHICLE DEPARTMENTS, BUT THERE WOULD BE NO OUTWARD EVIDENCE OF SUCH REGISTRATION OR VERIFICATION OF REGISTRATION, OR MEANS OF IDENTIFICATION OR THE LIKE, DISPLAYED ON EACH AUTOMOBILE FOR ALL TO SEE. TO SAY THAT THIS WOULD BE A CHAOTIC SITUATION IS A GROSS UNDERSTATEMENT."

DR. FELDMANN CALLED FOR THE KIND OF APPROVAL IDENTIFICATION ON DRUG PRODUCT LABELS THAT WOULD BE PERMITTED WITH THE ENACTMENT OF H.R. 1554.

AS MATTERS NOW STAND, THE FOOD, DRUG, AND COSMETIC ACT DOES NOT DENY FDA DRUG PRODUCT APPROVAL INFORMATION TO THOSE INTERESTED. IT MERELY PROHIBITS USE OF THE SIMPLEST AND MOST DIRECT MEANS BY WHICH THAT INFORMATION CAN BE PROVIDED. APHA BELIEVES THAT THE FACT OF FDA APPROVAL, OR THAT A PARTICULAR DRUG PRODUCT CAN BE ON THE MARKET WITHOUT THE NECESSITY OF FDA APPROVAL, IS AN IMPORTANT PIECE OF INFORMATION TO WHICH PRESCRIBERS, PHARMACISTS, AND, ULTIMATELY, THE PATIENTS THEY SERVE SHOULD HAVE READY ACCESS. WE BELIEVE THERE IS NO CURRENT JUSTIFICATION FOR THE 301(L) PROHIBITION, AND WE THEREFORE HEARTILY SUPPORT THE ENACTMENT OF H.R. 1554.

WE AGAIN THANK YOU, MR. CHAIRMAN, FOR YOUR INVITATION TO TESTIFY IN THIS HEARING, AND WE STAND READY TO ASSIST YOU IN FURTHERING FAVORABLE ACTION ON THIS BILL.

THANK YOU.

Mr. WAXMAN. Thank you very much.

STATEMENT OF BILL SCHULTZ

Mr. WAXMAN. We want to welcome you back again.

Mr. SCHULTZ. Thank you, Mr. Chairman.

With me is John Sims, who has considerable experience in the first amendment area. I would like to say a few words about the policy considerations, then let Mr. Sims spend a few minutes on the constitutional issue which you raised previously.

We also support the bill to repeal 301(l) and believe that drug companies should in fact be permitted to state on the labels of drugs that their drugs have been approved by FDA, if in fact they have. The reason for our support is such a statement would be truthful; it is an important piece of information that both consumers and pharmacists should have; and we don't believe that it could possibly mislead anyone.

The FDA supported the repeal of 301(l) last year, but now agency officials take a somewhat different position. They say the companies should be able to put on the drug label the NDA number, but that the companies shouldn't be able to state on the bottle that the drug has been approved by the FDA. In this way, the pharmacists would have a way of determining whether the drug has been approved by the FDA, but consumers who are not familiar with the Food, Drug, and Cosmetic Act, would have no way of obtaining this information.

We can't see any basis for limiting the legislation to a statement of the NDA number other than to keep this information from consumers, and we think the only effect would be to benefit the large drug companies.

There is one area that we would ask the committee to clarify legislation, and that concerns a group of drugs that were approved after the 1938 act, but before the 1962 efficacy amendments. Under the 1962 act, the FDA was directed to go back and look at that group of drugs to determine whether they were effective. These drugs are called DESI drugs. Again, they were approved between 1938 and 1962. The FDA has not yet finished that review, even though it was supposed to begin shortly after 1962.

There are about 130 DESI drugs still left. The FDA is required by court order to finish the review by September 1984. But the problem is that those drugs technically were approved by the FDA but they were approved only for safety—not for efficacy.

In our view it would be misleading for a company to state on the label that a DESI drug, never approved for efficacy, has been approved by the FDA. So we would ask that the bill be amended to account for that, or at a minimum that there be a statement in the committee report that such a statement that a DESI drug was FDA approved would not be allowed.

STATEMENT OF JOHN CARY SIMS

Mr. SIMS. We believe in viewing the constitutional issue, which provides for a useful and persuasive adjunct to the policy arguments in favor of your proposed bill, it is good to put the statute in context. That is, it was passed in 1938 and at that time the Su-

preme Court had not recognized that commercial speech was protected by the first amendment. In fact it had been held that it was not within the scope of protection.

That was changed explicitly by the Supreme Court in its 1976 decision involving the Virginia State Board of Pharmacy. There was a statute that had a blanket prohibition on advertising of prices of prescription drugs. The Supreme Court said that type of speech, even though it is a commercial product in a commercial context, did have first amendment protection. The test formulated by the Supreme Court in that case, and the test it has been applied since then is a stringent one.

It basically asks if the speech is truthful and is not misleading. The first question is what is the Government interest in banning the speech? And second, even assuming there is an important Government interest, is there some assurance that the restriction is as narrow and as precisely drawn as possible so that it does not restrict any speech that the Government doesn't have a good reason for regulating.

We believe that under that test which is certainly the test that the Supreme Court and the lower courts would apply in evaluating 301(l) that the statute is unconstitutional because it prevents the dissemination of truthful information that certainly would be useful. So contrary to what Mr. Scarlett said, there is nothing inherently misleading about this type of speech. We are fairly confident as to what the result would be if the issue has to be litigated.

Obviously that is not the preferred way to clarify the question.

Mr. WAXMAN. Thank you.

Mr. Rector, please.

STATEMENT OF JOHN M. RECTOR

Mr. RECTOR. Thank you, Mr. Chairman.

We are pleased to appear in support of your legislation, Mr. Chairman, H.R.1554. We represent the independent retail druggists who provide 70 percent of the prescription drugs and nearly 90 percent of the medicaid prescription drugs and services.

In the interest of time, I will highlight the statement we submitted for the record.

Unfortunately, pharmacists cannot reasonably assume that every marketed drug is approved by the FDA. The need for appropriate legislation is illustrated by a review of the possible answer to the following question: Namely, how does the retail pharmacist seeking to provide patients with the best possible prescription medicine determine whether a new drug has been approved by the FDA?

Presently there are two available means for verification, one is the publication by the FDA "Approved Prescription Drug Product List," the other is the hotline that earlier was referred to.

In each case there is a lack of economy and uncertainty that leaves the pharmacist in a vulnerable position with respect to the purchase of many of the drugs that are currently available in the marketplace. In recent years the need for this legislation has been underscored by the proliferation of medicaid pharmacy programs and the private third party reimbursement for pharmaceutical products and services for the drugs in question.

Under these programs through the fixed fee, which denies pharmacists adequate reimbursement, the pharmacist providers must often use the inexpensive, least well known generic product even to cover cost. It is precisely under these circumstances that the manufacturers or distributors have violated 505 of the law. Therefore, when less known generic manufacturers or distributors offer particularly attractive deals on prescription drugs there is a special need to determine whether the drugs are offered and approved by the FDA.

Thus, to assure that the public is dispensed only FDA approved drugs and to permit retailers to make sound and expeditious business purchase decisions the need to clarify approval status on the immediate basis is greater than ever.

In summary, it would help eliminate the expense presently incurred by pharmacists who attempt to determine approval status. It furthermore would strengthen FDA's 505 drug approval enforcement program and third, it would help eliminate the unintended dispensing of an unapproved drug.

I would like to comment on what we heard earlier from the Food and Drug Administration. Needless to say, we are very disappointed by the turnabout on this particular matter expressed by the FDA representatives this morning. We had been encouraged last August when they submitted to the Congress, the House and Senate, the suggested legislation. I think that, somewhat parallel to the discussion of your other bill, their turnabout and their foot dragging on an issue as important as this only underscores the need for the legislation that you have introduced.

Thank you.

[The statement of Mr. Rector follows:]

Statement of Mr. John M. Rector
Before the Health and the Environment Subcommittee
Energy and Commerce Committee

July 25, 1983

FDA Drug Approval

Mr. Chairman, Members of the Subcommittee*:

I am John M. Rector of Alexandria, Virginia. I serve as the Director of Government Affairs of the National Association of Retail Druggists.

The National Association of Retail Druggists (NARD) represents owners of more than 30,000 independent pharmacies, where over 75,000 pharmacists dispense more than 70 percent of the nation's prescription drugs. Together, they serve 18 million persons daily and provide nearly 90 percent of the Medicaid pharmaceutical services. NARD has long been acknowledged as the sole advocate for this vital component of the free enterprise system.

NARD members are primarily family businesses. They have roots in America's communities. The neighborhood independent druggist typifies the reliability, stability, yet adventuresomeness that has made our country great.

We are pleased to appear before the Subcommittee on Health and the Environment to express our support for H.R. 1554, the "FDA Approval Labeling Act". We would like to express our special appreciation to the Subcommittee, its Chairman, and staff for the

*Rep. Henry A. Waxman, (D-CA), Chairman
MAJORITY: Representatives Waxman, Scheur, Luken, Walgren, Mikulski, Wyden, Shelby, Leland, Wirth, Ottinger, Sikorski and Eckart.
MINORITY: Representatives Madigan, Dannemeyer, Whittaker, Bliley and Nielson.

cooperation that you have shown us in the planning of this legislative hearing.

No new drug may be sold without prior approval by the Food and Drug Administration. Yet, determining whether a particular prescription drug has been approved by the FDA has been perplexing, costly and an often impossible task for retail pharmacists, especially for the independent store owners that are represented by NARD.

Unfortunately, pharmacists cannot reasonably assume that every marketed drug is approved by the FDA. Although not widely publicized, many non-approved new prescription drugs are available to pharmacies.[1]

The need for appropriate legislation is illustrated by a review of possible answers to the question:

> How does a retail pharmacist, seeking to provide patients with the best possible prescription medicine, determine whether a new drug has been approved by the FDA?

Presently, two verification references are available:

1. The FDA publishes the "Approved Prescription Drug Products List" which is now in its second edition and is supplemented 12 times a year. The price is $45 per year which includes the monthly supplements for the year. The value of such an FDA publication is two-fold. First, one can tell with some accuracy

[1]Each issue of the FDA Consumer reports cases involving the marketing of a new drug without appropriate FDA approval.

whether or not a drug is approved. But secondly, if it is not on the list, one can serve notice on the manufacturer that it had better get approval, or if approved, get on the list before any purchase will be made. This list, however, is never current, and it is costly to obtain and maintain, especially by an independent retail pharmacist. Details of subscribing to the list may be obtained from the United States Government Printing Office, Washington, DC 20402.

2. The FDA has a hotline number available to verify FDA drug approvals. The number is 301/443-1016. Unfortunately, it is a toll call and delays in response are common.

As a general rule, when considering a product of a pioneer drug manufacturer, we believe that it is reasonable to assume that the drug is approved. Likewise, in most cases involving generic drugs, because of the surveillance of the Food and Drug Administration and the requirements for pre-market approval, an NARD member can feel a certain amount of assurance from generic manufacturers who have in the past displayed responsibility toward pharmacists and the consuming public.

In recent years, with the proliferation of Medicaid pharmacy programs and private third-party reimbursement for pharmaceutical products and services, problems associated with determining FDA approval have intensified. Under these programs which, through the fixed fee, deny pharmacists equitable remittance, the pharmacist

providers must often use inexpensive less well-known generic products to even cover cost!!

It is unfortunately precisely under these circumstances that the manufacturers or distributors have violated the law. Therefore, when less-known generic manufacturers offer particularly attractive deals on prescription drugs, there is a special need to determine whether the drugs offered are approved by the FDA. Additionally, especially in the case of the independent druggists, with limited research resources, it is easy to confuse approval of one generic product with another.

Thus, to assure that the public is dispensed only FDA approved drugs and to permit retailers to make sound and expeditious business purchase decisions, the need to clarify approval status on an immediate basis is greater than ever.

NARD has investigated a variety of possible solutions to this problem:

1. Some have suggested that a product's National Drug Code (NDC) number appear on the label. However, the NDC designation cannot serve as an indication of approval because these numbers which only identify the product and firm, are chosen by the manufacturer itself within certain regulatory guidelines, and have nothing to do at all with approval of the product.[2]

[2]See Attachment 1 for text of 11-20-81 FDA Advisory on this and related issues.

2. Another suggested approach would require that the label of each product bear a New Drug Application (NDA) or an Abbreviated New Drug Application (ANDA) number. These numbers, however, are assigned by the FDA upon receipt of a submission, for reference purposes only, and do not imply approval.

Thus, verification of either the NDC or NDA/ANDA provides no certainty that the product has been approved by the FDA.

Even if either of these suggestions would actually provide the information necessary for the retail pharmacist to make a decision about a purchase, there is another roadblock; namely, section 301(l) of the Federal Food, Drug and Cosmetic Act (FFDCA).

This provision of the FFDCA reads as follows:

"The following acts and the causing thereof are hereby prohibited:

(l) The using, or the labeling of any drug or device or in any advertising relating to such drug or device, of any presentation or suggestion that approval of an application with respect to such drug or device is in effect under Section 505, 515, or 520(g), as the case may be, or that such drug or device complies with the provisions of such section."

Thus, under present law, even the incorporation of a symbol or mark on the label of a prescription drug to indicate that the product has been approved by the FDA is illegal. FDA's Office of

General Counsel has instructed NARD that not only are manufacturers subject to the law, but the FDA itself cannot convey such information.

NARD believes that the repeal of 301(l),as provided by H.R.1554, will help remedy the difficulties presently associated with a pharmacist's effort to determine the approval status of prescription drugs. In repealing the prohibition on informing pharmacists and others, however, we view it essential that the Subcommittee mandate that the FDA require an appropriate symbol or mark on the label of all approved prescription drugs.[3]

Directly informing the pharmacist as to the status of approval will accomplish many objectives including:

1. The elimination of expense presently incurred by pharmacists who attempt to determine approval status.
2. A strengthening of FDA's 505 new drug approval enforcement program; and
3. The elimination of the unintended dispensing of an unapproved new drug.

We wholeheartedly concur with the recent comment by Chairman Waxman urging adoption of H.R.1554 when he said in part:

> "This statutory ban makes it difficult for pharmacists to determine whether a drug has been approved by FDA. Although it is illegal to market a drug without prior FDA approval, and FDA aggressively enforces the

[3]On October 14, 1982, assembled in Boston, MA at the 84th Convention of the NARD, the House of Delegates unanimously endorsed this remedy.

law, some unapproved drugs are available in the marketplace and have been inadvertently dispersed by pharmacists.

Presently, there is no simple way for a pharmacist filling a prescription to check whether a drug has been approved by FDA.....

.....The effect of the bill is to permit the inclusion of accurate statements concerning FDA approval in labeling or advertising for drugs. False or misleading statements would continue to be prohibited under section 301(b) of FFDCA." [4]

Again, on behalf of the Officers, Executive Committee and members of NARD, thank you for the opportunity to appear and to continue to participate in the formulation of this long overdue amendment to the FFDCA, which will permit pharmacists to readily determine when a new drug has FDA approval.

[4] Mr. Waxman, Congressional Record at E538, Feb. 17, 1983.

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Food and Drug Administration
Rockville MD 20857

DATE: November 20, 1981

TO: National and State Pharmaceutical Associations/Drug Trade Press

RE: Advisory - Status of Certain DESI Drugs and Related Issues

We continue to receive a considerable number of inquiries from community and hospital pharmacists, State Boards of Pharmacy, purchasing agents, and others which suggest that there exists a noteworthy degree of misunderstanding about the status of certain single-entity and combination drug products which have yet unresolved questions of effectiveness under FDA's Drug Efficacy Study Implementation (DESI) program. In addition, we find there is a good deal of confusion regarding the significance of an NDA (New Drug Application) or ANDA (Abbreviated NDA) number assigned to a specific product by the FDA and the NDC (National Drug Code) number.

First, we should point out that NDA or ANDA numbers are generally assigned by the FDA upon receipt of a submission, for reference purposes only, and do not imply approval. Therefore, confirmation of the existence of an NDA/ANDA number is no assurance that the product has been approved. Inquiries to the FDA or product sponsors should specifically question the approval status, not the assignment of a number. Likewise, there have been questions regarding a product's NDC number and its signficance. An NDC number only identifies the product and firm, but again, and this must be emphasized, it has nothing whatever to do with approval of the product.

The second issue concerns the status of certain DESI products and an apparently growing degree of erroneous information that is circulating in the professional community. The type of inquiries we receive suggests that the most frequently misunderstood product is the chlorzoxazone-acetaminophen combination, yet its status reflects that of several other products for which the effectiveness is in question. The DESI drugs, which include chlorzoxazone-acetaminophen (specifically Parafon Forte), are those originally approved for marketing by the FDA between the years 1938 and 1962.

New provisions to our laws, passed in 1962, added the demonstration of effectiveness to our approval criteria. The 1938-62 products (including Parafon Forte) were approved only for safety, not for effectiveness. Therefore, under the DESI program, these products are now being evaluated for efficacy. Once the effectiveness issues and/or other matters are resolved, an ANDA may be approved for DESI products. However, provisions in the administrative practices and procedures are time consuming and have delayed resolution of many of these issues.

It is FDA's policy that Abbreviated New Drug Applications (ANDAs) for products pending final determination of effectiveness will not be accepted for review, unless such a provision or requirement is published in the FEDERAL REGISTER (FR). It is also our policy that until a final determination of effectiveness is published specifying the conditions for marketing, firms may continue to market these products without FDA approval on their own responsibility. For example, Parafon Forte (chlorzoxazone-acetaminophen) has been classified under the DESI review as "probably effective." This indicates that the product has not been determined to be fully effective and the classification has not yet been finalized or a FR notice published. Until that time, we have deferred regulatory action on that product and other chlorzoxazone-acetaminophen combinations currently on the market. We are advising that those marketing "Parafon Forte generic substitutes" (and other unapproved versions of DESI drugs) do so on their own responsibility because we can neither comment on the quality aspects of the product nor guarantee that we will not seek regulatory action at some point in time. We are aware that states vary in positions on these products, therefore, we strongly encourage pharmacists and other professionals who dispense, use and purchase them (or otherwise have a need to know), to consult with their individual state authorities to determine their positions regarding these products.

We would appreciate it if you would give this information the greatest possible circulation among your memberships and patrons. We believe it should help to resolve some uncertainities in the professional community.

Should any questions arise, we will be pleased to provide whatever information is needed. We can be contacted at (301) 443-1016.

Sincerely yours,

Ross S. Laderman
Director
Consumer and Professional Relations Staff
Bureau of Drugs (HFD-5)

Mr. WAXMAN. Thank you very much.
Mr. Kelley.

STATEMENT OF TY KELLEY

Mr. KELLEY. Thank you, Mr. Chairman.

Regarding our prepared statement that will be included as part of the record, our apologies for a typographical misspelling of Mr. Madigan's name at the bottom of page 1.

Concerning the specifics of H.R. 1554, the FDA Approval Labeling Act, I would make the following points. We view the bill as beneficial to the chain drug industry as it would provide our members with an additional safeguard that a product has been approved by FDA.

The more common the use of a statement of approval by manufacturers, the greater the efficiency there will be for our members in ascertaining if a new drug has been approved. If possible, for the sake of uniformity, we feel that the legislation should allow for pre-1938 drugs that are grandfathered in, and DESI drugs that have not finished their review by FDA, to use an approval statement.

While the approval statement is useful in labeling and advertising directed at health care professionals, we do not believe that the approval statement should be used in labeling and advertising intended for patients.

To conclude, we support the objectives of your bill which will assist our corporate members in more easily determining whether a drug has indeed been approved by the FDA.

Thank you.

[The statement of Mr. Kelley follows:]

Statement of the National Association of Chain Drug Stores, Inc.

BEFORE THE HOUSE COMMITTEE ON ENERGY AND COMMERCE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

FDA APPROVAL LABELING ACT - H.R. 1554

July 25, 1983

NACDS

National Association of Chain Drug Stores, Inc.
P.O. Box 1417-D49
Alexandria, Virginia 22313
703-549-3001

INTRODUCTION

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE HOUSE ENERGY AND COMMERCE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT, MY NAME IS TY KELLEY AND I AM VICE PRESIDENT - GOVERNMENT AFFAIRS FOR THE NATIONAL ASSOCIATION OF CHAIN DRUG STORES, INC., (NACDS). ON BEHALF OF OUR MEMBERSHIP, I WANT TO THANK YOU FOR THE INVITATION TO APPEAR BEFORE THE SUBCOMMITTEE TO PRESENT OUR VIEWS ON LEGISLATION THAT PERTAINS TO THE CHAIN DRUG INDUSTRY AND THE PRACTICE OF PHARMACY.

FOR THE SUBCOMMITTEE'S BACKGROUND, WE ARE A NATIONAL ORGANIZATION FOUNDED IN 1933 TO REPRESENT AND PROMOTE THE INTEREST OF CORPORATE DRUG CHAINS. AT PRESENT, 160 DRUG CHAINS OPERATING IN EXCESS OF 15,000 RETAIL PHARMACIES THROUGHOUT THE UNITED STATES HOLD MEMBERSHIP IN OUR ASSOCIATION. DURING 1982, THE CHAIN DRUG INDUSTRY RECORDED A HEALTHY $20 BILLION IN SALES WHICH IS APPROXIMATELY 56 PERCENT OF ALL RETAIL DRUG STORE VOLUME. OF THE 1.4 BILLION PRESCRIPTIONS THAT ARE BEING DISPENSED EACH YEAR IN THIS COUNTRY, OUR MEMBERS ARE RESPONSIBLE FOR PROVIDING MORE THAN ONE-THIRD OF AMERICA'S OUTPATIENT PRESCRIPTION NEEDS AND SERVICES AS WELL AS A WIDE RANGE OF OTHER HIGHLY SPECIALIZED HEALTH CARE PRODUCTS INCLUDING OPHTHALMIC GOODS, DENTAL CARE AND CONVALENSCENT AIDS.

FDA APPROVAL LABELING ACT

ALTHOUGH THE SUBCOMMITTEE IS ACTIVELY CONSIDERING TWO SEPARATE PROPOSALS AT THESE HEARINGS THIS MORNING, OUR STATEMENT IS DIRECTED TO H.R. 1554 SPONSORED BY CHAIRMAN WAXMAN AND MR. MADEGAN WHICH WOULD AMEND THE FEDERAL FOOD, DRUG AND COSMETIC ACT TO ALLOW MANUFACTURERS TO INDICATE IN THEIR LABELING AND ADVERTISING THAT A

PRESCRIPTION DRUG PRODUCT HAS RECEIVED APPROVAL FROM THE FOOD AND DRUG ADMINISTRATION (FDA). AS WE UNDERSTAND THIS LEGISLATION, IT WOULD SIMPLY STRIKE A SOMEWHAT ARCHAIC PROVISION IN THE FD&C ACT SO THAT A MANUFACTURING CONCERN COULD MAKE A BRIEF AND TRUTHFUL DISCLOSURE THAT THEIR PRODUCTS HAVE BEEN GRANTED APPROVAL BY THE FDA AS HAVING MET THE AGENCY'S STATUTORY REQUIREMENTS FOR SAFETY AND EFFICACY.

IN THIS REGARD, NACDS VIEWS THE PROPOSAL AS A PROGRESSIVE INITIATIVE, DE-REGULATORY IN NATURE, THAT WOULD BENEFIT OUR INDUSTRY IN TERMS OF PROVIDING AN ADDITIONAL GUARANTEE OR SAFEGUARD THAT A PRODUCT HAS CLEARED FDA'S COMPLEX APPROVAL PROCESS. IN PARTICULAR, WE FEEL THAT SUCH AN INITIATIVE AS PERMITTED UNDER THE BILL WOULD BE OF MEASURABLE BENEFIT TO OUR SMALLER CHAIN DRUG CONSTITUENCY. THESE ARE NACDS MEMBERS THAT ARE OPERATING FROM 4 TO 10 PHARMACIES WHO MAY NOT HAVE THE PERSONNEL OR TIME TO DOUBLE CHECK WITH MANUFACTURERS, WHOLESALERS, OR FOR THAT MATTER WITH FDA, AS TO THE APPROVAL STATUS OF EVERY PRODUCT THAT COULD POTENTIALLY BE IN THEIR INVENTORY.

WITH AN ESTIMATED 65,000 TO 75,000 PRESCRIPTION DRUG PRODUCTS IN THE MARKETPLACE, WE FEEL THAT THE LEGISLATION ALLOWING FOR AN FDA "GOOD HOUSEKEEPING SEAL OF APPROVAL" WOULD HELP TO MINIMIZE ANY CONFUSION THAT CURRENTLY EXISTS IN THE DRUG DISTRIBUTION SYSTEM AS TO THE LEGITIMACY OF A GIVEN PRODUCT. STATED DIFFERENTLY, THE BILL WOULD BE AN EFFICIENT SUPPLEMENT TO OUR MEMBERS WHO ROUTINELY REQUEST DOCUMENTATION FROM A MANUFACTURER REGARDING FDA APPROVAL OR WHO CALL THE AGENCY TO VERIFY THAT A PRODUCT HAS RECEIVED CLEARANCE.

1938 PRESCRIPTION DRUGS - DESI DRUGS

WHILE WE FEEL COMFORTABLE WITH THE APPLICATION OF THE LEGISLATION ON MOST PRESCRIPTION DRUG PRODUCTS, NACDS IS SOMEWHAT UNCERTAIN AS TO THE IMPACT OF THE PROPOSAL ON PRE-1938 DRUG PRODUCTS WHICH HAVE BEEN "GRANDFATHERED" FROM HAVING TO SHOW SAFETY AND EFFICACY. IN THIS REGARD, IT WOULD SEEM APPROPRIATE THAT FOR UNIFORMITY A PROVISION IN THE BILL COULD BE MADE TO ALLOW THESE PRE-1938 PRODUCTS TO CARRY AN APPROVAL STATEMENT IN THEIR LABELING AND ADVERTISING, UNLESS OF COURSE, NEW EVIDENCE IS PRESENTED THAT WOULD WARRANT THEIR REMOVAL FROM THE MARKETPLACE.

ALONG THE SAME LINE, IT IS OUR UNDERSTANDING THAT THERE ARE A NUMBER OF PRESCRIPTION DRUG PRODUCTS WHICH HAVE NOT COMPLETED THE DRUG EFFICIENCY STUDY IMPLEMENTATION (DESI) REVIEW PROGRAM OF THE FDA. ALTHOUGH THESE PRODUCTS ARE IN A TEMPORARY HOLDING PATTERN IN TERMS OF THE DESI REVIEW, WE FEEL THAT IT MIGHT BE USEFUL TO ALLOW THEM TO CARRY AN APPROVAL STATEMENT PENDING COMPLETION OF THE AGENCY REVIEW AT WHICH TIME A FINAL DETERMINATION COULD BE MADE.

LABELING AND ADVERTISING

WITH RESPECT TO THE USE OF AN APPROVAL STATEMENT IN A PRESCRIPTION DRUG PRODUCT'S LABELING AND ADVERTISING, NACDS BELIEVES THAT THE LEGISLATION SHOULD ESTABLISH CERTAIN PARAMETERS. MORE SPECIFICALLY, WE FEEL THAT AN APPROVAL STATEMENT OR SYMBOL SHOULD ONLY BE USED IN THE ACCOMPANYING PROFESSIONAL PACKAGE INSERT, LABELING AND ADVERTISING WHICH IS DIRECTED TO HEALTH CARE PROVIDERS.

27-934 O—83——7

SINCE THE LEGISLATION IS AIMED AT CLARIFYING THE APPROVAL OF A PRODUCT BY FDA FOR PROFESSIONALS DISPENSING PRESCRIPTIONS THE USE OF AN OFFICIAL IMPRIMATUR IN ADVERTISING OR LABELING DIRECTED AT PATIENTS MAY BE MISLEADING AND NOT IN THEIR BEST INTEREST. THUS, WHILE WE ARE NOT ASKING FOR EXTENSIVE REGULATIONS FROM FDA TO GOVERN THE USE OF APPROVAL STATEMENTS OR SYMBOLS IN LABELING AND ADVERTISING, IT WOULD SEEM PRUDENT FOR FDA TO DEVELOP GUIDELINES OR PROCEDURES FOR THEIR USE AND DISSEMINATION WITH INPUT FROM ALL SEGMENTS OF THE DRUG DISTRIBUTION SYSTEM.

IN CONCLUSION, THE NATIONAL ASSOCIATION OF CHAIN DRUG STORES, INC., (NACDS) SUPPORTS THE OBJECTIVES OF H.R. 1554 WHICH WOULD ASSIST OUR CORPORATE MEMBERS IN MORE EASILY DETERMINING WHETHER A PRODUCT HAS BEEN APPROVED BY FDA. FROM OUR PERSPECTIVE, THE BILL WOULD HAVE NO MEASURABLE COST AND WOULD HELP TO PROMOTE EFFICIENCY AT THE RETAIL PHARMACY LEVEL.

THANK YOU.

Mr. WAXMAN. Thank you very much.

Let me thank each of you for your testimony today. I have no questions.

I believe you have covered the area well. I appreciate your support for the legislation.

That concludes the business of the subcommittee at this time. We therefore stand adjourned.

[Whereupon, at 12:05 p.m., the subcommittee was adjourned, subject to the call of the Chair.]

[The following statements were submitted for the record:]

DRUG PRICE COMPETITION ACT
STATEMENT OF THE
AMERICAN PUBLIC HEALTH ASSOCIATION
JULY, 1983

The American Public Health Association, representing a combined national and affiliate membership of over 50,000 public health professionals and community health leaders, strongly supports H.R. 3605, the Drug Price Competition Act. This bill will make available to consumers lower cost generic equivalent drugs by allowing the Food and Drug Administration (FDA) to approve generic equivalent versions of drugs approved after 1962.

APHA is a strong supporter of generic drugs. With this legislation, the elderly, the ill and those other consumers who regularly use prescription drugs can buy less expensive drugs. Consumers would save millions of dollars in drug costs while still being assured of drug safety and effectiveness.

Presently, FDA approves a generic drug on the basis of an Abbreviated New Drug Application (ANDA) if the generic is the same as the pioneer drug, is properly manufactured, and is properly labelled. The approval procedure is abbreviated in that the generic drug maker does not have to repeat the human tests conducted on the pioneer drug. Such retesting is unnecessary and wasteful because FDA has already determined that the drug is safe and effective.

However, FDA applies this (ANDA) policy only to drugs approved before 1962. For drugs approved after 1962, there is no ANDA procedure for the approval of an equivalent generic. The Drug Price Competition Act extends FDA's existing ANDA policy to permit the approval of generic equivalent versions of drugs approved after 1962. This is a change in the drug safety law only and does not, in any way, infringe upon the patent of a pioneer drug. Generic drug makers will not be able to market their product until after the patent on the pioneer drug has expired.

APHA supports this legislation and will work actively with Congress to see it enacted into law.

July 29, 1983

STATEMENT OF

THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

on

H.R. 3605

A BILL THAT WOULD AUTHORIZE THE FOOD AND DRUG ADMINISTRATION TO APPROVE GENERIC COPIES OF ALL PIONEER NEW DRUGS

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This statement presents the views of the Pharmaceutical Manufacturers Association (PMA) on H.R. 3605, a bill that would authorize abbreviated new drug applications (ANDAs) for all copies of approved new drugs. PMA represents the 135 companies that are responsible for nearly all of the new prescription medicines discovered and developed in this country. PMA members are therefore very interested in this proposed legislation because of its potential impact on U.S. public health policy and the development of medicines for consumers.

Summary

H.R. 3605 is intended to resolve, by legislation, the circumstances under which the Food and Drug Administration (FDA) may approve the marketing of generic copies of previously-approved pioneer new drugs. PMA agrees that this subject can be, and indeed can only be, resolved by congressional legislation.

This subject has been considered and debated extensively in Congress, FDA, prestigious commissions, academic reports, the pharmaceutical industry, and public organizations. It involves very complex questions of law, economics, drug safety, and public policy, and requires a detailed understanding of FDA regulation of new drugs during the past 45 years. As introduced, however, H.R. 3605 does not reflect this extensive background, does not recognize the factors which have occurred since the congressional debates of the 1970s, and fails to address important substantive issues that

must be resolved relating to FDA approval of generic drugs. Accordingly, PMA opposes its enactment as introduced.

In its present form, H.R. 3605 would substantially reduce the attractiveness of investing in new drug research. It would diminish existing mechanisms for surveillance of the safety and effectiveness of new drugs when they are first used in medical practice. It would also be a powerful disincentive to investment in the full potential of a new drug after its initial NDA approval -- a process which now typically continues for 15 or more years. Thus, the bill would have an adverse impact on public health in this country. Rather than helping the poor and elderly, it would reduce their opportunity to receive the benefits of important new medical advances in the future. It would indeed be an anomaly for this Subcommittee to sponsor the Orphan Drug Act to provide incentives for research on drugs to treat rare diseases and then to sponsor this bill to provide disincentives for research on drugs to treat common diseases.

If legislation to govern FDA approval of generic copies of previously-approved pioneer new drugs is to be considered by this Congress, it must address six essential elements.

First, it must establish the conditions for FDA approval of ANDAs.

Second, it must establish the conditions for FDA approval of paper NDAs or any other form of NDA for

the generic copy of a pioneer new drug. The requirements for these other forms of less-than-full NDAs must be the same as for ANDAs.

Third, the same conditions that apply to FDA approval of a generic copy of a pioneer new drug must also apply to any subsequent FDA approval of a generic copy of major modifications of that pioneer new drug. New indications, dosage forms, methods of manufacture, and other major modifications must be given the same protection as the initial pioneer product.

Fourth, the use by a generic manufacturer or FDA of non-public safety and effectiveness data in a pioneer NDA to gain approval of a generic copy of that pioneer drug, or the public disclosure of such data, must continue to be prohibited. The pioneer manufacturer has invested millions of dollars to obtain those data and they constitute a valuable property right that should not be given to others.

Fifth, approval of any form of less-than-full NDA for a generic copy of a pioneer drug must be prohibited during the period that the pioneer drug is the subject of a valid unexpired patent. FDA should not be granting approval of a drug that directly violates the exclusive marketing rights granted by the Patent Office.

Sixth, a term of years must be specified before any less-than-full NDA may be approved by FDA, in order to assure sufficient economic incentive for continued drug innovation in this country. Without such an incentive, the public health will suffer dramatically.

PMA opposes any legislation that fails to address, and fairly resolve, each of these six essential elements. We are prepared to work with the Subcommittee toward legislation that embraces these elements and thus adequately protects drug innovation and public health in the United States.

I. Only Congress Can Establish the Requirements for FDA Approval of Generic Copies of Previously-Approved Pioneer New Drugs

For 45 years, ever since enactment of the Federal Food, Drug, and Cosmetic Act of 1938 (FD&C Act), FDA has steadfastly and consistently taken the position that the law prohibits the public disclosure of non-public safety and effectiveness data contained in a new drug application (NDA) for a pioneer new drug, and thus prohibits the use of such data as support for the approval of a generic copy of the pioneer new drug. FDA has permitted ANDAs only where the drug entity has become generally recognized as safe and effective and thus no longer a new drug. For 20 years, the Agency has represented to Congress,[1] the

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[1] E.g., "Interagency Coordination in Drug Research and Regulation," Hearings Before the Subcommittee on Reorganization and International Organizations, Committee on Government

(footnote cont'd)

courts,[2] public commissions,[3] and the general public,[4] that it would not change this longstanding and consistent administrative interpretation of the FD&C Act without new legislation enacted by Congress.

Accordingly, this matter can now be resolved only by specific congressional legislation. FDA has no legal authority to change its interpretation and commitments at this late date, after nearly half a century of consistent application of the law, without explicit Congressional authorization.[5] If

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(footnote cont'd)

Operations, United States Senate, 88th Cong., 1st Sess. 1899-1900 (1963); "Competitive Problems in the Drug Industry," Hearings Before the Subcommittee on Monopoly, Select Committee on Small Business, United States Senate, 90th Cong., 1st Sess. 743-746, 748-749, 755, 761 (1967); "Small Business Problems in the Drug Industry," Hearings Before the Subcommittee on Activities of Regulatory Agencies, Select Committee on Small Business, House of Representatives, 90th Cong., 1st & 2d Sess. 370, 383 (1967 & 1968); "Drug Safety Amendments of 1976," Hearings Before the Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, House of Representatives, 94th Cong., 2d Sess. 60 (1976).

[2] E.g., Briefs for FDA in Morgan v. FDA, 495 F.2d 1075 (D.C. Cir. 1974); Weinberger v. Hynson, Westcott & Dunning, 412 U.S. 609 (1973); Weinberger v. Bentex Pharmaceuticals, Inc., 412 U.S. 645 (1973); and cases cited in notes 54 & 55 infra.

