

2013 SENATE HUMAN SERVICES

SB 2190

2013 SENATE STANDING COMMITTEE MINUTES

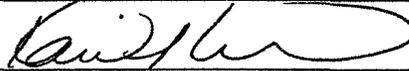
Senate Human Services Committee Red River Room, State Capitol

SB 2190
1/21/13

Recording Job Number: 17429

Conference Committee

Committee Clerk Signature:



Explanation or reason for introduction of bill/resolution:

Relating to biosimilar biological products.

Minutes:

You may make reference to "attached testimony."

Vice Chairman Larsen opens hearing on SB 2190.

Senator Dever, prime sponsor, introduces the bill to the committee.

Scott Setzepfandt, Senior Regional Manager for State Government affairs in the Central Region for Genentech, testifies in support. See attached testimony #1.

(0:08:10) Senator Larsen asks Mr. Setzepfandt to describe the biosimilar tests. Mr. Setzepfandt explains that the FDA is currently developing a pathway for how these can be approved by the manufactures that are interested in bringing these to the market. It is still in works regarding what kind of requirements will be made upon those manufactures. To be considered an interchangeable biosimilar, it is hopeful that it will include some clinical trials.

(0:09:10) Sen Axness asks if there are biosimilars still being used across the nation that the FDA has approved. Mr. Setzepfandt states that there are none on the market in the US but they anticipate it happening soon. There are some internationally but the approval process is different for those. These safeguards need to be put in place now rather than to wait until after they are on the market.

(0:09:58) Senator Larsen asks Mr. Setzepfandt to explain living cell DNA. Mr. Setzepfandt explains that they are actual living small cells that the products are being grown off of and he lists the different cells they use.

Senator Dever informs the committee that the sponsor list should also include Senator Berry.

Joel Gilbertson with the Bismarck office of the Vogel Law Firm on behalf of Biotechnology Industry Organization (Bio) presents a statement to the committee from Bio in support of the bill. See attached testimony #2.

Courtney Koebele, Executive Director of the ND Medical Association, steps up to express her support of the bill.

There is no further testimony favoring.

Mark Hardy, PharmD, Assistant Executive Director of the North Dakota State Board of Pharmacy, testifies in opposition. See attached testimony #3.

(0:20:17 - 0:22:03) Discussion between Senator Larsen and Mr. Hardy in regards to his testimony.

Senator Dever follows by expressing his confusion on why Mr. Hardy stands in opposition when there are parts of the bill he likes. Mr. Hardy states that the general concept is a legitimate conversation and could possibly support the bill with the right amendments.

Jonah Houts, Vice President of Government Affairs for Express Scripts, testifies in opposition. See attached testimony #4.

(0:28:54) Senator Larsen questions the costs and if they refer to overseas cost. Mr. Houts explains that they are the costs in the US for the existing brand biologics. The 40% savings is the current savings in the European Union and same is expected in the US. The European Union has public purchasing and drug price limits which the US doesn't have so it doesn't give an accurate comparison.

(0:29:50) Senator Anderson questions his objections to the bill and intends to offer some amendments. He references page 1, line 15, 2a which leads to further discussion on additional language to clean up the bill.

(0:32:51 - 0:36:45) Discussion between Senator Larsen and Mr. Houts on FDA approval. Chairman Lee offers input to help describe this.

(0:36:50) Senator Dever asks that if biosimilars are not yet developed, isn't there an advantage to the development process to understand what the rules of the market are. Mr. Houts doesn't know because he is not a manufacturer but thinks that the would-be biosimilar manufacturers are definitely paying attention to this and know where states will go. The legislation as written would have a chilling effect on would-be biosimilar applicants.

Jack McDonald, on behalf of Prime Therapeutics, testifies in opposition. See attached testimony #5. Chairman Lee expresses that she will welcome further written remarks from the individual who he was testifying on behalf.

Robert Harms, lobbyist for CVS Caremark, testifies in opposition on behalf of CVS and the National Association of Chain Drug Stores (NACDS). See attachments #6 and #7.

No questions from the committee and no further testimony.

The hearing is closed.

2013 SENATE STANDING COMMITTEE MINUTES

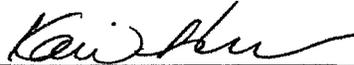
Senate Human Services Committee
Red River Room, State Capitol

SB 2190
1/21/13

Recording Job Number: 17462

Conference Committee

Committee Clerk Signature:



Explanation or reason for introduction of bill/resolution:

Relating to biosimilar biological products.

Minutes:

You may make reference to "attached testimony."

Committee discussion on SB 2190:

Senator Anderson begins by reviewing with the committee the amendments that he had the law intern draft:

Page 1, lines 16-17 - remove "for the specified indicated use;"

Page 2, line 3 - added "orally"

Page 2, line 5 - removed the word "written record"

Page 2 - remove lines 11-12

Senator Anderson moves to adopt these proposed amendments.

Senator Dever seconds the motion.

Discussion: Chairman Lee asks Senator Anderson if he has talked to the people on the opposing side to make sure they are comfortable with this. Senator Anderson states that he spoke to Dr. Hardy and he is okay with it but no one else. Chairman Lee is hesitant to act on this until the other parties have had a chance to review it and offer their opinion.

Senator Anderson moves to table his motion until 1/22.

Senator Dever seconds.

Chairman Lee has the law intern reach out to the opposing parties to get their input.

Discussion is closed.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee Red River Room, State Capitol

SB 2190

1/22/13

Recording Job Number: 17546

Conference Committee

Committee Clerk Signature:



Explanation or reason for introduction of bill/resolution:

Relating to biosimilar biological products.

Minutes:

You may make reference to "attached testimony."

Continued committee discussion on SB 2190:

Chairman Lee reminds the committee that there is an amendment that has been tabled by Senator Anderson and seconded by Senator Dever. She references and explains an email response from Dr. Brendan Joyce about Medicaid. See attachment #8.

Senator Anderson offers input and what he thinks the industry is asking for and further explains the notice requirement/therapeutic equivalents, per the request of Chairman Lee.

(0:08:44 - 0:18:24) The committee reviews the other submitted amendments and statements:

- Pat Ward on behalf of Express Scripts (see attachment #9)
- Vaun Olhausen, Associate Director of State & External Affairs Novartis Pharmaceutical Corporation (see attachment #10)
- Colon Cancer Alliance (see attachment #11)
- SafeBiologics (see attachment #12)
- Scott Setzepfandt's message on the number of additional states that are considering this (see attachment #13)
- Global Health Living Foundation (see attachment #14)

The committee narrows down amendments to Mr. Ward's and Mr. Harm's (they are both similar).

(0:18:30 - 0:29:53) Discussion between the committee and Scott Setzepfandt on removing lines 3-6 on page 2.

Chairman Lee states that the committee needs to now decide on whether or not to leave in lines 3-6 and whether or not to add "biosimilars to the protection from liability for pharmacists in 1902" based on the information that was just provided. Senator Anderson states that the additional language about 1902 is not necessary so they are just going to focus on the notice and records issues (lines 3-6). Senator Dever wants to leave this

information in and explains why. The committee decides that there is no interest in amending the amendment.

Roll call is taken on the motion to adopt the amendment by Senator Anderson that was tabled. The motion to adopt passes 4-1.

Senator Dever moves a Do Pass as Amended.

Senator Larsen seconds.

Roll call vote: 4-1, amendment is adopted.

Senator Dever is the carrier.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2190

1/23/13

Recording Job Number: 17636

Conference Committee

Committee Clerk Signature:



Explanation or reason for introduction of bill/resolution:

Relating to biosimilar biological products.

Minutes:

You may make reference to "attached testimony."

Chairman Lee opens the discussion SB 2190 and requests a motion to reconsider actions for purpose of receiving additional information.

Motion moved by **Senator Axness**.

Senator Anderson seconds.

Discussion: Senator Dever asks for explanation as to why they are revisiting this bill. Chairman Lee states that this requires a fiscal note and it should not have gone through without learning the costs. The committee verbally states they are all in favor of the motion and reconsidering is passed 5-0.

Dr. Brendan Joyce, Pharmacy Administrator with ND Medicaid, presents information on specialty medications/biopharmaceuticals to the committee. See attached charts #15, #16, and #17.

(0:12:13) Chairman Lee asks Dr. Joyce to review drug rebates.

(0:19:50 - 0:23:37) Dr. Joyce states that the department shares the same concerns that Novartis submitted (attachment #10) and supports this by explaining a previous bill that was brought to the legislature a few years back on anti-epileptic medications. He also proceeds to explain why they are not able to create a fiscal note for this bill.

(0:23:40 - 0:26:47) Chairman Lee - Is it appropriate to look at having a parallel path for the biosimilars that we currently have for generic drugs as opposed to prescription drugs as far as consideration by Medicaid? Dr. Joyce states that he has been following the progression of the biosimilar legislation nationally and explains his feelings.

(0:26:50 - 0:33:01) Chairman Lee references the email from Vaun Olhausen/Novartis (attachment #10) and needs clarification. Senator Anderson proceeds to help explain what

he means. Chairman Lee follows by asking Dr. Joyce if removing lines 3-6 on page 2 would accomplish what you need. Dr. Joyce states that it would be very similar to the existing generic substitution law within ND and that, yes, it would remove their concerns. Chairman Lee explains that they are primarily interested in the Medicaid concerns and reiterates what they have already amended. Dr. Joyce proceeds to further explain his thoughts on removing lines 3-6.

(0:33:55 - 0:38:50) Dr. Joyce discusses prior authorization.

Dr. Joyce then hands out another chart (attachment #18) on the Oncology Drug Spent and explains it to the committee.

(0:43:37) Chairman Lee asks if deleting lines 3-6 would interfere with good patient care, or is there a benefit to the patient leaving these lines in. Dr. Joyce doesn't see any detriment to the patients and feels that the pharmacists within the state have always done a good job of making sure they are taking care of the patients and communicating with the physicians. The national legislation rules and regulations that come down governing this are going to be the most scrutinized ever.

(0:45:40 - 0:48:00) Discussion on what doctors should have knowledge of biopharmaceuticals. Dr. Joyce lists the medications that would qualify under this classification and explains that there shouldn't be any type doctor that isn't involved or have awareness about biopharmaceuticals.

(0:49:44 - 0:55:57) Discussion between Senator Larsen and Dr. Joyce about prescription drugs being put on record and more explanation on the reasons of why lines 3-6 should be left in/removed.

No further questions from the committee for Dr. Joyce.

Senator Anderson stepped out of the room so discussion was postponed until all committee members are present.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2190

1/23/13

Recording Job Number: 17642

Conference Committee

Committee Clerk Signature:



Explanation or reason for introduction of bill/resolution:

Relating to biosimilar biological products.

Minutes:

You may make reference to "attached testimony."

Committee discussion continued on SB 2190:

Senator Axness motions to adopt the amendment to strike lines 3-6 on page 2.

Chairman Lee hands over chair position to Vice Chairman Larsen so she can second.

Chairman Lee seconds.

Discussion continues on this amended language. (Ends at 0:12:50)

Roll call vote: 3-2, motion passes.

Senator Dever moves a Do Pass as Amended.

Senator Anderson seconds.

Senator Anderson brings up the previous amendment and asks if it has been included. Chairman Lee asks for a motion to adopt those amendments again. Senator Dever withdraws his previous motion of Do Pass as Amended in order to proceed.

Senator Anderson moves to re-adopt the amendment.

Senator Dever seconds.

Roll call vote: 5-0, motion passes.

Senator Dever calls attention to another concern on page 1, line 23. Senator Anderson clarifies his question.

Senator Dever moves a Do Pass as twice Amended.

Senator Anderson seconds.

Senator Dever reads from Mr. Harms testimony and a brief discussion takes place.

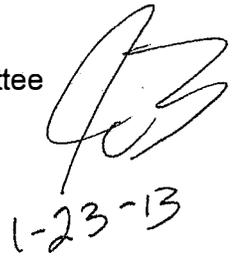
Roll call vote: 3-2, motion passes as amended.

Senator Anderson is the carrier.

13.0511.01001
Title.02000

Adopted by the Human Services Committee

January 23, 2013



Handwritten signature and date: 1-23-13

PROPOSED AMENDMENTS TO SENATE BILL NO. 2190

Page 1, line 16, remove "for the specified"

Page 1, line 17, remove "indicated use"

Page 1, line 22, after the underscored semicolon insert "and"

Page 2, line 2, replace the underscored semicolon with an underscored period

Page 2, remove lines 3 through 6

Page 2, line 7, remove the the underscored colon

Page 2, line 8, replace "a. Maintain" with "maintain"

Page 2, line 10, replace "; and" with an underscored period

Page 2, remove lines 11 and 12

Renumber accordingly

Date: 1/22/13
 Roll Call Vote #: 1

2013 SENATE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. 2190

Senate Human Services Committee

Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment
 Rerefer to Appropriations Reconsider

Motion Made By Sen. Anderson Seconded By Sen. Dever

Senators	Yes	No	Senator	Yes	No
Chairman Judy Lee	✓		Senator Tyler Axness		✓
Vice Chairman Oley Larsen	✓				
Senator Dick Dever	✓				
Senator Howard Anderson, Jr.	✓				

Total (Yes) 4 No 1

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Pg 1 LINES 16-17 Remove " For the specified indicated use "
 Pg 2 line 3 add "orally"
 Pg 2 line 5 - removed the word "written record"
 Pg 2 ~~line~~ remove lines 11-12 -

Date: 11/23/13
 Roll Call Vote #: 1

**2013 SENATE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. 2190**

Senate Human Services Committee

Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment
 Rerefer to Appropriations Reconsider

Motion Made By Sen Axness Seconded By Sen. Larsen

Senators	Yes	No	Senator	Yes	No
Chairman Judy Lee			Senator Tyler Axness		
Vice Chairman Oley Larsen					
Senator Dick Dever					
Senator Howard Anderson, Jr.					

Verbal vote to reconsider

Total (Yes) 5 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 1/23/13
 Roll Call Vote #: 2

2013 SENATE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. 2190

Senate Human Services Committee

Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment
 Rerefer to Appropriations Reconsider

Motion Made By Sen. Dever Seconded By Sen. Anderson

Senators	Yes	No	Senator	Yes	No
Chairman Judy Lee			Senator Tyler Axness		
Vice Chairman Oley Larsen					
Senator Dick Dever					
Senator Howard Anderson, Jr.					
<i>Motion withdrawn in order to re-adopt previous amendment.</i>					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 1/23/13
Roll Call Vote #: 3

2013 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2190

Senate Human Services Committee

Check here for Conference Committee

Legislative Council Amendment Number (Dr. Hardy Amendment)

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment
 Rerefer to Appropriations Reconsider

Motion Made By Sen. Anderson Seconded By Sen. Dever

Senators	Yes	No	Senator	Yes	No
Chairman Judy Lee	✓		Senator Tyler Axness	✓	
Vice Chairman Oley Larsen	✓				
Senator Dick Dever	✓				
Senator Howard Anderson, Jr.	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 1/23/13
Roll Call Vote #: 4

2013 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2190

Senate Human Services Committee

Check here for Conference Committee

Legislative Council Amendment Number 13.0511.01001

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment
 Rerefer to Appropriations Reconsider

Motion Made By Sen. Dever Seconded By Sen. Anderson

Senators	Yes	No	Senator	Yes	No
Chairman Judy Lee		✓	Senator Tyler Axness	✓	
Vice Chairman Oley Larsen		✓			
Senator Dick Dever	✓				
Senator Howard Anderson, Jr.	✓				

Total (Yes) 3 No 2

Absent 0

Floor Assignment Sen. Anderson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2190: Human Services Committee (Sen. J. Lee, Chairman) recommends AMENDMENTS AS FOLLOWS and when so amended, recommends **DO PASS** (3 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). SB 2190 was placed on the Sixth order on the calendar.

Page 1, line 16, remove "for the specified"

Page 1, line 17, remove "indicated use"

Page 1, line 22, after the underscored semicolon insert "and"

Page 2, line 2, replace the underscored semicolon with an underscored period

Page 2, remove lines 3 through 6

Page 2, line 7, remove the the underscored colon

Page 2, line 8, replace "a. Maintain" with "maintain"

Page 2, line 10, replace "; and" with an underscored period

Page 2, remove lines 11 and 12

Renumber accordingly

2013 HOUSE HUMAN SERVICES

SB 2190

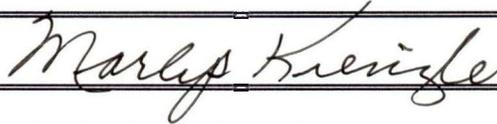
2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee Fort Union Room, State Capitol

SB 2190
March 11, 2013
Job# 19702

Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

Relating to bio similar biological products.

Minutes:

See Testimonies #1-6

Chairman Weisz opened the hearing on SB 2190.

Sen. Dick Dever: Senator from District 32 and the sponsor of this bill. Introduced and supported the bill. I will be talking about bio similar and biological products. 98 to 99% of the time the medicine that you receive is a chemical which can be broken down and duplicated by someone else. A Biologic is created from streams of cells and through a process can reproduce these special cells. Someone else can produce these also but they would not be the exact same. This bill comes about in part because of provision in Federal Health Reform, which provided that the FDA could make determination of the interchangeability between bio similar and biological. Now we have to come up with a set of guidelines in the marketplace in the State of North Dakota for what would need to happen in a bio similar that would be interchanged with the biological. In sub section two five different requirements.

(Went through the amendments the Senate put onto the bill.)

9:00 (spoke why he introduced the bill) Rep Dever explained that he knows that there is an open line between the pharmacy and most doctors but mail order pharmacy is growing. It is cheaper without extra service.

10:55 (fiscal note) The earliest fiscal note was 2-15 and went to vote without a fiscal note. This FN is based on one assumption, that if the is made aware of the changes in that medication, there is a likelihood that he will insist on the original prescription. I suggest you ask for another fiscal note on another assumption and that is if you pass this bill without that provision, that doctors will write brand necessary on the bill. We will then fail to realize the savings that come about by the appropriate substitution with the doctor in the loop.

There are similar bills being considered in several other states.

12:52 Chairman Weisz: Two questions for your rationale on notification part, why 24 hours?

Sen. Dever: They didn't want it to be too much of a requirement.

Chairman Weisz: Would this be the same answer for the 5 years on the records?

Sen. Dever: Insulin is an example of a biological. The reason for five years is if there are any adverse reactions they need to be able go back and look at what medications were used and what were substituted in the care of the patient.

Chairman Weisz: When other times does health care require that records be kept for 5 years

Sen. Dever: Pharmacists say they keep their records for that length of time anyway.

Rep. Muscha: You think doctors will start requiring a specific brand? Did you speak to any Doctors and they said they would do this?

Sen. Dever: I have not but I think it is a valid assumption as the bases of the fiscal note.

Rep. Oversen: When you are speaking of the doctors protecting themselves if they subscribe a bio similar. So is that implying that a bio similar is unsafe or not suitable substitute for a biologic prescription?

Sen. Dever: I should have said to protect themselves and the patient.

Rep. Oversen: How is this different from the current protection we have with generic substitutions that we already have.

Sen. Dever: I can't answer that.

18:55

Rep. Bill Devlin: Speaker of the House: I urge you to support SB 2190. In response to one question I do know that allowing the FDA approved interchangeable drugs products in this bill, without prior prescribers could send a slimmer substitution requirement under generics. The physician needs to know as they are looking at the product and patience records for the entire care of what is given at any time. The only concern I have is the fiscal note Sen. Dever talked about.

22:09 Rep. Oversen: Wouldn't it make more sense to add language to the generic section since they are identical, instead of creating another section?

Rep. Devlin: Some aspects are identical and some are going to need to be a little different.

23:36

Scott Setzepfandt: Senior Regional Manager, State Government Affairs testified in support of the bill. (See Testimony #1)

36:08

Chairman Weisz: Based on Subsection B, why do we need 5 years?

Setzepfandt: It is not a big deal. It is a consistency how we are going to do it in the state.

Chairman Weisz: Why 24 hours versus 2 days or immediately?

Setzepfandt: We feel if there is an emergency that the physician knows the next day. This gives pharmacist flexibility. This procedure can be done in writing, electronically, fax or by calling. Only about 1% of the prescriptions are filled out by pharmacists are Biological.

Rep. Laning: How are biologics or bio similar administered?

Setzepfandt: All of them are injected. Most of these are injected by infusion centers.

Rep. Fehr: You said it only affects retail pharmacies. Who does it not affect?

Setzepfandt: This updates the Pharmacy Practice Act. This only affects prescriptions that are dispensed in an outpatient setting where the pharmacist would be making the potential decision of whether to fill it with the brand or the bio similar. It does not affect the in patient.

Rep. Mooney: Jeff Lindo is VP with Government and Regular Affairs believes this is too soon as the FDA and congress will be working and are directing of the language of the bio similar and or state moving prematurely before the FDA, we are putting ourselves ahead of the cart.

Setzepfandt: I disagree with that. The FDA will be doing is creating a pathway for a manufacturer bring on of these to market. The definition of the bio similar and biologic has already been determined by congress. The FDA has nothing to do with this bill. This bill only states the State Progress ACT.

Rep. Mooney: How many other states are implementing procedures like this?

Setzepfandt: Thirteen states have legislation and Virginia is waiting for Governor to sign the bill. All of the bills that have been moved so far all have physician notification in them. None of them have a fiscal note.

47:02

Courtney Koebel representing the North Dakota Medical Association: Testified in support of the bill. It is a new technology and we need a physician notification.

Rep. Fehr: Did you get a sense of what it might mean to your physicians if they aren't notified.

Koebel: This is a new procedure and biologics is serious and if a wrong biologic given, it could be life threatening.

49:40: Joel Gilbertson from Vogel Law Firm: Testified in support and passed out a testimony by John A. Murphy III, Esq., senior director, states health policy. (See Testimony #2)

51:15: Geno Grampp: PHD, Regulatory Policy Director at Amgen testified in support of the bill. (See Testimony #3)

59:12: Rep. Silbernagel: Does the FDA have the same manufacturing standards for Bio similar or biological products?

Grampp: Yes they do.

1:00:15: Allen Todd Director of Patient Education & Advocacy for the Global Healthy Living Foundation: Testified in support of the bill. (See Testimony #4)

1:03: Brenda Kleinsasser A Rheumatoid arthritis patient: Testified in support of the bill. (See Testimony #5)

OPPOSITION:

1:07:23: Dr. Brendan Joyce: Administrator of Pharmacy Services for the Medical Services Division of the DHS provided information on the fiscal note on SB 2190. (See Testimony #6)

1:16:53: Chairman Weisz: Since there isn't any bio similar on the market, how are you able to determine the price between bio similar and the biological for the FN?

Joyce: We would expect interests groups involved in putting forth this bill would maybe have some dollars that we don't as far as how soon this is going to be happening. We didn't anticipate there would be generic biological this soon. It has been in a holding pattern for a long time in Washington DC.

Chairman Weisz: Currently how much is Medicaid spending on Biological?

Joyce: We just tracked the medications that were over a \$1,000. We don't differentiate between biological and non-biological. It is about 16% of our pre rebate drug spend, which was over 39 million per year for medication that cost over \$1,000. We don't have any numbers based on NDA versus BLA. We have not seen the reason to.

Rep. Porter: What is the process if a physician writes no substitution currently for to argue that back that this just what we will give you and you can't do that to us?

Joyce: The Drug Utilization Review Board is the committee that was put forth for the department is federally required and put forth this in statue by this Legislature in 2003. Patience must have a reason as to why they must have only a brand name prescription. Physician and patient desires are not enough.

Rep. Porter: By taking out the two components about notification process and records retention process that a physician can still say brand only on that prescription. Isn't that in essences going to drive up our costs going the opposite direction of what our FN says?

Joyce: Physicians have always had the brand name option when necessary. So that is just how the prescribing patterns go. Our concern would be line 3-6, which is the only thing that is new.

Rep. Porter: There is a fiscal note because of the language, but it appears there should be a fiscal note without the language also.

Joyce: If it would it would come out to where it was merged within the normal language which is already in existence for brand versus generic for the NDA products. It is the difference that it was added in. We are concerned with any additional burden.

Rep. Porter: Based on your own argument back to me, you can tell us specifically how much the brand provision costs the Medicaid program today with generic medications.

Joyce: The data that we have there where we have those prescriptions that were approved through the DAW process.

Rep. Porter: If we have these as a brand specific required component for bio similar there will be an increased cost to the Medicaid Program because just as they do now, physicians will argue the fact that it should be the biological or the brand name or instead of the bio similar or the generic.

Joyce: There are certain things that are obvious for Legislations and other things through over years. When we look at the DAW, over 50% of the medications that are brand name necessary or DAW exempted where it is costing the state money, it is the anti-convulsing medication.

Rep. Porter: Are you unwilling or incapable of answering the question? If we do nothing than the fiscal effect of taking that language out will also be negative to the Department of Human Services.

Joyce: Are you asking about line 3 - 6? If these were language is taken out the fiscal impact would go away.

Rep. Porter: Why would it go to 0 when you have proven to us on the current generic program that a cost does excises?

