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**IACP Publishes Draft Comments Regarding FDA's Compliance Policy Guide Regarding Compounding Pharmacy**

**DRAFT**

July 30, 2002

Dockets Management Branch (HFA-305)
Food and Drug Administration
Room 1061
5630 Fishers Lane
Rockville, Maryland 20852

Re: Docket No. 02D-0242: Compliance Policy Guides Manual Section 460.200, "Pharmacy Compounding"

Dear Sir or Madam:

The International Academy of Compounding Pharmacists ("IACP") appreciates the opportunity to comment on the Food and Drug Administration's ("FDA") Compliance Policy Guide ("CPG") Manual Section 460.200, entitled "Pharmacy Compounding." IACP's mission includes increasing awareness of the importance of compounding by providing accurate information on the benefits of compounding and providing assistance to pharmacists in improving their compounding activities. In this capacity, IACP wishes to address a number of issues in this Compliance Policy Guide. IACP submits these comments on behalf of its 1600 member compounding pharmacists and their patients, who benefit from compounded medications.

Initially, IACP objects to the publication of this guidance without public comment. Although FDA claimed that the CPG needed to be implemented immediately, pursuant to 21 C.F.R. § 10.115(g)(2) ("FDA will not seek your comment before it implements a Level 1 guidance document if the agency determines that prior public participation is not feasible or appropriate"),[1] IACP is hard-pressed to understand why the agency had "an urgent need to explain how, in light of the Supreme Court decision, it will exercise its enforcement discretion in regard to compounded human drugs."[2] The haste is unwarranted in that every state in the Ninth Circuit

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had been operating without Section 503A of the Federal Food, Drug, and Cosmetic Act ("FDCA") for months following the Ninth Circuit's decision in Western States Medical Center v. Shalala, 238 F.3d 1090 (9th Cir. 2001). Moreover, the practice of pharmacy, including compounding, is heavily regulated by the State Boards of Pharmacy. There was thus no need for the precipitous action taken by the agency. It was both appropriate and feasible for the FDA to allow public comment before publication of a final guidance.

FDA has spoken of how it wishes to work in a more cooperative and open manner with the pharmacy community. The abrupt issuance of the CPG in final form is inconsistent with the agency's purported objective of receiving meaningful input from interested parties. Accepting comments after the fact is not a substitute for soliciting comments before publication.

In addition, giving the public and regulated industry the opportunity to comment prior to release of the CPG would have helped FDA resolve some of the ambiguities that must now be addressed after the fact. The document issued has created unnecessary controversy and confusion, much of which, we believe, could have been avoided by allowing even a brief period for public comment. IACP requests that all future policy guides relating to pharmacy compounding (and revisions of such documents) be released for comment prior to the publication of the final guidance.

Seeking public comment may have helped the agency avoid a fundamental tension within the CPG. Although the FDA indicated that the CPG is intended to delineate the line between drug manufacturers and pharmacies engaged in compounding,[3] the CPG actually conflates two separate and distinct issues: first, distinguishing compounding from manufacturing and second, how to compound in a safe manner. Some of the factors in the CPG, which will be discussed in more detail below, even though they do not relate to the ostensible objective of the CPG, address the "safety" issue, not the scope and scale of the compounding activities.

For example, not obtaining written assurance from a supplier that each lot of a drug substance has been made in an FDA-registered facility, not ensuring that drug components meet official compendia requirements, or compounding a product that used bulk active ingredients that are not components of FDA-approved drugs, are each a factor listed in the CPG. However, there is virtually no relationship between those factors and whether a pharmacy is a manufacturer. Although the Supreme Court was not speaking of these variables in Western States, its language requiring that there be an appropriate "fit" between the regulatory goal and the means to achieve it is also appropriate here.[4] Factors 2 (compounding drugs that were withdrawn or removed from the market for safety reasons), 3 (compounding from bulk active ingredients that are not components of FDA-approved drugs), 4 (receiving, storing, or using drug substances without obtaining written assurance from the supplier that each lot has been made in an FDA-registered facility), and 5 (receiving, storing, or using drug components not guaranteed or otherwise determined to meet compendia requirements) all address safety issues, not whether a pharmacy is acting as

a manufacturer. In many instances, factor 9 (failing to operate in conformance with applicable state law regulating the practice of pharmacy) may have no bearing on either issue.

