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PUBLIC WORKSHOP
ON PATIENT-FOCUSED DRUG
DEVELOPMENT:
DEVELOPING AND SUBMITTING PROPOSED
DRAFT GUIDANANCE RELATING TO
PATIENT EXPERIENCE DATA

Conducted by the Food and Drug Administration
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1 P R O C E E D I N G S

2 MS. VAIDYA: Hello everyone, good afternoon --
3 if everyone could take their seats, good afternoon
4 everyone. My name is Pujita Vaidya and I'm in the
5 Office of Strategic Programs in the Center for Drug
6 Evaluation and Research.

7 I'd like to welcome everyone to our public
8 meeting today on developing and submitting proposed
9 Draft Guidance relating to patient experience data.

10 We're very happy to see such a great turnout.
11 With many patient, patient advocates, researchers,
12 folks from academia and medical product developers in
13 the audience, and we have several folks on the web as
14 well.

15 So FDA is having a workshop today to hear from
16 you all which will help us in the development of FDA's
17 guidance to support patient-focused drug development
18 and implement requirements under the 21st Century Cures
19 Act and PDUFA VI.

20 In our discussion today, we'll mainly focus on
21 identifying areas where patient experience data might
22 be particularly helpful to inform medical product

1 development and regulatory decision-making and how that
2 can be shared with others.

3 We will also reflect on the range of
4 opportunities for patient stakeholders and seek input
5 from patient stakeholders on what questions will be
6 most helpful for FDA to address in its forthcoming
7 guidance that we'll all be talking about today.

8 I do want to mention that in addition to this
9 workshop, a docket will remain open until May 18th,
10 2018 to which the public may submit general or detailed
11 comments around the topics that we covered today during
12 the Workshop.

13 We do have a full agenda for today's meeting
14 so let me quickly go through what's in store for you
15 all. Theresa Mullin, Associate Director for Strategic
16 Initiatives in the CDER will get us started this
17 afternoon with opening remarks.

18 After Theresa I will come back up to give a
19 short presentation to introduce CDER's external
20 resources webpage. We will then have two panels focus
21 on considerations on specific topics.

22 The panel sessions will be as follows:

1 Session 1 will be opportunities for patient
2 stakeholders and hearing from the FDA's perspectives so
3 we will have our FDA panelists appear. This session
4 will start off with two -- two presentations from our
5 FDA colleagues.

6 After that we'll have a short break and then
7 we'll have Session II which is opportunities for
8 patient stakeholders hearing from their stakeholder's
9 perspective.

10 Following Session II, we will have an audience
11 facilitated discussion so that those in the audience
12 can add to the discussion that we're having up here
13 after Session II.

14 We'll have many people attending via web.
15 Unfortunately, we will not be able to take comments or
16 questions or address them in the meeting itself, but we
17 encourage you to submit your comments to the public
18 docket and we'll be actively looking through those.

19 Following the sessions, we will provide time
20 for open public comment. If you wish to sign-up to
21 speak during the open public comment period please do
22 so at the registration table up front.

1 Participation is on a first-come, first-served
2 basis and we have about 20 minutes allocated for open
3 public comment so we'll be able to take up to maybe 10
4 speakers or so.

5 Before I get into some brief housekeeping
6 items I would like our FDA panelists sitting over here
7 to please introduce themselves.

8 MS. MULLIN: Hello, Theresa Mullin, the
9 Associate Director for Strategic Initiatives in the
10 Center for Drugs.

11 MS. MALONEY: Good afternoon, I'm Diane
12 Maloney, Associate Director of Policy in the Center for
13 Biologics.

14 MS. SIPES: I'm Grail Sipes, I'm the Director
15 of the Office of Regulatory Policy in the Center for
16 Drug Evaluation and Research.

17 MR. FLANAGAN: I'm Keith Flanagan with the
18 Office of New Drugs in CDER.

19 MS. PAPADOPOULOS: Elektra Papadopoulos, with
20 Clinical Outcome Assessment staff in the same office.

21 MS. VAIDYA: Thank you, so this kind of will
22 be in an active listening mode throughout the day. For

1 some of the sessions they will be moving over as they
2 are part of our Session I Panel as well. We'll have
3 our active panelist here for each session come up when
4 the time is -- when it's time for them.

5 So just a few brief housekeeping items -- this
6 meeting is being transcribed and a live webcast is
7 being recorded, both of which will be archived on our
8 website. We will have a 15-minute break at around 3
9 o'clock after Session I.

10 Bathrooms are down the hallway in the lobby to
11 the left and if you need the WIFI password, I think we
12 had it up earlier -- it will come up again during the
13 break or you could ask our folks in the lobby, they'll
14 be able to hand that over to you.

