FDA Media Briefing on Pregnancy and Lactation Labeling Proposal

Moderator: Susan Cruzan
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Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. During the question and answer session you may press star 1 on your touch tone phone.

Today's conference is being recorded, if you have any objections you may disconnect at this time. I will now turn the meeting over to your host for today, Miss Susan Cruzan of the FDA.

Ma'am you may begin.

Susan Cruzan: Thank you. Good afternoon ladies and gentlemen. My name is Susan Cruzan with the Food and Drug Administration's Office of Public Affairs. Welcome to our teleconference for credentialed media.

Today we are discussing a new proposal for prescription drug labeling that will provide better information about the effects of medicine used during pregnancy and breastfeeding.

With me today are FDA Commissioner Dr. Andrew von Eschenbach and Rear Admiral Sandra Kweder, Dr. Kweder is an MD and is the Deputy Director with the Center for Drug Evaluation and Research's Office of New Drugs.

Following brief remarks we will conduct a question and answer session for the media. I will now turn the call over to Dr. von Eschenbach.

Andrew von Eschenbach: Thank you Susan and thank you everyone who's on the call for joining us for this media teleconference.

I am pleased to be joined here at FDA by a number of our experts led by Dr. Sandy Kweder who will be available to answer your specific questions and I suspect your detailed questions about FDA's proposed final rule affecting prescription drugs and biologics labeling requirements for pregnancy and breast feeding.

But I wanted to take a few minutes as commissioner at the very beginning, not just to welcome you but to share with you the significance and the importance of this proposed final rule.

You're all well aware that the most important tool that FDA has in order to carry out its mission to protect and promote the health of every single American is the legal authority we've been given to determine the content and the format of labeling.

It's the source of information and knowledge that's essential for physicians and health care providers and more and more even patients to make appropriate decision about the use of these products.

And over recent years FDA has been engaged in a very concerted effort to make the label the most effective tool possible by providing the right information in the right way for the drugs and biologics that we're responsible for regulating.

You're all aware of the efforts that we've put into with regards to physician drug labeling rule. Today we're not proposing final changes, but we're only

here today to talk about proposed final rule that deals with drugs or biologics not specifically, but rather how they affect a specific population.

It's a population that has very, very special needs and it also quite frankly has very special concerns and risks. We know that there are six million pregnancies that occur each year in the United States and many women during pregnancy are taking as many as three to five medications.

Some of them for the pregnancy itself and issues related to it like the onset of high blood pressure, others because of associated conditions that they have, for example a condition like asthma.

And we need to address the importance of providing the right information in the right way for the use of drugs and biologics during this very critical and important time, during the period of pregnancy and breast feeding not only as it relates to the risks and needs of mother, but also the affected fetus or child.

FDA is not taking on this responsibility lightly or casually. We've been engaged in a multi-year effort that's involved a multi-disciplinary integrated approach within the agency including pediatricians like my good friend Bill Rodriguez, my classmate from Georgetown Medical School who's sitting here beside me.

But also representatives of the Office of Women's Health and individuals directly engaged in the care of women during this very important period of their life.

We've had numerous consultations with advisory committees, focus groups and outreach efforts to really come to grips with what works and what doesn't

work as it relates to our ability to provide the information that's essential and that has made up our proposal in this final rule.

What we are looking for is to provide information in a way that's most effective and useful. We'll redefine the content and its display in categories of providing general information, risks associated to the fetus, summary statements and the clinical considerations, and most importantly the data or lack or absence thereof that relates to those recommendations.

I'm going to turn over to Sandy Kweder in just a second the opportunity to take you through some of the details of this proposed final rule and answer your very important questions.

But before I leave you just let me end with one other editorial comment. We're all well aware that not everyone likes change. And we're going to be looking at a public commentary period to get even further input before we finalize this rule.

But what we must do is to address the needs of the patients we're here to serve. As a physician, a husband, a father and even a grandfather, I'm well aware, the most important question a woman asks when taking a drug and she finds out that she's pregnant is the question will this hurt my baby.

FDA wants to provide the right information and in the right way to appropriately address that question.

Thank you for taking the time to really give us the opportunity to brief you on these details. Sandy?