Whatever FDA's statutory power over pharmacies may be, IACP believes that FDA has no authority to set national safety standards for pharmacies that are not "manufacturers." While Congress clearly has the power to impose these requirements upon pharmacists, FDA, in the absence of legislation, does not. IACP does not believe this to be the forum to discuss this issue in depth. We strongly believe, however, that Congress never authorized FDA to act as the National Board of Pharmacy.

Congress authorized FDA to regulate manufacturers and set standards for safety and efficacy for new drugs produced by manufacturers. Conversely, as IACP demonstrated in its brief to the Supreme Court, Congress never intended FDA to regulate pharmacies to the same extent as manufacturers. That is why pharmacies are exempt from registration and listing requirements and the detailed inspections that manufacturers must undergo.[5] Whatever power FDA might have over pharmacists who have become manufacturers, there is no statutory basis for FDA to assert that it has the authority to prescribe standards for traditional pharmacies engaged in extemporaneous compounding.

According to the guidance, the CPG applies only to pharmacists who are manufacturing under the guise of compounding. The CPG distinctly excludes those pharmacists engaged in traditional compounding pharmacy (as stated in the discussion of the CPG) and, thus, no part of the CPG should be enforced against those pharmacists, provided they are not manufacturers. However, the criteria of the CPG do not operate this way. A pharmacist who compounds a single prescription from a bulk drug that is not the subject of an FDA-approval, without getting an assurance that the drug came from an FDA-registered facility or a guarantee that it met compendia standards has failed three of the nine criteria. That pharmacist could not possibly be considered a manufacturer. He is operating within the practice of pharmacy, subject to regulation by the State Boards of Pharmacy. Yet the CPG wrongly treats these factors as having a bearing on whether a pharmacist is a manufacturer in disguise. The stated objective of the CPG and its factors are at odds with one another.

IACP urges FDA to defer to the State Boards of Pharmacy and standard-setting organizations such as the U.S. Pharmacopeia ("USP") and the National Association of Boards of Pharmacy ("NABP") for the regulation of compounding practices. State Boards of Pharmacy and the cited organizations have been effectively regulating the practice of compounding pharmacy for many years through state pharmacy law and regulations, and USP Chapter 795 "Pharmacy Compounding" and NABP's Good Compounding Practices.[6] Therefore we believe that factors 2, 3, 4, and 5 should be removed from the CPG as irrelevant to its professed objective of regulating those pharmacies that "are engaged in manufacturing and distributing unapproved new drugs for human use in a manner that is clearly outside the bounds of traditional pharmacy practice and that violates

the Act."[7] CPG § 460.200 at 3.

Although the CPG lists extraneous factors, it omits the core of pharmacy: receiving a valid prescription or order from a licensed health care professional. IACP has long maintained that the pharmacist-physician-patient triad relationship is central to whether a pharmacy is acting as a pharmacy. IACP recommends that FDA drop factors 2,3,4, and 5, and include a factor relating to the existence of the triad relationship.

Specific Issues

IACP has additional concerns with the nine factors that FDA has stated it will consider when determining if the agency will initiate enforcement action.

**Factor 1**: The initial factor indicates that FDA will consider enforcement action when a pharmacy engages in "compounding of drugs in anticipation of receiving prescriptions, *except in very limited quantities* in relation to the amounts of drugs compounded after receiving valid prescriptions." See CPG Sec. 460.200 Pharmacy Compounding (emphasis added). This statement represents a significant change from FDA's prior position in its 1992 Compliance Policy Guide for Pharmacy Compounding, CPG Sec. 7132.16, which stated that FDA would consider enforcement action if a pharmacy were engaged in "compounding *inordinate amounts* of drugs in anticipation of receiving prescriptions . . .." The language in the 2002 CPG is also more restrictive than the Food and Drug Administration Modernization Act ("FDAMA") Section 503A, which was consistent with the 1992 Compliance Policy Guide. IACP believes that the change from allowing anticipatory compounding except in "inordinate amounts" (with evidence of prescription trends) to disallowing anticipatory compounding except in "very limited quantities," is unduly restrictive and significantly limits the ability of compounding pharmacists to run effective practices and to meet their patients' needs.

