

March 1, 2014

Federal Trade Commission
Office of the Secretary
Room H-113 (Annex X)
600 Pennsylvania Avenue NW
Washington, DC 20580

Re: Comments on Workshop on Follow-On Biologics: Project No. P131208

Dear Sir or Madam:

On behalf of AbbVie, Inc., I submit these comments concerning certain issues raised during the public workshop on biosimilars that the Federal Trade Commission (FTC) held on February 4, 2014.¹ AbbVie appreciated the opportunity to present at the workshop research on pharmacovigilance and patient welfare considerations related to biosimilar naming.² Our written comments address statements that stakeholders made at the workshop concerning: (1) the effect that current and proposed state laws requiring pharmacists to notify the prescribing physician of biosimilar substitution could have on biosimilar uptake in the United States; and (2) the effect that distinguishable nonproprietary names have had on biosimilar uptake internationally.³

AbbVie is a global, research-based biopharmaceutical company formed in 2013 following separation from Abbott Laboratories. We are dedicated to developing and marketing advanced therapies that address some of the world's most challenging and serious diseases. The focus of our discovery and development efforts include hepatitis C, neuroscience, immunology, oncology, renal disease, and women's health. We are committed to bringing medical innovation to more patients cost effectively, and we appreciate the efforts of the FTC and the Food and Drug Administration (FDA) in seeking public input on implementation issues related to the Biologics Price Competition and Innovation Act (BPCIA).⁴

¹ See "Notice of workshop and request for comments," 78 Fed. Reg. 68840 (Nov. 15, 2013) (announcing a "Public Workshop: Follow-On Biologics: Impact of Recent Legislative and Regulatory Naming Proposals on Competition").

² I presented on the topic "Reference Biologic Perspectives on Naming" and participated in the "Naming and Pharmacovigilance" panel discussion.

³ We also support the comments submitted by the Pharmaceutical Research and Manufacturers of America (PhRMA) in relation to this workshop, and in particular, the critical patient safety considerations discussed in the comments.

⁴ Pub. L. No. 111-148, Title VII, Subtitle A, 124 Stat. 119, 804-821 (2010).

I. Evidence Suggests That State Laws Requiring Prescriber Notification Do Not Impede Uptake of Generic Drugs

Several stakeholders at the workshop suggested that state substitution bills requiring a pharmacist to notify the physician *after* a biosimilar is dispensed instead of the prescribed product (automatic substitution) would significantly impede uptake of biosimilars. AbbVie’s research from an analogous context suggests that this concern is baseless.

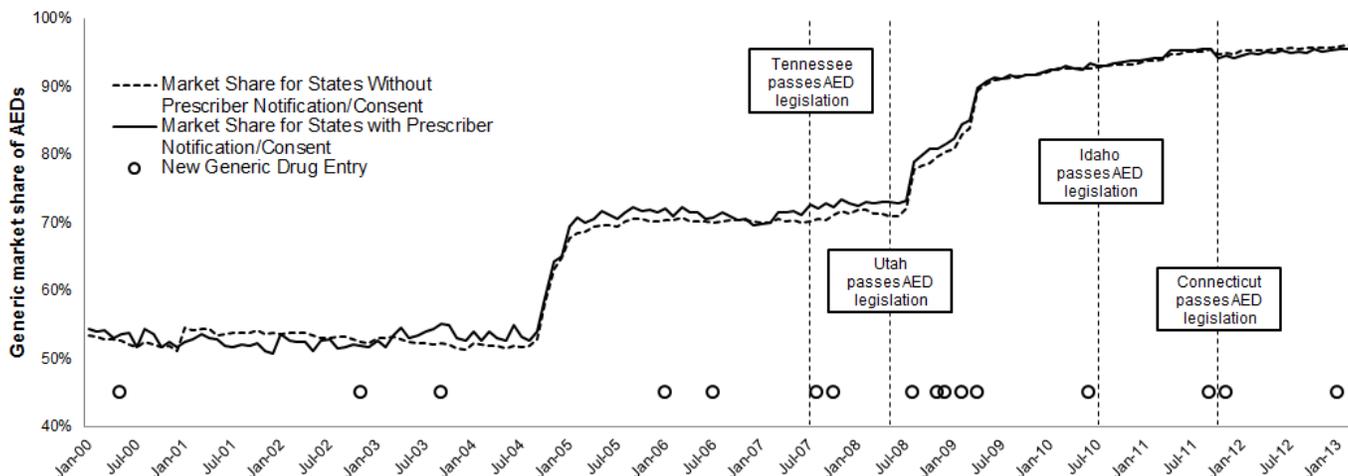
Several states have laws requiring that a pharmacist (1) seek the prescriber’s consent before automatically substituting certain generic anti-epileptic drugs (AEDs) for the prescribed drug or (2) notify the physician before or after such substitution has occurred. This is because research on AEDs has demonstrated that generic versions of some of these small molecule drugs may have subtle differences when compared to their innovative counterparts.⁵ Many AEDs are thus considered narrow therapeutic index (NTI) drugs, which means that even small differences in dose or concentration of the drug in the body could lead to potential therapeutic differences or adverse reactions. Although some of these state laws require prescriber consent *before* generic substitution (rather than biosimilar substitution bills that would merely require physician notification *after* substitution has occurred), they provide a proxy for gauging the potential market impact of requiring pharmacists to take steps in addition to those required for typical small-molecule drug automatic substitution.