Sandra Kweder: Great, thank you Dr. von Eschenbach for introducing this important effort by FDA and many others to ensure that women who are pregnant, breast feeding or of child bearing age and their health care providers have the best information available on prescription drugs.

Pregnant women as Dr. von Eschenbach alluded to earlier in every study that's ever been done in a Western country in recent years has shown that pregnant women are prescribed an average of between three and five different prescription drugs during pregnancy.

Women with medical conditions such as asthma or high blood pressure or depression may need to continue to use prescription drugs during a pregnancy, and like women who are not pregnant, pregnant women may develop new illnesses during pregnancy or conditions that are related to pregnancy that also require treatment with prescription drugs.

This proposed rule reflects FDA's thinking on how best to organize and present all information about the use of medicine during pregnancy and breast feeding.

Under this proposal drug labeling would explain the potential benefits and risks for the mother and the developing baby or fetus, and how these risks may change over the course of pregnancy, which changes continually.

FDA's goal is to ensure that pregnant women and their developing babies benefit from the safest and most effective medicines possible or available.

And our proposal today seeks to make drug labeling better and a more complete communication tool, and would potentially have a huge impact on public health and well being for women keeping in mind that this is really a

tool that's of importance to all women of reproductive age, because a woman can go from being not pregnant to pregnant in about an instant.

And pregnancy, the concerns of pregnancy and concerns for the developing fetus during pregnancy continue on past the nine months of pregnancy into the period of time where the woman is care - the reproductive age woman is caring for a child who is breast feeding.

The agency believes that our proposal today would help organize and present the scientific information that's available for each drug and keep labeling as a useful and - as useful and up to date as possible.

Now Dr. von Eschenbach mentioned change, why this is a change. Currently, drug and biologic labels employ under regulations a letter category system to describe the risks of drug use during pregnancy.

The system was established and has been unchanged since 1979. Over time, our experience has been and stakeholders have provided an enormous amount of feedback to us indicating that this system of letter categories has lead to an inaccurate and overly simplified view of prescribing in pregnancy and the attendant risks.

The category system has also by its very nature made it very difficult to update labeling as new information becomes available.

We at the agency have held public meetings, we've held focus groups and we've held advisory committee meetings to obtain input and comments on the current labeling system, the letter category system from the public health care practitioners and scientific experts.

As a result, the proposed rule would remove those letter categories. However, we believe that the proposed rule improves greatly on what we have today.

The proposed rule is described as a newly designed format for pregnancy labeling that would have three sections, three major sections and I will enumerate those.

The first subsection which is a fetal risk summary, would describe what is known about the affects of the drug on the developing baby or fetus and whether this risk is based on information available from humans, from animals or both.

The second section would be called clinical consideration, and would include information about the potential effects of the medicines used before a woman knows that she is pregnant which is a common scenario.

The section would also feature information or discussion to the extent such information is available about the risks to the mother and baby if the disease is left untreated.

Dosing for pregnant women and how to address any potential complications that could be anticipated, that might be different for a pregnant woman or someone who is not.

And the third section would describe the data in more detail for people who are interested and want to understand that in more detail. Importantly, information on use in humans would be carefully discussed separately from information on use in animals and information presented about using animals would be required to explain how that is thought to apply to humans.

The proposed rule would also require that labeling include a standard statement about something called background risk.

And what background risk is, is the risk that any developing baby has of being born with a birth defect, so that any information in the label could be put into - about what's known about the risk of the drug itself could be put into the context of risks that are already present for everyone.

The purpose - I mentioned that this is not the proposed rule about the pregnancy section of labeling, but that it goes beyond pregnancy to breast feeding or lactation information.

And the lactation section of the label is also divided into three parts, a risk summary, clinical considerations and data. And the information in this section would include importantly whether a drug is found in human breast milk, the amount of drug if it is found in breast milk that a breast feeding infant would be likely to consume each day, and the potential effects of that drug in the breast feeding infant.

The proposed rule also reminds health care practitioners to consider how the infant potential risks from the medicine measure up against the known benefits of breast milk feeding.

When the final rule publishes as I mentioned and becomes effective, the letter categories would be removed from the labeling for all drugs, and once the final rule is published, newly approved drugs would use the new pregnancy and lactation labeling format.

