Study 14

Complete Expulsion Rate for Efficacy Evaluable Population by Gestational Age

Gestational Age (days)	Events/N	Rate (%)
< 36	117/119	98.3
36-42	447/463	96.5
43-49	570/607	93.9
50-56	12/13	92.3
57-63	3/3	100.0
≤ 49	1134/1189	95.4

Study 24

Complete Expulsion Rate for Efficacy Evaluable Population by Gestational Age

Gestational Age (days)	Events/N	Rate (%)
< 36	15/15	100.00
36-42	163/171	95.3
43-49	293/306	95.7
50-56	358/389	92.0
57-63	196/223	87.9
≤ 49	471/492	95.7

Study 24: Treatment Outcome

Evaluable Patients with Gestational Age ≤ 49 Days

	n	Rate (%)
Total	**210**	
Misoprostol not administered		
Complete expulsion	19	100.0
Single dose misoprostol		
Complete expulsion	189	99.0
Incomplete expulsion	1	0.5
Surgery to stop bleeding	1	0.5
Complete expulsion rate	**208/210**	**99.0**

Analysis of Success Rates for Subgroups:
Studies 14 and 24

Subgroup	Study 14 n/N (%)	Study 24 n/N (%)
If GA≤ 49 days	1134/1189 (95.4)	471/492 (95.7)
. . and took ≤ 1 misoprostol dose	1134/1189 (95.4)	208/210 (99.0)
. . and known outcome	1160/1216 (95.4)	227/230 (98.7)
. . and if unknown outcome = failure	1160/1264 (91.8)	227/239 (95.0)

Success Rates:

Studies 14 and 24

	Study 14 (N=1286)	Study 24 (N=1194)
Evaluable (N)	1205	1104
No. of Patients with Success	1149	1025
Rate (%)	95.4	92.8

Adverse Events with Incidence >2%: Studies 14 and 24

Adverse Event	Incidence (%)	
	Study 14	Study 24
Painful contraction of uterus	78.5	85.6
Nausea	40.7	49.9
Vomiting	16.8	29.1
Diarrhea	12.3	15.4
Headache	2.6	3.1
Dizziness	1.2	2.6
Metrorrhagia	N/A	3.4
Anemia	N/A	2.9

Cardiovascular Adverse Events

- **Mild to moderate**
  - **tachycardia and palpitations**
  - **hypotension**
  - **hypertension**
  - **syncope**
- **Severe**
  - **1 case hypotension**

+3
14

Serious Adverse Events: Studies 14 and 24

- Enrolled 2480
- Hospitalizations 21 (1%)
- Heavy bleeding 52 (2%)
  - surgical intervention 15 (1%)
  - blood transfusion 4 (<1%)

#4 6/16/96

#[redacted] Malaut [redacted] (10)

POLLING OF COMMITTEE MEMBERS

COMMITTEE NAME: F + M 7/19/96 [Friday]

	DATE:	0 NO	
1/3 cvg	1. E. Davidson, M.D.		
1/6 cvg	2. J. Daling, Ph.D.		
	3. C Henderson, M.D.		
	4. ~~E Wallach, M.D.~~		~~Called his wife per Betty~~ him ~~will not attend~~ meeting per Christine *
1/6 cvg	5. J Zones, Ph.D.		
	6. T. Kosasa, M.D.		6/11 office closed
1/3 cvg	7. M. O'Sullivan, M.D.		
1/3 cvg	8. ~~K. Rynne, M.D.~~		~~Do not send pt~~ *
	9. V. Lewis, M.D.		6/11 called her
	10. D. Narrigan, MSN		6/11 out-of-country
1/6 cvg	11. D. Petitti, M.D.		
NEW Members	12. Ricardo Azziz		
	13. ~~Hollywood Brown~~		~~Do~~ *
	14. ~~Phyllis Wingo~~		~~Fyi~~ ✓1
	15. ~~Julia Scott~~		

Dr. WALLACH + Wingo did not get MAILOUT.

✓FOI 7

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Food and Drug Administration

Memorandum

Date ·16 July 1996 (Tuesday)

From Executive Secretary

Subject CONFIDENTIAL MATERIAL FOR JULY MEETING

To Members of the Advisory Committee for Reproductive Health Drugs

Attached is the Population Council's safety report on the studies they conducted with mifepristone in the United States.

Please be reminded that this is confidential information.

X Finally, I haven't heard from Lewis, Narrigan, O'Sullivan, Daling, and Azziz concerning the dinner Thursday night at which security and media issuee will be discussed. The discussion is scheduled for 7:30 pm in a private dining room and the dinner will start at 8.

Please confirm your attendance at the dinner. (Note my new phone number!)

Philip A. Corfman, MD
Executive Secretary
Food and Drug Administration

corfman@cder.fda.gov

SUMMARY OF SERIOUS ADVERSE EVENTS REPORTED IN PROTOCOL 166A/B

Introduction

This internal Population Council report was generated in preparation for the upcoming Mifepristone NDA 20-687 advisory committee meeting on July 19, 1996. The goal was to summarize all serious adverse events (SAEs) that occurred during the conduct of Protocol 166A/B. SAEs are defined as those events reported to the Council from the clinics which the Council then reported to the FDA on Medwatch forms. All of these SAEs reports have been previously submitted to the FDA in———— as well as documented in NDA 20-687.

Results

The data relevant to SAEs have been summarized in the following three tables. Table 1 lists each participating clinic by clinic number, principal investigator name, location and type of clinic. Table 2 identifies, in chronological order of occurrence, each subject for whom a SAE was reported to the FDA on a Medwatch form. The nature of the adverse event(s) is recorded as well as the need for a dilatation and curettage (D&C) or aspiration, intravenous fluids, transfusion or hospitalization. When available, the subject's duration of amenorrhea and ethnicity is provided. Finally, the IND submission number and date the Medwatch form was submitted to the IND are listed.

The summary of Table 2 indicates that a total of 52 subjects had at least one SAE. There was more than one adverse event reported for most subjects on the Medwatch forms. The most frequently reported SAE was hemorrhage (41 reports). This was followed by fainting/dizziness (20 reports) which includes all of the following events: fainting, feeling faint or lightheaded, dizziness, syncope, vasovagal reaction and passing out. Other serious adverse events that were reported by at least 4 subjects are listed in the Summary of Table 2

These serious adverse events resulted in the hospitalization of 26 subjects. Four subjects received transfusions. A total of 28 subjects received IV fluids (including 3 of the subjects that also had transfusions). A total of 34 subjects received a D&C or aspiration. All but two of the subjects who had a D&C or aspiration reported hemorrhage. Fifteen (15) subjects received methergine or oxytocin for treatment of bleeding, although 11 of these subjects eventually had a surgical procedure.

The Drug Surveillance Department of Roussel Uclaf maintains a database of all serious adverse events associated with mifepristone for any medical use. At the request of Roussel, the Council sends to them information on all SAEs from the U.S. clinical trials that were reported to the FDA. Roussel assigns an "International Drug Surveillance Number" (IDSN) to each SAE and then provides a medical code for the reported SAE. These SAEs from the U.S. trial are thus captured in Roussel's database and are included in their quarterly reports of international SAEsa associated with mifepristone use. The SAEs from the Council's U.S study have been reported in the NDA by this IDSN, in order to correspond to the report numbering system of other SAEs included in our NDA from international use of mifepristone in clinical trials and during post-marketing surveillance. However, this has caused some confusion in identification of subjects in the U.S. clinical trial for three reasons: 1) one subject may be assigned more than one IDSN by Roussel, depending upon how many adverse events occurred, since the IDSN is associated with an adverse event, not a subject; and 2) the medical code for the SAE assigned by Roussel may not precisely correspond to the description of the SAE as reported on the Medwatch form submitted to the FDA by the Council and 3) Roussel has made some mistakes in their coding of subject's identification. The purpose of Table 3 is to clarify the relationship between a subject in the U.S. trial and the IDSN(s) assigned to that subject by Roussel. In Table 3, each subject with an SAE in the Council's trial is identified and the IDSN(s), as assigned by Roussel, that are associated with that subject are listed. The medical code assigned by Roussel for the SAE(s) of each subject is also included.

For four subjects in the U.S. trial, Roussel has not yet assigned an IDSN or medical code (subject 123, clinic 01; subject 076, clinic 03; subject 070, clinic 02; and subject 159, clinic 01). The location in the NDA of the line listing of the SAE, as identified by the IDSN, is also indicated on Table 3. Line listings of all of the SAEs in the U.S. clinical trial were included in either the original NDA submission of March 14, 1996 (Volume 1.66, p. 32) or the NDA Safety Update Report of June 20, 1996 (Volume 3.2, p. 10).

Comparison of U.S. trials and pivotal NDA trials

It is not possible to make a complete comparison of the serious adverse events reported in the U.S. trial and the pivotal French studies in the NDA, due to different definitions of SAEs and different adverse event reporting requirements in the two countries. Also, the safety analysis of the U.S. trials has not been conducted, since the good clinical practice audit of the clinics is currently being completed. Therefore, at this time comparisons between the U.S. and NDA pivotal studies can only be made with the serious adverse events reported from these 52 U.S. subjects who had a Medwatch report, rather than other less serious adverse events that will be uncovered during the safety analysis of the entire U.S. database. However, some general comparisons can be made. The total number of subjects enrolled in U.S. Protocol 166A/B was 2,121. This is slightly less than the number of subjects (2480) enrolled in the pivotal French trials in the NDA. The number of transfusions is identical (4) in both studies and the number of hospitalizations is similar (26 in the U.S. trials and 21 in the pivotal trials). The number of reported cases of hemorrhage, metorrhagia or excessive bleeding was similar in the two studies. Hemorrhage was reported by 41 subjects in the U.S. studies who required a Medwatch report. In the NDA pivotal studies, 52 subjects reported metorrhagia or excessive bleeding, which was categorized as severe in 21 subjects. However, the manner in which the bleeding was treated differed in the two studies. In the U.S. trials, 32 of the 34 surgical interventions (D&C or aspiration) reported on the Medwatch forms were performed on subjects experiencing hemorrhage. In the NDA pivotal trials, a total of 15 subjects

received surgical interventions for bleeding. The greater number of surgical interventions by U.S. investigators is not unexpected, due to their initial lack of experience in the control of bleeding during medical abortion. This was the first clinical trial of medical abortion in the U.S., but medical abortion had been available in France for several years prior to the conduct of the French studies of mifepristone and misoprostol. The U.S. investigators have noted that as they gained experience with the bleeding that occurs during medical abortion, they were less likely to surgically intervene.

There were 5 cases of hypotension reported on Medwatch forms, although blood pressure readings were given for only 2 of these subjects. There were 7 cases of clinically relevant hypotension, one rated as severe, in the NDA pivotal trials. There were also a similar number of reports of tachycardia on the Medwatch forms for U.S. subjects and in the pivotal trials (4 and 5 reports, respectively).

The incidence of other adverse events reported on Medwatch forms of the U.S. subjects, such as cramping or vomiting, cannot at this time be fairly compared to the numbers of these adverse events reported from all subjects in the NDA pivotal studies. This comparison must await the safety analysis of the U.S. database.

Conclusions

The SAEs reported during the U.S. trial do not appear to differ significantly from those reported in the pivotal NDA trials, although a full comparison is not possible at this time. The higher incidence of surgical intervention in the U.S. trials may be explained by the initial inexperience of U.S. clinicians in providing medical abortion. Investigators in the U.S. trial have indicated that there was a learning curve associated with the treatment of bleeding during the trial. The incidence of other events such as hemorrhage, transfusions, and hospitalizations were similar in the two studies. In summary, the current comparison of SAEs between our U.S. trial and the NDA pivotal trials indicated that medical abortion can be safely delivered in a wide variety of U.S. settings.

Table 1

Clinics in Population Council U.S. Studies Protocol 166A/B

Clinic Number	Investigator Name	Location	Type of Clinic*	Protocol A or B
01	Mishell	Los Angeles, CA	University Hospital	A
02	Haskell	Des Moines, IA	Planned Parenthood	A
03	Poppema	Seattle, WA	Other	A
04	Tyson	Burlington, VT	Planned Parenthood	A
05	Blumenthal	Baltimore, MD	University Hospital	A
06	Borgotta	White Plains, NY	Planned Parenthood	A
07	Malloy	Atlanta, GA	Other	A
08	Rothenberg	Shrewsburg, NJ	Planned Parenthood	A
21	Poindexter	Houston, TX	Planned Parenthood	B
22	Vargas	Denver, CO	Planned Parenthood	B
23			Planned Parenthood	B
24	Westhoff	New York, NY	University Hospital	B
25	Nichols	Portland, OR	Other	B
26	Sheehan	San Diego, CA	Planned Parenthood	B
27	Dean	St. Louis, MO	Other	B
28	Creinin	Pittsburgh, PA	University Hospital	B
29	Sogor	Cleveland, OH	Other	B

* Other = Clinic or Private Office.