The phrase "very limited" may lead FDA to take action based on what has been regarded as acceptable anticipatory compounding, or cause pharmacists to unduly curtail anticipatory compounding based on historical prescribing patterns. IACP recognizes that the phrase "inordinate amounts," by itself, was not well defined. The same is true, though, for "very limited." IACP suggests that this section be revised to say "limited quantities based on historical prescribing patterns."

Anticipatory compounding is a well-accepted, beneficial component of traditional compounding. See, e.g. Ohio Admin. Code § 4729-9-21 ("A limited quantity may be compounded in anticipation of prescription drug orders based on routine, regularly observed prescribing patterns"); 22 Tex. Admin. Code § 291.31 (defining compounding to include "[t]he preparation, mixing, assembling, packaging, or labeling of a drug or device: . . . in anticipation of prescription drug orders based on routine, regularly observed prescribing patterns").

The NABP Model Rules state that:

Pharmacists may compound drugs in very limited quantities prior to receiving a valid prescription based on a history of receiving valid prescriptions that have been generated solely within an established pharmacist/patient/prescriber relationship, and provided that they maintain the prescriptions on file for all such products compounded at the pharmacy (as required by State law). The compounding of inordinate amounts of drugs in anticipation of receiving prescriptions without any historical basis is considered manufacturing.

Although the NABP guidelines refer to "very limited quantities," they specifically reference a history of prescription patterns to determine what is a "very limited quantity." Further, the NABP guidelines state that a pharmacist is engaged in manufacturing only when the pharmacist compounds "inordinate amounts of drugs" in anticipation of prescriptions and there is no historical basis for the anticipatory compounding. Thus, the NABP guidelines use the context of historical practice, whereas the CPG uses the more restrictive, absolute standard of "very limited."[8]

Additionally, this factor could have negative effects on drug quality if it forces pharmacists to compound multiple small batches of a drug product as opposed to a single, large batch. Producing multiple small batches of drug products may incur a greater risk of error and contamination than preparing a single batch of greater quantity. Compounding in larger batches may permit sterile compounding pharmacies to conduct sterility testing in advance of receiving prescriptions, thereby enabling pharmacies to determine sterility of the compounded product prior to releasing the product to the consumer. Patient-by-patient compounding precludes this testing. There are situations when larger batches can be tested and validated more efficiently because of the number of samples that have to be tested, the sensitivity of the analytical balances (minimum amounts that can be accurately weighed) and the measuring/mixing capabilities of the compounding equipment based on dilution factors.

Compounding pharmacists strive to assure maximum accuracy and safety in all compounded preparations regardless of batch sizes. Compounding pharmacies should not be restricted from preparing appropriate amounts of pharmaceutical products based on physician refill instructions and routine, historical prescribing patterns.

Allowing pharmacists who receive regular prescriptions for a drug the flexibility to compound sufficient quantities of that drug could under certain circumstances enhance quality and lead to greater efficiencies. This can benefit the patient, by permitting faster access to the medication, and also give the pharmacist more time for other necessary activities, such as patient counseling. Given the substantial nationwide shortage of pharmacists,[9] having pharmacists compound multiple small batches of the same medication may not be the most productive use of pharmacists' time.

**Factor 2:** The second factor references a list of drug substances that

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"were withdrawn from the market for safety reasons." While IACP generally agrees with the purpose of this factor,[10] we do have several concerns. First, it is IACP's position that there should be notice and an opportunity to comment before a drug is added to this "negative" list. A few recent additions to the list of drugs withdrawn from the market for safety reasons received no public input prior to their addition to the list. For example, three drug products – Cisapride, Grepafloxacin, and Troglitazone – were listed in the May 2002 CPG. These products had not previously appeared on the list of drug substances withdrawn from the market for safety reasons. In addition to the lack of opportunity to comment on the CPG overall, there was no public comment period given on these drug products before they were added to the list of drugs prohibited for use in compounding.