And there is - previously approved drugs would have to ultimately comply with it, and the proposed rule describes a schedule for how that would occur over a number of years.

Available information on the use of a drug during pregnancy and breast feeding would be included - as I mentioned would be included in the labeling; this proposal mostly addresses format and content. It does not require manufacturers to conduct new studies.

Manufacturers however would be able to include information from published studies in literature and certainly would be asked to include information from studies that they have done themselves that might have been collected in a number of ways such as from a tool that's increasingly used called pregnancy registry.

Many drug companies already maintain pregnancy registry studies. These are studies that enroll pregnant women - who seek to enroll pregnant women who are already under the care of their doctor taking a medication to treat a medical problem during pregnancy.

They - the registry then simply collects information about each mother and her baby throughout pregnancy and beyond birth. The proposed rule -- what the proposed rule would require is that information available from those registries would be published and information about the registry and how to enroll or contact the registry would also be included in labeling.

As Dr. von Eschenbach mentioned, this is a proposed rule. The usual way that this works is now that it's posted it will go out for public comment for 90 days.

We have specifically asked for comments on certain sections where we want to hear from the public more than we've already heard to date. And once all the comments are in our job would be to collate them and address them all and make a decision on how to finalize a regulation.

I'll stop there and take your questions.

Susan Cruzan: Thank you. We will now open up the call to our question and answer session. This will include Dr. Sandra Kweder and several other experts, Dr. William Rodriguez who is with the Office of Pediatric Therapeutics, Dr. Karen Feibus who is on our Maternal Health Team in CDER.

Christine Rogers who is regulatory counsel in CDER and Dr. Marion Gruber who is associate director for policy in the Center for Biologics, our CBER expert.

We can now start taking your questions, thank you.

Coordinator: Thank you, at this time if you would like to ask a question please press star 1. To withdraw your request, please press star 2. One moment please for the first question.

Our first question is from Peggy Peck of MedPage Today, your line is open.

Peggy Peck: Yes, thank you very much for taking my question, this is Peggy Peck from MedPage Today. I'm - I just wonder if somebody could, I'm not quite clear if this rule were to go into effect, explain to me existing drugs, what would happen to their labels at that point?

Sandra Kweder: What would happen is first and foremost, the letter itself, just the letter, A, B, C, D, X, would be required to be removed. Everything else that's in those labels today would stay. .

But we would remove the letters, and that was one of the things that we were urged to do by a number of stakeholders, because the letters are thought to - lead to some very imbalanced decisions about use of drugs in pregnancy.

However, more importantly is - the proposed rule sets out a schedule that would bring drugs already on the market up to date with this format, so for example, if a drug were having another labeling change they would be required - under certain circumstances, they would be required to update this section and make the change as well.

Peggy Peck: Okay, so just so that I understand, would there be a period of time, it seems to me that the letter, although you're indicating it might have caused some confusion but it would be something that might catch the eye.

So I'm wondering if there's going to be some way easily looking at the label for a clinician or pharmacist to identify the risks if any of this drug in terms of preg - in pregnancy or breast feeding or to a fetus.

Once the letter is removed would there just be small text there?

Sandra Kweder: You have to read the text. And under the physician labeling rule, any unique considerations or very high risk drugs, that would already have been elevated to the highlights section in order to be identified there.

So it would actually be - it's actually easier – since we have a physician labeling, the physician labeling rule, this is kind of the last piece of the physician labeling rule.

It was carved out in the beginning because it was going to require some unique considerations, and it was always intended to be - to fit into the physician labeling rule.

So if the letter is removed, the information will be - for example if it were a very high risk product it would already be in warnings. So it would be up front where it belongs and easy to identify.

Peggy Peck: I see. Thank you.

Susan Cruzan: Can we have our next question please?

Coordinator: Our next question is from Jennifer Smith of FDA Week, your line is open.

Jennifer Smith: Hi, thanks for answering my question. Actually this is the last phase of physician labeling rule, okay, so you answered that question, but it was also mentioned, I did a story on this last year about a lactation guidance.

Is there a guidance FDA expects to address, I mean expects to issue, excuse me, just about what type of evidence, what type of clinical information to include on the labels?

And just as a follow up to that, would that be separate from a final lactation guidance and when is that expected to be issued?