Table 2

IND Safety Reports (Med Watch) Submitted to IND

Patient No.	Clinic No.	Adverse Event	D&C/ Asp.	Meth./ oxy.	IV Fluids	Trans-fusion	Hosp.	DA	Race	IND No. and Date
C01 (005)	22	Hemorrhage	X		X	X	X	63		107 11/21/94
036	02	Hemorrhage Vomiting Fainting	X		X			44		108 12/01/94
033	02	Vomiting Diarrhea Dehydration			X			49		108 12/01/94
027	02	Hemorrhage Cramping	X			X	X	53	East Asian	109 12/07/94
042	02	Hemorrhage Cramping Dizziness	X		X		X	51	Cau-casian	109 12/07/94
(057)	01	Hemorrhage Dizziness Headache Hypotension (BP 88/55, pulse 101) Tachycardia	X		X	X		44		110 12/20/94
015	25	Hemorrhage Cramping	X+					46		113 01/18/95
012	25	Hemorrhage Cramping	X					49		113 01/18/95
061	01	Hemorrhage Weak Nausea Pale & Cold			X			57		113 01/18/95
076	02	Hemorrhage Vomiting Cramping Chlamydial infection								113 01/18/95
033	03	Hemorrhage Syncope Pallor	X	X				52		113 01/18/95
022	25	Hemorrhage Cramping Feeling Faint	X		X		X	56		114 01/23/95
050	03	Hemorrhage Dizziness Postural Hypotension (BP 60/ palpable)	X				X	30		114 01/23/95

Table 2 (Cont'd)

Patient No.	Clinic No.	Adverse Event	D&C/ Asp.	Meth./ oxy.	IV Fluids	Trans-fusion	Hosp.	DA	Race	IND No. and Date
009	26	Hemorrhage Cramping Syncope	X		X		X	57		115 02/07/95
062	01	Hemorrhage Cramping	X				X	57	His-panic	118 02/15/95
107	01	Vomiting Dizziness			X					118 02/15/95
114	01	Hemorrhage	X	X			X	62	His-panic	118 02/15/95
123	01	Hemorrhage Dizziness Headache		X	X			53		118 02/15/95
037	04	Hemorrhage	X		X			65		118 02/15/95
109	01	Hemorrhage Fever	X		X		X	45		119 02/17/95
116	01	Chest Pain					X			119 02/17/95
048	03	Hemorrhage Tachycardia	X				X	51		120 03/03/95
076	03	Hemorrhage Cramping		X						121 03/06/95
060	24	Hemorrhage Hypotension Tachycardia			X	X		54		122 03/10/95
017	23	Hemorrhage Orthostatic Hypotension	X	X	X			57		123 03/13/95
070	02	Gunshot					X			123 03/13/95
030	23	Hemorrhage Syncope Tachycardia Hypotension	X		X			52		124 04/11/95
032	23	Vasovagal reaction			X					124 04/11/95
035	23	Hemorrhage		X	X					124 04/11/95
037	23	Hemorrhage Dizziness Shortness of Breath	X	X	X			51		124 04/11/95
081	26	Hemorrhage Syncope/neck injury	X+				X	51		124 04/11/95
158	02	Hemorrhage Weakness	X	X	X			54		125 04/19/95

Table 2 (Cont'd)

Patient No.	Clinic No.	Adverse Event	D&C/ Asp.	Meth./ oxy.	IV Fluids	Trans-fusion	Hosp.	DA	Race	IND No. and Date
159	01	Hemorrhage	X+	X	X			50		125 04/19/95
036	27	Pneumonia					X			132 06/07/95
012	29	Hemorrhage Cramping Faintness	X				X	53		132 06/07/95
028	04	Hemorrhage Dizziness		X						132 06/07/95
075	04	Nausea Dizziness			X					132 06/07/95
004	28	Hemorrhage	X	X			X	55		132 06/07/95
027	28	Hemorrhage Vomiting Lightheaded	X		X		X	50		133 06/13/95
071	23	Hemorrhage Vomiting Dizziness	X		X		X	55	Afro-Amer-ican	136 07/18/95
030	28	Hemorrhage								136 07/18/95
033	28	Hemorrhage	X				X	46		138 07/25/95
063	28	Anxiety attack Depression Threatened suicide					X	50		139 07/28/95
147	27	Viral meningitis					X			141 08/04/95
074	28	Hemorrhage Passed out	X	X	X		X	60		143 08/09/95
088	28	Hemorrhage (2 Med Watch reports)	X	X	X		X	62		143 08/09/95 144 08/10/95
018	07	Abdominal pain	X					42		145 08/15/95
019	07	Hemorrhage								145 08/15/95
104	28	Hemorrhage Cramping	X	X	X		X	62		146 08/25/95
108	28	Cramping Fever, tender uterus	X	X			X	63		147 09/01/95

Table 2 (Cont'd)

Patient No.	Clinic No.	Adverse Event	D&C/ Asp.	Meth./ oxy.	IV Fluids	Trans- fusion	Hosp.	DA	Race	IND No. and Date
116	24	Hemorrhagia Cramping Fever Endometritis	X		X			61		149 09/21/95
165	25	Hemorrhage Dizziness	X		X		X	60		154 11/02/95

Summary of Table 2

Total No. of Patients	Total No. of Clinics	Total No. of Adverse Events	Total Number of Treatments				Total No. Hospitalized
			D&C/ Asp.	Meth./ oxy.	IV Fluids	Transfusion	
52	13	**Hemorrhage** 41 **Faint/Dizziness**** 20 **Cramping** 14 **Vomiting** 06 **Hypotension** 05 **Tachycardia** 04	34	15	28	04	26

* Listed in chronological order as reported to the FDA.
+ Surgical procedure not reported on Med Watch form.
D&C/Asp = Dilatation and Curettage/Aspiration.
Meth/oxy = Methergine/Oxytocin.
Hosp = Hospitalizations.
DA = Number of days of amenorrhea.
** includes fainting, feeling faint or lightheaded, dizziness, vasovagal reaction, syncope and passing out.

Table 3

Correlation between Population Council Subject and Serious Adverse Event Coded by Roussel

Patient No.	Clinic No.	IDSN*	SAE** Coded by Roussel	Location in NDA Volume Page
C01 (005)	22	199500076RU	Metrorrhagia Anemia	Vol. 1.66 p.32
		199500439RU	Metrorrhagia Abdominal pain	Vol. 3.2 p.10
036	02	199500072RU	Metrohagia Vomiting Malaise	Vol. 1.66 p.32
033	02	199500442RU	Dehydration Nausea Vomiting Diarrhea	Vol. 3.2 p.10
027	02	199500074RU	Abdominal pain Anemia Metrorrhagia	Vol. 1.66 p.32
042	02	199500075RU	Abdominal pain Metrorrhagia Anemia	Vol. 1.66 p.32
057)	01	199500071RU	Metrorrhagia Hypotension Anemia	Vol. 1.66 p.32
		199500440RU	Metrorrhagia Hypotension Headache	Vol. 3.2 p.10
015	25	199500066RU	Metrorrhagia	Vol. 1.66 p.32
012	25	199500067RU	Metrorrhagia	Vol. 1.66 p.32
061	01	199500068RU	Hypotension	Vol. 1.66 p.32
076	02	199500069RU	Urogenital Disorder	Vol. 1.66 p.32
033	03	199500070RU	Metrorrhagia Syncope	Vol. 1.66 p.32
		199500444RU	Metrorrhagia Dizziness Headache	Vol. 3.2 p.10
022	25	199500441RU	Abdominal Pain Hypotension	Vol. 3.2 p.10
		199500064RU	Metrorrhagia	Vol. 1.66 p.32

Table 3 (Cont'd)

Patient No.	Clinic No.	IDSN*	SA** Coded by Roussel	Location in NDA Volume Page
050	03	199500065RU	Metrorrhagia Postural hypotension	Vol. 1.66 p.32
009	26	199500077RU	Metrorrhagia	Vol. 1.66 p32
062	01	199500102RU	Metrorrhagia	Vol. 1.66 p.32
107	01	199500443RU	Vomiting Nausea Dizziness	Vol. 3.2 p.10
114	01	199500104RU	Metrorrhagia	Vol. 1.66 p.32
123	01	NA***	NA	Vol. 1.66 p.32
037	04	199500106RU	Metrorrhagia	Vol. 1.66 p.32
109	01	199500100RU	Metrorrhagia Fever	Vol 1.66 p32
116	01	199500101RU	Chest pain	Vol. 1 66 p.32
048	03	199500140RU	Metrorrhagia	Vol. 1.66 p.32
076	03	NA	NA	Vol. 1.66 p.32
060	24	199500139RU	Metrorrhagia Hypotension	Vol. 1.66 p.32
017	23	199500135RU	Metrorrhagia Postural Hypotension	Vol. 1.66 p.32
070	02	NA	NA	Vol. 1.66 p.32
030	23	199500175RU	Metrorrhagia Syncope	Vol. 1.66 p.32
032	23	199500446RU	Syncope	Vol. 3.2 p.10
035	23	199500447RU	Metrorrhagia	Vol. 3.2 p.10
037	23	199500176RU	Metrorrhagia	Vol. 1.66 p.32
081	26	199500172RU	Metrorrhagia Syncope	Vol. 1.66 p.32
158	02	199500179RU	Metrorrhagia	Vol. 1.66 p.32
159	01	NA	NA	Vol. 1.66 p.32
036	27	199500247RU	Pneumonia	Vol. 1.66 p.32

Table 3 (Cont'd)

Patient No.	Clinic No.	IDSN*	SAE** Coded by Roussel	Location in NDA Volume Page
012	29	199500248RU	Metrorrhagia	Vol. 1.66 p.32
028	04	199500249RU	Metrorrhagia	Vol. 1.66 p.32
075	04	199500448RU	Dehydration	Vol. 3.2 p.10
004	28	199500251RU	Metrorrhagia	Vol. 1.66 p.32
027	28	199500455RU	Metrorrhagia	Vol. 3.2 p.10
071	23	199500329RU 199500449	Vomiting Metrorrhagia Dizziness	Vol. 1.66 p.32 Vol. 1.66 p.32
030	28	199500330RU	Metrorrhagia	Vol. 1.66 p.32
033	28	199500454RU	Metrorrhagia	Vol. 1.66 p.32
063	28	199500340RU	Depression	Vol. 1.66 p.32
147	27	199500342RU	Meningitis	Vol. 3.2 p.10
074	28	199500450RU 199500355RU	Metrorrhagia Hypotension Metrorrhagia Hypotension Anemia	Vol. 3.2 p10 Vol. 3.2 p.10
088	28	199500356RU 199500451RU	Metrorrhagia Metrorrhagia	Vol. 3.2 p.10 Vol. 3.2 p.10
018	07	199500365RU	Abdominal pain	Vol. 3.2 p.10
019	07	199500366RU	Metrorrhagia	Vol. 3.2 p.10
104	28	199500452RU	Metrorrhagia Uterine spasm	Vol. 3.2 p.10
108	28	199500375RU	Abdominal pain Fever	Vol. 3.2 p.10
116	24	199500453RU	Metrorrhagia Endometrial disorder	Vol. 3.2 p.10
165	25	199500427RU	Metrorrhagia Malaise	Vol. 3.2 p.10

*IDSN= International Drug Surveillance Number.
**SAE = Serious Adverse Event.
***NA = Not available, not yet assigned by Roussel

FOOD & DRUG ADMIN
1901 CHAPMAN AVE
ROCKVILLE MD 20852
(301)443-5455

SHIP DATE: 16JUL96
ACCT# 176669500

ACTUAL WGT: 1 LBS HAN-WT
DIM WEIGHT CHECKED
(716)275-7891

TO: Vivian Lewis, M.D.
University of Rochester Medical Ctr
Div of Reproductive Endocrinol
601 Elmwood Avenue Box 668
Rochester NY 14642

388 8210 837

FedEx.

388 8210 837

REF:

GOVERNMENT OVERNIGHT WED
SERVICE

CAD# 0640371 16JUL96
TRK# 388 8210 837

Deliver by:
17JUL96

ROC

14642-NY-US ZY ROC

PART # 147923 FORMAT # 077 RIT 03/96

FOOD & DRUG ADMIN
1901 CHAPMAN AVE
ROCKVILLE MD 20852
(301)443-5455

SHIP DATE: 16JUL96
ACCT# 176669500

ACTUAL WGT: 1 LBS HAN-WT
DIM WEIGHT CHECKED
(615)385-2490

TO: Deborah Harrigan, M.S.N.

388 8210 846

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388 8210 846

REF:

GOVERNMENT OVERNIGHT WED
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CAD# 0640371 16JUL96
TRK# 388 8210 846

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PART # 147923 FORMAT # 077 RIT 03/96

FOOD & DRUG ADMIN
1901 CHAPMAN AVE
ROCKVILLE MD 20852
(301)443-5455

SHIP DATE: 16JUL96
ACCT# 176669500

ACTUAL WGT: 1 LBS HAN-WT
DIM WEIGHT CHECKED
(818)564-3460

TO: Diana Petitti, M.D., M.P.H.
Kaiser Permanente Medical Care Prog
393 East Walnut Street

Pasadena CA 91188

388 8210 855

FedEx.

388 8210 855

REF:

GOVERNMENT OVERNIGHT WED
SERVICE

CAD# 0640371 16JUL96
TRK# 388 8210 855

Deliver by:
17JUL96

LAX

91188-CA-US

PART # 147923 FORMAT # 077 RIT 03/96

FOOD & DRUG ADMIN
1901 CHAPMAN AVE
ROCKVILLE MD 20852
(301)443-5455

SHIP DATE: 16JUL96
ACCT# 176669500

ACTUAL WGT: 1 LBS HAN-WT
DIM WEIGHT CHECKED
(205)934-5768

TO: Ricardo Azziz, M.D., M.P.H.
University of Alabama at Birmingham
Old Hillman Building 549
618 South 20th Street
Birmingham, Alabama AL 35233-7333

388 8210 864

FedEx.

388 8210 864

REF:

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CHAPMAN AVE
KVILLE MD 20852
)443-5455
Jane S. Zones, Ph.D.

ACTUAL WGT: 1 LBS MAN-WT
DIM WEIGHT CHECKED
(415)661-9031

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PART # 147923 FORMAT # 077 RIT 03/96

1901 CHAPMAN AVE
ROCKVILLE MD 20852
(301)443-5455

TO: Ezra Davidson, Jr., M.D.
Charles R. Drew Univ. of Med.
Dept. of OBGYN
1621 E. 120th St.
Los Angeles CA 90059

ACTUAL WGT: 1 LBS MAN-WT
DIM WEIGHT CHECKED
(310)603-4601

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REF:

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MBERLY TOPPER
OD & DRUG ADMIN
01 CHAPMAN AVE
CKVILLE MD 20852
301)443-5455

SHIP DATE: 16JUL96
ACC# 176669500

ACTUAL WGT: 1 LBS MAN-WT
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(888)949-2304

): Thomas S. Kosasa, MD
Department of Obstetrics & Gyn.
John A. Burns School of Med.
1319 Punahou St., Suite 1040
Honolulu HI 96826

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PART # 147923 FORMAT # 077 RIT 03/96

FOOD & DRUG ADMIN
1901 CHAPMAN AVE
ROCKVILLE MD 20852
(301)443-5455

SHIP DATE: 16JUL96
ACC# 176669500

ACTUAL WGT: 1 LBS MAN-WT
DIM WEIGHT CHECKED
(206)667-4630

TO: Janet R. Daling, PhD
Fred Hutchinson Cancer Research Cen
1124 Columbia Street (MET 381)

Seattle WA 98104

388 8210 785 FedEx.