15 With that I'd like to now invite Theresa
16 Mullin to the podium.

17 MS. MULLIN: Thank you Pujita. You know if
18 you knew about this meeting and you've come here today,
19 you may not need any orientation to what I'm going to
20 tell you. I'm think I'm going to tell you maybe
21 something you're very well familiar with but I am --
22 just in case you're not.

1 I'm going to give you a little bit of
2 orientation to this guidance. We have a very long name
3 that we use for it which is pulled out of the statute,
4 but at FDA we've been referring to it for some time as
5 Guidance 5. So why are we doing Guidance 5?

6 And so this session today is really intended
7 to give you a better sense of the statutory
8 requirements that we're trying to meet here and -- and
9 let's begin with -- and this is a -- let me know if
10 that's just too loud and I'm hurting your ears, but
11 this is really to implement a section -- a paragraph
12 under Section 3002 of 21st Century Cures.

13 And under Section Title III which is Patient-
14 Focused Drug Development, we have to refer back to
15 Section 3001 which starts out by talking about patient
16 experience data.

17 And the statute defines patient experience
18 data but it also begins by saying, "Directing FDA, that
19 following the approval of an application, any
20 application approved after approximately June of 2017
21 should make a brief public statement about a patient
22 experience data and related information, if any, that

1 was submitted as part of that application and was
2 reviewed as part of that application."

3 And so FDA actually to -- to get ready for
4 that we put together a little template that in
5 consultation with our reviewers to identify various
6 types of patient experience data that we had been
7 seeing and might see, and we looked at our benefit risk
8 framework and the components, the five areas of
9 consideration there to just give us a -- a kind of data
10 collection template.

11 Because under Section 3004 of Title III, we
12 have to begin reporting on that use of patient
13 experience data in 2021 -- so that's a few years away,
14 we don't want to go back. We want to start collecting
15 that information going forward so that's the approach
16 we've been taking with every application and then to
17 prepare ourselves for later reporting.

18 Well what -- what is patient experience data
19 and how is this defined -- and again you probably are
20 all very familiar with this but just to go over it.
21 It's defined in the statute as data being collected by
22 any person and it gives examples including patients,

1 family members, caregivers of patients, patient
2 advocacy organizations, disease research foundations,
3 researchers, drug manufacturers as examples that are
4 intended to provide information about patients'
5 experiences with the disease or condition and in
6 particular, the impact -- physical and psychosocial of
7 that disease or condition, or regarded therapy or as
8 amended under FDARA, clinical investigations and also
9 patient preferences with respect to treatment of such
10 disease or condition.

11 So when we talk about it in short hand today
12 we might say patient advocacy group, we might say a
13 patient is still part of their group, but think of all
14 these groups that are named here as the longer list
15 that we're referring to -- we just can't keep repeating
16 that. You'll get tired of it and we'll never get
17 through the meeting. So that's who we're talking
18 about.

19 And now under 3002 there's a -- there are 8
20 paragraphs that are describing guidance that the
21 Secretary should issue over the next 5 years and -- and
22 our goal is to -- to issue this guidance, not to string

1 it out over the, you know, 5 years, but we will be
2 doing it more or less in the timeframes and the cadence
3 that we had described in FDARA commitments under Title
4 I PDUFA VI, but these are -- are provisions in 21st
5 Century Cures track really well and align with --
6 really compliment what we committed to under PDUFA and
7 so that makes things really much better for us and it
8 helps.

9 So this first area under 3002 is --
10 methodological approaches for how to collect patient
11 experience data and submit that for regulatory
12 decision-making so that it's accurate and
13 representative of the intended population.

14 And these methods are collecting new
15 meaningful patient input throughout drug development
16 and considerations for data collection reporting and
17 analysis. So that's a pretty broad remit but that's
18 what we're trying to do under our first guidance.

19 And the second guidance area to address would
20 be methodological issues for how to develop and
21 identify what's most important to patients in terms of
22 the burden of disease, burden of treatment, benefits

1 and risks.

2 The third area of focus is identifying and
3 developing methods to measure impacts that are -- to
4 patients that are most meaningful and also would be
5 facilitated in collection of clinical trials. The
6 remedies you are now focusing on the subset of impacts
7 that really would be measurable and impacted by a -- a
8 therapy or a technology that's being studied in a
9 trial.

10 Not all impacts that patients identified may
11 be affected by such treatments. And then the statute
12 goes on and the fourth area here is methodologies,
13 standards and technologies to collect and analyze
14 clinical outcome assessments for the purposes of
15 regulatory decision-making. So that's that broader set
16 of types of tools, the previous few might really in
17 many cases suggest a PRO but here, more broadly, we're
18 looking at COAs of which PRO is a subset.