AbbVie compared the uptake of AEDs in states that have a requirement for physician notification/consent with the uptake of AEDs in states without such requirements.⁶ As demonstrated in the chart below, we found that AEDs have nearly identical market share in states

⁵ See, e.g., Fitzgerald, CL, & Jacobson, MP, “Generic substitution of levetiracetam resulting in increased incidence of breakthrough seizures,” ANNALS OF PHARMACOTHERAPY 45: e27 (May 2011); Wilner, AN, “Therapeutic equivalence of generic antiepileptic drugs: results of a survey,” EPILEPSY & BEHAVIOR 5: 995-998 (2004); Medicines and Healthcare products Regulatory Agency, Drug Safety Update, vol. 7(4) A1 (Nov. 2013) (noting that “[d]ifferent ... AEDs ... vary considerably in their characteristics, which influences the risk of whether switching between different manufacturers’ products of a particular drug may cause adverse effects or loss of seizure control”).

⁶ Based on our research, the states that have enacted and implemented AED-specific substitution laws are Connecticut, Hawaii, Idaho, North Carolina, Tennessee, and Utah. To assess market share, we used the OptumHealth Reporting and Insights claims database, which is a claims database for private insurers covering 14 million beneficiaries in the United States. To compile the list of innovative AEDs of interest and their corresponding generic versions, we relied on the following sources: (1) FDA’s “Approved Drug Products with Therapeutic Equivalence Evaluations” (Orange Book), available at <http://www.accessdata.fda.gov/scripts/Cder/ob/default.cfm>; (2) the New York University Comprehensive Epilepsy Center, “Medications,” at <http://epilepsy.med.nyu.edu/diagnosis-treatment/medications#sthash.ITMRegvY.dpbs>; (3) Medi-Span’s Master Drugs Database, at <http://www.medispan.com/master-drug-database.aspx> (we selected from this commercial database Generic Product Identifier Codes associated with anticonvulsants); and (4) Pharmaprojects, at <http://www.citeline.com/products/pharmaprojects/> (we selected from this commercial database drugs with the therapy code corresponding to Anticonvulsants, Antiepileptics, and Epilepsy).

with prescriber notification/consent requirements when compared to states without such requirements.⁷



These data thus suggest that prescriber notification/consent requirements do not limit uptake of AEDs in any meaningful way. It is therefore reasonable to expect that a requirement for after-the-fact notification of biosimilar substitution similarly would not meaningfully limit biosimilar uptake.