Many of the drug products that are withdrawn are limited to certain doses, dosage forms, or indications. Public comment is critical to ensure the limitations on the use of the drug product are appropriate and take into consideration the differences between compounding and manufacturing.

Section 503A required that FDA receive public input before adding a drug to this list. IACP believes that this process allows for better decision-making. There have occasionally been instances where FDA has reversed its stance on an identified drug following public comment. For example, FDA decided not to add parenteral drug products containing neomycin sulfate to the list of drug substances withdrawn from the market for safety reasons following the public comment period.[11] Thus, IACP requests that the FDA procedure for modifying the lists adhere to its good guidance practices and permit a proposal stage, to allow for review and comments by the public, before the issuance of additions to any list.

**Factor 3:** The third factor in the CPG unnecessarily restricts those ingredients that may be used to compound drug products. Under Section 503A, compounding pharmacists were permitted to compound using three sources of bulk drug ingredients – bulk drugs that have been components of FDA-approved drug products, bulk drugs that complied with the standards of an applicable USP or National Formulary ("NF") monograph, and bulk drugs that appeared on the list of drug substances that may be used in pharmacy compounding.[12] However, the May 2002 Compliance Policy Guide references only bulk drug substances that are components of FDA-approved drug products. The reduction of approved bulk drug sources from three primary sources to one significantly reduces the ability of pharmacists to compound to meet patients' needs. IACP therefore recommends that FDA restore the approved bulk drug sources to the three sources cited in Section 503A.

The lack of the USP and the "Positive List"[13] as sources of approved bulk drug substances are both glaring omissions in the CPG. The USP should clearly be a source for approved drugs. Some old drugs that have been grandfathered have not been approved by FDA, but have a long history of compounding use. As worded, the CPG would exclude the use of many bulk drug substances that have USP monographs but are not found in

the Orange Book, FDA's defined source of approved drug substances. Examples include histamine diphosphate, phenobarbital, chloral hydrate, oxytetracycline dihydrate, estriol, collodion flexible, potassium permanganate, menadione and tinidazole. Some of these listed drug actives are even commercially available through finished drug products. Allowing use of only bulk drug substances that are components of FDA-approved drugs is evidently an inadequate provision for pharmacy compounding or even manufacturing.

Also, the FDA has already approved a proposed list of bulk drug substances that do not have USP monographs and that are not components of FDA-approved drug products. This list includes several commonly compounded drug products, such as metronidazole benzoate, caffeine citrate, and cantharidin. Just as the negative list places limits on access to drugs that are potentially unsafe, the positive list provides access to compounded drugs that potentially offer benefits to patients. FDA has previously recognized the necessity of expanding approved bulk drug sources through the provision of this positive list and an identified procedure for future additions to this list. There is no reason why these previous provisions should now be revoked. The symmetry found in FDAMA, Section 503A should be maintained.[14]

Additionally, the third factor discusses "bulk active ingredients that are not components of FDA-approved drugs . . .." The use of the present tense could be read as implying that pharmacists may not compound using active ingredients that were present in FDA-approved drugs, but that are no longer commercially available. FDA should revise this factor to clarify that pharmacists may compound using bulk active ingredients that are used in FDA-approved drugs, or were, at one time, present in FDA-approved drugs, as long as the drug products were not withdrawn from the market for safety reasons. Drug companies discontinue products for many reasons unrelated to safety, such as market position. The election by a drug manufacturer to stop selling an unprofitable but safe drug should have no impact on the ability of pharmacists to compound that drug to fill prescriptions.

**Factor 4:** The fourth factor requires that pharmacies obtain written assurance from suppliers that each lot of the drug substance has been made in an FDA-registered facility. This paper-trail requirement imposes an additional burden on the pharmacist that is unrelated to whether they are a manufacturer.