388 8210 785

REF:

GOVERNMENT OVERNIGHT WED
SERVICE

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PART # 147923 FORMAT # 077 RIT 03/96

FOOD & DRUG ADMIN
1901 CHAPMAN AVE
ROCKVILLE MD 20852
(301)443-5455

SHIP DATE: 16JUL96
ACC# 176669500

ACTUAL WGT: 1 LBS MAN-WT
DIM WEIGHT CHECKED
(305)585-6958

TO: Mary Jo O'Sullivan, M.D.
Univ. of Miami School of Medicine
1611 Northwest 12th Avenue
East Tower Bldg./4th Flr., Rm. 4070
Miami FL 33136

388 8210 821 FedEx.

388 8210 821

REF:

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TRK# 388 8210 821

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PART # 147923 FORMAT # 077 RIT 03/96

FOOD & DRUG ADMIN
1901 CHAPMAN AVE
ROCKVILLE MD 20852
(301)443-5455

SHIP DATE: 16JUL96
ACC# 176669500

ACTUAL WGT: 1 LBS MAN-WT
DIM WEIGHT CHECKED
(301)496-5064

TO: Cassandra E. Henderson, MD
National Institutes of Health
6100 Executive Blvd.
Room 7B
Bethesda MD 20892

388 8210 794 FedEx.

388 8210 794

REF:

GOVERNMENT OVERNIGHT WED
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TRK# 388 8210 794

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#2

Mailout 7/3/96

15

POLLING OF COMMITTEE MEMBERS

COMMITTEE NAME: F + M

7/19/96 [Friday]

	DATE:	YES	NO		
1/3 cvg	1. E. Davidson, M.D. ✓				
6 cvg	2. J. Daling, Ph.D. ✓				
	3. C Henderson, M.D. ✓				
	4. E Wallach, M.D.		—	Called 6/11 him	7/2 per — will not attend meeting per Charlene — #3 FYI ✓
16 cvg	5. J Zones, Ph.D. ✓				
	6. T. Kosasa, M.D. ✓			6/11 office closed	
1/3 cvg	7. M. O'Sullivan, M.D. ✓				
1/3 cvg	8. K. Ryan, M.D. ✓			Do Not Send pa John	#3
	9. V. Lewis, M.D. ✓		—	6/11 called her	
	10. D. Narrigan, MSN ✓		—	6/11 out-of-country	
4/6 cvg	11. D. Petitti, M.D. ✓				
NEW Members	12. Ricardo Azziz ✓				
	13. Haywood Brown ✓				
	14. Phyllis Wingo			FYI	✓#3
	15. Julia Scott ✓				

Dr. Wallach + Wingo did not get mailout.

✓ FOI

#2 Madaus 7/10/96
F+M 7/19/96

SHIP DATE: 10JUL96
ACCT 176669500
ACTUAL WGT: 2 LBS HAN-WT
DIM WEIGHT CHECKED
(617)732-5750

MD 20852

...th J. Ryan, MD
...man and Women's Hospital
...Francis Street

...ston MA 02115

...8209 954

FedEx.

388 8209 954

REF:

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SERVICE

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PART # 147923 FORMAT # 077 RIT 03/96

FOOD & DRUG ADMIN
1901 CHAPMAN AVE
ROCKVILLE MD 20852
(301)443-5455

SHIP DATE: 10JUL96
ACCT 176669500
ACTUAL WGT: 2 LBS HAN-WT
DIM WEIGHT CHECKED

TO: Diana Petitti, M.D., M.P.H.
Kaiser Permanente Medical Care Prog
393 East Walnut Street
Pasadena CA 91188
(818)564-3460

388 8209 981

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388 8209 981

REF:

GOVERNMENT OVERNIGHT THU
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FOOD & DRUG ADMIN
1901 CHAPMAN AVE
ROCKVILLE MD 20852
(301)443-5455

SHIP DATE: 10JUL96
ACCT 176669500
ACTUAL WGT: 2 LBS HAN-WT
DIM WEIGHT CHECKED
(317)638-7795

TO: Haywood L. Brown, M.D.
Dept. of Obst. and Gyn.
Indiana Univ. School of Medicine
1001 10th Street
Indianapolis IN 46202

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PART # 147923 FORMAT # 077 RIT 03/96

FOOD & DRUG ADMIN
1901 CHAPMAN AVE
ROCKVILLE MD 20852
(301)443-5455

SHIP DATE: 10JUL96
ACCT 176669500
ACTUAL WGT: 2 LBS HAN-WT
DIM WEIGHT CHECKED
(716)275-7891

TO: Vivian Lewis, M.D.
University of Rochester Medical Ctr
Div of Reproductive Endocrinol
601 Elmwood Avenue Box 668
Rochester NY 14642

388 8209 963

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388 8209 963

REF:

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PART # 147923 FORMAT # 077 RIT 03/96

FOOD & DRUG ADMIN
1901 CHAPMAN AVE
ROCKVILLE MD 20852
(301)443-5455

SHIP DATE: 10JUL96
ACCT 176669500
ACTUAL WGT: 2 LBS HAN-WT
DIM WEIGHT CHECKED
(205)934-5708

TO: Ricardo Azziz, M.D., M.P.H.
University of Alabama at Birmingham
Div Hillman Building 549
618 South 20th Street
Birmingham, Alabama AL 35233-7333

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FOOD & DRUG ADMIN
1901 CHAPMAN AVE
ROCKVILLE MD 20852
(301)443-5455

SHIP DATE: 10JUL96
ACCT 176669500
ACTUAL WGT: 2 LBS HA...
DIM WEIGHT CHECKED
(202)835-0117

TO: Julia Scott, R.N.
National Black Women's Health Proj.
1211 Connecticut Ave., N.W., #310
Washington DC 20036

388 8210 015

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REF:

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PART # 147920 FORMAT # 077 RIT 03/96

...OD & DRUG ADMIN
...01 CHAPMAN AVE
...CKVILLE MD 20852
...01)443-5455

SHIP DATE: 10JUL96
ACCT 176669500
ACTUAL WGT: 2 LBS HAN-WT
DIM WEIGHT CHECKED
(615)385-2490

...: Deborah Harrigan, M.S.N.

...8 8209 972

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MEM
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Amended
1. FR Notice The Population Council
2. NDA 20-687 - Pharm. Review of NDA
3. Clinical Pharm. & BioPharm. Review
4. Stat. Review + ~~Eff~~ Eval.
5. Medical Officer's Rev. Summary

[redacted] DRUG ADMIN
[redacted] CHAPMAN AVE
[redacted]YILLE MD 20852
[redacted]1)443-5455

SHIP DATE: 10JUL96
ACC#: 176669500

ACTUAL WGT: 2 LBS HAN-WT
DIM WEIGHT CHECKED
(206)667-4630

TO: Janet R. Daling, PhD
Fred Hutchinson Cancer Research Cen
1124 Columbia Street (MET 381)
Seattle WA 98104

388 8209 893

388 8209 893

REF:

GOVERNMENT OVERNIGHT THU
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FOOD & DRUG ADMIN
1901 CHAPMAN AVE
ROCKVILLE MD 20852
(301)443-5455

SHIP DATE: 10JUL96
ACC#: 176669500

ACTUAL WGT: 2 LBS HAN-WT
DIM WEIGHT CHECKED
(310)603-4681

TO: Ezra Davidson, Jr., M.D.
Charles R. Drew Univ. of Med.
Dept. of OBGYN
1621 E. 120th St.
Los Angeles CA 90059

388 8209 902

388 8209 902

REF:

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FOOD & DRUG ADMIN
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(301)443-5455

SHIP DATE: 10JUL96
ACC#: 176669500

ACTUAL WGT: 2 LBS HAN-WT
DIM WEIGHT CHECKED
(301)496-5064

TO: Cassandra E. Henderson, MD
National Institutes of Health
6100 Executive Blvd.
Room 7B
Bethesda MD 20892

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388 8209 911

REF:

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FOOD & DRUG ADMIN
1901 CHAPMAN AVE
ROCKVILLE MD 20852
(301)443-5455

SHIP DATE: 10JUL96
ACC#: 176669500

ACTUAL WGT: 2 LBS HAN-WT
DIM WEIGHT CHECKED
(415)661-9831

TO: Jane S. Zones, Ph.D.

388 8209 927

388 8209 927

REF:

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FOOD & DRUG ADMIN
1901 CHAPMAN AVE
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(301)443-5455

SHIP DATE: 10JUL96
ACC#: 176669500

ACTUAL WGT: 2 LBS HAN-WT
DIM WEIGHT CHECKED
(808)949-2384

TO: Thomas S. Kosasa, MD
Department of Obstetrics & Gyn.
John A. Burns School of Med.
1319 Punahou St., Suite 1040
Honolulu HI 96826

388 8209 936

388 8209 936

REF:

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PART # 147923 FORMAT # 077 RIT 03/96

FOOD & DRUG ADMIN
1901 CHAPMAN AVE
ROCKVILLE MD 20852
(301)443-5455

SHIP DATE: 10JUL96
ACC#: 176669500

ACTUAL WGT: 2 LBS HAN-WT
DIM WEIGHT CHECKED

TO: Mary Jo O'Sullivan, MD
Dept. of OB/GYN
Univ. of Miami, Jackson Memori
1611 Northwest 12th Ave., East
Miami FL 33136

4th Floor
Rm. 4070

388 8209 945

388 8209 945

REF:

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POLLING OF COMMITTEE MEMBERS

COMMITTEE NAME: F + M 7/19/96 [FRIDAY]

DATE:	YES	NO	
1. E. Davidson, M.D. ✓			
2. J. Dating, Ph. D. ✓			
3. C Henderson, M.D. ✓			
4. E Wallach, M.D.		Called 4/11 him	4/12 per [illegible] will not attend meeting per Charlene — #3 FYI ✓
5. J Zonas, Ph.D. ✓			
6. T. Kosasa, M.D. ✓		6/11 office closed	
7. M. O'Sullivan, M.D. ✓			
8. K. Ryan, M.D. ✓		Do Not Send pa John	#3
9. V. Lewis, M.D. ✓		6/11 called her	
10. D. Narrigan, MSW ✓		6/11 out-of-country	
11. D. Petithy M.D. ✓			
12. Ricardo Azziz ✓			
13. Haywood Brown ✓		~~Do Not Send~~	#3
14. Phyllis Wingo		FYI	✓#:
15. Julia Scott ✓		will not attend	

1/3 cnf — 1/6 cnf — 1/6 cnf — 1/3 cnf — 1/3 cnf — 1/6 cnf — NEW Members

Dr. Wallach + Wingo did not get mailout.

✓ FOIA

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Food and Drug Administration

Memorandum

Date 12 July 1996 (Friday)

From Executive Secretary

CONFIDENTIAL

Subject CONFIDENTIAL MATERIAL FOR JULY MEETING

To Members of the Advisory Committee for Reproductive Health Drugs

Attached is material provided by the sponsor of the NDA to be considered next Friday's meeting.

Included are a summary of the pivotal clinical trials upon which evidence for safety and efficacy primarily depend, and the draft package insert, including physician labeling, and, starting on page 10, the text of the patient information leaflet.

Since some of the discussion will involve recommendations for conditions of safe use in the United States, ~~~~~ asks that you read the draft package insert with particular care.

Please remember that this material is CONFIDENTIAL and should not be shared with anyone except FDA staff and other Committee members.

The dinner for Thursday remains booked for 8 pm, but we ask that you gather in the dining room at 7:30 in order for ~~~~~ senior FDA staff members, to discuss media and security issues.

Philip A. Corfman, MD
Food and Drug Administration

ADVISORY COMMITTEE FOR REPRODUCTIVE HEALTH DRUGS
CENTER FOR DRUG EVALUATION AND RESEARCH

CHAIRMAN

Davidson, Jr., Ezra C., M.D. 6/30/97
Professor and Chair
Department of Obstetrics and Gynecology
Charles R. Drew University of Medicine
and Science
1621 E. 120th Street
Los Angeles, California 90059

EXECUTIVE SECRETARY

Corfman, Philip A., M.D.
Supervisory Medical Officer
for Fertility and Maternal
Health Drugs (HFD-510)
Food and Drug Administration
5600 Fishers Lane, Room 14B-04
Rockville, Maryland 20857
(301) 443-3510 Fax: (301) 443-9282

MEMBERS

Kosasa, Thomas S., M.D. 6/30/97
Associate Professor
Dept. of Obstetrics and Gynecology
John A. Burns School of Medicine
University of Hawaii
1319 Punahou Street, Suite 1040
Honolulu, Hawaii 96826

O'Sullivan, Mary Jo, M.D. 6/30/97
Professor and Director of Obstetrics
Department of Obstetrics and Gynecology
University of Miami School of Medicine
Jackson Memorial Hospital
1611 Northwest 12th Avenue
East Tower Building
4th Floor, Room 4070
Miami, Florida 33136

Ryan, Kenneth J., M.D. 6/30/97
Professor and Chairman
Brighman and Women's Hospital
Harvard Medical School
75 Francis Street
Boston, Massachusetts 02115

Lewis, Vivian, M.D. 6/30/98
Director
Division of Reproductive Endocrinology
University of Rochester Medical Center
601 Elmwood Avenue, Box 668
Rochester, New York 14642

Narrigan, Deborah L., M.S.N., C.N.M.
Course Coordinator 6/30/98
Frontier School of Midwifery
and Family Nursing
P.O. Box 528
Hyden, Kentucky 41749

Petitti, Diana B., M.D., M.P.H. 6/30/98
Director, Research and Evaluation
Kaiser Permanente Medical Care Program
Southern California Region
393 East Walnut Street
Pasadena, California 91188

Former committee members with terms ending 6/30/96 attending this meeting as Consultants:

Daling, Janet R., Ph.D. 6/30/96
Member
Fred Hutchinson Cancer Research Center
1124 Columbia Street (MET 381)
Seattle, Washington 98104

Henderson, Cassandra E., M.D. 6/30/96
Associate Professor
Department of Obstetrics and Gynecology
Albert Einstein College of Medicine
1825 Eastchester Road
Bronx, New York 10461

Consumer Representative:
Zones, Jane S., Ph.D. 6/30/96
Adjunct Assistant Professor
Dept. of Social and Behavioral Sciences
University of California, N631Y
San Francisco, California

FDA Guest Speaker:
Ricardo Azziz, M.D., M.P.H.
Professor of Obstetrics and Gynecology
Department of Obstetrics and Gynecology
University of Alabama at Birmingham
Old Hillman Building 549
618 South 20th Street
Birmingham, Alabama 35233-7333

July 19, 1996

Reproductive Health Drugs Advisory Committee

FDA Technical Center
Gaithersburg MD
19 July 19[illegible]

AGENDA

0900-0905 Opening comments. Confirmation of subsequent meeting dates: 20-22 November 1996; 13-14 February 1997; 5-6 June 1997.