Joyce: We don't have a fiscal note coming into play for new medications that come on the market. The market place is calculated and is budgeted for during the budgeting process every biennium.

Rep. Porter: That fiscal effect of what you would think taken that language out and would cause the state of North Dakota is already built into the department's budget.

Joyce: The FN is the anticipation additional burden put on by lines 3 -6.

Rep. Porter: What I am talking about is the other affect, which is by taking the language out, you are saying that if we remove lines 3-6 in your budgeting process you have already accounted for that increased cost in the budget and then it would not need a FN.

Joyce: The way the market place is going the anticipations and projections for bio similar and any savings would have been in there, are all accounted for.

Rep. Porter: Can you get us that figure that you use?

Joyce: As mentioned previous, we do not track biological medications but track the Market Place as a whole. We track the market track the \$1000 medication. We do not have biological numbers for the next biennium. We have our drug budget anticipated for the next biennium.

Chairman Weisz: Assuming what you say is true, wouldn't the reverse happen if indeed there is no notification in line 3-6. Wouldn't physicians with the knowledge with the substituted by a bio similar, wouldn't they much more inclined to put medically necessary on for the biological so there would be less substitution for generic just to play it safe?

Joyce: That is why we have a fiscal note. This will be a rocky market for generics substitutions to start with. There has been plenty of information saying how the generics will not be true generics. There are plenty of physicians that already put brand name necessary already. Yes, they will have to prove to us it is necessary.

Rep. Porter: The fact they are all injectable and the fact that they all require or some could require immune responses 9-24 months into the process. Does the potential harm that could be done to the patient not out way the risk of the money?

Joyce: That is a good philosophical question; we just brought forth the potential fiscal impact it may have.

Rep. Porter: You will have to make those very decisions based on a philosophy that each member is going to carry. How is that going to be exercised forward for the best interest of the patient in relationship to the money? This comes down to the patient versus the money.

Joyce: We will be looking at the science, any comparative research that is done between them and the FDA will have their studies and requirements.

Chairman Weisz: Information was presented earlier that less than 10% will be going through retail. Do you have any data for the biologics that we are currently here through Medicaid that would be affected by lines 3 -6?

Joyce: I have not run that data.

Rep. Mooney: Are we talking money versus care? We are going to based legislation on the numbers from Medicaid and supersede doctor's care on Medicaid numbers?

Joyce: The DOR Board is a group of 6 physicians, 6 pharmacists and a couple of other representatives that try to figure out the science behind it because when you look like you are coming between the doctor and the patient that is never viewed appropriately. This was done in 2003 for prior authorization. When it comes to medication that cost this much and the rehabilitant nature of these products perhaps Medicaid is not in the minority, because many end up on Medicaid because of the disability or the cost of the medication.

Rep. Mooney: Do you have a philosophy when you make these decisions?

Joyce: They are done on science and not philosophy but the general direction from the board a number of years ago is to achieve appropriate cost savings without impacting care.

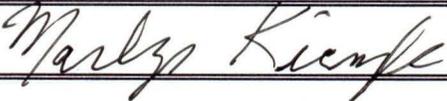
Chairman Weisz: Took a break and will come back and address for the remaining opposition.

2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee Fort Union Room, State Capitol

SB 2190
March 11, 2013
Job # 19710

Conference Committee



Explanation or reason for introduction of bill/resolution:

A BILL for an Act to create and enact a new section to chapter 19-02.1 of the North Dakota Century Code, relating to biosimilar biological products.

Minutes:

Attachments # 7-15

Chairman Weisz called the hearing back to order on HB 2190. (Second half of the hearing)

Jack Ward: From In script testified in opposition to the bill. (See handouts #7-8-9)

5:03 Dan Ulmer: Representing BC/BS testified in opposition to the bill. (See Testimony #10)

8:27 Chairman Weisz: You mentioned we may have to repeal this law and this is based on what?

Ulmer: Generics when they came in did the same thing about physicians and referrals. Pharmacist could not substitute without permission. That is not necessarily the case anymore.

Chairman Weisz: Nothing in this legislation requires the physician of approval of the name brand up front.

Ulmer: We can't substitute without the physician's permission. As such the pharmacist preceding forward, what the pharmacist is going to do if there are questions is going to connect directly with the physician.

10:32 Mark Hardy: Assistant Executive Director of ND State board of Pharmacy testified in opposition of the bill. (See Testimony #11)

15:18 Rep. Fehr: There is no bio similar on the market now. You want this bill to be killed and if it fails, what is your thought in terms in the time period when bio similar do come on the market, before they become interchangeable, what will the pharmacists do with the bio similar?

Hardy: We don't impose the bill in full. The only issue is the 24 hour notice. As far as what the pharmacist would do, we would ask them to follow the same standard as they use for Brand and generic prescriptions and counsel the patient.

John Olson: Represents generic Pharmaceutical Corporation testified in opposition to the bill. (Handed out the testimony of Brynna Clark: Sr. Director of State Affairs See Testimony #12.) A brand product is 22 times more than a generic drug. Bio similar is safe and used by many.

25:38 Josh Askvig: Associate State Director for Advocacy for AARP ND opposed the bill. (See Testimony #13)

26:39 Jack McDonald: Appeared on behalf of Prime Therapeutics testified in opposition. (See Testimony #14)

29:28 Robert Harms: Lobbyist for CVS/Caremark: Opposed the bill. (See handout #15) He went through the handout. We think this bill will cost the ND citizens higher drug costs.

38:10 Rep. Mooney: Questioned what exactly what the opposition is against. It is simply stating that the physician will be notified that a generic form of a biologic has been used in the patients care. It would seem logical that we would want a doctor to know that. Is that not the case?

38:50 Harms: What the AMA recommends for the state and practitioners is what we have in current law today. What we think is the impediment is listed in section 2 which sets up the five conditions in order to do the substitution. We think 2D is the most egregious and creates the most problems.

Rep. Mooney: One of the points you said who is in favor and who is opposed. One in favor was the AMA. The doctors are going to look at it from what makes sense as far as their patient care is concerned, aren't they?

Harms: I would say they are. Before we get to that issue, FDA is going to go through a rigorous analysis of any of these drugs. FDA is going to have to first step of approving a bio similar. If a doctor wants a particular drug the law will let him do that. Public policy today is that we look at the pharmacist as the one who has the greater level of knowledge when it comes to drug utilization and drug interaction the patient has.

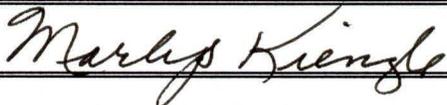
Chairman Weisz: Closed hearing on SB 2190.

2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

SB 2190
March 18, 2013
Job # 20071

Conference Committee

Committee Clerk Signature	
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Explanation or reason for introduction of bill/resolution:

Relating to bio similar biological products.

Minutes:

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Chairman Weisz: Opened meeting asking for the latest fiscal notes.

Rep. Fehr: I make a motion of do pass on SB 2190.

Rep. Looyen: Seconded the motion.

Rep. Oversen: In will be voting against this bill due to the articles, reports and that by the time FDA actually approves anything they are going to have to navigate with all the states have something different, which creates bearers.

Rep. Laning: I appreciated the part that asks for the physicians to be notified and don't see it as being that cumbersome.

ROLL CALL VOTE: 10 y 3 n 0 absent

MOTION CARRIED

Bill Carrier: Rep. Fehr

FISCAL NOTE
Requested by Legislative Council
02/14/2013

Revised
 Amendment to: SB 2190

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

- 1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties			
Cities			
School Districts			
Townships			

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

SB2190 allows a pharmacy to substitute biosimilars for a prescribed product only if requirements are met and gives individuals the right to refuse the biosimilar chosen by the pharmacist. Biosimilars are less costly; therefore, adding requirements to dispense biosimilars may increase Medicaid costs.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 allows a pharmacy to substitute biosimilars for a prescribed product only if specific requirements are met; and gives individuals the right to refuse the biosimilar chosen by the pharmacist. Biosimilars are less costly; therefore, adding requirements to dispense biosimilars may increase Medicaid costs. The potential increase to the Medicaid program budget cannot be determined.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

- A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

- B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

Name: Paul R. Kramer
Agency: Department of Human Services
Telephone: 701-328-1980
Date Prepared: 03/18/2013

FISCAL NOTE
Requested by Legislative Council
02/12/2013

Amendment to: SB 2190

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				\$210,206		\$418,820
Expenditures			\$208,614	\$210,206	\$418,820	\$418,820
Appropriations			\$208,614	\$210,206	\$418,820	\$418,820

- 1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties			
Cities			
School Districts			
Townships			

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

SB2190 allows a pharmacy to substitute biosimilars for a prescribed product only if requirements are met; and gives individuals the right to refuse the biosimilar chosen by the pharmacist. Biosimilars are less costly; therefore, adding requirements to dispense biosimilars increases Medicaid cost.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 allows a pharmacy to substitute biosimilars for a prescribed product only if specific requirements are met; and gives individuals the right to refuse the biosimilar chosen by the pharmacist. Biosimilars are less costly; therefore, adding requirements to dispense biosimilars increases Medicaid cost. The Department believes that the additional requirements, as noted in section 2A, discourage use of biosimilars. The estimated cost will be \$418,820 in the 13-15 biennium, of which \$208,614 would be General Fund. Based on the products scheduled for patent expiration in 2015-2017, the department estimates cost would double in the 15-17 biennium to \$837,640, of which \$418,820 would be General Fund.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

- A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The increase in revenues in each biennium is the additional federal funding the state will receive due to the increased expenditure relating to allowable expenditures.

- B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The costs associated with paying for brand name drugs over generics is estimated at \$418,820 in the 13-15 biennium, of which \$208,614 would be General Fund. The estimated cost in the 15-17 biennium is \$837,640, of which \$418,820 would be General Fund.

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The Department will need an appropriation increase of \$418,820 in 13-15 biennium, of which \$208,614 would be from the General Fund and \$210,206 would be from federal funds. The Department will need an appropriation increase of \$837,640 in 15-17 biennium, of which \$418,820 would be from the General Fund and \$418,820 would be from federal funds.

Name: Debra A. McDermott

Agency: Department of Human Services

Telephone: 701 328-1980

Date Prepared: 02/14/2013

Date: 3-18-13
 Roll Call Vote #: 1

2013 HOUSE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. 2190

House Human Services Committee

Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment
 Rerefer to Appropriations Reconsider

Motion Made By Rep. Fehr Seconded By Rep. Looyzen

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ	✓		REP. MOONEY	✓	
VICE-CHAIRMAN HOFSTAD	✓		REP. MUSCHA		✓
REP. ANDERSON	✓		REP. OVERSEN		✓
REP. DAMSCHEN	✓				
REP. FEHR	✓				
REP. KIEFERT	✓				
REP. LANING	✓				
REP. LOOYSEN	✓				
REP. PORTER	✓				
REP. SILBERNAGEL		✓			

Total (Yes) 10 No 3

Absent 0

Floor Assignment Rep. Fehr

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2190, as reengrossed: Human Services Committee (Rep. Weisz, Chairman)
recommends **DO PASS** (10 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING).
Reengrossed SB 2190 was placed on the Fourteenth order on the calendar.

2013 TESTIMONY

SB 2190



Testimony – Genentech
Scott Setzepandt, R.Ph., Senior Regional Manager, State Government Affairs
January 21, 2012

SUPPORT SENATE BILL NO. 2190

Madam Chair and members of the Human Services Committee, thank you for allowing me to speak on Senate Bill 2190 and express our support for this bill.

My name is Scott Setzepandt, and I am the Senior Regional Manager for State Government Affairs in the Central Region for Genentech. Considered the founder of the biotechnology industry, Genentech has been delivering on the promise of biotechnology for more than 35 years. Genentech discovers, develops, manufactures, and commercializes medicines to treat patients with serious or life-threatening medical conditions. Today, Genentech is among the world's leading biotechnology companies, with multiple products on the market, and a promising pipeline of future therapies. Genentech is a member of the Roche Group and is headquartered in South San Francisco, California. Americans across the country are prescribed our FDA-approved products, which are primarily a new class of drugs known as biologics.

Biologics differ from traditional pharmaceutical drugs in that they are created from living cell DNA strands as opposed to traditional drugs, which are made from a chemical recipe. In contrast to smaller molecule chemically produced drugs, biologic medications are large, complex molecules that have been developed by re-coding the DNA of living cells to produce the drug. Because they are created using specific genetic information, biologics have been and will continue to be an important innovative component of personalized medicine.

The 2010 federal health reform act created a pathway to allow for the development and manufacture of "biosimilar" products that are intended to have the same effect as the biologic medications created by companies like Genentech. Given the imminent introduction of biosimilar products in the US, an update of North Dakota statute is necessary to regulate the dispensing of biologics and the new biosimilar products.

As I mentioned earlier, traditional pharmaceutical drugs follow a chemical recipe and when those drugs go off patent, the generic drug makers are able to follow this recipe to make their drugs nearly the same as the original drug. Biologics, on the other hand, are produced from living cells and as such a biosimilar will likely never reach the same level of sameness as a generic drug can to its model. SB 2190 makes the necessary updates to North Dakota statute to allow for a safe dispensing process for substituting biologic products with biosimilar products.

First, biologic and biosimilar products currently are not defined in North Dakota statutes. The first section of SB 2190 updates state statutes to include definitions by referring to current federal definitions. This will provide consistency between state and federal law.

Secondly, current law does not provide for the consideration of substituting a biologic with a biosimilar product. The second section adds language that allows pharmacists to substitute a biologic product with a biosimilar product, if the FDA has determined that biosimilar product is interchangeable with the biologic product.

Switching between the original biologic product and a biosimilar product presents a potential safety risk. People's bodies might react in a different way to the biosimilar than to the original biologic. Switching should only be done with products that have demonstrated interchangeability through clinical studies and that the switch back and forth between the innovator's original biologic and the biosimilar causes no risk to the patient. The FDA is currently developing federal regulations to address this process.

SB 2190 safeguards the prescriber's and patient's choice to use a specific product. As with current law regarding generic substitution, the prescriber can prevent a substitution by indicating "brand medically necessary" on the prescription. SB 2190 also requires the patient be informed that the biologic may be substituted with a biosimilar product and that the individual has the right to refuse. If a substitution is made by a pharmacist, SB 2190 requires pharmacists to notify the prescriber within 24 hours of switching an interchangeable biosimilar for a prescribed biologic product and that the dispensing pharmacy keep a record of the substitution for a minimum of five years.

Finally, the North Dakota Board of Pharmacy would be directed to keep a list, or a link to a FDA posted list, of FDA approved interchangeable biosimilar products on its website. This will ensure pharmacist, prescribers and patients will have up to date information on the availability of interchangeable biosimilar products.

SB 2190 ensures substitutions are done in a safe and regulated manner and preserves health care providers' treatment choice in serving patients with serious and life threatening diseases. I urge you to support and vote "do pass" for SB 2190.



John A. Murphy III, Esq.
Director, State Affairs, Health Policy
202-962-9514 | jmurphy@bio.org

BIOTECHNOLOGY INDUSTRY ORGANIZATION
STATEMENT IN SUPPORT OF NORTH DAKOTA S.B. 2190

JANUARY 2013

The Biotechnology Industry Organization (BIO) is the world's largest biotechnology trade association. BIO represents more than 1,100 biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and 31 other nations. BIO members are involved in the research and development of healthcare, agricultural, industrial, and environmental biotechnology products. One of BIO's core missions is the promotion of a safe, innovative, and competitive market for biologics in the United States. To that end, BIO's member companies have approved five principles related to substitution of biologic medicines. The policies outlined in Senate Bill 2190 align with all five of BIO's Principles on Biologic Product Substitution and we therefore support its passage.

Biologics are very complex medicines. Unlike traditional "small molecule" drugs, biologics are not chemically synthesized but, rather, are manufactured from living cells and tissues using a highly controlled and optimized process. Each resulting biologic therapy is complex and unique, and in many cases cannot be fully characterized by current analytical tools. As a result, even minor differences in manufacturing processes can cause variations in the end product. Consequently, two biologics made using different cell lines and differing manufacturing processes will rarely, if ever, be exactly the same.

Biosimilars are biologic products manufactured with the goal of closely mirroring the composition and treatment profile of an innovator product but are produced without access to the innovator's proprietary manufacturing processes. The production of biosimilar products, therefore, will invariably lead to differences in composition compared to the original innovator product.

Currently, the Federal Food and Drug Administration (the "FDA") is developing guidance regarding the regulatory pathway for the approval of biosimilar and interchangeable biologic products. This approval pathway was established by federal law, and distinguishes clearly between biologic products that are "biosimilar" to an innovator biologic – meaning they are "highly similar" to an innovator product – and biologic products that meet a heightened standard to be deemed "interchangeable."

While FDA's role in the approval of biologic and biosimilar medicines includes the designation of an interchangeable status, the policy on whether one biologic product may be substituted by dispensers when a different biologic product was prescribed is governed by state law. In recognition of this state-level authority over biosimilar and interchangeable biologic medicines, BIO has developed a set of core Principles¹ that we believe should be considered by all states evaluating biologic substitution legislation. We believe that our Principles, if followed, strike the appropriate balance of preserving the physician-patient relationship, protecting patients, maintaining incentives for innovation, and promoting a competitive market for biologic therapies. As drafted, Senate Bill 2190 is in-line with BIO's own Principles and we therefore support its passage.

* * * *

¹ See Attached: BIO Principles on Patient Safety in the Substitution of Biologic Products



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State of North Dakota

E-mail= ndboph@btinet.net

www.nodakpharmacy.com

Jack Dalrymple, Governor

Mark J. Hardy, PharmD, R.Ph.
Assistant Executive Director
Howard C. Anderson, Jr, R.Ph.
Executive Director

SB 2190 – Biosimilar Biological Products

Senate Human Services Committee – Red River Room

11:00 AM – Monday - January 21, 2013

Chairperson Lee, members of the Senate Human Services Committee, for the record I am Mark J. Hardy, PharmD, Assistant Executive Director of the North Dakota State Board of Pharmacy. I appreciate the opportunity to be here to speak to you today on Senate Bill #2190.

I would like to provide our perspective of Biosimilar Biological Products, their current regulatory framework, with regards to the Food and Drug Administration [FDA] and provide our comments on this proposed legislation, including issues that we have with certain sections identified below.

Biological medications are seen by many in the pharmacy community as the newest and brightest future of the pharmaceutical industry. These biological products are highly specified medications used to treat unique medical conditions and disease states. These biological medications are extremely expensive, with most medications being well over a \$1,000 per month of treatment. We hear expectations that the cost savings from biosimilar products, compared to the innovator biological products, are likely to be between 10 to 40% less. In 2008, the Congressional Budget Office estimated that biosimilars would save approximately \$25 billion over 10 years. If the cost savings from using a biosimilar product will add up very quickly for both facilities and patients. It is very important to note that we have not seen any biogeneric or biosimilar products enter the market place. So the information and research regarding the interchangeability of these products is very limited.

The FDA has taken some initial steps in regulating biosimilar products and their interchangeability. However, much of the information is not specific and likely not going to be until we begin to see biosimilars enter the market place. From our perspective, it is important that we ensure a proper framework is in place for the interchangeability of biosimilar products that is consistent with what the FDA expects and is not tremendously burdensome on the practitioners and pharmacists involved so as to be a disincentive to utilize the biosimilar products. As I mentioned earlier, there is going to be a tremendous cost savings.

The Board of Pharmacy does feel that it is important when interchanging biosimilar products for biologicals, to adhere to the research based information from the FDA as to which can be interchangeable. This ensures that the patient is getting an equivalent product and that their care is consistent. This research on biosimilars is very limited.

We agree with section 2, b - that the practitioner should have the authority to ask for that the brand product be dispensed when they feel it is in the best interest of the patient's care. This is consistent with the current law and utilizes the same language currently in NDCC 19-02.

On section 2, c - we would like clarification on the language, specifically towards the end of this subsection. I believe, if you eliminated line 2 on page 2, the section would read better. Regardless of this section, we would expect a pharmacist to counsel the patient.

On section 2, d - we do not feel that this language is necessary, especially considering the products will be FDA approved for interchangeability. This may be a deterrent to the substitution of the more economical, yet interchangeable product.

On section 2, e - we would require the pharmacy to keep a record of the prescription for five years. It is also important that we allow them to keep it electronically as well due to the move towards electronic prescriptions and records.

On section 3, a - the Board of Pharmacy will be happy to maintain an internet link to the Food and Drug Administration approved list of interchangeable biological and biosimilar products. The only issue we have is that we do not know if the FDA will even maintain such a list, but a list would certainly be a resource for our pharmacists.

On section 3, b - we already have rules and administrative penalties for practice act issues. We would strongly recommend this subsection be eliminated as it is a duplication and serves no purpose. The Board of Pharmacy currently has the ability to adopt rules regulating the profession of pharmacy as need be.

In closing, we know biosimilar legislation is a common piece of legislation that is being introduced in many states and we certainly see the need to define the substances in state law. We also want the process to be smooth to utilize the apparent substantial cost savings of biosimilars, especially when they are deemed interchangeable without any compromise in the patient care and safety.

I will be happy to answer any questions at this time.

**Testimony
Senate Bill 2190
Senate Human Services Committee
Monday, January 21, 2013
Jonah C. Houts, Express Scripts, Inc.**

Good morning, Chairwoman Lee and members of the Senate Human Services Committee. My name is Jonah Houts, Vice President of Government Affairs for Express Scripts. I am here to provide testimony in opposition to SB 2190.

Express Scripts administers prescription drug benefits on behalf our clients – employers, health plans, unions and government health programs — for approximately 109 million Americans. Headquartered in St. Louis, we provide integrated pharmacy benefit management services including pharmacy claims processing, home delivery, specialty benefit management, benefit design consultation, drug-utilization review, formulary management, medical and drug data analysis services, as well as extensive cost-management and patient-care services. In North Dakota, we provide some or all of these services for more than half of the state's residents.

I appreciate the committee's attention to the issue of biosimilars. For far too long, North Dakotans have paid far too much for biologic medicines. These are the most costly medicines available, ranging in price from \$1000 to more than \$50,000 per treatment. Yet when we look across the world, patients elsewhere have been able to take advantage of biosimilars which have lowered their treatment costs by 40%.

The United States took the first step to making biosimilars a reality in 2010 when the Biologics Price Competition and Innovation Act was enacted. Since this time, the United States Food and Drug Administration (FDA) has been working to build this pathway so that it works for drug makers, prescribers, and patients across the country. The FDA has a lot more work to do. In fact, there is still such a lack of clarity on how FDA would approve these drugs that no manufacturer has submitted an application.

In the absence of any biosimilar applications at the FDA, which would take years, Senate Bill 2190 is premature. But in attempting to solve for potential market problems that are years away, I believe the bill has incorporated some elements that will cool the market for the eventual market entry of biosimilars at all. SB 2190, by its very consideration before biosimilars exist in the market, indicates that biosimilars are somehow substandard or of a lower quality. It creates a paradigm for substitution that is very different from how we treat generic drugs or brand biologics today.

The FDA will not approve an unsafe biosimilar. When the FDA approves interchangeable biosimilars, these products by statute will have demonstrated that repeated switching between the biosimilar and its reference product will not create a risk for the patient. State substitution laws already provide a number of safeguards for patients and physicians in pharmacy substitution.

Physicians can direct the pharmacist to dispense the originator or brand product and not fill the prescription with an interchangeable product. Patients have to be notified that the prescription is being filled with an interchangeable product, and the name and manufacturer of the product must appear on the printed label that is provided to the patient.

Among the arguments that proponents of this legislation use to justify the need for this bill is that there are unique risks to switching patients on biosimilars, which is simply not true.

- The risks of immunogenicity caused by a biosimilar are no greater than those posed by the brand name biologic, which varies measurably between different batches of the same product.
- Biosimilars have been marketed and used by tens of thousands of patients in other highly regulated markets (where switching studies have been conducted) and there have been no documented issues with immunogenicity.

If North Dakota and other states enact this legislation that is friendly to brand biotech manufacturers, will biosimilars ever become a reality in the United States? Our fear is that would-be biosimilars manufacturers will see states waving them off, and giving up on the best opportunity to lower prescription drug costs in this decade.

A large coalition formed to support the underlying federal legislation that created the biosimilar pathway at the FDA. It included health plans, large employers, and consumer and patient groups. They understood how high the stakes were and that controlling the rapidly rising costs of biologics is critical to sustaining our healthcare system. Since the federal biosimilars law's enactment, the American Medical Association has affirmed a position that biosimilars should operate under the same state substitution laws as generic drugs.