Furthermore, it is unclear who the "supplier" is. Does the wholesaler or importer of a bulk ingredient qualify as the supplier? Must the certification come from the manufacturer of the ingredient even though the pharmacist is very unlikely to have contact with that entity? After all, pharmacists rarely have contact directly with manufacturers. What should a pharmacy do if the manufacturer is not identified? Returning a drug that a pharmacy has received for lack of this piece of information will mean that prescriptions will go unfilled. That surely is not in the best interest of patients. IACP therefore recommends that if this factor is retained, pharmacists should be able to satisfy this requirement through receiving

from their immediate supplier any documentation that accompanies the drug, such as a statement on a Certificate of Analysis that the ingredient was manufactured in an FDA-registered facility.

The FDCA and FDA require that manufacturers register.[15] Pharmacists who compound should not be asked to serve as tools for enforcing this requirement directed at manufacturers.

Additionally, the terminology in factor four, "without first obtaining," is problematic. This phraseology could be interpreted to require pharmacists to receive written assurance prior to the receipt of a drug product. This interpretation would result in detrimental delays in providing patients with access to crucial medications. If the documentation required by factor four is maintained, the word "first" or the words "receiving" and "storing" should be removed to prevent excessive delays in drug delivery.

**Factor 5:** The fifth factor, prohibiting the "receiving, storing, or using drug components not guaranteed or otherwise determined to meet official compendia requirements," should be deleted as unrelated to the nominal purpose of the CPG. If retained, it needs to be clarified. FDA should explicitly state that this refers solely to active pharmaceutical ingredients that have USP monographs.

IACP agrees that it is generally better for pharmacists to use USP grade ingredients, when a USP monograph exists. In many cases, though, there are no monographs. Some older drugs were never subjects of monographs. Some newer drugs will eventually be covered by monographs, but it can take a long time for monographs to be written. Neither situation is a reason to preclude filling prescriptions that call for use of that compounded drug. This is more of a safety issue that is better addressed by the State Boards of Pharmacy, USP, and NABP. It is not a question of whether a pharmacy is engaged in manufacturing.

In any event, pharmacists should be able to rely on the designation of USP on an ingredient label. The labeled designation should suffice as the "guarantee," without need for anything more. If a company represents a drug as meeting USP standards but it does not, FDA has ample authority to proceed against the supplier.[16] This is a regulation matter to be addressed with manufacturers of ingredients, not pharmacists.

**Factor 6:** The sixth factor addresses the use of "commercial scale manufacturing or testing equipment for compounding drug products." IACP is concerned with any limitation on testing equipment. Pharmacists should not be deterred from using even highly sophisticated testing equipment that enhances product quality. The FDA has no reason to restrict testing of products to ensure quality and safety. IACP recommends removing any reference to testing equipment.

The restriction on commercial scale equipment is also a source of concern. The CPG provides no bright line test to determine whether a particular piece of equipment is of "commercial scale." Some

pharmaceutical manufacturers make small quantities of certain drug products (e.g., orphan drugs). There may be some overlap in scale or quantity in equipment that a manufacturer possesses and the equipment that a compounding pharmacist who receives numerous prescriptions might need to operate his or her business effectively. IACP recommends that the FDA remove this language in the CPG. Section 503A did not contain this provision;. If FDA retains this factor, FDA should include examples of equipment that it considers to be of commercial scale or provide an explanation of how the agency will determine whether a piece of equipment is of "commercial scale."

Also, FDA should never use sophistication of equipment as a surrogate endpoint for whether a pharmacy is a manufacturer. Pharmacists who use advanced technology will have an enhanced ability to compound properly. More pharmacists are using automated equipment, such as automated mixing and dispensing equipment, to facilitate compounding and increase the quality of compounded drugs. FDA should not confuse scale, which relates to volume and quantity, with sophistication or complexity, which relates to quality.

**Factor 7:** The seventh factor, "compounding drugs for third parties who resell to individual patients or offering compounded drug products at wholesale to other state licensed persons or commercial entities for resale," is also problematic. IACP agrees with FDA that pharmacies may not sell to wholesalers or distributors for resale, but believes that the current language is overbroad.

