THE MAGAZINE OF THE PLASMA PROTEIN THERAPEUTICS INDUSTRY FALL 2011

Breaking Down Roadblocks to Patient Access

The Future of Orphan Drug Development in the U.S. and EU

PPTA Interview: IPOPI's David Watters

Source and the Plasma Strategy

COST CONTAINMENT

INTER-CHANGEABLE ?

> UTILIZATION REVIEW

MANAGED CARE

BUDGET PRESSURE RESTRICTIVE

NATIONAL

POLICIES

AFFORDABLE CARE ACT



IN MY VIEW Society Has A Responsibility to Treat Patients With

I WANT TO TALK ABOUT AN INJUSTICE. I believe there is something fundamentally wrong in our society when outrageous sums of money are spent dealing with the negative effects of tobacco use in the United States when at the same time patients with life threatening diseases must routinely face gigantic hurdles to access healthcare. I recently read an article that made me think about the issues that we are dealing with on a daily basis. This is what I read:

GENETIC DISORDERS

Excerpt from:

FDA Regulation of Tobacco Products By Lawrence R. Deyton Source: "Food and Drug Law, Regulation and Education," May/June 2011 Edition

"It is difficult to overstate the toll tobacco use has taken on the United States. Each year smoking kills approximately 443,000 Americans; more deaths than from HIV/AIDS, alcohol use, cocaine use, heroin use, homicides, suicides, motor vehicle crashes and fires combined. No fewer than 8.6 million smokers suffer from at least one serious illness. In addition to its incontrovertible impact on public health, cigarette smoking also has a corrosive impact on our economy. We now know that smoking generates smoking, pipe smoking, etc., seem to be accepted by our society. I will not deny individuals the right to smoke in such a way that their smoking does not endanger others around them. That is a personal decision that everyone has the freedom to make. Every person who uses tobacco products is informed about the risks and understands the consequences. I must accept that these people not only choose to pay large sums of money for their addiction, but expect the U.S. healthcare system to help treat the common illnesses that result. I find it more difficult to accept that society has to pay for the costs associated with that personal decision.

What about the many patients that we serve? Whether this is hemophilia, immune deficiency, alpha-1 antitrypsin deficiency, hereditary angioedema, chronic inflammatory demyelinating polyneuropathy, none of these patients made a voluntary choice to have this condition, most are genetic disorders that they were born with. The struggles to get the right diagnosis, treatment and payment are enormous. Every month I hear new stories that confirm that.

The patients we are dealing with are small in numbers. The number of patients that our entire industry is serving does not even meet the criteria for an orphan drug in the

> United States (patient population less than 200,000). Yet, the costs of these therapies must be shared by this relatively small population and are higher compared to small molecule drugs that are used by millions of people. We have a societal responsibility to treat people with genetic disorders. They did not choose a lifestyle that induced their illnesses and they deserve an improved quality of life. We also have a societal responsibility to correct what seems to be wrong. If we can afford almost \$100 billion per year for self-inflicted diseases we have to ask the question: "Is this what we really want to do?" (

\$96 billion in medical costs and robs our economy of \$97 billion in productivity annually just from those who die prematurely. Yet, today, 26 percent of U.S. high school students currently use tobacco products. In addition, an estimated 4,000 young people start smoking each day and 1,000 kids become regular smokers."

The costs for self-induced illness are exorbitant—the article quoted above provides the numbers to flesh out the extent of the problem. Even with today's understanding of nicotine's deadly attraction, cigarette





PLASMA PROTEIN **FORUM 2011**

By Kara Flynn

THE WASHINGTON, D.C. SUBURBAN CENTER OF RESTON, VIRGINIA

served as the backdrop for a series of lively discussions on a wide array of topics that took place during PPTA's Plasma Protein Forum held on June 14-15.

Highlights of the event on June 14 featured a keynote address headlined by Prof. Dr. Herold J. Metselaar, a professor of liver failure and transplantation at Erasmus University Hospital in Rotterdam, The Netherlands. Dr. Metselaar discussed the immodulating effects of intravenous immune globulin and new insights in mechanisms of action. A panel on clinical experiences with albumin and new developments featured perspectives from Prof. Albert Farrugia, vice president of Global Access, PPTA discussing albumin's increased relevance to critical care, and Prof. Vincente Arroyo of the Hospital Clinic in Barcelona, Spain, who shared views on fluid therapy and the role of albumin in a range of medical indications. A second panel featured a lively discussion on the Orphan Drug Act and rare disease populations with Kay Holcombe, Genzyme Corp.; Patricia Knight, Knight Capitol Consultants; Jason Money, Generic Pharmaceutical Association; and Mark W. Skinner, World Federation of Hemophilia, discussing whether the current incentives under the Orphan Drug Act are sufficient to continue to spur the development of new drugs and biological for rare disease populations.

A panel that took place on the second day of the conference featured a noteworthy discussion on PPTA's voluntary standards programs, consisting of the International Quality Plasma Program (IQPP) and the Quality

Plasma Protein **Forum attendees** listen to presentations

2011 PLASMA PROTEIN



4



Prof. Dr. Herold J. Metselaar of Eramus University Hospital, Netherlands (above) and Dr. Mark Weinstein of FDA (below)



Professor Albert Farrugia Standards for Excellence, Assurance and Leadership (QSEAL). Joseph Rosen, Baxter BioLife; Tommaso Paoli, Kedrion SpA; and Miriam O'Day, Alpha-1 Foundation/Alpha-1 Association, explored the structure, purpose, relevance and future of the programs through stakeholder relations, importance to the industry and the program's relationship with regulatory authorities.

The full conference program featured sessions including topics addressing medically appropriate treatment regimes for patients using plasma protein therapies, milestones from the point of view of manufacturing and patient care and a panel where regulators from both the U.S. Food and Drug Administration and European Medicines Agency shared their perspectives on regulators' interactions and hurdles to true regulatory harmonization.

Please join us next year for Plasma Protein Forum 2012 on June 21-22 in Washington, D.C.

KARA FLYNN is PPTA's Director, Global Communications



Longtime Industry Veteran Reflects on PPTA's Mission

Dr. Don Baker, the recipient of PPTA's Robert W. Reilly award (see article on page 6) participated in a special session at the 2011 Plasma

Protein Forum reflecting on the mission of PPTA and its significant accomplishments over the years. Dr. Baker, a distinguished industry veteran with more than 30 years in the business, stated in his remarks that over the last 20 years, PPTA and its member companies have improved plasma protein therapies and have been particularly effective in developing and promoting standards to enhance the quality and safety of therapies. Dr. Baker said, however, that there is still more left to accomplish, including opportunities in quality assurance, and that PPTA must continue to work to educate and support, provide a forum for consensus building and promulgate standards as appropriate. He concluded his remarks by stating that there is an opportunity for PPTA to be an advocate for special licensure mechanisms for plasma-derived therapies. He said a risk-based approach, which takes advantage of the unique attributes of these therapies, is ideal.

Prof. Albert Farrugia of PPTA and Prof. Vincente Arroyo of Hospital Clinic in Barcelona, Spain (left)

Speakers on the panel "Orphan Drug Act and Rare Disease Populations" take questions from the audience (below)



DON BAKER Homored With REILLY AWARD 2011

By Kara Flynn

RECOGNIZING HIS TREMENDOUS VALUE to the plasma protein therapeutics industry, Dr. Don Baker was honored by PPTA with the prestigious Robert W. Reilly Award at the 2011 Plasma Protein Forum in Reston, Virginia.

Dr. Baker was honored by PPTA for the significant contributions he has provided to the industry including: his expertise in research and development, scientific affairs and quality assurance in promoting trade association activities, his work improving the image of the industry and his efforts to build a consensus among the Association's members.