[3] E.g., Review Panel on New Drug Regulation, Interim Report: An Evaluation of FDA's Trade Secrets and Freedom of Information Policies 2, 17-27 (November 1976).

[4] E.g., 39 Fed. Reg. 44602, 44634 (December 24, 1974).

[5] Norwegian Nitrogen Product Co. v. United States, 288 U.S. 294, 315 (1933); United States v. Leslie Salt Co., 350 U.S. 383, 395-396 (1956); Power Reactor Development Co. v. Int'l Union, 367 U.S. 396, 408-409 (1961); Udall v. Tallman, 380 U.S. 1, 4 (1965); Zuber v. Allen, 396 U.S. 168, 192 (1969).

there is a deficiency in the current law, it is up to Congress, not FDA, to change it.

PMA therefore agrees that the circumstances under which FDA may approve a generic copy of a pioneer new drug is properly one for congressional scrutiny and resolution. PMA strongly opposes H.R. 3605, however, because it discourages new drug innovation, discourages continued research on newly approved therapeutics, provides inadequate safety protection, and thus would be detrimental to public health in the United States.

II. The FD&C Act Was Intended To Encourage Drug Innovation and Thus Foster Public Health in the United States

From its enactment to the present, the FD&C Act has been intended by both Congress and FDA to provide adequate incentives for new drug innovation. Without such incentives, the discovery of important new medicines and expanded development of newly approved medicines would be discouraged and the public health substantially impaired. The following brief history summarizes the pertinent statutory and regulatory policy pursued for new drugs during these 45 years.

A. The 1938 Act. The original Food and Drug Act of 1906[6] contained no premarket notification or approval requirements, and the bills introduced in Congress between 1933 and 1937 to modernize the 1906 Act similarly contained no

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[6] 34 Stat. 768 (1906).

such provision.[7] After the elixir of sulfanilamide disaster of November 1937, however, FDA issued a report to Congress recommending legislation that would provide:

> "1. License control of new drugs to ensure that they will not be generally distributed until experimental and clinical tests have shown them to be safe for use. The definition of what constitutes a new drug should include (a) substances which have not been used sufficiently as drugs to become generally recognized as safe, (b) combinations of well-known drug substances where such combinations have not become generally recognized as safe, and (c) well-known drug substances and drug combinations bearing label directions for higher dosage or more frequent dosage or for longer duration of use than has become generally recognized as safe."[8]

Although separate legislation was initially introduced to implement these recommendations, it was soon combined with the long-pending revision of the 1906 Act and was in fact enacted as Sections 201(p), 301(j), and 505 of the FD&C Act of 1938.[9]

Under the 1938 Act, a new drug was defined in Section 201(p) as any drug not generally recognized as safe or as any drug which has become generally recognized as safe but which has not been used to a material extent or for a material time. Section 301(j) prohibited the public disclosure of any method or process obtained by FDA under Section 505 of the Act

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[7] E.g., S. Rep. No. 91, 75th Cong., 1st Sess. (1937).

[8] "Elixir Sulfanilimide," S. Doc. No. 124, 75th Cong., 2d Sess. 9-10 (1937).

[9] 52 Stat. 1040 (1938).

which is entitled to protection as a trade secret. Section 505 provided for the premarket notification of all testing of new drugs, including submission of "full reports" of all safety information, and authorized FDA to prevent marketing if that testing did not show the drug to be safe.

Beginning in 1938, FDA has interpreted the new provisions to require each individual NDA to contain its own information on safety.[10] The Agency has consistently prohibited the use of information in a pioneer NDA to support approval of a generic competitor.[11] All such information has been protected by FDA against public disclosure.[12]

Between 1938 and 1962, FDA did determine that a number of pioneer new drugs had become generally recognized as safe and had been used to a material extent or for a material time. For these no-longer-new drugs (commonly called "old drugs"), FDA permitted marketing of generic copies without the requirement of an NDA.[13] FDA did not specify, either formally or informally, any particular length of time after the pioneer

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[10] Sellers & Grundstein, Administrative Practice and Procedure in the Department of Agriculture Under the Federal Food, Drug, and Cosmetic Act of 1938 87 (1940); 46 Fed. Reg. 27396 (May 19, 1981).

[11] 39 Fed. Reg. 44602, 44634 (December 24, 1974).

[12] Id.

[13] 40 Fed. Reg. 26142-26143 (June 20, 1975).

NDA that would be required to satisfy the statutory requirement of marketing "to a material extent or for a material time."

B. The Drug Amendments of 1962. As a result of the discovery that the drug thalidomide, although not approved in the United States, caused major adverse reactions following its approval abroad, Congress enacted the Drug Amendments of 1962 to strengthen the drug approval process in the United States.[14] Of principal importance, regulation of new drugs was changed from premarket notification to premarket approval, and approval was required to be based upon proof of drug effectiveness as well as safety.

Although Congress provided FDA with major new enforcement authority in this legislation, it made no change in the basic regulatory framework for approving new drugs. Each NDA continued to be a separate approval for a specific drug product, the prohibition against public disclosure of NDA information was retained unchanged, and the statutory distinction between a new drug and an old drug remain the same as before. Nowhere in the legislative history is there any indication that Congress either failed to understand the system that had been employed by FDA from 1938 to 1962 or that it intended to alter that system except to add the new regulatory authority already mentioned.

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[14] 76 Stat. 780 (1962).

In implementing the 1962 Amendments, FDA concluded that it should formalize a procedure for determining old drug status. Accordingly, it revoked all existing informal old drug letters[15] and proposed a new procedure for determining the old drug status of products previously subject to an NDA.[16] This approach was reaffirmed in 1975 with a revised proposal for a procedure to determine old drug status.[17] More recently, however, FDA has concluded not to promulgate a procedure for determining the old drug status of established drugs. Throughout this time, FDA has insisted that old drug status must depend upon publicly available data and information, and has prevailed in this position in the courts.[18]

In addition, FDA concluded that there were some drugs for which the publicly-available data and information justified general recognition of safety and effectiveness, but for which some form of NDA was still needed to assure that generic copies were as safe and effective as the pioneer drug. This abbreviated NDA (ANDA) system was proposed in 1969[19] and

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[15] 33 Fed. Reg. 7758 (May 28, 1968).

[16] 33 Fed. Reg. 7762 (May 28, 1968).

[17] 40 Fed. Reg. 26142 (June 20, 1975).

[18] Weinberger v. Bentex Pharmaceuticals, Inc., 412 U.S. 645, 652 (1973).

[19] 34 Fed. Reg. 2673 (February 27, 1969).

promulgated in 1970.[20] Because this occurred before the use of explanatory preambles became routine, the Federal Register documents did not discuss the legal rationale of this new procedure. As FDA subsequently explained, however, it was based upon the determination that the drug active ingredient was indeed generally recognized as safe and effective, and the ANDA was needed only to demonstrate that each generic copy was also safe and effective:

> "The Commissioner recognizes that abbreviated NDAs have been used, since 1968, as a partial substitute for old drug determinations. Since their inception it has been well understood that an abbreviated NDA is appropriate only for those drugs which, from a generic standpoint, are generally recognized as safe and effective when they are properly labeled and manufactured. The submission of an abbreviated NDA has thus been required only to assure the quality of drug products and their proper labeling and manufacture, not to show the basic safety and effectiveness of the generic chemical entity involved."[21]

FDA took the legal position that drugs that had been subjected to the Drug Efficacy Study Implementation (DESI) program following enactment of the 1962 Amendments and had been found to be safe and effective for their labeled uses were, as generic chemical entities, no longer new drugs. The determination by an expert panel of the National Academy of Sciences,

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[20] 35 Fed. Reg. 6574 (April 24, 1970).

[21] 40 Fed. Reg. 26142, 26147 (June 20, 1975). See also 45 Fed. Reg. 82052, 82054-82055 (December 12, 1980).

based on published scientific literature and other publicly available data, was believed sufficient to support such a finding. Those drugs had all been marketed for a number of years, and FDA concluded that that period of marketing could also support findings that they had been used to a material extent or for a material time. Based upon this legal rationale, the pharmaceutical industry did not challenge the use of ANDAs for new drugs approved by FDA before 1962.

C. The Proposed Drug Regulation Reform Legislation of 1978-1979. When the Carter Administration took office, Secretary of HEW Califano and FDA Commissioner Kennedy determined to resolve the issues relating to FDA approval of generic versions of pioneer new drugs by legislation. Throughout 1977, extensive consultation was held within the Executive Branch and with Congress, consumer groups, and the pharmaceutical industry. After almost a year of such consultation and drafting, a 228-page bill was introduced in March 1978, H.R. 11611, the Drug Regulation Reform Act of 1978.[22] That bill prohibited any form of FDA approval of a generic copy of a pioneer new drug, other than through a full NDA, for five years following the promulgation of a drug monograph. The section-by-section analysis released by the Democratic administration explained this five-year period of exclusivity as giving:

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[22] An identical bill, S. 2755, was also introduced in the Senate the same day.

". . . to a pioneer drug firm a period of five years of exclusive use of the data developed by the firm to support the issuance of a monograph. During those five years, the pioneer firm may authorize a second firm to to be licensed; after the five years, a second firm may be licensed without authorization from the first firm and without submitting the kind of data and information needed to support the issuance of a monograph.

Subsection (b) reflects the fact that a pioneer drug firm may spend millions of dollars and several years developing the information to support the issuance of a monograph. A period of five years of exclusive use of that information provides a pioneer firm with reasonable protection of its investment. This exclusive use period is in addition to, and independent of, any protection the pioneer firm may derive from a patent, from a trade secret protection of its manufacturing techniques and processes, and from recognition of the brand name of its product. The period of exclusive use runs

concurrently with the patent period and does not extend it. If the patent has more than 5 years to run, the exclusive use period will expire before the patent does. The 5 year period does not begin to run until the monograph becomes effective. Thereafter, normal patent rights, if any, are applicable."[23]

In testimony presented on this proposed legislation during 1978, Secretary Califano and Commissioner Kennedy defended the need for some period of years after the pioneer NDA is

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[23] DHEW, Drug Regulation Reform Act of 1978: Section by Section Analysis 76-77 (1978).

approved before any less-than-full NDA could be approved.[24] Representatives of the pharmaceutical industry agreed, but urged that it should be ten years rather than the five years suggested in the bill.[25] When the legislation was reported out of committee[26] and passed by the Senate[27] in 1979, it provided a seven-year period before any generic copy of a pioneer drug could be approved without a full NDA.

D. The Orphan Drug Act. The identical issue was faced by Congress in 1982, in considering the Orphan Drug Act.[28] That statute, which resulted from the initiative of this Subcommittee, provided a seven-year period of exclusive marketing after the approval of an NDA for an orphan drug which is unpatentable. The House report on this provision explicitly stated that this seven-year period of exclusivity

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[24] "Drug Regulation Reform Act of 1978," Hearing Before the Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, House of Representatives, 95th Cong., 2d Sess. 982, 995-998 (1978); "Drug Regulation Reform Act of 1978," Hearings Before the Subcommittee on Health and Scientific Research, Committee on Human Resources, United States Senate, 95th Cong., 2d Sess. 241, 248-252, 277-282 (1978).

[25] "Drug Regulation Reform Act of 1979," Hearings Before the Subcommittee on Health and Scientific Research, Committee on Labor and Human Resources, United States Senate, 96th Cong., 1st Sess. 506 (1979).

[26] S. Rep. No. 96-321, 96th Cong., 1st Sess. 42 (1979).

[27] 125 Cong. Rec. 26244-26275 (September 26, 1979).

[28] 96 Stat. 2049 (1983).

was included "in order to provide some incentive for the development of these particular orphan drugs."[29]

E. The FDA Paper NDA Policy. In 1980, FDA adopted a paper NDA policy for all NDAs.[30] Under this policy, any information on safety or effectiveness published in the scientific literature may be relied upon by a generic manufacturer in submitting any form of an NDA for a generic version of a pioneer new drug. FDA may approve such an NDA, based in part or in whole upon such literature, if it determines that the published literature is reliable and sufficient to establish the safety and effectiveness of the drug.

Following court decisions upholding the FDA paper NDA policy as lawful,[31] a petition was submitted to FDA requesting the Agency to adopt specific criteria and procedures governing the approval of paper NDAs.[32] FDA has declined to issue any criteria or procedures, and continues to approve paper NDAs on an ad hoc basis.[33] Under the FDA policy, a

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[29] H.R. Rep. No. 97-840, 97th Cong., 2d Sess., Pt. 1, at 11 (1982).

[30] 45 Fed. Reg. 82052 (December 12, 1980); 46 Fed. Reg. 27396 (May 19, 1981).

[31] E.g., Burroughs Wellcome Co. v. Schweiker, 649 F.2d 221 (4th Cir. 1981).

[32] Citizen Petition 81P-0259/CP submitted by James R. Phelps (August 14, 1981).

[33] Letter from FDA Commissioner Hayes to James R. Phelps in response to Citizen Petition 81P-0259/CP (December 2, 1982).

paper NDA may be approved by FDA at any time after approval of the pioneer NDA.

F. FDA Policy on Approval Requirements for New Indications, Dosage Forms, Method of Manufacturing, and Other Significant Changes. Approval of the pioneer NDA constitutes approval only of the specific indications, dosage forms, manufacturing methods, and other drug characteristics explicitly set out in the NDA. Any substantial changes in the drug indications, dosage form, method of manufacturing, or other drug characteristics must be approved by FDA through a supplemental NDA or a new full NDA.

It is common that a pioneer drug for which FDA has approved an NDA is, over the years, found to be safe and effective for entirely new indications, or in new dosage forms, or in other ways, based on the continuing research efforts of the NDA sponsor. Indeed, it is possible that the new indications or other changes may be far more important to the public health than the pioneer product as originally approved. Obtaining FDA approval of a pioneer supplemental NDA, or a new full NDA, for such modifications may well involve as much time, effort, and investment as obtaining approval of the original pioneer NDA.

For all of these reasons, FDA has used the same procedures for handling supplemental NDAs and new full NDAs for such changes as it has for handling original NDAs. The requirements for safety and effectiveness are the same and the

protection against public disclosure of non-public NDA information is the same.

For pre-1962 new drugs, moreover, FDA has asserted a policy that new indications approved after 1962 will not be permitted to be included in an ANDA. This precludes a generic manufacturer from taking advantage immediately of any improvement made in a pre-1962 new drug by the pioneer manufacturer, and thus encourages the pioneer manufacturer to conduct research on new indications for pre-1962 new drugs.

The same issue arises with respect to paper NDAs, where FDA similarly will not rely upon the pioneer NDA to approve a new indication. Only a new indication on which there is published literature may be the subject of a paper NDA, under current FDA policy.[14] This encourages scientific research on important new medical indications by assuring the pioneer manufacturer that its research will remain its own property and will not be given to others.

G. Recent FDA Administrative Consideration of Post-1962 ANDAs. During the past two years, FDA has undertaken an administrative review of the use of ANDAs for pioneer new drugs approved by the Agency since 1962. In a lengthy memorandum submitted to the FDA Commissioner in February 1982, the FDA Bureau of Drugs recommended a 15-year period before an

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[14] Id. at 1-2.

ANDA would be approved for a post-1962 pioneer new drug.[33] The Bureau of Drugs, concerned about incentives for new drug innovation in the United States, explained the reason for the 15-year period as follows:

> "The 15-year period is intended to permit the pioneer drug product to have approximately 17 years of marketing before it is subject to competition through the ANDA procedure. It presupposes approximately an additional two-year period, after designation of ANDA suitability, that would be required for firms to submit and the Bureau to review and approve ANDAs. Since a 17-year period coincides with the statutory patent period, but we believe that it would provide an adequate period to maintain drug research incentives."[34]

The preamble to the draft regulation attached to that memorandum expanded upon FDA's concern about the need for adequate incentives to assure a continued supply of important new drugs for the public:

> "D. New Drug Innovation. FDA recognizes the commitment required to develop a new drug product and satisfy the premarketing clearance criteria, and the agency is concerned that adequate incentives for new drug innovation be maintained. Allowing secondary entrants in a drug market without the costly research that was required of the pioneer company may create a disincentive to innovation, but such disincentives are present in all competitive industries. In enacting the patent laws, Congress has determined the balance to be

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[33] Memorandum from Director of the Bureau of Drugs to the Commissioner on proposal to extend ANDA procedures to post-1962 approved drug products (February 8, 1982).

[34] Id. at 3.

struck between the policies favoring innovation, on the one hand, and competition, on the other, by protecting the innovator from competition for a legislatively determined period of time. It is only through the collateral effects of FDA's clinical testing requirements that drug companies have enjoyed greater protection from competition than other industries.

The agency recognizes that a number of factors affecting incentives for new drug innovation have changed since 1962. Before 1962, a showing of safety, not efficacy, was the basis for approval. Therefore, the cost incurred in the conduct of the studies necessary for approval essentially was limited to those intended to prove safety. Manufacturers who had conducted studies had thus made a less substantial economic investment in the support for their product, and risked less as a result of the DESI/ANDA policy than they would today under a similar policy for post-1962 drugs. Since 1962, manufacturers have been required to commit substantially more resources to new drug development to meet the statutory test of substantial evidence of effectiveness and to conform to the more sophisticated methodology employed in today's preclinical and clinical studies of safety and effectiveness.

In view of the greater costs associated with developing drugs today compared with the pre-1962 period, and to assure that adequate incentives for new drug innovation are maintained, FDA has determined in its discretion to extend the ANDA procedure only to post-1962 drugs approved at least fifteen years. The proposed procedure is consistent with the exclusive marketing period of the patent law. Whether subject to patent protection or not, pioneer drug products would not encounter competition through the ANDA procedure until after they have been marketed for a period of time that would substantially correspond to the patent protection period. The proposed procedure would thus not interfere with the incentives

for new drug innovation provided by the patent system."[37]

Earlier this year, after further consideration, FDA sent an action plan to the Secretary of HHS relating to ANDAs for post-1962 pioneer new drugs.[38] This memorandum states that, in view of the opposition of generic drug manufacturers to a 15-year period before generic copies of pioneer new drugs may be approved, FDA had revised its earlier proposal to state that 15 years would be "the maximum reasonable pre-eligibility period" and that FDA would invite comments on the question whether that period or a shorter period should be established.[39] Final action on this matter has not yet been taken by FDA or HHS.

H. FDA Policy on Disclosure or Use for Competitors of Non-Public Safety and Effectiveness Data in a Pioneer NDA. In developing a policy on approval of generic versions of pioneer new drugs, FDA has been required to consider the provisions of three laws relating to the public disclosure or use for generic competitors of data and information contained in the pioneer NDA. Three statutes protect confidential information submitted to the government against public disclosure:

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[37] FDA, Proposal to accept abbreviated new drug applications, at 20, attached to memorandum, note 35 supra.

[38] Memorandum from FDA Commissioner to Secretary of HHS on FDA's action plan for assurance of a proposed ruling to establish ANDA procedures to post-1962 approved drug products (Undated).

[39] Id. at 2.

the Federal Trade Secrets Act,[40] the Freedom of Information Act,[41] and the FD&C Act.[42]

Beginning in 1938, FDA has interpreted the FD&C Act to require that the agency not publicly disclose, or use for any purpose not explicitly authorized by the NDA holder, any safety or effectiveness data contained in the pioneer NDA. This interpretation has been embodied in regulations promulgated by the Agency,[43] in preambles published by the Agency in Federal Register notices,[44] in reports of commissions that have considered the matter,[45] in court briefs,[46] and in testimony by several FDA officials before several congressional committees.[47] At no time in the past 45 years, indeed, has any FDA official publicly stated any position to the contrary.

In 1963, House hearings explored what was then already "FDA's 25-year-long interpretation" that safety and effectiveness information in NDAs could not be publicly

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[40] 18 U.S.C. 1905.

[41] 5 U.S.C. 552(b)(4).

[42] 21 U.S.C. 331(j).

[43] 21 C.F.R. 20.61, 314.11, 314.14.

[44] 37 Fed. Reg. 9128, 9130-9131 (May 5, 1972); 39 Fed. Reg. 44602, 44612-44614, 44633-44638 (December 24, 1974); 40 Fed. Reg. 26142, 26148, 26160-26161 (June 20, 1975); 43 Fed. Reg. 12869, 12870 (March 28, 1978).

[45] Note 3 supra.

[46] Note 2 supra.

[47] Note 1 supra.

disclosed or used in another NDA.[88] DHEW supported FDA's interpretation of the law.[89] FDA Commissioner Larrick stated that:

> "A requirement that all research performed in connection with a new drug be made public would involve far reaching considerations of national policy which go beyond the administrative considerations with which we are concerned and involve judgments we are not in a position to make."[90]

In 1967, FDA Commissioner Goddard, while expressing personal concern about the policy, testified that:

> ". . . this is something that I think the Congress itself has to study. This is an established policy, it is an accepted policy.
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> . . . if Congress wishes us to make that information available generally to other manufacturers, we are prepared to do that.
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> Congress should get down to the issues involved here and see whether or not the interest of the public at large might better be served by a public policy which permitted disclosure of the clinical, the scientific information incorporated in New Drug Applications. * * * I as an administrator think the past policy of not revealing this type of information in effect binds me not to change the policy until there is proper discussion by Congress. * * * I think it would require law in this instance a change in the law."[91]

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[88] "Hearings on Interagency Coordination in Drug Research and Regulation," note 1 supra, at 1891.

[89] Id. at 1898-1899.

[90] Id. at 1900.

[91] "Hearings on Competitive Problems in the Drug Industry," note 1 supra, at 744, 746, 748.

FDA Chief Counsel Goodrich added that:

> "This is the policy that we have followed over the years and we propose to follow it from herein, up until the time that Congress changes the law."[12]

In 1974, the Agency summarized its position on this matter in the context of its Freedom of Information regulations:

> "254. A comment objected to the withholding of NDA information on the ground that it grants a monopoly that continues forever, since in order to market an approved drug a company must do all the testing required to show safety and effectiveness. It was pointed out that this may cost millions of dollars and has the effect of limiting the market to the company that did the original testing and to those other companies which are permitted by a first company to incorporate by reference its safety and effectiveness data into their applications. This system, referred to as a 'domestic cartel,' bars production of a drug because of the expense of reproducing the test data, irrespective of whether the patent has expired or is declared invalid or whether the product is unpatentable because it is a 'product of nature' or lacks novelty. Further, it was asserted that, once a drug was tested, there was no social gain in requiring duplication of the testing by other companies.
>
> The Commissioner advises that the Federal Food, Drug, and Cosmetic Act requires full reports of safety and effectiveness from each company submitting an NDA. The Food and Drug Administration has, on a number of occasions, pointed out to Congress the effect of this requirement, and has suggested that Congress consider whether this policy should be retained or changed. Congress has, to date, not taken action on this matter."[13]

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[12] Id. at 749.

[13] 39 Fed. Reg. 44602, 44634 (December 24, 1974).

FDA commissioners and chief counsels have reiterated that it is up to Congress, and not the Agency, to change this 45-year-old policy.

In all of the cases litigated thus far, the courts have held that non-public safety and effectiveness in NDAs are protected against public disclosure under one or more of the three relevant confidentiality statutes.[14] In the most recent case, involving the analogous situation of Class III medical devices, the court held that such data constitute confidential commercial information that is exempt from public disclosure under the Freedom of Information Act.[15]

Throughout this 45-year period the Agency has taken the position that there is no difference between publicly disclosing the safety and effectiveness data in a pioneer NDA so that a generic competitor could reproduce it and resubmit it to the Agency for approval of a generic copy of that pioneer drug, or simple reliance on those data at the request of the generic manufacturer, or on simple reliance on those data at the initiative of FDA itself. All three alternatives have the identical result -- approval of the generic copy of

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[14] Johnson v. DHEW, 462 F. Supp. 336 (D.D.C. 1978); Webb v. DHHS, Food Drug Cosm. L. Rep. ¶ 38,138 (D.D.C. 1981). See also Pharmaceutical Mfrs Ass'n v. Weinberger, 401 F. Supp. 444 (D.D.C. 1975); Syntex Corp. v. Califano, Food, Drug, Cosm. L. Rep. ¶ 38,221 (D.D.C. 1979).

[15] Public Citizen Health Research Group v. FDA, No. 79-01710 (D.C. Cir. 1983).

the pioneer new drug on the basis of the pioneer manufacturer's data. It was precisely to prevent this result that FDA has adopted and maintained its policy these 45 years, and has testified before Congress that it will continue that policy until Congress changes it.

In a 1977 decision, for example, FDA relied upon publicly available data and information to approve a generic version of a drug, but specifically declined to rely upon non-public information contained in a pioneer NDA because the generic manufacturer did not have "the express permission of the first applicant."[56] The Agency reiterated this position in a subsequent 1979 decision.[57] Most recently, in connection with its paper NDA policy, FDA stated that:

> "Present interpretation of the law is that no data in an NDA can be utilized to support another NDA without express permission of the original NDA holder."[58]

Indeed, in a recent court decision, it was explicitly recognized that there is no difference between public disclosure of confidential data and government use of those data to approve a competitive product.[59]

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[56] 42 Fed. Reg. 21847, 21851 (April 29, 1977).

[57] 44 Fed. Reg. 44943, 44949 (July 31, 1979).

[58] 45 Fed. Reg. 82052 (December 12, 1980). The Agency has always stated that data in any NDA file may be used to deny approval of other products, as contrasted with supporting approval. Id.

[59] Monsanto Co. v. EPA, No. 79-336 C (1), at 38-41 (E.D. Mo., April 12, 1983).

As part of its recent consideration of ANDAs for post-1962 new drugs, FDA has discussed internally the possibility of reversing its 45-year-old policy of not using the confidential material in the pioneer NDA to support the approval of a generic competitor.[66] PMA believes that any such abrupt administrative reversal would be clearly unlawful. Final action on this matter has not yet been taken by FDA or HHS.

Section 505 of the FD&C Act requires the submission in an NDA of "full reports" of all data and information necessary to demonstrate the safety and effectiveness of a new drug. There are no exceptions from this requirement. FDA successfully reconciled this requirement in permitting ANDAs for pre-1962 new drugs because of its determination that those drugs were, as generic entities, generally recognized as safe and effective and therefore no longer new drugs. It also successfully reconciled that provision with its paper NDA policy because of its determination that the published literature in fact constituted the "full reports" required by Section 505, and the courts endorsed that approach. For post-1962 new drugs, however, the Agency must limit approvals of generic drugs to those products which have become generally recognized as safe and effective as generic entities or for which there is sufficient literature to support a paper NDA.

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[66] Notes 35 and 38 supra.

I. FDA Policy on Approval of ANDAs for Pioneer Drugs Still Subject to a Valid Unexpired Patent. FDA does not consider the patent status of a pioneer new drug in considering the approval of an ANDA for a generic copy of that drug. For example, FDA has approved an ANDA for a generic version of an antibiotic that was subject to a valid unexpired patent, requiring the patent holder to obtain an injunction to prevent the generic manufacturer from marketing the drug.[61]

Under current patent law, a generic drug company may not lawfully manufacture a copy of a patented drug even for testing purposes during the effective life of that patent. In Pfizer, Inc. v. International Rectifier Corp.,[62] the court explicitly found that Rectifier, a generic drug company, was in violation of a court order enforcing Pfizer's patent, where Rectifier made the drug only for investigational purposes to obtain data for submission of an ANDA to FDA. The court held that such testing was commercial in nature because it was intended to result in ultimate FDA approval for marketing. The court ordered Rectifier to "withdraw all applications to the FDA" based upon testing in violation of Pfizer's patent, and to destroy its FDA applications in the presence of a

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[61] Eli Lilly & Co. v. Premo Pharmaceuticals, Inc., 630 F.2d 120 (3rd Cir. 1980). In another case, a generic manufacturer marketed a drug without obtaining an ANDA and was enjoined for marketing in a suit brought by the patent holder. BNA Patent, Trademark & Copyright J., March 13, 1980, at A-8.

[62] Pfizer, Inc. v. International Rectifier Corp., No. 73-58-pence (C.D. Cal. 1982).

United States marshal and representatives of Pfizer. Accordingly, it is apparent that any testing of a generic drug must, in order to comply with federal patent law, be undertaken only after the patent expires.

Section 702(c) of the FD&C Act currently authorizes FDA to obtain from the Patent Office any information necessary to determine whether a pioneer drug is subject to a valid unexpired patent, just as Section 702(d) authorizes the Commissioner of Patents to determine from FDA any information relating to a patent application for a drug. FDA has not used this authority.

III. Incentives for Research-Intensive Pharmaceutical Firms Initially to Develop Pioneer New Drugs and to Continue Research After Approval Are Critical to Improving the Public Health in the United States

A. Future Progress in Public Health Depends Upon Incentives for New Drug Research. Reducing incentives to conduct expensive research on important new drugs will do substantial harm to the public health of the country generally, and the poor and the elderly in particular. As Chairman Waxman stated in opening this Subcommittee's 1980 oversight hearings on drug regulation reform:

> ". . . we must be ever mindful that our regulatory climate must nurture productive research and innovation and that we must create and maintain incentives for the drug

industry to carry on vital research and development."[63]

It is the pharmaceutical firms that discover, develop, and expand our knowledge about pioneer new drugs to which the poor and the elderly must look for all future innovation in drug therapy. The generic firms who are pushing for quicker approval of generic copies of pioneer new drugs engage in only a trivial amount of drug development, largely related to copying pioneer new drugs. They have not developed a single break-through drug or made any major contribution to today's therapeutic armamentarium.

Immediate approval of generic copies of important pioneer new drugs will undoubtedly increase the profits of generic drug manufacturers. In the short term, such action may also save consumers a few dollars here and there, although that is by no means assured. But whatever short-term savings may be achieved will come at an enormous long-term cost to the public in terms of reduced pharmaceutical research, fewer new medicines in the future, and ultimately higher prices because of the new product competition that is deferred. If we are to pursue a strong public health policy in this country, it must be based upon adequate incentives for new drug research. Focusing solely upon short term lower prices -- a "cheap

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[63] "Drug Regulation Reform -- Oversight," Hearing Before the Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, House of Representatives, 96th Cong., 2d Sess. 1 (1980).

drugs" policy -- will inevitably reduce research and hinder our public health efforts.

It has been well-documented and has become well-recognized that, by any yardstick, the new regulatory requirements imposed upon the pharmaceutical industry by the Drug Amendments of 1962 have had a major adverse impact on drug innovation in the United States. The average yearly number of new chemical entity (NCE) drugs approved by FDA during the 1950s was more than twice the average yearly number approved by FDA in the two decades since then.[4] The cost of developing a single approved NCE drug has arisen more than ten-fold in 20 years, far outstripping the increase in pharmaceutical research. Thus, there has been an overall reduction of 81 percent in the number of NCE drugs entering human testing in 1975-1979 as compared with 1958-1962.[5]

This increase in regulatory requirements can be seen throughout the drug development process -- from preclinical research, through clinical investigation, to final NDA review. The 1980 report of the House Committee on Science and Technology found that preclinical research can consume 1-4 years,

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[4] "Health and the Environment: Miscellaneous -- Part 2," "Hearing before the Subcommittee on Health and the Environment, Committee on Energy and Commerce, House of Representatives, 97th Cong., 1st Sess. 292 (1981).

[5] May, Wardell, & Lasagna, New Drug Development During and After a Period of Regulatory Change: Clinical Research Activity of Major United States Pharmaceutical Firms, 1958 to 1979, 33 Clin. Pharmacol. & Ther. 691 (June 1983).

clinical investigation 4-6 years, and NDA review 2-3 years.[66] The investment in time, effort, and money to surmount these regulatory requirements is staggering.

PMA does not oppose valid requirements to demonstrate the safety and effectiveness of pioneer new drugs. It is readily apparent however, that there must be sufficient economic incentive for new drug research in order to overcome these regulatory disincentives. Where purely economic issues are involved -- as contrasted with health and safety requirements -- every effort should be made to encourage pharmaceutical research to the maximum extent feasible.

H.R. 3605 as drafted does exactly the opposite. In an area that does not involve health and safety issues, it nonetheless strives to reduce economic incentives for important pharmaceutical research still further. Without any public health justification, it undermines the foundation for today's efforts to find therapeutic answers to our most disabling diseases.

PMA urges that Congress forthrightly recognize that it is time to build more incentives for pharmaceutical research into the FD&C Act, not to take them away. It is time to recognize that, if pioneer pharmaceutical companies are to continue their research, they must be given the assurance of

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[66] "The Food and Drug Administration's Process for Approving New Drugs," Report of the Subcommittee on Science, Research and Technology of the Committee on Science and Technology, House of Representatives, 96th Cong., 2d Sess. 13 (1980).

an adequate period of protection of the fruits of their research investment in order to justify that investment. Only in this way can the public health and the public interest truly be advanced.

There is an old saying that "you get what you pay for." If Congress and the American public are unwilling to make a substantial investment in new drugs, they will get very little in return. Innovation will dry up. Only if Congress and the public are willing to pay for new drug research, through an adequate profit on pioneer new drug products, will the productive pharmaceutical enterprise in this country continue to provide the kind of products that have brought such a dramatic improvement in our health in the past 30 years.

B. Permitting Generic Competitors On the Market Immediately After Approval of a Pioneer NDA Would Reduce Professional Education and Surveillance of the New Drug in the Marketplace and Thus Diminish Public Health Protection and Reduce the Incentive for Research to Expand the Medical Application of New Drugs After Approval. It is well-understood that not all adverse reactions and other safety information can be obtained from animal studies and clinical investigation.[67] The ultimate test of the safety of a drug must come when it is marketed in much larger and more diverse population groups after FDA approval of the pioneer NDA.

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[67] Lasagna, Postmarketing Surveillance of Drugs (1977); Joint Commission on Prescription Drug Use, Final Report (1980).

Recognizing this fact, there has been a major increase in various forms of postmarket surveillance (PMS) of approved pioneer new drugs in the past several years. A small portion of this PMS activity has formally been required by FDA pursuant to regulatory authority. Most of it has been voluntarily undertaken by the manufacturers of the pioneer drugs.

These PMS activities have ranged from new clinical studies, to intensive investigation of discrete patient populations, to broad surveillance of a randomly selected portion of patients receiving the drug.[**] They have provided valuable information, on the basis of which FDA has made better postmarketing regulatory decisions.

Generic manufacturers seldom conduct PMS activities on the drugs they make. The function of the generic manufacturer is to deliver the cheapest possible drug, long after the safety and effectiveness of that drug has been fully explored and physicians know all the available information about it.

The scope and timing of this statement does not allow us to present here the extended process by which a new drug is first approved for one or only a few uses and then is a subject of continuing research by the NDA holder for a number of years. This process leads to new understanding and frequently to new uses in diseases and conditions not the subject of the original approval.

[**] Id.

The need for a period of exclusive marketing is therefore not simply a matter of adequate economic incentives for drug research. It also has important ramifications for assuring the safe and effective use of the pioneer drug during its first several years of marketing.

C. There Has Not Been and Will Not Be Any So-Called "Duplicative Human Research" If An Adequate Period of Exclusive Marketing is Established for Pioneer New Drugs. Generic drug firms have tried to disguise their purely economic motives in this legislation by arguing that, if a period of years is specified before FDA may approve generic copies of pioneer new drugs, "duplicative research" will have to be undertaken during that period for generic competitors to get on the market. This is a false issue.

The pharmaceutical industry knows of no instance, since 1938, where a generic manufacturer has conducted the full testing necessary to duplicate a pioneer new drug in order to obtain FDA approval of that drug and compete fairly with the pioneer manufacturer in the marketplace. It simply has not happened, because generic manufacturers do not do research on previously-approved pioneer new drugs. They simply manufacture these drugs as cheaply as they can. They will wait until they can get a free ride, and will never do the necessary clinical testing, because that would require them to make the same investment as the pioneer manufacturer. Generic manufacturers compete only on the basis of price, not on the basis of science.

Some have posed this "retesting" argument as a safety concern by asserting that the test population might be denied a safe and effective medication during the generic manufacturer's testing of its copy of the pioneer new drug. This is simply incorrect. FDA permits the use of an active control precisely where the use of a placebo would be unethical because of the existence of a safe and effective therapeutic agent.[**]

Finally, the argument that "retesting" is contrary to public policy does not acknowledge the continuing research efforts of NDA sponsors on already approved drugs which is supported and frequently urged by FDA. It is through this continuing research and testing that additional information is learned about approved products.

Accordingly, there is no health or safety reason to support the use of ANDAs.