NEW DRUG APPLICATION (NDA) FOR THE USE OF MIFEPRISTONE FOR INTERRUPTION OF EARLY PREGNANCY

0905-0915 Opening comments
David A. Kessler, MD
Commissioner of Food and Drugs

0915-1200 Presentations by the Sponsor, The Population Council (PC)

Sandra P. Arnold, BA (Mathematics)
Vice-President, Corporate Affairs (PC)

Ann Robbins, PhD
Scientist, Center for Biomedical Research (PC)

Irvin M. Spitz, MD
Senior Scientist, Center for Biomedical Research (PC)

C. Wayne Bardin, MD
Independent Consultant

Beverly Winikoff, MD, MPH
Program Director
Reproductive Health Programs Division (PC)

Elizabeth Newhall, MD
Medical Director, Downtown Women's Center
Portland, Oregon

1200-1300 Presentations by the FDA Reviewing Division

Introduction
Lisa Rarick, MD
Acting Director, Division of
Reproductive and Urologic Drug Products

Review of pharmacology and toxicology findings
Alexander Jordan, PhD
Pharmacology Team Leader

Review of non-US clinical findings
Ridgely C. Bennett, MD, MPH
Medical Officer

Review of US clinical findings and considerations for use
Lisa Rarick, MD

Reproductive Health Drugs Advisory Committee

FDA Technical Center
Gaithersburg MD
19 July 19

QUESTIONS

The regimen proposed for the use of mifepristone for the termination of early pregnancy consists of the oral administration of 600 milligrams of mifepristone within 49 days after the beginning of the last menstrual period, followed by oral administration of 400 micrograms of misoprostol 48 hours later.

1. a. Do the results of the open-label, historically controlled studies conducted in France establish the efficacy of this regimen for use in the United States?
   b. If not, what additional efficacy information should the applicant provide?
2. The safety database for this regimen consists of trials conducted in France, preliminary data from U.S. trials, and foreign post-marketing experience.
   a. Do these data adequately demonstrate that the regimen is safe for use in the United States when used for the proposed indication?
   In your discussion, please include comments on the following issues:
      - *Whether the adverse events associated with the regimen can be adequately managed when the regimen is administered as labeled.*
      - *The acceptability of the frequency of adverse events.*

   b. If not, what additional safety information should the applicant provide?
3. Taking into consideration the overall evidence for safety and effectiveness of the regimen, do you believe the benefits outweigh the risks for use of the regimen for the proposed indication in the United States?
4. If the regimen were to be approved, do you consider the labeling proposed by the applicant on how to administer the regimen and how to monitor patients who receive it to be appropriate?
5. If the regimen were to be approved, what further information, if any, do you recommend be included in the written information to be provided to the patient?
6. If the regimen were to be approved, do you have recommendations concerning the drug distribution system proposed by the applicant?
7. If the regimen were to be approved, what recommendations, if any, do you have for post-marketing studies?

DOCUMENTS CONNECTED WITH THIS MEETING MUST BE REQUESTED
IN WRITING FROM THE
FREEDOM OF INFORMATION OFFICE

Mail written request specifying date of meeting, name of committee, and a description of the documents requested to:

Food and Drug Administration
Freedom of Information Staff
HFI-35, Room 12A-16
5600 Fisher's Lane
Rockvilie, MD 20857

or fax to (301) 443-1726

Invoices are sent monthly by the Freedom of Information (FOI) Staff.
If requested, FOI will inform you of fees in advance.

TRANSCRIPTS OF THE OPEN SESSION WILL BE AVAILABLE FROM FOI FIFTEEN WORKING DAYS AFTER THE MEETING.

YOU MAY ALSO PURCHASE TRANSCRIPTS DIRECTLY FROM THE TRANSCRIBING COMPANY.

SUMMARY MINUTES WILL BE AVAILABLE APPROXIMATELY NINETY DAYS AFTER THE MEETING. PLEASE WAIT UNTIL THIS TIME PERIOD HAS ELAPSED BEFORE YOU PLACE YOUR ORDER.

This will allow time for the minutes to be written, edited, approved, and photocopied for distribution. You may phone (301) 443-5455 for status of minutes.

PHYSICIANS FOR
REPRODUCTIVE
CHOICE AND HEALTH

Suite 23o
459 Columbus Ave
New York, NY
10024

Tel: (212) 873-1118
Fax: (212) 724-2270

Testimony of Seymour L. Romney, M.D.

Chairman of

The Society of Physicians for Reproductive Choice and Health

Before the US Food & Drug Administration Advisory Committee for Reproductive Health Drugs

Concerning the New Drug Application for the Use of Mifepristone for the Interruption of Early Pregnancy

At the Center for Drug Evaluation and Research

July 19, 1996

Every Pregnancy A Wanted Pregnancy

I am Dr. Seymour L. Romney, the current Chair of the Society of Physicians for Reproductive Choice and Health. The Society of Physicians for Choice thanks the FDA for this opportunity to express our unqualified support for the new drug application that the Population Council has submitted concerning the safety of the antiprogesterone drug mifepristone. The Society of Physicians for Choice urges the FDA to promptly approve this application. It is vitally important to the reproductive health care of women and men that the known benefits of mifepristone and the to be-determined, safe and effective therapeutic usages of this agent, as well as other progestin analogues that can be synthesized, be carefully investigated and evaluated. The mission of The Society of Physicians for Reproductive Choice and Health is to enable concerned physicians to take a more active and visible role in support of universal reproductive health care. We are a national organization of physicians that works to ensure that everyone has the knowledge, access to quality services, and freedom of choice to make their own reproductive health care decisions. We educate and advocate that every pregnancy should be a wanted, intended pregnancy. We believe this condition is an essential component for the physical, mental and social well-being of women, men and children.

I am also here as an obstetrician-gynecologist of long standing duration, who has participated in the comprehensive health care of women as a clinician, a teacher and a researcher. I completed my training at two Boston institutions, the Boston Lying-In Hospital and the Free Hospital for Women in Brookline Massachusetts. Both no longer exist and have been fused into the now well known Brigham and Women's Hospital. My experience in Boston has been supplemented by more than 35 years in New York City where I was chair of the Department of Obstetrics and Gynecology at the Albert Einstein College of Medicine and currently serve as a Professor Emeritus. My credentials also include memberships in the American Gynecologic and Obstetric Society, the Society of Gynecologic Investigation, the American Association of Cancer Research, the American Association for the Advancement of Science and the American Association of Medical Colleges. The responsibility for teaching medical students and training residents, as well as maintaining high

quality standards for the health care of women is challenging and demanding. Many young motivated students want to know why mifepristone is not clinically available. In the past 45 years, significant progress has been made in almost eliminating maternal deaths, that we know are preventable. One of the most dramatic changes is the elimination of maternal deaths due to mismanaged septic abortions, back alley abortions or abortion complications including septic shock. Since Roe v. Wade, emergency rooms and hospital beds are not filled with dangerous or tragic self induced abortions. Mifepristone can be a valuable addition to this therapeutic armamentarium. It is one of the most important scientific advances in reproductive health care in decades.

My colleagues and I are acquainted with the details of the protocol and the implementation of the Population Council's multi-institutional mifepristone/misoprostol clinical trials. What we have learned in personal communications with responsible physicians participating in the trials in the United States, Sweden and England is that the clinical experience with mifepristone-misoprostol in this country is comparable to the ongoing and previously reported results recorded in the medical literature by well qualified physicians and investigators in France, Sweden, and Great Britain, where mifepristone was approved following clinical trials documenting its safety and effectiveness. More than 200,000 women in Europe have chosen to use mifepristone. The success rate for terminating early intrauterine pregnancy (up to 49 days from the beginning of the last menstrual period) is 95-97%. The side effects are equivalent to those encountered in a spontaneous miscarriage.

We have seen the informed consent form employed in the Population Council's sponsored clinical trials. It is accurately detailed, and can be easily understood by any woman seeking a non-invasive pharmacologic termination of pregnancy. That is her constitutional right. The exclusion criteria which need to be carefully evaluated in all patients is that the woman have no evidence of heart disease; is not a heavy smoker; does not have any ectopic tubal pregnancy nor any chronic liver or kidney disease which could complicate her care.

In support of the application, the Society of Physicians for Choice would like to include in this presentation, for the record, the extensive and detailed publication by the Institute of Medicine of the National Academy of Sciences entitled "**Clinical Applications of Mifepristone RU486 and Other Antiprogestins**" which is publicly available. This is a comprehensive report of a two day workshop involving the deliberations of a 7 member committee selected for their expertise in cell biology, pharmacology, epidemiology, reproductive endocrinology, care of women with hormone dependent clinical conditions and oncology. The workshop, convened in 1993, provided an unbiased evaluation of the science and potential clinical uses of antiprogestins for numerous diseases and conditions in addition to inducing abortion. The report identifies 20 recommendations of important work that should have been promptly undertaken at that time to further clarify the mechanisms of action of the antiprogestins and the potential for developing additional compounds involving the usefulness of inhibiting progesterone receptors. The FDA approval of this new drug application will predictably generate keen interest in possible other therapeutic uses of the antiprogestins that can be immediately pursued. If the drug is made available, there are a spectrum of important gynecologic problems including missed menses, term and post term labor induction, endometriosis and uterine leiomyomas that can hypothetically benefit therapeutically. Promising preliminary data has also been obtained in breast and endometrial cancer, meningiomas and antiglucocorticoid dependent conditions.

I am also providing for the hearing today, a resolution on mifepristone, identified here by its French brand name, RU 486 passed by the American Association for the Advancement of Science in April, 1991. The sense of this resolution is equally applicable today and comprehensively supports the Population Council's application. However, we now have the opportunity to make scientific and health care progress in 1996. The resolution reads:

"Whereas RU 486 a major new drug is both an antiglucocortiocid and antiprogesterone steroid that has many potential benefits for society, and whereas RU 486 is an effective treatment for Cushing Syndrome; it has shown effective activity in the treatment of some types of breast cancer; it has been used in France as a safe effective method for the termination of early pregnancy; and there is suggestive activity for its value in the treatment of endometriosis and difficult deliveries and whereas a hostile political climate has discouraged Roussel Uclaf, the French manufacturer of RU 486 from seeking a license to market the compound in the United States, and whereas the US Food and Drug Administration (FDA) has imposed an import alert on RU 486, and whereas AAAS is committed to freedom of scientific inquiry and the advancement of modern technology; be it resolved that the American Association of Advancement of Science encourages pharmaceutical companies and the FDA to make RU 486 and related agents available for further research and use as medically indicated."

Essential objective mifepristone clinical data is now available in the Population Council's new drug application that warrants FDA approval. The difficulties in obtaining the manufacture and distribution of RU 486 can be resolved. The **Society of Physicians for Reproductive Choice and Health** applauds the action of the Population Council and strongly urges the FDA to expedite the implementation of the manufacture and distribution of this important therapeutic molecule. We also encourage the submission of related therapeutic protocols to advance reproductive health care.

Thank you for your time.

SP71596

THE HENRY J. KAISER FAMILY FOUNDATION

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1995 Kaiser Family Foundation Survey on Mifepristone: Knowledge and Attitudes Among Obstetrician-Gynecologists

Prepared for
Reproductive Health Drug Advisory Committee
U.S. Food and Drug Administration

July 19, 1996

Conducted by Fact Finders, Inc. for the Kaiser Family Foundation

Abortion Delivery In the United States:
Half of Ob-Gyns Would Prescribe Mifepristone if Approved by the F.D.A.

One Third of Ob-Gyns Who Don't Currently Perform Surgical Abortions Say They Would Be Likely to Offer Mifepristone

A Kaiser survey found that six out of ten (59%) obstetrician-gynecologists (ob-gyns) familiar with mifepristone (also known as RU-486) -- or five out of ten (50%) of all ob-gyns -- say they would be "likely" to prescribe the drug for abortions if approved by the U.S. Food and Drug Administration (F.D.A.). (Sixteen percent of all ob-gyns surveyed said they were "not familiar" with mifepristone and therefore were unable to respond about their likelihood of prescribing the drug.)

Furthermore, many of the doctors who don't perform surgical abortions indicate that they would be likely to offer this non-surgical, or medical, method of abortion. Four out of ten (41%) ob-gyns who don't currently perform abortions and who are familiar with mifepristone -- or a third (33%) of all ob-gyns who don't perform abortions -- say they would be "very" or "somewhat" likely to prescribe the drug for abortions if approved by the F.D.A. (Nineteen percent of all ob-gyns surveyed who do not perform abortions said they were "not familiar" with mifepristone and therefore were unable to respond as to their likelihood of prescribing the drug.) Among ob-gyns who cite an "ethical," "moral," or "religious" reason for not performing surgical abortions, 2 out of 10 say they would be "likely" to prescribe mifepristone for abortions. Among ob-gyns who don't currently perform abortions, those most likely to say they would prescribe mifepristone are those who cite some reason other than "ethical," "moral," or "religious," such as community pressure, institutional barriers, or some other reason.

Ob-Gyns familiar with mifepristone consider it a "safe" and "effective" drug regimen to end a pregnancy. Ninety-seven percent of ob-gyns familiar with mifepristone say it is "effective," including three-quarters (76%) who say it is "very effective." The remaining three percent had "no opinion." Physicians are similarly confident about mifepristone's safety: more than nine out of ten ob-gyns familiar with mifepristone (94%) say it is "safe," including six out of ten (58%) who say it is "very safe." The remaining six percent had "no opinion." (The 16 percent of ob-gyns who said they "not familiar" with mifepristone were not asked about the effectiveness and safety of the mifepristone regimen.)

Methodology

The Kaiser Survey on Physicians' Attitudes and Practices Regarding Contraception and Unplanned Pregnancy was a telephone survey of 307 obstetricians/gynecologists drawn in a random-probability sample design from the American Medical Association's Physicians Masterfile. It was conducted for the Foundation by Fact Finders, Inc. between February 1 and March 21, 1995. The margin of sampling error for the national sample is plus or minus 5.7 percent. The margin of sampling error may be higher for some of the sub-sets looked at in this analysis, which have smaller populations.

