AMERICAN
ASSOCIATION
OF BLOOD BANKS

February 14, 2001

Dockets Management Branch (HFA-305)
Food and Drug Administration
5630 Fishers Lane, Room 1061
Rockville, Maryland 20852

Re: Docket #99N-2337: Current Good Manufacturing Practice for Blood and Blood Components; Notification of Consignees and Transfusion Recipients Receiving Blood and Blood Components at Increased Risk of Transmitting HCV Infection ("Lookback")

To Whom It May Concern:

These comments are filed on behalf of the interorganizational task force created to provide assistance to the blood banking community for HCV lookback. The task force, which consists of the American Association of Blood Banks and America's Blood Centers, appreciates the opportunity to comment on this proposed rule.

The Food and Drug Administration (FDA) requested comments on the appropriateness of three calendar days proposed for exemptions of the quarantine of prior collections and consignee notification under proposed §610.48 (a), (e), and (f) and the conforming amendment to §610.46 (a).

The task force wishes to reiterate its position that three calendar days is an unrealistic expectation for identification and quarantine of prior collections and notification of consignees to quarantine prior collections. This is particularly true if the quarantine action is based on the collection facility being notified that a donor at that establishment has tests elsewhere indicating evidence of HIV or HCV infection. The blood establishment is required to act upon this information if the test was performed by a laboratory certified under Clinical Laboratory Improvement Amendments of 1988 (CLIA), and performed using an FDA approved test. If the testing has been performed at another blood establishment these requirements will be relatively easy to determine. However, if this information arrives at the blood establishment on Friday afternoon, from a physician's office, that office may not be open until Monday, and the testing may be done in a reference laboratory across the country. Three calendar days will not permit adequate investigation to determine whether a laboratory is certified by CLIA and using an FDA approved test. **We request that this requirement be changed to seven calendar days or five business days.**

In addition, although three calendar days may be reasonable for tests that have just been

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performed in the blood establishment laboratory, it is not reasonable when we are dealing with historical record review. **We recommend that, for historical records, the time period should begin after identification of any indate component rather than the date of identification of the donor with a repeat test.**

The FDA requested comments on the provisions of §610.48 (c) and (d), including submission of data support the comments.

The task force believes that the published literature and the presentations at numerous public meetings support the requirements of 610.48 (c). However, we have a major concern with §610.48 (d) (3). The "*Third instance*" calls for lookback "where the donor tested repeatedly reactive for evidence of HCV infection on HCV EIA 1.0 screening tests, with a signal to cut off (S/CO) value less than 2.5 for at least two out of the three EIA tests (i.e., the initial EIA screening test and the duplicate retests), with no record of a supplemental test or multiantigen screening test for HCV performed on the repeatedly reactive sample or on a later sample from the same donor." It is our understanding, based on previous FDA statements, and more specifically on the language of the recommendation from the Public Health Service (PHS) Advisory Committee on Blood Safety and Availability, that lookback would be required only when the S/CO ratio is greater than or equal to 2.5. The whole point of the use of S/CO value was to minimize the need for consignee notification and lookback or recall for further phlebotomy of a large population of probable false positives with no supplemental results on record. **We request that § 610.48 (d)(3) be deleted and that reference to this section or to S/CO < 2.5 be deleted in any other section where this information appears. The column labeled S/CO < 2.5 in Table 4 should be deleted. Also, the final column should include "equal to," i.e., should read "S/CO ≥ 2.5 or No Determination of S/CO." The rest of the document should also be reviewed to be certain that S/CO always specifies both greater than or equal to.**

Likewise, §610.48 (i) (2) (iii) which discusses further testing if the S/CO ratio is < 2.5, should also be deleted since further testing is not required.

FDA requested comments on the appropriateness of the one-year time frame to complete all quarantine and notification, both for multiantigen and single antigen screening tests.

The task force agrees that one year after publication of the final rule should permit adequate time to complete quarantine and notification, as long as the final rule does not require lookback for single antigen screening with S/CO ratio of < 2.5.

The FDA requested comments on whether the transfusion service should be required to perform concurrent notification of the physician of record whenever the transfusion service notifies the transfusion recipients directly.

The task force does not believe that concurrent notification of the physician of

record, whenever the transfusion service notifies the transfusion recipients directly, should be an FDA requirement. Most frequently the patient is being notified directly because the physician is unwilling or unavailable to notify the patient. Second, in many cases, the "physician of record" at the transfusing facility has no ongoing relationship with the recipient to justify his or her involvement in the process.