Each year, PPTA awards the Robert W. Reilly Award to recognize an individual who best exemplifies the leadership qualities of Robert W. Reilly, a leader of the plasma therapeutics industry association.

The last two award winners were Dr. Ruedi Wager, former president and chief executive officer of Aventis Behring, a global plasma protein therapeutics business and Dr. Bernard Horowitz, one of the inventors of solvent detergent viral inactivation systems, now an industry standard in the manufacture of plasma-derived therapies.

Dr. Baker studied chemistry at the University of British Columbia in Vancouver, where he earned a doctorate in 1972 and earned a bachelor's degree from the same institution in 1968.

In addition to having held senior executive positions in research and development and regulatory and quality with Baxter Healthcare Corporation, he is a Baxter Distinguished Scientist. Further, he has been an active participant in the PPTA committees

REILLY AWARD Previous Honorees 2010 Dr. Ruedi Waeger, 2003 S. Tvrone Foster, Talecris Biotherapeutics formerly of Aventis-Bio-Services 2009 Dr. Bernard Horowitz, 2002 Richard Thomas, Horowitz Consultants, LLC formerly of Bayer Corporation 2008 Peter Turner, CSL Behring 2001 Victor Grifols Lucas, Chairman of the Board, Grifols 2007 Jean-Marie Vlassembrouck, BaxterBioScience 2000 Sammuel Penninger, Jr., 2006 David J. Gury, formerly of Nabi Biopharmaceuticals Serlogicals Corporation 1999 Jack Ryan, 2005 Joseph Rosen,

- formerly of Bayer Corporation 1998 John Bacich,
 - formerly of Baxter Healthcare Corporation

VICOLEPATON / ISTOCK

having lead the Quality and Regulatory Affairs committee for several years. Dr. Baker has been published in numerous journals including the *New England Journal of Medicine, Hematology and Transfusion.* After retiring from

Baxter BioScience/BioLife

2004 Dr. George Schreiber, Westat Inc.

Plasma Services

Baxter last year he has continued as a consultant to the plasma protein therapeutics industry. (

KARA FLYNN *is PPTA's Director, Global Communications*

Don Baker pictured with PPTA Global Board of Directors Chairman Larry Guiheen and PPTA President and CEO Jan M. Bult

EHC HOLDS ROUNDTABLE ON WOMEN WITH BLEEDING DISORDERS

By Siada El Ramly and Laura Savini



RECENTLY THE EUROPEAN HAEMOPHILIA CONSORTIUM (EHC) held a roundtable on women with bleeding disorders, attended by PPTA staff. The event featured presentations from patients and physicians and was moderated by Prof. Paul Giangrande (left) from the Oxford Haemophilia & Thrombosis Centre and Nuffield Department of Clinical Medicine, University of Oxford, United Kingdom.

Although bleeding disorders in men are widely recognized, diagnosed and treated, the same cannot be said for bleeding disorders in women. The conditions are rarer in women than in men and are frequently overlooked and remain untreated, often until patients reach middle age. This can be attributed to several factors. First of all, even among the patient community there is a lack of awareness that female carriers can be affected by lower levels of clotting factors; and, therefore, they tend to ignore symptoms such as menorrhagia (heavy menstrual periods), nose bleeds or easy bruising.

Another factor in the under diagnosis of women with bleeding disorders is the fact that even among physicians there is a misconception that bleeding disorders occur exclusively in male patients. This may cause physicians to overrule the diagnosis in women. For instance, Dorothée Pradines, one of the attendees of the EHC roundtable and a French patient with severe hemophilia A, described a situation that she faced as a child when she was on vacation in the French countryside. After she had cut her hand and needed treatment for heavy bleeding, she



went to the local hospital. The hospital's physician proceeded to tell her that women do not suffer from hemophilia and denied her the treatment necessary for her condition. This lack of awareness led to her having to go through an extended healing period instead of being treated effectively.

It is essential that more awareness is raised among general practitioners, gynocologists and obstetricians who, due to the rarity of the disorders, might never come across women with bleeding disorders. These practitioners need to be aware of the symptoms of these disorders and pick up on them when they encounter a patient who actually has these symptoms.

During the event, several female patients were present and they expressed the need for education beyond the medical professionals. They stressed the importance of efforts to educate women on bleeding disorders in women, including symptoms and implications for these disorders. Patient communities have started to organize events and campaigns to raise awareness among women, which have had varied success so far.

Following a series of factual, interesting presentations the participants discussed what needed to happen next and several recommendations were made on how to raise awareness among women regarding bleeding disorders.

Bleeding disorders in women, like in men, not only occur but have a detrimental impact on the patients' lives and more work is needed to ensure that these patients receive the care they need.

SIADA EL RAMLY is PPTA Europe's Director, Public Affairs and LAURA SAVINI is PPTA Europe's Manager, National Affairs

HEPATITIS B IMMUNE

Use in Liver Transplantation and Preventing Recurrence

By Kym H. Kilbourne

AS A HIGHLY SPECIALIZED IMMUNE GLOBULIN THERAPY, hepatitis B immune globulin (HBIg) is something most people have never heard of, let alone have ever needed. It doesn't grab headlines like a new cancer medicine for children and is not as relatable as RhoD immune globulin (covered previously in the *Source*), which has helped millions of expectant mothers. However, for those who know the product, and who were there from its earliest stages of development and witnessed the impact it has had on so many lives, two things are clear: HBIg plays an important role in liver transplantation and is life-saving. The people who work with the therapy are extremely proud to have such an extraordinary effect on people's lives.

Lifesaving immune globulins (Ig) are used to treat various disorders. They contain numerous specific antibodies to neutralize infectious agents that are damaging to the human body. Some immune globulins contain a much higher concentration (titer) of antibodies against a specific virus or other substance. Distinct immune globulins with high titers that "fight" against those viruses or substances include hepatitis B, cytomegalovirus, varizella-zoster, Rhesus, tetanus, rabies and many more.

Most of us remember receiving vaccinations as a child or when our children were immunized against certain viruses. These vaccinations are necessary to boost the human immune system to produce specific antibodies against potential threats from those viruses. When an individual becomes infected with a virus, the immune system responds with the massive production of specific antibodies to fight this infection. When you measure the concentration in the individual's plasma, higher titers will be present. Individuals who have higher titers either as a result of vaccinations or as a natural occurance are ideal donors to collect the specific plasma needed to manufacture these high-titer immune globulins (hyper-immunes).



Most of us remember receiving vaccinations as a child or when our children were immunized against certain viruses. These vaccinations are necessary to boost the human immune system to produce specific antibodies against potential threats from those viruses. Hepatitis B immune globulin (HBIg) is one of them and is prepared from donors who have been vaccinated.

Obtaining Plasma

Kirsten Seidel, the medical director for CSL Plasma in Germany, explains that the collection program for plasma used to manufacture HBIg is fairly straightforward. Today, most donors are immunized against hepatitis B as children, and donors are offered a booster to participate in the special plasma collection program, which represents a very small percentage of plasma collections. Typically, donors are between the ages of 18 and 30, and in Germany the collections take place in regular donation centers. In the U.S., collections vary and can take place in a specialty plasma collection center as well.

Seidel explains that HBIg is used in a patient who is exposed to hepatitis B, but has never had an active immunization. The therapy binds the antigen—the hepatitis B antibodies injected or infused bind the virus that is coming into the bloodstream and form an immune complex, which is removed from the body.