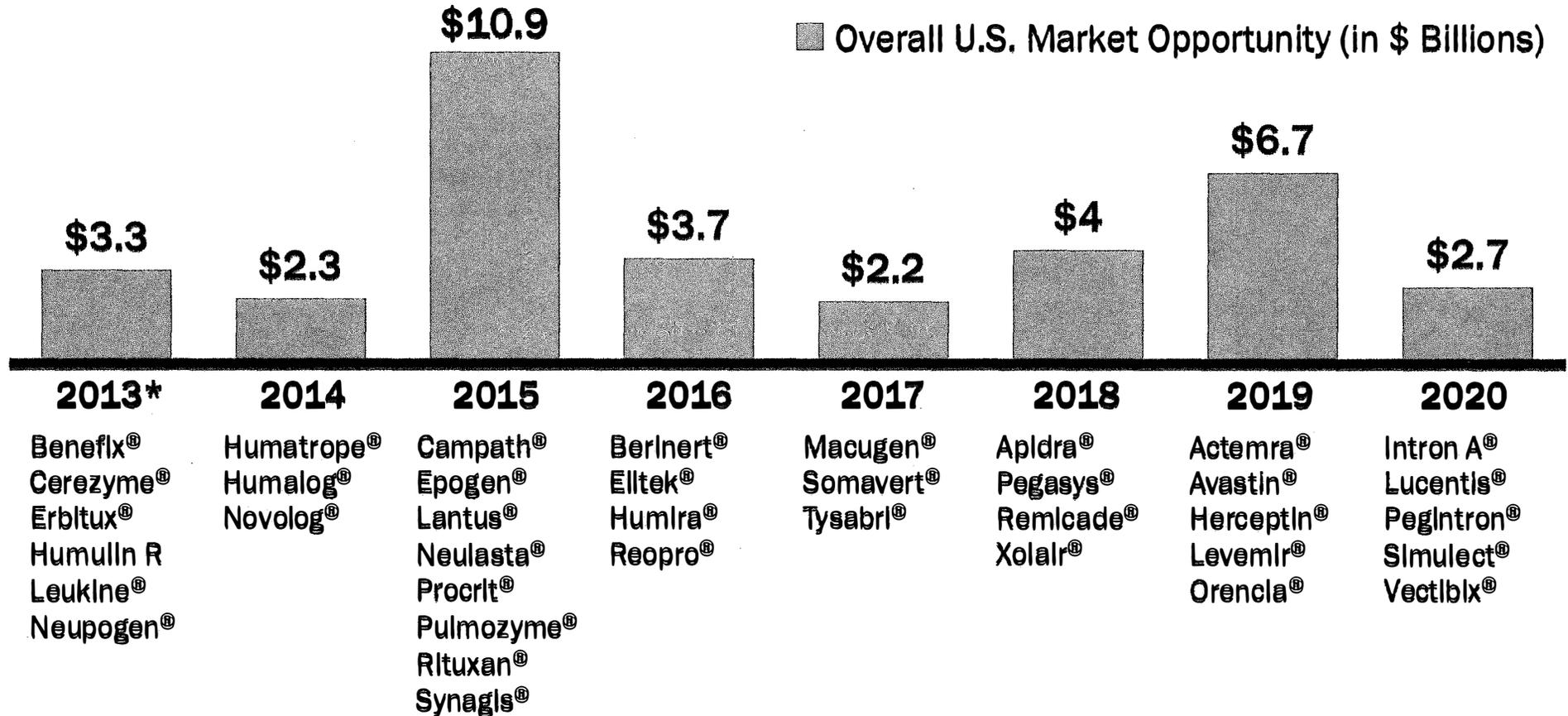
For all the patients who are struggling to afford their medicines, the payers who are paying much of the costs, and the prescribers who aren't asking for a complicated and premature substitution schema, I urge you to oppose Senate Bill 2190.

This concludes my testimony and I would be happy to answer any questions you may have.

SB 2190

\$38.2 Billion Biosimilar Opportunity

68 biotech products with patent expirations through 2020



*Includes all drugs with patent expirations through 2012

Source: U.S. Drug spend estimates are based on IMS Health data for 2011 (if available), manufacturer reported U.S. sales or a percent of manufacturer reported worldwide annual sales of the drug. The patent expiration dates of the biologic products is current as of November 2012. The availability of biosimilars is highly variable due to litigation, patent challenges, FDA's establishment of a aBLA pathway, or other factors.

Monday, January 21, 2013

SENATE HUMAN SERVICES COMMITTEE
SB 2190

CHAIRMAN LEE AND COMMITTEE MEMBERS:

My name is Jack McDonald. I am appearing today on behalf of Prime Therapeutics. We strongly oppose ██████████ SB 2190 and urge a **do not pass**.

The over arching issue here is that the bill is simply not necessary. It is not necessary because the FDA is currently looking at the issue of biosimilars to determine national substitution guidelines. This legislation is not necessary because the FDA is the only body in the United States with the scientific authority to make such a determination.

This is not a patient safety issue because the interchange of biologic products can't occur today without prescriber approval. North Dakota state law requires that when therapeutic interchange takes place, a new script must be written. Substitution can't take place until the FDA adopts a pathway for approval. So until that time therapeutic interchange would be the only mechanism to provide a different drug other than what was prescribed. And that would require a new script from the doctor.

Adopting state specific standards around biosimilars at this point in time would be like each state developing its own generic substitution drug list. Instead of one unified national compendia like we have now in the FDA Orange Book, we would have a confusing patchwork of rules and regulations. What would be legal in one state might be illegal in another for no meaningful reason. This would add cost, confusion and general safety concerns to the basic idea of substituting a generic drug for that of a brand.

Other issues with the bill are found page 2 lines 3-6. Requiring pharmacist notification is an attempt by these brand manufacturers to make substitution more difficult and burdensome, in the hopes that the pharmacist will simply sell only the branded product - increasing the brand manufacturers profit. Additionally, state law already requires a pharmacist to keep records, requiring any additional specified record retention for a biosimilar is again nothing more than an attempt to create a burden on the pharmacist in the hopes that they will simply stock only the brand drug.

Any premature legislation that impedes or limits biosimilar substitution is nothing more than an attempt by brand manufacturers to pre-emptively protect profit margins at the expense of consumers and payers.

Therefore, we urge you to give this bill a **DO NOT PASS**. If you have any questions, I will be happy to try to answer them.

THANK YOU FOR YOUR TIME AND CONSIDERATION.



NATIONAL ASSOCIATION OF
CHAIN DRUG STORES

Interchangeability of Biosimilar and Biologic Products

The Biologics Price Competition and Innovation Act of 2009 created an abbreviated pathway for FDA to give approval to biologic medications that are biosimilar to, or interchangeable with, already approved biologic “reference products.” With this framework now in place, FDA is undergoing the process to establish standards for approval of “biosimilars” and for determining interchangeability. According to FDA, the approval process for biosimilars will ensure that any product deemed interchangeable can be expected to produce the same clinical result in any given patient, who will experience no greater risk from alternating or switching between the two products than if the patient were to continue to use the reference product. Thus, biosimilars deemed interchangeable can be substituted without the prescriber’s intervention.

In light of this, chain pharmacy has serious concerns with proposals that seek to enact special requirements for the interchange of biosimilars. We caution state policymakers against enacting such measures for the following reasons:

- The FDA standards for biosimilars will be rigorous. The agency is cognizant of the complexities inherent to biologic products and has made clear that the standards will ensure that FDA can perform an overall assessment that a biologic is biosimilar to an approved reference product. Only biosimilar products that meet FDA’s standards for interchangeability will be approved and designated as interchangeable.
- Considering that FDA’s work in this area is ongoing and that there are currently no approved biosimilars on the market, enacting laws at this time that limit substitution of biosimilars would not only be premature, but could also potentially conflict with the standards that FDA is developing on this subject.
- We also oppose the creation of special notification and/or consent requirements for the substitution of biosimilars, as this would be redundant and serve no other purpose than to reaffirm decisions made by prescribers at the point when prescriptions are first issued. Prescribers have the ultimate authority to determine whether it is appropriate for a pharmacist to substitute biosimilars when issuing a prescription.
- Considering how costly biologic products are and that there are a growing number of biologic products expected to enter the market, enacting special requirements that make substitution of biosimilars more difficult and therefore less likely will unnecessarily drive up prescription drug costs for all payors, including state Medicaid programs. On average, biologic products cost the state Medicaid program \$1,134.05 per prescription and represent 3.5% of the overall drug spend. Clearly this growing category of products represents an area of the drug spend where the state stands to achieve much greater savings once less expensive biosimilars come onto the market.

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December 2012

g: / GOVT AFFAIRS AND PUBLIC POLICY / SGA Toolkit 2013 / Issue Briefs / Generic Drugs / Interchangeability of Biosimilar and Biologic Products

Biosimilar Legislation – Premature and Unnecessary

Legislation Premature and Unnecessary

- Draft legislation is circulating in some states that attempts to impede or limit biosimilar substitution.
 - What is a biosimilar?
 - A biosimilar is a biological product that is highly similar to a U.S.-licensed reference biological product notwithstanding minor differences in clinically inactive compounds. Just like traditional brand and generic drugs, there are no clinically meaningful differences between the approved biosimilar product and the reference biologic product in terms of their safety, purity, and potency.ⁱ
 - **Currently, the U.S. Food and Drug Administration (FDA) is in the process of creating a pathway for the approval of biosimilars and determining interchangeability – state legislation on this issue would be extremely premature.**
 - There are **NO** biosimilars in the United States marketplace right now.
 - There is **NO** patient safety issue because the interchange of biologic products cannot occur without prescriber approval.
- The FDA is fully cognizant of the complex nature of biologics and has made clear that the standards they develop for determining whether a biologic is interchangeable with an approved reference product will be rigorous.
- Additionally, the FDA is the only U.S. regulatory body with the scientific expertise to determine interchangeability. If the FDA approves a biosimilar as interchangeable, the interchangeable biosimilar should be substitutable as is the case with generics for branded drug products.
- States enacting any law that addresses biosimilars would be premature and may conflict with the national standards the FDA is developing.

Brand Manufacturers' Motive – Go Around FDA to Protect Bottom Line

- Brand manufacturers are misleading legislators by claiming the FDA is going to approve biosimilars without guidelines for interchangeability and thus substitutions will automatically occur. **This is not true.**
 - **Until interchangeability is determined by the FDA – no substitutions can occur even if there was a “biosimilar” in the marketplace. Biosimilars do not meet the traditional definition of a “generic” and thus cannot be substituted under current state substitution laws.**
- When the brand biologic medications go off patent, the brand manufacturers will see a significant drop in their profits – the average daily cost of a brand name biologic product is approximately 22 times greater than a traditional drug.ⁱⁱ
- It is in their financial interest to up-end the FDA's role and expertise in this area and to intentionally create confusion in state substitution laws – thus increasing the potential benefit to their own bottom line.
- As with generic medications today, the availability of biosimilars will give patients greater access to life-saving medications while saving significantly on the cost of their health care.
- **Premature legislation that impedes or limits biosimilar substitution is nothing more than an attempt by brand manufacturers to pre-emptively protect profit margins at the expense of consumers and payers.**

ⁱ FDA definition of a Biosimilar:

<http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/TherapeuticBiologicApplications/Biosimilars/ucm241718.htm>

ⁱⁱ Hilary Krame, Why Biologics Remain Expensive, *Forbes* (2009). <http://www.forbes.com/2009/12/03/kramer-health-care-intelligent-investing-pharmaceuticals.html>

home phone: 701-282-6512
e-mail: jlee@nd.gov

Attachment #8

From: Joyce, Brendan
Sent: Monday, January 21, 2013 1:10 PM
To: Lee, Judy E.
Subject: FW: > \$1000

Sen. Lee,

As discussed after the hearing today, here are some examples of biopharmaceuticals or specialty drugs.

Brendan
ND Medicaid
701-328-4023

This transmission is intended only for the use of the individual to whom it is addressed and may contain information that is made confidential by law. If you are not the intended recipient, you are hereby notified any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please respond immediately to the sender and then destroy the original transmission as well as any electronic or printed copies. Thank you.

Medications that ND Medicaid is currently paying for:

Firazyr, Hereditary Angioedema, \$22,000 per fill (unknown how often it would have to be filled as it depends on the number of events the person suffers).

Elaprase, Mucopolysaccharidosis, MPS-II (enzyme replacement), \$5,681 per week (\$295,000 per year).

Acthar, seizures, \$79,000 per fill

Helixate, Hemophilia, \$250,000 per patient per year average

Medications that have been approved recently –one patient taking these medications would increase the pharmacy budget significantly:

Gattex, short bowel syndrome, \$295,000 per year

Juxtapid, familial hypercholesterolemia, \$282,000 up to >\$1,000,000 per year, depending upon the dosage

PAT WARD'S PROPOSED AMENDMENTS TO SB 2190
OFFERED ON BEHALF OF EXPRESS SCRIPTS

Option A: this option is based on incorporating the comments of Mark Hardy and Senator Anderson in the hearing and would be acceptable to the PBMs that participated in the hearing.

Page 1, line 16, after the words "prescribed product" insert a period.

Page 1, lines 16-17, remove "for the specified indicated use;"

Page 2, line 10, remove semicolon and insert a period.

Remove lines 3-6.

Remove lines 11-12.

Option B would be a hog house amendment to Section 2190 which would do simply as Mr. Hout suggested in his testimony and insert in appropriate places current generic prescribing law which is North Dakota Century Code § 19-02.1-15(3) the words "for FDA approved interchangeable biologic after the phrase generic name and demonstrated therapeutical equivalency."

NDLA, S HMS - Herrick, Kari

From: Lee, Judy E.
Sent: Monday, January 21, 2013 6:06 PM
To: NDLA, S HMS - Herrick, Kari; NDLA, Intern 02 - Myles, Bethany
Subject: FW: Biosimilars - SB 2190

Please make copies for our books.

Senator Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
home phone: 701-282-6512
e-mail: jlee@nd.gov

-----Original Message-----

From: Olhausen, Vaun [<mailto:vaun.olhausen@novartis.com>]
Sent: Monday, January 21, 2013 4:58 AM
To: hcanderson@nd.gov
Cc: Hartmann, Ron; Dever, Dick D.; Lee, Judy E.
Subject: Biosimilars - SB 2190

Good evening Senator Anderson. Tomorrow morning you will hear SB 2190. Since my last email to you, Senator Lee and Senator Dever, I would like to point out some information that will show you why this legislation needs to be amended, or if it is needed at all. To my knowledge, no state has passed this legislation but currently legislation is under consideration in PA, VA, IN, and ND. It is also my understanding the NACDS and GPHA are both opposed to SB 2190. I have contacted NABP but have not heard back at this point.

Basically this issue is providing a generic product, a biosimilar, to treat current diseases with brand name drugs like Epogen, or Herceptin, and others, costing thousands of dollars for single treatments, with less costly generics. Sandoz, Novartis generic division, is the leader worldwide for the development of biosimilar drugs used in foreign countries for years. The FDA is just now approving these drugs for use in the U.S. This will provide a tremendous cost savings to patients being treated for various forms of cancer as an example. All biosimilars have to be FDA approved before they can be used in the U.S.

In SB 2190,

lines 15,16 and 17, should be removed. WHY?

"State laws (or federal law for that matter) should never limit use of ANY drugs to only labeled indications. FDA restricts promotion of off-label uses but not the usage." Novartis' position is that we support substitution of interchangeable biosimilars under the same conditions as small molecule(current generic drugs) substitution. In other words the current law allows for substitution of brand name drugs with generic drugs and biosimilars are just another generic drug.

Lines 13-24 page 1 and lines 1-12 should be removed. WHY?

Pharmacy should not have to hold biosimilars to a higher standard than current generics. Biosimilar drugs are proven safe and efficacious for patients by the FDA just like current generics. Pharmacy/Board of Pharmacy should not have to

#10

require prescriber notification and 5 year record keeping that exceeds small molecule(current North Dakota generic drug laws). Pharmacy should not be penalized in any way.

I have provided this information above to Senators Lee, Dever, Larson, and Axness on the committee. Thank you for your time and will catch up with you after I return.

Vaun

P.S. - Ron Hartmann c.c'd above is with Sandoz

Vaun Olhausen
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January 21, 2013

Senator Dick Dever
1416 Eastwood Street
Bismarck, ND 58504-6226

Senate Measure No. 2190

Dear Senator Dever,

As the CEO and co-founder of the Colon Cancer Alliance, the oldest and largest national patient advocacy group in America dedicated to colorectal cancer, I would like to express to you our support for Senate Bill 2190 on biosimilar biological products. The Colon Cancer Alliance (CCA) is an active member of the Alliance for Safe Biologic Medicines, an organization dedicated to ensuring that patients are at the forefront of the biosimilar policy discussion. Since the FDA was given the authority to bring biosimilars to patients in the U.S., CCA and ASBM have supported their efforts in introducing an approval pathway and we support your legislation promoting patient safety.

Through ASBM, I have been working to raise awareness on these next-generation biologic medicines that are treating cancer, rheumatoid arthritis, diabetes, MS, infertility and many other debilitating diseases.

Biologics are highly complex, advanced prescription medicines that, unlike drugs derived from chemicals, are manufactured using a unique process with living cells that are not easily identified or characterized. No two biologics made from different cell lines are ever identical. Biosimilars, which aim to replicate biologics, are – as the name suggests – similar, but not the same as the innovator drug. Even the smallest difference in the structure of a biologic medicine and its attempted copy can have a significant impact on a patient and therefore, the issue of substituting a biosimilar for a biologic medicine has created new challenges for policy makers.

We have been working with both physicians and pharmacists to develop principles to determine the best solutions for these challenges. In May 2012, ASBM convened a working group of our Advisory Board members to discuss the elements of a physician notification policy for interchangeable biosimilars that prioritizes patient safety and protects the relationship between physicians and their patients but also respects the sovereignty of pharmacists as healthcare providers. We released a statement in October 2012 on the key principles that we believe should be included

in a formal policy recommendations, which we see as aligning with SB 2190, specifically your inclusion that:

A pharmacy may substitute a prescription biosimilar product for a prescribed product only if:

a. The biosimilar product has been determined by the United States food and drug administration to be interchangeable with the prescribed product for the specified indicated use;

b. The prescribing practitioner does not specifically indicate in the practitioner's own handwriting "brand medically necessary" on a written prescription, does not expressly indicate that an oral prescription is to be dispensed as communicated, or has not taken a specific overt action to include the "brand medically necessary" language with an electronically transmitted prescription;

c. The pharmacist informs the individual receiving the biological product that the biological product may be substituted with a biosimilar product and that the individual has a right to refuse the biosimilar product selected by the pharmacist and the individual chooses not to refuse;

d. The pharmacist notifies the prescribing practitioner in writing or via electronic transmission within twenty - four hours of the substitution;

Protecting patients is our main concern and we thank you for making it your top concern as well. We support your efforts to pass Senate Bill 2190 that takes the crucial steps to ensure biosimilar safety in the Peace Garden State.

Sincerely,



Andrew Spiegel, CEO
Colon Cancer Alliance



SafeBiologics
ALLIANCE for SAFE BIOLOGIC MEDICINES

January 21, 2013

Senator Dick Dever
1416 Eastwood Street
Bismarck, ND 58504-6226

Senate Measure No. 2190

Dear Senator Dever,

As the chairman of the Alliance for Safe Biologic Medicines (ASBM), I would like to express to you our support for Senate Measure 2190 on biosimilar biological products. Our organization is dedicated to ensuring that patients are at the forefront of the biosimilar policy discussion and we have been working with patients, physicians, pharmacists, innovative medical biotechnology companies and others for over two years to make sure this happens. Since the FDA was given the authority to bring biosimilars to patients in the U.S., we have supported their efforts in introducing an approval pathway and we support your legislation promoting patient safety.

As a practicing endocrinologist, I have personally been very involved in working with physicians and patients across the country to raise awareness on these next-generation biologic medicines that are treating cancer, rheumatoid arthritis, diabetes, MS, infertility and many other debilitating diseases.

Biologics are highly complex, advanced prescription medicines that, unlike drugs derived from chemicals, are manufactured using a unique process with living cells. No two biologics made from different cell lines are ever identical. Biosimilars, which aim to replicate biologics, are – as the name suggests – similar, but not the same as the innovator drug. Even the smallest difference in the structure of a biologic medicine and its attempted copy can have a significant impact on a patient and therefore, the issue of substituting a biosimilar for a biologic medicine has created new challenges for policy-makers.

We have been working with both physicians and pharmacists to develop principles to determine the best solutions for these challenges. In May 2012, we convened a working group of our Advisory Board members to discuss the elements of a physician notification policy for interchangeable biosimilars that prioritizes patient safety and protects the relationship between physicians and their patients but also respects the sovereignty of pharmacists as healthcare providers. We released a statement in October 2012 on the key principles that we believe should be included in formal policy recommendations, which we see as aligning with SB 2190, specifically your inclusion that:

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- c. The pharmacist informs the individual receiving the biological product that the biological product may be substituted with a biosimilar product and that the individual has a right to refuse the biosimilar product selected by the pharmacist and the individual chooses not to refuse;
- d. The pharmacist notifies the prescribing practitioner in writing or via electronic transmission within twenty - four hours of the substitution;

Protecting patients is our main concern and we thank you for making it your top concern as well. We support your efforts to pass Senate Measure 2190 that takes the crucial steps to ensure biosimilar safety in the Peace Garden State.

Sincerely,



Richard Dolinar, M.D.
Chairman, The Alliance for Safe Biologic Medicines

Members:

Alliance for Patient Access
American Academy of Dermatology
American Association of People with Disabilities
American Council on Science and Health
Amgen
Association of Black Cardiologists
Association of Clinical Research Organizations
Association of Gastrointestinal Motility Disorders, Inc.
Biotechnology Industry Organization
Colon Cancer Alliance
Colorectal Cancer Coalition
Genentech
Global Healthy Living Foundation
Interamerican College of Physicians and Surgeons
International Cancer Advocacy Network
Kidney Cancer Association
MANA
National Alliance on Mental Illness
RetireSafe

NDLA, S HMS - Herrick, Kari

From: Lee, Judy E.
Sent: Monday, January 21, 2013 5:34 PM
To: NDLA, S HMS - Herrick, Kari; NDLA, Intern 02 - Myles, Bethany
Subject: FW: States with similar legislation

Please make copies of this message and put in our books.

Senator Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
home phone: 701-282-6512
e-mail: jlee@nd.gov

-----Original Message-----

From: Scott Setzepfandt [<mailto:setzepfandt.scott@gene.com>]
Sent: Monday, January 21, 2013 5:28 PM
To: Dever, Dick D.; Lee, Judy E.
Subject: States with similar legislation

Hi Senator Lee and Senator Dever,

Just a follow up on how many states are addressing biosimilar substitution. The following is a list of states that have introduced legislation so far this year that includes the 5 BIO principles for safe substitution, as does the ND legislation. I thought you might appreciate that North Dakota is not alone in addressing this topic.

Thank you for your time and consideration on this matter.

Scott

CO HB 1121
FL HB 365
IN HB 1315
MS SB 2085
ND SB 2190
TX SB 190 and HB 542 (identical)
VA HB 1422



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Upper Nyack, New York 10960 USA
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+1 845 348 0210 fax
www.ghlf.org

January 21, 2013

Senator Dick Dever
1416 Eastwood Street
Bismarck, ND 58504-6226

Senate Measure No. 2190

Dear Senator Dever,

I am writing you today on behalf of the Global Healthy Living Foundation (GHLF) and the more than 56,000 members we represent to express our support for SB 2190. We represent patients living with chronic illnesses nationwide, from those with osteoporosis to those with chronic mental illness. Many of the patients we represent, including the nearly 30,000 with Rheumatoid Arthritis, take biologics.

At the GHLF, our focus is on improving the lives of patients with chronic illnesses through health care education and mobilization programs that stress the importance of diagnosis, early and innovative medical intervention, long-term lifestyle improvement and therapeutic compliance. Using various channels of influence, we work to communicate and leverage new and improved medical treatments, such as biologics, to patients. As promising as these innovative drugs are, GHLF believes that assuring their safety should be of paramount concern.

We believe that SB 2190 takes positive steps toward updating North Dakota law to cover biologics and biosimilars in a way that protects patients. Unlike traditional chemical drugs, biologics have very unique, complex structures made from living cells that are not easily understood or replicated. A small change or difference in the biosimilar or biologic has the potential to either help or adversely affect the patient.

As an active member of the Alliance for Safe Biologic Medicines (ASBM), an organization dedicated to ensuring that patients are at the forefront of the biosimilar policy discussion, we have been working with both physicians and pharmacists to develop principles to determine the best solutions for these challenges.

In May 2012, ASBM convened a working group of our Advisory Board members to discuss the elements of a physician notification policy for interchangeable biosimilars that prioritizes patient safety and protects the relationship between physicians and their patients but also respects the sovereignty of pharmacists as healthcare providers. ASBM released a statement in October 2012 on the key principles that we believe should be included in a formal policy recommendations, which we see as aligning with SB 2190, specifically your inclusion that:

A pharmacy may substitute a prescription biosimilar product for a prescribed product only if:

- a. The biosimilar product has been determined by the United States food and drug administration to be interchangeable with the prescribed product for the specified indicated use;
- b. The prescribing practitioner does not specifically indicate in the practitioner's own handwriting "brand medically necessary" on a written prescription, does not expressly indicate that an oral prescription is to be dispensed as communicated, or has not taken a specific overt action to include the "brand medically necessary" language with an electronically transmitted prescription;
- c. The pharmacist informs the individual receiving the biological product that the biological product may be substituted with a biosimilar product and that the individual has a right to refuse the biosimilar product selected by the pharmacist and the individual chooses not to refuse;
- d. The pharmacist notifies the prescribing practitioner in writing or via electronic transmission within twenty - four hours of the substitution;

As patient advocates, it is our duty to ensure that patients and physicians are in charge of the drugs prescribed, that patient safety is the top priority in the health care process and that medical decisions remain between a doctor and his or her patient. We urge the passage of SB 2190 because it introduces biosimilars in a way that ensures the safety of patients and preserves the physician-patient relationship.