Sandra Kweder: Karen Feibus, do you want to answer that question?

Karen Feibus: Sure. This is Karen Feibus. I'm the medical team leader on the maternal health team.

Jennifer Smith: Sure, hi Karen.

Karen Feibus: Hi. A few years ago as you know there was a draft guidance published on the conduct of clinical lactation studies. And we received a number of excellent comments through the comment period and as we started to address those, there were some unresolved issues.

So we took the guidance to an advisory committee in November of 2007 and we are currently in the process of updating that guidance. Ultimately it will be published as a final guidance with some changes and that provides information to sponsors who will be actually putting together protocols for clinical lactation studies about how to go about doing that.

Which is different from what the proposed rule does, explains how to then take information from those clinical lactation studies and actually present that in the label for clinicians to use.

Jennifer Smith: Okay. Is there any data on that though like this year at least, or this summer?

Sandra Kweder: We hope to put that up as soon as possible.

Jennifer Smith: Okay.

Sandra Kweder: So that guidance and we also have another guidance that is out and we're also looking at trying to update on doing clinical pharmacology studies in pregnancy and other - conducting pregnancy registries that all serve as tools

for conducting sound and ethical studies where they're called for, for products that are likely to be used in the setting of women who might be pregnant or breast feeding.

Jennifer Smith: This is another guidance, it's another one on clinical pharmacology, pregnancy registry.

Sandra Kweder: Yes.

Jennifer Smith: Okay.

Susan Cruzan: Can we have our next question please?

Coordinator: Our next question is from Judith Graham of Chicago Tribune, your line is open.

Judith Graham: This is a two part question. One is the changes that are being proposed on the labeling meant for physicians or consumers primarily, and can you discuss how you might expect to see them used and then I'll ask the second part after that.

Sandra Kweder: Sure. Can you hear us okay?

Judith Graham: Yes.

Sandra Kweder: Okay great, we've had trouble with this sound system, we're just doing a check. This is physician, this is professional labeling, this is the proposal that's for professional labeling.

So it's mostly intended - you know at first stop is intended for prescribers. However, one thing that we do know is that information is - this is the part of information that consumers and patients are very interested in.

And - it forms - and this information forms the basis for other kinds of materials that are written and more consumer accessible language such as patient package inserts or medication guides that are often part of formal product labeling.

But also that gets written by other people who are simply interested in putting together information sheets or compendia for consumers about medication.

We - one of the reasons that we wanted to be as comprehensive as we are is so that in doing so - that groups or parties who are interested in more complete information can find it through labeling and not have to comb through the medical literature and then interpret it.

But it's all pulled together in one place.

Judith Graham: Great. And then the second piece is you talked about a schedule for the existing medications that they would have to change their labeling. Is there a final date by which that would have to occur, or would it be triggered by things such as requesting other labeling changes?

Sandra Kweder: There are a couple of things that come into play, one is other labeling changes, but the other is for drugs that prove within certain windows of time, they have a certain, you know 'x' or 'y' number of years to come into compliance with it.

If we frankly given the number of prescription products that are on the market, if we simply went out and said tomorrow everyone has to come in with their new proposed labeling, we wouldn't be able to get to reviewing them all.

You know they all have to be reviewed by FDA and we - you know we don't just put a rubber stamp on these. So we try to set up a schedule that's reasonable and workable but still presses on to get as many drugs updated in as reasonable a time frame as possible over a few years.

Judith Graham: And this is Dr. Kweder who's speaking, correct?

Sandra Kweder: Yes it is.

Judith Graham: Thank you.

Susan Cruzan: Next question please.

Coordinator: Your next question is from Liz Szabo of USA Today. Your line is open.

Liz Szabo: Hi, yeah I noticed that it looks like you've been working on this since 1997.

Susan Cruzan: Hello?

Liz Szabo: It looks like you've been working on this since 1997. Why has this taken 11 years? That seems like a lot of pregnancies have come and gone?

Sandra Kweder: Liz, that's a great question, and I have to say I have been at the agency for a very long time. This is the most complicated, difficult project I have ever worked on.

It is - if you think of it as a population for which, you're talking about pregnant women and developing babies. These are people who about whom the most information is desired and the least information seems to be available.