IV. Six Essential Elements Must Be Included In Any Effective Legislation Establishing the Conditions Under Which FDA May Approve Generic Copies of Pioneer New Drugs

From the above discussion, it is apparent that this matter goes far beyond the provision relating to ANDAs set out in H.R. 3605. It must, in addition, establish all of the

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[**] 21 C.F.R. 314.111(a)(5)(ii)(a)(4)(iii) ("Active treatment control" allowed where "no treatment or administration of a placebo would be contrary to the interest of the patient.").

conditions regarding FDA approval of ANDAs and paper NDAs, changes in the pioneer NDA after it has been approved, the use and release of confidential safety and effectiveness data, an adequate term of years before FDA may approve generic copies of pioneer new drugs to assure a strong incentive for drug research in the United States, and the prohibition of FDA approval of a generic copy while there is a valid unexpired patent for the pioneer new drug.

Each of these six elements requires substantial discussion and in-depth Congressional inquiry before any ANDA program can be considered. Many are interdependent, and their precise resolution therefore depends on how the others are handled. Particularly because this proposed legislation has been brought up so quickly, without adequate time for consideration, it is not feasible to suggest in detail how each might best be resolved. It is sufficient to recognize, at this time, that all must be resolved directly and in detail in any new legislation on this subject, and to consider in broad scope the way that they should be approached.

A. The Conditions for an ANDA. It is essential that any new legislation amend the FD&C Act to establish the criteria and procedures for FDA acceptance and approval of ANDAs for generic copies of pioneer new drugs.

The FD&C Act should be amended to include the criteria under which ANDAs would be approved. These criteria would include determinations by FDA that the drug substance

has become generally recognized as safe and effective as a generic entity, that the drug substance has been used to a material extent or for a material time and in any event for a specified minimum period of years, that a full NDA is no longer necessary to assure safety and effectiveness, that any relevant patent has expired (or been declared invalid or unenforceable), and that the drug has been listed by FDA as suitable for an ANDA. FDA should then be required to issue general procedural regulations establishing the process by which ANDAs would be handled by the Agency. Such regulations should require all ANDAs to include complete manufacturing information, proposed labeling, and bioavailability data. Clinical studies would be required to demonstrate the safety and effectiveness of a drug product when there was no validated bioavailability test method.

The FD&C Act should require FDA to establish, by informal rulemaking, a list of established prescription drugs for which ANDAs would be suitable. Drugs meeting the statutory criteria could be added to that list on the initiative of FDA or as a result of the petition of any interested person. Proposals would be published in the Federal Register as notices of proposed rulemaking for public comment.

It is essential to include provision for development of appropriate labeling and bioavailability assay methods. FDA guidelines on these matters should be required to be made a part of the rulemaking record, so that comment can be submitted on them by all interested persons.

The FD&C Act should provide that FDA would accept and process ANDAs as soon as the final regulation was promulgated adding the drug to the ANDA list. At this time, final labeling and bioavailability assay methods would have been established.

Such a system would extend the principles of the present ANDA system to cover post-1962 new drugs. It would ensure that generic copies of pioneer new drugs are approved and ready for marketing as soon as feasible after an appropriate period for exclusive marketing and the expiration of relevant patents.

The proposed administrative procedure for ANDAs is the simplest that affords any meaningful opportunity for prior notice and public participation. A proposal to accept ANDAs, in accordance with the statutory criteria, is essential in order to allow public participation in the regulatory process. At the same time, it would require only informal notice-and-comment rulemaking and would not require formal procedures.

The notice proposing to add a drug to the list of products suitable for ANDAs would be less detailed than the drug efficacy study implementation (DESI) notices that establish conditions for ANDAs for pre-1962 drugs under current FDA procedures. It would consist simply of the statement that FDA proposed to add a drug (or a particular use of a drug) to a list of drugs for which ANDAs could be submitted and a description of how the statutory criteria have been satisfied. Detailed requirements for labeling, bioavailability test

methods, and other scientific prerequisites for ANDAs would be set out in guidelines included in the rulemaking record. In accordance with FDA regulations, such guidelines would be exempt from rulemaking procedures although they would be subject to public comment and would be binding on the Agency until they were explicitly modified. Such a procedure would give both the pioneer manufacturer and the generic manufacturer clear notice of the information required for approval of ANDAs and ample opportunity to provide comment.

This procedure is entirely consistent with the Agency's longstanding administrative interpretation of the new drug provisions of the FD&C Act. Under the statute, a drug remains a new drug until it becomes generally recognized safe and effective and, in addition, has been used to a material extent or for a material time. FDA takes the position that general recognition of safety and effectiveness requires the same quantity and quality of safety and effectiveness data as an NDA and must be based upon publicly available data and information.[78] As discussed fully above, there are important health and safety reasons, as well as economic justification, for these requirements. Until a drug has been used sufficiently in medical practice, the full range of its safety and effectiveness cannot be determined. Accordingly, it is sound public policy to require that FDA determine that a drug, as a

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[78] Note 18 supra.

generic entity, is no longer a new drug, before an ANDA will be accepted for it.

B. The Conditions for a Paper NDA. It is equally essential to include in the FD&C Act the criteria and procedure for FDA acceptance and approval of paper NDAs.

The FD&C Act should require that the same quantity and quality of animal and human studies on the safety and effectiveness of a pioneer new drug for a paper NDA as for a full NDA, except that the paper NDA could be based in part or in whole upon adequate published literature. No paper NDA should be permitted during a specified minimum statutory period or before any relevant patent has expired (or been declared invalid or unenforceable).

FDA should be required to issue regulations establishing the procedure under which paper NDAs would be approved by FDA for generic versions of pioneer new drugs. It would not be necessary to establish a list of drugs for which paper NDAs are appropriate, but the same information on bicavailability, labeling, and manufacturing should be required in paper NDAs as in ANDAs. As with ANDAs, the statutory amendments would assure adequate protection of the public health while at the same time permitting adequate public literature to substitute for a company's own testing.

It is likely that, with the establishment of ANDA procedures for post-1962 pioneer new drugs, the use of paper NDAs would substantially diminish. It is entirely possible,

however, that there would be circumstances where a paper NDA would be submitted before FDA concluded that it was appropriate to add the drug to the list of products suitable for ANDAs generally. Thus, the FD&C Act should be amended to establish clear criteria for these forms of NDAs.

Thus far, FDA has declined to issue general procedures governing the handling of paper NDAs, relying instead upon ad hoc notices, letters, and decisions. The FD&C Act should be amended to require that all of the criteria and procedures for the acceptance, review, and approval of paper NDAs be established in regulations on which the public has an opportunity for comment. Such matters as the criteria for determining the adequacy of published literature, the need for the availability of raw data, and verification of compliance with good laboratory practices, are of fundamental importance to this entire procedure and should be established by informal rulemaking.

The approach outlined above is both consistent with the current statutory structure and FDA's administrative approach to paper NDAs. Like the ANDA procedure, it is designed to ensure the proper use of published studies on safety and effectiveness of pioneer new drugs while recognizing the need to protect public health and safety and provide adequate economic incentive for pharmaceutical innovation in this country.

C. The Conditions for Substantial New Indications, Dosage Forms, Manufacturing Procedures, and Other Changes. The FD&C Act must be amended to adopt FDA's current policy that neither an ANDA nor a paper NDA incorporates subsequent substantial changes made in the pioneer NDA.

Quite frequently, major changes occur in a new drug after initial FDA approval of the pioneer NDA. Some of these changes can be accomplished through supplemental NDAs but others can require a new full NDA. Such changes include new indications, new dosage forms, and new methods of manufacture. Each of these major changes requires the same investment by the pioneer drug manufacturer, and potentially raises the same health and safety questions, as the initial marketing of the drug. Thus, any major change of this nature must be made subject, by statute, to the same conditions for ANDAs and paper NDAs as the initial pioneer NDA itself.

If, for example, a new drug approved to treat disease A is proved by the pioneer manufacturer fifteen years later to be safe and effective for an entirely different disease B, an ANDA or paper NDA for disease A should not be permitted to include disease B unless and until the statutory and administrative criteria for extension of the ANDA or paper NDA to disease B have been found fully applicable. Thus, the pioneer manufacturer would be entitled to the same minimum statutory period before FDA could approve generic copies for the new indication as it received for the initial indication.

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If this were not required, there would be no incentive whatever for pioneer drug manufacturers to conduct studies on important new indications of previously-marketed new drugs. FDA has long urged drug manufacturers to conduct studies on unapproved uses of approved new drugs, in order to assure that approved drug labeling keeps up with current medical practice.[71] No pioneer manufacturer could responsibly comply with that FDA request if generic competitors could immediately take the result of that research, without making a commensurate investment, and include it in their own labeling.

Nor would making this information immediately available to generic competitors be consistent with FDA's own concern about the public health and safety. Major new indications, dosage forms, and manufacturing procedures, require a period of close surveillance in the marketplace for potential adverse effects or other problems before they should be made broadly available to the generic drug industry. Thus, the same statutory requirements for an ANDA or paper NDA should apply equally to substantial changes in a pioneer new drug.

D. Prohibition of the Use/Public Release by FDA of Non-Public Safety and Effectiveness Data in the Pioneer NDA. The FD&C Act must be amended to confirm FDA's longstanding interpretation of the law that prohibits public use or disclosure of safety and effectiveness data in the pioneer NDA if those data have not previously been made public.

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[71] 37 Fed. Reg. 16503 (August 15, 1972).

Such data are of enormous economic value. They represent literally millions of dollars of investment by a pharmaceutical company. They are one of the most important property rights owned by the company. The FD&C Act should make clear that this property cannot be given away to generic competitors by FDA.

To the extent that pioneer pharmaceutical companies themselves publish these studies, the studies enter the public domain and may freely be disseminated and used. For example, such public information may be used in support of a paper NDA, after an appropriate period of exclusive marketing. To the extent that companies choose to retain such information as confidential, however, FDA cannot be permitted to destroy their property value.

Such data are of major importance abroad, where patent laws differ from those in the United States or simply do not exist at all. Making these valuable safety and effectiveness data publicly available could have major adverse economic consequences for the American pharmaceutical industry abroad.[72]

There is, of course, no difference between making such data publicly available, allowing generic competitors to

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[72] "Drug Regulation Reform Act of 1978," Hearings Before the Subcommittee on Health and Scientific Research, Committee on Human Resources, United States Senate, 95th Cong., 2d Sess. 299-307 (1978).

refer to it, or FDA using the data on its own initiative to approve a generic competitor's NDA. In all three instances, the pioneer drug company's property has been taken from it and given to others. No pharmaceutical firm can responsibly continue to make investments if those investments are then to be redistributed by the government to its generic competitors.

In the recent case of Monsanto Co. v. EPA, indeed, the United States District Court for the Eastern District of Missouri has declared this type of practice unconstitutional.[73] Prior to 1972, the pesticide registration provisions of the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) were interpreted and applied in exactly the same way as the NDA provisions under the FD&C Act. No safety or effectiveness data were used or released without the explicit consent of the original registrant. Consistent with this pre-1972 nonuse and non-disclosure policy, USDA (EPA's predecessor) had developed a list of compounds with respect to which there were adequate publicly-available data to support registrations without referring to confidential company submissions. This pre-1972 pesticide system was directly comparable to the way in which FDA presently handles paper NDAs and the way that it has handled pre-1962 ANDAs based upon "old drug" determinations.

Starting in 1972, Congress amended FIFRA to provide a means for EPA to issue new pesticide registrations for

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[73] Note 59 supra.

generic products in reliance on previously-submitted confidential data, without obtaining the consent of the owner of the confidential data. For some pesticide products, FIFRA provides mandatory monetary compensation to the owner of the data. Nonetheless, in the recent Monsanto case the court overturned the entire statutory structure as an unconstitutional taking of property without the adequate compensation guaranteed by the Fifth Amendment to the Constitution. The court ordered EPA to reinstate the pre-1972 approach.

In reaching this decision, the court determined that a company has a legitimate property right in the safety and effectiveness data it generates on pesticides, that this property right is separate from whatever patent protection the company may have, that the government was "taking" that property by permitting generic competitors to rely on the confidential data for their own approvals, and that Congress had not adopted an adequately-protected system of compensation for the taking. The court specifically held that there was no difference between making the confidential data public and using the confidential data to approve another company's registration for a generic product.

The applicability of the Monsanto decision to post-1962 ANDAs is readily apparent. The FD&C Act must make clear that, as has long been the FDA interpretation, confidential safety and effectiveness data may not be used by the Agency for a generic competitor or publicly disclosed.

E. A Reasonable Period of Years Before Any Generic Copy May Be Approved. The FD&C Act must be amended to provide that no ANDA, paper NDA, or other form of application for a generic copy of a pioneer new drug, may be approved by FDA prior to a reasonable period of years.

Every group that has reviewed this issue has come to the inescapable conclusion that such a period prior to permitting generic copies is essential for both the safety reasons and the economic considerations already discussed fully above. The Democratic Administration initially suggested a period of five years before approving generic copies in the 1978-1979 legislation, and then agreed with the seven years included in the legislation passed by the Senate in 1979. This Subcommittee has concluded that seven years is an appropriate period in the Orphan Drug Act. Representatives of the pharmaceutical industry have argued that a minimum of ten years constitutes an appropriate period. The FDA Bureau of Drugs has recently concluded that this should be 15 years.

F. Prohibition of FDA Approval of A Generic Copy of a Pioneer New Drug in Violation of a Valid Unexpired Patent. The FD&C Act must be amended to prohibit FDA from approving any generic copy of a pioneer new drug while a valid patent remains unexpired for that pioneer new drug.

FDA has a legitimate interest in declining to approve ANDAs or paper NDAs for drugs that are subject to valid unexpired patents. The policy of the United States, as

expressed both in the Constitution[74] and the federal patent law,[75] is to encourage invention by protecting for a fixed period the fruits of an inventor's labors. It is consistent with that constitutional and statutory policy for FDA to refuse to approve drugs that would infringe patents.

There is also a narrower regulatory interest for prohibiting FDA from approving ANDAs or paper NDAs for patented drugs. FDA's resources for reviewing and approving such applications are limited, and it is wasteful to expend them on applications for drugs that cannot lawfully be marketed. A procedure under which ANDAs and paper NDAs would not be approved for patented drugs would be comparable to the "early warning system" developed by FDA's Bureau of Drugs, under which staff work is suspended on ANDAs for drugs for which the Agency has initiated proceedings to withdraw approval.[76]

This would not require FDA to become embroiled in disputes about the validity or applicability of patents. On the well-established principle that patents are presumed to be valid,[77] the procedure would require FDA to refrain from approving generic copies of pioneer new drugs whenever it

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[74] Article I, Section 8.

[75] 35 U.S.C. 1 et seq.

[76] Washington Drug Letter, March 23, 1981, at 4.

[77] 35 U.S.C. 282.

received a notification that a drug or drug use was subject to an unexpired patent.

Persons who wished to contest the validity of the patent, or the applicability of the patent to the use of the drug for which generic approvals were proposed, could institute actions in the courts for declaratory judgments,[78] or, in appropriate cases, could take advantage of recently-enacted procedures for administrative reexamination of the issuance of patents by the Patent Office.[79] In short, generic manufacturers could still seek administrative or judicial determination that an existing patent was invalid. If they were successful, ANDAs or paper NDAs could then be obtained, assuming that all of the other applicable criteria were met. They would not, however, be permitted to obtain approval in the face of a valid unexpired patent.

The FD&C Act should therefore provide that, when an NDA for a patented new pioneer drug is first submitted to FDA, it must contain information on the patent status of the drug, including the dates on which any relevant patents expire. That information would be included in the summary basis of approval released by FDA after the NDA was approved. FDA could use the existing authority in Section 702(c) of the FD&C

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[78] E.g., Sherwood Medical Industries, Inc. v. Deknatel, Inc., 512 F.2d 724 (8th Cir. 1975).

[79] 35 U.S.C. 201-307.

Act to verify the patent status of the product. A pioneer drug could be listed as suitable for an ANDA prior to expiration of the patent, but no ANDA or paper NDA could be approved until the patent expired.

The FD&C Act should also explicitly recognize the recent decision in Pfizer, Inc. v. International Rectifier Corp.,** where the court held that a generic drug manufacturer may not make a patented drug even for investigational purposes to obtain data for submission of an ANDA to FDA prior to expiration of the patent. In that case, the court ordered the withdrawal of the ANDA because it was based upon testing of a product manufactured in violation of the patent. Accordingly, the FD&C Act should prohibit FDA from considering any scientific testing, as part of an ANDA or paper NDA, if it was conducted in violation of a valid unexpired patent.

V. Conclusion

These matters are extraordinary complex. They require very detailed consideration of intricate questions of economics, drug safety and public policy by the Subcommittee before legislative action is taken. PMA is willing and eager to work with the Subcommittee in developing fair and responsible legislation in this area.

** Note 62 supra.

DRUG ABUSE: QUAALUDES

MONDAY, OCTOBER 3, 1983

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, D.C.

The subcommittee met, pursuant to call, at 9:55 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will please come to order.

This morning the subcommittee will receive testimony on legislation to tighten Federal controls on the availability of the drug "methaqualone."

I suspect few—outside the medical profession—have heard of this drug. Yet its brand name—Quaalude—is well known within the drug culture.

It is a member of a large class of sedative-hypnotics used to promote drowsiness and sleep. It is also a highly abused street drug valued for its heroin-like effects and availability by prescription.

Currently, methaqualone is subject to the tightest Federal controls still permitting a drug's availability by prescription. In spite of these controls, it is a leading cause of drug-related death and injury.

The illicit use and abuse of methaqualone is promoted by two factors. First, sophisticated international drug trafficking networks promote sales of counterfeit versions of the brand name drug. The second are so-called stress clinics, staffed by physicians, who prescribe the real thing to anyone with the cash to buy a prescription.

Although our hearing will address only the availability of the drug by prescription, the demand for methaqualone within the illicit market is strongly influenced by the actions of script doctors and the availability of Quaaludes as a pharmaceutical. Obviously, the manufacture of counterfeits reflects strong street demand for the brand name product.

Our first witnesses this morning will be Representatives Roy Rowland and Larry Smith. Both are House leaders in the fight against drug abuse. They have closely examined this issue as State legislators and were instrumental in securing passage of legislation to ban methaqualone in their home States of Georgia and Florida. I am particularly grateful for their leadership in bringing this issue to the subcommittee's attention.

We will also hear from other individuals active in these State efforts to ban methaqualone. The subcommittee looks forward to

learning about these State experiences in order to determine whether a nationwide ban is warranted.

H.R. 1055 and H.R. 1097 propose to place methaqualone within schedule I of the Controlled Substances Act. These bills propose a finding of Congress that the abuse potential of this drug far outweighs its therapeutic value.

For the Congress to take this action it must carefully weigh the benefits of the drug against its societal consequences. It must determine whether the drug possesses unique clinical advantages over other available hypnotics.

I look forward to learning about the motivation behind these Georgia and Florida bans and their impact on medical practice, the demand for methaqualone on the illicit market, and methaqualone-related deaths and injuries.

Before beginning I want to note that the subcommittee extended an invitation to present testimony this morning to the Lemon Co., the licensed distributor for methaqualone, and the American Medical Association. Although both organizations declined to appear, I understand written statements will be submitted for the record and without objection those written statements will be made a part of the record when we receive them. [See pp. 230, 255.]

[The text of H.R. 1055 and H.R. 1097 follows:]

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98TH CONGRESS
1ST SESSION

H. R. 1055

To place methaqualone in schedule I of the Controlled Substances Act.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 27, 1983

Mr. SMITH of Florida introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To place methaqualone in schedule I of the Controlled Substances Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That methaqualone is transferred from schedule II of section 202 of the Controlled Substances Act (21 U.S.C. 812) to schedule I of that section.

SEC. 2. This Act shall take effect on the expiration of the thirty-day period beginning on the date of the enactment of this Act.

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98TH CONGRESS
1ST SESSION

H. R. 1097

To place methaqualone in schedule I of the Controlled Substances Act, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 31, 1983

Mr. ROWLAND (for himself, Mr. LELAND, Mr. JENKINS, Mr. BARNARD, Mr. FOWLER, Mr. LEVITAS, Mr. THOMAS of Georgia, Mr. RAY, Mr. MCDONALD, Mr. HATCHER, and Mr. GINGRICH) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To place methaqualone in schedule I of the Controlled Substances Act, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That methaqualone is transferred from schedule II of section 202 of the Controlled Substances Act (21 U.S.C. 812) to schedule I of that section.

SEC. 2. This Act shall become effective upon the expiration of the sixth-month period beginning on the date of enactment of this Act.

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Mr. WAXMAN. Our first two witnesses this morning are our congressional colleagues and authors of Federal legislation to reschedule methaqualone nationwide. Each was active in his respective State legislature in securing a ban on the statewide distribution of this drug. Roy Rowland is a physician by training and represents Georgia's Eighth District. Larry Smith is an attorney representing Florida's 16th District. I welcome both of you to our hearings today and express my appreciation for your efforts in bringing this serious issue to the attention of our subcommittee.

STATEMENTS OF HON. J. ROY ROWLAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA, AND HON. LARRY SMITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. ROWLAND. Thank you very much, Mr. Chairman and members of the subcommittee. I appreciate this opportunity to discuss with you my personal experience in prescibing the drug "methaqualone" and my reasons for introducing H.R. 1097 which would move this drug from schedule II to schedule I of the Controlled Substances Act.

Prior to my election to Congress, I was in private practice in family medicine in Dublin, Ga. About 15 years ago I had the experience of prescribing methaqualone for a very brief period of time, about 6 months, and I stopped prescribing it because I noticed that many of the people that I was prescribing this medication for, particularly the elderly people, were experiencing undesirable side effects such as mental confusion and agitation. I also learned after a month or two that people were coming back more often to get their prescriptions refilled than was really necessary. There are other more suitable drugs that we could use for sleep and sedation than this such as Dalmane and chloral derivatives, and these do not have the undesirable side effects that methaqualone had.

After my experience with prescribing methaqualone I was unaware of the increased prescribing and abuse until I became a member of the Georgia General Assembly. It seemed that in a relatively brief period of time methaqualone had become a drug of choice of the underground drug culture.

It did not take long for the drug abusers to realize that the use of Quaalude potentiates the effect of other drugs, particularly alcohol and the tricyclic depressants. Alcohol and the methaqualone act synergistically. They are both central nervous system depressants. They result in a loss of motor activity and impaired mental acuity. They were used together often with a dramatic increase in the number of automobile injuries and fatalities that were attributed to this combination.

In addition in the State of Georgia, particularly in the Atlanta area, so-called stress clinics sprung up around town, where people could walk in off the street, complain of sleeplessness or being under stress, and after a perfunctory-type examination receive prescriptions for methaqualone, and of course at a price. They were profitable for the entrepreneurs who became involved in this activity.

I began to talk with some doctors in and out of the general assembly about this problem. I talked to the State board of medical examiners, and it seemed that these clinics were operating just barely within the letter of the law, and the Georgia Bureau of Investigation and the State medical board were having a very difficult task in trying to deal with this so-called legally prescribed methaqualone by these unethical physicians.

The frustrated efforts caused the secretary of state to talk with me about the possibility of transferring this drug from schedule II to schedule I on a State basis, and with the support of the Medical Association of Georgia, and the secretary of state's office, I introduced legislation to move this drug from schedule II to schedule I.

Legislation passed in February 1982. We adopted a new constitution in Georgia in November 1982 and the legislation did not become effective until after that constitution was adopted. However, in that period of time, from the time it was enacted until it became effective in November, there was a 40-percent drop in methaqualone-related emergencies such as overdoses that were being taken care of in emergency rooms in the Atlanta area.

Unfortunately, solving this problem on a statewide basis only resulted in the movement of these stress clinics to other States. As a matter of fact, after Georgia and Florida passed these laws to ban methaqualone, the biggest operators apparently moved to Chicago. I understand that just recently the Governor of Illinois has signed into law legislation banning methaqualone in that area, and I was told just last week that Texas also dealt with the problem in the same manner by passing legislation to ban methaqualone. These clinics simply move to another area. They move out of the State where the legislation has been passed and move to another area.

Mr. Chairman, this is a unique situation in that there are businesses that set up specifically for the prescribing of one drug, and these stress clinic doctors are prescribing this drug for the treatment of so-called stress disorders and sleeplessness, and according to the American Medical Association, there is really no need for this drug at all at this time.

According to the AMA's most recent statement on methaqualone, there is only one disease that it should be considered for, porphyria, and that is apparently an extremely rare disease. In over 30 years of medical practice I do not recall ever having seen a patient that had porphyria. In fact in checking on it, there are 80 congenital cases of porphyria that have been reported in the United States. Potential side effects and potential abuse of this drug far outweigh any justification for prescribing methaqualone for porphyria when there are other suitable drugs that can be used.

There is simply no reason to keep methaqualone as a schedule II drug. I am also greatly concerned that since it is still a legal drug it will lend legitimacy to the drug and it will result in a proclivity in our young people, since it is, to seek this drug more often than they would otherwise. The line between legitimate and illicit methaqualone is very thin indeed. The ease with which an individual can obtain legal Quaaludes; become addicted; then move on to illicit sources, certainly perpetuates the demand on the black market suppliers.

I know the U.S. Drug Enforcement Administration has made great strides in stemming the flow of illegal methaqualone into this country. And I am aware that the prescription writing of Quaalude represents a small part of a much larger drug problem. But it would be negligent and short-sighted not to take this small step to curb the methaqualone abuse problem. Eliminating the prescription supply may well have an indirect effect of reducing the demand for the black market Quaaludes. There is absolutely no reason whatsoever for keeping this drug on the market.

DEA has already substantially reduced the annual quota for methaqualone. It is not manufactured in this country. The powder is brought from outside and the tablets are compressed here. Most physicians and many pharmacists have quit prescribing and dispensing the drug. The only people using the drug that have voiced any opposition to this bill are those who are abusing it.

As I understand the process for reclassifying a controlled substance, the Food and Drug Administration must make recommendations to the Attorney General to do so. The FDA has taken no action to move methaqualone from schedule II to schedule I, since apparently there is still legitimate prescribing of the drug in the country.

The main distinction between the criteria used to classify drugs in schedule I and II is whether there is any accepted medical use in treatment. It seems that there are insufficient guidelines for the FDA to use in discerning legitimate as opposed to profit-related acceptance of a drug by the medical community. In order for methaqualone to be rejected for movement into schedule I, it is only necessary that there exists an accepted medical use in treatment of the drug.

To take this line of reasoning one step further, I am convinced that a drug need only be manufactured or distributed in the United States, and not originally placed on schedule I by the Congress, in order for it to be considered medically acceptable.

Apparently in 1974, the DEA had no reservations about recommending to the FDA that a drug which is virtually indistinguishable in its pharmacology from methaqualone be placed in schedule I. This drug, mecloqualone, is the only depressant listed in schedule I. It also is a hypnotic/sedative compound, but the distinction held by mecloqualone is that it has never been legally manufactured or distributed in this country.

Mr. Chairman, in light of FDA's reluctance to recommend the reclassification of methaqualone, even in the presence of overwhelming evidence that this is a dangerous drug no longer recommended for treatment in the medical community, I hope this subcommittee will see fit to favorably remand this legislation to the full committee.

It would be truly unfortunate if the Congress does not continue to exercise its role, as stated in the Controlled Substances Act, and that is to combat drug abuse.

Thank you very much, Mr. Chairman.

[Mr. Rowland's prepared statement follows:]

STATEMENT OF REP. J. ROY ROWLAND

BEFORE THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT RECLASSIFICATION OF METHAQUALONE (H.R. 1097/H.R. 1055)

OCTOBER 3, 1983

MR. CHAIRMAN. MEMBERS OF THE SUBCOMMITTEE. I APPRECIATE THIS OPPORTUNITY TO DISCUSS MY PERSONAL EXPERIENCE IN PRESCRIBING THE DRUG METHAQUALONE AND MY REASONS FOR INTRODUCING H.R. 1097...A BILL WHICH WOULD MOVE THIS DRUG FROM SCHEDULE II TO SCHEDULE I OF THE CONTROLLED SUBSTANCES ACT.

PRIOR TO MY ELECTION TO THE CONGRESS, I WAS IN PRIVATE PRACTICE IN FAMILY MEDICINE IN DUBLIN, GEORGIA. ABOUT 15 YEARS AGO, I VERY BRIEFLY PRESCRIBED METHAQUALONE FOR PATIENTS OF MINE WHO WERE HAVING DIFFICULTY SLEEPING. DURING A SHORT PERIOD OF TIME, I NOTICED THAT MANY OF THOSE WHO WERE TAKING THIS MEDICATION, PARTICULARLY THE ELDERLY, WERE EXPERIENCING UNACCEPTABLE SIDE EFFECTS SUCH AS MENTAL CONFUSION AND AGITATION. I ALSO NOTICED THAT THERE WERE A NUMBER OF REQUESTS FOR REFILLS MORE OFTEN THAN WAS NECESSARY.

SINCE THERE WERE, AND ARE, OTHER SUITABLE DRUGS FOR TREATMENT OF SLEEP PROBLEMS, I.E. DALMANE AND CHLORAL DERIVITIVES, THAT DO NOT HAVE THESE UNDESIRABLE SIDE EFFECTS, I STOPPED PRESCRIBING METHAQUALONE COMPLETELY WITHIN 6 MONTHS AFTER FIRST USING IT.

AFTER MY EXPERIENCE WITH PRESCRIBING METHAQUALONE, I WAS UNAWARE OF THE INCREASED PRESCRIBING AND ABUSE UNTIL I BEGAN SERVING IN THE GEORGIA GENERAL ASSEMBLY OF THE STATE OF GEORGIA. IT SEEMS THAT WITHIN A RELATIVELY BRIEF PERIOD, METHAQUALONE OR "QUAALUDE" HAD BECOME A DRUG OF CHOICE IN THE UNDERGROUND DRUG CULTURE.

IT DID NOT TAKE LONG FOR DRUG ABUSERS TO REALIZE THAT THE USE OF QUAALUDE POTENTIATES THE EFFECTS OF OTHER DRUGS -- PARTICULARLY ALCOHOL AND TRICYCLIC ANTIDEPRESSANTS. SINCE ALCOHOL AND METHAQUALONE BOTH ACT AS CENTRAL NERVOUS SYSTEM DEPRESSANTS, RESULTING IN A LOSS OF MOTOR COORDINATION AND IMPAIRED MENTAL ACUITY, THERE WAS A DRAMATIC INCREASE IN THE NUMBER OF AUTOMOBILE INJURIES AND FATALITIES THAT WERE ATTRIBUTED TO THIS COMBINATION.

IN ADDITION, IN THE STATE OF GEORGIA, PARTICULARLY IN THE ATLANTA AREA, SO-CALLED "STRESS CLINICS" HAD SPRUNG UP AROUND TOWN WHERE A PERSON COULD JUST WALK IN OFF THE STREET; COMPLAIN OF SLEEPLESSNESS OR STRESS; SUBMIT TO A PERFUNCTORY EXAM; AND WALK OUT IN JUST A FEW MINUTES WITH A PRESCRIPTION FOR METHAQUALONE -- AT A PRICE, OF COURSE. THESE ARE VERY PROFITABLE ENTERPRISES.

AT THIS TIME, I STARTED TALKING WITH OTHER DOCTORS, IN AND OUT OF THE GENERAL ASSEMBLY, AND ALSO DISCUSSING THIS PROBLEM WITH THE STATE BOARD OF MEDICAL EXAMINERS. IT SEEMS THAT THE STRESS CLINICS WERE OPERATING BARELY WITHIN THE "LETTER OF THE LAW," BUT ENOUGH SO THAT PROSECUTION OF INDIVIDUAL PHYSICIANS WAS A NEARLY IMPOSSIBLE TASK. IN ORDER TO PROSCECUTE AN UNETHICAL PHYSICIAN, IT MUST BE PROVEN THAT THE DOCTOR IS ACTING OUTSIDE OF HIS MEDICAL PRACTICE.

I LEARNED OF THE FRUSTRATED EFFORTS OF BOTH THE STATE BOARD AND THE GEORGIA BUREAU OF INVESTIGATION TO STOP THIS UNETHICAL ACTIVITY. WITH THE SUPPORT OF THE GEORGIA MEDICAL ASSOCIATION, AND AT THE REQUEST OF THE SECRETARY OF STATE, I INTRODUCED LEGISLATION IN THE GEORGIA HOUSE TO RECLASSIFY METHAQUALONE FROM SCHEDULE II TO SCHEDULE I, TAKING IT OUT OF THE REALM OF NORMAL PRESCRIPTION WRITING.

THIS LEGISLATION PASSED, AND AS OF NOVEMBER 1982, METHAQUALONE HAS NOT BEEN PRESCRIBED IN GEORGIA. AS A MATTER OF FACT, THERE WAS A 40 PERCENT DROP IN THE METHAQUALONE-RELATED EMERGENCY ROOM REPORTS DURING THE SIX MONTH PERIOD FOLLOWING THE PASSAGE OF THIS BILL. I THINK IT IS IMPORTANT TO NOTE THAT THIS DECREASE IN THE REPORTED ABUSE OCCURRED PRIOR TO THE ACTUAL IMPLEMENTATION OF THE LAW.

UNFORTUNATELY, SOLVING THE PROBLEM STATEWIDE ONLY RESULTED IN THE MOVEMENT OF THE STRESS CLINIC OPERATORS TO OTHER STATES. AS A MATTER OF FACT, AFTER GEORGIA AND FLORIDA PASSED LAWS TO BAN METHAQUALONE, THE BIGGEST OPERATORS MOVED TO CHICAGO. I UNDERSTAND THAT THE GOVERNOR OF ILLINOIS HAS RECENTLY SIGNED INTO LAW A BILL TO BAN METHAQUALONE, BUT THIS ACTION HAS NOT RUINED THE CAREERS OF THESE ENTREPRENEURS. THEY WILL SIMPLY RELOCATE. THIS IS PRECISELY WHY THERE IS SUCH A NEED FOR FEDERAL LEGISLATION -- TO ADDRESS THIS PROBLEM ON A NATIONAL LEVEL. EVEN THE STATE LAWS MOVING THIS DRUG INTO SCHEDULE I DO NOT PROTECT THE STATE FROM HAVING PRESCRIPTION METHAQUALONE FROM BEING BROUGHT IN ACROSS STATE LINES.

MR. CHAIRMAN, THIS IS A UNIQUE SITUATION IN THAT THERE ARE BUSINESSES SET UP FOR NO OTHER REASON THAN TO PRESCRIBE QUAALUDES. THESE STRESS CLINIC DOCTORS ARE PRESCRIBING A DRUG FOR THE TREATMENT OF STRESS AND SLEEP DISORDERS WHEN METHAQUALONE IS NOT EVEN A RECOMMENDED DRUG FOR THE TREATMENT OF THESE DISORDERS ACCORDING TO THE OFFICIAL AMERICAN MEDICAL ASSOCIATION POSITION.

ACCORDING TO THE AMA'S MOST RECENT STATEMENT ON METHAQUALONE, THERE IS ONLY ONE DISEASE THAT IT SHOULD BE CONSIDERED FOR, PORPHYRIA. AND EVEN THEN, THE POTENTIAL SIDE EFFECTS AND THE POTENTIAL FOR ABUSE FAR OUTWEIGH ANY JUSTIFICATION FOR PRESCRIBING METHAQUALONE FOR PORPHYRIA WHEN THERE ARE NUMEROUS OTHER MORE SUITABLE DRUGS WITHOUT THE HIGH POTENTIAL FOR ABUSE.

THERE IS SIMPLY NO REASON TO KEEP METHAQUALONE AS A SCHEDULE II DRUG. I AM GREATLY CONCERNED THAT CONTINUING THE LEGAL PRESCRIPTION OF THIS SUBSTANCE GIVES IT A LEGITIMACY THAT MAY VERY WELL INFLUENCE OUR YOUNG PEOPLES' PROCLIVITY TO ABUSE QUAALUDE. AND THE LINE BETWEEN LEGITIMATE AND ILLICIT METHAQUALONE IS VERY THIN INDEED. THE EASE WITH WHICH AN INDIVIDUAL CAN OBTAIN LEGAL QUAALUDES; BECOME ADDICTED; AND THEN MOVE ON TO ILLICIT SOURCES, CERTAINLY PERPETUATES THE DEMAND ON THE BLACK MARKET SUPPLIERS.

I KNOW THE U.S. DRUG ENFORCEMENT ADMINISTRATION HAS MADE GREAT STRIDES IN STEMMING THE FLOW OF ILLEGAL METHAQUALONE INTO THIS COUNTRY. AND I AM AWARE THAT THE PRESCRIPTION WRITING OF QUAALUDE REPRESENTS A SMALL PART OF THE LARGER DRUG PROBLEM. BUT IT WOULD BE NEGLIGENT AND SHORT-SIGHTED NOT TO TAKE THIS SMALL STEP TO CURB THE METHAQUALONE ABUSE PROBLEM. ELIMINATING THE PRESCRIPTION SUPPLY MAY WELL HAVE AN INDIRECT EFFECT OF REDUCING THE DEMAND FOR THE BLACK MARKET QUAALUDES. THERE IS ABSOLUTELY NO REASON WHATSOEVER FOR KEEPING THIS DRUG ON THE MARKET.