We appreciate your thoughtful consideration on this legislation and would be pleased to provide any further information that you may require.

Sincerely,



Seth Ginsberg
President, Global Health Living Foundation

CC:

Senator Judy Lee
Senator Oley Larsen
Senator Howard C. Anderson
Senator Tyler Axness



Proposed Amendments to SB 2190



Page 1 Line 16-17 (delete a phrase)

"administration to be interchangeable with the prescribed product. ~~for the specified indicated use;~~

Page 2 Line 3 (add "orally" & insert commas as needed)

d. The pharmacist notifies the prescribing practitioner orally, in writing, or via electronic transmission

Page 2 Line 5 (remove the word "written")

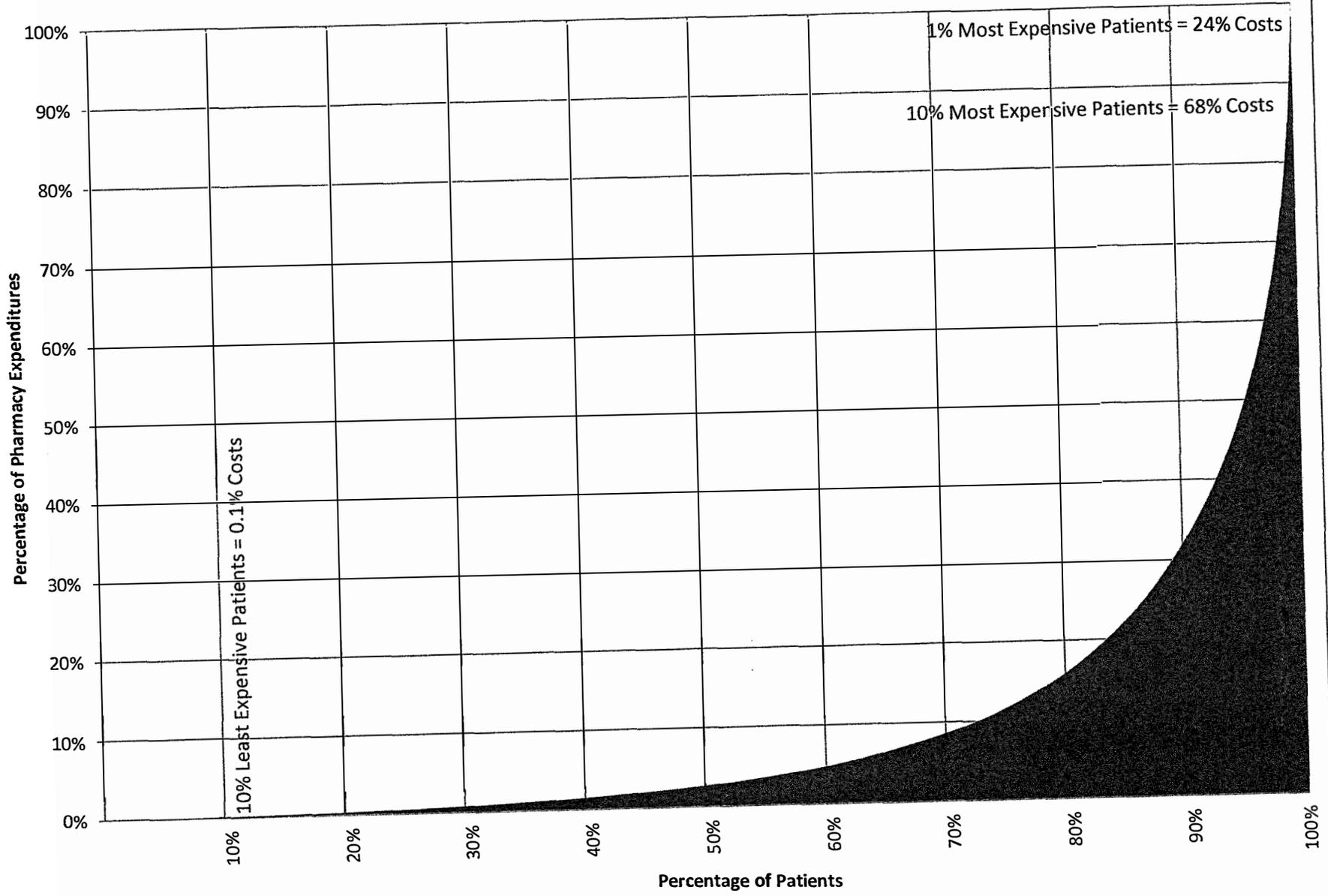
e. The pharmacy and the prescribing practitioner retain a ~~written~~ record of the



Page 2 Lines 11-12 (Remove Lines)

b. ~~Adopt rules for compliance under which a pharmacy that violates subsection 2 is subject to a specified civil money penalty.~~

A Few Patients Cost a Lot



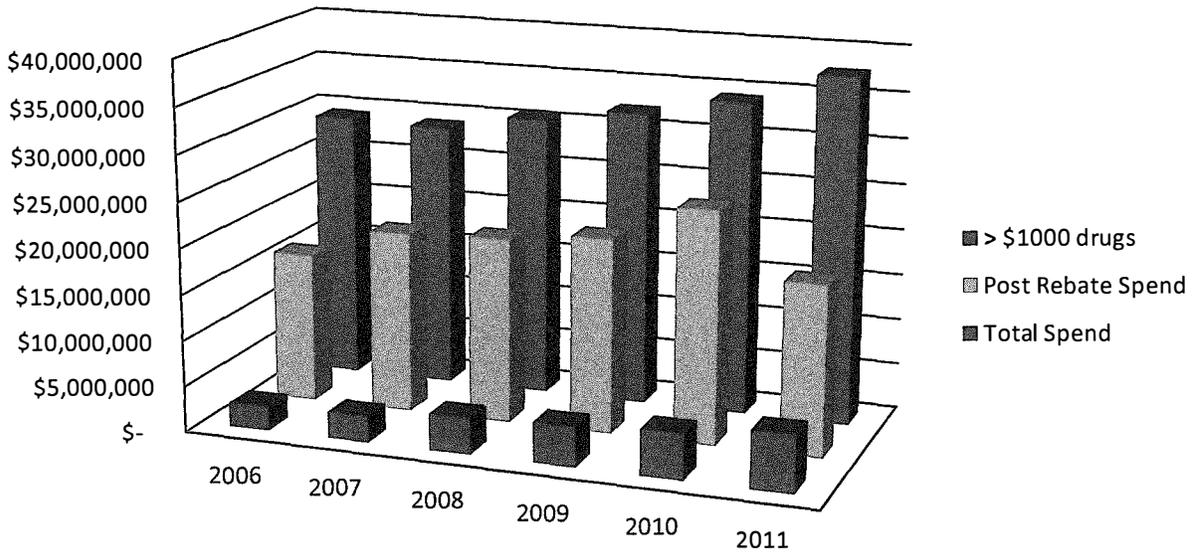
Dr. Brendan Joyce

Attachment #15

SB 2190 information
 Top 50 Medicaid patients by cost
 Accounts for 7% of drug spend

Amt Paid	Avg Paid Per Rx
\$ 27,110	\$ 512
\$ 27,162	\$ 533
\$ 27,193	\$ 378
\$ 27,748	\$ 159
\$ 28,148	\$ 144
\$ 29,003	\$ 271
\$ 29,161	\$ 941
\$ 29,200	\$ 171
\$ 29,242	\$ 344
\$ 29,467	\$ 124
\$ 29,614	\$ 370
\$ 29,879	\$ 1,299
\$ 30,330	\$ 722
\$ 30,733	\$ 134
\$ 31,123	\$ 288
\$ 31,436	\$ 374
\$ 31,684	\$ 495
\$ 31,944	\$ 283
\$ 32,360	\$ 2,023
\$ 32,819	\$ 316
\$ 33,145	\$ 11,048
\$ 33,567	\$ 282
\$ 34,590	\$ 432
\$ 36,736	\$ 185
\$ 37,193	\$ 219
\$ 38,548	\$ 214
\$ 39,365	\$ 1,125
\$ 39,461	\$ 617
\$ 39,485	\$ 548
\$ 39,698	\$ 529
\$ 43,784	\$ 6,255
\$ 46,026	\$ 1,841
\$ 46,270	\$ 586
\$ 48,321	\$ 1,858
\$ 48,370	\$ 1,423
\$ 48,936	\$ 670
\$ 49,385	\$ 235
\$ 50,191	\$ 405
\$ 50,538	\$ 211
\$ 50,640	\$ 265
\$ 51,318	\$ 3,207
\$ 53,117	\$ 272
\$ 54,123	\$ 1,230
\$ 72,872	\$ 1,088
\$ 74,450	\$ 792
\$ 79,038	\$ 2,725
\$ 116,184	\$ 887
\$ 181,575	\$ 4,323
\$ 198,982	\$ 11,705
\$ 249,750	\$ 16,650

Growth in Medicaid Specialty Drug Costs Prepared by DHS 1-23-13

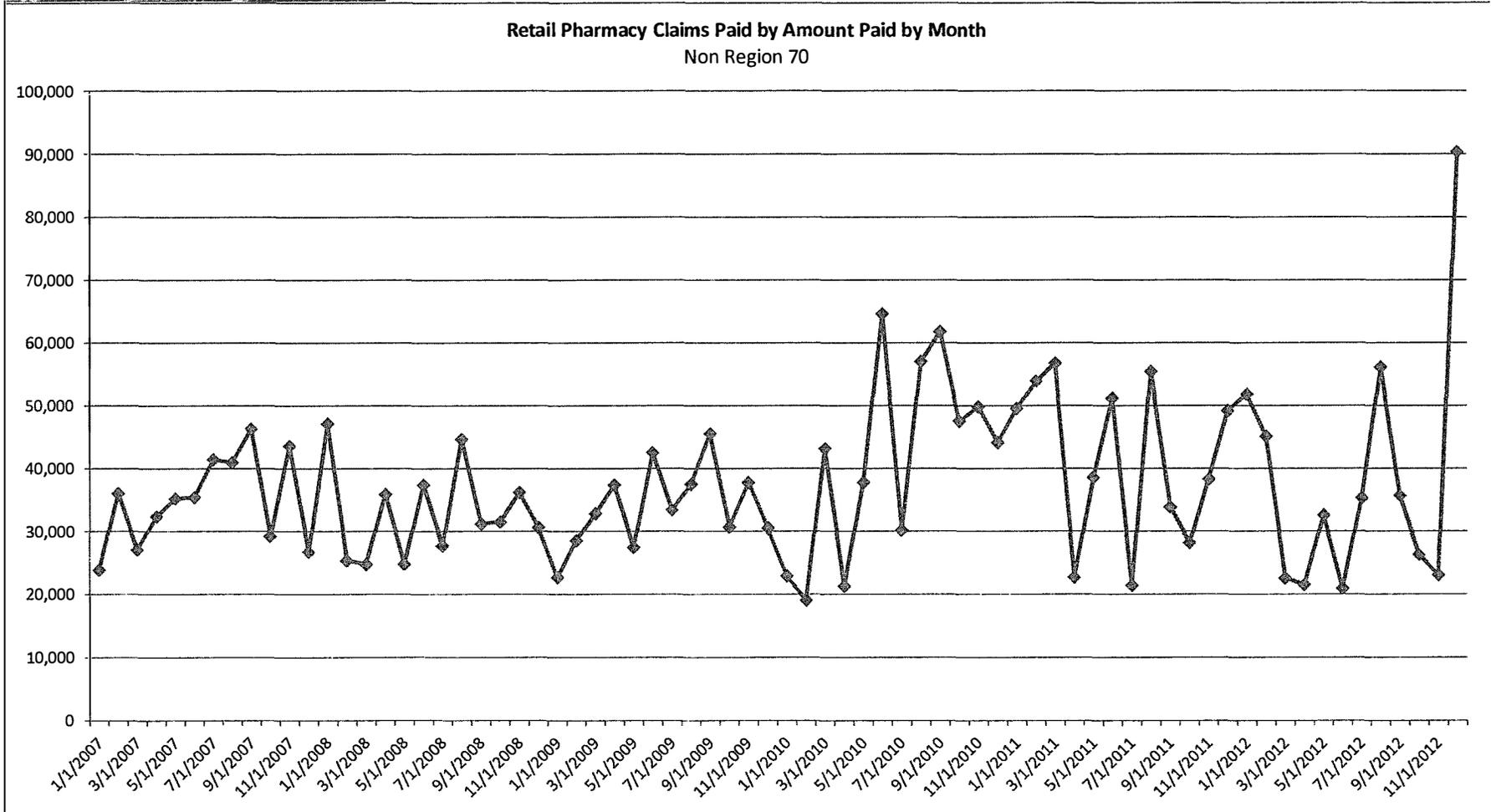


SB 2190

Information to show growth in specialty drugs in relation to overall pharmacy expenditures

Year	Total Spend	Post Rebate Spend	> \$1000 drugs	Growth		> \$1000 drugs	
				Total Spend	Post Rebate Spend	> \$1000 drugs	% of spend
2006	\$29,287,575	\$16,319,871	\$2,627,472				9.0%
2007	\$28,989,461	\$19,687,056	\$2,852,309	-1.0%	20.6%	8.6%	9.8%
2008	\$30,713,332	\$20,101,315	\$3,952,767	5.9%	2.1%	38.6%	12.9%
2009	\$32,214,845	\$21,141,723	\$4,344,528	4.9%	5.2%	9.9%	13.5%
2010	\$34,213,369	\$25,226,671	\$4,970,666	6.2%	19.3%	14.4%	14.5%
2011	\$37,696,303	\$18,459,290	\$6,220,363	10.2%	-26.8%	25.1%	16.5%

Type of Drug Oncology



Attachment #18

Testimony – Genentech
Scott Setzepfandt, R.Ph., Senior Regional Manager, State Government Affairs
March 11, 2013

SUPPORT SENATE BILL NO. 2190

Chairman Weisz and members of the Human Services Committee, thank you for allowing me to speak on Senate Bill 2190 and express our support for this bill.

My name is Scott Setzepfandt, and I am the Senior Regional Manager for State Government Affairs in the Central Region for Genentech.

Considered the founder of the biotechnology industry, Genentech has been delivering on the promise of biotechnology for more than 35 years. Genentech discovers, develops, manufactures, and brings medicines to market to treat patients with serious or life-threatening medical conditions. Today, Genentech is among the world's leading biotechnology companies, with multiple products on the market, and a promising pipeline of future therapies. Americans across the country are prescribed our FDA-approved products, which are primarily a new class of drugs known as biologics. Examples of disease we are addressing with our biologic products are brain, kidney, prostate, breast and colon cancer, leukemia, difficult to treat rheumatoid arthritis, cystic fibrosis and stroke. Genentech is constantly in search of solutions to unmet medical needs including these, and even here in North Dakota we have 74 clinical trials at 27 locations across the state.

Biologics differ from traditional pharmaceutical drugs in that they are created from living cell DNA strands as opposed to traditional drugs, which are made from a chemical recipe. In contrast to smaller molecule chemically produced drugs, biologic medications are large, complex molecules that have been developed by re-coding the DNA of living cells to produce the drug. Important to note is that we use a very specific cell line, which has been cloned to ensure consistency and have ongoing quality controls to ensure consistency of product. Biosimilar products will be produced from a different cell line and as a result will have some variations in end product, which is why they will not be identical. Because biologics are created using specific genetic information, biologics have been and will continue to be an important innovative component of personalized medicine.

As I mentioned earlier, traditional pharmaceutical drugs follow a chemical recipe and when those drugs go off patent, the generic drug makers are able to follow this recipe to make their drugs nearly the same as the original drug. Biologics, on the other hand, are produced from living cells

and as such a biosimilar will likely never reach the same level of sameness as a generic drug can to its model.

The 2010 federal health reform act created a pathway to allow for the development and manufacture of biosimilar products that are intended to have the same effect as the biologic medications created by companies like Genentech. Given the imminent introduction of biosimilar products in the US, an update of the North Dakota pharmacy practice act is necessary to regulate the dispensing of biologics and the new biosimilar products.

Current North Dakota law is very specific with regard to substitution. It allows for the pharmacists to substitute a generic for a branded product if the prescriber does not indicate otherwise, without the need to contact the prescriber first. North Dakota law does not address the substitution of biologics with interchangeable biosimilar products. So currently the only way an interchangeable biosimilar could be substituted for a biologic in North Dakota is if the pharmacists contacted the prescriber for every prescription prior to making that substitution.

So how does SB 2190 fix this?

First, SB 2190 updates state statutes by applying current federal definitions for “biologics”, “biosimilars” and “interchangeability” to North Dakota Code. This will provide consistency and clarity between state and federal law.

SB 2190 also updates the current pharmacy practice act to allow for a process similar to the generic substitution to be done with biologics and interchangeable biosimilars.

SB 2190 includes 5 key principles that BIO, the national biotech association, has adopted to ensure safe substitution of biologics with interchangeable biosimilar products.

To address the first Bio principle of safety, as I mentioned before, current law does not provide for the consideration of substituting a biologic with a biosimilar product. SB 2190 adds language that allows pharmacists to substitute a biologic product with a biosimilar product, if the FDA has determined that biosimilar product is interchangeable with the biologic product.

Interchangeability is an important factor. A biosimilar product is not a generic product, it is not identical to the original biologic. And while it may produce the same results, it is different. As such, switching between the original biologic product and a biosimilar product presents a potential safety risk. People’s bodies might react in a different way to the biosimilar than to the original biologic. Switching should only be done with products that have demonstrated “interchangeability” through clinical studies and that the switch back and forth between the innovator’s original biologic and the biosimilar causes no risk to the patient. The FDA is currently developing federal regulations to address the process necessary for companies to bring biosimilar products to market that the FDA will approve as “interchangeable” with the original biologic.

SB 2190 also safeguards the prescriber’s and patient’s choice to use a specific product. As with current law regarding generic substitution, the prescriber can prevent a substitution by

indicating substitution is not permitted on the prescription. SB 2190 also requires the patient be informed that the biologic may be substituted with a biosimilar product. This is consistent with current law regarding generic substitution.

If a substitution is made by a pharmacist, SB 2190 requires pharmacists to notify the prescriber within 24 hours of switching an interchangeable biosimilar for a prescribed biologic product and that the dispensing pharmacy keep a record of the substitution for a minimum of five years. Informing the prescriber and keeping records are important should problems develop and for the prescriber to assess treatment outcomes. This is not to say one product is better than another or one product is safer than another. But they are different and this is to ensure that if a patient has an adverse reaction or the treatment isn't working as it should or a number of other unanticipated issues, the prescriber knows exactly what product they are on. These are large, highly complex molecules being injected into people's bodies. Knowing that anytime you inject something into the body there is a potential risk, it is important to be able to attribute any problems to the appropriate product.

Finally, the North Dakota Board of Pharmacy would be directed to keep a list of FDA approved interchangeable biosimilar products on its website. Having this available will ensure pharmacist, prescribers and patients will have up to date information on the availability of interchangeable biosimilar products.

As I mentioned in my introduction, I currently work for Genentech. But I am also a registered pharmacist in Minnesota and have had experience in both retail and hospital pharmacy. As such I look at this issue with two hats, one of policy and the one of how this works in the real world. To me SB 2190 is an issue of safety and sound process. SB 2190 makes the necessary updates to North Dakota statute to allow for a safe dispensing process for substituting biologic products with interchangeable biosimilar products.

For the pharmacists, passing SB 2190 it will make it clear which products are substitutable and streamlines the process for pharmacists to make substitutions. It also ensure that the pharmacist maintain open communications with the patient and the treating physician.

In closing, SB 2190 ensures substitutions are done in a safe and regulated manner and preserves health care providers' treatment choice in serving patients with serious and life threatening diseases.

I urge you to vote "Do Pass" for SB 2190.

What the experts say about prescriber notification

Biotechnology Industry Organization (BIO)

"**The prescribing physician should be notified of the substitution.** Even though interchangeable biologics will be "expected" to produce the same clinical result, it remains the case that patients could react differently to an interchangeable biologic than if they were given the innovator product due to the complex nature of biologic products and how they work in the human body. In these circumstances, the treating physician must know that the products were substituted at the point of dispensing in order to appropriately assess a patient's experience and further treatment options. Moreover, it is in the interest of public health to be advised of which biologic is being administered as it will facilitate attribution to the proper product for adverse event reporting."

Alliance for Specialty Medicine

(a coalition of national medical specialty societies representing more than 100,000 physicians and surgeons)

"The practice of automatic substitution that is seen with generic drugs is not entirely appropriate for biosimilar products given that they are not simply "generic" versions of biologics. **Physicians need to know what medicine their patient receives and therefore, the prescribing physician should be notified whenever a patient's biologic medicine is substituted.**"

Coalition of State Rheumatology Organizations (CSRO)

(state and regional rheumatology societies formed to advocate for excellence in rheumatologic care)

"CSRO recognizes that follow-on biologic products are a natural evolution of biotechnology and we welcome the introduction of these medications. However, we must insist that physicians know what medicine their patient receives and that the prescribing physician is notified in a timely manner whenever a patient's biologic medicine is substituted."

Alliance for Safe Biologic Medications (ASBM)

"Physicians and pharmacists should work collaboratively **to ensure that the treating physician is aware of the exact biologic – by manufacturer –** given to a patient in order to facilitate patient care and accurate attribution of any adverse events that may occur;"

International Myeloma Foundation (IMF)

"States must consider the following:

- **Require prescribing health care providers be notified of the substitution.** Even though interchangeable biologics may produce the same clinical result, there is still a risk that the patient could have a negative reaction to the change and having the primary provider in the loop from the start, will help to ensure quick and appropriate treatment to unintended consequences. This will also help facilitate the reporting of an adverse event.
- **Direct pharmacist and primary health care providers to keep records of the substitution.** Because many biologic medicines are used to treat cancers and other life threatening conditions that can change over time, it is important for a patient's treatment team to have records that document how and when a patient was treated with biologic therapies. These records will also provide insight down the road in the event of an adverse reaction."

American Academy of Dermatology (AAD)

The American Academy of Dermatology Association supports a prohibition of biosimilar substitution unless six criteria are achieved and two of those are prescriber notification and retention of a record of the substitution by the prescriber and pharmacy.

#2



Biotechnology
Industry
Organization

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**BIOTECHNOLOGY INDUSTRY ORGANIZATION
STATEMENT IN SUPPORT OF NORTH DAKOTA S.B. 2190**

MARCH 2013

The Biotechnology Industry Organization (BIO) is the world’s largest biotechnology trade association. BIO represents more than 1,100 biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and 31 other nations. BIO members are involved in the research and development of healthcare, agricultural, industrial, and environmental biotechnology products. One of BIO’s core missions is the promotion of a safe, innovative, and competitive market for biologics in the United States. To that end, BIO’s member companies have approved five principles related to substitution of biologic medicines. The policies outlined in Senate Bill 2190 align with all five of BIO’s principles on biologic substitution and we therefore support its passage.

Biologics are very complex medicines. Unlike traditional “small molecule” drugs, biologics are not chemically synthesized but, rather, are manufactured from living cells and tissues using a highly controlled and optimized process. Each resulting biologic therapy is complex and unique, and in many cases cannot be fully characterized by current analytical tools. As a result, even minor differences in manufacturing processes can cause variations in the end product. Consequently, two biologics made using different cell lines and differing manufacturing processes will rarely, if ever, be exactly the same.

Biosimilars are biologic products manufactured with the goal of closely mirroring the composition and treatment profile of an innovator product but are produced without access to the innovator’s proprietary manufacturing processes. The production of biosimilar products, therefore, will invariably lead to differences in composition compared to the original innovator product.

Currently, the Federal Food and Drug Administration (the “FDA”) is developing guidance regarding the regulatory pathway for the approval of biosimilar and interchangeable biologic products. This approval pathway was established by federal law, and distinguishes clearly between biologic products that are “biosimilar” to an innovator biologic – meaning they are “highly similar” to an innovator product – and biologic products that meet a heightened standard to be deemed “interchangeable.”

While FDA’s role in the approval of biologic and biosimilar medicines includes the designation of an interchangeable status, the policy on whether one biologic product may be substituted by dispensers when a different biologic product was prescribed is governed by state law. In recognition of this state-level authority over biosimilar and interchangeable biologic medicines, BIO has developed a set of core Principles¹ that we believe should be considered by all states evaluating biologic substitution legislation. We believe that our Principles, if followed, strike the appropriate balance of preserving the physician-patient relationship, protecting patients, maintaining incentives for innovation, and promoting a competitive market for biologic therapies. As drafted, Senate Bill 2190 is in-line with BIO’s own Principles and we therefore support its passage.