The FDA requested comment on the appropriateness of requiring a minimum of three attempts to notify affected transfusion recipients as proposed for HIV and HCV "lookback."

Specifying a minimum of three attempts to notify recipients is unnecessarily inflexible. Three may be a reasonable number under most circumstances, but transfusion services should be given the flexibility to stop if they have solid information suggesting further attempts will not be fruitful. For example, a transfusion service may make a single attempt, find the recipient no longer at the address they have available, and with no other source of information available should be allowed to stop as long as documentation is maintained. **We request that this provision be changed to permit one notification attempt made using a traceable method,** such as certified mail, return receipt requested. A signed return receipt or a return letter should constitute proof that notification was attempted and was unsuccessful, and that further attempts will also be unsuccessful.

The FDA asked for comments relating to the minimum number of attempts that should be required to notify transfusion recipients identified in the records that are more than five years old.

The task force believes that notification procedures should be identical regardless of whether the transfusion recipient was identified in records that are more than five years old. That is, one attempt made using a traceable method should be acceptable.

Additional Comments

The task force has the following additional comments:

NAT Assays performed under an FDA approved IND should suffice in lieu of further confirmation testing, and should also trigger lookback procedures. NAT is now being performed on the vast majority of the blood supply.

§610.48 (g) exempts from quarantine products meeting certain criteria. **The FDA should clarify the intent of this exemption to indicate that blood collection facilities are not required to notify consignees of units for which appropriate supplemental testing is available that would exempt them from quarantine.**

§606.116 (d) establishes a retention period of 10 years after the records of processing have been completed or six months after the latest expiration date for the individual product. The task force agrees with this time frame. However, we wish to point out that because recovered plasma does not have an expiration date, blood establishments that prepare recovered plasma will be forced to retain records indefinitely. This proposed rule is not the appropriate place to correct that problem. **We strongly suggest that the FDA establish an expiration date for recovered plasma.**

We further suggest that **prospective lookback should be confined to a "rolling" ten year period.** This would be consistent with the proposed Health Care Financing Administration (HCFA) rule requiring transfusion services to maintain records of disposition for 10 years.

The preamble of the proposal states that "the proposal would not require quarantine of products that have already been pooled for further processing because the process of fractionation inactivates or removes HCV." There is no mention of this exception in the regulatory text itself. **This statement should be included in both §610.46 and §610.48.**

There appears to be a typographical error on page 69381 of the Federal Register Notice. In the section III, titled Highlights of the Proposed Rule, **Jan. 1, 1998 should be January 1, 1988** in order to be consistent with the rest of the document.

The proposed rule is intended to harmonize the requirements for HIV and HCV lookback. §610.46 (a) is not identical to §610.48 (a). §610.48 (a) states that action should be taken for in-date blood and blood components collected from that donor at any time prior to the repeatedly reactive test. §610.46 (a) omits the word in-date. **We request that the word in-the date be inserted in section §610.46 (a).**

We note that there are aspects of HCFA's proposed rule for HIV lookback that are not addressed in this proposal. **We urge FDA and HCFA to work together to resolve any inconsistencies.** The task force believes that it is imperative that the FDA rule and the HCFA rule be parallel. We are enclosing copies of our comments to the HCFA proposed rule for your information, and will be sending copies of the FDA-related comments to HCFA as well.

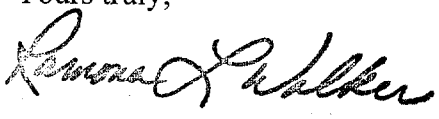
In general, this regulation is very difficult to follow. The task force encourages the FDA to provide a guidance that includes flowcharts that will be easier to follow.

Finally, we believe that the FDA estimates of the cost of prospective HCV lookback are flawed by restriction of the calculations to components of the current donation. The current donation is discarded, and it is past donations that generate lookback and its resultant cost. Based on the experience of members of the task force with seroconverting donors, the number of components for each new HCV positive donor ranges from 2-10

prior components. The FDA estimated only 1.1 components. Thus, the cost is 3-5 times higher than the FDA estimates.

The interorganizational HCV lookback task force appreciates the opportunity to comment on the FDA HCV lookback proposed rule. Any questions or comments for the task force may be directed to Kay Gregory, Director, Regulatory Affairs, AABB, at 301-215-6522 or kayg@aabb.org.

Yours truly,



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