The Kaiser Family Foundation, based in Menlo Park, California, is a non-profit, independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. The Foundation's work is focused on four main areas: health policy, reproductive health, HIV, and health and development in South Africa.

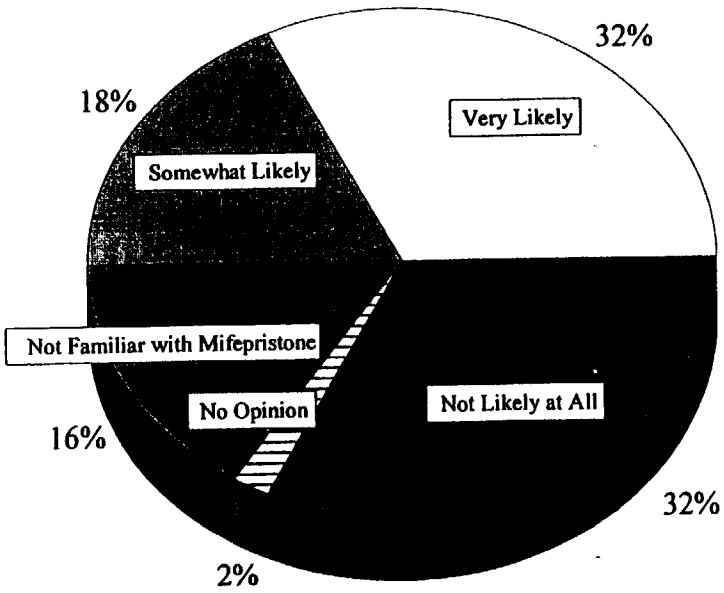
* * *

CHART 1

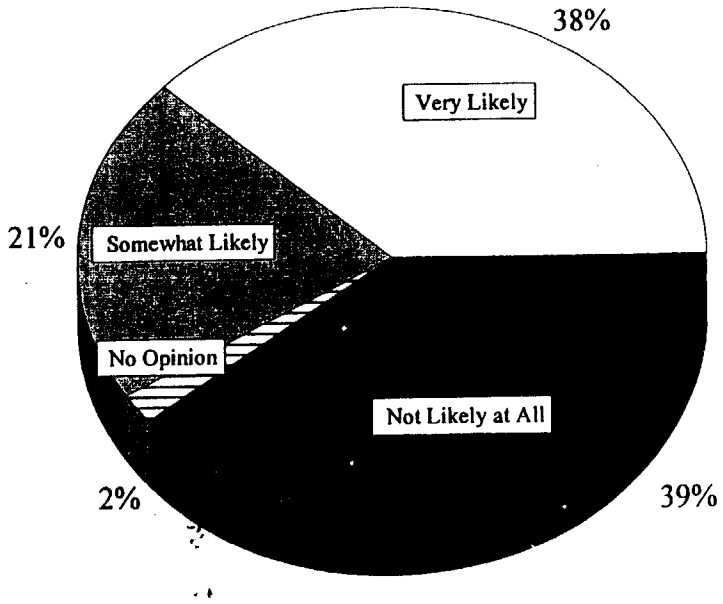
Many Ob-Gyns Say They Will Offer Medical Abortion

Likelihood to Prescribe Mifepristone (RU-486) if Approved by the F.D.A.

Among All Ob-Gyns
(N = 305)



Among Ob-Gyns Familiar with
Mifepristone
(N = 255)



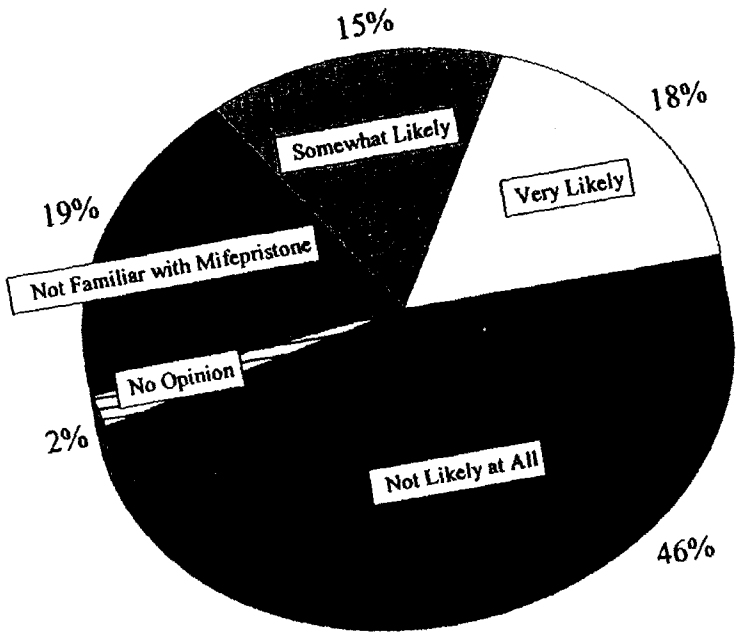
Source: 1995 Kaiser Family Foundation Survey on Physicians' Attitudes and Practices Regarding Contraception and Unplanned Pregnancy

CHART 2

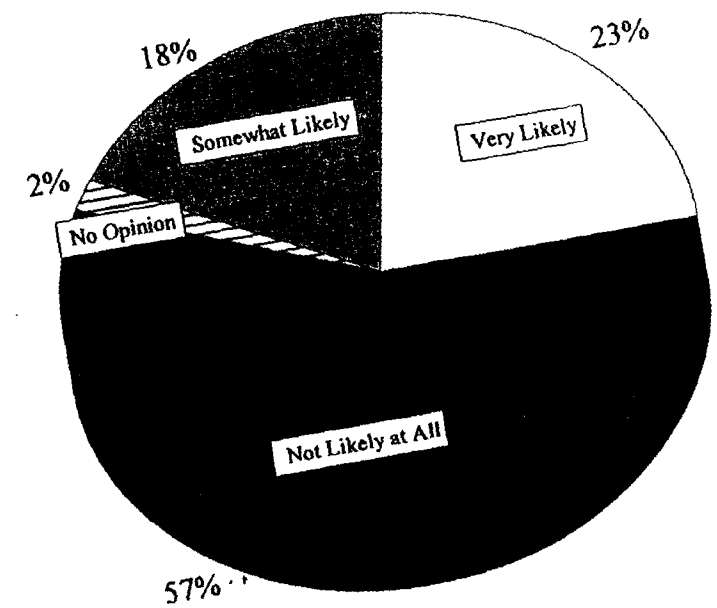
Medical Abortion May Expand Number of Providers

Likelihood of Ob-Gyns Who Don't Perform Surgical Abortion to Prescribe Mifepristone (RU-486) if Approved by the F.D.A.

Among All Ob-Gyns Who Don't Currently Perform Abortions (N = 201)



Among Ob-Gyns Who Don't Currently Perform Abortions and Who Are Familiar with Mifepristone (N = 155)



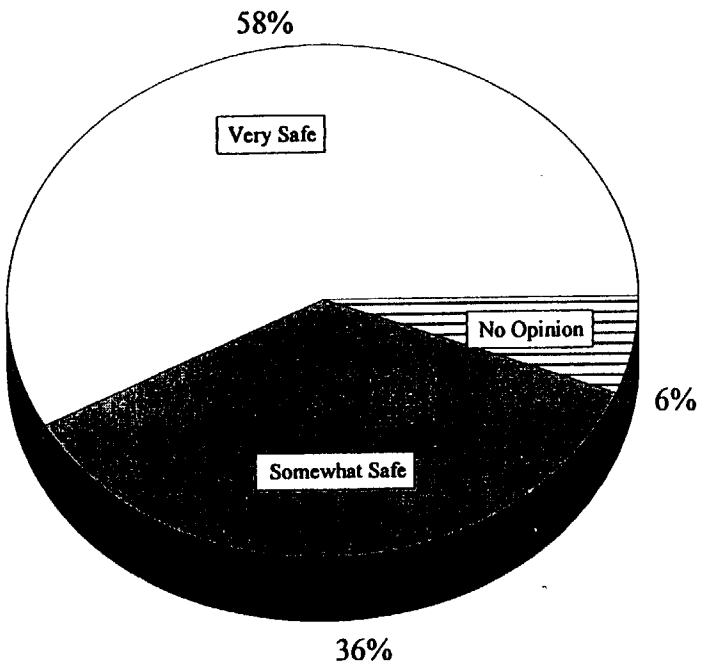
Source: 1995 Kaiser Family Foundation Survey on Physicians' Attitudes and Practices Regarding Contraception and Unplanned Pregnancy

CHART 3

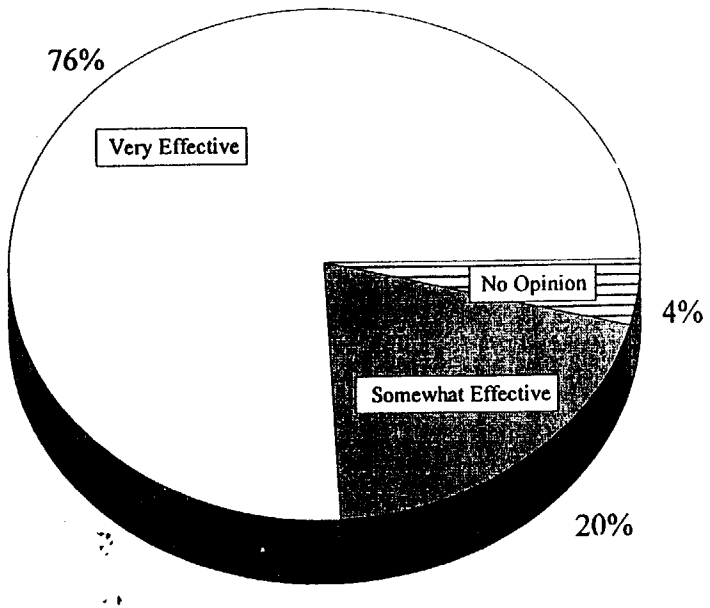
Ob-Gyns Consider Mifepristone "Safe" and "Effective"

Views Among Ob-Gyns Familiar with Mifepristone

Safety of Mifepristone



Effectiveness of Mifepristone



Source: 1995 Kaiser Family Foundation Survey on Physicians' Attitudes and Practices Regarding Contraception and Unplanned Pregnancy

Planned Parenthood®
Federation of America, Inc.

TESTIMONY OF
GLORIA FELDT, PRESIDENT,
PLANNED PARENTHOOD FEDERATION OF AMERICA,
BEFORE THE FOOD AND DRUG ADMINISTRATION'S
ADVISORY COMMITTEE ON REPRODUCTIVE HEALTH DRUGS

JULY 19, 1996

I am Gloria Feldt, President of the Planned Parenthood Federation of America. Each year, our nearly 1,000 health care centers across the country provide medical and educational services to more than five million patients. The first birth control clinic in the United States was opened 80 years ago by our founder, Margaret Sanger. Ever since, family planning to enable people to prevent unintended pregnancies and plan wanted ones has been the heart and soul of our work.

Planned Parenthood centers provide abortion services to about 130,000 women each year. Six of our centers were part of the US mifepristone clinical trials. The women we serve, and millions of other women, have a strong interest in the issue before you today. Every time there is a news story about medical abortion, women call Planned Parenthood. Often they are women who have just missed their periods -- they are early in an unintended pregnancy.

Many women want to end their unintended pregnancies without surgery or anesthesia. They want to have an abortion as early as possible. Mifepristone gives women the ability to do both these things. Women ask us about medical abortion, and we have to

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tell them, "yes, we know it is available in Europe, but we cannot offer it to you here." These women are understandably frustrated.

Political reasons, not medical reasons, stood in the way of introducing mifepristone in France at first, until the Public Health Service declared it to be "the moral property of women" and went forward with it. It has taken us longer to overcome the political obstacles here in the United States. We are gratified that mifepristone, which has been used successfully by more than 200,000 women in Europe, has finally reached the point of FDA consideration. Mifepristone should be reviewed in the same manner as any other drug.

For many years, a small band of groups opposed to both family planning and abortion, has limited women's access to advances in reproductive health technology. Strident opposition, including threats of boycott, from these religious political extremists has chilled -- indeed, frozen -- critical research and testing for all kinds of health advances that would help protect the fertility and lives of women, and might also contribute to medical treatment for other conditions. I know you must be under tremendous political pressure from opponents of mifepristone. But I am convinced, from the experience that women had with mifepristone at Planned Parenthood centers, that mifepristone can be used safely and effectively in the United States as it is in Europe.

I hope this hearing today will mark the beginning of a new era for women as they strive to plan and space their children responsibly.

The acceptability study presented today by the Population Council backs up what our physicians, nurses, and counselors all experienced. They found that most women were quite satisfied with medical abortion. Women chose to participate in the test trial only after a thorough consultation, during which the expectation and events of the procedure were explained. Because of that in-depth counseling, women said they were prepared for the mifepristone process. The side effects some experienced did not surprise or

scare them. For most women in fact, the procedure was what they expected, or better than they expected. Some said they felt the mifepristone procedure was more natural. Certainly, there is no drug or medical procedure that comes without some level of risk, which is why we have the FDA, to determine the degree of risk associated with drugs and procedures.

Unintended pregnancy is a tremendous problem in the United States -- close to 60% of pregnancies are not intended. We at Planned Parenthood do our best to serve women with contraceptive information and services. But when women come to us with an unintended pregnancy, we offer them full information on all of their options, from prenatal care and adoption, to abortion. It is imperative that American women have access to the newest, safest methods of ending a pregnancy -- and as early as possible. Mifepristone should be an important part of that.

Making mifepristone available will also eventually increase women's access to abortion services, and make harassment and violence less effective as a weapon against women and the health care professionals who serve them. A survey of obstetrician/gynecologists by the Kaiser Family Foundation concluded that a third of the OB/GYNs who do not now offer surgical abortion would be likely to administer mifepristone. That would make a difference to women in areas with no surgical abortion provider, and that is what the opponents of mifepristone truly fear.

In summary, our experience with mifepristone was what we at Planned Parenthood, and the women we serve, expected. For the overwhelming majority of women, mifepristone proved safe and effective. The complications that arose were the ones we expected and were manageable. Serious ones were rare. Most women were satisfied.

