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ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

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June 4, 2015

Dr. Janet Woodcock
Director
Center for Drug Evaluation and Research
U.S. Food and Drug Administration
10903 New Hampshire Avenue
Silver Spring, MD 20993

Dear Dr. Woodcock:

Thank you for appearing before the Subcommittee on Health on Thursday, April 30, 2015, to testify at the hearing entitled "Legislative Hearing on 21st Century Cures."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Thursday, June 18, 2015. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

Attachment —Additional Questions for the Record

The Honorable Gus Bilirakis

Dr. Woodcock, I held a 21st Century Cures related roundtable which featured a constituent of mine living with Chronic Obstructive Pulmonary Disease (COPD). She talked about some of the work that the COPD Foundation is doing including the creation of the COPD Biomarker Qualification Consortium (CBQC). The CBQC is a unique public-private partnership driven by the need to address our nation's need for new therapies for the treatment of COPD, third leading cause of death. If the CBQC fails, it is possible that we may never see a unique partnership that engages the patient advocacy community, academia, industry and the NIH collaborate on amassing this amount of pre-clinical data, pre-competitive data again.

1. With this example in mind, if 21st Century Cures legislation codifies the biomarker process at the FDA without timelines, what do you predict the time frame will be for biomarker qualification?

2. Could you update my office on the present timeline for the CBQC fibrinogen application?

The Honorable Renee Ellmers

1. It seems evident that not all therapies "fit" into the FDA's pathway (section 351/361) for small molecules. For example, FDA has already developed a separate pathway for biologics. Has FDA given consideration to the notion that other therapies, like personal precision regenerative stem cell therapies may require a separate regulatory path, similar to the more flexible and workable pathway that currently exists/ is in the future direction for Europe, Korea and Japan?

2. Has the FDA examined how the European Medicines Agency (EMA) and European National Agencies handle advanced therapy regulation, e.g. regenerative cell products, and also the future global trends for regulation in these areas?

3. It is clear that other countries have developed processes on how to accelerate stem cell product approvals, while still ensuring patient safety. Is the FDA willing to consider a new regulatory framework for regenerative cell therapy that follows a hybrid of some of the current models, for example those involving "minimally manipulated" regenerative cell products?

4. Is the FDA considering any regulatory changes or guidance changes with regards to regenerative therapies, in light of the advancements and changes in other countries? And if not, why not?

5. In 2014, the FDA finalized licensure requirements for public cord blood banks to ensure the safety, purity and potency of cord blood units for transplantation. To date, five unrelated cord blood banks in the USA have obtained a Biologics License Application (BLA). The FDA licensure requirements are based on regulations that were created for pharmaceuticals rather than specifically for cells or cord blood units and, as such, impose unnecessary burdens on public cord blood banks.

   In addition, the FDA requirements stifle innovation in this emerging field, and they unnecessarily divert the limited funds available for public cord blood banking to processes that are detrimental to the growth of the national cord blood inventory. This, in turn, limits access to life-saving transplantation for patients with serious life-threatening diseases and conditions, especially among minority populations.

The licensure requirements have created challenges for public cord blood banks as follows:

- Barriers to making improvements. The current Good Manufacturing Processes in the FDA licensure requirements delay the ability of banks to make timely adjustments to their processes, which may be necessary to enhance safety and effectiveness or promote innovation.
- Duplicative validation. The FDA has required cord blood banks to validate a number of processes and products used in the manufacturing process, although many of the processes and products are already FDA approved for their intended use.
- Burdensome environmental monitoring requirements. The preparation of cord blood is not comparable to the manufacture of pharmaceuticals – in fact, cord blood is processed in an automated closed system. However, the FDA licensure requirements have not modified the environmental monitoring requirements to reflect this difference. This has resulted in the imposition of requirements that exceed the conditions under which manufacturing occurs.
- Required expiration date. Before there was FDA licensure, cord blood banks always tested units to ensure high quality before use for transplant. FDA now requires annual testing of licensed units which, in turn, leads to fewer units for actual patient use. There is no science indicating that cord blood loses potency over time in storage. Therefore, it is difficult to understand why expiration dates are required in the labeling of these units. Units that are identified for therapeutic use should, of course, be tested before release, but it makes little sense to annually sacrifice good units that might be the unique match for a patient in need.
- Required stability testing. The current Good Manufacturing Processes also require cord blood banks to sacrifice units for stability testing, although such testing has not been shown to improve potency, integrity or sterility. Again, this testing leads to fewer units being available for patient use.

With this background, would FDA be willing to work with the cord blood community to resolve these important issues?

The Honorable Doris O. Matsui

This draft includes a provision relating to studying and improving drug manufacturing practices. The draft does not address the proper manufacturing practices for cord blood units, which are currently treated as a drug by the FDA.

The FDA requires licensing of cord blood banks that provide cord blood units for non-family use. Currently, it uses the framework developed for pharmaceutical manufacturing for regulation of these banks. This framework does not reflect the unique nature of cord blood banking in many respects.

How will the FDA adapt its regulatory approach to achieve the goals of licensing without imposing undue burden?