GLOBULIN (HBIG) of Hepatitis B

HBIg is administered to neutralize hepatitis B (HBV) infection in a person who has not received an active immunization or whose immune system is suppressed. If an individual is not immunized against HBV and is not given HBIg after exposure to the virus, he or she can develop hepatitis B, which can severely damage the liver and lead to end stage liver disease years to decades later requiring a liver transplant.

"Prior to the availability of HBIg, if you were accidentally exposed to blood, you were potentially exposed to hepatitis," said Bob Suarez, former Director of International Sales for Biotest Pharmaceuticals, who worked with the the therapy for 17 years. There was no treatment to prevent the development of the disease, and one could only hope that the amount of antigen transmitted was not high enough to cause it to develop. "Imagine individuals waiting for two to six months to see if they develop hepatitis or not. It was absolutely horrendous," Suarez added.

Today, in the Western World, most children and individuals in the medical profession or other high-risk professions are immunized against HBV by active vaccines. This practice may be different in developing countries. When HBIg is used prophylactically, it should immediately be administered after a patient who has not been immunized, is exposed to HBV.

The therapy also is used, in combination with other drugs, to prevent hepatitis B recurrence following liver transplantation resulting from residual HBV in the patient's blood. Data have shown that the use of HBIg to prevent HBV recurrence following liver



HBIg is produced through the same highly complex fractionation process used to produce other plasma-derived therapies, although in a much smaller volume.

transplantation has improved patient outcomes and post transplant survival according to Daniel Samphir, the product manager for HBIg for Cangene Corporation, one of several manufacturers of HBIg. In fact, Dr. Thomas Achtstäetter, director of Medical Marketing with Biotest Ag in Germany, explains that HBV-liver transplantation could not successfully be performed before the introduction of HBIg for HBV-reinfection prophylaxis. He adds that this is the most important indication for intravenous HBIg and without the therapy, HBV-reinfection of the transplant liver was 100 percent.

Today the "gold-standard" is the combination prophylaxis consisting of iv/sc HBIg and a virostatic drug. (A subcutaneous product entered the market in 2010 in Europe and provides another option that facilitates greater compliance among patients who require



the lifelong treatment.) Both pharmaceuticals complement each other and thus offer the optimal protection from HBV-reinfection of the liver transplant. In fact, today there is no measurable difference between regular liver transplant in terms of survival rates during the first year, according to Dr. Achtstäetter. He adds that it is no longer a very risky transplant, and that survival rates while excellent, depend on reinfection prophylaxis.

The typical number of HBV-related liver transplants fluctuates annually; over the past five years 150 to 300 transplant procedures were performed annually in the United States. In Canada, the number of transplants is much smaller. In Germany, there were a total of 1,100 liver transplants last year with about 5 to 8 percent for hepatitis B. Dr. Achtstäetter adds that in general, one can say that in the western industrialized countries (Europe, the U.S. and Canada) 3 to 5 percent of the annual liver transplants are due to HBV-induced liver failure (either liver cirrhosis or hepatocellular carcinomas).

Hepatitis B Vaccine

The hepatitis B vaccine became available in the U.S. in 1982, and in1986 and 1989 two recombinant therapies were introduced. With the availability of the new vaccine, many believed that the need for HBIg would disappear. Suarez explains that the situa-

Cartrell, Jr. (pictured left) and his father both donate for the HBIg program. Alicia (right) has donated for the HBIg program at a Cangene center in California for six years. tion proved to be quite the contrary. With the availability of the vaccine, it was now possible for active immunization against HBV, in addition to the passive immunization provided by HBIg. But many high-risk individuals did not become vaccinated in the early days of its availability and were infected with the virus, thus requiring injections of HBIg. A lack of education and knowledge, coupled with the expense of producing this highly specialized biologic were contributing factors. Further, there were incidences in the U.S. when hospitals failed to immunize their employees due to expense until it became required in 1991 by the Occupational Safety and Health Administration (OSHA) through its Occupational Exposure to Bloodborne Pathogens Standard.

While HBIg use in liver transplantation is the most significant indication today, hepatitis B is endemic in Africa and most Asian countries. However HBIg is not readily accessible there due to inadequate reimbursement.

"I hope someday newborns there will be given HBIg and active immunizations as routine practice" Seidel adds. But neither active nor passive immunization is the standard of care in those countries. (\$

SPECIAL THANKS to Daniel Samphir, Dr. Kirsten Seidel, Iliana Carlisle, Dr. Thomas Achtstäetter and Bob Suarez

Кум H. Kilbourne is PPTA's Director, Public Affairs, North America.





Additional Resources

The Changing Epidemiology of Hepatitis B in the United States: Need for Alternative Vaccination Strategies, Journal of the American Medical Association, 1990, M. Alter, et al.

Liver transplantation in HBs antigen (HBsAg) carriers: Prevention of hepatitis B virus (HBV) recurrence by passive immunization, *Journal of Hepatology*, 1991, R. Müller, et al.

Liver Transplantation in European Patients with the Hepatitis B Surface Antigen, New England Journal of Medicine, 1993, D. Samuel, et al.

Immunomodulating Effects of IVIG: New Insights in Mechanisms of Action, *H. Metselaar, Plasma Protein Forum, 2011.*



BREAKING DOWN ROADBLOCKS to Patient Access

THE WORLDWIDE ECONOMIC CONDITIONS

mean there is less money to spend on healthcare benefits while there is greater demand for services from individuals seeking public assistance. As a result, all payers are looking for ways to pay for health benefits at a lower price. Cost containment policies are the tools used by payers to reduce the price of goods and services, but they can often be roadblocks to patients seeking their medically appropriate therapy. In the United States, state Medicaid programs that provide health benefits to the poor, aged and disabled are considering numerous cost containment policies that will allow them to reduce spending. Advocacy is the answer to making sure these changes, and they are coming, do not result in limited access for patients who require plasma protein therapies.

POLICIES

Mandatory managed care is a common policy change that many state legislatures are considering to manage their growing expenditures because of

UTILIZATION

REVIEW

COST CONTAINMENT

14 | THE SOURCE | Fall 2011

their increasing enrollment. Mandatory managed care is a policy where states require all Medicaid recipients to enroll in a Medicaid Health Maintenance Organization (HMO). With each patient switched from Medicaid fee-for-service to a Medicaid HMO, the states reduce their appropriation for Medicaid because the Medicaid HMOs are paid less than the expected cost of a non-managed Medicaid recipient.

Medicaid HMOs are a way for states to spend money more efficiently, while providing quality care to certain Medicaid recipients who currently don't have their care managed by anyone. The mistake for states would be taking Medicaid recipients from providers who currently manage their care well and placing them with Medicaid HMOs that don't have the experience in providing quality care for the Medicaid recipients with rare, chronic conditions such as hemophilia.

The Florida Legislature recently considered legislation that would place all Medicaid recipients in Medicaid HMOs. PPTA, working with a coalition that included the two hemophilia chapters in the state and individual manufacturers, advocated successfully to have individuals with hemophilia receive their clotting factor concentrates through the current disease management program rather than forcing them to receive their factor from vendors selected by their Medicaid HMO. This preserved their current access to all medically appropriate therapies.

The concern was that Medicaid HMOs aren't familiar with managing hemophilia like other diseases because it is a challenge to develop accurate capitation models for individuals with hemophilia. The coalition argued persuasively that Medicaid recipients with hemophilia currently have their care managed properly, just not by a Medicaid HMO. Their care is well managed through the current system, which includes a disease management program in the Florida Medicaid program that guarantees Medicaid recipients pharmaceutical care that meets most recommendations of the National Hemophilia Foundation's (NHF) Medical and Scientific Advisory Council's (MASAC).

As a result of the efforts of all involved, Medicaid recipients in Florida are ensured access to their medically appropriate clotting factor from qualified vendors.