Many physicians and institutions request from pharmacists compounded drugs for use in the office or institution that are not commercially available. Many of these drug products – such as most injectable drug products – must be administered in the provider's office. FDA recognized this fact by including cantharidin on the "positive" "List of Drug Substances That May Be Used in Pharmacy Compounding" with the restriction that the drug be administered topically "in the professional office setting only."[17] There is clearly a need for some provision for licensed institution and office use of compounded drugs. Pharmacists, however, cannot ensure that the purchaser will not resell the product once it is dispensed to the purchaser.

IACP recommends that the FDA instead adopt the approach of some State Boards of Pharmacy, which require compounding pharmacists to attach a label to their compounded product which reads "FOR OFFICE USE ONLY" and "NOT FOR RESALE."[18] With the affixing of this label, the pharmacist declares his or her intent that the product is not to be resold to a third party provider. However, pharmacists should not be held accountable for the actions of the purchaser, which is beyond their control.

The CPG should also clarify that it is permissible if a pharmacist dispenses a drug for office use, and the physician then charges his or her patient for that drug (or a hospital charges its patient). A pharmacy should not sell to a hospital or physician with the intention that the hospital or

physician will sell to another entity. The hospital or physician, though, may charge the patient for the drug which it received from the pharmacist and which that hospital or physician then administered or dispensed.

**Factor 8:** IACP is concerned with the lack of definition of the phrase "commercially available FDA-approved drug product." IACP recommends that FDA clarify this provision using a clause similar to section 503A(b)(2). The definition of a commercially available drug should read: "the term 'essentially a copy of a commercially available drug product' does not include a drug product in which there is a change which produces a significant difference, as determined by the prescribing practitioner, between the compounded drug and the comparable commercially available drug product." Without such a definition, this factor offers no guidance to the pharmacy profession. The definition chosen by Congress was appropriate, and FDA should similarly adopt it.[19]

FDA should also clarify that a product is not commercially available if health care providers cannot obtain the product from the FDA-approved manufacturer. In many instances, pharmacies compound drugs that are in short supply, are temporarily unavailable, or, although they have not been withdrawn for safety reasons, are off the market. If a pharmacist receives prescriptions for copies of FDA-approved drugs, is told by the health care provider that the health care provider is unable to obtain the FDA-approved product through normal chains of commercial distribution, and the pharmacist verifies this status, the pharmacist should be permitted to compound the product. Otherwise, patients will be denied access to necessary medications. Unfortunately, many drug products that have been approved by FDA are in short supply or are temporarily not being produced; compounding by pharmacists can fill these gaps.

Finally, IACP recommends that FDA delete the requirement of "documentation of the medical need for the particular variation of the compound for the particular patient." A prescription from a licensed practitioner for a compounded drug should be sufficient documentation of the medical need. It is inappropriate for FDA to demand more documentation from a licensed practitioner of the medical need of a particular patient. Pharmacists have never been required to receive documentation of medical need beyond the prescription. FDA should not interfere with the practice of pharmacy and disrupt the interaction between physicians and pharmacists by the imposition of this brand new requirement. IACP also believes that requiring physicians to justify the decision to prescribe a particular drug for a patient is utterly without any statutory basis. Physicians are free to prescribe off-label uses without documentation.[20] They are equally free to prescribe compounded medication without written explanations.[21] (This is a state board of pharmacy/state medical issue.)

**Factor 9:** The ninth factor of the CPG relates to whether pharmacists "fail[] to operate in conformance with applicable state laws regulating the practice of pharmacy." While IACP agrees that pharmacists must act in conformance with applicable pharmacy laws, FDA should clarify that this

factor relates to those aspects of state pharmacy law that indicate whether the pharmacy is acting as a manufacturer. State boards of pharmacy impose numerous requirements on pharmacies, such as the need to pay its registration fee in a timely manner,[22] establishing a pharmacist to pharmacy technician ratio[23] and the need to notify the board of pharmacy of the designated pharmacist-in-charge.[24] There are numerous other requirements of state pharmacy law that have no bearing on whether a pharmacy is acting as a manufacturer. The failure to comply with every single element of a statute or regulation does not mean that a pharmacy is a manufacturer. Thus, if a specific state law violation indicates that a pharmacy is a manufacturer, FDA may appropriately consider it in assessing a pharmacy's status. Otherwise, enforcement should rest solely with the State Boards of Pharmacy.