* * * *

¹ See: [BIO Principles on Patient Safety in the Substitution of Biologic Products](#)



Biotechnology
Industry
Organization

BIO Principles on Patient Safety in the Substitution of Biologic Products

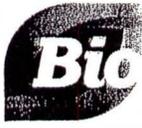
Biologics are complex medicines manufactured from living organisms. Unlike traditional “small molecule” drugs, biologics are not chemically synthesized but rather are manufactured from living cells by programming a particular cell line to produce a desired therapeutic substance in a highly controlled sterile environment. Each individual biologic therapy is a complex, heterogeneous mixture, which in many cases cannot be well characterized by current science. Because of this complexity, even minor differences in manufacturing processes can cause variations in the end product. Consequently, two biologics made using different cell lines and differing manufacturing processes will rarely, if ever, be exactly the same.

Follow-on biologics, or “biosimilars,” are biologic products manufactured using different cell lines and manufacturing processes with the goal of closely mirroring the composition and treatment profile of an innovator product produced by another company. Due to the innate complexity of biologics in general, however, the production of biosimilar products will invariably lead to some differences between the composition of a biosimilar and the original innovator product, and these differences could potentially lead to clinical differences in a patient’s experience or reaction. In other words, unlike generic copies of traditional small molecule drugs, biosimilar biologic products will be therapies that are similar to, but not the same as, an innovator therapy.

Currently, the Federal Food and Drug Administration (the “FDA”) is developing guidance regarding the regulatory pathway for the approval of biosimilar and interchangeable biologic products. This approval pathway was established by federal law, and distinguishes clearly between biologic products that are “biosimilar” to an innovator biologic – meaning they are “highly similar” to an innovator product – and biologic products that meet a heightened standard to be deemed “interchangeable.” The standard for interchangeability in the law is a stringent one; one that is consistent with the FDA’s role in protecting patient safety. In order to deem a biologic product interchangeable with an innovator product, FDA must determine that a biologic is not only “biosimilar,” but also that it “can be expected to produce the same clinical result as the [innovator] product in any given patient.” Further, if a patient might be switched back and forth between two products, the FDA must determine that there is no additional risk in such switching compared to using the innovator product alone.

While FDA’s role in the approval of biologic and biosimilar medicines includes the designation of an interchangeable status, the policy on whether one biologic product may be substituted by dispensers when a different biologic product was prescribed is governed by state law. As such, the introduction of biosimilar and interchangeable biologics into clinical practice will present some new challenges that have not historically been present with small molecule generic medicines. In considering patient safety and pharmacovigilance monitoring, current state rules on substitution will very likely need to be updated or completely re-written in the context of biosimilar and interchangeable biologic medicines.

BIO believes that a sound policy in each state outlining parameters for safe substitution of interchangeable biologics is the best option to ensure patients have access to high-quality, safe, and effective biologic medicines. BIO’s core concerns are to safeguard patient safety and the primacy of the physician-patient relationship, recognizing that treating physicians and their patients are in the best position to determine appropriate therapies. BIO believes the FDA will develop appropriate standards for the approval of safe biosimilar and interchangeable biologic products in order to best protect patient safety. To ensure transparency and communication between patients and their treatment teams, however, BIO also believes that certain safeguards should guide substitution policies for interchangeable biologics under state law as well. The principal safeguards necessary for states to address include:



- Substitution should occur only when the FDA has designated a biologic product as interchangeable. Only in this situation can patients and their physicians be assured that all reasonable efforts have been undertaken to assess the possible adverse effects on a patient, in terms of diminished safety or effectiveness, when one biologic product is substituted for another. In these cases, the FDA will have more thoroughly evaluated the possibility for immunogenic reactions, side effects, and other safety or efficacy differences to help ensure that a patient will react favorably to a given treatment if there is a substitution of an interchangeable biologic for an innovator product, or vice versa.
- The prescribing physician should be able to prevent substitution. The prescribing physician is in the best position to evaluate a patient's treatment history and options, and thus it is important for the treating physician to be able to designate exactly which product he/she believes should be dispensed to the patient. Product determinations should include a patient's values and preferences following informed discussion of the interchangeable biologic product's risks, benefits, and uncertainties. By permitting prescription pads to contain the phrase "dispense as written," or "brand medically necessary," the physician can control the delivery of biologic products at the outset and be better able to manage potential patient side effects.

In addition to these two principal safeguards, which BIO believes to be a necessary inclusion for interchangeable biologics in every state, several other patient protections should be considered as well. Additional safeguards can help to ensure transparent discussion between the patient and pharmacist at the point of dispensing, as well as ensure all appropriate parties are included in the patient's care continuum so that any downstream reactions can be documented and appropriately addressed. These patient protections include:

- The prescribing physician should be notified of the substitution. Even though interchangeable biologics will be "expected" to produce the same clinical result, it remains the case that patients could react differently to an interchangeable biologic than if they were given the innovator product due to the complex nature of biologic products and how they work in the human body. In these circumstances, the treating physician must know that the products were substituted at the point of dispensing in order to appropriately assess a patient's experience and further treatment options. Moreover, it is in the interest of public health to be advised of which biologic is being administered as it will facilitate attribution to the proper product for adverse event reporting.
- The patient, or the patient's authorized representative, should, at a minimum, be notified of the substitution. Often times patients managing chronic medical conditions have tried multiple treatment regimens with their physician to get to a point of comfortably managing the condition while minimizing side effects to the greatest extent possible. In these cases, patients are generally aware of which treatments work best in their unique circumstances. Providing notice to the patient, or in some cases – depending upon current state law – requiring patient consent, of the intent to switch gives that patient the opportunity to discuss with the pharmacist or physician past treatment experiences so that any potential future problems can be avoided.
- The pharmacist and the physician should keep records of the substitution. Because many biologic medicines are used to treat chronic conditions that can change over time, it is important for a patient's treatment team to have records that document how and when a patient was treated with biologic therapies. These records will also provide insight down the road should an adverse reaction or disease evolution occur.

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#3

• **Testimony of Gustavo (Gino) Grampp, PhD, Regulatory Policy Director at Amgen, on March 11, 2013 for North Dakota SB 2190**

- Good morning. My name is Gino Grampp. I currently serve as Director of Regulatory Policy at Amgen, but spent most of my 20 year career developing and supporting the manufacturing processes for Amgen's biologic medicines. I still live in the Denver area where Amgen manufactures several biologics. **Through this experience I've learned how important it is to monitor quality and safety of biologics over time.**
- **Biologics differ from many chemical drugs because they are complex and relatively sensitive to the way they are manufactured.** Allow me give you just one example. A couple years ago we discovered that parts per million of a tungsten carried over from our product containers could react with the biologic and cause one of our products to become cloudy. Since cloudy syringes were unacceptable from a quality perspective, and could have potentially impacted safety, we culled all of the effected units, but we also fixed the underlying problem that by working with the supplier to reduce the tungsten levels and prevent further impact to our products.
- **We occasionally change our manufacturing processes to ensure consistent supply of medicines to patients. Because biologics are so complex and sensitive, there's always a possibility that we might not detect a subtle change in quality.** Therefore, in addition to generating a large data package and obtaining regulatory approval before we make a change, **we are also required by regulatory agencies to continuously monitor the safety data coming in from patients and physicians to verify that there are no new issues.**
- Let me be clear: Amgen is not supporting the physician notification and other provisions in SB 2190 because we question the safety of biosimilar products. Indeed, Amgen is currently developing several biosimilar products to treat cancer and autoimmune diseases so we have no reason to question their safety. No, we are supporting physician notification, but because product variability and sensitivity to manufacturing are long-term hazards inherent to all biologics.
- Some in the opposition believe that generics and off-patent biologics should be treated exactly the same with regard to post-approval safety monitoring, but this overlooks the fact that European regulators and FDA have both emphasized that biologics and biosimilars merit special treatment for safety monitoring, different from generic drugs.
- Indeed, here's what FDA wrote in a 2011 publication about the nations biosimilar program:
"The FDA process for biosimilars must include product specific safety monitoring. Tracking adverse events associated with the use of reference and biosimilar products will be difficult if the specific product or manufacturer cannot be readily identified."
- **And this brings me to another difference from many chemical drugs: Some safety issues with biologics are related to the patient's immune response.** As with a vaccine, a patient's immune system can recognize a biologic medicine, and it can sometimes take several months for the immune response to ramp up. Published reports demonstrate that it can take 9 months or longer for some patients to develop a full-blown immune response.

- **So, what I'd like to leave you with is the understanding that biologic manufacturers are obligated to verify that their medicines remain safe over time.** And patients and physicians should understand that a patient's experience with a biologic might change over time. If this should occur, the physician might choose to communicate with the manufacturer and the FDA about a potential adverse drug reaction.
- **This safety monitoring system works fine when there is one manufacturer and the patient receives exactly the medicine the doctor prescribed.** But when substitution enters the picture, a critical piece of the information may be missing, if, months later, a physician determines that a safety report should be filed. It is very important to close the information loop between pharmacists, patients, and physicians so that the supply of biologic medicines can remain safe. **Physician notification is a simple measure that North Dakota can take to close this loop.**



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#4

North Dakota House Human Services Committee
March 11, 2013

As prepared for delivery

- Good morning. I would like to thank Chairman Weisz and each of you on this committee for allowing me to be here today.
- My name is Allen Todd and I the Director of Patient Education & Advocacy for the Global Healthy Living Foundation.
- At the Global Healthy Living Foundation, we represent more than 56,000 patients nationwide who are living with chronic illnesses.
- Our focus is on improving the lives of these patients through health care education and programs that stress the importance of diagnosis, early and innovative medical intervention, long-term lifestyle improvement and therapeutic compliance.
- On a personal note, I am a patient taking a biologic. I have been successfully managing type 1 diabetes for over 30 years.
- In addition to my diabetes, our President and co-founder Seth Ginsberg, was diagnosed with Spondyloarthritis, which is an inflammatory rheumatic disease, at age 13.
- We take the healthcare of patients with chronic illness seriously because we live it every day.
- Many of the patients we represent, including those like me with diabetes and those with RA, take biologics to manage their conditions.

- As an organization, we strongly support the use of biosimilars. Ensuring patients access to affordable, effective medicine is a core part of our mission.
- However, we believe that the choice of treatment should be decided only by patients and their physicians.
- The fact that Senate Measure 2190 requires a pharmacist to notify the prescribing physician after the substitution has been made is key to our support and is a common sense step for patients who rely on these medications to manage chronic conditions.
- Let me give you an example to explain why. Many of our patients have Rheumatoid Arthritis. They have spent months or, in some cases, years establishing the drug regimen and course of treatment that works best for them.
- The last thing they want is for their medication to be switched without their knowledge or the knowledge of their physician.
- We are patient advocates. Access and safety are our top priorities in the health care process.
- We believe Senate Measure 2190 takes positive steps to update North Dakota law by covering biologics and biosimilars in a way that protects patients and puts their needs first. That is why we strongly support it.
- We appreciate your thoughtful consideration of this legislation and urge you to pass it.
- I would be pleased to answer any questions you may have.



#5

Testimony before North Dakota
House Human Services Committee
March 11, 2013

As prepared for delivery

- Good morning. My name is Brenda Kleinsasser.
- I would like to thank Chairman Weisz and each of you on this committee for allowing me to be here today to provide a patient's perspective on Senate Measure 2190.
- I have lived in North Dakota all my life and I currently reside in Bismarck.
- I am here today because I have been living with rheumatoid arthritis for almost 22 years, and I have been taking a biologic, Enbrel, for almost 12 years.
- I am here on behalf of all of us who are on a biologic for various inflammatory diseases such as rheumatoid arthritis.
- And I am here to express support for Senate Measure 2190 because it introduces biosimilars in a way that protects patients like me.
- As you may know, rheumatoid arthritis is a chronic inflammatory disorder that may affect many tissues and organs, but mainly attacks the flexible joints.
- It can be a disabling and painful condition, which can lead to substantial loss of function and mobility if not adequately treated.
- In fact, before I was prescribed Enbrel, just the simple task of getting out of a chair after sitting for a time was pure agony. My ankles were so swollen that getting into shoes was really hard, which made walking difficult.

- As you can see, I have visible damage to my hands. This occurred before finding the right medication and this damage is irreparable.
- I spent years trying other drugs and medications that simply did not help me manage my disease and simply did not work for me.
- However, when my doctor prescribed Enbrel, my life changed.
- I have been able to continue my full time employment. One of the first big differences that people noticed was how much better I was walking than before I was on Enbrel.
- As you can see, my medication and treatment is important to my daily life.
- My doctor and I have worked hard over the years to find the right medication and dosage that works for me. Decisions about those things should be left up to us.
- The only reason I have been able to successfully manage my rheumatoid arthritis is because I went through the trial and error process of finding the right medication.
- That was a long and painful process that lasted almost 10 years.
- This legislation ensures that if my pharmacist substitutes my biologic for a biosimilar, my doctor and I know.
- For patients like me, this is extremely important. For someone who spent 10 years finding the right one, it is simply not too much to ask to know exactly what medication I am taking.
- Again, I would like to thank the committee for considering this important legislation and I urge you to pass it without delay.
- I am happy to try to answer any questions you may have.

- As an organization, we strongly support the use of biosimilars. Ensuring patients access to affordable, effective medicine is a core part of our mission.
- However, we believe that the choice of treatment should be decided only by patients and their physicians.
- The fact that this bill requires a pharmacist to notify the prescribing physician after the substitution has been made is key to our support and is a common sense step for patients who rely on these medications to manage chronic conditions.
- For example, many of our patients have Rheumatoid Arthritis. They have spent months or, in some cases, years establishing the drug regimen and course of treatment that works best for them.
- The last thing they want is for their medication to be switched without their knowledge or the knowledge of their physician.
- We are patient advocates. Access and safety are our top priorities in the health care process.
- We believe Senate Measure 2190 takes positive steps to update North Dakota law by covering biologics and biosimilars in a way that protects patients and puts their needs first. That is why we strongly support it.
- We appreciate your thoughtful consideration of this legislation and urge you to pass it.
- I would be pleased to answer any questions you may have.



Testimony
Re-Engrossed Senate Bill 2190 – Department of Human Services
House Human Services Committee
Representative Robin Weisz, Chairman
March 11, 2013

Chairman Weisz, members of the House Human Services Committee, I am Dr. Brendan Joyce, Administrator of Pharmacy Services for the Medical Services Division of the Department of Human Services. I am here to provide information regarding the fiscal note for Re-Engrossed Senate Bill 2190.

Biological medications are not approved by the Food and Drug Administration (FDA) in the same manner as the more familiar small molecule medications. Instead of being approved under a New Drug Application (NDA), they are approved under a Biological Licensing Application (BLA). Drugs approved under an NDA are subject to generic competition once their patent expires. However, drugs approved under a BLA are not subject to generic competition after their patent expires because the United States Congress has not passed any law allowing the FDA to approve generics for drugs originally brought to market under a BLA.

Biological medications are by far the fastest growing segment for pharmacy costs nationwide, growing 18.4% this past year. Some of the costs are enormous, including North Dakota Medicaid recipients receiving single medications that cost \$200,000 or more per year. Examples of such biological medications are:

- Elaprase[®] for Hunter syndrome – only 2000 patients in the world have the disease, including one on ND Medicaid
- Fabrazyme[®] for Fabry's disease – only 2200 patients in the world have the disease, including one on ND Medicaid
- Aldurazyme[®] for Hurler syndrome – only 600 patients in the world have the disease, including one on ND Medicaid

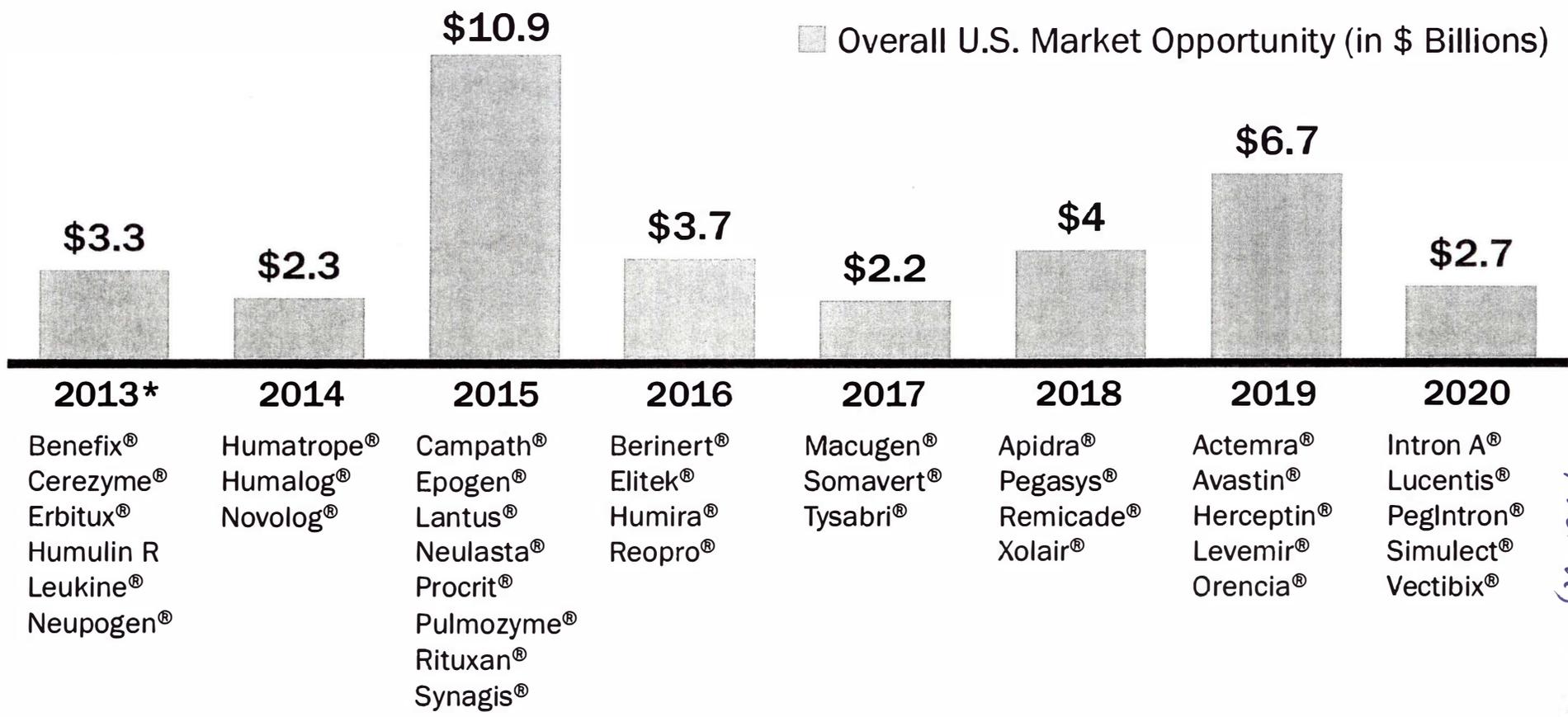
North Dakota Medicaid tracks prescriptions that cost greater than \$1000 per month. These medications account for 16% of North Dakota Medicaid's pre-rebate drug spend, and an even higher percentage of the post rebate spend as the effective rebate percent for biological medications is lower than the Medicaid average. It is also worth noting that many of these biological medications are only available through limited distributorship models involving only out-of-state pharmacies.

Given these enormous costs, any additional requirements placed on pharmacists and physicians beyond what is current practice for normal generic substitution will impact the expenditures for North Dakota Medicaid because the generic substitution rate will decrease.. Senate Bill 2190 was amended to remove the additional requirements (page 2, lines 3-6), so the Department did not have a fiscal note attached to the bill. Since the additional requirements were amended back into the Re-Engrossed version of Senate Bill 2190, the Department prepared the fiscal note.

I would be happy to answer any questions.

\$38.2 Billion Biosimilar Opportunity

68 biotech products with patent expirations through 2020



*Includes all drugs with patent expirations through 2012

Source: U.S. Drug spend estimates are based on IMS Health data for 2011 (if available), manufacturer reported U.S. sales or a percent of manufacturer reported worldwide annual sales of the drug. The patent expiration dates of the biologic products is current as of November 2012. The availability of biosimilars is highly variable due to litigation, patent challenges, FDA's establishment of a aBLA pathway, or other factors.

*SB 219 D
Mar 11, 2013 #7
6 pages*

Biosimilars in EU

Summary

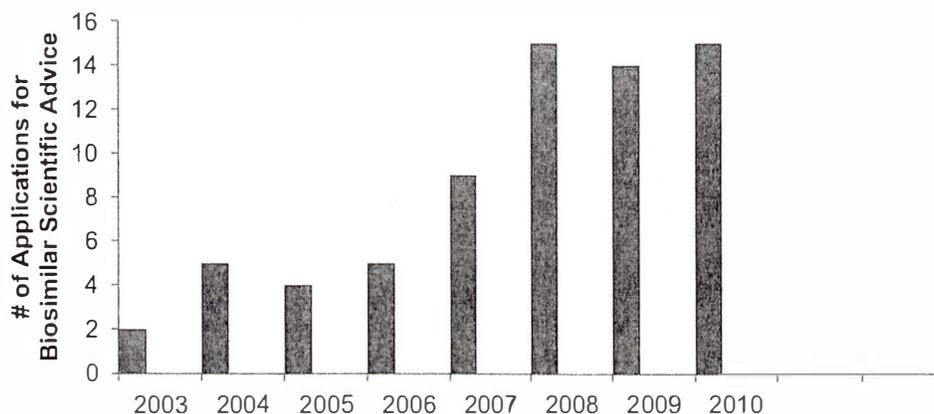
Biosimilars have been widely and safely used in Europe since 2006. In 2004, the European Commission (EC) passed legislation creating a biosimilars approval pathway (Directive 2001/83/EC Directive 2004/27/EC). In 2005 and 2006, the European Medicines Agency (EMA) released its first set of biosimilar guidelines, and in 2006, approved its first biosimilar. To date, there have been 14 biosimilars authorized, with biosimilar monoclonal antibodies expected soon. Despite a rigorous monitoring, tracking, and tracing system, Europe has identified no safety problems with biosimilars.

What has been the EU approach to regulating biosimilars?

EMA requires a stepwise head-to-head comparison between the biosimilar and the reference product to demonstrate similar levels of quality, safety and efficacy. Depending on the similarity of the quality profile, non-clinical and clinical testing may be reduced for biosimilars compared to a new biologic. Any differences in levels of quality between the biosimilar and its reference require the sponsor to satisfactorily explain potential implications of the quality difference on product safety and efficacy. FDA's Feb. 2012 biosimilar guidance uses a similar approach.

EMA allows biosimilar extrapolation to other indications once the biosimilar has been established as sufficiently comparable to its reference. Extrapolation means inferring conclusions from data using one or more indications to other indications in which there hasn't been the same analysis. Other aspects of EMA regulation of biosimilars include: biosimilars shares the same International Nonproprietary Name (INN) as its reference; each biosimilar has a unique brand name or the name of the active substance with the company name; and automatic substitution of brand drug for its biosimilar is regulated by each member state in the EU.

Increasing Number of Applicants Seeking Scientific Advice for Biosimilars in EU



What does the EMA require to ensure biosimilar safety after approval?

All manufacturers are required to submit a Risk Management Plan (RMP) to the EMA. All medicines marketed in the EU require such a plan to detect, assess, and prevent adverse

events be submitted to EMA. For EMA to approve the RMP, the sponsor must demonstrate how it will monitor for safety, minimize risk, and be updated regularly throughout a product's lifecycle.

To date, there have been no specific safety concerns identified for approved and marketed biosimilars based on EMA's monthly reports from its Pharmacovigilance Working Party. EMA has recently provided online access to suspected side-effect reports in all official EU languages.