Like the United States, Europe has known in the recent past a wave of increasingly stricter budgetary measures to counter the effects of the financial crisis, to pre-emptively contain expenditure and to contain national debts. Such measures are affecting all areas managed by the government including the healthcare sector. In the past years, restrictive measures have been seen across Europe both in old and new Member States, including but not limited to reference pricing according to the average of the lower prices in Europe, increases in compulsory rebates for pharmaceutical companies and evaluation of product efficacy in relation to their cost.

However, these measures do not provide a solution or an adequate response to the current situation. First of all, patients need to continue receiving adequate treatment and should not carry the burden for the economic mismanagement of previous governments. Furthermore, Europe is trying to showcase Patients its technological advancement and investment in research including need to continue receiving in healthcare. Nevertheless, the reality is that saving adequate treatment and should not carry measures need to be evaluated and the burden for implemented and the economic furthermore, other innovative medicines and mismanagement treatments are competing of previous for attention and funding. So governments. what can the industry do to obtain more favorable outcomes when introducing reimbursement requests? As discussed during the Focus meeting held in Europe earlier in July, it seems that the industry needs to be more visible and make not only government representatives but also paying bodies aware of the uniqueness of the plasma industry. This is the message that PPTA is disseminating across the Atlantic both in North America and Europe and it points out the rarity and fragility of source material, the biological nature of the products (with all the precautionary steps of viral inactivation, testing, etc), the burdens for the development and implementation of clinical trials on small populations, the fact that these products treat small patient populations with chronic, congenital, life-

The plasma protein therapies industry needs to constantly educate these stakeholders to point out its differences compared to both the chemical-based pharmaceutical industry and the biotechnology industry. It needs to stress the importance for the patients to continue to have access to safe and efficient treatments.

threatening diseases.

BILL SPEIR is PPTA's Director, State Affairs and LAURA SAVINI is PPTA Europe's Manager, National Affairs

By Joshua Penrod

SOURCE AND THE

IN 2009, THE INDUSTRY AND PPTA SET ABOUT PERFORMING AN IN-DEPTH STRATEGIC REVIEW. As a result of that process, the strategic objective of "plasma" was articulated as one of the priority areas for the Association. It was recognized as an underpinning for many of the challenges and opportunities faced by the industry, and it also encompasses a number of areas within the activities of PPTA Source. Some of the activities "touch" the area of the strategic objective of plasma, while others are fully involved in the discussion. Some of the areas implicated in the plasma objective are regulatory advocacy, safety, quality, standards, donor compensation, and industry image and credibility.

The most salient aspect of the discussion of plasma as a strategic objective is the recognition that plasma is truly what differentiates this industry from any other. The ultra rarity of the conditions that plasma therapies treat, the uniqueness of the patient groups who cope with these diseases, and the many other aspects that make up the conversations about our industry all stem from the foundation of what truly sets us apart: plasma.

With human plasma as the starting material, the issues managed and the challenges faced by the industry come from virtually every direction: safety, quality, access, ethics, standards, profile, trade, and so on. The use of plasma has a long history, and the industry's efforts have resulted in extraordinarily safe and high-quality therapies. In addition, the distinction of "plasma" as a strategic objective has resulted in a number of high-profile initiatives and discussions. Some of these efforts have been long standing –and therefore underscore the long-term nature of plasma as a core strategy—and some have been created as a result of this renewed effort and focus.

In one sense, this discussion could revolve solely around our efforts at industry image and credibility—a project now four years in the running directed toward addressing some of the misconceptions about plasma. Plasma collection means many things to many different people, and the Association has endeavored to use the latest technology in an effort to bring coherent messages about our industry to as many diverse audiences as possible.

The focus of the work has been on education. This means dispelling myths, offering quality information for a variety of audiences, being able to address media inquiries, and many other important goals. The industry image projects have yielded a number of tangible tools and positive outcomes for the industry:

- English and German-language websites devoted strictly to plasma collection and boosting PPTA members' profiles in various communities (www.donatingplasma.org and www.dieplasmaspende.de and .at);
- Several campaigns that have utilized social media, particularly Facebook, to impart educational messages about plasma donation and plasma therapies; and
- Film, video, and interactive software to educate viewers about plasma, and center personnel on handling media inquiries.

These and other efforts have also resulted in increases in intangible benefits as well, such as an enhanced ability to distribute key messages to personnel in member companies responding to media inquiries. As a result of these new capabilities, negative media impact and misperceptions about the industry have been minimized and, in some cases, turned to positive messages about the importance of plasma.

But a project devoted toward improving perception of the industry and increasing education is only part of the discussion. The image must also have substance. If the industry had not made so many significant efforts (including the International Quality Plasma Program (IQPP) standards, regular stakeholder communications and outreach, improved safety and quality, and countless others), then industry image and credibility would be an empty shell. Fortunately, the plasma collection industry has tremendous substance and, through the strategic objective of plasma, can demonstrate it.

The cornerstone of the image and credibility project, as well as the larger strategic objective of plasma, is the IQPP voluntary standards program. Now celebrating its 20th anniversary, the IQPP has undergone significant improvements and optimization over the past several years. Every existing standard was reviewed in detail by a technical working group, and updated (along with accompanying documents) according to the determinations of the industry. In addition, the industry developed the Cross Donation Management Standard, which helps centers ensure that donors do not donate in excess of the regulatory requirements. The IQPP Standards stand as a testament to the industry's commitment to stakeholders and PPTA is looking forward to taking them to the next level of excellence.

Moving beyond standards, PPTA has also undertaken a number of regulatory initiatives reflecting the importance throughout the industry. Examples include:

The industry's Donor History Questionnaire (DHQ). The DHQ is the end result of a long, painstaking process that will benefit all source plasma collectors. Despite the timeframe of the undertaking, Source members and PPTA realized that the benefit will be significant and that a change and project of this significance and scope would require long-term thinking and operations. We're pleased to have been able to generate such a carefully considered, constructive result.

PLASMA STRATEGY

- Managing donor epidemiology issues in Europe. While this initiative is still very much in flux, its importance is well-understood by the participants. Formulation of the plasma strategic objective has brought focus to bear on this issue, and has been essential in developing creative and novel approaches.
- Responding to significant regulatory proposals. PPTA has been vigilant in monitoring draft guidance documents and proposed rules bearing on source plasma collection practices. Where appropriate, these messages include support for a risk-based approach to regulatory structures, differentiation from other industries, and recognition of the broader context in which our industry manufactures its lifesaving therapies. The comments provided to the U.S. Food and Drug Administration (FDA) and other regulatory agencies may be brief or, in some cases, quite lengthy, as was the case with a recent proposal that advocated more than 100 separate changes to the regulatory structure for plasma collection. All of these efforts in accordance with a consistent application of sound regulatory policy to our industry are in accordance with the core principles of the plasma strategic objective.

Much of what our industry takes on in the global and international sphere is also reliant upon our strategic understanding of plasma. In the recent past, PPTA has engaged in workshops in China, as well as discussions in Japan, directly related to our industry's interests and advancement with regard to quality and safety. Sometimes, these forums are opportunities for clarifying misconceptions that exist. Examples include: the nature of compensated donation, the need for safe products and effective diagnosis and acceptable treatment levels. In this way, one can see the growth from a regional or national issue, either in terms of regulatory requirements or perception, to an area of global concern.

The developments and activities stemming from the plasma strategic objective are complex and more numerous than can be described in a brief article. As previously discussed, they run the gamut from standards and profile to regulatory policy and international trade. The strategic objective of plasma is a systematic and useful way of bringing all these issues together. Consequently though we have many issues and concerns that await resolution, a foundational framework and strategy are now firmly in place to get us where we need to go.