We at Planned Parenthood look forward to offering medical abortion using mifepristone. We are ready. French women have had access to mifepristone since 1988. It is time to offer American women this new, safe choice. Thank you.

FEMINIST MAJORITY FOUNDATION
Working for Women's Equality

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TESTIMONY BEFORE THE U.S. FOOD AND DRUG ADMINISTRATION ADVISORY COMMITTEE ON REPRODUCTIVE HEALTH

JULY 19, 1996

ELEANOR SMEAL, PRESIDENT FEMINIST MAJORITY FOUNDATION

My name is Eleanor Smeal. I am President of the Feminist Majority Foundation.

For the past eight years, French women and now women in Great Britain, Sweden, and China have had available to them the option of medical abortion. For eight long years, American women have fought to have this safe, effective choice available to them.

Every step of the way, rather than decisions being based on pure science and medicine, politics instead have blocked or slowed the distribution of Mifepristone. If the medical well-being of women were the only issue, Mifepristone would have been approved eight years ago.

The Feminist Majority Foundation has led the nation's largest public education campaign to make Mifepristone available in the United States. We began our Campaign for RU 486 and Contraceptive Research in 1988 after an exhaustive review of scientific data on Mifepristone, extensive consultations with leading scientists and health care providers in the United States and abroad, and visits to clinics in France where we spoke with women who had undergone medical abortions with Mifepristone. As women's health advocates, we wanted to make sure Mifepristone was as safe, effective, and acceptable to women as it appeared from news reports. Our conclusion: Mifepristone as a method of early abortion and as a potential treatment for diseases and conditions ranging from some forms of breast cancer to endometriosis is a major medical breakthrough in women's health care that must be made available to women in the United States.

The feminist and scientific communities in the United States share this very positive assessment of Mifepristone. Over the past seven years, we have delivered over 700,000 petitions from women and men in this country urging the French pharmaceutical company that developed RU 486 and its German parent company to license the compound in the United States. We also presented petitions from 3,000 scientists and academicians who were outraged at the "medical McCarthyism" of

allowing politics to prevail over scientific research. All major feminist and women's organizations and medical and scientific associations in this country have passed resolutions asking for introduction of Mifepristone to the United States and for an expansion of trials on the compound's many promising indications. These associations include the American Public Health Association, National Organization for Women, American Psychological Association, American Association for the Advancement of Science, National Abortion and Reproductive Rights Action League, Association of Reproductive Health Professionals, National Women's Health Network, Endocrine Society, and American Institute of Biological Sciences, to name a few.

The public supports Mifepristone as well. Last year, Louis Harris, the dean of pollsters, asked a nation-wide cross-section of Americans whether or not they thought RU 486 should be made available to women in the United States. An overwhelming 66% said yes, which is especially significant since Mifepristone is not yet on the market here. Legislatures in states such as New Hampshire, California, Hawaii, Colorado, and Maine have passed resolutions in support of Mifepristone.

Physicians also are ready to incorporate Mifepristone into their practice of medicine. The Kaiser Foundation found that one-third of obstetricians and gynecologists who do not currently perform abortions are interested in administering Mifepristone.[1]

Most importantly, women want Mifepristone in the United States. The Feminist Majority Foundation receives calls almost daily from women wanting to know where they can go to obtain RU 486. Some of these women want access to this medication so desperately that they are willing to travel to Great Britain to the Marie Stopes Clinic, which accepts American patients.

Women who have had access to Mifepristone greet the new procedure very positively. In France, approximately 80% of women seeking abortion during the early stage of pregnancy (for which Mifepristone is appropriate) choose the medical procedure over surgical abortion. In the United States, almost 50% of abortions now take place in the first nine weeks of pregnancy and 90% of abortions are performed in the first trimester. Mifepristone will probably replace at least one-half of surgical abortions.

Why has Mifepristone inspired such enthusiasm among women and health care providers? Used in France up to 49 days and in Great Britain and Sweden up to 63 days, Mifepristone is a safe, effective method of early abortion. Since physicians generally do not perform vacuum aspiration abortions until the seventh week of pregnancy or later, Mifepristone is the only method of early abortion a women can seek as soon as she knows she is pregnant. Mifepristone gives women greater control over the termination of their pregnancies. The Mifepristone procedure is non-invasive, does not require anesthesia, and has no risk of infection.

A leading Mifepristone researcher, Dr. Gary Hodgen, who is President of the Jones Institute Foundation and Professor of Reproductive Medicine at the Eastern Virginia Medical School, had planned to testify today. Dr. Hodgen was called away for a family emergency, but he wanted me to convey to you his conclusions about the compound's safety. Dr. Hodgen brought the first RU 486 into the United States in 1982. He has studied Mifepristone extensively in both pre-clinical and

clinical trials. He has published over 30 peer-reviewed articles on RU 486. In all of this research experience, Dr. Hodgen has found no scientific evidence of safety problems from Mifepristone. Even embryonic and fetal development progressed normally, despite early exposure to RU 486 either *in vitro* or *in utero*. Dr. Hodgen concludes, "I believe that this drug is safe for women!"

The Feminist Majority Foundation has fought long and hard to protect women's access to abortion and other medical services. In addition to our work to bring Mifepristone to this country, we lead a nationwide National Clinic Access Project to help protect clinics from anti-abortion violence and to help keep clinics open and accessible. We work closely with all types of clinics: for-profit and non-profit, independent and those affiliated with large organizations, and individual doctors that perform abortions. We also conduct an annual clinic violence survey. Our 1995 Survey found that violence at clinics declined overall, but 38.7% of clinics still faced one or more of the most severe forms of violence, including death threats, stalking, bomb threats and bombings, chemical attacks, blockades, invasions, arson and arson threats. Availability of Mifepristone could significantly curb anti-abortion violence. As more physicians begin to administer Mifepristone, abortion services will become more decentralized, significantly undermining anti-abortion violence at clinics.

The time for approval of Mifepristone is now -- and long overdue. Every day that Mifepristone is not available to American women is another day that some woman will suffer needlessly. Equally important, every day Mifepristone is not available is another day that scientific development of anti-progestins for a number of serious diseases and conditions primarily affecting women will be delayed.

Today's hearing is on the safety and efficacy of Mifepristone as a method of pregnancy termination. But your actions today and the FDA's ongoing review process of The Population Council's New Drug Application for Mifepristone as an abortifacient have even broader implications for women's health care.

In 1989, under the Bush Administration, the FDA issued an "import alert" on RU 486 that sent the message that the United States was hostile towards the research and development of Mifepristone. The import alert, as scientific researchers testified before Congress, effectively brought to a halt even non-abortion research on Mifepristone. It is time for the FDA to reverse this negative symbolism. With its approval of Mifepristone, the FDA will signal scientists and manufacturers that research on the compound's many indications for improving women's health can move forward at long last.

Here are just some of the promising uses of Mifepristone that result from the compound's properties as both as anti-progestin and an anti-glucocorticoid:

* Mifepristone shows promise as a treatment for progesterone-dependent breast cancers,[2] which account for some 40% of all breast cancer tumors. New research has found Mifepristone may inhibit the proliferation of ovarian cancer cells.[3]

* Other trials have found that Mifepristone may be used to treat endometriosis and fibroid tumors.[4]

* Meningiomas, brain tumors which can be fatal if inoperable, have shown some response to Mifepristone in clinical trials. Meningiomas occur two times more frequently in women than men.[5]

* Some forms of Cushing's Syndrome, an adrenal disorder that results from the over-production of cortisol and that primarily affects women in their twenties through forties, can be treated with Mifepristone.[6] Two survivors of Cushing Syndrome testified before Congress in 1990 that Mifepristone saved their lives.[7]

* Labor induction[8] and post-coital contraception[9] are two of the many other serious conditions for which Mifepristone may be an effective treatment.

* Mifepristone's anti-glucocorticoid action may have profound indications for the treatment of HIV virus, Alzheimer's, depression and other diseases and conditions related to elevated levels of cortisol.[10]

Scientists want to do this research. Two prominent researchers who have studied non-abortion indications of Mifepristone asked me to submit their testimony today and to convey to this Committee how much your recommendation and FDA approval of Mifepristone will mean to women's health research. Dr. Kathryn Horwitz is a breast cancer researcher at the University of Colorado who testified before Congress that the FDA's import alert had impeded her ability to secure supplies of RU 486. Dr. Ana Murphy and her colleagues conducted pioneering research on the use of Mifepristone as a treatment for endometriosis and fibroid tumors. This research, too, has been stalled by limits on the supply of Mifepristone available for U.S. trials in the absence of an American distributor for the compound. Approval of Mifepristone by the FDA will finally open the doors to much-needed medical research.

The women of this nation have already waited far too long for access to the same medical treatment available to women in Europe. Over 200,000 women from around the world have used Mifepristone as a method of early abortion. It is safe. It is effective. Mifepristone has met and exceeded all FDA requirements for licensing. The Population Council has submitted 163 volumes of data to the FDA. We urge this Advisory Committee and the FDA to act expeditiously to allow this medical advance ~~to~~ finally be available to American women.

Thank you.

ENDNOTES

[1]Kaiser Family Foundation, National Survey of Obstetricians and Gynecologists on Contraception and Unplanned Pregnancy, 1995.

[2]Klign JGM, *et al.* "Pre-clinical and Clinical Treatment of Breast Cancer with Antiprogestins." *Human Reproduction.* Vol. 9 Supp 1, 1994.

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[6]Nieman, LK *et al.* "Successful Treatment of Cushing's Syndrome with the Glucocorticoid Antagonist RU486." *Journal of Clinical Endocriiology and Metabolism.* Vol 61 (3), 1985; 536-540.

[7]House of Representatives, Subcommittee on Regulation, Business Opportunities, and Energy, Committee on Small Business, RU 486: The Import Ban and its Effects on Medical Research, serial no. 101-85, November 19, 1990.

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[9]Baird, DT, Dewar M, Glasier A, *et al.* "Mifepristone (RU486) Compared with High-Dose Estrogen and Progestogen for Emergency Postcoital Contraception." *New England Journal of Medicine.* Vol 327 N 15, October 8, 1992; 1041-1044.

[10]Weiner, *et al.* The glucocorticoid receptor type II complex is a target of the HIV-1 vpr gene product. *Proc. Natl. Acad. Science, USA,* 92, 3621-3625: (Apr) 1995; "New International Association Provides Evidence of Cortisol's Major Role in AIDS and Other Diseases." *PR Newswire, Financial News.* June 21, 1996.

STATEMENT OF

THE ALAN GUTTMACHER INSTITUTE

BEFORE THE

ADVISORY COMMITTEE FOR REPRODUCTIVE HEALTH DRUGS

OF THE

FOOD AND DRUG ADMINISTRATION

JULY 19, 1996

Presented by

Lisa Kaeser, JD
Senior Public Policy Associate

Good afternoon. I am Lisa Kaeser, representing The Alan Guttmacher Institute (AGI), an independent, not-for-profit corporation for research, policy analysis and public education on issues relating to reproductive health. We appreciate the opportunity to make a statement regarding the committee's consideration of the use of mifepristone for the interruption of early pregnancy.

As you may know, six in 10 pregnancies in the United States are unintended. Nearly half of these end in abortion. Currently, abortion is a legal procedure used by almost half of all women in this country at some point in their lives. Any new method of abortion, including medical abortion such as mifepristone, should be judged and made available based on the scientific evidence of its safety and effectiveness, according to the criteria and processes applicable to other medical treatments. Thus, if the Food and Drug Administration (FDA) determines, based on the evidence presented and its own best judgement, that mifepristone is safe and effective, it should be approved, and a new option can be made available to women in the U.S.

Once the decision to have an abortion is made, time is of the essence. The risk of complications increases with the length of gestation, and most women who have made the decision to terminate pregnancy want to do so as soon as possible. Even though currently available surgical methods of abortion are very safe, medical methods of abortion, such as mifepristone, could be extremely useful to women who prefer not to have surgery.

Moreover, while 98% of abortion facilities will provide services at eight weeks' gestation, most providers of surgical abortion set minimum gestation limits before which

they will not perform the procedure. According to AGI's most recent abortion provider survey, conducted in 1993, the most common gestation requirement is six weeks since a woman's last menstrual period (LMP), the criterion used by 43% of nonhospital facilities. In fact, only 26% of surgical abortion providers offer care to women at four or five weeks LMP. Some 24% of facilities do not provider surgical abortion until women are at least seven weeks (19%) or eight weeks (five percent) from LMP, that is, at least five weeks since conception.

Many of these limitations continue to exist, despite the fact that the newest pregnancy tests are highly sensitive, some accurately predicting pregnancy as soon as ten days after conception, and allowing women who ultimately choose abortion to make their decisions earlier. For those who do not want to wait until later in the pregnancy to obtain surgical abortion, a medical method that can be used earlier could be highly beneficial.

While the availability of medical abortion has the potential to reduce some of the barriers to abortion services, at this time we do not know what kind of eventual impact the approval of mifepristone will have. It would be unrealistic to expect this new method to solve *all* problems of access. As it is, few providers are available to perform surgical abortions – particularly in some areas of the country. Currently, 66% of private fee-for-service and 77% of HMOs in the U.S. cover surgical abortion. If mifepristone is deemed by the FDA to be safe and effective for the termination of early pregnancy, and is approved, coverage for this new option should be at least the same as that for surgical abortion.

Clearly, the political pressures brought to bear against surgical abortion and its providers have already affected the development of medical abortion. Unfortunately,

these pressures have also served to slow research on mifepristone and related drugs for other purposes, including their possible use for contraception. Should the FDA approve mifepristone, we hope that these other avenues can be pursued.