DEA HAS ALREADY SUBSTANTIALLY REDUCED THE ANNUAL QUOTA FOR METHAQUALONE. IT IS NOT MANUFACTURED IN THIS COUNTRY. MOST PHYSICIANS AND MANY PHARMACIES HAVE QUIT PRESCRIBING AND DISPENSING IT ALREADY. AND THE ONLY PEOPLE WHO ARE USING THIS DRUG THAT HAVE VOICED ANY OPPOSITION TO THIS BILL ARE THOSE WHO ARE ABUSING IT.

AS I UNDERSTAND THE PROCESS FOR RECLASSIFYING A CONTROLLED SUBSTANCE, THE FOOD AND DRUG ADMINISTRATION MUST MAKE RECOMMENDATIONS TO THE ATTORNEY GENERAL TO DO SO. THE FDA HAS TAKEN NO ACTION TO MOVE METHAQUALONE FROM SCHEDULE II TO SCHEDULE I.

THE MAIN DISTINCTION BETWEEN THE CRITERIA USED TO CLASSIFY DRUGS IN SCHEDULE I AND II IS WHETHER THERE IS ANY ACCEPTED MEDICAL USE IN TREATMENT. IT SEEMS THAT THERE ARE INSUFFICIENT GUIDELINES FOR THE FDA TO USE IN DISCERNING LEGITIMATE AS OPPOSED TO PROFIT-RELATED ACCEPTANCE OF A DRUG BY THE MEDICAL COMMUNITY. IN ORDER FOR METHAQUALONE TO BE REJECTED FOR MOVEMENT INTO SCHEDULE I, IT IS ONLY NECESSARY THAT THERE EXISTS AN "ACCEPTED MEDICAL USE IN TREATMENT" OF THE DRUG.

TO TAKE THIS LINE OF REASONING ONE STEP FURTHER, I AM CONVINCED THAT A DRUG NEED ONLY BE MANUFACTURED OR DISTRIBUTED IN THE UNITED STATES, AND NOT ORIGINALLY PLACED IN SCHEDULE I BY THE CONGRESS, IN ORDER FOR IT TO BE CONSIDERED MEDICALLY ACCEPTED.

APPARENTLY IN 1974, THE DEA HAD NO RESERVATIONS ABOUT RECOMMENDING TO THE FDA THAT A DRUG, WHICH IS VIRTUALLY INDISTINGUISHABLE IN ITS PHARMACOLOGY FROM METHAQUALONE, BE PLACED IN SCHEDULE I. THIS DRUG, MECLOQUALONE, IS THE ONLY DEPRESSANT LISTED IN SCHEDULE I. IT ALSO IS A HYPNOTIC/SEDATIVE COMPOUND, BUT THE DISTINCTION HELD BY MECLOQUALONE IS THAT IT HAS NEVER BEEN LEGALLY MANUFACTURED OR DISTRIBUTED IN THIS COUNTRY.

MR. CHAIRMAN, IN LIGHT OF FDA'S RELUCTANCE TO RECOMMEND THE RECLASSIFICATION OF METHAQUALONE, EVEN IN THE PRESENCE OF OVERWHELMING EVIDENCE THAT THIS IS A DANGEROUS DRUG NO LONGER RECOMMENDED FOR TREATMENT IN THE MEDICAL COMMUNITY, I HOPE THIS SUBCOMMITTEE WILL SEE FIT TO FAVORABLY REMAND THIS LEGISLATION TO THE FULL COMMITTEE.

IT WOULD BE TRULY UNFORTUNATE IF THE CONGRESS DOES NOT CONTINUE TO EXERCISE ITS ROLE, AS STATED IN THE CONTROLLED SUBSTANCES ACT, AND THAT IS TO COMBAT DRUG ABUSE.

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Mr. WAXMAN. Thank you very much, Dr. Rowland.
Mr. Smith.

STATEMENT OF HON. LARRY SMITH

Mr. SMITH. Thank you very much, Mr. Chairman. I appreciate the opportunity to present this testimony this morning on an item that we feel is of major importance in the United States. I have a statement which I have submitted which I would like to read and would ask that it be made part of the record.

Mr. Chairman, I appreciate your giving me the opportunity to appear before the subcommittee today to speak in support of my bill H.R. 1055, a bill to move the chemical methaqualone from schedule II of the Controlled Substances Act to schedule I.

Methaqualone is a central nervous system depressant, a nonbarbiturate hypnotic—only one of a number of drugs effective for sedation and sleep. Methaqualone is now considered a schedule II drug. By its very definition, a schedule II drug has a high potential for abuse, which may lead to severe psychological or physical dependence.

Quaaludes, the drug produced from methaqualone, increasingly have become the drug of choice for adolescents. More high school students use methaqualone than use PCP, LSD, and/or barbiturates. And they use it almost as much as tranquilizers. According to south Florida medical experts, Quaaludes are a primary factor in automobile accidents, where their abuse—alone or combined with alcohol—which is now a major concern and is daily growing in major proportions—is estimated to cause nearly half of all traffic fatalities involving drivers between the ages of 15 and 44. Methaqualone abuse, therefore, poses a significant social and health problem that affects not only the abusers but also innocent citizens.

The actual cost of this drug is incalculable, not only in young wasted lives, but also in the cost to our whole society through the waste of private and public funds. Quaalude-related accidents have a dramatic escalating effect on auto and medical insurance rates. We fight to adequately fund education for young people who, if they continue their schooling, float through classes in the haze of this drug. We have ample evidence of the economic impact drug abuse of any kind has on our criminal justice system. Drug abusers must resort to crime to pay for their habit. Crime in turn overloads law enforcement, our courts, our jails. Taxpayers not directly touched by Quaaludes or other substance abuse still end up paying as society's cost climbs to what can only be estimated in the billions of dollars.

I believe that the problem of the abuse of Quaaludes is so important that this is the first bill that I introduced in the Congress.

I became acquainted with the problems of Quaaludes as a member of the Florida State Legislature and frankly even before then. Floridians, primarily teenagers and young adults, would go to so-called stress clinics and receive prescriptions for Quaaludes. They would keep some of the pills for themselves and sell the remainder. As the chairman pointed out and Congressman Rowland has pointed out, the availability of Quaaludes at these stress clinics

was as much as you want anytime you want, and all you had to do is pay the fee, usually $75 to $100 for the visit, and the only thing they attempted to use as a medical device was a questionnaire about how you felt and whether or not you felt that there was any reason you could not take Quaaludes, and they gave you a blood pressure examination. That was the total medical examination and history required to get Quaaludes from a stress clinic. When their supplies were exhausted, they would visit the same or another clinic and receive another prescription.

As chairman of the criminal justice committee in the Florida House, I sponsored and worked for the passage together with a gentleman here with me today who will speak as a witness, Fred Lippman, that moved methaqualone from schedule II to schedule I of the Florida controlled substances act. The result was illuminating. Stress clinics moved across the State line to Georgia immediately after folding up. Floridians unfortunately then traveled up to Atlanta and other Georgia cities to repeat the process that had led to Florida's change in the law. The situation became so bad there that the Georgia Legislature also changed the classification of the drug just a few months after Florida. Teenagers would take a bus up to Atlanta, go to a stress clinic, pay for the pills, come back, sell half of them, keep half, make enough money on the half they sold to take another bus trip to Atlanta and just repeat this month after month after month.

Now, we find stress clinics continuing in those States that still permit the dispensing of methaqualone by prescription. News reports abound of the abuse of the drug by practitioners not associated with stress clinics who dispense Quaalude prescriptions to those who abuse the drug. Some of the prescriptions are innocent, but there have been numerous instances of deliberate repeated prescriptions to individuals who abuse the drug.

Another method that was very unique was that people who wanted to obtain large amounts of Quaaludes for sale on the street would find disabled veterans who were mostly handicapped in wheelchairs, search them out, tell them that they could make a lot of extra money, all they had to do was go with them to doctors' offices or to the stress clinics and they would be paid a certain amount for each place that they visited. Many of them as you know are easily subject to being preyed upon by those people who have no conscience, no qualms, and they would use disabled veterans for the purposes of obtaining Quaaludes. Naturally a doctor would be sympathetic if a veteran said he could not sleep, had problems or pains or nightmares, Quaaludes would control that kind of sleeplessness. We have reports from the Florida Department of Law Enforcement and other agencies that actually checked on this that there were times four and five in 1 day the same veteran would go to different doctors, always accompanied by people, not the veteran, him or herself.

Experts do not question the fact that Quaaludes are dangerous. In its issue of February 4, 1983, the Journal of the American Medical Association published an article entitled "Changing Patterns of Methaqualone Abuse," by Dr. Charles Wetli, deputy chief medical examiner in Dade County. I have brought also with me today Dr. Ronald Wright, who is a well-known expert in the field. He is the

chief medical examiner of Broward County, Fla., and on the staff of the University of Miami Hospital and he also will testify. Dr. Wetli noted that, in 1971, autopsies revealed the presence of methaqualone in two victims. This rose to 70 in 1981. By 1982, when the Florida law was changed, preliminary estimates showed a decrease to 38. In addition, one-third of the victims died in traffic accidents, and Dr. Wetli observed that the drug may have been combined with cocaine and alcohol.

If I may be permitted to add a parenthetical comment: Only too recently did we acknowledge the problem of drunk driving. Most States and Congress have yet to realize the impact of drugged drivers on our safety.

Finally, the article noted that suicides involving this drug rose dramatically: 19 between 1971 and 1980, but 19 alone in 1981.

Limiting legal Quaaludes has a positive impact. In late July 1983, I received a memo from Dr. Ron Wright, who will testify on changes in drug use in DUI arrested drivers. Let me quote one paragraph:

> On July 1, 1982, Methaqualone became schedule I narcotics and the new DUI statute became law. Subsequently, while total arrests and total number of persons tested for drugs both increased, the types and combinations of drugs changed. In July-December 1981, 72 percent of the tested positive drivers had methaqualone in their system. That dropped to 23 percent in January-July, 1983.

In a 6-month span from July 1, 1982, until we started testing in January 1983 the reduction had been noted immediately and by July 1983, a reduction from 72 percent to 23 percent in the tests of drugged drivers.

Granted there were a number of reasons behind this reduction: Improved Federal antidrug activities, a tougher DUI law in Florida, and the new Florida statute on methaqualone. But I believe that Florida's making it more difficult for people to get Quaaludes legally contributed the most to this reduction in DUI/Quaalude drivers.

By making legal Quaaludes impossible to obtain, we may not eliminate the market. Not enough is being done to stop the flow of illegal Quaaludes from abroad. But, if potential abusers knew that legal Quaaludes were impossible to obtain, they might think twice about purchasing illicit Quaaludes, look-alike, or counterfeit drugs that might contain some adulterated substances. When ingested, these phony drugs do not produce the anticipated feeling. So, the abuser overuses the fake drugs in an attempt to get the necessary feeling. When they do get the real thing, they overdose. If a young person is taking 8 or 10 of these counterfeits which contain mostly nontoxic but adulterated substances, whether it is sugar or cornstarch or talc, they take 8 or 10 of them, they get maybe at the most a buzz if there is aspirin in it. Now they come across the legal ones. They do not know the difference. They look the same. They take 8 or 10 of them just like they were of the others and out they go.

Mr. Chairman, I do not view the methaqualone/Quaalude problem as a health or medical problem. We are dealing with a drug abuse control problem. Quaaludes have no real therapeutic medical value that cannot be met with another safer drug. They are comparable, in this way, to heroin, which is a schedule I drug. If metha-

qualone were so important, surely more than one American pharmaceutical firm would be distributing methaqualone products today.

The need for my bill has been questioned by those who point out that the Federal Government already possesses authority to shift methaqualone to schedule I. The law does permit that. What disturbs me is the apparent unwillingness of Government to exercise the authority it has. When methaqualone was put on schedule II, Quaaludes were not a major drug of choice or abuse. By 1978, however, it had become a problem. The simple solution would have been for FDA to move methaqualone to schedule I. Yet this has not been done by the FDA. Rather, the individual States have had to change their laws, and the DEA has cracked down on some dispensers of this drug. The simpler, cheaper, and safer solution would be to just put methaqualone on schedule I and get it off pharmacy shelves and away from the ability of medical practitioners to prescribe it.

I want to draw your attention to a comment made by Dr. Edward C. Tocus, drug abuse staff chief at FDA, in an article in Medical World News, March 15, 1982. Dr. Tocus is quoted as saying that FDA will not make methaqualone a schedule I drug "without some pretty heavy data on methaqualone as an imminent hazard to the public health nationally." The article then goes on to state that he suggests Congress could emulate the Florida Legislature without the difficulties FDA would have administratively. Well, I am giving Congress that opportunity.

Mr. Chairman, I must express my disappointment at the response that I have received to date from administration officials on this problem. We have a major drug abuse problem in this country, and the administration has expressed its concern in various ways. But, when it comes to practical action, the rhetoric seems to exceed the deeds.

I asked Dr. Carlton Turner, head of the White House Office on Drug Policy, about the nonmedical use of legitimate pharmaceuticals. In a letter to me dated July 19, Dr. Turner called this "a major drug abuse problem." He went on to state that FDA reviews certain studies, DEA decides the maximum amount of a pharmaceutical that could be available for distribution, the National Institute of Drug Abuse [NIDA] chairs an interagency panel that considers this subject, practitioners are urged to deal with this through education and other means. Everybody talks, but nobody moves the bureaucracy.

Mr. Haislip of the DEA's Office of Diversion Control told the Judiciary Committee's Subcommittee on Crime, on which I serve, on June 29 that we are not through with the methaqualone problem. I asked if he was in favor of State help in moving the drug to schedule I. He replied that he does favor it as a "rational approach to the problem in view of the situation—the States—are facing." When I asked if it would be rational for the Federal Government to do the same, he hedged a bit. His personal feeling was that most methaqualone comes from abroad but "a substantial amount of that available in the United States was being diverted." It might not be necessary to take it off schedule II, but it might.

Quaalude abuse is a small piece of a very large puzzle. We all talk about the drug problem. Many people, unfortunately, are looking for a one-shot panacea that would eliminate the problem. Well, it will not happen.

We have to take appropriate action as the situation warrants. This is one area in which the Federal Government could act. If we had a coordinated policy—and 8 months on three committees dealing with drugs has convinced me that we do not have such a policy—FDA would be moving on its own to eliminate a legal drug that is abused by most. FDA has not moved, so Congress must.

I also have heard some talk that if Congress were to make a change in the scheduling of methaqualone it then would make changes in other drugs. Congress has chosen to delegate this authority, but it retains the right to make its own determination if circumstances require action. If the drug is subject to abuse and if it serves no unique medical purpose that cannot be replaced by other drugs less subject to abuse, then its scheduling should be changed. If the officials who deal with the impact of drugs on society do not exercise the authority given to them, then Congress must exercise this responsibility itself.

Mr. Chairman, the experience in Florida—prior and subsequent to our changing our State statutes—proves to me that a change in the Federal law is necessary. Individual and piecemeal State action only shifts the problem from one State to another. It does not deal with the national problem. A national problem requires a national solution. I, therefore, urge the subcommittee to act favorably on this legislation.

Thank you very much, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Smith. I want to thank both of you for your presentation to us and for your leadership on this legislation. I gather that your home States have been more successful in fighting the drug abuse problem posed by Quaaludes Is that correct?

Mr. SMITH. Yes.

Mr. ROWLAND. Yes; that is correct.

Mr. WAXMAN. We have a substance that is otherwise legal. It is a drug that right now can be prescribed by a physician and that drug is being counterfeited and sold illegally. Is that correct?

Mr. SMITH. Yes. The amount of counterfeit Quaaludes are not as high as they once were, but are still very high. The major problem has always been the amount of legal Quaaludes being diverted into the illegal market by virtue of these schemes that I related to the committee, how ostensibly legal patients wind up getting this drug legally and then diverting it into the illegal market. But the compounds being illegally manufactured do present a major problem. What happened in Florida, and I believe in Georgia also, was when the legal substance became schedule I, the illicit market dried up to some degree because everyone who was purchasing knew they were buying what could only be the illicit compound and therefore a question was raised in their mind whether they were buying anything that had any quality control, how much toxic substances were in them.

Just before we passed our law, almost 20-some-odd children were reported into two or three medical facilities in south Florida complaining of terrible stomach pains and exhibiting all the symptoms not only of drug overdose but of toxic substance abuse. That is because a bad batch of Quaaludes had been sold. That is still in many people's minds, and I think many young people have been turned off from purchasing the illicit Quaaludes because they realized that could not be legal in Florida and if it was a legal one, it would be very rare.

Mr. WAXMAN. Mr. Smith, you are anticipating a question I wanted to ask you. If we have an illicit market where counterfeit Quaaludes are sold, if we make the sale of what is now a legal prescription drug illegal, why wouldn't we still have a market for it? Why wouldn't people just buy the illegal drugs from the illicit market?

Mr. SMITH. I doubt seriously whether you will ever be able to totally remove the illicit market from the street. There is always going to be a market and a marketmaker to those people who want to sell illicit drugs. What has happened is that with the advent of the impossibility of obtaining the legal drugs to a large degree, obviously it is not totally foreclosed, but it has created a situation where many of the buyers of Quaaludes are now hesitant to purchase the street ones because they realize that they in fact are probably not legal drugs.

We also have a counterfeit drug law in Florida which makes the production of look alikes illegal and the sale of those look alikes illegal as well and that has helped.

Mr. WAXMAN. It is both of your purposes that all sales of methaqualone will be illegal. Anyone using the drug will know they are purchasing a drug that is against the law and they may be getting a drug that is not in any way the same quality that they would get from the prescription drug that is now available?

Mr. ROWLAND. May I comment on the statement. As I mentioned in my statement, Mr. Chairman, I think that since the drug still is prescribed legally, that lends legitimacy to it and it makes it where young people will say "If that is a legitimately prescribed drug, then maybe it is not so bad after all." As was pointed out by Mr. Smith also, the counterfeit drugs have benzodiazapines in them which is a schedule IV drug and not nearly as addictive as a schedule II drug.

So when people were using these counterfeit drugs, they found they had to take more of them in order to get the effect, and then when they got the Quaaludes, which looked exactly like that, they took an overdose without realizing they were taking the actual drug. So the legitimacy that is lent to Quaaludes by still being in schedule II, plus the fact that these counterfeits had been made available in the manner in which they were, are I think both very good reasons for us to take this drug off the market legally.

Mr. WAXMAN. I have a limited amount of time. I will have to call on my other colleagues for questions. I want to get more questions in during the few seconds I have left.

Dr. Rowland, as a physician, aren't you concerned that rescheduling this drug may encourage demands to ban other legal pharmaceuticals based solely upon their nontherapeutic use?

Mr. ROWLAND. No. I am not concerned about that. We, as Members of Congress and I, as a member of the State legislature, had control over that already so I don't think that we are doing anything that we haven't been doing as a matter of past history.

Mr. WAXMAN. Mr. Nielson.

Mr. NIELSON. I would like to ask Dr. Rowland a couple of questions. What representations were made to you by the manufacturers of methaqualone that induced you and other physicians to prescribe it 15 years ago?

Mr. ROWLAND. When it first came on the market, it was touted as a drug that would have very few side effects, would be rapidly excreted. There were several drugs that came on at the same time, doriden, placidyl, noludar—were in a period in medicine at that particular time where tranquilizers and sedative hypnotics had really become the thing to do and this was just another drug one of those drugs that we had access to.

Mr. NIELSON. You discovered after a few months that it was not working and had undesirable side effects. Why did it take over a dozen years for you to take action on this? You are the leading States in this area.

Mr. ROWLAND. I think what happened was many other physicians found that these drugs were not ones that they wanted to use and they simply fell into disrepute in the medical profession and only in about 1978 or 1979 did they come to the fore again when it was discovered by people that were drug abusers that it was a drug that could be used in conjunction with alcohol and other drugs that synergistically potentiated the effect of these other substances and that is when it came back. But there was a period of some 12 years or so that we heard almost nothing about it.

Mr. NIELSON. Congressman Smith, can you tell me what has happened on the Select Committee on Narcotics and Drug Abuse? Have they discussed this problem or recommended any action?

Mr. SMITH. The Select Committee on Narcotics and the International Operations Subcommittee, on which I serve, and Foreign Affairs, which deals with the programs in the State Department for crop eradication, both are working very hard to determine whether or not we can in fact start banning the importation and in fact destroying crops at their source. With reference to methaqualone, much of it is produced in Red China and is shipped around the world, and a lot of pressed Quaaludes tablets are coming in from Colombia transshipped through the Bahamas, but all of it, of course, is illicit drugs.

We had one or two small factories that actually compressed the tablets in Miami, but they were closed down fairly rapidly. So what they were doing in these stress clinics was selling the legal drug and the illicit market was on the street. We are trying to develop legislation now to prevent the source from shipping these drugs, whether it is Colombia or the People's Republic of China. That is what we are trying to do.

That would be the easy way.

Mr. NIELSON. I appreciate that. So the Select Committee on Narcotics is recommending this legislation now?

Mr. SMITH. They have no substantive jurisdiction.

Mr. NIELSON. But they do recommend?

Mr. SMITH. Absolutely.

Mr. NIELSON. You both alluded that FDA has not moved methaqualone from schedule II to schedule I. They certainly have the power to do that. You both mentioned that they have not exercised the authority they have that they feel somewhat restricted in their authority. Should we just give them a little more leeway? Is that the problem?

Mr. ROWLAND. Since there is still some accepted medical use in the country, FDA is reluctant to give the Justice Department the authority to move the drug. It is still being prescribed, very rarely, in legitimate instances, and for that reason, FDA is reluctant to say there is no longer any accepted medical use. As long as they will not make the statement that there is no longer any accepted medical use, then the Justice Department cannot move it.

Mr. NIELSON. So, in other words, you are saying they have the authority and if we were to pass this law, we would be essentially saying "We will go over your heads on this particular matter?"

Mr. ROWLAND. I think the FDA is in a catch-22 situation. I think that they would like to see it placed in schedule I but are in a situation where they can't do it.

Mr. NIELSON. I will ask the chairman, are we going to hear from FDA on this matter?

Mr. WAXMAN. Yes; we are. We have them later on the agenda.

Mr. NIELSON. Why hasn't the AMA taken some kind of a stand on this? There was an article that Larry Smith mentioned in the February Journal of the AMA. Why haven't they taken a stand or why haven't they come out more strongly on this issue?

Mr. ROWLAND. The AMA originally opposed this legislation. I appeared on a program in New York, The Today Show, and my opposition on that program was from the AMA. However, since that time I think they have thought better about opposing it and at this particular time could not plan to actively oppose it, to the best of my knowledge.

Mr. SMITH. I spoke to the AMA and their legislative lobbyists, and they have indicated to me that while they originally did oppose the legislation, they are taking no position on it at this time. The reason they would not come out and support it is something you will have to ask them. I don't know why frankly, but I feel they don't want to be in the forefront of setting an example for the FDA trying to get them to put any kind of a legal drug from one schedule to another. But they are not at this time opposing this legislation.

Mr. NIELSON. May I compliment you both for your respective efforts in your legislatures. I think that is very good. I will yield back my time.

Thank you.

Mr. WAXMAN. Mr. Sikorski.

Mr. SIKORSKI. I just wanted to commend Congressman Rowland and Congressman Smith for their efforts in informing the public on this problem and trying to steer a course away from business as usual in this area of substantial drug abuse and commend the chairman for holding the hearings and pursuing this.

Thank you.

Mr. WAXMAN. Thank you, Mr. Sikorski.

Gentlemen, let me thank you again. We are going to hear from others on this subject and then we want to work with you on whatever legislation would be appropriate.

Mr. ROWLAND. Mr. Chairman, thank you very much. I ask that my full statement be made a part of the record.

Mr. WAXMAN. Without objection, both of your full statements will be made a part of the record.

Our next panel is composed of physicians and attorneys active in the successful efforts to ban methaqualone in the States of Georgia and Florida. Dr. Ronald Wright is chief medical examiner of Broward County, Fla. Dr. William C. Dudney is a physician from Macon, Ga. Fred Lippman is a member of the Florida State Legislature. David Poythress is an Atlanta attorney and former Georgia secretary of state.

Thomas Kirkpatrick, executive director of the Illinois Dangerous Drugs Commission, was scheduled to appear but was taken ill. Illinois is the most recent State to take action rescheduling methaqualone. Mr. Kirkpatrick has forwarded a written statement endorsing the pending legislation and without objection, it will be included in the record. [See p. 223.]

I want to welcome all of you to our hearings today. Your full statements will be made part of the record in full. What we would like to ask you to do is to summarize your written testimony so we will have an opportunity for questions and answers. We would like to ask you to try to keep as close to 5 minutes as possible.

Dr. Wright, why don't we start with you.

STATEMENTS OF RONALD K. WRIGHT, M.D., CHIEF MEDICAL EXAMINER, BROWARD COUNTY (FLA.) MEDICAL EXAMINER'S OFFICE; FRED LIPPMAN, FLORIDA STATE REPRESENTATIVE; WILLIAM C. DUDNEY, M.D., ADDICTIVE DISEASE DIRECTOR, PSYCHIATRIC ASSOCIATES OF MIDDLE GEORGIA; AND DAVID B. POYTHRESS, ATTORNEY, ATLANTA, GA.

Dr. WRIGHT. Thank you, Mr. Chairman and members of the committee. I appreciate the opportunity to be here today. I have prepared a short statement along with statistics of the changes in methaqualone abuse as reflected in the DUI arrests which we have seen in south Florida. I would like basically to say a couple of things.

No. 1, methaqualone, as far as I am concerned, demonstrates the continuing problem which we as a society have in dealing with psychoactive drugs of abuse. This drug has demonstrated a severe potential for abuse, primarily because the young people feel that this drug is an aphrodisiac and it gives you a reasonably good high. I sometimes, in listening to the earlier testimony, wonder what would have been said differently had we been here in 1915 and 1916 talking about making heroin, the equivalent of a schedule I narcotics—as I understand it, heroin is a registered trademark of the Eli Lilly Co. and is a drug which is very effective for the treatment of pain.

Methaqualone is similar. It is an effective hypnotic agent. It is good to put people to sleep, but it has such a tremendous abuse potential. It, unlike heroin, kills not only the people who use it, but it

kills other innocent folk because the kids who use it get out on the highways. This drug has a lot of interesting street names. Randy-Mandy was one of the street names when it was introduced in England, referring to its aphrodisiac quality. It is also called Wallbangers. It is called that because people who take this drug lose such control that they bang into walls.

Right now in the United States, this evening, we will have a number of people killed because somebody who was high on methaqualone came across the road and smashed into an innocent person coming the other way. To imagine that the U.S. Government feels for some obscure reason that this kind of danger is counterbalanced because there is some slight use of this drug as a hypnotic seems to me to be completely wrong. I would ask very much that you would support this legislation.

Thank you.

[The statement of Dr. Wright follows:]

Statement of Ronald K. Wright, M.D.
Broward County Medical Examiner

Methaqualone - (ludes) is called "heroin for lovers". The reason for this denomination is that Methaqualone is felt to be a drug which produces a very pleasant "high" and is at the same time an aphrodisiac. Because of these beliefs in the drug's properties - kids in junior high, high school and college age are the primary abusers.

Methaqualone is currently a prescription drug - schedule II under the Federal System and Schedule I in Florida. In Florida on July 1, 1982, 'ludes became Schedule I because the Florida legislature felt the potential for abuse exceeded the therapeutic value of the drug.

The evidence for this was:

- In Broward County in 1980 more fatally injured drivers between the ages of 15 - 44 were intoxicated with 'ludes than alcohol.
- In Broward County in 1981 - 73% of the drivers charged with DUI-drugs were intoxicated with 'ludes.

After the legislation was passed the percentage of 'ludes drivers dropped from 73% to 23% January thru June 1983. Methaqualone deaths which were 49 in 1981 dropped to 36 in 1982 (23 before July 1, 13 after July 1) and dropped to 6 so far in 1983.

The legislation worked in Florida (raising Methaqualone to Schedule I). The tons of the drug coming through "legitimate" prescriptions dried up and the price doubled and tripled on the street. This drug is used by kids and they apparently are price sensitive.

Is this a national problem? In my opinion it is. However, it is invisable. Testing for methaqualone in intoxicated drivers or deceased persons is not done except in a few places in the United States. This problem is known only if the testing is done.

Projecting the Broward County experience on to the national statistics reveals that there would be a reduction well in excess of 1,000 accidental deaths if Methaqualone were made a Schedule I narcotic.

	Jan. 1, 1981 thru June 30, 1981	July 1, 1981 thru Dec. 31, 1981	Jan. 1, 1982 thru June 30, 1982	July 1, 1982 thru Dec. 31, 1982	Jan. 1, 1983 thru June 30, 1983
TRAFFIC DEATHS	136	161	127	91	114
DUI ARRESTS - Drug & Alcohol	1493	1685	1617	3082	3002
DUI-DRUG PERSONS TESTED	119	159	146	330	400
% Tested of all arrested	8.0%	9.4%	9.0%	10.7%	13.3%
PERSONS POSITIVE for DRUGS*	104	136	116	200	250
% of tested Positive	87.0%	86.0%	79.0%	61.0%	63.0%
% of all arrested Positive	7.0%	8.1%	7.1%	6.5%	8.3%
METHAQUALONE (Ludes)					
Persons Positive	79	98	70	99	58
% Positive of Drug Positive	76%	72%	60%	50%	23%
BENZODIAZEPINES (Valium & similar)					
Persons Positive	24	39	71	92	110
% Positive of Drug Positive	24%	29%	61%	46%	44%
COCAINE					
Persons Positive	11	13	21	42	50
% Positive of Drug Positive	10%	10%	18%	21%	20%

*Excludes Marijuana

Mr. WAXMAN. Thank you very much.
Mr. Lippman.

STATEMENT OF FRED LIPPMAN

Mr. LIPPMAN. Thank you, Mr. Chairman and members of the subcommittee. You will forgive me for not having a prepared text, but I would be glad to supply that to you at some later point in time.

Very interesting comments have been made here today, and, Mr. Chairman, if I might just state to you, just for the record, that schedule II enumerates and lists those controlled substances which have high potential for abuse but which have a currently accepted but severely restricted medical use and treatment in this country. And it is a given that methaqualone has a medical use. And it is totally understandable not only as a member of the Florida Legislature, but as a practicing pharmacist for these past 25 years to understand the position of FDA and to understand the constraints that are placed upon FDA as the technical body in making a decision and moving a drug from schedule II to schedule I or whatever the schedule.

I really believe that it was the actions of this Congress in creating the original BNDD, which then was taken up as the DEA in reacting to the problem of social drugs and their abuse.

As you might remember, for many years the nature of abuse was built around the derivatives of morphine—derivatives of cocaine, heroin, and opiates. The schedules were A, B, and C, and then turned into a new DEA schedule of I, II, III, IV, and V; based not upon their primary pharmacologic extraction from those elements or those drugs previously stated, but based upon the social abuse and the effect upon our society, because there is no way that FDA or anyone else pharmacologically can prove the harm that is done by a product such as dilaudid versus a product such as codine.

I would say to you that the product methaqualone is a very interesting substance. It is very interesting in the fact that it is a social tranquilizer which has become violently abused.

You have heard testimony today—I have been through this testimony many times as the cosponsor with your now-Congressman Smith of the bill which passed in the State of Florida. What we did do, Mr. Chairman, members of the subcommittee, was we knew very well that there would be illicit product on the market and there will continue to be illicit product on the market, but in recognition of the fact that this is a social drug abuse item, primarily used by young people, we found that the quickest way to place a burden upon the entrepreneurial interests, those who were playing for dollars, those who were willing to subvert their own professional activities just to make money, was to place a control, that control which is available through the Federal Government.

We scheduled methaqualone, better known to most of you branded as Quaaludes on schedule I in the State of Florida forcing stress clinics and hospitals to maintain thorough inventory controls. Inventory controls which they were not willing to maintain and therefore packed up and in 2 or 3 weeks and moved unfortunately on to Georgia and then on to Chicago and now someplace else.

We recognize the fact that, and I am not going to go through all the detail with the death, but I think that Congressman Smith made a very, very important point, and that was that this gentleman to my left, Dr. Wright, has told us of the death and carnage on the streets of the State of Florida, and the fact that 72 to 73 percent of those that were tested end up in related incidents indicated by this gentleman were involved with methaqualone percentage in their blood and that the reduction to the level of 23 to 25 percent was dramatic and why was it dramatic? Very simply: Methaqualone is a social drug used by the nonconventional drug abuser. It is used by the college student, by the high school student, by the middle-class housewife, by the folks who are working in office buildings, not primarily by what we perceive to be the typical drug abuse community, the junky, the guy lying on the street, the woman lying in some hotel who has to hustle for her dollars.

What we are looking at is we are looking at the socially accepted, legally protected methaqualone product. That product and its legitimacy as explained by Congressman Rowland is the issue that we are here to talk about. The legitimacy of this product creates a feeling in the mind of the abuser to the fact that this substance is controlled, it is without toxicity, and they can take it without fear.

The equation is built around the fact that this is a legal substance of medical value as stated by the Federal Government and therefore "I can control the dosage within my own body." Well, we are saying that if you will remove this product from schedule II and place it in schedule I, I think that the aura of legitimacy around the product will be dispelled. I believe that the people who are in use of this product and are abusing this product and causing death to themselves and others will recognize it and are not willing to take the chance.

One last statement: Just think very carefully about the LSD question of maybe a decade ago. For many, many months if not almost 2 years, LSD became the product of choice in college campuses and social activities in this Nation. Why? Because it gave you this euphoric, just incredible method of losing reality and placing yourself someplace where you did not want to therefore share with anyone else, but death occurred, uncontrolled death. The fear of seeing your friend walking out of a window of a 20-story building or a driving a car over into some ravine. Those vivid remembrances of social drug abusers stopped primarily the use of LSD.

I can tell you, Mr. Chairman and members of the subcommittee, that the issue at hand is a legitimacy of a product which is not necessary in this country. We have other hypnotic substances which are available which are safe. Not to say that they will not also be a potential to abuse someday, but I will tell you that methaqualone is a major product of abuse by a statement from the New York Times nearly 3 years ago.

I think by their statement, nearly 120 tablets per Floridian were dispensed in the State of Florida in 1979. Now I can tell you that is an awful lot of methaqualone that was legally dispensed for illegal purposes, and what I mean by ill purposes is the insane abuse of a product which really does not belong as a legitimate substance, as far as I am concerned, in this Nation. I have no qualms to say that I think that it is responsible for any corporate entity in this Nation

to be involved in the dispensation or the manufacture of this product.

I can also make mention, Mr. Chairman, and you might note, that at one point in time there were three major manufacturers and distributors of this product in this Nation, the Arnor Stone Corp., the Parke-Davis Corp., and at one time the Rohrer Corp. Of course, Rohrer sold their product to Lemon, Parke-Davis no longer manufacturers the product, and neither does Arnor Stone. With that, Mr. Chairman, I appreciate the time and I hope my ramblings weren't as rambling as I felt they were.

Mr. WAXMAN. Thank you very much. They weren't.

Dr. Dudney.

STATEMENT OF WILLIAM C. DUDNEY, M.D.

Dr. DUDNEY. Mr. Chairman, I am here because I am a medical doctor, and my specialty is psychiatry and addictive disease. My training in those areas was in your home State, California, the University of California, San Francisco, and the Navy Alcohol Rehab Center. I have practiced in the State of California as well as Virginia, Arkansas, and am currently the addictive disease director for Psychiatric Associates of Middle Georgia. I am here because I see and treat alcoholics, drug abusers, and drug addicts every day, 7 days a week. It has been accurately stated that Quaalude is a sedative-hypnotic. In nonmedical terms what that means is a small dose of this drug will lead a person to be sedativized, and a larger dose will lead him to become hypnotized, and an overdose can cause him to be eulogized.

This medication is one of three subcategories of the sedative-hypnotic class. These are alcohols, the antianxiety tranquilizers of which Librium and Atavan are well known, and the third category the barbiturates and barbiturate-like drugs.

Quaalude is a barbiturate-like drug. Like all sedative-hypnotics, Quaalude does not affect all brain cells at once. It affects the brain in a stepwise and progressive manner, and the first part of the brain that is affected by Quaalude is that part of the brain that controls fear and anxiety, and when that part of the brain is sedated one feels more relaxed, at ease, and socially lubricated, a similar experience to social drinking.