JOSHUA PENROD *is PPTA's Vice President, Source*

THE FUTURE OF ORPHAN

WITH MORE THAN 7,000

identified rare diseases, disorders, and conditions affecting more than 350 million people worldwide, the treatment of rare diseases has become a global health priority in recent years. Unfortunately, most of these diseases remain untreated or ineffectively treated. Incentive programs in the U.S. and European Union (EU) have been relatively successful in encouraging manufacturers to bring rare disease therapies to market. The success of the U.S. and EU orphan drug programs is evidenced by the 379 orphan designated drugs receiving Food and Drug Administration (FDA) approval since the enactment of the Orphan Drug Act in 1983, and more than 60 new orphan medicines approved by the European Medicines Agency (EMA) for market in the EU since the enactment of the European orphan legislation in 2000. Yet, strong financial incentives are not by themselves sufficient to accelerate the development of rare disease therapies at the global level.

Many key opinion leaders suggest that the recent transformational advancement in scientific knowledge is the key factor allowing researchers to identify highly complex drug targets and in turn design mechanisms of action with unprecedented accuracy. With 80 percent of rare diseases being genetic in origin, the transformational advancements in genomic knowledge and fundamental scientific understanding are proving highly effective for the development of new and existing rare diseases therapies. Before one can even test a research hypothesis in a clinical trial, there must first be an understanding of the characteristics of the patients affected by

DRUG DEVELOPMENT

Under the Spotlight in the U.S. and EU

these diseases, which global patient registries would be able to provide. Developing quality and statistically conclusive patient registries, however, has been a difficult challenge because of the expense associated with establishing and maintaining the necessary data intake systems.

The rare disease patient community should have roles beyond merely establishing patient registries. The FDA should follow the EMA's lead in empowering the rare disease patient community with its establishment of the Committee on Orphan Medicinal Products. The three patient representatives on the committee are able to provide input on the assessment of a drug's application for orphan designation. Clinical trial design and the type of review process used by the regulators are also areas in which the patient community could provide value to the drug approval process. The Prescription Drug User Fee Act reauthorization negotiations are reportedly including a process that will allow drug sponsors to request a joint scientific meeting with EMA and FDA in instances where they see discrepancies in, for example, clinical trial endpoints in the trial design for the drug. The type of harmonization that may be achieved by such collaboration between EMA and FDA will help eliminate differences in drug approvals and approval times. Some patient organizations view this lack of harmonization as a barrier to rare disease therapy development. Providing manufacturers with more certainty is a key to accelerating development in this space.

Shortening the diagnosis time for rare diseases is also an area where the patient community can influence policy. In recent years, the U.S. has taken a leading role in neonatal screening. The individual states determine the tests used and the genetic conditions for which those tests will screen in its jurisdiction. The rare disease patient community has had success in working with the states to have several rare diseases included in these screening programs. For example, according to the Immune Deficiency Foundation, 20 states, the District of Columbia, and Puerto Rico are currently screening for severe combined immune deficiency (SCID). The success of neonatal screening for SCID is primarily due to the efforts of the Jeffrey Modell Foundation working with the Centers for Disease Control and Prevention, the National Institutes of Health, and the University of California, San Francisco to develop the original pilot program in Wisconsin. The EU Member States have taken a particular interest in patients with rare diseases and have started the implementation of "national rare disease plans," which are intended to ensure that patients have access to high-quality care, including diagnostics, treatments, habilitation for those living with the disease and, if possible, effective orphan drugs. The plans and strategies will be adopted by the end of 2013 at the latest and will integrate initiatives at local, regional and national levels to yield a comprehensive approach to rare diseases. The plans will define a number of priority actions with objectives and follow-up mechanisms. Additionally, the ability to identify more patients at earlier stages will have the effect of encouraging manufacturers to enter the market, and will, it is hoped, yield even more well-established therapeutic classes to satisfy unmet patient needs.

Patients suffering from rare diseases, disorders and conditions must have access to the therapeutic intervention best suited for their individual needs. The financial incentives provided by the Orphan Drug Act in the U.S. and by regulation (CE) N° 141/2000 in the E.U. have provided some encouragement in terms of the development of therapies for the rare disease patient population. With these incentives firmly in place for manufacturers, scientific advancements, global patient registries, neonatal screening, and harmonization in clinical trial design are among the critical additional components of a patient-centric drug development model necessary for increasing the number of approved rare disease therapies worldwide.

JAY GREISSING *is PPTA's Senior Director, Federal Affairs,* SIADA EL RAMLY *is PPTA Europe's Director, Public Affairs and* EVERETT CROSLAND *is PPTA's Manager, Federal Affairs*



DAVID WATTERS Retiring Executive Director of the International Patient Organisation for Primary Immunodeficiencies (IPOPI)

AFTER A CAREER OF HELPING OTHERS, David Watters is retiring from the International Patient Organisation for Primary Immunodeficiencies (IPOPI) and handing the reins to Johan Prevot, executive director designate. While looking forward to enjoying the next chapter in his life, he will look back fondly on his experiences and continue to educate all who he comes in contact with about primary immune deficiency (PID) and the challenges faced by patients with this disorder.

Can you briefly describe IPOPI?

IPOPI is the global network of national member organizations (NMOs) and it seeks to better equip NMOs to be effective advocates for their patients through the promotion of early diagnosis and effective, safe, therapies. It has been my very great privilege to be involved in the work of IPOPI for over 16 years—first as a Board member, then as a servant of the Board on a part-time basis, culminating in the past six years when, as Executive Director, almost every waking hour has been dedicated to what I see as a great and worthwhile cause.

What are your most proud achievements while working at IPOPI?

It is a deeply humbling experience to work alongside, and be trusted by, patients who are, on the whole, getting a rough deal from their national health agencies and that humility is deepened when you see wonderful things starting to happen in countries where there has been very great disadvantage—I think of Africa, Latin America—but also of Europe. To realize that one has played a small part is very humbling! It has also been very good to see IPOPI grow in strength—now with 41 NMOs—and still growing and showing signs of good health and heart!

How have both the association and patients' attitude changed over the years?

Over the years it has been good to see patients and patient groups become much more assured, confident and empowered to take a lead in affairs affecting their health and the health of their families. This has not been easy and it comes as a result of many interested stakeholders working together—ranging from affected individuals, national groups, politicians and policy makers, industry, and IPOPI itself. Ten years ago "advocacy training" would be seen as something very threatening—now it is something that people see as essential if they are to adequately represent their patients at a national level.

What are the priorities for the future?

IPOPI has set itself a tough challenge in its objectives and they are lasting objectives that will stay fresh and active for many years to come—early diagnosis, enhanced available therapies, better medical and social awareness of PID, developing more and more NMOs and funding the operation to keep the very busy ship afloat! Those are enduring priorities—sure we will campaign for early testing for severe combined immunodeficiency (SCID), we will want to influence policy decisions and keep abreast of developments in areas like health technology assessments (HTAs) and other developments in health policy—but the core priorities will always be to secure the very best for patients through early diagnosis, adequate therapy and empowerment of NMOs.

How has the treatment for PID evolved over the years and what remains to be done?

Sixteen years ago it was so very easy to "spot the PID patient" at any gathering—generally speaking they were in poor health, with racking coughs and, often, poor digestive systems. Today, as a great tribute to all concerned with the provision of health care, it is much harder to tell who has a PID! The availability of therapies, the development of subcutaneous infusions, the development of care programs at national levels—they have all helped to secure a brighter future for people with primary immunodeficiency.

Who was the most significant person you met (or the person that has marked you the most) during your work with IPOPI?