We appreciate the opportunity to provide the FDA with comments on this issue.

Respectfully submitted,

L.D. King
Executive Director
International Academy of Compounding Pharmacists

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[1] See 67 Fed. Reg. 39,409, 39,410 (June 7, 2002).

[2] Id.

[3] See CPG § 460.200 at 3 ("FDA believes that an increasing number of establishments with retail pharmacy licenses are engaged in manufacturing and distributing unapproved new drugs for human use in a manner that is clearly outside the bounds of traditional pharmacy practice and that violates the Act. Such establishments and their activities are the focus of this guidance.") There are two points worth noting here. First, IACP questions the basis for the statement that there are an "increasing number" of pharmacies acting as manufacturers. This language was taken almost verbatim from the 1992 CPG, and is thus ten years old. Unless FDA has information to support this assertion, it should be deleted from the CPG. Second, although this is not the forum for an extended discussion of this issue, as IACP, and others, demonstrated in their briefs in the Western States appeal before the United States Supreme Court, pharmacy compounding does not result in an unapproved new drug. Historically, pharmacy compounding was exempted from the new drug requirements of the FDCA. Brief of the International Academy of Compounding Pharmacists, *amicus curiae*, in Thompson v. Western States Medical Center, No. 01-344, 2-5 (2002).

[4] Western States, slip op. at 13-14; dissent at 11.

[5] FDCA § 510(g)(1); 704(a)(2)(A).

[6] National Association of Boards of Pharmacy, Good Compounding Practices Applicable to State Licensed Pharmacies, Appendix C.

[7] Although we have commented on these factors, we urge FDA to drop them from the CPG. Factor 9 should be clarified so that FDA utilizes state law only to the extent that the law addresses the manufacturer versus compounding issue.

[8] As stated above, we also recommend removing the modifier "very" as unnecessarily restrictive.

[9] Bureau of Health Professions, Health Resources and Services Administration, Report to Congress: The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists, 4-6 (2000).

[10] However, as noted above, IACP also believes this factor to be unrelated to the pharmacist-manufacturer dichotomy.

[11] See 64 Fed. Reg. 10944, 10946 (Mar. 8, 1999). Adding a drug to the list, and then soliciting comments is not an adequate substitute. This sequence may lead to patients foregoing necessary therapy for as long as the product is listed.

[12] FDCA § 503A(b)(i)).

[13] Ibid.

[14] This discussion, though, underscores how the CPG has muddled safety issues with delineating compounding from manufacturing.

[15] FDCA § 510(b); 21 U.S.C. § 360(b).

[16] See, e.g., FDCA § 501(b); 21 U.S.C. § 351(b).

[17] 64 Fed. Reg.998, 1002 (Jan. 7, 1999).

[18] See, e.g., Ark. Admin. Code 07-02-002(L)(3); 22 Tex. Admin. Code § 291.33(i)(2)(D)(i).

[19] Congress' definition did refer to an "identified individual patient." This language could have been construed as precluding compounding for office use. IACP endorses FDA's recognition in the CPG that there should be no prohibition against compounding for office use.

[20] 21 C.F.R. § 312.2(d).

[21] This element also creates an extraordinary practical challenge:

how to evaluate a physician's rationale. It places FDA in the unprecedented position of second-guessing decisions by doctors, effectively leading FDA to regulate the practice of medicine. See Chaney v. Heckler, 718 F.2d 1174 (D.C. Cir. 1984); rev'd, 470 U.S. 821 (1985) (legislative history of FDCA "expressed a specific intent to prohibit FDA from regulating physicians' practice of medicine"). The prescription should suffice; nothing more is needed.

[22] See, e.g., Cal. Bus. & Prof. Code §§ 4400, 4401; Cal. Code Regs. tit. 16 § 1749.

[23] See, e.g., Cal. Bus. & Prof. Code § 4115(g); Cal. Code Regs. tit. 16 § 1793.7(f).

[24] See, e.g., Cal. Bus. & Prof. Code § 4113(a); Cal. Code Regs. tit. 16 § 1709.