Because of cultural myths and rumors, public relations work, and media hype, this particular sedative-hypnotic has been correlated among users many of whom are useful users, as a strong inducer of a euphoric sensation. It markedly decreases social anxiety, and again by myth, is a sexual aphrodisiac. From a pharmacological standpoint, as I am sure my colleagues would attest, there is no medical basis for this. However, that nevertheless is the cult myth and reputation of this particular drug, which makes it outstanding from the other sedative-hypnotics.

This drug has been illegal in Georgia for about 1 year now, and I again had the opportunity to practice in the State before and after this type of legislation occurred. There was a marked decrease in my clinical practice among users of this drug as well as those actually admitted to the hospital intoxicated on this substance. I still see patients who enter treatment and claim to be using Quaalude.

Their drug screen almost always comes back positive for benzodiazepine, which is Valium.

In the State of Georgia, most street users have become wise enough now to recognize that what is sold on the street as Quaalude is counterfeit, and this knowledge alone has significantly decreased the use of this drug. There is no legitimate medical indication for this substance. By making the drug more difficult to obtain through legislation, the use is clearly decreased, and that clear decrease saves lives and prevents the pattern of progressive drug abuse and addiction in young people.

It also promotes a cultural attitude that abuse of chemicals is both dangerous and morally wrong.

There are three components to the addictive disease. There is a biological component. This is perfectly clear with alcoholism, and is becoming more clear with the other drugs of abuse. By that I mean that there is something different about those who develop a chemical-dependent pattern, and that this difference is biological in nature. In other words, drug abuse and alcoholism clearly run in families. Every family study that has ever been done has shown a clear-cut familial tendency. Now, there are reasons that things run in families other than biology and genetics, of course.

Cake recipes run in families and that is not genetic. However, Scandinavian adoption in twin studies have clearly shown this biological component is present. That is not something we can legislate.

The second of the three criteria to develop a chemical dependency pattern is to live in a culture and society where intoxicants are readily available and socially acceptable, and the third is to use and experiment. As I stated, we cannot change our biological makeup. Young people are going to use and experiment, but we do, hopefully, have some control over the cultural attitude toward using dangerous and illegal substances, and that is what I think this legislation would accomplish.

Thank you.

[Dr. Dudney's prepared statement follows:]

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September 27, 1983

Congressman Henry Waxman
Chairman, Sub-Committee on Health and Environment
Room 512, House Annex #1
Washington, D.C. 20515

Attention: Mr. Ripley Forbes

Dear Sirs:

I was born and raised in Texarkana, Arkansas and attended college and medical school at the University of Arkansas. I specialized in Psychiatry and Addictive Diseases at the University of California-San Francisco and the Long Beach Naval Alcohol Rehabilitation Center. As a Lieutenant Commander in the U. S. Navy, I served as Medical Director of the Navy's largest Alcohol Rehabilitation Center and was an Associate Professor of Psychiatry at Eastern Virginia Medical School. I am currently the Addictive Disease Director for Psychiatric Associates of Middle Georgia and Charter Lake Hospital.

Quaalude is a drug of the pharmacologic category "sedative-hypnotic". These drugs are so named because a small dose has a sedative effect and a larger dose has a hypnotic, or sleep-inducing effect. There are three sub-categories of drugs in the sedative-hypnotic categorization. These are: (1) alcohol, (2) barbiturates and barbiturate-like drugs, and (3) anti-anxiety tranquilizers. Quaalude is in the second category. Like all sedative-hypnotics, Quaalude acts on the brain in a step-wise, progressive manner not affecting all nerve cells at once. The first part of the brain which is affected is that part of the brain that controls fear and anxiety. Sedating this part of the brain with Quaalude leads to a decrease in social anxiety and a euphoric aensation of self confidence. Cult myths and rumors have also been connected with this drug for an implicated sexual aphrodisiac effect. Not because of any unique pharmacologic properties, but because of media-hype and public relations, this particular drug was widely abused by young people. Since legal Quaaludes are no longer available in the state of Georgia, there has been marked increase observed by me in my clinical practice. I no longer see patients who abuse genuine Quaalude. There are still some who enter treatment giving a history of heavy Quaalude abuse but drug screen reveals "counterfeit Quaaludes" which are almost always benzodiazepines (Valium). Although the counterfeit Quaaludes still are abused in Georgia, most users are street-wise enough to have become aware that the drug is counterfeit and they are not getting what they are paying for. The fact that the drug is not legal and not manufactured by reputable drug companies in the state of Georgia has cleared decreased the abuse of this one substance. Although legislation to outlaw the sale of legal Quaaludes may seem to be a very minor action in the total war against drug abuse, even the smallest action can save lives and most importantly, emphasize the cultural attitude that it is dangerous and morally wrong to abuse these medications.

I look forward to testifying at the Sub-Committee Hearing and answering further questions on the aforementioned text.

Sincerely,

WC Dudney MD

William C. Dudney, III, M.D.
Corporate Consultant on Addictive Diseases
Charter Medical Corporation

WCD:shc

Mr. WAXMAN. Thank you very much, Dr. Dudney.
Mr. Poythress.

STATEMENT OF DAVID B. POYTHRESS

Mr. POYTHRESS. My purpose this morning is to describe briefly the experience of the State of Georgia in dealing with methaqualones through the so-called stress clinics. I would like to describe the nature and the extent of the problem we confronted, the options that were available to us, a comment or two on the environment in which we took the action that we took, a statement of our results, and then, finally, my own recommendation on the subject.

By early 1982, investigators from the State, the secretary of state's office of the State of Georgia, had identified and extensively documented the problem of methaqualone distribution through the stress clinics. Georgia ranked eighth nationally in per capita distribution of the drug. With a relatively small population of 5½ million, we ranked seventh nationally in the total prescription of the drug by weight. In fact, more methaqualone was distributed in the 303 ZIP code area of Atlanta in 1981 than in 33 other States and the District of Columbia.

In 1981, more than 214,000 grams of the drug was prescribed in Georgia. Of that amount, approximately 80 percent was dispensed in the ZIP code area where the three stress clinics were located.

The procedures whereby the drugs were prescribed were as outlined by Dr. Rowland.

The patient would present complaining of characteristic symptoms such as sleeplessness and nervousness for which methaqualone would be an appropriate medication. The physican would go through a perfunctory physical and psychological evaluation, and then invariably prescribe methaqualone, usually in relatively small doses.

I have characterized it as a game with no written rules, the result of which was that the person who wanted the drug came into possession of it, undoubtedly with the intention of dealing it on the street. The entire transaction was shielded from legal scrutiny by the veil of professional judgment on the part of the prescription physician.

That the so-called medical judgment was, in fact, a sham I think is graphically illustrated by a tape of a conversation which was taken by the Georgia Bureau of Investigation during our investigation between a physician and the manager of one of the stress clinics. If you would like, I will play it later on in this presentation. It graphically illustrates the gaming attitude on the part of the proprietors of the stress clinics.

Our options for dealing with the problem were limited.

The traditional law enforcement methods, that is, criminal prosecutions and administrative actions to lift licenses on the part of the offending practitioners, were virtually useless. The veil of professional medical judgment was nearly impossible to penetrate. Persuading a judge or a jury that a physican was guilty of specific criminal intent or even poor medical judgment under the circumstances that I have described was all but impossible.

The remaining option was to move legislatively to restrict the availability of the drug, and that was the course of action that we took in Georgia. The legislation which was recommended by myself as secretary of state and by the Georgia Board of Medical Examiners and introduced by Congressman Rowland, who was then a Member of our House of Representatives, simply moved the drug from schedule II to schedule I of the Georgia Dangerous Drug List, making it unavailable for prescribing physicians but still available for research or scientific purposes.

Before discussing the success of that legislation, it may be worthwhile to comment on a number of the factors in the environment at the time we took this action. The first was the sheer magnitude of the drug problem in Georgia, which was then, and still is now, a transshipment point for vessels and aircraft coming from South America, and also as a marketplace for the drugs themselves, whether legally or illegally manufactured, particularly in the metro area.

Against that backdrop, the stress clinics represented a clearly identifiable type of illegal activity that could be dealt with by a single decisive legislative act.

Perhaps the most important environmental factor was the growing frustration and outrage within the medical profession in Georgia about the stress clinics. The medical board was receiving increasing reports of overdoses and abuses. When the idea of the legislation was first proposed, a few people argued that it represented an unwarranted curtailment of the physician's medical judgment, and that the physicians in the stress clinics should be dealt with under the criminal law.

But the Board of Medical Examiners seized upon the idea which we had presented them. They wholeheartedly endorsed it and vigorously supported the legislation, which passed virtually without opposition. Thus the frustrations of the medical community had almost instantly been transformed in Georgia into a courageous determination that the profession would regulate itself, that it would support the legislation, that it would drive the clinics and the physician working there out of business and out of the State.

That determination was carried even a step further shortly thereafter, when the medical board, anticipating that the clinics would shift into other drugs, adopted tough standards of professional practice with respect to amphetamines.

The results of the legislative action in Georgia may be stated simply. They were a success. The stress clinics have vanished. We believe they have moved to other States that continue to permit the wholesale prescribing of the drug.

Prescriptions for the drug dropped precipitiously just before its effective date, and there is data as yet unpublished that suggest that overdoses of methaqualone in Georgia have been reduced by something on the order of 40 percent since the law passed.

My recommendation, Mr. Chairman, is that the Congress adopt legislation similar to that passed in Georgia and Florida. Methaqualone is a drug that is highly susceptible to abuse. As has been said here, and according to physicians who supported our legislation, it is a drug whose medical effects can be achieved equally as well or better through other drugs, that are not so susceptible to

abuse. Its use among legitimate practitioners is minimal. It's damage to the public through stress clinics is extensive and obvious.

I wholeheartedly agree with those who say that a physician should have broad discretion in the practice of his profession, but to advance that argument in favor of keeping methaqualone as a schedule II drug is to miss the larger picture and to put a narrow self-interest of no practical consequence ahead of a major social problem that touches the lives of everyone in this country.

A single decisive legislative step can solve a major part of the drug problem in this country, that cannot be solved in any other way. Thank you.

Mr. WAXMAN. Thank you very much.

Mr. Poythress, you talked about the attitude of the medical community in your State. How would you describe what it was like before the ban, and what was their reaction after the ban went into effect?

Mr. POYTHRESS. We frankly anticipated opposition from the medical community. We knew that there were individual cases of physicians calling, reporting overdoses who were angry and upset about the stress clinics. At the same time we felt that the medical community generally would oppose the legislation as a curtailment of professional judgment. We were delighted when the profession essentially closed ranks behind the legislation, with a clear-cut determination that they would regulate themselves, that they would deal with those members of their own profession who were abusing their professional license.

Mr. WAXMAN. Mr. Lippman, what was the medical profession's attitude toward the ban in your State?

Mr. LIPPMAN. Well, Mr. Chairman, I can tell you very honestly we sort of boxed them legislatively. What had happened was, in the previous session, we had attempted to create a law in the State of Florida which would allow for triplicate prescription blanks to be used for any controlled substance product. That meant that there would have been ultimate inventory control not only by the regulatory agency, the Department of Professional Regulation in the State of Florida, but as well as DEA and the inventory control directly in the pharmacy as well as the doctor's office.

Out of that consequence, and there was a great deal of harangue between the organized medical community and the legislature, we did come up with an agreement to run a test of one particular product. That particular product happened to be methaqualone in the State of Florida, and what we did was we inventoried all of the prescription items in the State, dispensed as well as inventory and wholesalers and in pharmacies in the State of Florida.

I think the medical community was quite shocked to see the number of methaqualone prescriptions that were being dispensed in the State of Florida, and as a result of that particular oversight and action by the legislature, a number of physicians were brought up on charges, and therefore ended up losing their licenses, and/or suspending of the same.

I say that in light of the fact that it was very difficult then for them to state the aforementioned statements that were brought to your attention, that is, that they themselves. And it is very inter-

esting to hear—your colleague Congressman Smith and your colleague Congressman Rowland have said that they are sort of on a no opposition, or they are staying clear of this particular piece of legislation now.

That sounds like going to one of my own supporters and saying, "Well, are you going to be with me this time?"

They say, "Well, I have to sit out this election."

Those are the people you have to watch out for.

I really believe, Mr. Chairman, that generally the organized medical community does not want anyone to interfere with their professional prerogative, but I believe that if you would look very carefully at the fact that nearly 60 to 65 percent of all the costs built around drug products dispensed in this Nation have to do with detailing and advertising, then you would see that much of their professional prerogative is nothing more than public relations or hype that comes from many of the different public relations firms in this Nation.

So I would say to you, Mr. Chairman, that I think it is their professional responsibility to recognize, and that is where we lead them to believe that that was their professional responsibility, after providing them with information to the fact that many of their colleagues were prescribing methaqualone, that it is their professional responsibility to remove the product from the market because of the tremendous death rate that was occurring in the State of Florida.

Mr. WAXMAN. Dr. Dudney and Dr. Wright, I would like to ask what the effect has been in the illicit market since the rescheduling of methaqualone. Has this affected the demand in the illegal market, and what impact has it had on price within that market?

Dr. WRIGHT. About the time that the publicity concerning the passage of the State legislation was going on, we saw a change in what was available. We closed the biggest stress clinic by finally, after years of work, a Federal arrest. We began to see more of the illegal, illicit type of methaqualone that was the Valium alone or Valium-Quaalude combination.

Soon after the law passed and went into effect, starting—it went into effect on July 1—by September-October a year ago, the illegal stuff began to dry up as well. The cost on the street went from going somewhere in the vicinity of $2.50 to $5 a tablet up to its current approximately $15, occasionally $20 on the street, and just an apparent considerable dropoff in the use of this drug.

We have a very sensitive way to gauge this. The legislature of Florida has given us an exceptionally good law in regard to DUI drugs. We are one of the few States in the United States that has a good DUI drug law, and we have a very nice way then to measure the use of drugs in the community, and what we have seen is a just spectacular decline in the use of methaqualone since it became a schedule I.

Dr. DUDNEY. The illegal substances follow pretty much standard supply-and-demand economics. When the drug first became illegal in Georgia the price went up, because the availability went down, and then after a period of months, when the quality dropped because the drugs were counterfeit, likewise the price dropped, and

what is now alleged to be a Quaalude in the middle Georgia area sells for $4 or $5 apiece.

But again let me stress here in my opinion, the problem is not the stress clinics. The stress clinics can be controlled from ways other than what we are talking about here today. The problem is that this particular drug has a disproportionate amount of damage in terms of its national pattern, because of its reputation for being a particularly exciting euphorian.

Mr. WAXMAN. So the drug has a reputation which makes it attractive to people who want to use and abuse drugs?

Dr. DUDNEY. And no medical indication.

Mr. WAXMAN. And no medical indication?

Dr. DUDNEY. No legitimate medical indication. There are safer drugs that can be used for anything that a Quaalude could be legitimately prescribed for.

Mr. WAXMAN. The only thing, therefore, that methaqualone can be used for is for abuse?

Dr. DUDNEY. That is essentially correct, yes.

Mr. WAXMAN. Mr. Nielson.

Mr. NIELSON. Mr. Lippman, you wanted to comment on that last question?

Mr. LIPPMAN. I was just going to say, Mr. Chairman, one of the very interesting things about methaqualone is the fact that the time that it appeared as a popular product was a very interesting period in our history. It was the Vietnam conflict, and the residual effect of seeing so many heroine addicts coming back to this Nation, and it was the periphery of heroin use in this Nation at that particular point in time, and LSD use and everything from smoking bananas to smoking book covers.

The product itself gained the reputation, as stated by these experts, as an aphrodisiac, and therefore became the safe product. I think that that is a very important point. It is important because I can understand once again the reticence of FDA or any other regulatory body that has to make statements based upon technical data.

But the State of Florida, in passing its law, made statements to the effect that we recognize that this has medical capabilities and medical use. However, that the overriding consideration was the harm caused by the overdosage and the abuse of the product in the State of Florida. So it became not a medical decision; it became a policy decision of the State of Florida to take action based upon the abuse.

Mr. NIELSON. Dr. Dudney, Dr. Wright, either one of you or both, let me ask the same question I asked Representative Dr. Rowland; why has the AMA been so unwilling to take a stand on this one way or the other, particularly in view of the Journal written in February outlining some of the things you mentioned here today? What is your opinion?

Dr. DUDNEY. I am sorry, I don't have an opinion on that issue.

Mr. NIELSON. Dr. Wright, do you have an opinion?

Dr. WRIGHT. You probably ought to ask a member of the AMA.

Mr. NIELSON. I assume that—you are MD's—I assume you are members of AMA. You don't have any clue as to what the policy is. They are not going to speak to us today, apparently.

Mr. WAXMAN. The AMA has been invited. They will be submitting written testimony, so we will have the benefit of their official views on this bill.

Mr. NIELSON. I am disappointed that the man from Illinois is not here. I was going to ask about what happened in Illinois. Both Florida and Georgia indicated they have problems that have been passed on to Illinois now. Do any of you have any clues as to what is happening in Illinois or in any other State after it has left Florida and Georgia?

Mr. LIPPMAN. Congressman Nielson, if I might. Immediately upon passage of our bill, I had a number of conversations with the news networks that were doing investigative reports in Chicago about the stress clinics. Then I had spoken to people from the attorney general's office and the speaker's office of the Illinois House, and they basically inherited that which we chased out of our States.

When you recognize the tremendous sums, the gentleman at my far right—and I have apologized for not knowing the gentleman's name—from Georgia made mention of the fact that the tremendous quantum of product being dispensed in one ZIP code, the point that I made before, if you multiply 120-some-odd tablets times 10 million people in the State of Florida, you recognize the tremendous quantum of drugs that was being dispensed in our State based upon a legal premise, that is, legal product.

I think that the people in Illinois were primarily responding to "What did you do to us" and as I understand, they have just passed a law which is similar to our law, once again looking at the fact that they have stated by policy the fact that they recognize that this product does have medical acceptance, but it does have a tremendous abuse potential.

I mentioned before, and some of you might want to look very carefully at the LSD question, because in essence LSD or a deriviative of LSD was a legal substance in this country for many years, made by Sandoz. The product in itself was not a class product, but has been removed from the market, so there is some, at least some standard here by which you can look to, not based upon just again the technical knowledge of the fact that this product does not have a true hypnotic effect, but it does have a tremendous abuse potential and problem in this country.

Mr. NIELSON. Mr. Poythress, would you like to comment on that?

Mr. POYTHRESS. Yes, sir. Our information is, indeed, that the people who came to visit us from Florida moved on to Chicago where they are now operating. I might point out one small characteristic of the problem that we haven't mentioned. We have not totally eliminated the problem in Georgia, nor would I suggest that Florida has. To the extent that States have reciprocity in their medical communities, a properly labeled prescription bottle from another State becomes a suitcase in which you can lawfully possess a methaqualone in Georgia or Florida or any other State that outlaws it.

I think that illustrates as well as anything we have said the national nature of the problem.

Mr. NIELSON. Thank you, Mr. Chairman.

Mr. WAXMAN. Let me ask members of the panel if they would comment on whether further reducing the methaqualone quota, whether that in lieu of rescheduling, would be adequate to reduce the abuse.

Mr. LIPPMAN. These folks around me are all technical folks. I am just a plain old street person, so let me just talk from that point of view, Mr. Chairman.

I think the abuse potential would be dramatically reduced, because of the fact that this drug is very peculiar in the fact that the classification of individual using the drug is not usual to the typical drug abuse community, and I think that what they are looking for, they are looking for quality control.

They are looking for the semblance of legitimacy in the fact that this is a product that is available. I think that once the legitimacy and the quality control question is placed before these same folks, and it is said to them that you no longer can get a Quaalude or a methaqualone product that is properly manufactured, I think that the abuse potential would be dramatically reduced.

Mr. WAXMAN. You are saying the abuse potential would be dramatically reduced if we just reduced the quota?

Dr. DUDNEY. I disagree with that. If a high-quality product was still made, then you would get into the problem of the street user being hoodwinked into buying what they would assume was a good quality high.

Mr. WAXMAN. So if the Drug Enforcement Administration's recommendations, which we will hear in a few minutes, were in lieu of rescheduling, to reduce the allowable quota of Quaaludes——

Dr. DUDNEY. That would not help the problem.

Mr. WAXMAN. Why would it not help the problem?

Dr. DUDNEY. Because the street user would still believe that good Quaalude was available, even if the quantity was smaller. It, of course, would raise the price, and it would actually increase the cult myths and public relations about just how wonderful Quaaludes are, because the more rare they became the more people would talk about how terrific they were, whenever they found some.

Mr. WAXMAN. I assume in Florida and Georgia your controlled substances statutes are similar to the Federal law. Why didn't your States find it necessary to reschedule the drug by statute rather than administrative action? Do any of you have any opinion whether FDA or DEA have sufficient administrative discretion to place methaqualone in schedule I? Mr. Lippmann.

Mr. LIPPMAN. Mr. Chairman, in the State of Florida we don't have the administrative capability of rescheduling.

Mr. WAXMAN. You have to do it by statute?

Mr. LIPPMAN. We have to do it by statutes, and also to be very blunt, even if we did have that administrative capacity, I would assume—and I am not demeaning the corporate entity, but I assume that the Lemon Corp. would have us in court for the next 10 years.

Mr. POYTHRESS. The same is true in Georgia. We do not have administrative authority to reschedule it.

Mr. WAXMAN. As I understand what FDA is going to tell us, under the Federal statute they would have to make a finding that

there is no currently accepted medical use for this drug. Methaqualone has an approved NDA which demonstrates its effectiveness when used for therapeutic purposes. It does not appear, therefore, that the Federal Food, Drug and Cosmetic Act gives FDA authority to withdraw a drug based upon a drug's actual or potential illicit use. I think that is the argument we are going to hear from them.

I guess if they feel they don't have enough administrative authority then changing the statute is the only recourse open to us.

Let me thank each of you very much for your testimony. We appreciate your assistance in looking at this issue, and we want to work with you as we prepare Federal legislation. Thank you.

Our final panel is composed of Gene Haislip, Deputy Assistant Administrator of the Drug Enforcement Administration, and Dr. Mark Novitch, Acting Commissioner, Food and Drug Administration. Mr. Novitch is accompanied by Thomas Scarlett, Chief Counsel, and Dr. Paul Leber, Director of the Division of Neuropharmacological Drug Products.

Without objection, all of your statements will be made part of the record and printed in full, and we would like to ask you if you would care to summarize those statements. Mr. Novitch, why don't we hear from you first.

STATEMENTS OF MARK NOVITCH, M.D., ACTING COMMISSIONER, FOOD AND DRUG ADMINISTRATION, OFFICE OF ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY THOMAS SCARLETT, CHIEF COUNSEL, AND DR. PAUL LEBER, DIRECTOR, DIVISION OF NEUROPHARMACOLOGICAL DRUG PRODUCTS, OFFICE OF NEW DRUG EVALUATION; AND GENE R. HAISLIP, DEPUTY ASSISTANT ADMINISTRATOR, OFFICE OF DIVERSION CONTROL, DRUG ENFORCEMENT ADMINISTRATION, DEPARTMENT OF JUSTICE

Dr. NOVITCH. Thank you, Mr. Chairman.

Mr. Chairman, I would like to submit my statement for the record and read only the major points.

Mr. WAXMAN. We would appreciate that. Your statements are part of the record now and we would like you to summarize the major points.

Dr. NOVITCH. Thank you. We welcome the opportunity to discuss the use and abuse of methaqualone and to comment on the bills before you, H.R. 1055 and H.R. 1097, which would reschedule methaqualone from schedule II to schedule I of the Controlled Substances Act.

I think it would be useful at the outset, Mr. Chairman, to summarize briefly the Food and Drug Administration's authorities and responsibilities with respect to drugs of abuse. Under the Food, Drug, and Cosmetic Act, our primary responsibilities are to insure that new drugs are safe and effective for their recommended use prior to marketing and that marketed drugs are not adulterated nor misbranded.

FDA's role in the drug abuse area is limited primarily to preparing domestic scheduling recommendations which are forwarded to DEA by the Assistant Secretary for Health. In preparing these rec-

ommendations, we consult closely with our sister agency, the National Institute on Drug Abuse, and in addition we often seek the advice of our own drug abuse advisory committee.

It was through this domestic scheduling process that methaqualone was placed in schedule II of the CSA in 1973, and as we have heard today, schedule II is the most restrictive schedule for drugs with an accepted medical use.

In addition to scheduling, FDA also assists DEA by providing information that the agency uses in establishing annual quotas for schedule II drugs including methaqualone.

The issue presented today is whether the Congress should pass a law that would reschedule methaqualone from schedule II to schedule I, thereby removing it effectively from the legitimate market. The rationale for such legislation would be that the societal implications of methaqualone's abuse outweigh its utility as a therapeutic agent. Knowing the history of methaqualone abuse that has been recounted so graphically here today, it is very difficult for me to counsel a different approach, but there are at least three points that in my view suggest that legislation is not needed at this time.

First, all indicators available to us show that the scope of methaqualone abuse is declining rapidly and substantially.

Second, additional administrative actions are being considered by the agencies to reduce methaqualone abuse still further.

Third, the legislation would, as you said and others have said today, in effect remove a safe and effective therapeutic agent from medical practice.

Mr. Chairman, I think it would be helpful for me to describe briefly the medical utility of methaqualone, the scope and trends of methaqualone abuse, to the extent that we know them, and additional administrative actions that may be available to us.

FDA approved the first new drug application for methaqualone in 1965 for use as a sedative-hypnotic drug. Data since then have confirmed the safety and effectiveness of methaqualone for its intended use, and FDA is not aware of any unique risks associated with methaqualone that are not shared by other marketed sedative-hypnotic drugs.

Methaqualone may be classified in a miscellaneous category of about 10 sedative-hypnotic drugs that are distinct from both barbiturates and benzodiazepines. For this reason their miscellaneous categories, often referred to as the nonbarbiturate, nondiazepine hypnotics. Others of this group all introduced around the same time as recounted by Congressman Rowland include placidilechorvanol, Dordin, or glutethamide and Noludar, whose generic name is methperalon.

In terms of relative safety, methaqualone appears to fall somewhere along the spectrum between the barbiturates on the one hand and benzodiazepines on the other. For example, methaqualone appears to be intrinsically less lethal than commonly used barbiturates. In contrast, benzodiazepines as a class appear to be relatively safer than either the barbiturates or the misellaneous group that incudes methaqualone.

In particular, benzodiazepines have a much wider gap between their therapeutic doses and their lethal doses than do any other class of hypnotics including methaqualone. It is not possible, how-

ever, to state that benzodiazepines are superior to all hypnotics in all patients under all conditions of reasonable use.

Thus, in our view, methaqualone continues to be safe and effective for use under the conditions for which it was approved. While methaqualone has no unique therapeutic advantage over other marketed drugs, physicians often prefer one drug over a similar one and it is not uncommon for some patients to respond differently to different drugs apppoved for the same indication.

Today we recognize that virtually all sedative, hypnotic drugs have the potential to cause both psychic and physical dependence although with varying severity.

Methaqualone is considered to have a high potential for abuse and accordingly in 1973 was put in schedule II of the Controlled Substances Act.

As the abuse potential of methaqualone became apparent, FDA revised its labeling to draw attention to the drug's ability to cause psychic as well as physical dependence and the current labeling of methaqualone clearly identifies this risk.

Regarding the current scope of actual abuse, diversion and illicit trafficking of methaqualone, I will defer to my colleague from the Drug Enforcement Administration who is also testifying here today, but I would like to share with you several facts that suggest that the scope of methaqualone abuse is in fact decreasing.

First, prescription sales of methaqualone have steadily decreased in the decade following full recognition of the drug's abuse potential.

In 1973, at the height of its use, over 4 million prescriptions were written.

By contrast, in 1982, last year, less than 300,000 prescriptions were written, a reduction of more than 90 percent, and this total includes prescriptions written in the so-called stress clinics.

Second, data supplied to us by the National Institute on Drug Abuse based on the drug abuse warning network or DAWN system, show that DAWN mentions for methaqualone declined by about 50 percent over the last 3 years.

A declining scope of abuse mirrors what we understand to be a sharply decreased supply of illicit methaqualone based on efforts by DEA and State and local authorities, more of which we will hear in a few minutes.

We believe that the most promising administrative action is for us to modify our methods used to arrive at quota estimates for legitimate medical need, thereby using our existing mechanisms under the CSA schedule II.

As I said earlier, we are required under the Public Health Service Act to supply DEA on an annual basis with estimates of legitimate medical needs for schedule II drugs.

DEA uses this and other information to arrive at the actual quota for the year and under DEA regulations the quotas can be adjusted during the year if the estimates do not correspond to actual medical needs.

Traditionally our quota estimates have been based on trend analyses of prescriptions written in the preceding several years.

Thus our estimates are basically reactive in nature rather than proactive. By this I mean we look at the number of prescriptions

written for the drugs in question over the past several years, and if these data show a downward trend, then we would project a further downward trend in the same degree.

In the case of methaqualone, the quota estimates have been steadily decreasing. The question is whether they could justifiably be reduced even more rapidly using a prospective model.

For example, such reduction could possibly be justified by subtracting the number of prescriptions being written by the so-called stress clinics referred to earlier, assuming that that amount could be estimated with any degree of certainty.

We are examining ways to define more precisely the appropriate medical use of methaqualone, in which case the amount needed for legitimate medical use may also decrease.

We are pursuing with DEA these and other avenues for quota reductions as we work jointly toward reducing methaqualone abuse.

One alternative we would not support would be for FDA to withdraw approval of the new drug application for methaqualone under section 505 of the Food, Drug and Cosmetic Act.

This is because the type of abuse found with methaqualone is independent of its safety for the use recommended in the approved labeling. We do not think as a general rule FDA ought to consider extra label abuse in assessing the safety of a drug under section 505, particularly when there are alternative means to limiting abuse of the drug.

The agency's principal mandate under section 505 is to decide whether a drug has a legitimate medical purpose and whether it can be safely used for that purpose under the conditions provided in the labeling.

We also don't believe that the FDA may administratively recommend rescheduling under the Controlled Substances Act from schedule II to schedule I so long as methaqualone has an approved NDA.

In summary, Mr. Chairman, we believe that methaqualone continues to have a legitimate medical use; that the scope of abuse appears to be declining rapidly, and that there are further administrative actions that can be taken, and so it does not appear that the legislation under consideration, at least not to us, is necessary at this time.

My colleagues and I will at the appropriate time be willing to answer any questions you may have.

[The statement of Dr. Novitch follows:]

STATEMENT

BY

MARK NOVITCH, M.D.

ACTING COMMISSIONER

FOOD AND DRUG ADMINISTRATION

PUBLIC HEALTH SERVICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman:

We welcome the opportunity to appear before your Subcommittee to discuss the use and abuse of methaqualone, and to comment on bills, H.R. 1055 and H.R. 1097, which would reschedule methaqualone from schedule II to schedule I of the Controlled Substances Act (CSA).

BACKGROUND

I think it would be useful, at the outset, to summarize briefly the Food and Drug Administration's (FDA) authorities and responsibilities with respect to drugs of abuse.

Under the Federal Food, Drug, and Cosmetic Act (FD&C Act), our primary responsibilities are to ensure that new drugs are safe and effective for their recommended uses prior to marketing, and that marketed drugs are not adulterated or misbranded. Although Congress in 1965 passed the Drug Abuse Control Amendments to the FD&C Act, thereby vesting FDA with considerable drug control functions, under a 1968 reorganization plan these functions were transferred to the Department of Justice, and ultimately to the Drug Enforcement Administration (DEA). In 1970, DEA's authority was expanded and formalized by the passage of the Controlled Substances Act.

Today, FDA's role in the drug abuse area is limited primarily to preparing domestic scheduling recommendations, which are forwarded to DEA by the Assistant Secretary for Health. In preparing these recommendations, we consult closely with our sister agency, the National Institute on Drug Abuse (NIDA); in addition, we often seek the advice of our Drug Abuse Advisory Committee. Under the CSA, domestic scheduling recommendations from the Department of Health and Human Services are binding upon DEA with respect to scientific and medical matters.

It was through this domestic scheduling process that methaqualone was placed in CSA schedule II in 1973. As you know, schedule II is the most restrictive schedule for drugs with an accepted medical use.

In addition to scheduling, FDA also assists DEA by providing information DEA uses in establishing annual quotas for schedule II drugs, including methaqualone. Under the Public Health Service Act, FDA has the responsibility for estimating the legitimate medical needs for these drugs. I will discuss the process for arriving at quota estimates a little later. Under current regulations, our quota estimates are considered advisory in nature, and DEA is empowered to take other factors into account in establishing these quotas.

SUMMARY OF POSITION

The issue presented today is whether the Congress should pass a law that would reschedule methaqualone from schedule II to schedule I of the CSA, thereby removing it from the legitimate market. The rationale for such legislation would be that the societal implications of methaqualone's abuse outweigh its utility as a therapeutic agent. We believe the facts should be compelling before such action is taken. In this connection, we would like to emphasize three points:

1. The legislation would have the effect of removing a safe and effective therapeutic agent from the market,

2. The scope of methaqualone abuse appears to be declining, and finally

3. There are additional administrative actions that are being considered in order to reduce methaqualone abuse even further.

Thus, we do not believe that legislation is needed at this time.

I would now like to describe for you briefly the medical utility of methaqualone, the scope and trends of methaqualone abuse to the extent we know them, and administrative actions that may or may not be available.

METHAQUALONE'S LEGITIMATE MEDICAL USE

FDA approved the first new drug application for methaqualone in 1965 for use as a sedative/hypnotic drug. In concluding that methaqualone was safe and effective for its intended uses, FDA relied on over 30 clinical studies that included over 1,000 human subjects. More recent data have confirmed the safety and effectiveness of methaqualone for its intended uses, and FDA is not aware of any unique risks associated with methaqualone that are not shared by other marketed sedative/hypnotic drugs.

Methaqualone may be classified in a miscellaneous category of approximately ten sedative/hypnotic drugs that are distinct from both barbiturates and benzodiazepines. For this reason, their miscellaneous category is often referred to as non-barbiturate, non-benzodiazepine hypnotics, or "non-B's, non-B's" for short. Other well-known non-B's, non-B's include ethchlorvynol (Placidyl), glutethimide (Doriden), and methyprylon (Noludar).

In terms of relative safety, methaqualone appears to fall somewhere along the spectrum between the barbiturates on one end and benzodiazepines on the other. For example, methaqualone appears to be intrinsically less lethal than commonly used barbiturates (such as secobarbital, pentobarbital, and amobarbital) and even chloral hydrate, a non-B, non-B sedative/hypnotic drug that is commonly promoted as

quite safe for use in certain patient populations, such as the elderly.

In contrast, benzodiazepines as a class appear to be relatively safer drugs than either barbiturates or non-B, non-B drugs like methaqualone. In particular, benzodiazepines have a much wider gap between their therapeutic doses and lethal doses than do any other class of hypnotics, including methaqualone. It is not possible, however, to state that benzodiazepines are superior to all other hypnotics in all patients under all conditions of reasonable medical use.

Thus, in our view, methaqualone continues to be safe and effective for use under the conditions of use for which it was approved. While methaqualone has no unique therapeutic advantages over other marketed drugs, physicians often prefer one drug over a similar one, and it is not uncommon for some patients to respond differently to two different drugs approved for the same indication.

METHAQUALONE AS A DRUG OF ABUSE

Although this fact was not understood at the time methaqualone was first approved for marketing in 1965, today we recognize that virtually all sedative/hypnotic drugs have the potential to cause both psychic and physical dependence, although of varying severity. Methaqualone is considered to have a high potential for abuse and, accordingly, in 1973 was placed in schedule II of the CSA, the most restrictive schedule for marketed drugs.

As the abuse potential of methaqualone became apparent, FDA revised its labeling to draw attention to the drug's ability to cause psychic and physical dependence. The current labeling of methaqualone clearly identifies this risk. As mentioned earlier, these risks are not unique to methaqualone. Several barbiturates have also been placed in schedule II. In contrast, benzodiazepines are considered to have a lower abuse potential and are listed in schedule IV.

Regarding the current scope of actual abuse, diversion, and illicit trafficking of methaqualone, I would defer to officials from the Drug Enforcement Administration who are also testifying here today. However, let me share with you several facts that suggest that the scope of methaqualone abuse is decreasing.

First, prescription sales of methaqualone have steadily decreased in the decade following full recognition of the drug's abuse potential. In 1973, at the height of its use, over 4 million prescriptions were written. In contrast, in 1982, less than 300,000 prescriptions were written--a reduction of more than 90 percent-- and this total includes prescriptions written in so-called "stress clinics." Thus, as the scope of medical prescriptions for methaqualone has dramatically decreased, so presumably would the scope of abuse. Currently, methaqualone represents less than 1.5 percent of prescriptions written for sedative/hypnotic drug products.