II. Evidence Suggests that Distinguishable Names Have Not Impeded Biosimilar Uptake Internationally

At the workshop, a representative from Sandoz asserted that the distinguishable nonproprietary names assigned by national regulators to epoetin biosimilars in Japan and Australia have “reduce[d] market penetration [of] and consumer access [to]” those products.⁸ Sandoz asserted that the distinguishable names of biosimilar epoetins have contributed to disparity between the market uptake of biosimilar epoetin and innovative somatropins in Japan and between biosimilar epoetin and biosimilar filgrastims in Australia. These claims are unfounded. Sandoz misconstrued the data it cited and evidence shows significant uptake of biosimilar epoetins with names distinguishable from the reference product.

First, Sandoz presented no evidence that a product’s nonproprietary name was responsible for any differences in prescriptions of biosimilar epoetin, biosimilar filgrastim, and

⁷ Additional information concerning this analysis is provided in Attachment C. Underlying data are on file with AbbVie.

⁸ Presentation by Mark McCamish, Global Head Biopharmaceutical Development, Sandoz, “Effect of Naming on Competition and Innovation,” at slides 42, 43 (Attachment A).

innovative somatropin. The greater use of particular biosimilars in certain product classes could be due to a number of complex, interrelated, and not always well-understood factors, including for example patient treatment considerations in a particular therapeutic area, country-specific reimbursement policies, or marketing dynamics such as share of voice and level of company investment. And as noted in Sandoz's slides, multiple epoetin products are marketed in Australia and Japan, and all of them bear distinguishable nonproprietary names. All products in the class, biosimilar and innovative, are thus similarly situated in this respect.

Second, data that Sandoz cited support the view that distinguishable nonproprietary names do *not* limit biosimilar uptake. Specifically, Sandoz's data concerning Japan show that biosimilar epoetin has a *greater* share of the epoetin market (5%) than that of biosimilar somatropin in the somatropin market (1%). Yet biosimilar epoetin bears a *distinguishable* nonproprietary name (Epoetin Kappa (rDNA) [Epoetin alpha Biosimilar 1]) and biosimilar somatropin bears the *same* nonproprietary name as its reference product and other innovative products in the class (Somatropin rDNA).⁹ Contrary to the statement on Sandoz's slide, Japanese law permits physicians to prescribe biologics (including biosimilars) by brand *or* nonproprietary name,¹⁰ and the distinct name for biosimilar somatropin — Somatropin BS Injection [Sandoz] — is the product's *brand* name.¹¹

Third, Sandoz compared the number of biosimilar epoetin prescriptions dispensed against the number of prescriptions for all products in the class. Comparing the sales of a biosimilar with those of its reference product — the product with which the regulatory authority determined the biosimilar is highly similar — provides a more accurate measure of biosimilar uptake. In 2013 in Japan, biosimilar epoetin (which bears a distinguishable nonproprietary name) accounted for roughly 73% of sales in the market consisting of biosimilar epoetin and its reference product.¹² And in Australia in fiscal year 2013-2014 Q1 and Q2, biosimilar epoetin (which bears a distinguishable nonproprietary name) accounted for roughly 21% of the “total cost” (cost to the government plus the patient's expense) of hospital dispensed epoetin treatment in the market consisting of biosimilar epoetin and its reference product.¹³ This

⁹ Notification No. Yakushoku-shinsa hatsu 0214-1 (Feb. 14, 2013).

¹⁰ Hoi-hatsu 0305-13 (March 5, 2012).

¹¹ Notification No. Yakushoku-shinsa hatsu 0214-1 (Feb. 14, 2013).

¹² See JCR (marketing application holder of biosimilar epoetin), Quarterly Reports for October to December 2013 (submitted February 12, 2014), at <http://contents.xj-storage.jp/xcontents/AS06067/e9d79013/fa1a/4f15/9d03/f9ac6b752a67/S10013CQ.pdf>; Kissei (distributor of biosimilar epoetin through agreement with JCR), Summary of Accounts for the Third Quarter of the Business Year Ending March 2014, additional documents (February 6, 2014), at http://www.kissei.co.jp/vcms_lf/26_3_hosoku_2.pdf; Kyowa Hakko Kirin (marketing application holder of biosimilar epoetin's reference product, Espo (epoetin alfa)), Summary of Accounts for the Business Year Ending December 2013, additional documents (January 31, 2014), at http://v4.eir-parts.net/v4Contents/View.aspx?template=ir_material_for_fiscal_ym&sid=7524&code=4151.