And so finding a way in a regulatory framework to require scarce information to be pulled together and then explained in a way that is balanced and scientific and conveys information practically is extraordinarily challenging.

One of the reasons that it took so long is that we have held several public advisory committee meetings, we've held focus group meetings, we've met with stakeholder groups.

We have looked - we have turned this approach and all - and many others inside and out trying to come up with a model that is practical and useful to clinicians who are - and patients who are in the real world trying to make some very difficult decisions.

And that's you know ultimately why it has taken so long. By way of example let me just explain a little bit, you know some people have said you know the letters were so simple, could just have come up with something like that.

I will assure you that we have looked at letters, we've looked at numbers, we've tried score - risk scores. We even tried to look at visual analog scales and the bottom line is that every drug is so uniquely different that at the end of the day putting together what we did with a risk summary supplemented by some clinical consideration for the doctor and the patient in the room to take and their families to take into account in making decisions was what we think is the best that we can provide and what the public deserves.

And it took a long time to get to that.

Liz Szabo: Thanks.

Coordinator: Our next question is from (Fran Kritz) of the Washington Post, your line is open.

(Fran Kritz): Hi, thanks for taking my question. My question is once you - the final rule has been adopted how long do you think it would take to get this implemented when for new drugs, what would be the time frame, let's say the rule goes into effect January 1st?

Or what's the time frame we're looking at here?

Sandra Kweder: You know we usually depending - we usually require - the first thing that would be required for example for products that the applications were submitted you know on the day of or following the day that the rule was thought to go into effect, those would - it would be required to be incorporated for those.

So for example if it was an application, you might see the first one within say six months.

(Fran Kritz): And a follow up to that would be and how do they get updated? So when pregnancies, you might have a woman who's taking a drug that's - that is thought to be relatively safe for her first pregnancy and then new data comes out over the course of time and she's pregnant two years later.

And now there's new data that shows that it may not be as safe as originally thought. Given the fact that you have pregnancies coming up quickly and that

this is information that women need updated as quickly as possible, how fast - how are you going through the process of getting information as quickly as it's available?

And then getting it into the hands of women. So for example now there's a delay time, if there's an old lot of a drug, a label is not - a doctor may not have a new label.

How are you going to make sure that new information is in the hands of the physician when it's needed?

Sandra Kweder: You know we face this problem for every safety issue that we incur. It's not unique to this population. And I think that you know we are may - one of the things that this proposed rule makes clear is that this is a really important section of labeling that we are going to require that companies main - keep up to date which has not been the case prior to this.

Companies have not frankly done a very comprehensive job of keeping this section of labeling up to date, most labels are sorely out of date.

The combination of this with the FDA, with the new FDA amendment (sec), I think which also makes clear that this is a population of particular interest, pregnant women and breast feeding infants, really sends the message that this is something that we expect to be well monitored and a section of labeling to be well maintained.

One of the things that we have done is that all labeling now as soon as it's approved, within basically within the first 24 hours of its approval is posted by the National Library of Medicine on a site called Daily Med, which is publicly available.

So the most up to date label, but really within 24 hours, even minor changes get posted on that within 24 hours of approval, and that is rapidly becoming as it grows as a database an extremely important tool for clinicians to remain up to date.

(Fran Kritz): And do you know the physicians are using it, you have some sense….

Sandra Kweder: Rather than physicians using it a lot of other websites pick up on it, a lot of other websites that physicians use are linking to it, which is exactly what we hoped would happen.

(Fran Kritz): Thanks.

Susan Cruzan: Thank you, next question please.

Coordinator: Your next question is from Lisa Richwine of Reuters, your line is open.

Lisa Richwine: Hi, thanks for taking my question. Dr. von Eschenbach mentioned at the beginning that you realize that people are resistant to change. So I'm wondering who are the groups that have concerns about it?

Sandra Kweder: What - say that last part again, I'm sorry?

Lisa Richwine: Can you tell us, Dr. von Eschenbach mentioned there's some resistance to changing the label format, can you tell you who is opposed to it or has concerns about it?

Sandra Kweder: You know I don't know that anyone is opposed to it frankly, I think but any time we make a change in labeling, it was the same when we proposed the physician labeling, there's always a lot of anxiety in general.