EU Guidance on Biosimilars

Overarching Biosimilar Guidelines	<ul style="list-style-type: none"> ▪ General ▪ Quality Issues (updated 2012) ▪ Non-clinical and Clinical Issues 		
Product Specific Biosimilar Guidelines	<table style="width: 100%; border: none;"> <tr> <td style="border: none;"> <ul style="list-style-type: none"> ▪ Insulin ▪ Somatropin ▪ G-CSF ▪ FSH ▪ Epoetin </td> <td style="border: none;"> <ul style="list-style-type: none"> ▪ LMW heparin ▪ IFN-alpha ▪ IFN-beta ▪ Monoclonal antibodies </td> </tr> </table>	<ul style="list-style-type: none"> ▪ Insulin ▪ Somatropin ▪ G-CSF ▪ FSH ▪ Epoetin 	<ul style="list-style-type: none"> ▪ LMW heparin ▪ IFN-alpha ▪ IFN-beta ▪ Monoclonal antibodies
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Other Relevant Guidelines	<ul style="list-style-type: none"> ▪ Comparability- Quality Issues ▪ Comparability- Non-clinical and Clinical Issues ▪ Immunogenicity 		

Approved Biosimilars in Europe

Product Name	Active Substance	Manufacturer	Authorization Date
Abseamed	epoetin alfa	Medice Arzneimittel Pütter GmbH&Co KG	2007
Binocrit	epoetin alfa	Sandoz GmbH	2007
Biograstim	filgrastim	CT Arzneimittel GmbH	2008
Epoetin alfa Hexal	epoetin alfa	Hexal AG	2007
Filgrastim Hexal	filgrastim	Hexal AG	2009
Filgrastim Ratiopharm	filgrastim	Ratiopharm GmbH	2008
Nivestim	filgrastim	Hospira UK Ltd	2010
Omnitrope	somatropin	Sandoz GmbH	2006
Ratiograstim	filgrastim	Ratiopharm GmbH	2008
Retacrit	epoetin zeta	Hospira UK Limited	2007
Silapo	epoetin zeta	Stada R&D AG	2007
Tevagrastim	filgrastim	Teva Generics GmbH	2008
Valtropin	somatropin	BioPartners GmbH	2006
Zarzio	filgrastim	Sandoz GmbH	2009

Biosimilar Products Not Approved/ Withdrawn in EU

Product Name	Active Substance	Manufacturer	Status	Year
Alpheon	interferon alfa	BioPartners GmbH	<ul style="list-style-type: none">• Negative opinion• Not comparable to reference product• Clinical and non-clinical studies indicated differences	2006
Biferonex	interferon beta-1a	BioPartners GmbH	Withdrawn after negative opinion	2009
Epostim	epoetin alfa	Reliance Genemedix	Withdrawn	2011
Insulin	insulin	Marvel Life Sciences	<ul style="list-style-type: none">• Withdrawn• Incomplete comparability exercise• Inadequate validation of manufacturing process• Batch traceability missing	2007
Ratioepo	epoetin theta	Ratiopharm GmbH	Withdrawn after positive opinion due to administrative reasons	2010

Biosimilar Legislation – Premature and Unnecessary

Legislation Premature and Unnecessary

- Draft legislation is circulating in some states that attempts to impede or limit biosimilar substitution.
 - What is a biosimilar?
 - A biosimilar is a biological product that is highly similar to a U.S.-licensed reference biological product notwithstanding minor differences in clinically inactive compounds. Just like traditional brand and generic drugs, there are no clinically meaningful differences between the approved biosimilar product and the reference biologic product in terms of their safety, purity, and potency.¹
 - **Currently, the U.S. Food and Drug Administration (FDA) is in the process of creating a pathway for the approval of biosimilars and determining interchangeability – state legislation on this issue would be extremely premature.**
 - There are **NO** biosimilars in the United States marketplace right now.
 - There is **NO** patient safety issue because the interchange of biologic products cannot occur without prescriber approval.
- The FDA is fully cognizant of the complex nature of biologics and has made clear that the standards they develop for determining whether a biologic is interchangeable with an approved reference product will be rigorous.
- Additionally, the FDA is the only U.S. regulatory body with the scientific expertise to determine interchangeability. If the FDA approves a biosimilar as interchangeable, the interchangeable biosimilar should be substitutable as is the case with generics for branded drug products.
- States enacting any law that addresses biosimilars would be premature and may conflict with the national standards the FDA is developing.

Brand Manufacturers' Motive – Go Around FDA to Protect Bottom Line

- Brand manufacturers are misleading legislators by claiming the FDA is going to approve biosimilars without guidelines for interchangeability and thus substitutions will automatically occur. **This is not true.**
 - **Until interchangeability is determined by the FDA – no substitutions can occur even if there was a “biosimilar” in the marketplace. Biosimilars do not meet the traditional definition of a “generic” and thus cannot be substituted under current state substitution laws.**
- When the brand biologic medications go off patent, the brand manufacturers will see a significant drop in their profits – the average daily cost of a brand name biologic product is approximately 22 times greater than a traditional drug.ⁱⁱ
- It is in their financial interest to up-end the FDA's role and expertise in this area and to intentionally create confusion in state substitution laws – thus increasing the potential benefit to their own bottom line.
- As with generic medications today, the availability of biosimilars will give patients greater access to life-saving medications while saving significantly on the cost of their health care.
- **Premature legislation that impedes or limits biosimilar substitution is nothing more than an attempt by brand manufacturers to pre-emptively protect profit margins at the expense of consumers and payers.**

¹ FDA definition of a Biosimilar.

<http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/TherapeuticBiologicApplications/Biosimilars/ucm241718.htm>

ⁱⁱ Hilary Krame, Why Biologics Remain Expensive, *Forbes* (2009) <http://www.forbes.com/2009/12/03/kramer-health-care-intelligent-investing-pharmaceuticals.html>



GENERIC PHARMACEUTICAL ASSOCIATION

Biosimilars: The Future of Affordable Medicine

A **biosimilar** is a biological product that is highly similar to a U.S.-licensed reference biological product notwithstanding minor differences in clinically inactive compounds. Just like traditional brand and generic drugs, there are no clinically meaningful differences between the approved biosimilar product and the reference biologic product in terms of their safety, purity, and potency.ⁱ The Biologics Price Competition and Innovation Act of 2009 created an abbreviated pathway for FDA to give approval to biologics that are biosimilar, or interchangeable with, already approved biologic reference products. FDA is in the process of establishing standards for the approval of biosimilars, including standards for interchangeability.

Considering FDA is in the early stages of developing standards, GPhA strongly cautions against enacting substitution rules.

- **Biologics Treat a Variety of Diseases:** Including cancer, AIDS, psoriasis, heart disease, rheumatoid arthritis, asthma, and multiple sclerosis, among others.
- **Brand Biologics are Expensive:** The average daily cost of a brand name biologic product is approximately 22 times greater than a traditional drug.ⁱⁱ
- **Biologics are the Future of Medicine** By 2016 it is predicted that eight of the top ten drugs on the market will be biologics.ⁱⁱⁱ
- **The Price of Brand Biologics Keeps Growing:** US average annual spending growth from 2002 to 2007 was 16% for biologics, compared with 3.7% for drugs. This price trend will be a significant cost driver for publicly financed health care programs including Medicare and Medicaid.
- **Biologics can be made Accessible:** When biologics go off patent, the generic industry is ready to make them widely accessible. Biosimilar leaders in the generic industry have been successfully producing safe and effective biosimilars for sale outside the U.S. since the early 2000s. The biosimilars market is primed to take off, as the generic drug market did after the 1984 Hatch-Waxman Act.
- **Biosimilars Arc Safe and Save Money:** Biosimilars have been used in Europe for several years and without any safety issues. Like generic drugs, biosimilars will generally cost less than their branded counterparts. A recent European study determined 8 EU countries could save up to \$40.7 billion by 2020 by utilizing biosimilars.^{iv} Patients and governments will significantly benefit from the savings generated by interchangeable biosimilars.
- **Interchangeability:** The FDA is fully cognizant of the complex nature of biologics and has made clear that the standards for determining whether a biologic is interchangeable with an approved reference product will be rigorous.

FDA is the only U.S. regulatory body with the scientific expertise to determine interchangeability. If FDA approves a biosimilar as interchangeable, the interchangeable biosimilar should be substitutable as is the case with generics for branded drug products. States enacting any law that addresses biosimilars would be premature, and even worse, may conflict with the national standards FDA is developing.

- **The Campaign Against Access:** There is concern that legislation will be introduced in the states which will impede or limit biosimilar substitution. In 2011 legislation in Illinois proposed several unnecessary and burdensome conditions to be met before an interchangeable biologic could be substituted for the reference brand biologic product.^v This legislation failed due to staunch opposition.

January 28, 2013

Biotech Firms, Billions at Risk, Lobby States to Limit Generics

By ANDREW POLLACK

In statehouses around the country, some of the nation's biggest biotechnology companies are lobbying intensively to limit generic competition to their blockbuster drugs, potentially cutting into the billions of dollars in savings on drug costs contemplated in the federal health care overhaul law.

The complex drugs, made in living cells instead of chemical factories, account for roughly one-quarter of the nation's \$320 billion in spending on drugs, according to IMS Health. And that percentage is growing. They include some of the world's best-selling drugs, like the rheumatoid arthritis and psoriasis drugs Humira and Enbrel and the cancer treatments Herceptin, Avastin and Rituxan. The drugs now cost patients — or their insurers — tens or even hundreds of thousands of dollars a year.

o companies, Amgen and Genentech, are proposing bills that would restrict the ability of pharmacists to substitute generic versions of biological drugs for brand name products.

Bills have been introduced in at least eight states since the new legislative sessions began this month. Others are pending.

The Virginia House of Delegates already passed one such bill last week, by a 91-to-6 vote.

The companies and other proponents say such measures are needed to protect patient safety because the generic versions of biological drugs are not identical to the originals. For that reason, they are usually called biosimilars rather than generics.

Generic drug companies and insurers are taking their own steps to oppose or amend the state bills, which they characterize as pre-emptive moves to deter the use of biosimilars, even before any get to market.

“All of these things are put in there for a chilling effect on these biosimilars,” said Bryanna M

Clark, director of state affairs for the Generic Pharmaceutical Association. The

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...n't sound too onerous but undermine confidence in these drugs and are bu

Genentech, which is owned by Roche, makes Rituxan, Herceptin and Avastin,

cancer drugs in the world. Amgen makes Enbrel, the anemia drugs Epogen and Aranesp, and the drugs Neupogen and Neulasta for protecting chemotherapy patients from infections. All have billions of dollars in annual sales and, with the possible exception of Enbrel, are expected to lose patent protection in the next several years.

The trench fighting at the state level is the latest phase in a battle over the rules for adding competition to the biotechnology drug market as called for in the Patient Protection and Affordable Care Act of 2010.

A related battle on the federal level is whether biosimilars will have the same generic name as the brand name product. If they did not, pharmacists could not substitute the biosimilar for the original, even if states allowed it.

Biosimilars are unlikely to be available in the United States for at least two more years, though they have been on the market in Europe for several years. And the regulatory uncertainty appears to be diminishing enthusiasm among some companies for developing such drugs.

“We’re still dealing with chaos,” said Craig A. Wheeler, the chief executive of Momenta Pharmaceuticals, which is developing biosimilars. “This is a pathway that neither industry nor the F.D.A. knows how to use.”

Biotech drugs, known in the industry as biologics, are much more complex than pills like Lipitor or Prozac.

That makes it extremely difficult to tell if a copy of a biological drug is identical to the original. Even slight changes in the cells that make the proteins can change the drug’s properties.

The 1984 law governing generics does not cover biologicals, which barely existed then. That is why it was addressed in the 2010 law.

One reason generic pills are so inexpensive is that state laws generally allow pharmacists to substitute a generic for a brand-name drug unless the doctor explicitly asks them not to. That means generic drug manufacturers need not spend money on sales and marketing.

The bills being proposed in state legislatures would expand state substitution laws to include biosimilars. So Amgen and Genentech say the bills support the development of biosimilars.

But the bills would impose restrictions that do not apply to chemically produced pills. For a substitution, they say, the Food and Drug Administration must find a biosimilar “interchangeable” with the branded product. The F.D.A. has said interchangeability will be a higher standard than merely being similar to the branded product.

Some of the bills would also require patient consent for the substitution, for the pharmacist to notify the doctor if a switch is made and for the pharmacist and doctor to maintain records of the switch for years.

Lobbyers say these safeguards are necessary to enable the tracing of any safety problems that might arise with a biosimilar.

“These are really complex, highly sensitive molecules,” said State Senator Patricia Vance of Pennsylvania, who plans to introduce a bill. “We want to make sure we are not hurting people.”

The generic drug association and insurers do not object to limiting substitution to drugs declared interchangeable by the F.D.A.

But they say that once the F.D.A. makes that determination, the other restrictions are unnecessary and are there merely to deter substitution.

Gillian Woollett, who tracks biosimilars for Avalere Health, a Washington advisory firm, said extra restrictions on substitution could put the state bills into conflict with the federal law, which defines interchangeability as meaning that a biosimilar can be substituted without the involvement of the prescribing doctor.

Ms. Woollett said the lobbying efforts by the biotech companies, which she characterized as “putting a few more tree trunks on the road,” might not make much difference as long as insurers have policies encouraging use of the biosimilars. She noted that only a small percentage of biologicals are dispensed through retail pharmacies. Most are infused or injected in a hospital or doctor’s office. That has not reduced the intensity of the skirmishes in state houses.

Dr. John O’Bannon III, a Republican delegate who introduced the bill that was passed last week in the Virginia House, said he did so because as a practicing neurologist, he was familiar with biologicals. Then he added, “The Amgen folks actually did come and talk to me.”

Amgen gave \$22,000 to Virginia state legislators in both 2011 and 2012, more than double the \$11,000 it gave in 2010, according to the Virginia Public Access Project. Dr. O’Bannon received \$1,500 over the last two years.

In North Dakota, a bill has cleared a committee in the State Senate, though it was amended to remove some restrictions.

Amgen was the one that brought the bill to me,” said State Senator Dick Dever, a Republican, who introduced the bill.

In Indiana on Monday, the House Public Health Committee approved a bill, but lawmakers, responding to objections from the generic association, removed the requirement that patients consent to any substitution. Ed Clere, chairman of the committee and author of the bill, said the bill “doesn’t do anything to prevent or discourage the use of biosimilars.” He said the bill had been brought to him by Genentech and supported by Eli Lilly, which is based in Indiana.

Also supporting the push for such legislation is the Alliance for Safe Biologic Medicines.

This is not the first time drug companies have turned to states to try to blunt generic competition. In the late 1990s, DuPont Merck Pharmaceutical pushed for laws that would restrict substitution for its blood-thinning drug Coumadin, known generically as warfarin, on the grounds that the drug was extremely difficult to use safely.

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REPORT 1 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-11)
An Abbreviated Approval Pathway for Biosimilars
(Reference Committee K)

11 pages

EXECUTIVE SUMMARY

Objective. The existence of a biosimilar approval pathway raises several questions related to the requirements for approval, drug efficacy and patient safety, potential cost savings, clinical acceptance, substitution practices, off-label uses, naming and pharmacovigilance, and the educational needs of prescribers. This report reviews the current status of biosimilar implementation in the U.S., examines the preceding issues in this context, and refines current AMA policy in this area.

Methods. English-language reports were selected from a PubMed and Google Scholar search from 2005 to August 1, 2011 using the MeSH terms “biological products/*economics/therapeutic use,” “therapeutic equivalency,” and “drug approval/*legislation,” and using the text terms “biosimilar(s),” or “follow-on biologics.” Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of the U.S. Food and Drug Administration (FDA), the United States Adopted Names Council, the World Health Organization, and the European Medicines Agency. Additionally, some verbiage in this report is synonymous with comments previously submitted by the AMA in response to an FDA public hearing regarding the approval pathway for biosimilar and interchangeable biological products held on November 2, 2010.

Results. A two-tiered framework for an abbreviated approval pathway for biological products that are “highly similar” (i.e., biosimilar) to, or further demonstrated to be “interchangeable” with an FDA-licensed biological product has been established in the U.S. General guidance on the specific requirements for a biosimilar application has not been forthcoming from FDA, but is expected by the end of the year. Achieving biosimilarity is a two-part test with products having to demonstrate on a structural basis that they are highly similar and that they exhibit “no clinically meaningful differences” compared with the reference product. The European experience indicates that biosimilarity can be achieved through the use of appropriate preclinical analytical and toxicity studies, product purity and biological activity, results of comparative clinical trials, and monitoring for immunogenicity.

Conclusion. The AMA supports a science-driven, abbreviated approval pathway for biosimilars that prioritizes product efficacy and patient safety and provides FDA with the latitude and necessary authority to determine whether no clinically meaningful differences exist on a case-by-case basis between the proposed biosimilar and reference product in terms of safety, purity, and potency. The European experience indicates that therapeutically equivalent biosimilars can be successfully approved using an abbreviated pathway. Patient safety remains a primary concern including the potential for immunogenicity and the substitution of biosimilar products. General agreement exists that a process must be in place for product-specific safety monitoring of biosimilars and to prevent confusion among prescribers and patients; part of this process will revolve around non-proprietary naming issues. Substitution practices in the outpatient arena should be governed by the same standards that apply to A-rated traditional generic products.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-I-11

Subject: An Abbreviated Approval Pathway for Biosimilars

Presented by: Lee R. Morisy, MD, Chair

Referred to: Reference Committee K
(D. Robert McCaffree, MD, Chair)

1 INTRODUCTION

2
3 The Patient Protection and Affordable Care Act contains a subtitle (Biologics Price Competition
4 and Innovation Act of 2009 or BPCI) that establishes an abbreviated approval pathway for so-
5 called “follow-on” biologic drugs or “biosimilars” for existing products whose patent protection
6 has expired.¹ This framework is similar in concept to the Drug Price Competition and Patent Term
7 Restoration Act of 1984 (commonly referred to as the Hatch-Waxman Act), which established an
8 Abbreviated New Drug Application process for generic drugs. Passage of the Hatch-Waxman Act
9 both encouraged the development of new innovator drugs by extending patent rights and
10 established procedures facilitating the approval of low-cost generic drugs. Generic drugs are
11 approved for marketing based on an average bioequivalence approach to assure interchangeability
12 of generic and brand name reference products, thus obviating the need to conduct additional
13 clinical trials.

14
15 The driving force for establishing a science-based abbreviated approval pathway for biosimilars is
16 the recognized benefit, but very high cost of many of these products. However, in contrast to the
17 process for generic drug approval, an abbreviated biosimilar approval pathway will likely require
18 clinical trial data to verify the safety and efficacy of these complex molecules. Therefore,
19 biosimilar development costs are still likely to be substantial and are not expected to generate the
20 same cost savings as small molecule generic drugs. One estimate from the Congressional Budget
21 Office placed the potential cost savings at approximately \$300 billion by 2029.² The European
22 biosimilar market indicates that a 25% cost savings can be expected based on the experience with
23 biosimilar erythropoietin products.³

24
25 Current AMA policy supports the existence of an abbreviated pathway for the approval of
26 biosimilar products, which retains appropriate patent protection for innovator companies but also
27 facilitates the approval of biosimilar products while ensuring patient safety and preserving the
28 authority of physicians to select the specific products their patients receive (Policies H-125.980, D-
29 125.989, AMA Policy Database).

30
31 The existence of a biosimilar approval pathway raises several questions related to the requirements
32 for approval, drug efficacy and patient safety, potential cost savings, clinical acceptance,
33 substitution practices, off-label uses, naming and pharmacovigilance, and the educational needs of
34 prescribers. This report reviews the current status of biosimilar implementation in the U.S.,
35 examines the preceding issues in this context, and refines current AMA policy in this area.

1 METHODS

2
3 English-language reports were selected from a PubMed and Google Scholar search from 2005 to
4 September 1, 2011 using the MeSH terms “biological products/*economics/therapeutic use,”
5 “therapeutic equivalency,” and “drug approval/*legislation,” and using the text terms
6 “biosimilar(s),” or “follow-on biologics.” Additional articles were identified by manual review of
7 the references cited in these publications. Further information was obtained from the Internet sites
8 of the U.S. Food and Drug Administration, the United States Adopted Names Council, the World
9 Health Organization, and the European Medicines Agency. Additionally, some verbiage in this
10 report is synonymous with comments previously submitted by the AMA in response to an FDA
11 public hearing regarding the approval pathway for biosimilar and interchangeable biological
12 products held on November 2, 2010.

13
14 BIOLOGICS IN THE U.S.

15
16 *Biologics--Definition*

17
18 Biologics comprise a wide range of products including vaccines; blood and blood components;
19 allergenic extracts and allergen patch tests; somatic cells, human cells or tissue intended for
20 implantation, transplantation, infusion, or transfer into a human recipient; and recombinant
21 therapeutic proteins. Biologics are regulated separately from other drugs under federal law. The
22 Biologics License Application (BLA) is a request for permission to introduce, or deliver for
23 introduction, a biologic product into interstate commerce (21 CFR 601.2). The BLA is regulated
24 under 21 CFR 600–680.

25
26 Depending on the biologic product category, regulation is under the domain of either the Center for
27 Biologics Evaluation and Research (CBER) or the Center for Drug Evaluation and Research
28 (CDER). On June 30, 2003, FDA transferred some of the therapeutic biological products that had
29 been reviewed and regulated by CBER to CDER.⁴ CBER retains authority over: (1) vaccine and
30 vaccine associated products; (2) allergen patch tests and allergenic extracts used for the diagnosis
31 and treatment of allergic diseases; (3) blood, blood components, plasma derived products, blood
32 substitutes, plasma volume expanders, and polyclonal antibody preparations including radiolabeled
33 forms, as well as related products such as cell separation devices, blood collection containers and
34 HIV screening tests that are used to prepare blood products or to ensure the safety of the blood
35 supply; (4) human cellular and tissue-based products intended for implantation, transplantation,
36 infusion, or transfer into a human recipient;⁴ (5) antitoxins, antivenins, and venoms; and, (6) gene
37 therapy products. Although the FDA has not yet approved any human gene therapy product for
38 marketing, it regulates products intended to introduce genetic material into the body to correct the
39 function of faulty, or replace missing, genetic material.

40
41 Biologic products now regulated by CDER include: (1) monoclonal antibodies for *in vivo* use; (2)
42 proteins intended for therapeutic use, including enzymes (e.g., thrombolytics), and other novel
43 proteins including therapeutic proteins derived from plants, animals, or microorganisms and
44 recombinant versions of these products; (3) immunomodulators (e.g., cytokines, chemokines,
45 growth factors, and other proteins) acting in an antigen-specific fashion and intended to treat
46 disease by inhibiting or modifying a pre-existing immune response; and (4) growth factors,
47 cytokines, and monoclonal antibodies intended to mobilize, stimulate, decrease or otherwise alter

⁴ CBER does not regulate the transplantation of vascularized human organ transplants such as kidney, liver, heart, lung or pancreas. The Health Resources Services Administration oversees the transplantation of vascularized human organs.

1 the production of hematopoietic cells *in vivo*. These therapeutic biologic products currently
2 regulated by CDER are the major focus of biosimilar development.

3 4 *Biosimilar Approval Pathway*

5
6 Under the BPCI, a sponsor may seek approval of a “biosimilar” product under new section 351(k)
7 of the Public Health Service Act that establishes an abbreviated approval pathway for biological
8 products that are “highly similar” (i.e., biosimilar) to, or further demonstrated to be
9 “interchangeable” with an FDA-licensed biological product.⁵

10
11 Thus, a two-tiered framework was established as follows:

12
13 Biosimilar products are “highly similar to the reference product notwithstanding minor
14 differences in clinically inactive components” and exhibit “no clinically meaningful differences
15 between the biological product and the reference product in terms of the safety, purity, and
16 potency of the product.”¹ The BPCI Act requires that an application for a proposed biosimilar
17 product include information demonstrating that the proposed product is highly similar to the
18 reference product based on analytical, animal, and/or clinical studies, and that the FDA at its
19 discretion can determine what is necessary to designate such a product as biosimilar (see Table
20 1 for specific statutory requirements).

21
22 In order to meet the higher standard of interchangeability, the sponsor must demonstrate that an
23 interchangeable biologic product “produces the same clinical result as the reference product in
24 any given patient” and the “risk in terms of safety or diminished efficacy of alternating or
25 switching between use of the biological product [biosimilar] and the reference product
26 [originator/brand] is not greater than the risk of using the reference product without such
27 alteration or switch.” Furthermore, the BPCI states that “the [interchangeable] biological
28 product may be substituted for the reference product without the intervention of the health care
29 provider who prescribed the reference product.”

30 31 *FDA Implementation of the BPCI Act*

32
33 General guidance on the specific requirements for a biosimilar application has not been
34 forthcoming from FDA, but is expected by the end of the year. Achieving biosimilarity is a two-
35 part test:

36
37 First, the biosimilar must be “highly similar.” While small molecule drugs and their generic
38 equivalents are chemically synthesized, therapeutic biologics are synthesized by living cells or
39 organisms and are considerably larger in size and more complex in structure. Therapeutic
40 biologics are developed by identifying and cloning the genetic sequence encoding the active
41 protein, inserting the cloned DNA sequence into a unique living cell line that will carry out
42 translation of the biologic protein, expanding and maintaining the cultured cells to support large-
43 scale biologic protein production,^β harvesting and purifying the biologic product, and developing a
44 stable dosage form. In order to be therapeutically active, the proteins must exhibit a specific set of
45 structural features, including their primary amino acid sequence, secondary post-translational
46 modifications (e.g., glycosylation), and tertiary folding native to the specific protein structure.
47 Because biologics are generated from a unique cell line and are harvested through a complex and

^β Approximately 90% of currently approved biologic products are produced using cultured *E. coli*, yeast, or mammalian cell (e.g., chinese hamster ovary cells) lines.

1 sensitive process, any change to this process could affect the key structural features of the final
2 product, potentially modifying its pharmacologic effects or immunogenicity.