¹³ Department of Health, Australian Government, “Highly Specialised Drugs Programme, Private Hospital Dispensed National Expenditure Report,” at <http://www.pbs.gov.au/info/statistics/hsd-expenditure-reports/hsd-private-hospital-expenditure>; Department of Health, Australian Government, “Highly Specialised Drugs (continued...)”

represents growth from FY 2012-2013 in Australia, during which biosimilar epoetin accounted for about 5% of the total cost of hospital dispensed epoetin treatment in the market consisting of biosimilar epoetin and its reference product.¹⁴

Limited publicly available information also suggests that in Europe, biosimilars with a name distinguishable from the name of the reference product have achieved sales comparable to or exceeding sales of biosimilars in the same product class that have the same name as the reference product. All epoetin biosimilars marketed in Europe share the same reference product: Eprex/Erypo (epoetin alfa). Epoetin biosimilars marketed under brand names Silapo and Retacrit have a distinguishable nonproprietary name: epoetin zeta. The other epoetin biosimilars marketed in Europe are marketed under three brand names and have the same nonproprietary name as the reference product: epoetin alfa. Sales of Silapo and epoetin alfa biosimilars in Germany were similar in 2008 (roughly \$3 million for Silapo in Q1-Q3 2008 vs. \$5 million for all epoetin alfa biosimilars in Q1-Q4 2008).¹⁵ And sales of Silapo in Germany exceeded those of epoetin alfa biosimilars in 2009 (roughly \$12 million for Silapo in Q1-Q3 2009 and \$7 million for all epoetin alfa biosimilars in Q1-Q4 2009).¹⁶ Moreover, these sales figures for epoetin zeta are highly conservative. They do not include sales of Silapo in the fourth quarters of 2008 and 2009 and they do not include sales of the second epoetin zeta biosimilar marketed in Germany, Retacrit. Although product sales vary in any given year and member state, these data contradict Sandoz's premise that distinguishable names contribute to low penetration of biosimilar epoetin internationally. Indeed, Hospira, the marketing authorization holder for Retacrit, presented data at the FTC workshop that Retacrit "is one of the largest brands of biosimilar [epoetin] in the EU" and had experienced significant growth over time.¹⁷

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Programme, Public Hospital Dispensed National Expenditure Report," at <http://www.pbs.gov.au/info/statistics/hsd-expenditure-reports/hsd-public-hospital-expenditure>.

¹⁴ *Id.*

¹⁵ Stada Arzneimittel (marketing application holder of Silapo), "Corporate News STADA: Revived business development as expected in Q3/2009 – development as planned in 1-9/2009 – confirmation of minimum goal for 2009" (Nov. 12, 2009), at 8, available at <http://www.stada.com/media-public-relations/press-releases/detail-view/news/detail/News/stada-revived-business-development-as-expected-in-q32009-development-as-planned-in-1-92009-co.html>; Rovira, J., et al., "The impact of biosimilars' entry in the EU market" (January 2011), at 55, available at <http://citeseerx.ist.psu.edu/viewdoc/summary?doi=10.1.1.357.2218>. Sales figures were converted to U.S. dollars using the New York Times conversion rate on February 28, 2014.

¹⁶ *Id.*

¹⁷ Presentation by Sumant Ramachandra, MD, PhD, MBA, Senior Vice President, Chief Scientific Officer, Hospira, "Lessons for the United States: Biosimilar Market Development Worldwide," at slide 10 (Attachment B).

Thank you for your consideration of these comments. I would be pleased to answer any questions you may have.

Sincerely,

Emily A. Alexander
Director, Regional Lead
U.S. Regulatory Affairs
Biologics Strategic Development
AbbVie, Inc.