Second, data supplied to us by the National Institute on Drug Abuse, based on the Drug Abuse Warning Network (DAWN), show that DAWN mentions for methaqualone (indicating medical consequences of abuse necessitating a visit to an emergency room or other health professional) have decreased sharply within just the last three years. To give an example, DAWN mentions have dropped by approximately 50 percent over the last three years.

A declining scope of abuse mirrors what we understand to be a sharply decreased supply of illicit methaqualone, based on efforts by DEA and State and local authorities. This involves both a decrease in the illegal importation of methaqualone from foreign countries, a source

that apparently accounted for much of the illicit U.S. supply of methaqualone in the past, and the fact that a number of so-called "stress clinics" have been closed.

ADMINISTRATIVE ACTION

We believe that the most promising administrative action is for us to modifiy our methods used to arrive at quota estimates for legitimate medical need, thereby using our existing mechanism under CSA schedule II.

As noted above, we are required under the Public Health Service Act to supply DEA, on an annual basis, with estimates of the legitimate medical needs for schedule II drugs. DEA uses this and other information to arrive at the actual quota for the year. For example, DEA also considers data about existing inventories, the amount of drug substance imported or exported, the time needed to manufacture a finished drug product from the bulk substance, and drug supply in the distribution "pipeline." Thus, FDA's estimate is but one factor considered in the quota determination. Under DEA regulations, the quotas can be adjusted during the year if the estimates do not correspond to actual medical needs.

Traditionally, our quota estimates have been based on trend analyses of prescriptions written in the preceding several years. Thus, our estimates are basically "reactive" in nature rather than "proactive." By this I mean we look at the number of prescriptions written for the drugs in question over the past several years. If those data show a downward trend, then we would project a further downward trend in the same degree. The same would work in reverse were there an upward trend.

In the case of methaqualone, the quota estimates have been steadily decreasing. The question is whether they could justifiably be reduced even more rapidly using a prospective model. For example, such reduction could possibly be justified by subtracting the number of prescriptions being written by the so-called "stress clinics" referred to above, assuming that amount could be estimated with any degree of certainty. We are examining ways to define more precisely the appropriate medical uses of methaqualone, in which case the amount needed for legitimate medical use may also decrease. It should be recognized that the effect of decreasing the quotas is a complex issue, and one on which everyone might not agree. For example, some people view decreasing the quotas as limiting only legitimate use, but that those who seek to abuse the drug will manage somehow to

get it. Nevertheless, we are pursuing with DEA these and other avenues for quota reductions as we work jointly towards reducing methaqualone abuse.

One alternative we would not support would be for FDA to withdraw approval of the new drug application for methaqualone under section 505 of the Federal Food, Drug, and Cosmetic Act. This is because the type of abuse found with methaqualone is independent of its safety under the conditions prescribed, recommended, or suggested in the approved labeling. We do not think that, as a general rule, FDA ought to consider extra-label abuse in assessing the "safety" of a drug under section 505, especially when there are alternative means to limiting the abuse of the drug. The Agency's principal mandate under section 505 is to decide whether a drug has a legitimate medical purpose and whether it can be safely used for that purpose under the conditions provided in the labeling.

We also do not believe that FDA may administratively recommend rescheduling under the CSA from schedule II to schedule I so long as methaqualone has an approved NDA.

CONCLUSION

In summary, we believe that methaqualone continues to have a legitimate medical use, that the scope of abuse appears to be declining rapidly, and that there are further administrative actions that can be taken. Thus, it does not appear that the legislation under consideration is necessary at this time.

My colleagues and I will be happy to answer any questions you may have.

Mr. WAXMAN. Thank you very much.
Mr. Haislip.

STATEMENT OF GENE R. HAISLIP

Mr. HAISLIP. Thank you, Mr. Chairman. I am pleased to be able to appear and testify in connection with legislation that is being considered, H.R. 1055 and H.R. 1097, to reschedule methaqualone from schedule II into schedule I. What I would like to do first, having submitted a statement for the record, is to summarize its contents and, in the course of doing so, I have a number of graphics which I think illustrate certain points in my testimony. If I may, I would like to present those to you at the appropriate moment.

Methaqualone is a unique drug when considered from the standpoint of abuse and illicit traffic. I do not know the reasons for this uniqueness, but its history has been marked by explosive abuse on two occasions.

When methaqualone was first introduced into legitimate medical practice, it was a noncontrolled drug under our law, and there was no reason at that time to suppose that controls would be necessary.

Shortly thereafter, we experienced a sudden and otherwise unexplainable surge of abuse and illicit traffic in methaqualone. This was in 1972, which led us to place this drug into the highest schedule of control reserved for drugs which do have a legitimate need.

Now, at that time it appears that that legal action had a substantial impact in reducing methaqualone abuse, so that for several years thereafter the situation was more favorable, reduced and somewhat stabilized.

Then quite suddenly again, beginning in 1979, there was another and even more rapid and larger explosion of methaqualone abuse. We saw at one period of time that this was the fastest growing drug of abuse in the United States, faster than any other drug of abuse, including heroin or cocaine, and in a very short period of time this drug was causing as many deaths and injuries as heroin or any other drug, and in some months apparently more.

It appears that the drug was being abused primarily by a younger group of people. We saw the greatest increase on a percentage basis of abusers between the ages of 11 and 20 years.

Also, it appears to be affecting predominantly middle-class and predominantly white young people.

We also found that drug dependence, a physical addiction, was an increasing reason from the abuse of methaqualone. This drug does produce physical dependence, and it does result in overdose deaths. In addition to that, it appears that a great deal of harm and death and injury have been caused to innocent people because of the many automobile and other types of accidents associated with methaqualone abuse, in which innocent people are involved as victims.

Now, if we look at the production and availability of methaqualone in the United States, which I will show you in a moment, we see that there has been a continuous decline in that, in spite of the fact that this problem was growing at a tremendous pace. We identified several reasons for this but perhaps the major reason was the

importation, the smuggling of methaqualone in very large quantities into the United States from overseas, and I would like to show you the chart, if I may, at this time.

What we discovered, Mr. Chairman, was that most of the methaqualone in the illicit traffic was coming from Colombia, in the form of counterfeit tablets which looked exactly like the Quaalude tablets that are legitimately available in the United States.

These tablets were being counterfeited from methaqualone powder that had been obtained from legitimate sources in several countries overseas.

Now, the map that you see in front of you shows those sources, but I should hasten to point out that at the time that we began our program to attack this traffic, we did not know that each of these sources existed.

We discovered them one by one, and the first source we discovered was the People's Republic of Hungary in Central Europe, which was a major source of supply.

In this case, and in all of the cases, the manufacturing sources were unaware of what was happening because it was being arranged by middlemen, international commodities brokers, principally stationed in the free zones, and principally in the Port of Hamburg.

When the Hungarians were apprised of the situation, they took immediate and effective action. Their cooperation was outstanding in this regard.

Then we discovered that a great deal of the methaqualone was coming from the Federal Republic of Germany and, of course, their processes are more like our own. They tend to take a little bit of time, but after appropriate inquiry remedial action was taken.

Then we discovered that considerable amounts of methaqualone were also at this same time coming from Austria. Action has been taken in Austria.

Finally, it was learned that perhaps in excess of 30 or 40 tons of methaqualone was entering the illicit traffic from the Peoples Republic of China, again through brokers who were organizing this traffic with the violators, principally in Colombia, but to some extent also in Canada and Mexico.

After a period of time, working with the Chinese Government, with the help of Members of Congress, that situation has also been controlled.

Switzerland was the last identified source, and it was only within the last several months that the Swiss imposed the legislation needed to deal with the problem.

Now, you see on the map that India is also a source of supply. That is correct, and we believe most of the methaqualone manufactured in India is also diverted into the illicit traffic, but at least at the moment does not appear to be affecting this country.

We discovered that a number of countries in the world were affected by this diversion, similarly to the United States.

Now, the important thing about the traffic that is illustrated by the chart is the size of it. I would like to show you the next chart, if I may.

These are photographs of different seizures of methaqualone, which were diverted from international commerce from these var-

ious countries, all of which was destined for the illicit traffic in the United States.

Each seizure is a different one, and each seizure involves customarily several tons of material.

In this case, the ship was smuggled into the United States by aircraft, and is disguised as common salt. Here this material was disguised as fertilizer.

Many of these barrels and drums that you see here were not disguised at all, but were clearly labeled methaqualone when they were seized.

The volume of this traffic we believe was enormous.

In 1980 and 1981 approximately 7 or 8 metric tons of material was available from legitimate sources in the United States, but we think that in the calendar year 1981 approximately 120 tons, 120 metric tons or more, was being diverted from international commerce into the United States by way of Colombia, where the powder from the drums would be manufactured into counterfeit Quaalude tablets.

Next, I would like to show you the tablets themselves that have made up the problem in the United States.

In the blue patch you see are the authentic methaqualone tablets. The Quaaludes have been most common in the United States; sopors which are no longer manufactured and have not been manufactured for some years; and the less common Mequin. All three are legitimate preparations manufactured in the United States. This tablet here called Mandrax is also methaqualone.

Mandrax is the name of the tablet most common in Europe. Clustered around these blue authentics you see various kinds of counterfeit Quaaludes that are made in Colombia, Mexico, and Canada, Perhaps one of the most important things to point out about this is it shows that in many cases drugs other than methaqualone have been used to manufacture these counterfeits.

For example, we have something as harmless as sugar. This is what we call our candy Quaalude. On the other hand, we have Quaaludes made from PCP; others from phenobarbitol, a controlled drug, and even aspirin.

The most common at the present time are Quaaludes made out of diazepam, what is called Valium (R) here in the trade, but at the time that most of this traffic was flourishing, the overwhelming number of Quaaludes were made out of methaqualone. They generally tended to have about the same amount of methaqualone in them as the legitimate tablets that you see here in the blue; that is to say, approximately 300 milligrams.

I would like to return to this chart a little bit later.

In addition to the very enormous amount of methaqualone being diverted from overseas, we also have found that a great quantity of the methaqualone that is legitimately available in this country is also diverted into the illicit traffic, principally through the technique of the stress clinics that you have heard described, but nevertheless, it is important to keep these problems in perspective. If you will look at this chart, you will see represented the quotas for methaqualone on an annual basis that were established by the Drug Enforcement Administration from 1978 to 1983. What you

will see is a very significant, sharp decline in the quantity of the material that is available for either legitimate use or otherwise.

Now, in 1981 we discovered that distribution exceeded the amount that we thought should be available, and we undertook a series of quota cuts which cumulatively over two years amount to a 70-percent reduction.

Again, this was based on the significant evidence of diversion of methaqualone from the illicit traffic.

The DEA program of attacking this traffic had hinged basically on two efforts. The first is to secure the elimination and control of supplies abroad through diplomacy, using the intelligence and cases that we were able to make to demonstrate what was happening.

We pursued these objectives both bilaterally with each individual country, and multilaterally at the United Nations Commission on Narcotic Drugs.

As you can imagine, Mr. Chairman, pursuing the effort in each case presented its own unique problems, and in some cases was easier than others, but, nevertheless, it is a fact that we have thus far successfully pursued this diplomatic effort. New controls have been applied in each of these countries and we believe in those cases, the sources of methaqualone for international diversion have been eliminated.

We are not entirely satisfied that we have identified every source or that there are no cracks in this control system, but basically we believe that the basis for eliminating the sources have been established.

The methaqualone that is available legitimately in the United States, of course, presented a whole different problem. What we did in that case was to undertake, sometimes in cooperation with the state authorities and sometimes independently, a series of criminal investigations against the stress clinic operators and their financiers.

We often found that the stress clinics were organized by financiers and the furnishings were recruited for this purpose.

We have had a number of successful prosecutions One resulted in one of the longest trials in the Southern District of New York in recent history. In each case convictions were obtained, as well as substantial sentences. So, through the DEA investigations and cooperative investigations with state authorities, as well as the legislative action taken by some States, approximately 40 stress clinics have been eliminated and are no longer functioning.

The combination of the attacks on the foreign sources, the attack on the stress clinics and the reductions in quota have given us a much improved picture, and I would like to show you the next chart.

The best system, the best single system we have for monitoring the drug traffic and the availability is the deaths and injuries report of the DAWN system, and what you see here in this chart is a graphic presentation of the recent cases of methaqualone abuse in that system. When we first became aware of the magnitude of this problem and began to work on it was somewhere late in 1979, and we were already on a sharp upward slope. Of course the slope continued because it took us time to make any of our measures ef-

fective. Now we see a sharp downward trend and we believe that the level is now well below where it was when we first started our efforts. I am unaware of any achievement of this kind connected with any other single drug of abuse in the last several years. Now, again, we think this shows a very favorable picture, but of course we cannot predict with absolute certainty what will happen at a later time. If I may, I will return to my seat and quickly summarize.

So although we are greatly pleased with what has been accomplished, I think it is worthy to point out some new and alarming developments that we are still dealing with. That is, of course, the persistence at some level of counterfeit Quaalude tablets which do not contain methaqualone. Most of these we now find contain diazepam, but we find that in most cases the amount of diazepam contained in these pills vastly exceeds the kind of therapeutic dosage that would be available in this country for legitimate uses. In some cases as much as 300 milligrams of diazepam have been used to make these counterfeit Quaaludes, and that is approximately 30 times the usual therapeutic dose of diazepam or Valium® that is prescribed in this country for any cause. In addition to that we know of a case in which industrial polyester materials were used which could be extremely toxic for the abuser. So this is a new aspect of the problem that we have seen but one which our laws do not clearly address.

In view of this activity, I would like to try to reach for you what would be our present feeling about the legislation that has been proposed. We have to accept the judgments of the medical authority, the Food and Drug Administration, and others that there is a legitimate need for this drug until that is changed. So, we are bound by law to provide a quota for its distribution and we are continuing to do that. I think in view of the recent pronouncements of the American Medical Association and in view of the intention of the Food and Drug Administration to examine the extent of these uses, I believe it indeed may be possible to use our current administrative tools to examine further reductions in the already quite small quota. We would look forward to doing just exactly that in the immediate future and I think that this would be bound to have some further salutary effect on the illicit traffic and abuse.

Removing the drug from schedule II and placing it into schedule I is a radical type of action. At this particular time, in view of the progress that we have made, I am not convinced it will be necessary to deal with the problem but I would want to reserve judgment as to the future course of action because it is difficult to foresee precisely what will transpire now. So, I would say that there is no clear need for the legislation at this time. I would not be willing to say that this necessarily would always be the case. I would want to see what is going to happen in the illicit traffic at this point.

[Testimony resumes on p. 217.]

[The prepared statement of Gene Haislip follows:]

STATEMENT

OF

GENE HAISLIP
DEPUTY ASSISTANT ADMINISTRATOR
OFFICE OF DIVERSION CONTROL

DRUG ENFORCEMENT ADMINISTRATION
U. S. DEPARTMENT OF JUSTICE

Chairman Waxman and Members of the Subcommittee on Health and the Environment:

I am pleased to appear before you to discuss the very serious problem of methaqualone abuse and the various strategies that have been employed to curtail such abuse. Methaqualone is one of the many drugs that has approved medical uses and is legally manufactured in this country, yet finds its way into the illicit market. Legally produced drugs, those used in medicine, account for approximately one-half the drug abuse problem in terms of drug injuries or deaths.

Methaqualone, the subject of today's hearing, has been abused in the United States for over a decade. It was originally brought under the controls of the Controlled Substances Act (CSA) in October of 1973 after an explosion in its abuse, particularly on college campuses and among young adults. It was immediately placed under Schedule II of the CSA, the highest level of control that can be placed on a drug that has a currently accepted medical use in the United States. Schedule II controls required all legitimate handlers to be registered with DEA, placed strict security requirements on manufacturers and distributors of the drug, allowed the DEA to set production quotas to limit production, did not allow prescriptions for methaqualone to be refilled and established other stringent controls. These strict controls appeared to moderate the illicit availability and abuse of methaqualone through most of the 1970s. While it remained an abuse problem, its abuse was fairly stable and generally not among the top 10 controlled drugs in terms of injuries.

Rise in Methaqualone Abuse

The year 1979 marked the start of the major upswing in the trafficking and abuse of methaqualone. Despite an approximate 40 percent drop in the quota for legitimately produced methaqualone, injuries rose approximately

40 percent in 1979. This increase in injuries continued into 1980 when a 81 percent increase over 1979 occurred while the quota for legitimate methaqualone was being reduced by an additional 28 percent. In total, over the three year period from 1978 through 1980, methaqualone emergency room mentions rose 154 percent while the quota for legitimate production declined nearly 57 percent.

The reason for the rather unusual inverse relationship between methaqualone injuries and production was the introduction of a new source of methaqualone available in the illicit market. This new source was diversion from international commerce. Millions, likely tens of millions, of counterfeit methaqualone tablets were being shipped from clandestine South American tableting plants destined for the United States illicit market. The bulk powder used to manufacture these tablets was diverted from legitimate sources throughout Europe. This sudden and dramatic increase in the smuggling of counterfeit methaqualone tablets is demonstrated by seizures of methaqualone. In 1978, only 630 kg. of methaqualone were seized. In 1979, at the start of the major upswing in methaqualone injuries, a total of 7,921 kg. were seized. By 1980, when methaqualone injuries reached their peak, the seizure totals reached 12,587 kg. The increase in injuries during the years 1978 through 1980 clearly tracks the increase in smuggling activity demonstrated by the increase in the interdiction of methaqualone. This increase in smuggling activity explains why injuries continued to rise while domestic quotas were being sharply reduced.

Efforts to Curtail Foreign Sources

In 1980, DEA began making large seizures of methaqualone tablets from aircraft originating in Colombia, a country that was not a major methaqualone producer. Through the efforts of DEA's International Diversion Program, information was developed regarding worldwide methaqualone production and distribution, major shipping routes and methods of diversion from international commerce. What was discovered was a worldwide stockpile of over 120 tons of methaqualone powder, compared to a total U.S. annual consumption of less than three tons. Also uncovered was a complex worldwide network of manufacturing countries, transiting countries and free ports where brokers and violators could reroute and mislabel methaqualone shipments,and clandestine tableting operations in Colombia. From Colombia, the finished methaqualone tablets, manufactured to replicate Quaalude tablets, were smuggled into the United States.

In response to this growing problem, DEA initiated a multifaceted approach that involved enforcement, diplomatic and regulatory actions. Increased effort was placed on identifying shipments of bulk powder from Europe and other sources and also on intercepting methaqualone shipments into the United States. Cooperation between DEA's European and Mexican based personnel and officials of source and transit countries greatly increased our information on methaqualone shipments in international commerce. In addition, DEA and U.S. Customs developed a Drug and Chemical Watch Manual to assist Customs personnel in identifying and interdicting illicit shipments of all pharmaceuticals and chemicals diverted in international commerce. These increased foreign cooperative efforts contributed to the seizure of nearly 58 tons of methaqualone in 1981.

Despite the success of the enforcement efforts against methaqualone, the key element in this effort was the diplomatic effort made at the international level with the U.N. Commission on Narcotic Drugs (CND) and bilaterally with source and transit countries. At the 1981 CND meeting, DEA played a key role in the adoption of a resolution calling for certain voluntary measures to prevent diversion of legitimately manufactured drugs from international commerce. Perhaps more importantly, it provided a forum to bring to the attention of the major source and transit countries the scope of the international diversion problem. Bilateral diplomatic efforts with these countries were also a major part of the effort against methaqualone. Supported by information developed through our cooperative and enforcement efforts, U.S. officials were able to clearly demonstrate the respective roles each source and transit country played in the international diversion of pharmaceuticals.

The diplomatic initiatives concerning methaqualone were highly successful. During the past two years, the Federal Republic of Germany, Hungary, Austria and, more recently, the People's Republic of China (PRC) and Switzerland, have responded favorably to diplomatic initiatives on this subject. This means that all known major European source countries, as well as the PRC, have now agreed to reduce or cease methaqualone production and to place strict controls on its exportation. The effectiveness of these efforts in reducing the availability of methaqualone for illicit purposes is demonstrated by the fact that seizures of methaqualone decreased from over 57,000 kg. in 1981 to less than 11,000 kg. in 1982 and to approximately 2,200 kg. for the first six months of 1983.

These efforts have clearly reduced the availability of methaqualone in the illicit traffic. It is important to note that, based on the amounts produced domestically versus the amounts of methaqualone that have been smuggled into the country, the foreign source of methaqualone was the *major contributor to the methaqualone problem in the United States. It* is this aspect of the problem that is not affected by the proposed scheduling action.

Domestic Diversion of Methaqualone

While it has been demonstrated that the major contributor to the increase in methaqualone abuse and injuries was diversion from international commerce, the role of domestically produced methaqualone cannot be overlooked. As previously noted, methaqualone has been a drug of abuse since the early 1970s. Prior to the large scale smuggling of counterfeit methaqualone tablets, which began in 1979, the primary source of methaqualone was diversion of legally produced methaqualone from domestic sources (i.e., from licensed manufacturers, distributors, physicians and pharmacies) and, to a lesser extent, from domestic clandestine laboratories.

During most of the 1970s, diversion from legitimate handlers was primarily the result of individual criminal activity, theft, prescription forgery and other nonorganized activity. However, beginning in 1979, a new phenomenon developed. This new phenomenon was the so-called "stress" clinic. While somewhat reminiscent of the "weight" clinics of the early 1970s which were used to divert large quantities of amphetamines, these "stress" clinics were far more organized and well financed. These clinics purported to be legitimate businesses treating the effects of "stress." They were staffed by physicians, nurses and clerical staff. They performed perfunctory examinations involving the weighing of "patients" and the taking of blood

pressures and, in some cases, even showed video tapes on weight loss. However, these clinics were actually used as prescription mills for methaqualone. Hundreds of "patients" passed through their doors each day, each getting a prescription for methaqualone and sometimes other drugs as well. These clinics were financed by nonpractitioner financiers who hired physicians to write methaqualone prescriptions. Physicians who would not write methaqualone prescriptions on demand were dismissed. Often, these prescriptions were routinely filled by satellite pharmacies owned by or in collusion with the clinics' financiers.

In response to the growing stress clinic problem, DEA focused on these clinics under its Targeted Registrant Investigation Program (TRIP). Diversion documented by criminal cases under the TRIP program was also used to support reductions in the domestic methaqualone quota. The procurement quota for methaqualone, the amount that can be purchased by manufacturers for sale as finished dosages, was reduced from over 17,000 kg. in 1978 to 2,250 kg. in 1983. In addition to Federal enforcement and regulatory actions, many individual states imposed their own restrictions on methaqualone.

As of early September of this year, approximately 40 of these clinics have been closed down. Most of these clinics were in the New York metropolitan area, Miami and Atlanta. Others were in Baltimore, Boston, Chicago, Las Vegas, and Los Angeles. There are currently 74 defendants in these cases against stress clinics - 27 physicians, 10 pharmacists, 2 attorneys, 35 financiers/operators.

Although, as in the case of international diversion, we appear to have counteracted these efforts to divert methaqualone, the adverse impact while these clinics were in operation was significant. One clinic in New York dispensed over 2.5 million methaqualone tablets during the two years it was in operation.

Current Methaqualone Situation

The methaqualone epidemic that raged from late 1979 to early 1982 appears to have been overcome by domestic and foreign efforts. On the international scene, all known source countries have now agreed to reduce or cease methaqualone production and to place strict controls on its exportation. The major transit countries have also cooperated by limiting the ability of traffickers to use their countries to redirect or mislabel methaqualone shipments. The impact on the availability of methaqualone to international traffickers is demonstrated by the extraordinary decline in seizures. In the first six months of 1983, less than 2,200 kg. of methaqualone were seized, compared to almost 58,000 kg. during the height of methaqualone trafficking in 1981. Intelligence information indicates a shortage of methaqualone that has prevented the Colombian tableting operations from obtaining bulk methaqualone powder. This shortage is demonstrated by the recent substitution of other pharmaceuticals and nondrug substances in counterfeit Quaalude tablets. These substitutions, while demonstrating the effectiveness of the methaqualone effort, pose their own particular dangers. Dangerously high dosages of diazepam have been substituted for unavailable methaqualone and some poisonous chemicals have also been discovered in counterfeit tablets. While the methaqualone smuggling problem appears to be under control, this new problem of smuggling counterfeit tablets containing lethal doses of drugs and chemicals needs serious consideration.

The domestic diversion situation, which is the one aspect of that methaqualone problem that would be affected by rescheduling, appears to have been reduced to its lowest level in more than a decade. The quota for

methaqualone has been reduced to just 2,250 kg. for 1983 and further reductions may be possible. This is a reduction from 17,468 kg. in 1978. The stress clinic phenomenon has been effectively counteracted by a combination of enforcement actions and the reduction in the availability of methaqualone. Forty stress clinics have been closed in the last two years and those still in operation are reportedly having difficulty obtaining the large quantities of methaqualone necessary for their operation. Following the stress clinic indictments in New York City, in January of 1978, distribution of methaqualone into New York City declined 37 percent.

The clearest and most important measure of our successful efforts against methaqualone is the decline in injuries attributable to methaqualone. The methaqualone mentions reported to the Drug Abuse Warning Network (DAWN) system have declined dramatically since their peak in 1980. By the second quarter of 1983, methaqualone injuries had declined to approximately the level they were prior to 1978, before the sharp rise in abuse. The trend is expected to continue which would reduce methaqualone injuries to the lowest level since injury statistics have been collected.

Future Actions Concerning Methaqualone

We will continue our current efforts against methaqualone diversion including the close scrutiny of the methaqualone quota, the monitoring of international commerce and the immobilization of violators. We expect these continuing actions to be sufficient to prevent a reoccurrence of the drastic increase in methaqualone abuse we recently witnessed. Although we expect that there will continue to be some level of methaqualone abuse, we expect it will probably be lower than at any time since 1971.

Even with the extraordinary success we have had with regard to methaqualone, we are not standing still on the issue. We are continuing to seek new avenues

which will further impact on methaqualone abuse. We have recently asked FDA to review the medical uses for methaqualone in light of the recent report of the AMA's Council on Scientific Affairs concerning methaqualone. The report stated that:

> The high order of abuse potential and high incidence of dependence risk of methaqualone, combined with the availability of many hypnotics of equal or greater efficacy, argue for avoiding the prescription of this drug in patients other than those with porphyria.

In addition to requesting an FDA review of the medical use of methaqualone, we have also requested that they reevaluate the estimate of the amount of methaqualone that might be needed for legitimate medical use. We believe that the high potential for abuse and actual abuse of methaqualone will continue to reduce its legitimate use in medicine as more and more physicians agree that its limited medical usefulness is more than offset by the negative aspects. The FDA has already begun to look more closely at the medical uses of methaqualone and has assured us that they will proceed with a full scale review as quickly as possible.

Strictly limiting its indications for use would provide DEA with the basis for even further reductions in the methaqualone quota. Even without a reduction in the medical indications for use, the legitimate prescribing of methaqualone is decreasing. This combined with continued action to close the remaining stress clinics and other diverters should result in a continued decline in the methaqualone quota. Reduced domestic availability, combined with the lack of smuggling activity, should continue the trend towards lower abuse levels for methaqualone.

Clearly, the methaqualone crisis is over but admittedly we will continue to feel the effects of methaqualone abuse for some time to come. However, I would like to address another problem that has been created by our success in cutting off the supply of bulk methaqualone diverted from international commerce and the closing of the stress clinics. While we have been effective in curtailing the supply of methaqualone, we have not significantly reduced the demand of the abusing population. To meet this demand, some traffickers have substituted a variety of drugs and chemicals in counterfeit Quaalude tablets. Although they are indistinguishable from the tablets that abusers are familiar with taking, they may contain a dangerously high dose of diazepam or a toxic chemical. These actions pose dangers far in excess of the penalties the violators are subject to for illegal importation of a Schedule IV drug such as diazepam or for a toxic chemical. We need to explore the need for specific penalties for these types of despicable activities.

Legislative Rescheduling of Methaqualone

DEA has traditionally opposed attempts to legislatively reschedule substances under the Controlled Substances Act (CSA). The CSA was a landmark piece of legislation when it was passed, in 1970, which provided for an administrative procedure for scheduling actions that recognized the delicate balance between health and law enforcement issues.

In establishing five distinct drug schedules, Congress recognized the differences in both potential and actual abuse of different drugs. It created Schedule I to include those drugs that have no currently accepted medical use in treatment in the United States. Despite the abuse problems associated with methaqualone, it clearly has an accepted medical use in the United States as defined by FDA, the competent medical authority on the subject for the Secretary of HHS.

Unless there is some evidence that the current administrative framework is inadequate to make the required medical determinations, it is the position of DEA that these administrative mechanisms continue to be relied upon for scheduling decisions. If, in its medical judgement, FDA were to find that methaqualone had no accepted medical use in treatment, DEA would move immediately to place it in Schedule I.

One caveat I must add is that if it were determined that the current administrative mechanisms were not adequate to deal with the problem, then DEA would have to reconsider its position in regard to the legislative rescheduling of methaqualone.

Conclusion

The experience of the last three years with regard to the trafficking and abuse of methaqualone has been frightening. It directly affected the lives of thousands of those who were injured or died from methaqualone abuse, their families, friends and everyone in society which must pay the social costs of drug abuse. However, on a positive note, our experience with methaqualone has shown us that the mechanisms do exist to deal with even the most difficult trafficking problems. Through the cooperation of all the Federal and state/local government agencies involved, a large number of foreign nations, the international drug control bodies, citizen/parent groups and others, we are successfully meeting the challenge of methaqualone abuse.

We will not relax our vigilence with regard to methaqualone. While we may be passed the crisis stage, we will continue to seek ways of further reducing the diversion of methaqualone. However, we must realize that methaqualone is just one of the many legally produced drugs that dominate the drug injury statistics. The entire area of diversion and abuse of legally produced drugs needs increased attention and effort.

Mr. WAXMAN. Thank you. Because Congressman Nielson may have to leave for another scheduled appointment, I want to recognize him at this time.

Mr. NIELSON. Thank you, Mr. Chairman.

Dr. Novitch, I read your statement very carefully. I note that you indicated three different things that you could do on the position. One of those is there are administrative actions which are being considered in order to reduce methaqualone abuse even further. I have read that particular section rather carefully, and it appears that that section is more what you do not want to do rather than what you do want to do. You indicate, for example, you do not want to withdraw approval of the new drug application for methaqualone even though abused, and you think you should not be worried about the things that happen, the extralabel abuses. Do you really think that FDA can ignore the extralabel abuses?

Dr. NOVITCH. I do not think so, Mr. Chairman, but we are faced with a very difficult position for FDA. As long as there is a legitimate recognized use for the drug as represented in the NDA, and in the absence of any information that persuades us that the drug represents a danger to those for whom it is being legitimately prescribed, it is very difficult for us to say that there is no accepted medical use and therefore the drug should be controlled in schedule I.

Mr. NIELSON. May I add to that? Do you not believe that you should look at the total effect of a medicine?

Dr. NOVITCH. I do, and I rather agree with Mr. Haislip that progress is being made in curbing imports, in cracking down on stress clinics, on educating physicians to the dangers. Physicians are, I think, very well aware of the dangers. The drug, once very, very popular, now accounts for only about 1½ percent of all the legitimate prescriptions written in this country. I think that by clamping down on illegal use and educating health professionals and potential abusers about the dangers of the drug we are making substantial progress, but if that progress does not continue or if the committee and the Congress do not believe that sufficient progress is being made, it becomes a societal issue which they will have to address. But I think we are headed in the right direction and it is a rather large and controversial step, either to reschedule into schedule I or to lift an NDA for an approved drug with a legitimate medical use.

Mr. NIELSON. So you do not want to withdraw the approval of the new drug application, and you do not want to change it from schedule II to schedule I. The only thing you are proposing that I see is to modify how you arrive at the quotas, by trend analysis now you want to subtract certain portions to use a different trend situation—are you trying to change the data in order to come up with a conclusion that we are trying to tell you you should come up with?

Dr. NOVITCH. I do not think we are trying to change the data. We are trying to look at data that suggest the actual legitimate medical need and make the quota conform with the actual legitimate use of the drug and not to come up with any phony figures. The figures up to now have been reactive. We are looking at a trend based on what has happened in the past. What we can do now is subtract—cut those uses proactively that we know are illegitimate

and contributing to abuse—subtract those out and reduce an already declining quota still further.

Mr. NIELSON. Do you do that with any other drug? Do you ever use the proactive method elsewhere?

Dr. NOVITCH. I defer to Mr. Haislip on that.

Mr. HAISLIP. Certainly DEA does and I think the Food and Drug Administration often cooperates with us in studying these problems. I can think of two or three other cases in which we are studying it together in this fashion.

Mr. NIELSON. You mention the fact that use has gone down, you are labeling the drug's ability to cause side effects and so on. How effective has that labeling been?

Dr. NOVITCH. I think the fact that legitimate and misguided prescribing together declined from a total of some 4 million a decade ago at the height of its use to 300,000 today I think tells a story. There is less than 10 percent being prescribed of what it was when it was a new drug.

Mr. NIELSON. So labeling is effective as far as physicians are concerned in terms of prescribing?

Dr. NOVITCH. Yes. I think we ought not rest on that completely. The AMA is very active in counseling physicians and we are working with them and other professional groups, and I think that legitimate prescribing will decline still further. There are other sedative hypnotic drugs that can be used. This possesses no unique advantage. But there are physicians who do believe and have said to us that this drug works where others do not, and that is true of a lot of drugs in medical practice. You will have an array of drugs and you will try them successively; some will work and some will not. This drug falls in that class. There may be a small class of patients for whom no other drug will work and this may.

Mr. NIELSON Mr. Haislip, do you feel the fact that the prescriptions have gone down from 4 million to 300,000 prescriptions in the last 5 years, and the fact that the problem is solving itself—do you think that that is sufficient reason not to pass this legislation or do you think that 300,000 is still too many and we ought to take a very close look at it?

Mr. HAISLIP. First of all, the problem is not solving itself. I think that we, and I mean we both at the Federal and the State level, including the gentlemen who appear before you this morning, we are solving it. It is not solving itself. I am convinced there is still some abuse and illicit traffic in this drug. Because of the recent changes and accomplishments, it is less clear as to the extent. I have a less clear picture than I had previously. I think we need to study that and I think it is likely that we may need to further reduce production, but at this time, speaking at this particular moment, I am not sure that we really need to do this legislatively. I would say that it is a matter that should be closely considered and the situation needs to be closely monitored. I am certainly not opposed to it if that appears to be necessary. It may be, in view of what has transpired, that it is not necessary.

Mr. NIELSON. One last question. Either can answer this one. Are either of you philosophically opposed to taking the drug off the market, somehow limiting people's use or choice of the drug they may want to use or a physician's choice of which prescription drug

he should use? Is there any element that would restrict you from making a recommendation that it be schedule I instead of schedule II?

Dr. NOVITCH. As far as I am concerned it is not a matter of philosophy, it is a matter of practical need and a view of medical practice. I think that if a drug has the effect that is claimed for it and is safe for that use, despite extralabel abuse, you want to be careful once it has come to the market about removing the drug from the market. But I am not so blind as to suggest to you that if there is very widespread abuse that cannot be controlled in any other way, and if that chart were going in the opposite direction, we would be sitting here having this kind of conversation. I think that you want to take the least drastic method of controlling the problem from both an administrative standpoint and a medical standpoint that will solve the problem. So I guess if that is a philosophy, that is mine.

Mr. HAISLIP. I would like to respond to the question, too. Of course I have no philosophical reservations about doing that when it is necessary. What I think is important to understand it that there are a great many other drugs which are also diverted into the illicit traffic and cause a great deal of damage. None of them are abused to the extent of this particular drug, which has been unusual, but drugs such as Dilaudid, which is a more powerful narcotic than heroin, Preludin, which is probably a more powerful stimulant than cocaine, Pentazocine of the so-called t's and blues which has been the second drug of abuse in cities like Chicago, second only to heroin, and many other legal drugs cause problems equal to or greater than the so-called illicit drugs. We need to control these and we have legislation to do that, but we are asking the Congress for additional authority to do so in legislation which is now pending before Congress. We have faced this problem with many drugs.

Mr. NIELSON. I thank the gentleman and thank the chairman for letting me speak first.

Mr. WAXMAN. Gentleman, you represent FDA and DEA and you appear to be in agreement that this legislation is not necessary. Apparently a growing number of State legislatures disagree with your conclusion. Would either of you oppose this legislation if the subcommittee proceeds with its consideration?

Dr. NOVITCH. We would really have to consider the legislation. I can say for myself that if the committee and the Congress believed that the legislation was necessary, that the measures that we have outlined today were not working and that this was the most appropriate way to solve the problem, then I personally would not oppose it, no.

Mr. HAISLIP. Inasmuch as the legislation would not increase the likelihood of abuse but rather decrease it, then we would not oppose it, but I think that we are simply not convinced that that kind of a radical measure is necessary at this time.