DOCUMENTED OR SUSPECTED PHARMACOLOGICAL ACTIONS OF RU486

Appendix A

		References
1.	Interference with pinopod function.	1
2.	Stimulation of steroidogenesis.	2
3.	Disruption of folliculogenesis.	3
4.	Inhibition of ovulation.	3
5.	Decreased intracellular calcium.	4
6.	Decreased penetration of oocytes by spermatazoa.	4
7.	Interference with progesterone receptor function.	5
8.	Inhibition of aldosterone effect.	6
9.	Altered ratios of LH:FSH.	7
10.	Altered ratios of testosterone:estradiol.	7
11.	Increased serum prolactin.	7
12.	Altered release of androgen.	7
13.	Increased testosterone.	7
14.	Relative deficiency of FSH.	14
15.	Decreased ovulatory LH release.	15
16.	Increased LH during follicular growth.	15
17.	Altered serum estrogen profiles.	16
18.	Suppressed progesterone levels.	8
19.	Inhibition of E2 secretion.	8
20.	Induction of cervical ripening during pregnancy.	9
21.	Delayed emergence of the periovulatory progesterone rise.	10
22.	Induced dilatation and softening of the uterus.	17
23.	Disruption of sexual development in rat embryos.	11
24.	Inhibition of in vitro development of mouse 2 celled embryos, morulae, and early blastocytes.	18
25.	Interference with egg transport.	19
26.	Reduced perivascular decidual cell hemostasis.	12
27.	Degradation of endometrial extracellular matrix	12
28.	Inhibition of normal secretory transformation of the endometrium.	13
29.	Inhibition of steroidogenesis.	2

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NATIONAL ABORTION FEDERATION

Testimony of Dr. Paul Blumenthal Before the Food & Drug Administration's Advisory Committee For Reproductive Health Drugs On Behalf of the National Abortion Federation[1]
July 19, 1996

My name is Paul Blumenthal. I am a Board-Certified Obstetrician-Gynecologist practicing at Johns Hopkins' Bayview Medical Center. I am an Associate Professor of Gynecology and Obstetrics at The Johns Hopkins University School of Medicine and am the Medical Director of Planned Parenthood of Maryland. I am also a specialist in epidemiology and reproductive health care and am a Fellow of the American College of Obstetricians and Gynecologists (ACOG). In addition, I am an advisor to the World Health Organization and the United States Agency for International Development on issues relating to safe motherhood, contraception, reproductive health care and quality assurance. I am here today speaking for the National Abortion Federation, the national organization of abortion providers, and to share with you our experiences with mifepristone.

The National Abortion Federation (NAF) was established in 1977 as a professional association of abortion providers committed to ensuring that abortion services remain legal, safe,

[1]The opinions expressed here are those of Dr. Blumenthal and not necessarily those of the Johns Hopkins University, the Johns Hopkins Health System or the Johns Hopkins Bayview Medical Center.

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and accessible for all women. NAF's members provide about half of all abortions in the United States each year: Several NAF members, including me, participated in the Population Council's clinical trial of mifepristone. Our experience matched that reported in other countries: mifepristone is a safe and effective form of early abortion which should be an option for women wishing to terminate a pregnancy.

As you are aware from this morning's presentations, mifepristone blocks the action of progesterone, a hormone needed to sustain a pregnancy and in trials to date, has been proven safe and effective in terminating early pregnancy. Our experience during the clinical trials was consistent with the experience in Europe -- the drug was quite safe and effective, and women who participated were generally very positive about this method. I believe one of the reasons medical abortion with mifepristone is successful is the thorough counseling that both providers and women receive. As a provider, I knew what to expect and how to treat women who were going through this process. There were no unexpected side effects and at no time did I feel that my patients were in danger. Equally as important, my patients knew what to anticipate and as a result, felt confident using the drug. Many of the women in the clinical trial at my site expressed their strong support for this drug because it allowed them to participate in and have a sense of control over this experience.

As a doctor, I believe that not only is mifepristone safe and effective, but for some women, it may be the most appropriate method of pregnancy termination. In some settings, especially in resource poor settings such as the developing world, legal access to mifepristone

may result in improved health care for millions of women who are exposed to and die from unsafe and ineffective abortions. Approval by the FDA of mifepristone, would undoubtedly improve access to a safe and effective abortion method worldwide.

As you know, mifepristone is the culmination of many years of research. It has been tested in both developing and industrialized countries by the Population Council and the World Health Organization. The governments of France, England and Sweden have all approved the use of mifepristone after their own rigorous clinical trials, and worldwide, over 200,000 women have used this non-surgical abortion method. Moreover, mifepristone has many other potential uses besides that of an abortifacient. It has been tested as an emergency/postcoital contraceptive with promising results. Mifepristone could also be used in treating several other conditions related to pregnancy (induction of labor and cervical dilation); gynecological disorders (infertility, endometriosis, and uterine fibroids); and other medical problems such as breast cancer. With so many potential uses and an impressive and efficacious record, we hope that mifepristone will be favorably reviewed by the Food and Drug Administration (FDA). Mifepristone is an important option for women faced with unwanted pregnancies, and I urge you to approve it for use in the United States.

American Victims of Abortion

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Washington, D.C. 20004

202/626-8800
202/737-9189 (FAX)

STATEMENT OF OLIVIA L. GANS
TO THE FDA REPRODUCTIVE HEALTH DRUGS ADVISORY COMMITTEE
JULY 19, 1996

My name is Olivia Gans. I am the director of American Victims of Abortion, a national organization developed by women who have suffered from the aftermath of an abortion decision. I have held this position for over ten years and have addressed this issue in all fifty states. In addition to my work here in the USA, I have worked with women and professionals to establish similar programs in fifteen other countries.

I had a surgical abortion in 1981. I know all too well the grief, anger and pain which defined my personal experience with abortion. I am also accustomed to having those feelings and memories ignored by those who have supported legal abortion. However, after twelve years of involvement with women throughout our own country and abroad, I have learned that my experience is not unique.

Emotional difficulties following abortion are well-documented. Several long-term studies of women who have had abortions indicate that there are a wide range of emotional repercussions that affect women often as long as five to seven years following their abortions (Reardon, 1986; Speckhard, 1987; Speckhard & Rue, 1990). These emotional repercussions include intense grief, pain and guilt.

Abortions performed using RU 486 have already produced evidence of having effects on women similar to those of surgical abortions, although good long-term studies are not yet available. However, the particular method associated with this chemical abortion technique provides a different set of experiences that may create a different and possibly more troubling pattern of negative reactions.

When women are aware that the abortion causes them to participate in the deaths of their children, they often feel more guilt and pain. Any patient who sees the results of the abortion, that is, the developing child, is more apt to suffer than others. This is one reason why women who have late abortions are traumatized, since they will see a fully developed baby.

With RU 486 abortions, it is important that the woman identify the results of the abortion. She must look at these results. Seeing her dead baby can be traumatic. Even abortionists like Dr. Judy Tyson of Planned Parenthood of New England have reported that patients are "somewhat shocked at the tissue they passed" (New York Times, 1/30/95). Thus, the "privacy and control" which is used to sell RU 486 may actually lead to greater trauma.

In a surgical abortion, the woman generally does not see the baby. Women taking RU 486 see their aborted babies. *Newsweek* magazine spoke of "Sarah" who saw her baby swirling around in the shower drain; and "Becky", who kept talking about her baby's little fists. There have been similar accounts in *Time*, the *Boston Globe*, *Health* magazine and the Des Moines *City View* magazine. There is little doubt among those of us who work with post-abortion peer support groups that a woman who takes, by her own hand, the RU 486 drug cocktail which will kill her child could experience an emotional backlash of devastating proportions.

Women in peer support groups around the world share stories of nightmares and flashbacks to surgical abortion experiences which they cannot erase. Given the horrible dreams that are commonly experienced by women who have survived surgical abortions, one can only shudder to think what nightmares will someday visit those who actually see the tiny, emaciated bodies of their aborted children. Women who have surgical abortions speak of physical pain during the operation as well as after. They complain of humiliating treatment from facility personnel and degrading responses to their needs and requests for more information. We are afraid that the already careless treatment women receive in abortion facilities will only worsen with the approval of RU 486.

Common themes of alienation and isolation are reported in peer groups of post-abortive women. There has been little encouragement for women to share publicly any negative feelings they believe are related to their abortions. In order to cope with these feelings, many of us have denied that what we have aborted is our unborn children. In fact, most of us have felt silenced for years. Will RU 486 only serve to close the circle of isolation and silence all the more?

My sincere request to this committee today, on behalf of the thousands of women across the country struggling with complications and grief from abortion, is that we do not recklessly disregard their pain. It is imperative that the locomotive of the pro-abortion agenda not be allowed to supersede the rights of American women to have safety and honesty in their medical treatment. We are not guinea pigs. Women deserve truly life-affirming answers for themselves and their children. Please halt the approval of RU 486 in the USA.

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July 16, 1996

Center for Drug Research and Evaluation

Meg Parsons
Post Office Box 10
Nebraska City, Ne. 68410

Dear Advisory Committee,

I have grave concerns about using the French abortion pill, RU 486, in the United States. This drug kills unborn children and endangers the lives of the women who take this drug. Also, the time for clinical trials does not seem adequate and is brief compared to other drugs.

It would seem wise to have a minimum of five (5) years of published trials before a decision is made to approve RU 486 which has resulted in maternal deaths due to cardiac involvement.

Thank You,

Meg Parsons

Meg Parsons

University of Colorado Health Sciences Center

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July 11, 1996

The FDA Advisory Committee on
Reproductive Health Drugs

RE: Hearing on Mifepristone (RU486)
Friday, July 19, 1996

Ladies and Gentlemen:

I am a Professor of Medicine at the University of Colorado School of Medicine, engaged in basic research on the role of progesterone and antiprogestins on the growth of breast cancers.

I have two comments about the impact of current federal policies on my ability to conduct basic research on breast cancer using RU486:

1). Despite many years of discussions, THERE IS STILL NO AMERICAN SOURCE FOR THIS DRUG. Research scientists either have to network with foreign colleagues and institutions in order to obtain paltry supplies of RU486, or they can not get it at all. I urge the FDA to rectify this problem expeditiously.

2). Some Members of Congress continue to request detailed information from National Institutes of Health (NIH) administrators about 1) individual scientists who are using RU486 for research; 2) the type of research being done with RU486; 3) dollar amounts of grants, etc. I doubt that these individuals are requesting similar information from NIH about funding of Testosterone research.

I find these congressional inquisitions frightening, and needless to say, such tactics have a chilling effect on the progress of research into the uses of antiprogestins to improve the reproductive health of American women.

Thank you for the opportunity to air my views.

Sincerely yours,

Kathryn B. Horwitz, Ph.D.
Professor of Medicine and Pathology
University of Colorado Health Sciences Center

Advisory Committee; Notice of Meeting

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: This notice announces a forthcoming meeting of a public advisory committee of the Food and Drug Administration (FDA). This notice also summarizes the procedures for the meeting and methods by which interested persons may participate in open public hearings before FDA's advisory committees.

FDA has established an Advisory Committee Information Hotline (the hotline) using a voice-mail telephone system. The hotline provides the public with access to the most current information on FDA advisory committee meetings. The advisory committee hotline, which will disseminate current information and information updates, can be accessed by dialing 1–800–741–8138 or 301–443–0572. Each advisory committee is assigned a 5-digit number. This 5-digit number will appear in each individual notice of meeting. The hotline will enable the public to obtain information about a particular advisory committee by using the committee's 5-digit number. Information in the hotline is preliminary and may change before a meeting is actually held. The hotline will be updated when such changes are made.

MEETING: The following advisory committee meeting is announced:

Advisory Committee for Reproductive Health Drugs

Date, time, and place. July 19, 1996, 9 a.m., FDA Technical Center, 16071 Industrial Dr., Gaithersburg, MD. Attendees should allow time to proceed through security procedures. Admission to the facility by public participants will be available on a first come, first serve basis, and will be limited to approximately 200, the number of seats available to the public in the conference room. There will be an overflow room with both audio and video link to the meeting. The overflow room is located at the Hilton Hotel, 620 Perry Pkwy., Gaithersburg, MD.

Type of meeting and contact person. Open committee discussion, 9 a.m. to 1:30 p.m.; open public hearing, 1:30 p.m. to 3:30 p.m., unless public participation does not last that long; open committee discussion, 3:30 p.m. to 5 p.m.; Philip A. Corfman, Center for Drug Evaluation and Research (HFD–580), Food and Drug Administration, 5600 Fishers Lane, rm. 14B–04, Rockville, MD 20857, 301–443–3510, FAX 301–443–9282, or e-mail july19@cder.fda.gov. Information concerning the meeting is available from FDA Advisory Committee Information Hotline, 1–800–741–8138 (301–443–0572 in the Washington, DC area), Advisory Committee for Reproductive Health Drugs, code 12537. Please call the hotline for information concerning any possible changes.

General function of the committee. The committee reviews and evaluates data on the safety and effectiveness of marketed and investigational human drugs for use in the practice of obstetrics, gynecology, and related specialties.

Agenda—Open public hearing. Interested persons may present data, information, or views, orally or in

writing, on issues pending before the committee. Those desiring to make formal presentations should notify the contact person in writing by mail, e-mail, or fax no later than 5 p.m., EDT on July 12, 1996, with a brief statement of the general nature of the evidence or arguments they wish to present, the names, telephone numbers, and addresses of proposed participants, and an indication of the approximate time required to make their comments. The time for presentations will be allotted equitably, and will depend on how many individuals give advance notice within the time indicated of their intention to speak. In the interest of time, the agency may require persons with common interests to make joint presentations.

Open committee discussion. The committee will discuss the new drug application for mifepristone for the interruption of early pregnancy.

FDA public advisory committee meetings may have as many as four separable portions: (1) An open public hearing, (2) an open committee discussion, (3) a closed presentation of data, and (4) a closed committee deliberation. Every advisory committee meeting shall have an open public hearing portion. Whether or not it also includes any of the other three portions will depend upon the specific meeting involved. There are no closed portions for the meetings announced in this notice. The dates and times reserved for the open portions of each committee meeting are listed above.

The open public hearing portion of each meeting shall be at least 1 hour long unless public participation does not last that long. It is emphasized, however, that the 1 hour time limit for an open public hearing represents a minimum rather than a maximum time for public participation, and an open public hearing may last for whatever longer period the committee chairperson determines will facilitate the committee's work.

Public hearings are subject to FDA's guideline (subpart C of 21 CFR part 10) concerning the policy and procedures for electronic media coverage of FDA's public administrative proceedings, including hearings before public advisory committees under 21 CFR part 14. Under 21 CFR 10.205, representatives of the electronic media may be permitted, subject to certain limitations, to videotape, film, or otherwise record FDA's public administrative proceedings, including presentations by participants.

Meetings of advisory committees shall be conducted, insofar as is practical, in accordance with the agenda published in this Federal Register notice. Changes in the agenda will be announced at the beginning of the open portion of a meeting.

Any interested person who wishes to be assured of the right to make an oral presentation at the open public hearing portion of a meeting shall inform the contact person listed above in writing, prior to the meeting.