We're comfortable with what we have, will this make it better or worse or what should we expect? And so I think that the letter categories are something that has been in place since 1979.

So many physicians practicing today, this predates their birth. So you know in the community, these are well known. And the way they are used very commonly is they appear; with the letters appear by themselves without any additional information.

And so drugs are selected or decisions are made solely on the basis of the letter itself.

And you know there's - so it's likely that many people will find the absence of those letters to be concerning, what should I do now? And we understand that.

What we are going to do is we are going - we are proposing that what this will do is it will improve on that by orders of magnitude and provide clinicians not only with comprehensive information but information that will really help them make decisions and help them counsel patients.

Lisa Richwine: Okay, and you mentioned that many stakeholders did want the letter system removed? Can you tell us what kind of groups those are, where they physician groups, consumer groups, industry groups, was it a broad range?

Sandra Kweder: It was a broad range. It was a very broad range of groups.

Lisa Richwine: Okay. Were there people that wanted to maintain the letter system?

Sandra Kweder: I think there were people, I think there were a lot of people that hoped we could come up with something that was as simple as the letter system is; we did not maintain it.

And unfortunately the information about risks and pregnancy don't lend themselves very well to a simplistic system.

Lisa Richwine: Okay. If I could just throw in one other thing that you've alluded to, I mean is it still the case that for most drugs you don't have good information about how they might affect the developing fetus?

Sandra Kweder: I think that for most drugs we don't have as much information as we would like to have. What we also know is that there is a lot of information out in medical literature about drugs that never makes it to labeling.

I can give you an example if that would be helpful.

Lisa Richwine: Sure.

Sandra Kweder: When in 2001, when the country was confronted with letters that included anthrax in them, going to post offices and office buildings. The first drug- at the time, ciprofloxacin, an antibiotic had been approved or on the market for a number of years.

But it had recently been approved for use to prevent anthrax in cases of exposure. So it was going to be widely administered to people who might have been exposed.

The first question that came to us at FDA was what should we do about pregnant women? Ciprofloxacin is the drug of choice. What do we know about it?

We looked at the label- when we went to the label for ciprofloxacin, basically it warned against use in pregnancy because of risks you know, risks seen in animals.

Well we actually went further than that because we were sure that there was other information. We were able to identify a number of very large studies that have looked at this issue of exposure in pregnancy deliberately to try and understand the risks.

And were able to summarize those data and ultimately conclude that there did not appear to be great risk of the drug in pregnancy and we ultimately changed the label, it is what is there today.

Clinicians were not aware of this information previously and it was a great example of how there's often information that just - never makes its way to labeling.

If that hadn't happened in 2001, I expect that the labeling for Cipro today would be exactly the same as it was at the time without the benefit of that additional information.

We should not have to have a public crisis in order to get labels updated.

Lisa Richwine: Thank you.

Susan Cruzan: thank you, can we have our next question please.

Coordinator: Yes, our next question is from (Jill Weschler) of the Pharmaceutical Executive Magazine, your line is open.

(Jill Weschler): Thanks for taking my question. I just wanted to clarify if there's much impact of this new proposal on the existing revised physician labeling that is would you normally expect some kind of statement from the risk summary to be included in the highlight section?

And does it change where this information goes in the labeling itself? And did the old letter categories go in the…

Susan Cruzan: Could you speak up a little bit (Jill) please?

(Jill Weschler): And did the - just as a clarification did the old letters appear at the top of the label or just back in the pregnancy section?

Sandra Kweder: Okay, let's take it in reverse order, the old labels do not appear up in the highlight section, they stay - they are in the pregnancy section.

If there is a - however, if there is a specific risk that is of concern or if there is a contraindication it would appear in warnings and would move up to the highlight section.

Now what was your first question is would the risk summary statement appear in the highlight section?

(Jill Weschler): Yes. That was the question; would you normally expect some kind of summary of the risk information on pregnancy to be in the highlights?

Sandra Kweder: Yeah, it will depend on the individual product and whether there's enough information to say something definitive for the highlight section.

In many cases we expect that there will be something brought up to the highlight section.

That was the original intent of the PLR.

(Jill Weschler): Okay thank you.

Susan Cruzan: Thank you. Can we have our next question please?