3
4 Second, the biosimilar must exhibit “no clinically meaningful differences” compared with the
5 reference product. This demonstration will require some combination of comparative analytic
6 characterization, *in vitro* pharmacologic and/or toxicologic assessments and functional assays,
7 human pharmacokinetic equivalence determinations, and a randomized comparative clinical
8 trial(s). Meeting the “highly similar” standard may permit some reliance on what is known about
9 the safety and effectiveness of the reference product (extrapolation), but this should be allowed
10 only when scientifically justified and the mechanism of action is established.

11
12 The FDA has indicated that review and approval of a biosimilar application will be a risk-based
13 exercise relying on the totality of the evidence.⁶ Under this scenario, the amount of clinical data
14 required will likely be influenced by the complexity of the product, its formulation, and the
15 intended indications or clinical population (e.g., oncology versus rheumatology). In the meantime,
16 FDA is not precluded from approving biosimilar or interchangeable products in the absence of
17 industry guidance. The Agency also is currently negotiating a user fee structure with the industry
18 for biosimilar applications.

19 20 *Comparability versus Highly Similar*

21
22 Pharmaceutical companies that develop and market therapeutic biologics sometimes make
23 manufacturing-related changes. The International Conference on Harmonization Guideline 5 on
24 comparability (Quality of Biotechnological Products) notes that after manufacturing changes, the
25 new product needs to be compared against the old product in a step wise process from chemical-
26 physical comparability and other analytical/pharmacologic studies to clinical studies, if needed.⁷
27 After changes in manufacturing, the demonstration of comparability does not necessarily mean that
28 the quality attributes of the pre-change and post-change products are identical, but that they are
29 highly similar. Thus, a process already is in place to compare biologics emerging from a revised
30 production process with an existing product.

31
32 During the public debate on biosimilars, it has often been stated that due to the complexity of the
33 manufacturing process for biologics and use of unique cell lines, another manufacturer cannot
34 create an exact copy. Despite the complexity of biologic production, innovator companies that
35 changed one or more elements in their manufacturing process have been able to demonstrate
36 largely through analytic techniques that the resulting product is “comparable” to the original
37 product. For example, Rituxan®, Herceptin®, and Enbrel® each underwent post-approval changes
38 in their manufacturing processes (e.g., manufacturing site or cell line) but were not required to
39 conduct new clinical efficacy trials for each indication.⁸ On the other hand, in some cases,
40 additional clinical trials have been required to demonstrate that the “new” product retains the safety
41 and efficacy profile of the original product (e.g., Aranesp®, Epogen®).⁸ When the initial
42 manufacturing process for Epogen® was replaced with what was thought to represent a more
43 efficient process, subsequent clinical trials failed to demonstrate comparable efficacy with the
44 previous product and the new manufacturing process was abandoned.

45 46 EUROPEAN EXPERIENCE WITH BIOSIMILARS

47
48 While the abbreviated pathway for approval of biologics is new and as yet untested in the U.S, the
49 European Union under the aegis of the European Medicines Agency (EMA) has had general
50 guidance in place since 2005 and has published a number of specific guidance documents on non-
51 clinical, clinical, and quality issues for biosimilars.⁹⁻¹¹ In Europe, biosimilarity is established by an

1 appropriate comparability exercise that examines preclinical analytical and toxicity studies, the
2 product's purity, physicochemical properties and biological activity, results of comparative clinical
3 trials (usually), and monitoring for immunogenicity. The EMA also has issued guidelines on
4 specific biologic classes, including insulin, somatropin, granulocyte-colony stimulating factor, a
5 draft guidance on monoclonal antibodies, and concept papers on low-molecular weight heparins
6 and interferon alfa. European regulations have no equivalent to the "interchangeable" designation
7 in the BPCI and European countries currently do not allow automatic substitution of a biosimilar.
8 Fourteen biosimilars of three reference products (erythropoietin, filgrastim, somatropin) have been
9 approved by the EMA since 2006 (Table 2).¹²

10 11 PATIENT SAFETY ISSUES

12 13 *Immunogenicity*

14
15 Because an exact copy of a biologic cannot be made with current technology, patient safety is a
16 primary concern including the potential for immunogenicity and the substitution of biosimilar
17 products. However, immunogenicity issues are not unique to biosimilars but rather reflect the fact
18 that all biologics have the potential to be immunogenic and human responses cannot be predicted
19 by animal studies. Risk factors for human immunogenic responses to a biologic product include
20 the structure of the biologic, use of the subcutaneous rather than intravenous route of
21 administration, the patient's genotype and immune status, and the duration of exposure. Therefore,
22 risk mitigation strategies for biosimilars should be no different than that of originator products. All
23 biologic products require a sufficient period of human exposure during clinical trials and vigilant
24 post marketing surveillance.

25 26 *Pharmacovigilance and Naming*

27
28 General agreement exists that a process must be in place for product-specific safety monitoring and
29 recalls of biosimilars, and to prevent confusion among prescribers and patients. Part of this process
30 involves the name of the drug or biologic. In the U.S., nonproprietary names are issued by the
31 United States Adopted Names (USAN) Council, a tripartite organization headquartered at the
32 AMA and also sponsored by the American Pharmacists Association and the United States
33 Pharmacopeia.¹³ In addition, the FDA cooperates with and is represented on the USAN Council.
34 Using established rules of nomenclature based on chemical structure and class, the nonproprietary
35 (USAN) name eventually adopted by the Council is synonymous with the "generic" name of the
36 drug product. Adopted USANs are submitted to the World Health Organization's International
37 Nonproprietary Name (INN) expert panel for deliberation (including linguistic evaluation) and
38 approval in order to harmonize drug nomenclature internationally.

39
40 The naming of biologics is complicated by three issues.

41
42 (1) Several nonproprietary names for biologics were assigned 20 to 30 years ago in the absence of a
43 biosimilar framework. For example several interferons are marketed in the U.S. Interferon was
44 published as an INN in 1962 and the name was revised in the 1980s when human interferon and its
45 variations *alfa*, *beta* and *gamma* were produced by recombinant DNA technology.¹⁴ Arabic
46 numbers are used to distinguish subspecies that differ in primary amino acid sequence but are still
47 considered to be in one of the primary groups, and small lower case numbers are used to subdivide
48 such groups further on the basis of less significant differences, such as post-translational
49 modifications, including glycosylation (e.g., interferon alfa-1a, interferon alfa-2b, interferon alfa-
50 n3, interferon-alfacon-1). Pegylated versions carry the "Peg" prefix. Similar examples exist for
51 botulinum toxin (A or B) and epoetin (alfa, beta, zeta, Darbepoetin).

1 (2) The advent of a biosimilar approval pathway in the European Union prompted the need to
2 distinguish different products. The INN program coordinated by the WHO instructed that
3 biosimilars should have unique brand names but recommended against unique INNs for non-
4 glycosylated products. For the latter, Greek letters are used to indicate differences in glycosylation
5 (See Table 2).
6

7 (3) The BPCI is silent on the topic of naming and FDA Guidance is currently lacking on the
8 requirement for the U.S. abbreviated pathway for biosimilar approval. Up to this point, the USAN
9 Council has harmonized the naming of biologics with the WHO INN Program. Because the BPCI
10 is silent on naming, the USAN Council will have to rely on the FDA to make a determination
11 regarding unique naming conventions for biosimilars in the U.S.
12

13 It also has been argued that assigning unique names to biosimilars would assist in identifying
14 adverse events associated with specific products. However, the USAN (or INN) is only one of
15 several components that together constitute the surveillance system for marketed drugs and
16 biologics, including the product or brand name, the manufacturer, a unique NDC number for each
17 product (even when it is a multisource product) and lot number. The existing system relies on a
18 combination of these markers for initiating recalls linked to a problem with a specific product and
19 has generally worked effectively. For example, in September 2010, there was a recall of Epogen®
20 and Procrit® which was due to a lot-specific problem across multiple manufacturing sites.¹⁵ If the
21 USAN was the seminal unit for analysis, a much larger recall of the entire product off the
22 marketplace would have occurred, not just limited to those specific lots in which the complications
23 were noted. It also is possible that unique naming of biosimilars may introduce confusion by
24 implying that such products are not clinically comparable. Conceptually, biosimilar products that
25 are deemed interchangeable by the FDA should have the same USAN, while products that are not
26 interchangeable but merely biosimilar could be distinguished in some minor way through use of
27 prefixes, Arabic numerals, or Greek letters added to the USAN stem.
28

29 *Substitution* 30

31 Although the BPCI provides that “interchangeable products may be substituted for the reference
32 product by a pharmacist without the intervention of the prescribing health care provider,” the AMA
33 believes that the congressional intent was to treat biosimilars categorized as interchangeable in the
34 same way that traditional A-rated generic medications are managed. With interchangeable A-rated
35 generic medications, physicians in every state have the authority to designate which product
36 (branded or generic) is dispensed. Only when the prescriber is silent on the issue of substitution or
37 proactively authorizes substitution can the pharmacist act independently to dispense A-rated
38 generic drugs.
39

40 Congress did not intend to pre-empt state laws authorizing physicians to make such a designation
41 for biosimilars. Furthermore, physicians cannot be compelled to prescribe a reference biological
42 product, a biosimilar, or an interchangeable biological product. An alternative interpretation of the
43 statute would be inconsistent with basic rules of construction governing preemption and would
44 require a very high regulatory approval bar for deeming a biosimilar as interchangeable given the
45 potential safety risks and medical consequences associated with substitutions between reference
46 biological products and biosimilars. Automatic substitution by a pharmacist in the outpatient
47 setting should not be permissible with biosimilars that do not meet the regulatory standard for
48 interchangeability. On the other hand, pharmacy and therapeutics committees acting under an
49 established formulary system will evaluate, appraise, and select from among the numerous
50 available drug and biological products those that are considered most useful in patient care in the
51 inpatient setting.

1 *Off-Label Use*

2
3 It is not established whether the FDA will allow clinical data on the use of a biosimilar in one
4 condition to be extrapolated to all labeled indications for the reference product where the
5 mechanism of action is the same. Thus, the clinical decision to use a biosimilar off-label will be
6 somewhat more challenging than with small molecule generic drugs.

7
8 CONCLUSION

9
10 The AMA supports a science-driven, abbreviated approval pathway for biosimilars that prioritizes
11 product efficacy and patient safety and provides FDA with the latitude and necessary authority to
12 determine whether no clinically meaningful differences exist on a case-by-case basis between the
13 proposed biosimilar and reference product in terms of safety, purity, and potency. A substantially
14 higher hurdle should exist with respect to the data that is required by the FDA for the designation
15 of a biosimilar product as interchangeable. The European experience indicates that biosimilars can
16 be successfully approved using an abbreviated pathway and that they can be therapeutically
17 equivalent in safety and efficacy.

18
19 It is important that the appropriate balance be struck in implementing the BPCI so that the
20 development of biosimilars is encouraged, but regulatory barriers do not unnecessarily impede
21 biosimilar development. The AMA supports an approach that provides exclusivity and patent
22 protections that promote innovation but does not unduly inhibit the competition needed to bring
23 biosimilar products to the market and reduce escalating costs.

24
25 It is important to recognize that the current substitution practices for small molecule generics are
26 regulated at the state level by Pharmacy Practice Acts, all of which permit the pharmacist to
27 substitute a generic equivalent if the prescriber consents to substitution on the prescription (e.g.,
28 may substitute) or remains silent. In each state, however, a mechanism also exists for the
29 prescriber to dictate which product is dispensed (i.e., “dispense as written,” “do not substitute,”
30 etc.). The same situation should apply to biosimilars. Because these products are injectable
31 formulations and many are administered in the hospital or affiliated care centers, Pharmacy and
32 Therapeutics Committees and third party payers will play prominent roles in determining patterns
33 of use in these settings.

34
35 Based on experiences with small molecule A-rated generic drugs, education of physicians and
36 patients on biosimilars will be needed. Despite substantial evidence to the contrary, some
37 prescribers believe that generic drugs are not therapeutically equivalent to the brand name product,
38 especially for narrow therapeutic index drugs. Biosimilars represent an even more complicated
39 scenario, although the extent to which this issue becomes relevant in the outpatient arena remains
40 to be seen. As the FDA develops the necessary guidance to implement the BPCI, the Agency
41 should develop a strategic plan and allocate significant resources to ensure that physicians
42 understand the distinctions between biosimilar products that are merely considered comparable,
43 and those that are deemed interchangeable. The strategic plan should include regular interaction
44 and feedback from medical specialty societies, at a minimum, and include components that
45 facilitate the establishment of partnerships between the FDA, industry, and physicians that promote
46 effective communication on drug and biological product concerns and issues.

47
48 RECOMMENDATIONS

49
50 The Council on Science and Public Health recommends that the following statements be adopted
51 and the remainder of the report be filed:

- 1 1. That Policy H-125.980 “Follow-on Biologic Medications” be renamed “Abbreviated Pathway
2 for Biosimilar Approval” and be amended by insertion and deletion as follows:
3

4 AMA policy is that pharmaceutical companies should be allowed to make ~~follow-on biologic~~
5 biosimilar medications available to physicians and their patients in a reasonable period of time
6 with a reasonably predictable pathway to bring them to market, ~~and Our AMA will advocate~~
7 for appropriate FDA Guidance and implementation of the Biologics Price and Competition Act
8 of 2009 enactment of federal law that would establish a follow-on biologic to be allowed on the
9 market, with two guiding principles: 1) a reasonable time frame for US Food and Drug
10 Administration exclusivity and patent expiration with a that: 1) includes a straightforward
11 regulatory process for an abbreviated approval pathway for biosimilars; follow-on biologic
12 competitors to be brought to market, and 2) places appropriate emphasis on the protection of
13 patient safety in both the original branded products and all biosimilar follow-on products that
14 are brought to market; and 3) includes planning by the FDA and the allocation of sufficient
15 resources to ensure that physicians understand the distinctions between biosimilar products that
16 are considered highly similar, and those that are deemed interchangeable.
17

- 18 2. That Policy D-125.989 “Substitution of Biosimilar Medicines and Related Medical Products”
19 be amended by insertion and deletion to read as follows:
20

21 Our AMA urges that State Pharmacy Practice Acts and substitution practices for biosimilars in
22 the outpatient arena: (1) mirror the current practices for A-rated generic drugs by preserving
23 the right of physicians and other prescribers to designate which product is dispensed to their
24 patients; (2) limits the authority of pharmacists to automatically substitute only those biosimilar
25 products that are deemed interchangeable by the FDA will: (1) monitor legislative and
26 regulatory proposals that to establish a pathway to approve follow-on biological products and
27 analyze these proposals to ensure that physicians retain the authority to select the specific
28 products their patients will receive; and (2) work with the US Food and Drug Administration
29 and other scientific and clinical organizations to ensure that any legislation that establishes an
30 approval pathway for follow-on biological products prohibits the automatic substitution of
31 biosimilar medicines without the consent of the patient’s treating physician.

Fiscal Note: Less than \$500

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SB 2190

#10

Mar 11

SB 2190

Mr Chairman and Members of the Human Services Committee

I'm Dan Ulmer representing Blue Cross Blue Shield of North Dakota and we strongly oppose this bill. At a minimum SB2190 is premature as there are presently no FDA approved biosimilar drugs available. From our perspective, this bill represents a classic case of a drug manufacturer protecting its brand name products by creating a roadblock to something that doesn't yet exist...biosimilar drugs.

If there were any FDA-designated biosimilar products available today, they may be discounted 10%, 20%, 30%, etc. off the originator product. Since there are zero FDA-designated biosimilar products on the market today, you can pick your number. The notification and recordkeeping requirements in this bill may reduce the chance that a pharmacist will make a biosimilar substitution by 5%, 10%, 15%, etc. Again, you can pick your number because there are no FDA-designated biosimilar products on the market today. On the other hand, there will be no biosimilar substitutions if there isn't a statute allowing substitution of FDA-designated biosimilars when they do become available.

Therefore if and when biosimilars become available this bill will have a chilling effect that is similar to the one we went through when generics first came on the market. Back then pharmacists, who know more about drugs than physicians, had to get a physician's permission to substitute generics up until statutes were passed to allow pharmacists to use their expertise when substituting a generic for a brand drug. This has not only improved the quality of care but saved patients billions of dollars in drug costs.

Obviously this bill is an attempt by the biologics industry to protect their brands by creating roadblocks that will increase the expense for those of us who actually have to pay their bills.

For instance, NDPERSs spent a bit over \$5,000,000 in 2012 on biologics. Given that there are a raft of other variables in this calculation let's say that the FDA approved a biosimilar drug that allowed a discount of 10%...NDPERS could save \$500,000/yr. However there are no FDA approved biosimilars today and given the FDA's approval process there most likely will not be any for a few years to come.

As such we oppose this bill based on the notion that it creates a problem similar to the scare tactics that the drug manufacturers used when generics came into the market. Secondly we see 2190 as premature and thus likely to significantly increase costs to our members (your constituents) while the states that fend off this type of legislation will be able to save their constituents from the substantial costs this bill would impose.

Thus it's our thinking that if 2190 is passed and biosimiars become available we will have no choice except to go through the angst of repealing this act. Therefore we oppose having this type of legislation imposed on the folks who pay the bills that this type of legislation creates.

Dan Ulmer

Blue Cross Blue Shield of North Dakota



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#11
SB 2190
11 Mar
2 pgs.

BOARD OF PHARMACY
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Jack Dalrymple, Governor

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Assistant Executive Director
Howard C. Anderson, Jr, R.Ph.
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SB 2190 – Biosimilar Biological Products

House Human Services Committee – Fort Union Room
10:30 AM – Monday – March 11, 2013

Chairman Weisz, members of the House Human Services Committee, for the record I am Mark J. Hardy, PharmD, Assistant Executive Director of the North Dakota State Board of Pharmacy. I appreciate the opportunity to be here to speak to you today on Senate Bill #2190.

I would like to provide our perspective of Biosimilar Biological Products, their current regulatory framework, with regards to the Food and Drug Administration [FDA] and provide our comments on this proposed legislation.

Biological medications are seen by many in the pharmacy community as the newest and brightest future of the pharmaceutical industry. These biological products are highly specified medications used to treat unique medical conditions and disease states. These biological medications are extremely expensive, with most medications being well over a \$1,000 per month of treatment. We hear expectations that the cost savings from biosimilar products, compared to the innovator biological products, are likely to be between 10 to 40% less. In 2008, the Congressional Budget Office estimated that biosimilars would save approximately \$25 billion over 10 years. The cost savings will add up very quickly for both facilities and patients when able to interchange biosimilar products for biologics. It is very important to note that we have not seen any biogeneric or biosimilar products enter the U.S. market place. So the information and research regarding the interchangeability of these products is very limited.

The FDA has taken some initial steps in regulating biosimilar products and their interchangeability. However, much of the information is not specific and likely not going to be until we begin to see biosimilars enter the market place. From our perspective, it is important that we ensure a proper framework is in place for the interchangeability of biosimilar products that is consistent with what the FDA expects and is not tremendously burdensome on the practitioners and pharmacists involved so as to be a disincentive to utilize the biosimilar products. As I mentioned earlier, there is going to be a tremendous cost savings.

The Board of Pharmacy does feel that it is important when interchanging biosimilar products for biologics, to adhere to the research based information from the FDA as to which can be interchangeable. This ensures that the patient is getting an equivalent product and that their care is consistent. This research on biosimilars is very limited.

We agree with section 2, b - that the practitioner should have the authority to ask for the brand product be dispensed when they feel it is in the best interest of the patient's care. This is consistent with the current law and a duplication of the same language currently in NDCC 19-02.

On section 2, c – Regardless of this section, we would expect a pharmacist to counsel the patient, consistent with our laws and rules, which covers the substitution of a generic, or in this case a biosimilar.

On section 2, d – we do not feel that this language is necessary, especially considering the products will be FDA approved for interchangeability. This may be a deterrent to the substitution of the more economical, yet interchangeable product. We feel the FDA will need to address a substitution framework for biosimilars, based on the clinical studies and evidence of the differences, as they are closer to approving them in the U.S. marketplace. We feel that federal uniform substitution requirements set by the FDA would be ideal for continuity.

On section 3 – the Board of Pharmacy will be happy to maintain an internet link to the Food and Drug Administration approved list of interchangeable biological and biosimilar products. The only issue we have is that we do not know if the FDA will even maintain such a list, but a list would certainly be a resource for our pharmacists.

In closing, we know biosimilar legislation is a common piece of legislation that is being introduced in many states and we certainly see the need to define the term interchangeability for biologics and biosimilars. We also want the substitution process to be consistent to utilize the apparent substantial cost savings of biosimilars, especially when they are deemed interchangeable by the FDA without any compromise in the patient care and safety.

I will be happy to answer any questions at this time.



3 pgs.

#12

SB 2190
11 Mar

Written Comments of the Generic Pharmaceutical Association to the House Committee On Human Services Re Senate Bill 2190

**Submitted by
Brynna Clark, Sr. Director of State Affairs**

Dear Chairman Weisz, Vice Chairman Hofstad, and Honorable Members of the Committee on Human Services,

The Generic Pharmaceutical Association (GPhA) represents the manufacturers and distributors of finished dose generic pharmaceuticals. Generic pharmaceuticals fill 80 percent of the prescriptions dispensed in the U.S. but account for only 27 percent of total drug spending. GPhA's members provide more than 90 percent of the generic medicines dispensed in the U.S.

GPhA respectfully requests that you oppose SB 2190. This bill allows for substitution of biosimilars and requires the pharmacist to notify the prescriber of the substitution. This creates a new pharmacy practice and is a typical brand play to thwart competition. Legislation like this is being pushed across the U.S. by two bio-tech companies who stand to lose \$60 billion dollars in patent expiry between 2012-2020. Their motives and end-game must be questioned as they do not have a compelling interest in allowing competition to their marketplace. SB 2190 is premature, it erects substitution barriers, implements a new pharmacy practice, and creates doubt about the safety and effectiveness of affordable biosimilar drugs.

Biologics and biosimilar drugs currently treat a variety of diseases such as cancer, HIV, and rheumatoid arthritis. Biosimilar leaders in the generic industry have been successfully producing safe and effective biosimilars for sale outside the U.S. since the early 2000s. This marketplace has opened up competition, lower costs, and more importantly, access.

A biosimilar is a product that is highly similar to a U.S.-licensed reference biological product notwithstanding minor differences in clinically inactive compounds, **and for which there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product.** The Biologics Price Competition and Innovation Act (BPCIA) of 2009, part of the Affordable Care Act, created an abbreviated pathway for the Food and Drug Administration to review and approve biologic medications that are biosimilar to already approved "reference products." FDA is currently establishing standards for approval of "biosimilars."

Once approved, FDA will separately make a determination if a biosimilar can be designated as "**interchangeable.**" According to FDA, a biosimilar deemed interchangeable will produce the same clinical result in a patient as the reference biologic. The patient will experience no greater risk from alternating or switching between the two products than if the patient was to continue using the reference product. Therefore, interchangeability = substitutability. The federal statute explicitly states: [Interchangeable biologic products] *"may be substituted for the reference product without the intervention of the prescribing healthcare provider."* (U.S.C. §262(i)(3)).



For years, FDA has reviewed and approved biologic reference products and the FDA will use the most rigorous standards to approve a biosimilar product and determine interchangeability. The agency has the skills and expertise to understand the complex nature of biologic products. The strict statutory standard for interchangeability, will render any additional state barriers to substitution completely unnecessary for patient protection. In addition to being unnecessary, these burdens would chill biosimilar substitution, and lead to increased health care costs for consumers and for the state of North Dakota.

Since the FDA has not issued final guidance, and biosimilars will not be on the marketplace before 2015 – with interchangeable biosimilars coming even further down the line – legislation at this stage premature. The FDA has not fully implemented the law, reviewed a biosimilar application, or deemed a product interchangeable. This legislation is being introduced before a single biosimilar is on the marketplace, making it impossible to put an accurate fiscal note on this legislation. However, the fiscal impact will no doubt be significant.

When biologics go off patent, the generic industry is ready to make them widely accessible to consumers. The biosimilars market is primed to take off, as the small molecule generic drug market did after the 1984 Hatch-Waxman Act. Brand-backed legislation like SB 2190 has been introduced in 15 states and is rumored in over 20 more, but has not been signed into law anywhere. This type of legislation was rampant in the 1980s when generic drugs first came on the market and we see the same types of bills every time a blockbuster drug is about to go off patent. “Carve Out” legislation not only treats a certain class of drugs differently, but it also undermines confidence in their safety and effectiveness.

North Dakota stands to benefit greatly from the introduction of lower-cost biosimilars. Biologics are a major cost driver for your state Medicaid program. Interchangeable biosimilars have the potential to initially reduce the price by 40 or 50 percent. The average daily cost of a brand name biologic product is approximately **22** times greater than a small-molecule drug and this area of drugs is growing. By 2016 it is estimated that 8 of the top 10 drugs in the United States will be biologics. In 2011 North Dakota portion of Medicaid costs for biologics was over **\$2.9 million dollars**. As more biologics are prescribed, this number will increase exponentially – with potentially dire budget consequences.