19 And then here we are paragraph 5 -- how a
20 person seeking to develop and submit the post draft
21 guidance related to patient -- relating to patient
22 experience data for consideration by the Secretary may

1 submit such proposed draft guidance to the Secretary --
2 so that's the focus of the meeting today.

3 And as you can see it just is a fairly -- it's
4 -- it's one of perhaps a number of different ways that
5 information could be submitted. So in trying to -- to
6 planning for this meeting today, we're trying to
7 balance, not excluding or saying this is the only way
8 to do it, but trying to talk about all the ways and
9 when this guidance submission may be particularly
10 appropriate or one that you might prefer to try using.

11 Paragraph 6 gets into the specifications of
12 the format and content for a submission to the
13 Secretary that would be including this kind of
14 information and how we would intend to respond to those
15 submissions and the timeframes, if it's not part of a
16 regulatory submission that already has a timeframe.

17 And finally, paragraph 8 here, how the
18 Secretary, if appropriate, anticipates using this
19 information in its benefit risk assessment framework
20 that was described elsewhere in the statute.

21 And so these are all the areas that we will be
22 covering and those first four as I said, really align

1 pretty nicely with the first four areas of guidance
2 development that we had identified as a commitment
3 under PDUFA VI which is included in FDARA
4 reauthorization last summer.

5 But in addition to that we have planned
6 workshops that we will be conducting in each of those
7 four guidance areas. And so we first thought we'd be
8 having -- issuing a guidance, by now on this Guidance 5
9 but we thought better of it -- we thought really you
10 would benefit for having a kind of discussion like this
11 -- having a workshop first because we really get a lot
12 of helpful input.

13 We'd get more insight about what's useful by
14 hearing from our stakeholders and having discussions
15 like this. So instead of having a guidance produced
16 now, we're having this workshop so we can get that
17 information in and we'll produce the guidance -- draft
18 guidance later this year.

19 In addition, in PDUFA VI we're going to have
20 MAPPs -- developing MAPPs and SOPPs to try to further
21 integrate this kind of data collection in our
22 regulatory processes internally in our own internal

1 review processes. We are committed to develop a
2 repository of information that we'd make publicly
3 available on the tools that are publicly available and
4 other information that might be submitted to us and
5 Pujita is going to say a little bit more about our
6 initial efforts there.

7 We're committed to conduct a workshop where
8 we'll really hear more about patients' experiences with
9 clinical trial participation and get the
10 recommendations of patients, caregivers, and others in
11 the community about ways to enhance participation of
12 patients in clinical trials.

13 And finally, we committed to increase our
14 staff because we have rather limited staffing with
15 expertise in the review of these kind of submissions
16 and COAs and clearly, if people are going to want
17 advice, or want us to do timely review, we need enough
18 capacity to do it.

19 I'm not going to go through these in detail --
20 this is just a more lay version of what are we doing in
21 each of these four guidances that are related to
22 methodology -- related to PR roles and COAs and patient

1 experience data as it's called by the -- named by the
2 statute.

3 We've also been asked, how do these guidances
4 really apply and I think that you can consider these
5 four guidances to really track very well with those
6 first four paragraphs in 3002.

7 And we see the first two of these guidances
8 really -- including the Glossary of Terms that we've
9 included under PDUFA VI in the first guidance to be
10 applicable throughout the lifecycle of a drug and
11 really encourage that people think about applying and
12 collecting and thinking about bringing in this kind of
13 information as early as possible.

14 If identifying the disease and treatment
15 burdens and outcomes that might be appropriate to
16 address really would affect design issues and may
17 affect the instruments you need to develop and have
18 ready when you're ready for clinical trials, and so
19 those are the things that begin to be addressed in
20 Guidances 1 and 2.

21 Guidance 3 and 4 really become particularly
22 important to apply by pre-clinical development

1 anticipating clinical trials and all the way through to
2 post-approval studies, but it also is somewhat relevant
3 in those earliest stages, so, -- so we think these
4 guidances will have broad applicability.

5 This is not readable but it's taken from the
6 back of our plan for issuance of guidance that we
7 published last summer and it's available, yes on our
8 website. You can Google "Applying for Issuance of
9 Patient Focused Guidance," or things like that and the
10 link is also there.

11 And this shows you the timing that we've kind
12 of aligned our FDARA commitments to the 21st Century
13 Cures timelines and there you have what we're doing.
14 Only with the amendment that as I mentioned on this
15 Guidance 5 -- we're having a workshop right now to get
16 input and we'll have that post-draft guidance produced
17 a little bit later this year.