Coordinator: Our next question is from Jennifer Smith of FDA Week, your line is open.

Jennifer Smith: Hi, I mean is this consistent discussion of how there's just a lack of information as far as before, or just a (dearth) of information when it comes to pregnant/lactating women in studies.

And since then why is there not a strong emphasis on FDA to make a proposed rule to - is it possible to mandate studies, is it possible to you know even have like strong recommendation or urgent recommendations to do these studies?

Is this something that all drug makers should be engaging in, in FDA's viewpoint or only drugs targeted for the pregnant or lactating population?

Sandra Kweder: Well actually most of the concern here is for drugs that are not necessarily targeted for conditions unique to pregnancy.

You know pregnant women have all the same medical problems and more sometimes than women who are not pregnant. So this would apply more broadly.

The rule itself is really about how to present the information, what type of information should be presented.

However, we in - we have other tools that are available to us that particularly through the FDA Amendments Act or FDAAA, that will allow us where we have a concern about a risk in pregnancy or a risk in breast feeding children or in any population to require that certain types of studies be done.

And we're fully prepared to use those tools when they are called for. Does that answer your question?

Jennifer Smith: It does, I guess I'm just wondering how often will FDA actually use this concern or risk, I mean is this something that I guess FDA has the intention of using more often considering if you're asking companies to present risk, how do they know what kind of risk?

Is it - sorry, they know the information that much on risk, then how can they present this information if it's lacking.

Sandra Kweder: So for example, there are some drugs that we can anticipate will be widely used by women of reproductive age.

Jennifer Smith: Okay, are there some examples of widely used…

Sandra Kweder: Well maybe let's say conditions that are common in reproductive aged women. Depression for example.

Jennifer Smith: Okay, okay.

Sandra Kweder: …common. Skin conditions.

Jennifer Smith: Okay.

Sandra Kweder: Seem like specific - you know depending on the drug and what we understood about it from animals or how it's used.

Jennifer Smith: Okay.

Sandra Kweder: We would be talking to companies, but look, this is a population you need to be carefully taking a look at, and there are a variety of ways to assess risk.

We look at you know what do we understand about the animal data, what do they tell us? Would we rec - do we want to require or recommend that you conduct a pregnancy registry?

Jennifer Smith: Okay.

Sandra Kweder: Monitor women who are using this drug, is it available over seas, what's the experience in pregnancy from some database overseas, there are a variety of...

Jennifer Smith: Oh interesting okay.

Sandra Kweder: types of information. And we put - we really expect that this is one of the sub populations, you know special populations that need to be addressed for any drug that's likely to be used in that particular at risk group.

Jennifer Smith: Okay, okay. So I guess I mean just a final point I just want to make sure I can clarify that kind of sum that up as saying we will be seeing or FDA will be pursuing I guess more companies doing studies on pregnant woman or a lactating woman.

Sandra Kweder: Yeah, I think that's fair.

Jennifer Smith: Okay.

Susan Cruzan: Thank you Jennifer. Can we have our next question please?

Coordinator: Our next question is from Judith Graham of Chicago Tribune, your line is open.

Judith Graham: This may have already been answered. I was - you made several references to problems with the letter system. You've indicated that it frequently did not - was not updated and did not reflect the totality of information available in the scientific literature.

Are there other problems that you uncovered with the letter system above and beyond those you've already talked about?

Sandra Kweder: I think that really summarizes all of the problems. The other - one of the others that I think you know falls in the same category but people don't often think of is the letter category system was developed back in the '70s with the intent that this section of the label was going to be used by prescribers who were sitting in the office or in the hospital taking care of a woman who is known to be pregnant.

And making a decision about first whether to prescribe a medication and second which medication to prescribe. What we all know is that in this country while there are you know about six million pregnancies a year, believe it or not about half of those pregnancies according to the CDC are unplanned.

And so it is very common for a woman to be taking a medication and not know that she's pregnant, only to find oh my goodness I'm pregnant and I've been taking this medication.

That's the not the same decision as should I prescribe a medicine. So the - in those cases the woman's you know making other kinds of decisions, what should I watch - you know doctor's thinking and it helped our system thinking what should I advise this woman about what the risks are to the pregnancy, she's already incurred the risk.