GPhA has always opposed legislation that creates special prescriber notification and/or consent for the substitution of products the FDA has deemed interchangeable, because it is bad public policy. There is no need for such as it is already in North Dakota law. Under current North Dakota law, prescribers have the ultimate authority to determine whether it is appropriate for a pharmacist to substitute biosimilars when issuing a prescription, by specifically indicating in their own handwriting: "brand medically necessary" on a written prescription. North Dakota Century Code 19-02.1-14.1(3).

The FDA is aware of these issues in the states and Dr. Hamburg, the FDA Commissioner commented that, *“The high standard for approval of biosimilar and interchangeable products mean that patients and healthcare professionals can be assured that when those products go to market, they will meet the standards of safety and efficacy and high quality that everyone expects and can count on. Efforts to undermine trust in these products is worrisome and represents a disservice to patients who could benefit from these lower cost treatments.”*¹

¹ Dr. Margaret Hamburg, M.D. Commissioner of the FDA, February 22, 2013,



In a time where employers are struggling to provide health benefits to their employees and states are looking for ways to balance Medicaid budgets, policymakers should focus on encouraging the use of safe and cost-effective medications and opening up competition in the biologics sector.

Please let us know if we can provide any additional information. Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Brynna Clark". The signature is written in a cursive style with a large initial "B".

Brynna Clark
Senior Director of State Affairs
Generic Pharmaceutical Association



#13
SB 2190
11 Mar
2 pgs.

SB2190- OPPOSE BIOSIMILAR bill
Monday, March 11, 2013
House Human Services
Josh Askvig- AARP-ND
jaskvig@aarp.org or 701-989-0129

Chairman Weisz and members of the House Human Services Committee. I am Josh Askvig, Associate State Director for Advocacy for AARP ND. We oppose SB2190.

AARP has long understood the importance of generic versions of biologic drug products and biosimilars as potential benefits to our members. The concept of affordable health care and the associated vigilance on health care related costs is one that AARP and its membership strongly supports.

The value and need for appropriate medication is something that speaks not only to our members, but to consumers of all ages. This legislation is premature, has the potential to negatively impact access to prescription medication, and may lead to affordability issues that could cripple consumers. We strongly encourage a more prudent, thoughtful discussion of how North Dakota will incorporate the guidance of the FDA with an emphasis on ensuring access to appropriate medication, based on the needs of the patients and the collaborative input of their health care providers.

AARP is voicing opposition to SB2190 because current FDA process for approval of biosimilars and determination of interchangeability is under development and is a draft guideline only. For example, the FDA was given explicit authority to review and approve biosimilars under the health-care-reform legislation of March 2010. There are differences in the approval processes for biosimilars and generic drugs because separate statutes govern the reference products. AARP believes it is extremely important that FDA have the flexibility and responsibility to determine, based on scientific evidence, those instances, in which biosimilar products can be designated as interchangeable with the reference products.

What's more, the enactment of premature state legislation may contradict federal standards as these are not yet known. In addition, until interchangeability is determined by the FDA, no biosimilar substitutions can occur. Not until March 2010 did the FDA have specific guidance or regulation of biosimilar product development and approvals. Those that have been approved were developed and reviewed as new products. The 2010 legislation created an approval, which includes analytical studies demonstrating that the biological product is "highly similar" to the reference product. In the past year, FDA issued its draft guidance for industry on biosimilars. As only nine biosimilars applications for development are currently submitted to FDA, it will be several years before biosimilars legislation at the state level is necessary. *AARP opposes any premature use of state resources for biosimilars administration.*

While North Dakota does have the authority to provide more strenuous limits on access to pharmaceuticals, exceptions to federal law regarding the safe substitution of medication has, to-date, focused on specific therapeutic classes of drugs rather than an entire type. Establishing state law that seeks to address substitution and access to an entire type of medication, prior to the establishment of a federal pathway and approval process, is extraordinarily premature. Further, such legislation has the potential to unfairly and

unreasonably restrict access to medications that would present significant cost savings to both the consumer and to the state. This legislation serves only those who seek to manufacture biologic pharmaceuticals and would harm the rest of the industry along with consumers, health care providers, and the state.

Access to pharmaceuticals, as well as the affordability of medication, is an issue that has direct impact on our members. Spending on biologics accounts for about one-fourth to one-fifth of total United States expenditures on prescription drugsⁱⁱ. Given biologics' use among older populations and the industry's overall movement that direction, it's extremely important that substitution remain possible if we don't want beneficiary and state costs to skyrocket.

AARP's position on SB2190 is that the legislation is extremely premature, as the biosimilar approval pathway is still under development. Furthermore, AARP does not support any language that would seek to restrict access to medication as well as negatively impact the affordability of care. Any legislation that unnecessarily impedes the substitution of medication in a reasonable and legitimate manner based upon evidence and in consultation with a prescriber, pharmacist and patient, is not in the best interest of our members or the population as a whole. AARP has long supported policies that ensure access to appropriate prescription medication at an affordable price. While we enter a new age in pharmaceutical care, we continue to support policies that ensure that all consumers have access to medications that are appropriate for their needs and affordable.

We encourage a DO NOT PASS Recommendation. Thank you for your time and I would be happy to try and answer any questions.

ⁱ Kolzowski, Steven, Janet Woodcock, Karen Midthun, and Rachel Behrman Sherman. "Developing the Nation's Biosimilars Program". NEJM. 365.5:385-388. 4 Aug 2011.

ⁱⁱ IMS Health; Express Scripts

Monday, March 11, 2013

#14
SB 2190
11 Mar

HOUSE HUMAN SERVICES COMMITTEE
SB 2190

2 pgs.

CHAIRMAN WEISZ AND COMMITTEE MEMBERS:

My name is Jack McDonald. I am appearing today on behalf of Prime Therapeutics. We strongly **oppose** SB 2190 and urge a **do not pass**.

The over arching issue here is that the bill is simply not necessary at this time. The FDA has not approved biosimilars for interchangeability and is not likely to do so in the next few years. When it does so it will make its scientific findings and issue guidelines for substitution.

However, the brand name manufacturers can't wait so they are trying to get a patchwork of legislation introduced around the country that will make this interchange or substitution more difficult. So far there are bills like SB 2190 introduced in 16 states other than North Dakota. Two states – Mississippi and Washington – defeated the legislation. Legislation is still pending in AZ, AR, CA, CO, FL, IL, IN, MD, MA, OR, PA, TX, UT and VA. No doubt in some of the states different versions of the bill will pass resulting in a confusing hodge podge of state regulations that should be uniform.

If this legislation is so vital, then what will happen in the states where there is no legislation? The answer is the same as what will happen in North Dakota without this legislation. Nothing.

This is not a patient safety issue. No biosimilars are being prescribed today because none are approved. There are no concerns about doctor and patient relationships...there are no concerns about pharmacy records...and there are no concerns about physician notificationbecause the problem does not exist.

The safety guidelines for interchangeability will be developed by FDA so that they are not different in each of the 50 states. However, by trying to get this patchwork of legislation enacted in various states, the manufacturers are doing their best to make sure substitution is as confusing, onerous and difficult as possible.

Prime exists to keep the cost of medications as low as possible for its client – Blue Cross and Blue Shield. It believes, as does U.S. Food and Drug Administration Commissioner Margaret Hamburg in her comments on the back side of this testimony, that legislation such as SB 2190 will only drive these costs up.

Therefore, we respectfully urge you to give this bill a DO NOT PASS. If you have any questions, I will be happy to try to answer them.

THANK YOU FOR YOUR TIME AND CONSIDERATION.

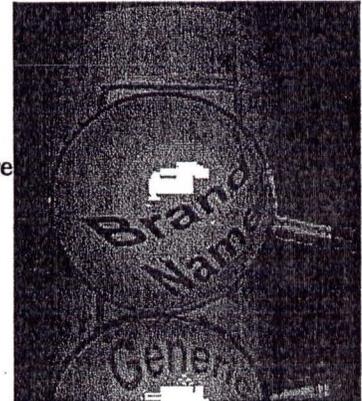
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US FDA defends biosimilar substitution Posted 01/03/2013

US FDA Commissioner Margaret Hamburg defended the substitution of interchangeable biosimilars at the Generic Pharmaceutical Association (GPhA) Annual Meeting which was held in Orlando, Florida, USA, on 20–22 February 2013.

Commissioner Hamburg said that attempts to undermine trust in biosimilars are 'worrisome and represent a disservice to patients who could benefit from these lower-cost treatments'. She added that 'substitutability helped spur the growth of the generic[s] industry and is similarly essential to help foster competition in the biological drug market. Ultimately, such competition will spur innovation, improve consumer choice and drive down medical costs.'

The comments came in response to actions by biotech giants Amgen and Genentech, which it is thought may limit the use of biosimilars in the US. Amgen and Genentech are lobbying US states to pass legislation that the generics industry says will create hurdles for the uptake of biosimilars [1]. Amgen, however, has denied the accusations, saying that the company believes that 'enhanced safety monitoring and transparency of substituted biologicals is in the interest of patient safety' [2].





NCSL

WOMEN'S LEGISLATIVE NETWORK NEWS

Winter 2013



WOMEN'S LEGISLATIVE NETWORK OF NCSL

11 Mar
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Note from the President

Hello,

I'd like to give a hearty welcome and congratulations to all the women who are beginning your first terms in the legislature. This is a very exciting time. As you settle in to your new role, I hope you will turn to the National Conference of State Legislatures for assistance and ideas. NCSL staff will give you well-researched and balanced information about any policy issue from A to Z and are available to provide technical assistance in your state. NCSL training materials will give you the tools you need to be effective. Through my participation with NCSL, I have learned about human trafficking and veteran supports and taken that information back to Nebraska.



The Women's Legislative Network exists to promote the participation, empowerment and leadership of female legislators. We bring together women from the 50 states to learn from one another and rejoice in our common bond. I recently enjoyed participating in a roundtable discussion about advice for newly elected women. This "webinar" is archived on the Network website, and I hope you will take the time to listen. We had a lot of fun sharing stories and recounting what we wish we had known when we were first elected.

To all female legislators, new and veteran, I hope you will stay involved with the Network in 2013 and beyond. I am always interested to hear your ideas for meetings and workshops. We are planning events for NCSL's Spring Forum in May and the Legislative Summit in August, so stay tuned. In the meantime, please keep us informed of events involving women in your state, whether it is a meeting of a women's legislative caucus, a women's day at the capitol, or the female high school students you mentor. I look forward to meeting many of you at NCSL events, and I wish each of you success in 2013!

Amanda McGill
State Senator, Nebraska
Acting President, Women's Legislative Network of NCSL

Join Us!

NCSL Spring Forum | May 2-4, 2013 | Denver, Colorado

The Women's Legislative Network will host events at the Spring Forum. May is a beautiful month in Colorado, so consider joining us if your schedule permits. Check the Network website for more information.

Events at the NCSL Fall Forum

December 4-7, 2012 | Washington, D.C.

For complete meeting information and handouts, visit www.ncsl.org Go 25500.

Improving Women's Health: Research, Innovation and Leadership

This preconference for legislators and legislative staff featured lively discussion among women's health experts and meeting participants. Session topics included an overview of women's unique health care needs from the Centers for Disease Control and Prevention; a discussion of several state women's health initiatives; and a panel about women, Alzheimer's and long-term care. The second day of the meeting featured a special workshop with trainer Morag Barrett about cultivating winning relationships. Participants also were asked to review and comment on a draft of an NCSL publication about women's health that will be released soon.

Expanding Employment for Military Veterans

Labor and Economic Development Committee, Task Force on Military and Veterans' Affairs, Women's Legislative Network

This session featured several examples of work being done to expand and grow job opportunities for our military veterans and ensure that they receive the benefits they deserve. Speakers were from the Department of Veterans Affairs, VetJobs.com, Humana Inc. and the Boot Campaign.

Leadership Workshop: Tough Conversations

Legislative Effectiveness Committee and the Women's Legislative Network

This workshop was led by trainer Morag Barrett of Skye Associates. She shared tips about how to prepare for and get through difficult conversations in our professional and personal lives.

Roundtable Discussion

Legislators gathered for an informal roundtable discussion about the 2012 election, top issues for state legislatures and ideas for Network programming in 2013.

Sharing Our Views

Sharing Our Views provides an opportunity for some of our most dedicated Alliance members to express their perspectives. If you would like to see your company's viewpoint included in the next edition, contact Katie Ziegler at (303) 856-1514 or katie.ziegler@ncsl.org.

In the last decade, significant advances in the treatment of serious medical conditions, such as rheumatoid arthritis and cancer, became possible because of our ability to make human proteins using recombinant DNA technology. These products are known as biologics.



More recently, “biosimilars”—subsequent versions of biological medicines that share the same mechanism of action and have the same therapeutic indications as the originator biologics—promise safe, efficacious and less-costly treatments. Biosimilars have been widely and safely used in Europe since 2006.

In the United States, there was no formal regulatory approval pathway for biosimilars prior to the Biologics Price Competition and Innovation Act of 2009 (BPCIA.) The law specifies that the FDA may approve a product as a biosimilar or as an interchangeable biosimilar. It defines an interchangeable biosimilar as one where switching between the biosimilar and its reference product creates no greater risk than using the reference product alone.

The substitution of traditional generic drugs is governed by states, not the FDA. States likely will want to consider amending their existing drug substitution laws or regulations to accommodate biosimilars and interchangeable biosimilars. The AMA has concluded that, for biosimilars, “Substitution practices in the outpatient arena should be governed by the same standards that apply to A-rated traditional generic products.”

Appropriately, Congress charged the FDA with making interchangeability determinations since it is the only agency that sees the data. State governments will want to recognize this scientific expertise and the FDA decisions when they update laws or regulations governing substitution. In this way, patient safety will be assured, enabling state savings and increasing access to these important products.

Walmart's Global Women's Economic Empowerment Initiative

In September 2011, Walmart launched its Global Women's Economic Empowerment Initiative, an effort that leverages our global size and scale to improve women's lives across the world. By working with leaders of Non Governmental Organizations, philanthropic groups, academia and other partners, by the end of 2016 we aim to:



Increase Sourcing from Women-Owned Businesses:

- Source \$20 billion from women-owned businesses in the United States and double sourcing from women suppliers in international retail markets.
- Launch a dedicated women-owned product marketplace on walmart.com.

- Train 200,000 women for their first jobs in retail in our emerging markets through partnerships with NGOs, public schools, multilateral institutions and universities.

Empower Nearly 1 Million Women Through Training:

- Implement a women's empowerment program to train 60,000 women in 150 factories and processing facilities that are producing for top retail suppliers in industries with high percentages of women.
- In emerging markets, train 500,000 women in the agriculture value chain.
- Empower 200,000 women through job training, education, career counseling and mentoring in the United States through Walmart Foundation giving targeted at workforce readiness for women.

Promote Diversity and Inclusion Representation Within Our Merchandise and Professional Services Suppliers:

- In the United States, work with our major professional service firms and merchandise suppliers with more than \$1 billion in sales to increase women and minority representation within the Walmart-facing teams.
- Internationally, focus on gender balance of supplier teams starting with global accounts.

We're embedding these goals within our business. We also will support these goals with more than \$100 million in grants from the Walmart Foundation and corporate donations, making economic opportunity for women one of the largest areas of focus for Walmart's philanthropic giving. For more information, please visit www.walmartstores.com.

Editorial: Improper Efforts to Limit Competitive Drugs

February 9, 2013

The New York Times

The New York Times

Two big biotechnology companies, Amgen and Genentech, are lobbying state legislatures to limit competition to their biological drugs that will lose patent protection in the next several years. Before taking any action, lawmakers should wait for guidance from the Food and Drug Administration, the agency that reviews all drugs and their generic versions for safety and effectiveness.

Biological drugs are made from large molecules, and the processes, involving living cells, are more complex than those used to make conventional drugs. The cheaper competitors to brand-name biological drugs are called "biosimilars" to indicate that they are not exact copies but are close enough to work the same way.

American consumers, insurers and health care providers could potentially save billions of dollars a year by using cheaper versions of brand-name biologicals that now cost tens or hundreds of thousands of dollars a year per patient. States should not move to limit access to biosimilar drugs before the F.D.A. has issued final guidelines on how to ensure their safety. In their lobbying campaign, revealed by Andrew Pollack in *The Times* recently, the two companies have persuaded legislators to introduce bills that would restrict the ability of pharmacists to substitute cheaper biosimilars in filling prescriptions.

The Affordable Care Act empowered the Food and Drug Administration to use an accelerated process to determine whether a biosimilar drug could be deemed "interchangeable" with the brand-name drug for clinical purposes. Once a biologic is deemed interchangeable, it can be substituted by pharmacists without permission from a doctor. Biosimilars are unlikely to be available in this country for at least two years, though more than a dozen have been approved in Europe with no evidence of adverse consequences.

Amgen and Genentech say they want state laws to protect patient safety. But it makes more sense for the states to see what the F.D.A. does first before

imposing administrative hurdles on pharmacists and patients -- like requiring a patient's consent every time a substitution is made -- when using less expensive biosimilar drugs.



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One Down, 13 To Go: A Biosimilar Bill Falls Flat

By Ed Silverman // [February 8th, 2013](#) // 9:16 am

[1 Comment](#)



As more than a dozen state legislatures mull over bills that would make it more difficult to allow substitution of biosimilars, at least one effort appears to have gone nowhere. Despite identical bills that were introduced in the state Senate and House in Mississippi, the twin pieces of legislation failed to proceed to committee votes and, as a result, cannot be reintroduced in the current legislative session.

This apparently marks the first such defeat for a closely watched effort by such big biotechs as Genentech and Amgen to thwart rivals from having easy entry to their lucrative markets. Over the past few weeks, you may recall, legislators in several states have been introducing bills that would allow interchangeable biosimilar substitution, but only if more cumbersome conditions are met by prescribing physicians and pharmacies ([back story](#)).

A key condition noted in the bills is that a biosimilar must have been deemed by the FDA to be interchangeable with the prescribed medicine for the specified indicated use (read the two Mississippi bills [here](#) and [here](#)). The legislation was hatched even though the FDA has not yet approved a biosimilar yet or decided whether a biosimilar is interchangeable with a brand-name biologic.

As we reported previously, there is debate about interchangeability. The Alliance for Safe Biologic Medicines, a group that includes Amgen (AMGN), Genentech and the BIO trade group, wants clear lines drawn for substitution, such as giving physicians authority to specify “do not substitute” and that such an option should override any policy from payers or state law that would have substitution be the standard or default practice ([see more here](#)).

Conversely, the American Pharmacists Association, the National Association of Chain Drug Stores and the National Community Pharmacists Association support automatic substitution of interchangeable biosimilars and believe that if the FDA grants interchangeability pharmacists should be able to automatically substitute biosimilars under the provision of the Public Health Service Act.

“The push for these new measures has nothing to do with safety and everything to do with Amgen and Genentech, two biotech Goliaths, trying to thwart competition,” said Ralph Neas, ceo of the Generic Pharmaceutical Association, which also opposes the legislation. “With

US biotechs "lobbying states to restrict access to biosimilars"

WORLD NEWS | FEBRUARY 04, 2013

LYNNE TAYLOR

Industry and consumer groups are urging action against what they say is lobbying by biotechnology companies of US state legislators aimed at restricting access to biosimilar versions of branded biologic drugs.

The protests follow a report in the New York Times that Amgen and Genentech are proposing bills that would restrict the ability of pharmacists to substitute generic versions of brand-name biologics which, it says, now cost patients or their insurers "tens or even hundreds of thousands of dollars a year." The Virginia House of Delegates approved such a bill last month, by a 91-6 vote, and similar legislation has been introduced in at least eight states since the new legislative sessions began in January, with others pending, it says.

Related Links

[Physicians concerned at biosimilar "confusion," study shows](#) [US FDA urged over biosimilars](#) [Amgen calls for clinical trial clarification on biosimilars](#) [Biosimilars: physicians cite concerns over supporting data](#)

The Pharmaceutical Care Management Association ((PCMA), which represents pharmacy benefit managers (PBMs), has condemned the companies' actions, saying they are designed to pre-empt moves now underway at the Food and Drug Administration (FDA) to create a pathway for approval of biosimilars by "creating a flurry of state laws that will conflict with the FDA's forthcoming national standards."

"Creating a patchwork of duelling state and federal rules would make it harder for pharmacists to know when they can dispense a biosimilar. That would raise costs for patients and their employers, who typically cover two-thirds of prescription drug benefit costs," says the Association.

And industry group the Generic Pharmaceutical Association (GPhA) describes the efforts as "a pre-emptive strike by Amgen and Genentech designed to choke the flow of safe and affordable life-saving biologic medicines to patients" - even before they have received FDA approval.

"This is unfortunate because it puts profits ahead of the patients who need these treatments but many times cannot get them because of their prohibitive high cost," says the GPhA. "While in the guise of supporting biosimilar efforts, Amgen and Genentech are making every effort to limit consumer and patient access to safe and effective biosimilars in the future," it adds.

Amgen has said that state efforts to create substitution rules for interchangeable biologics will help accelerate successful implementation of the biosimilars pathway, and that it is helping to educate stake policymakers on the issues that need to be considered, to ensure that physicians, patients and pharmacists share important information about biologic substitution.

"Amgen endorses state policies that would put patients first and, in doing so, increase confidence in the biosimilar pathway. It is important to have consistent policies in place at the federal and state level," said Scott Foraker, vice president and general manager of biosimilars at the company.

Nevertheless, seniors' group the Association of Mature Americans (AMAC) is calling on its members, their families and friends to urge their local and federal lawmakers to act to protect access to generics.

"Biosimilar pharmaceuticals may be a special class of drugs but they represent a potential opening shot in a new war against generics," AMA president Dan Weber warns.

"The big drug companies are targeting generic versions of such important brands as Humira [adalimumab] and Enbrel [etanercept], which treat rheumatoid arthritis, and Herceptin [trastuzumab], Avastin [bevacizumab] and Rituxan [rituximab], which target cancer. If they succeed, it could put treatment out of the reach of many seniors, particularly those on fixed incomes," he says.

And in an interview on the Fox Business News channel, AMAC spokesman Andrew Mangione called for leadership on the issue from both the Administration and the FDA.

"We're in uncharted territory," said Mr Mangione. "The federal government has to work in concert with drug organisations to make sure they come up with a fair and equitable solution, but they should not do it on the backs of senior citizens."

- The Pharmaceutical Research and Manufacturers of America (PhRMA) has commented that, as states consider legislation specific to biosimilars substitution, "we believe it essential that patient safety be the utmost priority."

Biosimilar Legislation – Myths vs. Facts

MYTH: This legislation creates a clear pathway under state law for the substitution of biosimilar drugs.

FACTS:

- Currently, there are no biosimilars in the United States marketplace today that have been approved under section 351(k) of the Public Health Service Act (42 U.S.C. § 262). **In fact, Food and Drug Administration (FDA) Commissioner Margaret Hamburg stated on February 22, 2013 that the FDA has not yet received an application for a biosimilar drug.**
- Any legislation enacted in the states that addresses biosimilars would be premature and may conflict with the national standards the FDA is currently developing.
- This legislation actually puts in place numerous hurdles to substitution, including notifying the patient and prescriber that the prescribed drug has been approved by the FDA as an interchangeable biosimilar product.
- This legislation is clearly being pushed by brand manufacturers in order to protect their bottom line. When brand biologic medications go off patent, brand manufacturers will see a significant drop in their profits. It is in their financial interest to up-end the FDA's role and expertise in this area and to intentionally create confusion in state substitution laws.

MYTH: Substitution of biosimilar drugs will automatically occur because there is no state law governing their substitution.

FACTS:

- Brand manufacturers are misleading legislators by claiming the FDA is going to approve biosimilars without guidelines for interchangeability and thus substitutions will automatically occur. This is not true.
- Until interchangeability is determined by the FDA – **no** substitutions can occur, even if there was a “biosimilar” in the marketplace. Biosimilars do not meet the traditional definition of a “generic” and thus cannot be substituted under current state substitution laws. Therefore, there is no patient safety issue because the interchange of biologic products cannot occur without prescriber approval.
- According to the FDA Commissioner: “[t]he high standards for approval of biosimilar and interchangeable products means that patients and health care professionals can be assured that when those products go to market, they will meet the standards of safety, efficacy and high quality that everyone expects and count on. **Efforts to undermine trust in these products are worrisome and represent a disservice to patients who could benefit from these lower-cost treatments.**”

MYTH: States must take the lead because the FDA is not moving quickly enough on this issue.

FACTS:

- The FDA is fully cognizant of the complex nature of biologics and has made clear that the standards they develop for determining whether a biologic is interchangeable with an approved reference product will be rigorous.
- Additionally, the FDA is the only U.S. regulatory body with the scientific expertise to determine interchangeability. If the FDA approves a biosimilar as interchangeable, the interchangeable biosimilar should be substitutable as is the case with generics for branded drug products.
- The FDA is currently in the process of creating a pathway for the approval of biosimilars and determining interchangeability. Commissioner Hamburg recently stated that the FDA is working toward finalizing draft guidance to the industry on biosimilar development.