Wow-how do you separate them out! Perhaps the most significant people would be children in a very poor hospital ward in Soweto in South Africa. Their treatment facilities were very limited—their surroundings were far from Western standards-while we were there the water was turned off and there was a massive storm and a power cut—BUT they were being cared for by a dedicated, bright, jovial team of young doctors and nurses who let nothing stand in their way. Those are the significant people who influenced me and kept me going in face of all kinds of local problems in other countries. I would also have to add that at Board level it has been my privilege to work with two very inspiring ladies-Bianca Pizzera and Jose Drabwell-both of whom have driven the work of IPOPI with enthusiasm and very great courage. That, too, is important, along with motivated Board members from around the world. But let's hope that it is always those highly disadvantaged people who stay in the sights of IPOPI as it heads into the future!

> LAURA SAVINI *is PPTA Europe's* Manager, National Affairs

EPIDEMIOLOGY REGULATORY LANDSCAPE

By Ilka von Hoegen, Ph.D

The Plasma Master File (PMF) concept

Historically, licensing of plasma-derived therapeutics required submission of identical information about the plasma starting material with each Marketing Authorization (MA) for a plasma-derived medicinal product. This required manufacturers to submit duplicate details on each of several products derived from the same starting material. Ideally, reference to one document containing all information on the starting material would be more efficient for the manufacturer: the concept of a Plasma Master File (PMF) was born.

In support of its member fractionators, PPTA began advocating in the 1990s for the introduction of a PMF as a stand-alone dossier as part of the MA for a plasma-derived medicinal product. A stand-alone PMF could be independently administered from the other elements of the MA dossier and would better accommodate the specific requirements related to human plasma as starting material.

In June 2003 Commission Directive 2003/63/EC provided the legal basis for a PMF by amending Directive 2001/83/EC for medicinal products derived from human blood or plasma. The amendment allowed replacing the dossier requirements related to the starting and raw materials by a PMF certified in accordance of the provisions of the Directive.

As proposed by PPTA, the PMF was designed to be a standalone dossier, which would be reviewed and certified by the European Medicines Agency (EMA). The PMF Certificate would then be submitted to the European National Competent Authorities for acceptance into the marketing authorization dossiers for the products licensed in those countries. A number of different guidelines of the EMA were developed to provide guidance on procedural and content details for the PMF.

Epidemiology and the International Quality Plasma Program (IQPP)

An important common goal of our industry and regulatory bodies is to ensure that plasma for fractionation is obtained from donors who do not have an elevated risk of having infectious disease. In this light, emphasis is being focused on donor or donor center quality, as measured by epidemiological data on infectious disease risk. While donor selection is important, it must be acknowledged that steps such as sensitive infectious disease testing and viral removal and inactivation are crucial to ensuring the safety of plasma protein therapies. Identification of collection centers with high infectious disease rates is valuable for quality control. Interpretation of epidemiological data for identifying "outliers" is like navigating a field of quicksand. False steps can lead to dire consequences that negatively impact plasma availability needlessly. It is important to note that no known viruses have been transmitted by plasma protein therapies in almost two decades.

Since the late 1990s, PPTA has had a viral marker standard to assess donor center quality as a central component of the International Quality Plasma Program (IQPP). This standard

has been an effective measure for quality improvement by the source plasma industry.



The EMA Guideline on epidemiological data on blood transmissible infections

The requirement to collect epidemiological data on blood transmissible infections is intended to provide information on the theoretical infection risk in a specific donor population and is seen as an important part of the measures to ensure an adequate selection of donors of blood and plasma. Recently, a revised version of the 2005 Guideline on epidemiological data on blood transmissible infections came into force. Regulators felt that a revision of the guideline will benefit and improve the PMF dossiers with better submission of data and consistency across evaluation. To comply with the provisions of the guideline the PMF holder must

- Report and analyze individual plasma center epidemiology data;
- 2. Facilitate tracking and time trending of these data; and
- **3.** Establish a range of limits for acceptability of donor centers based on epidemiology data.

PPTA's International Quality Plasma Program (IQPP) and the PPTA Viral Marker Standard address issues of donor quality and limits of acceptability for source plasma. The EMA approach also includes recovered plasma as starting material for the production of medicinal products under the supervision of the agency. The most significant difference is that the PPTA standards are based on the donations actually fractionated, while the EMA guideline is based on donors.

IQPP classifies donors as either Applicant or Qualified do-

nors and calculates positivity rates based on the number of Qualified donations. The PPTA Qualified Donor Standard treats every person who has not donated in the last six months as an Applicant donor. EMA categorizes donors as either first-time tested (FTD) or repeat tested (RTD) and defines positivity rates for each based on the number of donors. RTDs are classified as persons, whose plasma or blood has been previously tested for infectious disease markers in a given collection system. This definition difference has resulted in two different systems for quality assessment and data reporting. The definitions of the measures are shown below.

		IQPP	EMA
Donor definitions	A1	Applicant donors	FTD
	A2		RTD
	Ar		
	Q	Qualified donors	
	·		
Rate calculation	Numerator	Positives	Positives
	Denominator	# donations	# donors

A1: 1st Applicant donation

A2: 2nd applicant donation

Ar: Qualified donor returning after more than 6 months

Q: Donor who has successfully completed two health screenings

and is negative on the two qualifying donations for all infectious diseases

The consequence of the different approaches for calculating the positivity rates is an increased data collection burden for collectors and fractionators. However, it helps ensure the end goal of product safety. The need for EMA to include the two different plasma types that contribute to the quality and safety of the final plasma-derived medicinal product they regulate is obvious. To help member fractionators identify outlier donor centers with higher than expected viral marker rates so that corrective action steps can be taken, PPTA, through its Epidemiology Data Task Force, has developed a metric for assessing center donor quality that can be applied to all donor centers. This has been presented and discussed with the EMA on several occasions, the most recently in June, 2011 and can be used by member companies for their 2011 PMF assessments.

However, donor selection is only one of the multiple safety measures in place. Measures like inventory hold, NAT testing of donations as well as manufacturing pools, and the virus inactivation/and removal during the manufacturing process, provide the most important contribution to the overall safety of the

> plasma-derived products. But these safety measures, mostly part of PPTA's voluntary industry initiatives are not taken into account in the guideline. The current revised guideline appears strongly linked to the supervision and the practices in blood collection centers, transfusion needs and more broadly to public health surveillance. It seems to neglect the efforts the

plasma collection industry has made to provide patients with plasma-derived medicinal products with high margins of safety.

The source plasma industry is committed to providing an adequate supply of safe products to those who depend on them for their health. Working with regulatory agencies to have meaningful steps to help maintain product safety is crucial and a process to which industry is committed. (\$

ILKA VON HOEGEN, PH.D is PPTA's Europe's Senior Director, Quality and Safety

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ALPHA-1 PATIENT



IN THE LATE 1980s, Lynn Lothian started having trouble breathing. She was told she had COPD—chronic obstructive pulmonary disease—and was advised to quit smoking, which she did in 1990. But, her health never improved. Lynn continued to suffer from frequent colds and bronchitis.

In 1999, Lynn learned that she needed spinal surgery and was required to see a pulmonologist to evaluate her COPD and assess her treatment and health prior to the surgery. However, the specialist took a look at her age she was 42 at the time—and symptoms and quickly concluded that she had alpha-1 antitrypsin deficiency. Lynn's augmentation therapy infusions began in March of 2000 and she receives a 15 to 20 minute infusion at home once a week, administered by a nurse.

In addition to receiving regular infusions and being treated with oxygen, Lynn also uses a portable nebulizer, frequently uses inhaled drugs including albuterol, fluticasone and tiotropium depending on her symptoms.