The agenda, the questions to be addressed by the committee, and a current list of committee members will be available at the meeting location on the day of the meeting.

Transcripts of the open portion of the meeting may be requested in writing from the Freedom of Information Office (HFI–35), Food and Drug Administration, rm. 12A–16, 5600 Fishers Lane, Rockville, MD 20857, approximately 15 working days after the meeting, at a cost of 10 cents per page. The transcript may be viewed at the Dockets Management Branch (HFA–305), Food and Drug Administration, rm. 1–23, 12420 Parklawn Dr., Rockville, MD 20857, approximately 15 working days after the meeting, between the hours of 9 a.m. and 4 p.m., Monday through Friday. Summary minutes of the open portion of the meeting may be requested in writing from the Freedom of Information Office (address above) beginning approximately 90 days after the meeting.

This notice is issued under section 10(a)(1) and (2) of the Federal Advisory Committee Act (5 U.S.C. app. 2), and FDA's regulations (21 CFR part 14) on advisory committees.

Dated: June 25, 1996.

Michael A. Friedman,

Deputy Commissioner for Operations.

[FR Doc. 96–16770 Filed 6–28–96; 8:45 am]

BILLING CODE 4160–01–F

Thereafter, on December 6, 1993 (58 FR 64121), the expiration date of the musculoskeletal system listings in both parts A and B was extended, as were the expiration dates for several other body system listings. That rule provided that the musculoskeletal system listings would no longer be effective on June 6, 1996.

Also, we published a notice of proposed rulemaking (NPRM) on December 21, 1993 (58 FR 67574) that included proposed revisions to these listings. We will publish any changes to the listings based on that NPRM in a subsequent final rule.

In this final regulation, we are extending for one year, to June 6, 1997, the date on which the musculoskeletal system listings will no longer be effective. We believe that the requirements in these listings are still valid for our program purposes. Specifically, if we find that an individual has an impairment that meets the statutory duration requirement and also meets or is equivalent in severity to an impairment in the listings, we will find that the individual is disabled without completing the remaining steps of the sequential evaluation process. We do not use the listings to find that an individual is not disabled. Individuals whose impairments do not meet or equal the criteria of the listings receive individualized assessments at the subsequent steps of the sequential evaluation process.

Regulatory Procedures

Pursuant to section 702(a)(5) of the Social Security Act, 42 U.S.C. 902(a)(5), as amended by section 102 of Public Law 103–296, SSA follows the Administrative Procedure Act (APA) rulemaking procedures specified in 5 U.S.C. 553 in the development of its regulations. The APA provides exceptions to its notice and public comment procedures when an agency finds there is good cause for dispensing with such procedures on the basis that they are impracticable, unnecessary, or contrary to the public interest. We have determined that, under 5 U.S.C. 553(b)(B), good cause exists for dispensing with the notice and public comment procedures in this case. Good cause exists because this regulation only extends the date on which the musculoskeletal system listings will no longer be effective. It makes no substantive changes to the listings. The current regulations expressly provide that the listings may be extended, as well as revised and promulgated again. Therefore, opportunity for prior comment is unnecessary, and we are issuing this regulation as a final rule.

In addition, we find good cause for dispensing with the 30-day delay in the effective date of a substantive rule, provided for by 5 U.S.C. 553(d). As explained above, we are not making any substantive changes in the listings. However, without an extension of the expiration date for the musculoskeletal system listings, we will lack regulatory guidelines for assessing musculoskeletal system impairments at the third step of the sequential evaluation processes after the current expiration date of the listings. In order to ensure that we continue to have regulatory criteria for assessing these impairments under the listings, we find that it is in the public interest to make this rule effective upon publication.

Executive Order 12866

We have consulted with the Office of Management and Budget (OMB) and determined that this rule does not meet the criteria for a significant regulatory action under Executive Order 12866. Thus, it was not subject to OMB review.

Regulatory Flexibility Act

We certify that this regulation will not have a significant economic impact on a substantial number of small entities. Therefore, a regulatory flexibility analysis as provided in Public Law 96–354, the Regulatory Flexibility Act, is not required.

Paperwork Reduction Act

This regulation imposes no reporting/recordkeeping requirements necessitating clearance by OMB.

(Catalog of Federal Domestic Assistance Program Nos. 96.001, Social Security-Disability Insurance; 96.002, Social Security-Retirement Insurance; 96.004, Social Security-Survivors Insurance; 96.006, Supplemental Security Income)

List of Subjects in 20 CFR Part 404

Administrative practice and procedure, Blind, Disability benefits, Old-Age, Survivors and Disability Insurance, Reporting and recordkeeping requirements, Social Security.

Dated: May 20, 1996.

Shirley S. Chater,

Commissioner of Social Security.

For the reasons set forth in the preamble, part 404, subpart P, chapter III of title 20 of the Code of Federal Regulations is amended as set forth below.

PART 404—FEDERAL OLD-AGE, SURVIVORS AND DISABILITY INSURANCE (1950–)

Subpart P—[Amended]

1. The authority citation for subpart P of part 404 continues to read as follows:

Authority: Secs. 202, 205(a), (b), and (d)–(h), 216(i), 221(a) and (i), 222(c), 223, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 405(a), (b), and (d)–(h), 416(i), 421(a) and (i), 422(c), 423, 425, and 902(a)(5)).

2. Appendix 1 to subpart P of part 404 is amended by revising item 2 of the introductory text before part A to read as follows:

Appendix 1 to Subpart P—Listing of Impairments

* * * * *

2. Musculoskeletal System (1.00 and 101.00), June 6, 1997.

* * * * *

[FR Doc. 96–13882 Filed 6–3–96; 8:45 am]

BILLING CODE 4190–29–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 14

Advisory Committee; Change of Name and Function

AGENCY: Food and Drug Administration, HHS.

ACTION: Final rule.

SUMMARY: The Food and Drug Administration (FDA) is amending the standing advisory committees' regulations to change the name and the function of the Fertility and Maternal Health Drugs Advisory Committee. This action is being taken to more accurately describe this committee.

EFFECTIVE DATE: June 4, 1996.

FOR FURTHER INFORMATION CONTACT: Donna M. Combs, Committee Management Office (HFA–306), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–443–2765.

SUPPLEMENTARY INFORMATION: FDA is announcing that the name of the Fertility and Maternal Health Drugs Advisory Committee has been changed. After reestablishment of this committee, on March 23, 1978, the agency decided that the name "Advisory Committee for Reproductive Health Drugs" would more accurately describe the subject areas for which the committee is

responsible. The mandate of the committee has expanded significantly in recent years to include drugs for menopausal women and drugs used in the practice of andrology. The change is consistent with the growing use of this term by specialists in the field of reproductive health, which includes obstetrics, gynecology, endocrinology, andrology, epidemiology, and related specialties. The committee reviews and evaluates data on the safety and effectiveness of marketed and investigational human drugs for use in the practice of obstetrics, gynecology, and related specialties.

The Fertility and Maternal Health Drugs Advisory Committee's name was changed in the charter renewal dated March 23, 1996. In this document, FDA is hereby formally changing the name and the function of the committee by revising 21 CFR 14.100(c)(9).

Publication of this final rule constitutes a final action on this change under the Administrative Procedure Act. Under 5 U.S.C. 553(b)(3)(B) and (d) and 21 CFR 10.40(d) and (e), the agency finds good cause to dispense with notice and public procedure and to proceed to an immediately effective regulation. Such notice and procedures are unnecessary and are not in the public interest, because the final rule is merely a clarifying amendment to existing regulations and when effective will reflect the current committee charter.

List of Subjects in 21 CFR Part 14

Administrative practice and procedure, Advisory committees, Color additives, Drugs, Radiation protection.

Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs, 21 CFR part 14 is amended as follows:

PART 14—PUBLIC HEARING BEFORE A PUBLIC ADVISORY COMMITTEE

1. The authority citation for 21 CFR part 14 continues to read as follows:

Authority: Secs. 201–903 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321–394; 21 U.S.C. 41–50, 141–149, 467f, 679, 821, 1034; secs. 2, 351, 354, 361 of the Public Health Service Act (42 U.S.C. 201, 262, 263b, 264); secs. 2–12 of the Fair Packaging and Labeling Act (15 U.S.C. 1451–1461); 5 U.S.C. App. 2; 28 U.S.C. 2112.

2. Section 14.100 is amended by revising the heading of paragraph (c)(9) and paragraph (c)(9)(ii) to read as follows:

§ 14.100 List of standing advisory committees.

* * * * *

(c) * * *

(9) *Advisory Committee for Reproductive Health Drugs.*

* * * * *

(ii) Function: Reviews and evaluates data on the safety and effectiveness of marketed and investigational human drugs for use in the practice of obstetrics, gynecology, and related specialties.

* * * * *

Dated: May 28, 1996.

Michael A. Friedman,

Deputy Commissioner for Operations.

[FR Doc. 96–13978 Filed 6–3–96; 8:45 am]

BILLING CODE 4160–01–F

21 CFR Part 14

Standing Advisory Committees; Change of Name and Function

AGENCY: Food and Drug Administration, HHS.

ACTION: Final rule.

SUMMARY: The Food and Drug Administration (FDA) is amending the standing advisory committees' regulations to change the name and the function of the Generic Drugs Advisory Committee to the Advisory Committee for Pharmaceutical Science. This action is being taken to more accurately describe this committee.

EFFECTIVE DATE: June 4, 1996.

FOR FURTHER INFORMATION CONTACT: Donna M. Combs, Committee Management Office (HFA–306), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–443–2765.

SUPPLEMENTARY INFORMATION: FDA is announcing that the name of the Generic Drugs Advisory Committee has been changed. After establishment of this committee, on January 22, 1990, the agency decided that the name "Advisory Committee for Pharmaceutical Science" would more accurately describe the committee. The Committee reviews primary scientific issues dealing with pharmaceutical science including testing, research, biopharmaceutics, pharmacology, and new chemistry. The Committee also gives advice on scientific and technical issues concerning the safety and effectiveness of human generic drug products for use in the treatment of a broad spectrum of human diseases. Therefore, the agency feels the name change will more accurately describe this Committee to the public. In the Federal Register of February 21, 1996 (61 FR 6644 at 6645), FDA published a notice that indicated that the name of the Generic Drugs Advisory Committee had been changed in the charter renewal dated January 22, 1996. In this document, FDA is hereby formally changing the name and function of the committee by revising 21 CFR 14.100(c)(16).

Publication of this final rule constitutes a final action on this change under the Administrative Procedure Act. Under 5 U.S.C. 553(b)(3)(B) and (d) and under 21 CFR 10.40(d) and (e), the agency finds good cause to dispense with notice and public procedure, and to proceed to an immediately effective regulation. Such notice and procedures are unnecessary and are not in the public interest, because the final rule is merely a clarifying amendment to existing regulations and when effective will reflect the current committee charter.

List of Subjects in 21 CFR Part 14

Administrative practice and procedure, Advisory committees, Color additives, Drugs, Radiation protection.

Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs, 21 CFR part 14 is amended as follows:

PART 14—PUBLIC HEARING BEFORE A PUBLIC ADVISORY COMMITTEE

1. The authority citation for 21 CFR part 14 continues to read as follows:

Authority: Secs. 201–903 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321–394; 21 U.S.C. 41–50, 141–149, 467f, 679, 821, 1034; secs. 2, 351, 354, 361 of the Public Health Service Act (42 U.S.C. 201, 262, 263b, 264); secs. 2–12 of the Fair Packaging and Labeling Act (15 U.S.C. 1451–1461); 5 U.S.C. App. 2; 28 U.S.C. 2112.

2. Section 14.100 is amended by revising the heading for paragraph (c)(16) and paragraph (c)(16)(ii) to read as follows:

§ 14.100 List of standing advisory committees.

* * * * *

(c) * * *

(16) *Advisory Committee for Pharmaceutical Science.*

* * * * *

(ii) Function: Gives advice on scientific and technical issues concerning the safety and effectiveness of human generic drug products for use in the treatment of a broad spectrum of human diseases.

* * * * *

COMMUNICATION CONCERNING SPEAKERS
FOR THE OPEN PUBLIC HEARING
DURING THE 19 JULY ADVISORY COMMITTEE MEETING
(as of 96.07.09.)

ATE	*	CALLER	ORGANIZATION	SPEAKER
Jul	P	Richard Glaso 714-586-3091	Life Issues Institute	same
	F	Seymour Romney, MD 212-873-1116	Society for Physicians for Reproductive Choice and Health	same
	E	Elizabeth Arndorfer 202-667-5881	National Abortion Federation	same
	E	Jennifer Jackman, PhD 703-522-2219	Feminist Majority Foundation	Eleanor Smeal
	E	Anne Pritchett 703-838-0500/3312	American Medical Women's Association	Diana Dell, MD
	F	Marcy Wilder 202-973-3096	National Abortion and Reproductive Rights League	same
Jul	F	Gary Hodgen, PhD 804-446-5266	Technology Development Center	same
	F	Ann Kolker 202-588-5180	National Women's Law Center	NA
Jul	F	Janet Benshoof 212-514-5534	The Center for Reproductive Law and Policy	same
Jul	F	Cynthia A. Peason 202-347-1140	National Women's Health Network	same
Jul	E	Allan Rosenfield, MD 212-305-3929	American Public Health Association	same
Jul	F	Marie Bass 202-328-2200	Reproductive Health Technologies Project	same
Jul	F	M. Louviere, MD 319-235-3568	Northwest Waterloo Family Practice	same

* P = phone
F = fax
E = email

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Mifepristone 200 mg
Population Council

Federal Register Notice
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Author(s) of above
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Pub Date(MM/DD/YY): / /1995 Vol:8 Issue # Pages:92
Edition: MDLine ID:09217062

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Received:14-JUN-2000 Status:COMPLETED/ML Date:19-JUN-2000

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Author(s) of above
E.A. SCHAFF ET.AL...

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Pub Date(MM/DD/YY): / /2000 Vol:61 Issue #1 Pages:41
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Needed by:10-MAR-2000 Pickup/Mail:M
Title of Article, Book Chapter or Conference Paper
MECHANISM BASED INACTIVATION OF CYTOCHROME P450 3A4 BY MIFEPRISTONE(RU4
Author(s) of above
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Pub Date(MM/DD/YY): / /1999 Vol:288 Issue #2 Pages:791-7
Edition: MDLine ID:

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