And it can be a very frightening situation. One of the things we know is that the letters often don't help clinicians in those settings; they weren't really intended to help counsel patients about those - in those scenarios.

One of the things that we have in this proposal under clinical considerations is to try and incorporate a perspective on risks when that type of an exposure may occur.

Judith Graham: Thank you, that helps.

Sandra Kweder: Okay.

Susan Cruzan: Do we have another question please?

Coordinator: Yes, our last question is from Jared Favole of the Dow Jones Newswire, your line is open.

Jared Favole: Hi, how are you, this is Jared Favole, Dow Jones Newswire.

Susan Cruzan: Hi Jared, could you speak up just a little bit.

Jared Favole: Can you hear me better now?

Susan Cruzan: Yes.

Jared Favole: Okay. I just - you had said earlier that you want to make sure that these - once this proposed rule goes in place that the companies continue to have updated information related to how the drugs affect pregnant women.

I wanted to know how are you going to ensure that they do have up to date information?

Are you going to throw more personnel or more resources at this?

Sandra Kweder: You know one of the things that we have learned is that once people get in the habit of paying attention to a certain area of medical literature and focusing on certain populations, it's amazing how well people start to pay - start to continue to pay attention to it.

And one of the things that we fully recognize is that over the years this has just been a section of labeling that has for lack of a better term been orphaned.

Our experience is that even with companies that have already sought to begin to update certain labels, they're doing a remarkable job of continuing to do that because their attention has been called to it.

So the requirements for updating, the requirements for staying up to date we don't think are going to require - we expect not to have to do a great deal more than the regulation itself requires because it will become part of the general expectation.

On the other hand, we do have a team of experts in house and one of their jobs is to keep up to date with the literature and be continually working to see that the most current information is available.

We already have begun to develop such a team and I expect that they're here to stay.

Jared Favole: And you said you've already - is this team related specifically to this issue or just labels in general, not just the effects on pregnant women and…

Sandra Kweder: No, this is a team that's specific - maternal health team is specifically focused on concerns related to drug and biologic use in pregnancy and lactation.

They form a wonderful bridge between our - with our pediatricians and our other scientific experts in the other clinical fields that work integrally with them all the time.

Jared Favole: And you said the team is already formed or is close to being formed, it is formed.

Sandra Kweder: Yes it is. For some time and they are the folks who have been working on this role for a number - for some period of time and preparing a lot of scientific guidance documents that are ultimately going to facilitate collection of good information to populate the rule.

Jared Favole: Okay, thank you very much for your time.

Susan Cruzan: Okay. And we have - do we have one last question?

Coordinator: Our last question is from Liz Szabo of USA Today, your line is open.

Liz Szabo: Hi, when do you anticipate this…

Susan Cruzan: Can you speak up please?

Liz Szabo: Hi, yes, when do you anticipate this change would take effect? A year, two years?

Sandra Kweder: Well the comment period for the proposal is 90 days. We have in the rule sought - you know we have actually in the rule itself, we've asked for comments on certain areas.

How long it will take - the real question is how long it will take us to make the revisions, any revisions or address all of the comments. And that really depends on what they are.

So - but we are committed to getting it done quickly, we think it's high time to get this thing published.

Usually there's a few months period of time between final rule publishing and you know the effect date.

But as soon as possible is my answer. And I just - I'd like to also point folks to the information posted on our website as of 2 o'clock –there is more printed information about this that summarizes some of the things that we talked about today.

One of the pieces that's up there is a - like a one page summary each of in text boxes of what the format is for the pregnancy section and the lactation section, one page each that I think will provide a good synopsis of what this would look like.

And it also includes some examples of made up products.

Susan Cruzan: Thank you Sandy, this is Susan Cruzan again. As Sandy said we can point you to our website, the press release is actually posted on the home page in the Spotlight section. It does link to a complete CDER page that has the graphic for the format, some additional information, the guidances that are in development or that have been published are listed as well.

And we also have a consumer information article, so please do visit that for your graphics. We also have a replay of the call that will go up at 3 o'clock; it will run to June 5th.

The toll free number is 866-469-7805 and for our European colleagues it's 203-369-1473. Thank you all so much for joining us today. Have a great day.

Coordinator: Thank you. This concludes today's presentation. You may disconnect at this time.

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