Today, Lynn's lung function is merely 22 percent, however, she continues to work as an administrative assistant for Northrop Grumman in Arlington, Virginia, a company she has been with for 21 years. Lynn praises her employer for working with her as she manages her alpha-1.

Understanding Her Therapy and Thanking Donors

Several years ago, Lynn was able to visit a fractionation facility with other plasma protein therapy users and met donors at a plasma collection center—ironically the same center where her son was once a donor. "It was nice to sit down and meet with donors, to say 'thank you for saving my life," Lynn said. She describes the full day as a wonderful experience.

Advocating for Other Alphas

About four years ago, Lynn attended an advocacy day on Capitol Hill, teaming up with an alpha-1 patient who was liver-affected. Lynn describes the experience as an awakening for both patients, who have different symptoms and treatments as a result of the disease. On that first advocacy day, Lynn explains that her partner did most of the talking. However, this spring Lynn attended PPTA's annual Capitol Hill Fly-In and had the chance to share her story first hand. "I wasn't expecting to lobby—I thought I would be listening more than speaking," she said. "Going to the offices was very different for me. I was actually speaking with health delegates. Being able to tell my story and talk to them about what it's like to breathe, or rather, not breathe. Some of the staff looked at me like, 'you have to be kidding," Lynn said.

"Telling my story over and over again, sometimes it made me feel, 'gosh, I'm really sick'. But I look at it like some others are so much sicker. It makes me feel good that I can advocate for the community, especially those who can't, and I would truly like to do it again."

RSNAP / ISTOC

KYM H. KILBOURNE is PPTA's Director, Public Affairs, North America

INSIDE PPTA PPTA NEWS FROM AROUND THE GLOBE

PPTA'S NEW BROCHURE "INDUSTRY VOLUNTARY STANDARDS: The Value of the IQPP and QSEAL Designation" is now available

This new publication discussing global standards programs administered by the Association, including the International Quality Plasma Program (IQPP) and Quality Standards of Excellence, Assurance and Leadership (QSEAL), contains useful information about the hallmarks of the program and features quotes from representatives of a number of patient organizations highlighting the importance of the industry's active commitment to the safety and quality of source plasma and finished plasma protein therapies. The brochure was created as part of PPTA's Source Industry Image and Credibility Campaign, which was developed to promote the source plasma collection industry through positive recognition of plasma donors and lifesaving plasma-derived therapies. To obtain a copy of PPTA's new brochure, please contact Diana Krueger at dkrueger@pptaglobal.org.

MONTH

PLASMA PROTEIN THERAPIES MONTH

will be recognized in September 2011 in California and Florida, helping to raise awareness for the rare, genetic diseases treated with plasma protein therapies and to value the contributions of voluntary plasma donors in the states. Californians and Floridians will be recognized for their outstanding contributions to these lifesaving therapies that treat critically ill individuals and for their donations of plasma that make the creation of these unique therapies possible.

▼ PPTA COLLABORATED WITH THE NETHERLANDS MINISTRY OF HEALTH, WELFARE AND SPORT

and the patient community to host a discussion forum in The Hague that focused on blood and plasma products in the Netherlands now and in the future. The informative presentations provided participants, which included Members of Parliament, government representatives, physicians, patients and industry, with an insightful view of the current situation and developments concerning blood and plasma products

in the Netherlands and entertained an interactive session on the various stakeholder views that were voiced.

PPTA SUBMITTED COMMENTS TO THE INTERNAL REVENUE SERVICE

regarding Notice 2011-9, Proposed Guidance Implementing the Annual Pharmaceutical Fee on Branded Prescription Drug Sales. The Association's comments focused on the agency's interpretation of the orphan drug exclusion and its proposed methodology for calculating Medicare Part B sales, and are consistent with the advocacy strategy regarding the fee and overarching goals to protect patient access to all brands of plasma protein therapies. The letter is posted on PPTA's global website, www.pptaglobal.org.

INSIDE PPTA

PPTA'S ANNUAL CAPITOL HILL FLY-IN

on Wednesday, May 11 brought together patients, patient representatives, members and staff for an unprecedented 108 meetings. The Association, with the support of patient organizations and members, advocated for policies that would continue to encourage the development of therapies

for rare diseases by excluding all drugs and therapies that are only indicated by U.S. Food and Drug Administration (FDA) for a rare disease or condition from the annual pharmaceutical fee, which is part of the new health reform law. H.R. 2672 and S. 1423 were introduced in July and, if passed, would address this issue.

▼ WITH U.S. FOOD AND DRUG ADMINISTRATION (FDA)

and Department of Health and Human Services (HHS), PPTA co-sponsored a public workshop, Risk Mitigation Strategies to Address Potential Procoagulant Activity in Immune Globulin Products, on May 17-18, 2011. Association staff and members participated in the workshop as session co-chairs, speakers, and panelists. The workshop examined the pathogenesis of events in recipients; studies of products/processes for procoagulant activity and removal; and assay methods and validation feasibility. Among outcomes were increased awareness of the complexity of events, including role of procoagulants and host factors; understanding of fractionation processes with respect to procoagulant presence and removal; and status of assay development, feasibility for validation and use in a manufacturing environment.

▼ IN JUNE, the U.S. Department of Health and Human Services (HHS) appointed PPTA industry expert Mary Gustafson to serve for a two-year term on its Advisory Committee on Blood Safety and Availability (ACBSA). The Committee is a Federal advisory committee used by HHS. Ms. Gustafson is currently the Vice President of Global Regulatory Policy at PPTA and has 20 years of experience at the U.S. Food and Drug Administration (FDA). Prior to joining the Association, Ms. Gustafson served as the Senior Director of Regulatory Affairs at Nabi Biopharmaceuticals in Boca Raton, Fla. Julie Birkofer, Senior Vice President, North America, PPTA, had represented the industry on the ACBSA for the previous five years. Welcome to Alabama the Beautiful

PPTA STATE AFFAIRS STAFF ATTENDED ALABAMA MEDICAID'S MEETING ON HEMOPHILIA STANDARDS

OF CARE hosted by the state's Medicaid pharmacy director, a national leader in Medicaid pharmacy policy. PPTA took the opportunity to discuss the Association's initiative, the State Patient Access Coalition, and the need for access to all FDA-approved clotting factors with the pharmacy director.



PPTA, WORKING IN COALITION WITH PATIENT ORGANIZATIONS AND

OTHERS, achieved a successfully carved out clotting factor from mandatory managed care in a statewide proposal that will create a managed care program in Florida (HB 7107). Florida is a trendsetter in Medicaid nationwide and therefore this is a model for access to all clotting factors for patients in Medicaid programs.

MEET THE PPTA

STAFF CHARLES WALLER

MY FIRST DAY ON THE JOB was Sunday June 12, 1994. It started at La Guardia Airport in New York when I greeted a European Commission official ahead of a tour of plasma donation centers and testing laboratories. It was a whirlwind week taking in Tennessee, Missouri, South Carolina, Michigan and Maryland. It culminated in a dramatic race to Baltimore's airport and two missed flights narrowly avoided.

I served my industry apprenticeship working as a consultant for Immuno, later acquired by Baxter, which introduced me to the fledgling association then known as the International

> Plasma Products Industry Association (IPPIA). At that time I joined a group that was so small you could count on the fingers of one hand the number of people who worked there. My first introduction to the industry was through an inspirational work colleague in London who has hemophilia. Simon Taylor showed me the light into this complex and fascinating world. He also set an example for all to follow, but

that's another story. Simon and I were encouraged to compete against each other at Ogilvy & Mather, a large international advertising and communications company. Despite



this, we got along better and better and I was delighted to be a guest at his wedding in the late 1990s.