Mr. WAXMAN. Let me see if I understand. You do not think the bill is necessary, but if we determine that it is necessary and we want to make that change and we report a bill out to the full House of Representatives and try to move it through the Congress,

would it be your position—you know what the bills say—to recommend that Members oppose it or that the President veto it?

Dr. NOVITCH. That is very difficult for me to say here, Mr. Chairman. We strongly advocate the measures that we have ongoing, and I could not say whether the administration will—whether the President would—veto the legislation. I am saying that it is a close issue, it is a very, very difficult issue for the Congress to decide, and that I personally would not be opposed to that legislation if in the judgment of the Congress it is needed and that the measures that we have outlined today will not work.

Mr. WAXMAN. Dr. Novitch, do you have any doubt over your legal authority to recommend that a drug be placed in schedule I on the grounds of its extralabel abuse?

Dr. NOVITCH. Mr. Chairman, I think Tom Scarlett, Chief Counsel of the Agency, is in a better position to answer that.

Mr. SCARLETT. The question of extralabel abuse does not really enter into it. For us to make a recommendation for scheduling a drug we have to make several findings for schedule I. We have to find that the drug does not have a legitimate use. We are not in a position at the current time to make that finding, and therefore we would not be able to supply the Drug Enforcement Administration with the necessary scientific conclusion upon which it could base a schedule I decision.

Mr. WAXMAN. Is it fair to say that even if you reach the conclusion that rescheduling would be helpful in curtailing this particular drug's abuse that because there is a new drug application and FDA has found that there is some legitimate use of the drug, that you do not have the legal authority to withdraw the NDA?

Mr. SCARLETT. I think that is a fair statement.

Mr. WAXMAN. Mr. Haislip, I am interested in your response to a point that was made by several witnesses earlier about the chilling effect on the marketing of these counterfeit methaqualone tablets when we remove the legally approved drug from prescription use. How do you respond to that?

Mr. HAISLIP. Well, this is an interesting and important point. Unfortunately, there is not much basis to really know what the effect would be. It might depend upon how widely publicized the measure was. Generally speaking, most drug abusers have very little knowledge about the true nature or status of the drugs that they take.

Mr. WAXMAN. Let me ask you this. We had testimony that many of the people abusing these particular kinds of drugs are middle-class people, people who would go to a stress clinic. In Florida they changed the law, in Georgia they have changed the law—they seem to think from their experience that some of those people who otherwise would abuse the drug are knowledgeable about the fact that it is now illegal and are staying away from it because they are worried about the quality. Do you doubt that testimony?

Mr. HAISLIP. I think that is a chance that would affect some percentage of drug abusers. I do not know how large a percentage, but this is a possibility and it could be that it would have some effect of that kind. I would not want to deny it because I think that that possibility does exist.

Mr. WAXMAN. Well, if we have a possibility to discourage the abuse of this drug by passing this legislation, what harm would it do for us to pass this legislation?

Mr. HAISLIP. The only harm that I can think that it would do is that it would inconvenience any legitimate uses that there are for the drug.

Mr. WAXMAN. We have heard suggestions that there are other drugs that can fulfill all the legitimate uses of this particular drug. Is that a correct statement, Dr. Novitch?

Dr. NOVITCH. As I said, there are individual physicians who believe that this drug works when other drugs have not worked. Whether that makes it absolutely necessary to have the drug I do not know. That is one of the reasons why we advocate that we stay on the course that we are on.

Mr. WAXMAN. There is a drug called mecloqualone, which I think is pharmacologically similar to methaqualone, and it is in schedule I rather than schedule II. Can anyone give us an explanation of why that is the case?

Mr. SCARLETT. I think initially because there has not been found to be a legitimate medical use for that substance. I am unaware that a new drug application was ever approved for that product. Dr. Leber may be able to elaborate on that.

Dr. LEBER. That is basically my understanding. I am not aware of an NDA. Without an NDA we have no accepted medical use.

Mr. WAXMAN. No one has applied to you to approve a new drug application for this substance?

Dr. LEBER. I have no way of knowing who has applied, but I know that we do not have an approved NDA and until that happened we would not schedule it out of schedule I.

Mr. HAISLIP. It happens often that there are several drugs in schedule I which are in schedule I simply because no one has sought to have them approved or marketed. There are several drugs for example which are marketed in Europe which are in schedule I in this country because no one has sought to obtain approval or marketing for them, and that may be the explanation.

Mr. WAXMAN. Dr. Novitch, you indicated that the number of prescriptions in recent years has been going down. Do you have any evidence or information about the amount of pills per prescription and whether that might counter the conclusion you reached?

Dr. NOVITCH. No; I do not, Mr. Chairman, but the number of kilograms produced every year, the quotas are going down, so you have to assume that the prescriptions as well as the amount of the drug being used, both are going down.

Mr. WAXMAN. I appreciate your testimony. I will just ask you one other question, Dr. Novitch. You said that if you thought that the time was right for us to pass legislation that you would support it. What standard would you use for us? What should we wait for? What should we expect before the time would be right for you to recommend us to ban this drug?

Dr. NOVITCH. In order to come to the conclusion that legislation is necessary now you have got to, at least in my judgment, you have got to conclude that the measures that we have outlined and that others have outlined today, actions by the States, actions to curb imports, actions to reduce quotas, educational efforts with the

professions are not likely to succeed in any time to avoid serious consequences to the public health. If you come to the conclusion that we have reached a plateau and that there is no further likelihood of reduction, if as other witnesses said, the problem is simply being passed around to other States and that it is not likely to go away with the efforts underway and new ones to be undertaken, then I think you have to conclude that we are wrong and that legislation is necessary.

Mr. WAXMAN. Can I not conclude that you are right, that you are doing a pretty good job, both DEA and FDA, and that in fact abuse of this drug is going down, but that if we pass this legislation we would further that cause and prevent more tragedy for those people who are users of the drugs and those who become the innocent victims of these users?

Dr. NOVITCH. I think that that is a close issue, Mr. Chairman. You may conclude that we are right and still want to pass legislation. We think that we are on a sound course, but I think you just have to reflect on the testimony you have heard and reach your conclusion and make your recommendations to your colleagues.

Mr. WAXMAN. Thank you. That concludes the hearing. We therefore stand adjourned.

[Whereupon, at 12:10 p.m., the subcommittee was adjourned.]

[The following statements were submitted for the record:]

Testimony of

Thomas B. Kirkpatrick, Jr.
Executive Director
State of Illinois
Dangerous Drugs Commission

before the

U.S. House Subcommittee on Health and the Environment

October 3, 1983

Mr. Chairman and Members of the Subcommittee:

I welcome the opportunity to appear before you in support of H.R. 1055 and H.R. 1097, legislation which would place methaqualone on Schedule I of the Controlled Substances Act, thus making the drug virtually unavailable to anyone other than a qualified researcher scientist and accomplishing several other things that we who work in the drug abuse field at the state level would like to see happen.

Since methaqualone first appeared on the market in the United States in the 1960s, it has regrettably enjoyed far more use on the street than in the legitimate practice of medicine. It was originally developed in Europe in the mid-1950s, along with other drugs, in an attempt to find a non-addictive alternative to the barbiturates, and was introduced in the United States as a substitute for the barbiturates and chloral hydrate, as a hypnotic agent for treating insomnia and for daytime sedation, being advertised as having non-addictive properties and relative "safety." The medical use of this drug during the early 1970s eventually led to the equally widespread abuse

of the drug, and thus to the placement of methaqualone on Schedule II of the Federal Controlled Substances Act. While classified as a non-barbiturate sedative-hypnotic, methaqualone is of a pharmacologically different structure than the benzodiazepines or the other major sedative-hypnotics. The drug has a well-established history of producing tolerance and eventual physical dependence, despite the optimistic claims made for it upon introduction. Methaqualone has been established to rapidly produce intense euphoria even when taken orally; users report a satisfactory "high" within 15-20 minutes after ingestion. Generally, this drug is credited with having dependence liabilities similar to secobarbital.

It is currently marketed as a "hypnotic agent useful in the treatment of insomnia and in medical situations requiring restful sleep." The drug has also been used to produce sedation in the daytime at lower dosage than that used in inducing sleep. However, other pharmaceuticals are available to the medical profession for relief from insomnia and/or stress, including: a broad variety of benzodiazepines and other anti-anxiety agents such as diazepam (Valium), Chlordiazeporide (Librium), flurazepam (Dalmane) which are often preferred by physicians. There also appear to be other sedative/hypnotics which are effective in relieving sleeplessness, including drugs such as ethchlorvynol (Placidyl). Other minor tranquilizers such meprobamate (Miltown) are also prescribed for the same reasons that methaqualone is used, with the result that methaqualone is far from the drug of choice in all but the most questionable medical practice.

In Illinois, my agency, the Dangerous Drugs Commission, is the scheduling authority under the Illinois Controlled Substances Act. However, despite numerous indicators of extensive methaqualone abuse and diversion, and the

assurance of medical professionals that it was rarely, if ever, used in practice, the Commission was unable to administratively reclassify the drug from state Schedule II into Schedule I because our statutory criteria for Schedule I require that "the substance has no currently accepted medical use..." While methaqualone remains in Federal Schedule II, the assumption is made that it has some currently accepted medical use in this country, albeit with severe restrictions.

The Illinois General Assembly, thankfully, is not bound by the same constraints as my agency, however, and I am pleased to report that legislation was introduced and passed independent of the agency to place methaqualone on Schedule I in Illinois. That bill was signed by the Governor just a few days ago, and will become law January 1. While that means that methaqualone can no longer be legally sold, prescribed, dispensed or possessed within the borders of Illinois, and while I am grateful for all the help I can get, it is not enough. Our experience in state scheduling matters tells us that when a drug is popular and profitable from the abuse perspective, the result of scheduling changes will be a decrease in business within Illinois and an increase in business in our neighboring states, particularly in close-by metropolitan areas. When we placed pentazocine on Schedule II, the marketing demand was met in large part by entrepreneurs in Milwaukee, St. Louis, Gary and Detroit. Now Wisconsin has also placed pentazocine on Schedule II, and we have noticed an improvement. However, the jigsaw puzzle approach to scheduling is neither responsible nor satisfactory. In the case of a drug like methaqualone, Federal action, effective nationwide, is the logical and effective answer.

Our methaqualone experience in Illinois supports my position. In recent years, unscrupulous practitioners and businessmen have set up what are known as

"stress clinics" which are merely fronts for the sale of Quaaludes to anyone with the cash to pay. We in state government have been in the frustating position of not being able to end this practice once and for all by making the drug unavailable, and we have consequently had to deal with these clinics and physicians on an individual basis relative to their licensure, in what is a time-consuming process. Time is the stress clinic's best friend, because in the months that it takes to bring licensure action against the principals, they can sell hundreds of thousands of doses of methaqualone, reaping hundreds of thousands of dollars in profits, then close up and leave town before the slow-moving regulatory process reaches them. A complete ban on methaqualone would make it impossible for these vultures to do business. The ban must be nationwide, because they are migratory birds of prey, coming into a city and doing business for a few months and then moving on elsewhere when regulatory and enforcement pressures become uncomfortable. The clinics are often exposed in the media, which serves the dual purpose of providing advertising and increasing regulatory attention. Clinic operators in Chicago came there from Georgia and Florida, and have now moved to new territory in other states. The pattern is consistent; when they leave town they are enormously wealthier, and they leave behind them a new group of drug dependent individuals, which I can assure you the treatment system does not need. This practice will not stop, and the demand will not cease, until you on this sub-committee, who control the supply of methaqualone, put a stop to it. If the drug is not there, the clinics won't be, the money won't be, and the addicts won't be - it's that simple. You will undoubtedly hear something from some opponents to this measure, and I suppose their argument may include the argument that methaqualone has some legitimate medical circumstances and is

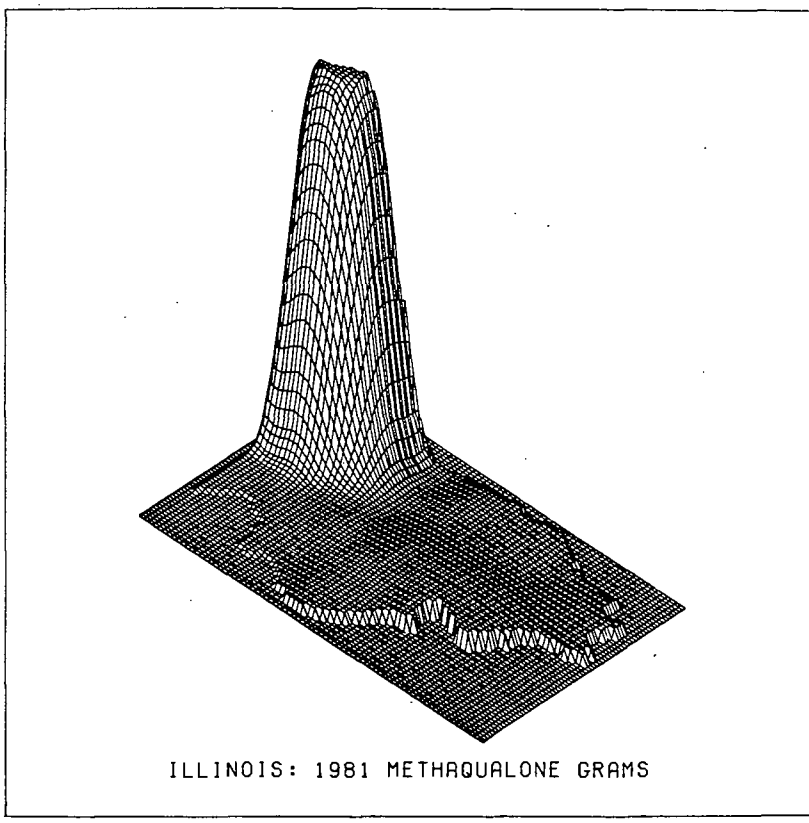
the drug of choice for some indications. By way of reassurance, let me tell you that the professional health care community in Illinois was silent on the legislative methaqualone ban which just occurred in our state. The medical and pharmaceutical interests are not known to be favorably inclined toward legislation which restricts practice; if they did not oppose the Illinois bill, on principle if not substance, you can be assured that legislative banishment must be a pretty good idea. Doctors will tell you freely that methaqualone is a bad drug and one which they do not prescribe; pharmacists will tell you that they do not stock it because there is no legitimate call for it and it only serves to invite burglaries, not business.

I have appended to this testimony computer-generated maps illustrating methaqualone distribution in Illinois in 1981 on a per capita and an overall basis. Where the projections indicate distribution density, stress clinics in Chicago and single practitioners downstate were responsible; the rest of the state is virtually flat, indicating methaqualone was not in use. To the best of my knowledge, the clinics and practitioners are no longer operating, and similar practices will be impossible in Illinois after Jaunary 1, but they can and will continue in those states which have not banned methaqualone unless this subcommittee takes action.

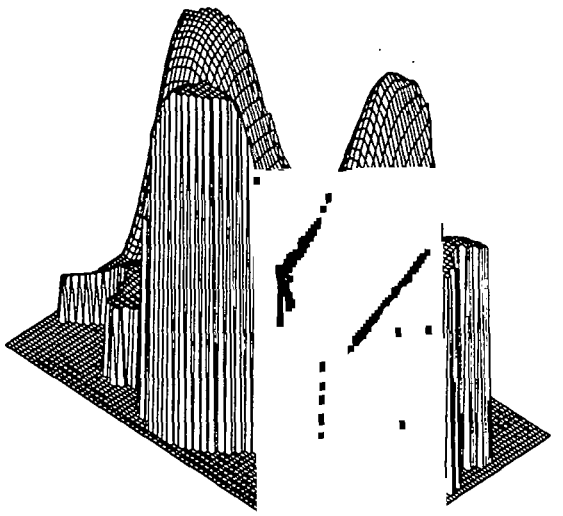
Finally, there is yet another reason for you to enact a national ban on methaqualone, and that is to serve clear public notice that it is a dangerous, widely abused drug with no purpose other than illicit drug use. If methaqualone is outlawed by the Federal government, it will become an outlaw - it will no longer be a sought-after commodity in the street, for the marketplace will be aware that there is no legitimately, pharmaceutically produced methaqualone; any that is available will be counterfeit.

The Quaalude story is a clear and simple one: the citizens of this country, including the medical and substance abuse professionals, don't need it; we don't want it; and we are looking to you to take it off the market, off our streets and off our hands.

Thank you.



ILLINOIS: 1981 METHAQUALONE GRAMS



ILLINOIS: 1981 METHAQUALONE GRAMS PER CAPITA

STATEMENT

OF

WILLIAM A. FLETCHER

PRESIDENT

LEMMON COMPANY

Honorable Henry A. Waxman
Chairman, Subcommittee on Health & Environment
Washington, D.C. 20001

Sir,

William A. Fletcher
President and CEO

Your Subcommittee is about to consider legislation which would in effect prohibit the prescribing of methaqualone for all purposes, including legitimate medical purposes.

Lemmon Company is the only registered and legitimate domestic manufacturer and distributor of drug products containing methaqualone, a Schedule II controlled substance. The products which Lemmon sells have been marketed under three names: Quaalude, Mequin and Parest. Lemmon purchased the Quaalude product line from William H. Rorer, Inc., in September 1978, and the Parest product line from the Parke-Davis Division of Warner-Lambert Company in October 1980. The Mequin brand of methaqualone was first marketed by Lemmon in the Fall of 1979. These products are legally marketed under New Drug Applications approved by the Food and Drug Administration who determined the products were both safe and effective when used as directed in the approved labelling.

Methaqualone is a hypnotic agent with a recognized, legitimate medical use in the treatment of insomnia and in medical situations requiring restful sleep. In certain patients, methaqualone offers distinct advantages over other sedative/hypnotic drug products. For example, it can be used effectively and safely for longer periods of time than barbiturates because induction of self-metabolizing enzymes by methaqualone occurs to a lesser degree than with barbiturates, and, therefore, there is less tendency to increase dosage to achieve therapeutic usefulness. In addition, unlike barbiturates, and, as noted in its approved labelling, methaqualone may be used in conjunction with anticoagulant therapy.

Lemmon Company | Sellersville, PA 18960 USA | Telephone (215) 723-5544
TWX-510-661-6145 LEMMON SLRS

The "hangover" effect of the drug appears to be less than that of secobarbital, flurazepam or diazepam. This fact makes methaqualone a good choice for patients in hospitals and in geriatric-care centers who may need to be awakened in emergency situations. Indeed, methaqualone has been found to be well tolerated and effective in geriatric use without any increased incidence of side effects. It should be noted that VA Hospitals contract for the purchase of methaqualone from Lemmon Company.

Several physicians have contacted us to offer their support and cooperation in resisting attempts to re-schedule methaqualone. For your reference enclosed please find a letter which we believe best presents some of the legitimate uses for methaqualone.

The principal cause of methaqualone abuse is the wide-spread availability of illegally manufactured metha-qualone tablets - not legally manufactured and prescribed Quaalude. In the December 1980 edition of American Pharmacy, Nicholas Kozel, a Public Health Analyst for the NATIONAL INSTITUTE OF DRUG ABUSE, stated that

> "Most of the supply of (methaqualone) is diverted from the international market rather than at the dispensing level."

Mr. Kozel also referred to complications resulting from "bogus" methaqualone; that is, a substance manu-factured and sold as methaqualone but, in reality, composed partially or totally of another drug, often diazepam.

The recently published FEDERAL STRATEGY FOR PREVENTION OF DRUG ABUSE AND DRUG TRAFFICKING 1982 estimates that 85% of methaqualone in the U.S. illicit market is produced overseas and illicitly imported into the United States. An additional 5% is estimated to be produced in domestic clandestine laboratories while only 10% is diverted from the legitimate U.S. distri-bution system, mainly via so-called "stress clinics".

The proper choice of drug therapy in our society lies principally with the registered physician who is governed by specific rules of practice and is subject to enforcement action if these rules of practice are violated. Because of the vast quantity of "bogus" methaqualone available for "street use" and the indiscriminate prescribing of Quaalude by a few unscrupulous physicians operating "stress clinics", otherwise well-meaning legislators are proposing to prohibit legitimate practitioners from prescribing methaqualone for legitimate medical purposes. It is the responsibility of federal and state enforcement agencies to prevent the availability of "bogus" methaqualone. It is the responsibility of state enforcement agencies, the American Medical Association and local medical societies to prohibit the illicit and the indiscriminate prescribing of methaqualone. As noted above, the availability of "bogus" methaqualone is the primary source of methaqualone abuse. The rescheduling of methaqualone into Schedule I will not remove "bogus" methaqualone from the streets.

The widespread availability of illegally manufactured and illegally distributed methaqualone and "bogus" methaqualone tablets has led to the abuse of methaqualone and has detracted from its legitimate therapeutic use. Quaalude has been the subject of intense adverse publicity as a result of this abuse. As the manufacturer of Quaalude, Lemmon is committed to reducing the abuse of legitimate prescription drugs. Lemmon fully supports measures that will aid in eliminating the problems associated with the abuse of therapeutic drugs. However, Lemmon believes that the public interest is best served by measures directed to reducing the abuse problem while preserving the legitimate therapeutic use of the drug.

In this connection, Lemmon has voluntarily restricted the distribution of methaqualone to registered pharmaceutical wholesalers. Lemmon does not distribute methaqualone to either retail pharmacies or direct to physicians.

Shortly after Lemmon Company acquired the Quaalude product line from William H. Rorer Company, it prepared the enclosed "Position Statement: Methaqualone - Its Use and Misuse and Proper Role in Current Therapy". This Position Statement has been distributed to law enforcement agencies, physicians, pharmacists and other persons who have an interest in drug enforcement and controlled drug substances. The Position Statement attempts to deal realistically with the issues involving methaqualone - both the myths and realities of this substance.

In light of the facts presented above, Lemmon Company reaffirms its position that the current Schedule II regulations governing the manufacture and distribution of methaqualone enable us to serve the legitimate medical demand for a pharmaceutical product which has been approved as safe and effective by the United States Food and Drug Administration.

If you have any questions or require further information, please do not hesitate to contact the undersigned.

Very truly yours,

William A. Fletcher

WAF:df

POSITION STATEMENT: METHAQUALONE ITS USE AND MISUSE AND PROPER ROLE IN CURRENT THERAPY

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Introduction

Extensive clinical studies and years of clinical experience have established methaqualone as a safe and effective hypnotic when used according to approved labeling. For insomniac patients where the progressive accumulation of benzodiazepine metabolites in the blood could present a problem, or for patients on anticoagulant therapy, methaqualone may be the hypnotic drug of choice.

The widespread availability of illegally manufactured and illegally distributed methaqualone tablets has led to the abuse of methaqualone and has detracted from its legitimate therapeutic use. The principal brand of methaqualone, Quāālude®, has been the subject of intense adverse publicity as a result of this abuse. As the manufacturer of Quāālude, Lemmon is committed to reducing the abuse of legitimate prescription drugs. Lemmon fully supports measures that will aid in eliminating the problems associated with the abuse of therapeutic drugs. However, Lemmon believes that the public interest is best served by measures directed to reducing the abuse problem while preserving the legitimate therapeutic use of the drug.

Hypnotic Drug Abuse—An Overview. Lemmon believes the roots of drug abuse are more sociological and psychological than medical and the solution to the problems created thereby cannot be found through the imposition of restrictions limiting legitimate medical use of drugs. Rather, we believe the solution lies in the effective enforcement of existing regulations, the curtailment of traffic in illegally manufactured and distributed drugs and educational programs directed to medical practitioners, pharmacists and the general public.

Lemmon has not been reluctant to tell the full story about methaqualone. In fact, in the late fall of 1979, Lemmon mailed a brochure entitled "Methaqualone—Its Proper Role in Current Therapy" to 37,000 known prescribers of hypnotic drugs. The brochure states that one of the unfortunate results of the abuse of methaqualone has been that many physicians are reluctant to prescribe Quāālude when indicated. Recognizing this fact, Lemmon initiated the marketing of a methaqualone alternative to Quāālude named Mequin that is identical therapeutically to Quāālude. Mequin will accommodate physicians who prefer to prescribe methaqualone as opposed to barbiturate and flurazepam hypnotics, but are sensitive to the adverse publicity attendant to the brand name Quāālude.

Counterfeits—Cause of Methaqualone Abuse. There is clear and convincing evidence that the principal cause of methaqualone abuse is the widespread availability of illegally manufactured methaqualone tablets—not legally manufactured and prescribed Quāālude. Colombia, South America is well-known as a principal source of illegally manufactured methaqualone tablets. Miami is a main port of entry for these illegal tablets.

The Drug Abuse Warning Network, or DAWN system, reports that in Miami methaqualone was ranked by emergency room mentions as the third leading abused drug for the 12 month period ended December 1978.[1] During this same period, Los Angeles, a city known for its drug abuse problems, reported methaqualone as the 15th leading abused drug and in New York, methaqualone was not ranked in the top 20 abused drugs. Nationwide, methaqualone was ranked as the 15th leading abused drug behind the well-known benzodiazepines, diazepam (Valium®) —ranked second, and flurazepam (Dalmane®)—ranked sixth.[1]

For the first nine months of calendar year 1979, hospital emergency room mentions of methaqualone in the Miami area accounted for 29.7% of all national methaqualone mentions and nearly 50% of national street-buy methaqualone mentions. A street-buy was identified as the source of the drug in nearly 42% of the national methaqualone mentions.[2]

Why does Miami report such a high incidence of methaqualone drug abuse when contrasted with methaqualone's ranking on a nationwide basis? One can only conclude that Miami's high incidence of methaqualone abuse is the result of the availability in Miami of illegally manufactured tablets for purchase on the street.

Efficacy

Much has been said and written about the effectiveness of hypnotic drugs. In 1979, the Institute of Medicine of the National Academy of Sciences published a report entitled "Sleeping Pills, Insomnia and Medical Practice."[3] The report reviews the safety and usefulness of hypnotic drugs, concentrating on the barbiturates and benzodiazepines, especially flurazepam, which is sold under its brand name, Dalmane®.

The first widely used benzodiazepine, chlordiazepoxide (Librium®) was first marketed in 1961. A large number of benzodiazepine compounds are used clinically but only flurazepam is specifically marketed as a hypnotic in the United States and Canada. The use of flurazepam has increased greatly since its introduction in 1970 and is now by far the single most commonly prescribed hypnotic.

Quāālude and Dalmane have displaced a wide variety of barbiturates in hypnotic drug therapy because (a) both drugs can be used effectively and safely for longer periods of time than the barbiturates—they do not induce self metabolizing enzymes and, therefore, there is less tendency to increase dosage to achieve therapeutic usefulness[4], and (b) both drugs may be used in conjunction with anticoagulant therapy.[5]

Quāālude's approved labeling, in fact, states that:

> "Quāālude (methaqualone) may be administered in conjunction with oral anticoagulant therapy without significant clinical interaction."

"Hangover" Effect. The significance of a hypnotic's half-life is essential to a complete evaluation of the proper use of hypnotic drug therapy. The National Academy of Sciences report noted that the major psychoactive metabolite of flurazepam has a plasma half-life of 50 to 100 hours. The cumulative effect of flurazepam's active metabolite is the cause of some concern. It has been reported that by the 7th to the 10th morning after consecutive nightly administration, the accumulation will level off at four to six times the concentration in the bloodstream than had been present on the first morning.[6] Methaqualone has been reported as having a moderate half-life—18 to 42 hours.[7]

This "hangover" effect of hypnotics has been the subject of extensive clinical study. In a study of 67 volunteers, no side effects were observed in subjects on methaqualone; whereas, significant "hangover" effects were observed in subjects receiving secobarbital.[8] In a subsequent study,[9] the frequency of hangover in 27 hospitalized patients receiving daily doses of methaqualone for five days was found to be insignificant compared with the results of those taking secobarbital.

In a study of flurazepam which appeared in the January 1975 edition of *Clinical Pharmacology and Therapeutics*,[10] it was noted that one of the side effects of flurazepam was morning drowsiness, or hangover. In a Finnish study,[11] normal volunteers were administered flurazepam for 14 nights and tested on the mornings after the 7th and 14th nights. These volunteers displayed significantly impaired psychomotor skills related to driving. When subjects who had received flurazepam on the previous night also drank alcohol the following morning, the coordinated skills were the poorest of any combination studied. Other drugs in this study of nightly administered hypnotics were amobarbital, glutethimide and methaqualone, with and without alcohol. It was reported that glutethimide and methaqualone did not impair morning performance and did not contribute to impairment when combined with alcohol.[12]

Blood measurements taken during the Finnish studies confirmed previous work which showed that by the second week of consecutive nightly use, the metabolite of flurazepam had accumulated to a level of four to six times greater than on the first morning after use. Amobarbital, glutethimide and methaqualone did not accumulate—blood levels on the 14th day were reported to be not significantly higher than on the first day.[11,12]

The NAS study concluded that flurazepam closely resembles diazepam.[13] The study reported that although blood samples of flurazepam have not been sought from victims of traffic accidents, there are several studies in which diazepam had been measured and in which a level of significance had been attached to the role of diazepam in driving accidents. Inasmuch as the effects of diazepam and flurazepam are chemically related and inasmuch as both drugs showed a substantial additive effect with alcohol resulting in sharply decreased performance, the study concluded that it was reasonable to speculate that nightly users of flurazepam put themselves in somewhat increased risk of daytime auto accidents.[13]

Quāālude's approved labeling, in fact, states that:

> "Patients usually awaken without 'hangover,' i.e., without post-hypnotic CNS depression."

Geriatric Drug Therapy. Certainly, no hypnotic is indicated in the treatment of all types of insomniac conditions. We recognize the recreational abuse potential of methaqualone, particularly among the young and believe that Quāālude is a good choice in the treatment of geriatric insomniacs and post-surgical cases, since these patients often receive the drug in a controlled environment. The fact that patients usually awaken easily and without evidence of hangover is of particular importance when treating patients in hospitals and nursing homes who may need to be awakened in emergency situations.

The National Academy of Sciences study noted that the data which was reviewed by the panel suggested that methaqualone may

be useful on a short-term basis, particularly for elderly patients.[14] The NAS study concluded that methaqualone's hypnotic effects, especially in the elderly, deserve further investigation[15]—investigations which Lemmon is in the process of conducting.

Methaqualone has been found to be well tolerated and effective in geriatric use without increased incidence of side effects. One of the studies cited in the NAS report was a comparison of the adverse reactions in 35 geriatric patients receiving methaqualone or chloral hydrate.[16] The quality of sleep induced by the administration of chloral hydrate was graded as good in only 3 of 12 patients and as poor in the remaining patients; whereas the quality of sleep was graded as excellent in 14 of the 16 patients receiving methaqualone and significantly better than that following the use of chloral hydrate.

The National Academy of Sciences study reported that the benzodiazepines (e.g., diazepam, flurazepam and nitrazepam) have been linked to increased rates of adverse reactions in elderly patients in frequent or prolonged medication.[17]

One of the studies cited in the NAS report was a study on 750 geriatric patients, 195 of whom had received flurazepam during the previous year.[18] The study noted that flurazepam had been considered safe for use in geriatric patients, but 26% of the patients taking flurazepam experienced problems such as ataxia, confusion and hallucinations.

The Boston Collaborative Drug Surveillance program studied 12,577 hospitalized medical patients, of whom 2,542 (20.2%) had received flurazepam.[19] The study concluded that the frequency of adverse reactions to flurazepam increased significantly as the average dose became larger. Unwanted effects were also reported as being more common with increasing age. Among patients under sixty years of age, only 1.9% experienced unwanted effects of flurazepam, whereas among those seventy or older who had received an average daily dose of 30 mg or more of flurazepam, unwanted effects were attributed to flurazepam in 39% of the cases. The survey does not suggest that a significant percentage of patients given flurazepam experience adverse reactions—unwanted effects were attributed to the drug in 3.1% of the total patients.[19]

Without clearly measured risk/benefit ratios of hypnotic drugs in patients, especially in prolonged nightly treatment or in long-term intermittent use, each hypnotic agent must be judged on its own merits. The task of judging which hypnotic agent is best suited for a patient should be left to the prescribing physician. Once having evaluated these factors, the well publicized safety issues of hypnotic drugs, particularly Quāālude, can then be analyzed.

Safety

Drug Dependence. All hypnotic agents can be abused and addiction and dependence can occur. Therefore, the choice of which hypnotic should be used must depend on the relative risk/benefit ratio of the hypnotic agent for the patient in question. It has been reported that chronic ingestion of large amounts of methaqualone for extended periods may lead to dependence. Clinical estimates indicate that ingestion of seven times the hypnotic dose for one month may be sufficient to produce withdrawal seizures.[20] There has been growing concern about dependence on benzodiazepines. It has been estimated that ingestion of three to five times the hypnotic dose for one month may lead to withdrawal seizures.[21] Mild withdrawal symptoms may be seen after cessation of therapeutic doses[22] and severe withdrawal syndromes, including delirium and seizures, may result from an abrupt withdrawal of high doses.[23]

Due to its lipid solubility, methaqualone tends to concentrate in the fatty tissues of the body. When the high blood levels associated with overdoses are brought under control, the drug becomes redistributed and the blood levels again rise.[24] Methaqualone overdosage is managed by prompt evacuation of the gastric contents, maintenance of adequate ventilation, support of blood pressure, if necessary, and the usual supportive measures for the unconscious patient.

Both Quāālude and Dalmane have been found to have a low order of toxicity in animals.[24] The LD^{50} of Quāālude in mice is greater than 1200 mg per kilo, and that of Dalmane is 870 mg per kilo.

Misuse of Methaqualone. When and why did Quāālude become popular as a "recreational drug"? It has been suggested that Quāālude's popularity began in the late 1960s and early 1970s when students began to invest Quāālude with aphrodisiac qualities not proven to be possessed by the drug. The myths about Quāālude and news reports which have romanticized the drug, coupled with Quāālude's relative safety, resulted in recreational abuse of the drug in the early 1970s. Over the past several years, Quāālude has become one of the most, if not the most, counterfeited drug products in this country. It has been reported that between 100 million and 1 billion illegally produced Quāālude tablets are available for street use annually.

In 1978, there were approximately 400 million Dalmane capsules sold on prescription compared to approximately 35 million Quāālude tablets. Although the ratio of Dalmane prescriptions to DAWN mentions is far less than with Quāālude, the extensive use of illegally manufactured methaqualone brings methaqualone and Dalmane toward parity. Equally significant is the fact that DAWN system reporting does not distinguish between the legally manufactured and prescribed Quāālude and its illegal counterfeits.

Dawn Data. The Drug Abuse Warning Network or DAWN system is a large scale data collecting system reporting the number of "mentions" of a drug following contact with or treatment of individuals in emergency rooms and offices of medical examiners or coroners. The episodes reported within the DAWN system are (a) non-medical use of a drug for its psychic effects, (b) dependence or (c) self-destruction. Included in the DAWN system are twenty-four Standard Metropolitan Statistical Areas which are statistical units composed of a relatively large core city or cities and the geographic area adjacent (examples are Miami, New York, Los Angeles, New Orleans). In addition, a national panel of 193 emergency rooms outside the twenty-four Standard Metropolitan Statistical Areas is also used as a data gathering center.