It is a common error among non-Europeans to see Europe as to some extent a homogenous entity. But the richness of Europe comes from its diversity. Twenty-seven Member States of the European Union (EU) hide at least as many different ways of providing and paying for healthcare. One size does not fit all.

Unlike most European associations, PPTA is not a confederation of 27 national associations. The task for PPTA in Europe is to pick the priorities and manage resources accordingly. I keep in mind sage advice: don't take on battles you can't win and only fight those challenges that have to be won, and win them.

Delivery of healthcare in this world comes in many forms. Most of them can be found in the European Union. It is interesting to note that the European average spending on healthcare is about 10 percent of country's gross domestic product but this hides national rates that go down to less than 5 percent in some countries.

About 1.7 percent of gross domestic product (GDP) is spent on prescription medicines, 0.03 percent is spent on plasma proteins.

Our industry goal is to ensure that wherever possible doctors and patients have the choice of a plasma protein therapy that best meets their clinical need. It is frustrating that it is still common to find countries where the quantity of locally collected plasma determines the quantity of plasma derivatives that are available for doctors and patients to use, regardless of their needs.

As it is still the case that most people that need plasma products get substandard or no treatment, the collection of plasma for fractionation, be it recovered or source plasma, should be maximised.

Tell us about your background.

The best office I ever had was also my first office. If you've seen the tower of Big Ben and the Houses of Parliament in London you've seen the window I looked out of on my first day at work (see photo above). First as a junior researcher and later a speech writer, this was a dream for an eager politics graduate. I quickly settled into the long hours as a political "gofer" eventually specializing in British colonial issues and working on behalf of various peoples who had suffered at the hands of the British Empire makers. Clients included the displaced people of Banaba in Micronesia, the Government of Nevis in the Caribbean, now part of the country of St. Kitts and Nevis and most memorably the native peoples of Alberta in Canada.

My linguistic challenges didn't start at PPTA. Hard to believe, the number of languages spoken by the North American Indians makes Europe seem positively monoglot by comparison. Trying to convince a large group of distinguished native Elders who only spoke Stoney Cree, Blackfoot or Iroquois and many more unique languages I can barely remember, that Britain was never going to go to war with Pierre Trudeau's Canada because of a 150 year old treaty their forebears signed with Queen Victoria was a challenge.

These were exotic experiences for a 25 year old fresh from Essex, that slandered county of England on the north side of the river Thames, by way of the University of Southampton: nuclear waste, tax reform in Poland and the Czech Republic, journalism and investor relations in New York and San Francisco.

I am an avid movie goer, a supporter of Chelsea football (soccer) club and once represented my county and region at field hockey. But my first love is live entertainment: concerts, the theatre and Shakespeare in particular. Living near London, one is spoiled for choice.

Those who know me know that my wife, Anne, and my two daughters, Rosie and Megan are my inspiration, though I'm not sure how they would describe me!

What is most rewarding about working in this industry?

I realize this may be a little clichéd, but for many reasons, it is working with the people whose lives can be so affected by their access to plasma protein therapies. In these complex days it is understandable that there are increasingly strict rules covering the relationship between patients and the producers of the drugs they need. PPTA is able to partly fill the gap, ensuring that the basis of the relationship is mutual respect and trust. Treading this sensitive path correctly is of paramount importance. The credibility of both parties depends on making the right judgements. Ingrained in my memory is the Romanian boy enduring the agony of "a bleed" at a European Haemophilia Consortium meeting in Timisoara. The seemingly magical restorative qualities of Factor VIII infused by one of the assembled leading medics quickly provided some relief. It is a tragedy that too many people with hemophilia still have to endure such suffering. This focus is important to me and it provides a very easy reference point when we have to choose priorities.

What is your proudest professional achievement?

PPTA's work with the International Patient Organisation for Primary Immunodeficiencies (IPOPI) and other patient organizations and physicians during the campaign to have immunoglobulin reinstated on the World Health Organization's Essential Medicines List does shine out. Not only was this a great success for the patients that PPTA was pleased to support, but this one issue encapsulates an important reason why all the stakeholders in the treatment of plasma protein deficiencies must remain constantly vigilant and be ready and prepared to work together. I want to believe that the original decision to remove immunoglobulin from the Essential Medicines List was an innocent bureaucratic oversight. it is unlikely to be the last occasion that his happens.

I believe good policies and regulations are the result of well informed and objective decision making. I see this as the Association's primary goal and I am guided by the proverb:

"There is nothing in this world, next the favour of God, I so much desire as to be familiarly understood."



ACBSA	Advisory Committee on Blood Safety and Availability
COPD	Chronic Obstructive Pulmonary Disease
DHQ	Donor History Questionnaire
EHC	European Haemophilia Consortium
EMA	European Medicines Agency
FDA	U.S. Food and Drug Administration
FTD	First Time Tested
HBIg	Hepatitis B Immune Globulin
HBV	Hepatitis B Virus
HHS	U.S. Department of Health and Human Services
нмо	Health Maintenance Organization
HTA	Health Technology Assessment
IG	Immune Globulin

IPOPI	International Patient Organisation for Primary Immunodeficiencies
IPPIA	International Plasma Products Industry Association
IQPP	International Quality Plasma Program
MA	Marketing Authorisation
NAT	Nucleic Acid Testing
NMO	National Member Organization
PID	Primary Immune Deficiency
PMF	Plasma Master File
QSEAL	Quality Standards of Excellence, Assurance and Leadership
RTD	Repeat Tested
SCID	Severe Combined Immunodeficiency

EVENTS UPCOMING CONFERENCES & SYMPOSIUMS 2011 20

September 22 – 23	Seventh WFH Global Forum on the Safety and Supply of Treatment Products for Bleeding Disorders <i>Montreal, Canada</i>
October 1 – 10	24th European Society of Intensive Care Medicine Annual Congress <i>Berlin, Germany</i>
October 11 – 13	U.S. Conference on Rare Diseases and Orphan Products National Organization for Rare Disorders (NORD) <i>Washington, D.C., United States</i>
October 13 – 15	2nd Meeting of the Latin American Society for Immunodeficiencies (LASID) <i>Mexico City, Mexico</i>
October 7 – 9	European Haemophilia Consortium Conference <i>Budapest, Hungary</i>
October 22 – 25	AABB Annual Meeting San Diego, California, United States
October 23	Source Business Forum San Diego, California, United States
November 5 – 8	International Society for Pharmacoeconomics and Outcomes Research (ISPOR) 14th Annual European Congress <i>Madrid, Spain</i>
November 10 – 12	National Hemophilia Foundation 63rd Annual Meeting <i>Chicago, Illinois, United States</i>
November 18	RODIN Symposium 2011: Unravelling the Effect of Factor VIII, Prophylaxis & Intensive Treatment on Inhibitors <i>Amsterdam, The Netherlands</i>
November 20 – 23	XXII Regional Congress of the ISBT, Asia

2012

March 8 – 11	Second ASID Congress of the African Society for Immunodeficiencies <i>Hammamet, Tunisia</i>
March 13 – 14	International Plasma Protein Congress (IPPC) Madrid, Spain
March 20 – 23	32nd International Symposium on Intensive Care and Emergency Medicine <i>Brussels, Belgium</i>
June 16 – 20	European Academy of Allergy and Clinical Immunology Congress 2012 <i>Geneva, Switzerland</i>
June 21 – 22	Plasma Protein Forum Washington, D.C. , United States
June 21 – 22 July 7 – 12	
	Washington, D.C., United States XXXIInd International Congress of the ISBT

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