The following table sets forth information relating to emergency room and medical examiner mentions of tranquilizers and sedative drugs for the period January - December 1978.[1]

Drug Category (Common Brand Name)	*No. Emergency Room Mentions*	*% Tranquilizer & Sedative Drug Emergency Room Mentions*	*No. Medical Examiner Mentions*	*% Tranquilizer & Sedative Drug Medical Examiner Mentions*
Tranquilizers	41,083	62.4	957	35.0
Diazepam (Valium®)	20,072	30.5	400	14.6
Chlordiazepoxide (Librium®)	3,060	4.6	48	1.8
Chlorpromozine (Thorozine®)	2,147	3.3	62	2.3
Thiroidazine (Mellaril®)	2,034	3.1	62	2.3
Meprobamate (Miltown®)	1,040	1.6	98	3.6
Chlorazepate (Tranxene®)	1,604	2.4	13	.5
Oxazepam (Serax®)	501	.7	5	.1
Perphenazine/Amitriptyline (Etrafon®)	1,567	2.4	5	.1
All Other Tranquilizers	9,057	13.8	264	9.7
Barbiturate Sedatives	10,194	15.5	1,286	47.0
Secobarbital (Seconal®)	1,867	2.8	347	12.7
Secobarbital/Amobarbital (Tuinal®)	2,750	4.2	223	8.2
Phenobarbital (Luminal®)	2,863	4.4	223	8.2
Pentobarbital (Nembutal®)	742	1.1	228	8.2
Amobarbital (Amytal®)	163	.2	129	4.7
Butabarbital (Butisol®)	183	.3	32	1.2
All Other Barbiturate Sedatives	1,626	2.5	104	3.8
Non-Barbiturate Sedatives	14,517	22.1	492	18.0
Flurazepam (Dalmane®)	4,614	7.0	81	3.0
Methaqualone (Quāālude®)	2,308	3.5	68	2.5
Glutethimide (Doridan®)	529	.8	88	3.2
Ethchlorvynol (Placidyl®)	2,234	3.4	152	5.6
Methapyrilene/Scopolamine (Sominex®)	1,628	2.5	1	—
All Other Non-Barbiturate Sedatives	3,204	4.9	102	3.7
Total Drug Category Mentions	65,794	100.0	2,735	100.0

6 *Methaqualone*

The following table sets forth the rankings on a national basis and by city of the top twenty drugs of abus emergency rooms.[1]

	Total Drug Mentions	Total Drug Episodes	Alcohol-in-Combination	Diazepam	Heroin/Morphine	Aspirin	PCP/PCP Com	Flu
Total DAWN System	178,377	117,023	1	2	3	4	5	6
Atlanta	3,600	2,441	2	1	↔	3	↔	4
Boston	6,444	3,870	1	2	3	4	16.5	5
Buffalo	4,258	2,664	1	2	20.5	3	5	7
Chicago	11,881	7,850	1	2	3	6	4	7
Cleveland	3,830	2,499	2	1	14	3	9	5
Dallas	2,907	1,982	2	1	20.5	3	↔	5
Denver	5,327	3,372	1	2	18	3	↔	4
Detroit	13,395	8,970	2	3	1	5	14	8
Indianapolis	2,641	1,637	1	2	16	3	10.5	6
Kansas City	3,231	1,941	2	1	↔	3	12	4
Los Angeles	16,819	12,126	3	2	5	6	1	7
Miami	11,106	7,090	1	2	4	11	13	9
Minneapolis	4,005	2,463	1	2	↔	3	5	6
New Orleans	2,022	1,514	3	1	6	4	14.5	11
New York	24,767	16,576	1	2	4	9	7	10
Norfolk	1,590	1,030	2	1	↔	3	↔	
Oklahoma City	1,410	899	2	1	↔	3.5	6.5	3
Philadelphia	11,722	7,796	2	1	15.5	4	12	
Phoenix	4,587	2,786	1	2	5	3	11	
San Antonio	1,970	1,252	2	1	17	3	↔	
San Diego	5,119	3,258	1	2	3	5	4	
San Francisco County	4,243	3,016	2	3	1	14.5	8	
Seattle	4,886	2,799	1	2	13.5	3	16	
Washington, D.C.	6,500	4,091	2	1	5	3	4	

↔ Below top 20 drugs

— Denotes 0 mentions

rom

Marijuana	d-Propoxyphene	Amitriptyline	Chlordiazepoxide	Phenobarbital	Acetaminophen	Secobarbital/Amobarbital	Methadone	Methaqualone	Diphenylhydantoin Sodium	Ethchlorvynol	Chlorpromazine	Thioridazine	Cocaine
7	8	9	10	11	12	13	14	15	16	17	18	19	20
17.5	5	7	9	8	6	↔	↔	15	19	10	17.5	11	↔
10	6	9	7	11	16.5	↔	14.5	↔	12	↔	13	14.5	19
4	6	11.5	9	15	14	20.5	↔	↔	18.5	↔	13	17	↔
8	10	18	13	11.5	14	↔	15	↔	11.5	9	↔	↔	17
6	4	11	8	7	10	↔	↔	↔	20	↔	13	12	↔
↔	4	8	12	9	6	↔	↔	7	15.5	19	18	10	↔
14	5	12	8.5	7	6	↔	↔	16	11	↔	↔	15	↔
4	6	10	7	18	9	12	↔	↔	↔	11	17	16	↔
12	4	7	5	9	8	↔	↔	14	15	13	20	↔	↔
11	5	6	7	10	8	↔	↔	14.5	13	↔	14.5	9	↔
14	12	9	↔	13	17	4	↔	15	20	8	18	19	↔
5	↔	↔	↔	7.5	↔	18	17	3	7.5	12	10	20	6
7	9	6	15	10	8	↔	↔	↔	14	↔	16	12	↔
18	5	8	2	↔	16	↔	8	12	↔	↔	↔	14.5	↔
6	13	10	17	18	↔	5	3	↔	16	11	12	↔	8
13	4	7	8	16	5	↔	—	↔	20.5	↔	9	12	↔
↔	5	6.5	8	9	10	↔	↔	11	↔	17	20	17	↔
6	5	8	10	17	18	9	↔	11	20	7	15.5	19	↔
↔	6	8	9	7	10	↔	↔	18	15	↔	20	↔	↔
↔	5	6	16	11	7	13	↔	8	14.5	↔	12	14.5	↔
9	11	7	16	8	20	↔	↔	10	↔	18.5	↔	12	↔
11.5	↔	19	20	17.5	↔	6	↔	6	17.5	↔	↔	↔	13
6	8.5	8.5	11	7	10	↔	↔	↔	20	↔	↔	19	↔
7	10	12	9	13.5	8	↔	↔	↔	18	19	16	15	17

8 *Methaqualone*

The following table sets forth the ranking on a national basis and by city of the top twenty drugs of abuse from Medical Examiners.
Note that methaqualone is not ranked as one of the twenty leading drugs of abuse.

	Total Drug Mentions	Total Drug Episodes	Alcohol-in-Combination	Heroin/Morphine	d-Propoxyphene	Diazepam	Secobarbital	Amitriptyline
Total DAWN System	6,903	3,519	1	2	3	4	5	6
Atlanta	62	41	5	2	14	5	1	3
Boston	121	85	1	6.5	2	10.5	5	10.5
Buffalo	62	43	6	14	2	3.5	1	—
Chicago	558	279	1	2	3	7	10	8
Cleveland	102	50	3	12	1	2	4	5.5
Dallas	116	68	10.5	4	3	1	5	2
Denver	99	54	1	13	2	7.5	5	3
Detroit	388	166	2	1	4	3	8	12.5
Indianapolis	89	39	3.5	6	2	1	8	6
Kansas City	88	42	9	3	4.5	1	12	6.5
Los Angeles	1,742	838	1	2	10	5	6.5	6.5
Miami	418	191	1	6	4	2	5	13.5
Minneapolis	62	41	1.5	8.5	3.5	8.5	14	3.5
New Orleans	67	39	1	2	6.5	3	12.5	12.5
New York	538	266	2	5.5	7	9.5	5.5	4
Norfolk	42	23	1.5	13.5	1.5	7.5	4	7.5
Oklahoma City	21	13	3.5	7.5	1.5	—	—	7.5
Philadelphia	352	172	1.5	1.5	4	5	3	7
Phoenix	95	60	2	4.5	1	—	6.5	6.5
San Antonio	89	42	2	10.5	3	5	10.5	4
San Diego	224	116	1	2	3	8.5	11	4
San Francisco	651	356	1	2	3	5	4	6
Seattle	109	69	1.5	11.5	1.5	3	6	8.5
Washington, D.C.	113	64	1.5	3.5	6	18	3.5	1.5

↔ Below top 20 drugs
— Denotes 0 mentions

Codeine	Pentobarbital	Secobarbital/Amobarbital	Phenobarbital	Methadone	Ethchlorvynol	Aspirin	Amobarbital	PCP/PCP Combination	Meprobamate	Glutethimide	Cocaine	Flurazepam	Acetaminophen
7	8	9.5	9.5	11	12	13	14	15	16	17	18	19	20
—	—	14	14	—	8.5	8.5	14	—	14	—	7	—	—
6.5	4	—	15	20	—	10.5	20	—	—	3	20	10.5	—
9	9	—	—	—	14	14	3.5	14	14	9	—	—	—
5	15	14	6	4	9	19.5	11.5	11.5	16.5	19.5	16.5	++	++
19	8.5	19	—	—	19	5.5	12	—	8.5	19	19	19	7
23	7	23	15.5	23	15.5	23	7	23	7	15.5	—	—	—
7.5	13	—	10	10	17	17	10	—	17	—	5	17	5
6	10.5	++	12.5	7	9	5	10.5	16.5	—	++	—	20.5	14.5
3.5	19.5	—	11.5	6	11.5	11.5	11.5	—	19.5	19.5	19.5	11.5	19.5
2	—	—	17.5	9	17.5	—	—	4.5	17.5	—	—	12	—
3	9	4	8	17	11	18	15	12	13.5	16	++	++	++
++	11	7	++	12	19.5	8	++	17	15.5	19.5	3	15.5	13.5
—	8.5	—	1.5	8.5	—	14	14	—	—	—	8.5	—	8.5
4.5	12.5	—	12.5	8.5	12.5	—	—	6.5	—	—	—	—	12.5
13	13	3	9.5	1	11	8	20.5	++	++	19	20.5	13	16.5
13.5	—	—	4	13.5	13.5	—	—	—	—	13.5	—	13.5	7.5
—	—	—	7.5	—	1.5	—	—	3.5	7.5	—	—	7.5	—
11	20.5	++	++	6	9	17.5	9	15	15	12	++	15	++
—	3	11.5	8	17.5	11.5	17.5	—	—	17.5	—	11.5	4.5	—
19	10.5	—	10.5	19	19	19	10.5	1	—	—	—	19	—
5.5	8.5	7	11	22	5.5	22	22	—	13.5	16	22	13.5	11
9	7	17.5	8	11.5	19.5	11.5	10	14	17.5	++	++	13	++
15	5	—	4	8.5	15	11.5	—	20.5	8.5	15	15	20.5	8.5
18	5	—	—	18	10.5	10.5	7	—	10.5	18	18	10.5	18

Please note that methaqualone was ranked as the third leading abused drug from emergency rooms in Miami, but ranked 15th in Los Angeles and unranked in New York, cities known for their drug abuse problems. Please also note that methaqualone is unranked in ten of the twenty-four reporting units, whereas flurazepam is ranked in the top twenty drugs of abuse in every reporting unit (from third in Philadelphia to fourteenth in New York). Furthermore, we have been reliably informed that counterfeit Quaalude look-alike tablets (some not even containing methaqualone) were identified as the abused drug in more than 90% of the drug prosecutions in Miami involving methaqualone.

Frederick A. Rody, Regional Director of Region II of the Drug Enforcement Administration (Region II includes Florida) has stated that the Gulf and the Eastern Seaboard States are being faced with heavy trafficking from South American source countries in counterfeit methaqualone which is being passed off as legitimately manufactured Quaalude and with moderate trafficking from Mexico in clandestinely manufactured methaqualone tablets.[25]

The high ranking of methaqualone in Miami appears to be due to the fact that this city is a known port of entry for illegally manufactured drugs, specifically, counterfeit Quaalude tablets. These counterfeit tablets are primarily responsible for the drug abuse problem and not legitimately manufactured and prescribed Quaalude.

In 1979, there were approximately the same number of legally manufactured Quaalude tablets sold per capita in the states of California and Florida, but there were approximately three times as many emergency room methaqualone mentions in Florida (623 mentions) as in California (211).[2] Emergency room mentions of methaqualone in other states show a similar ratio of Quaalude sales per capita to emergency room mentions, providing further support that it is the illegally manufactured methaqualone tablets which are responsible for the preponderance of methaqualone emergency room mentions.

Statistics tracing emergency room mentions stemming from apparently legal prescriptions are noteworthy. During the May 1977 to April 1978 fiscal period, 63.8% of flurazepam emergency room mentions were traced to legal Dalmane prescriptions. In the same fiscal period, 22.8% of methaqualone mentions were traced to legal Quaalude prescriptions.[26] For the first nine months of 1979, street purchases accounted for nearly 42% of hospital emergency room mentions of methaqualone.[2] It has been widely reported that one of the prime means of obtaining methaqualone has been the use of forged prescriptions. These same DAWN statistics reveal that less than 1/2 of 1% of all emergency room mentions of methaqualone were traced to a forged prescription.

Conclusion

All hypnotic drugs and for that matter all drugs, whether or not they are controlled drug substances, are subject to abuse. Lemmon is not suggesting that other hypnotic drug products are subject to more or less abuse than methaqualone.

The choice of hypnotic drug therapy is dependent upon many factors, not the least of which is the evaluation of the risks inherent in the use of the drug and the benefits to be achieved by the use of the drug. However, the abuse of legitimately manufactured drug products cannot be curtailed by actions which are designed to reduce therapeutic usefulness.

Lemmon Company fully supports HEW's hypnotic drug education effort. "Project Sleep." Physicians and pharmacists should be better educated in the problems of drug abuse and how they can avoid contributing to the problem either in inappropriate prescribing or dispensing or by being exploited by persons seeking drugs. Lemmon believes that efforts should be directed through the communications media to the public, particularly to adolescents, to create negative attitudes towards stimulants and depressants and to inform of the dangers inherent in abuse. News stories which romanticize a drug only serve to encourage illicit use.

The clinical and other data referred to in this paper are available upon request from Lemmon Company, Box 30, Sellersville, Pennsylvania, or by calling our toll free number 800-523-6542.

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Quaalude®/Mequin™ (methaqualone) CII

Full Prescribing Information

DESCRIPTION: Quaalude/Mequin (methaqualone) is chemically 2-methyl-3-(2-methylphenyl)-4 [3H] -quinazolinone. Methaqualone occurs as a white crystalline powder with a bitter taste and is slightly soluble in water and freely soluble in alcohol. The drug is highly lipid soluble.

CLINICAL PHARMACOLOGY: Methaqualone is rapidly absorbed from the G.I. tract. The onset of action of the drug is rapid; sleep is usually induced within 30 minutes and lasts 5 to 8 hours following usual hypnotic doses; and patients usually awaken without "hangover", i.e. without post-hypnotic CNS depression.

The decline of serum levels of methaqualone is biphasic. The half-life for the first (distribution) phase is 1 to 4 hours. There is extensive tissue distribution of the drug, particularly in adipose tissue.

Although the metabolic fate of methaqualone has not been completely elucidated, there is considerable evidence that therapeutic doses of methaqualone are almost completely metabolized in the liver by hydroxylation. In doses of up to 300 mg in man, very little unchanged drug is found in the urine. Quaalude/Mequin (methaqualone) may be administered in conjunction with oral anticoagulant therapy without significant clinical interaction.

INDICATIONS: Quaalude/Mequin (methaqualone) is a hypnotic agent useful in the treatment of insomnia and in medical situations requiring restful sleep.

CONTRAINDICATIONS: Quaalude/Mequin (methaqualone) is contraindicated in patients with known hypersensitivity to methaqualone, and in women who are or may become pregnant. Reproduction studies in the rat revealed minor but clearcut skeletal abnormalities in the young.

WARNINGS: The hypnotic dose should be taken only at bedtime, immediately before the patient retires, since Quaalude/Mequin (methaqualone) may produce drowsiness within 10 to 20 minutes. The patient on Quaalude/Mequin (methaqualone) must be warned against driving a car or operating dangerous machinery while on the drug, since methaqualone may impair the ability to perform hazardous activities requiring mental alertness or physical coordination.

The patient shall be warned about the possible additive effects when methaqualone is taken concomitantly with other central nervous system depressants such as alcohol or barbiturates.

Since insomnia is often transient and intermittent, the prolonged administration of Quaalude/Mequin (methaqualone) is generally not necessary or recommended.

USAGE IN CHILDREN—Methaqualone is not recommended for use in children, since its safety and effectiveness in the pediatric age group have not been established.

Psychological and Physical Dependence—Illicit use of the drug or abuse of the drug for non-therapeutic purposes may lead to severe psychological dependence. Physical dependence has been reported on occasion. In the presence of dependence, dosage should be reduced gradually. Caution must be exercised in prescribing methaqualone to individuals whose history suggests they may increase dosage on their own initiative. For this reason, care must be taken not to prescribe an excessive amount of the drug. As with all hypnotic agents, good medical practice suggests that the patient should be reevaluated before repeating the prescription.

PRECAUTIONS: The possibility of the use of sedative/hypnotic drugs in suicide attempts should be kept in mind and the drugs prescribed in small quantities. Since methaqualone is metabolized in the liver, it should be given in reduced doses, if at all, to those with impaired hepatic function.

ADVERSE REACTIONS:

Neuropsychiatric: headache, hangover, fatigue, dizziness, torpor, transient paresthesia of the extremities. Restlessness or anxiety occur occasionally. Peripheral neuropathy has been reported.

Hematologic: aplastic anemia possibly related to methaqualone has been reported.

Gastrointestinal: dry mouth, anorexia, nausea, emesis, epigastric discomfort, diarrhea.

Dermatologic: diaphoresis, bromhidrosis, exanthema. Urticaria has been particularly well documented.

DOSAGE AND ADMINISTRATION

Usual Adult Dosage: For sleep, the usual adult hypnotic dose of methaqualone is 150 to 300 mg at bedtime.

Geriatric Dosage: Dosage for aged, debilitated or highly agitated patients should be individualized in accordance with the judgment of the physician. The principle to be followed is to observe the response to small doses and determine the desirability of adjusting the dose.

Overdosage: Acute overdosage may result in delirium and coma with restlessness and hypertonia progressing to convulsions. Spontaneous vomiting and increased secretions are common and may lead to aspiration pneumonitis or respiratory obstruction. Large overdoses have been accompanied by cutaneous edema, pulmonary edema, hepatic damage, renal insufficiency, and bleeding. Pupillary dilation, tachycardia and hyperreflexia may also occur. Overdoses of methaqualone appear to be less often associated with cardiac or respiratory depression than are overdoses of the oral barbiturates, but shock and respiratory arrest may occasionally occur. Coma has occurred with acute overdosages averaging 2400 mg. Death has occurred following ingestion of 8000 mg. Recommended management includes prompt evacuation of gastric contents, maintenance of adequate ventilation, support of blood pressure if necessary, and the usual supportive measures for the unconscious patient. Dialysis may be helpful. Analeptics are contraindicated.

HOW SUPPLIED:

Quaalude—150: white scored tablets containing 150 mg methaqualone.

Quaalude—300: white scored tablets containing 300 mg methaqualone.

Mequin: white scored tablets containing 300 mg methaqualone.

THE RHEOLOGICAL RESEARCH INSTITUTE OF NEW YORK
16 East 65th Street
New York, New York 10021
212 628-4009

Thursday, September 29th, 1983

The Honorable Henry A. Waxman,
Chairman
Subcommittee on Health
And The Environment
Committee on Energy & Commerce
House of Representatives
Washington, D.C. 20001

Re: Medical indications for methaqualone

Dear Mr. Waxman:

I am writing in support of the statement submitted by The Lemmon Company concerning the scheduling of methaqualone under the Controlled Substances Act. I understand that your Subcommittee is considering two bills which would re-schedule the drug into Schedule I. This letter briefly summarizes the pertinent scientific literature concerning the unique pharmacologic actions of the drug "methaqualone". (The numbers in parentheses refer to references listed in the appendix to this letter.) I believe a review of the literature demonstrates that there are valid medical indications for methaqualone and I could therefore urge the Subcommittee to adopt different legislation to prevent its abuse.

MEDICAL USES OF METHAQUALONE

The answers to the following questions help form the basis upon which clinicians choose a particular sedative and/or hypnotic agent (1):

a. Which agent produces a sleep state most closely resembling that found during 'natural' sleep, i.e., sleep that has not been drug induced?

b. Which sedative/hypnotic agent is least likely to interact with other therapeutic modalities?

and c. Which agent has the least potential for producing

addiction and is least likely to produce harm if taken with suicidal intent? Examination of the pharmacologic properties of methaqualone in light of these considerations shows that methaqualone remains a valuable addition to the medical armamentarium.

Methaqualone-induced vs. "Natural" Sleep

The effects of therapeutic doses of methaqualone (150 - 300 mgs.) on rapid eye movement ("REM") sleep patterns have been taken as one measure of the degree to which this drug alters "natural" sleep. Studies of this type have been reported from several "sleep laboratories." (2, 6-7, 13) The results of these investigations have been conflicting: Kales and co-workers from the Sleep Research and Treatment Center in Hershey, Pennsylvania (2) reported that while all hypnotics tested (including flurazepam, methaqualone, secobarbital, chloral hydrate, ethchlorvynol and glutethimide) had similar short-term (i.e., up to three days of continuous therapy) sleep-inducing effectiveness, only flurazepam and methaqualone continued to show decreases in total wake time (expressed as a percentage change from the baseline time required for a patient to fall asleep) with protracted administration in patients with uncomplicated insomnia. These studies also showed that upon abrupt withdrawal of hypnotic therapy, baseline values for total wake time return in patients treated with methaqualone (250 mgs./day), in contrast to those treated with secobarbital and glutethimide, in whom total wake time increased following drug withdrawal.

In a review of the pharmacologic and toxicologic properties of methaqualone, Russell noted that this drug raises the threshold for electrically induced seizures and produces

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only "minor suppression of REM sleep." (3) His statements are re-confirmed by a consultant writing in The Medical Letter (4), and by Goldstein and co-workers. (7) In contrast, Kales and his associates (6), as well as Modell (5), reported REM depression during methaqualone therapy.

In part, these differing results may reflect differences in (a) the composition of the study groups (e.g., normal volunteers vs. hospitalized patients; psychiatric patients vs. patients with uncomplicated insomnia, etc.), (b) the dose of the drug administered and the duration of continuous therapy or (c) the presence of complicating medical disorders and/or concomitant drug therapy. The available evidence suggests that methaqualone is as effective in producing sleep as other hypnotics, both barbituate and non-barbituate. Additional well-controlled studies concerning the effects of methaqualone on sleep patterns are required before any conclusive statements regarding this area are made.

Like all hypnotic drugs, methaqualone induces sleep by changing the activation state of the cerebral cortex. The benzodiazepines (flurazepam, diazepam, etc.) are another class of sedative/hypnotic drugs, which have become among the most commonly prescribed drugs in the world. (8) Certain authors have either implied (9) or categorically stated (10) that methaqualone offers no therapeutic advantage over the benzodiazepines in treatment of insomnia. However, several well-controlled, comprehensive studies in the medical literature (11-12) confirm that chronic benzodiazepine therapy in the elderly commonly results in variable degrees of ataxia, confusion, hallucinations, delusions and other signs of disturbed central nervous system (CNS) function. Methaqualone, on the other hand, has been conspiciously lacking in these untoward side-effects. (13) Whether or not these clinical observations reflect a different CNS locus of activity or simply altered drug metabolism in the geriatric population, remains to be definitively established. Regardless of the outcome of this basic research, it seems abundantly clear that in an increasingly large population of patients, methaqualone offers at least one important therapeutic advantage over the benzodiazepine-type drugs for the patient with insomnia.

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Drug Interactions with Methaqualone

A number of reports have confirmed that neither methaqualone nor the benzodiazepines alter any of the components of the blood clotting cascade in a clinically significant manner, and hence may be simultaneously administered with drugs known to change the metobolism of these enzyme systems. In a recent report, Udall (14) compared the anticoagulant interferences of phenobarbital, secobarbital, gluthemide, chloral hydrate and methaqualone in patients receiving coumadin therapy. He concluded that methaqualone alone could be administered safely to these patients, since it caused no significant change in the prothrombin time.

Reports such as Udall's and those cited previously (11-12) led us to use methaqualone for sedation and hypnosis in patients with severe atherothrombotic peripheral vascular disease who were undergoing therapy with ancrod (ARVIN), a fibrinogenolytic drug derived from the venom of the Malayan pit-viper (Ankistrodon rhodostoma). ARVIN lowers the elevated fibrinogen levels, and hence reduces blood viscosity resulting in an improved blood flow in these patients, almost all of whom are elderly (Mean age = 68 ± 5 yrs. [±SEM]). Due to ARVIN's effects on fibrinogen (one of the proteins involved in clotting) and because of the age of the patients and the nature of their illnesses, we decided upon methaqualone as the drug to administer exclusively for both hypnosis and sedation.

Methaqualone: Risk-Benefit Ratio

In recent years, the abuse potential of methaqualone has been widely publicized, both in the lay press and in the medical literature. As we are concerned here with a review of the revelant scientific literature, I will confine my remarks to this area.

Methaqualone was first synthesized in 1951 as an anti-malarial agent. (15) Subsequently, a series of studies completed in 1959 documented its hypnotic and sedative properties. (15) When administered in the manufacturer's suggested dose of 75 to 150 mgs. (for sedation) and 300 mgs.

(for hypnosis), the drug is rapidly absorbed into the bloodstream. Its therapeutic effects become manifest within twenty to thirty minutes and persist for approximately six to eight hours. (15) Although there are scattered and contradictory reports in the medical literature (15-17), tolerance to these therapeutic effects has not been conclusively established. (17) In one study, 300 mgs. of methaqualone was administered to 40 healthy adults for three consecutive months without any indication of the development of tolerance. In contrast, the literature abounds with what can only be descrived as sensationalistic (e.g., papers entitled "Methaqualones, Heroin for Lovers" (3), "Methaqualone Abuse: 'Luding Out'" (18), "Quaalude Alley: A One Way Street" (19), etc.) and anectodal accounts of individuals who consume ten to twenty times the suggested dose of methaqualone in addition to illicitly obtained hypnotic and/or narcotic drugs. (15-16, 18-19) Such individuals come to medical attention when they are unable to obtain their polypharmaceuticals and begin to experience withdrawal symptoms. "Tolerance" to methaqualone is inferred from such cases when "methaqualone" (quotation marks have been used to indicate that counterfeit methaqualone and legally manufactured methaqualone are not differentiated in these reports) is given as one of the abused drugs by the individual presenting himself for emergency treatment. I have been unable to find a single report documenting methaqualone "tolerance" in a patient receiving the drug under a physician's care or when it was the sole drug abused. The latter is an important distinction since in most, if not all, of the reports barbituates were simultaneously abused. (15-16, 18-19) The development of tolerance to barbituates and the subsequent withdrawal symptoms upon their abrupt discontinuation are well-known. Thus, it will be appreciated that withdrawal of the barbituates--and not methaqualone--may have misled many investigators into attributing characteristics of the former to the latter medication. In short, methaqualone was guilty by its association with barbituates.

Summary

In summary, at the recommended doses, methaqualone remains a uniquely valuable therapeutic agent in the medical armamentarium. In very high doses, methaqualone, like alcohol, other sedative/hypnotic agents and even some vitamin preparations can be hazardous. To the best of my knowledge, the Drug Enforcement Administration (DEA), in cooperation with

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appropriate state agencies and The Lemmon Company, has been working to prevent the illicit production and subsequent abuse of methaqualone and/or its imitations, without denying its legitimate use to the medical community.

On the basis of the foregoing remarks, I believe that legislation directed toward curbing methaqualone abuse must be balanced by a consideration of the uniquely beneficial effects of this drug. Because of its value in the medical armamentarium, I do not believe that it is appropriate to reschedule the drug into Schedule I. I do, however, share the concerns which have led to the introduction of the legislation. Based on my experience, I would offer the following alternative suggestions.

In my opinion, one approach might be to increase the severity of punishment for the individuals involved. Furthermore, physicians (especially those working in so-called "stress clinics") should not be treated as innocent bystanders or allowed to escape their responsibilities on technicalities. If all states required the use of "triplicate prescriptions" for prescribing Schedule II drugs, I feel that much of the illicit diversion of legally manufactured methaqualone would stop largely because the prescribing physician would know that a DEA computer was monitoring the number of methaqualone tablets he was prescribing. Thus, this approach places the responsibility for methaqualone abuse on the responsible parties and not on the manufacturer or the patients whose health care would be needlessly jepardized if methaqualone were unavailable.

Thank you for your consideration of my remarks.

Sincerely,

R L Letcher

R. L. Letcher, M.D.

RLL/ls

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STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommitte on Health and the Environment
Committee on Energy and Commerce
United States House of Representatives

Re: H.R. 1097 - Rescheduling of Methaqualone

October 14, 1983

The American Medical Association takes this opportunity to comment on H.R. 1097, a bill which would reschedule the drug methaqualone from Schedule II to Schedule I under the Controlled Substances Act. Scheduling methaqualone as a Schedule I drug would prohibit its availability for medical use in the United States.

Comments

We believe that H.R. 1097 is a well-intentioned response to the serious problem of methaqualone abuse. Nevertheless, the AMA must oppose the bill on a number of grounds. First, methaqualone has a currently accepted medical use in this country. Second, the preferred and appropriate method for rescheduling a drug is through the regulatory process already established by existing law. Finally, the AMA believes that a more effective approach to prescription drug abuse is to identify and eliminate the sources of illicit drug diversion rather than to ban the specific drugs that may be abused and thereby make the drug unavailable for appropriate purposes.

Medical Use of Methaqualone

Methaqualone is a recognized hypnotic agent. Its clinical utility, however, is recognized to be limited because of its high abuse potential and high risk of physical and/or psychological dependence. Nonetheless, when properly administered under the supervision of a physician, methaqualone is a safe and effective hypnotic drug.

The Controlled Substances Act provides that in order to be placed in Schedule I, a drug must have a high potential for abuse and have no currently accepted medical use in treatment in the United States. In addition, there must be a lack of accepted safety for use of the drug under medical supervision. The criteria for scheduling under Schedule II is that the drug must have a high potential for abuse, abuse of the drug may cause severe psychological or physical dependence, and the drug has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.

Methaqualone has an accepted use in this country as a hypnotic agent. Thus it does not satisfy the criteria established for a Schedule I drug. Methaqualone is appropriately scheduled under Schedule II because it has an accepted medical use but also has a high abuse potential and abuse of the drug may cause severe physical and/or psychological dependence.

Regulatory Mechanism for Drug Scheduling

The appropriate avenue for rescheduling a drug is through the administrative process rather than by legislation. The Controlled Substances Act authorizes the Attorney General through the Drug Enforcement Administration (DEA) to initiate proceedings to schedule or reschedule a drug or to remove controls on a drug. However, before

action can be taken, the Attorney General must request a scientific and medical evaluation of the drug from the Secretary of Health and Human Services through the Food and Drug Administration (FDA). The FDA also makes a recommendation as to whether the drug should be controlled (and if so under what schedule) or removed from the schedules. If the DEA concludes that the information provided by the FDA constitutes substantial evidence that a drug has potential for abuse, it must initiate proceedings to schedule it. If, however, the FDA recommends that a drug not be controlled, the DEA is not authorized to control it. Finally, if the data provided by FDA constitutes substantial evidence that a drug should be removed entirely from the schedules, proceedings for removal of the drug must be initiated by DEA.

This regulatory mechanism, which utilizes the expertise of the FDA and DEA, has proven to be a highly satisfactory means of reviewing and reevaluating drugs. No convincing reasons exist to forego it in favor of legislative rescheduling. Moreover, we believe that using the legislative process to reschedule drugs would inappropriately preempt a well-developed regulatory program designed to deal specifically with the scientific and medical issues.

Another administrative procedure for curbing illicit drug diversion is DEA's authority under the Controlled Substances Act to set manufacturing quotas for Schedule II drugs. The quotas are based on an annual estimate of the legitimate medical need for the drug and the amount of the drug in reserve. By restricting the amount of the drug that can be manufactured, DEA is able to reduce illicit diversion of a drug whose legitimate medical need is decreasing.

DEA has been able to reduce the manufacturing quota for methaqualone in recent years because the legitimate medical need for the drug has decreased dramatically and adequate reserves of the drug have been available.

AMA Efforts Against Drug Abuse

The AMA believes that a more effective approach to prescription drug abuse is realistic action directed, not toward specific drugs that may be abused, but toward identifying and eliminating the sources of illicit drug diversion. In recent months, the AMA has been working on the issue of prescription drug diversion with federal and state officials, as well as with representatives of medicine, pharmacy, dentistry, podiatry, veterinary medicine, nursing and other professions whose members are authorized to prescribe and dispense controlled substances. Together, we have devised a highly effective mechanism known as the Prescription Abuse Data Synthesis (PADS) model for identifying practitioners who inappropriately prescribe or dispense drugs that are subject to abuse.

PADS is designed to help state officials identify potential sources of drug diversion within their jurisdictions through a rapid, economical, and non-intrusive process of data integration and analysis. Use of PADS will help the states curtail prescription drug abuse by more effectively identifying the locus of illicit drug diversion. Thus, state resources can be focused on investigating specific persons or institutions rather than on routine case-finding audits.

The development of PADS has been possible because of the cooperative activity of the AMA, the DEA and other governmental agencies, and private sector organizations. Field tests of the PADS model in five states have

elicited the same type of inter-disciplinary cooperation in problem identification and intervention.

The AMA and its Informal Steering Committee on Prescription Drug Abuse are developing a range of programs that will build on this cooperative effort to provide effective action against the inappropriate prescribers and criminal purveyors of prescription drugs. We are also developing preventive and remedial measures for the practitioners who unwittingly contribute to the problem because their knowledge is out of date or because they have been deceived by "professional patients" or other drug abusers. These programs will include professional education units for physicians and pharmacists, patient and public education materials, legislative surveys and reference materials for use by the state, and research into the costs and benefits of various diversion control methods that have been used by the states.

The potential of PADS and the other programs of the Informal Steering Committee was recognized in the October 1982 report by the Comptroller General to the U.S. Congress entitled, "Comprehensive Approach Needed to Help Control Prescription Drug Abuse," which urged all federal agencies to cooperate in this initiative. These programs were also acknowledged in the August 1982 Service Delivery Assessment Report on Drug Abuse to the Secretary of the Department of Health and Human Services, which said that these activities "have sweeping implications for the future and deserve recognition and encouragement."

Conclusion

The AMA recognizes that methaqualone abuse is a serious problem. However, for the reasons stated above we oppose H.R. 1097. Instead, we urge Congress to provide continued financial support for the federal agencies involved in attempting to curb illicit drug use.

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STATEMENT BY STEWART TURLEY, CHAIRMAN, JACK ECKERD CORPORATION
TO THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
HOUSE ENERGY AND COMMERCE COMMITTEE

Mr. Chairman, members of the committee. I am Stewart Turley, chairman of the board and president of the Jack Eckerd Corporation. Our principal subsidiary is the Eckerd Drug Company which operates 1,335 retail drug stores in 15 states. Our pharmacies operate in all areas of the Sunbelt from Texas to Oklahoma through the south and up the eastern seaboard into Delaware and New Jersey. Our company is the nation's largest private provider of prescriptions to the American public.

Over the years our company and our pharmacists have supported both public and governmental efforts to better inform the public on health care and the proper use of drugs and prescription medication. Likewise, we have been deeply involved in community, private and governmental efforts which seek to curb the misuse and abuse of drugs.

In 1981 the subject of methaqualone and concerns regarding escalating abuse was seriously discussed within our organization. Upon further study it became apparent that this drug was being severely abused in many of our major metropolitan markets in which our company operates as well as in other areas of the country. Numerous accidents, injuries and deaths can be directly linked to the use of methaqualone, either alone or with alcohol.

Further research on the drug, its medical history, comments from our pharmacists and the input from physicians and other health practitioners, with whom we are very close, clearly indicated that this drug was considered a problem and that there were several alternative products available for the same medical purposes that were less dangerous.

On January 12, 1982, we stopped stocking methaqualone in our pharmacies in all the states in which we operate. In taking this voluntary action we

sought to bring additional public attention to the serious abuse problem that has been identified with methaqualone. At the same time we urged through several communications that the Federal Drug Enforcement Administration (DEA), state drug enforcement agencies and the various state pharmacy and medical boards support regulation or legislation that would reclassify methaqualone into Schedule I -- making it illegal to stock or dispense the drug in any pharmacy.

It is fair to say that legal prescriptions for the drug methaqualone were steadily diminishing as its abuse steadily increased. And, since there were several other therapeutic drug products available for the same medical purpose, we sincerely believe that the value of its legal availability was far overshadowed by its growing abuse.

Fortunately, public, government, health provider and employee response has overwhelmingly supported our action.

Since this time seven states have enacted legislation which effectively prohibits dispensing of methaqualone as a prescription drug. There is similar legislation pending in several states.

Another objective of our Company was to provide greater safety to our employees, and we have seen a significant reduction in the number of thefts and armed robberies in our stores since January, 1982. Prior to taking this step, criminal action in our pharmacies accounted for approximately 30 percent of the thefts and robberies committed in our stores. Today, some 18 months later, pharmacy-related crimes account for only 18 percent, a 40 percent reduction. While we have instituted several programs to make our pharmacies and employees more secure, we believe that the elimination of methaqualone has made an important contribution.

In May of last year I also had the opportunity to appear before the Senate Labor and Human Resources Subcommittee on Investigations and General

Oversight to testify on the subject of methaqualone abuse. At these hearings our company endorsed legislation (S 2478) sponsored by Senator Paula Hawkins of Florida which is very similar to the measures before this subcommittee today.

We believe that the legislation embodied in the two House proposals (HR 1055 and HR 1096) is appropriate and we encourage your favorable action on this legislation which will prohibit its manufacture and distribution and, hopefully, contribute to reducing the abuse of this product in our nation.

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