18 Here's an update on where we are with the work
19 related to these things. We had that first workshop on
20 Guidance 1 -- Collecting Comprehensive and
21 Representative Input last December, and there's a link
22 to the discussion draft that we produced in advance of

1 that meeting and we are planning targeting having our
2 draft guidance on number 1 in by June or in June --
3 depending on the clearance process.

4 And we have launched a website for externally
5 submitted information related to patient experience
6 data and Pujita can tell you more about that. We felt
7 the need to have something ready because we're
8 receiving a lot of very helpful information from
9 external groups and we want to be able to share it, so
10 this is the way we put this together so we can begin
11 sharing that without any more delay there.

12 And today's workshop is to help us with -- you
13 can see why we call it Guidance 5 because there is the
14 title of it, "Developing and Submitting Proposed
15 Guidance Related to Patient Experience Data for FDA
16 Consideration."

17 And so with that I'll turn it over to Pujita.

18 MS. VAIDYA: Thank you Theresa. I apologize
19 if I start coughing -- my allergies have kicked in so
20 please bear with me. So now as Theresa mentioned I'll
21 be going over our new external resources page that
22 we've -- we've just recently put out.

1 Things I will be covering at a high level here
2 -- What is patient experience data -- I probably won't
3 go over that since Theresa has talked about that. Give
4 an overview of our CDER external resource webpage --
5 then kind of go into a little bit of detail about some
6 of the categories of external resources that we've
7 included as of now and some additional resources that
8 we have available for everyone.

9 So just frequently asked questions, cover page
10 guidelines and stuff like that.

11 Okay, so as Theresa's mentioned in her opening
12 remarks in 21st Century Cures Act, we were introduced -
13 - formally introduced to the term "patient experience
14 data" and we'll walk through this because we -- I think
15 by now we know what patient experience data -- or as
16 they call it, PED, actually is.

17 We recognize that there are various types of
18 patient experience data. It can be collected in many
19 ways and we've seen different work products coming out
20 of this so let's say for example meeting reports
21 capturing the patient's perspective or proposed draft
22 guidance is what we'll be talking about today.

1 And as Theresa mentioned in her opening
2 remarks, we heard from our patient stakeholders that
3 there really was a need for a centralized location to
4 house these types of information and to not only to
5 house it, but to share it with folks so they can serve
6 as a resource for not just us, but for all of our
7 stakeholders.

8 So keeping that in mind in January of 2018
9 CDER launched its external resources or information
10 related to patient's experiences webpage. This is a
11 pilot webpage and this is intended to be a platform to
12 help facilitate public discussion on a patient focused
13 drug development.

14 What we have here on this webpage of certain
15 links -- publicly available links that are either
16 excellent reports or other resources and information.
17 We see these resources serving as a resource for all of
18 the stakeholders, for patient groups out there,
19 patients themselves, the researchers, drug developers,
20 mobile product developers and federal agencies as well
21 -- like FDA.

22 Anyone can submit this information and -- but

1 we would like to note that although FDA reviews the
2 materials that are housed on these specific links so
3 when we do get a request we do go in and review the
4 materials just to make sure that they are in within the
5 scope of the webpage itself.

6 We, however, do not assess their scientific
7 merits or compliance with regulatory requirements.
8 Please also understand that FDA's decision to post
9 links to the materials does not necessarily reflect an
10 endorsement of the authors, responses, or the content
11 itself.

12 So now I'll talk a little bit about the
13 various categories that we have so far on our webpage.
14 Currently we have three focus areas -- x-ray, led PFDD
15 meeting reports or other stakeholder meeting reports --
16 that's the first one.

17 So what do we mean by that? So in this
18 category we -- we plan to include meeting reports from
19 x-ray led PFDD meetings -- the types of meetings that
20 several of you in the audience are conducting or have
21 already conducted. It's in the reports that are
22 generated from that. Along with that we also -- we'll

1 be housing other stakeholder meeting reports where you
2 have kind of a list of the patient's perspective on
3 disease burden and disease areas. So that's what we
4 plan to put in this category.

5 The next we have here are proposed draft
6 guidance relating to patient experience data -- the
7 topic of conversation today. So here external --
8 external stakeholders may submit links to publicly
9 available proposed draft guidances and we were looking
10 to including that on our website.

11 I would like to note though there is also an
12 existing procedure for submissions of external
13 guidances which are provided under -- this is a lot of
14 jargon -- 21 CFR 10.11 F3. If you have any questions
15 come find me and I can talk to you a little bit more
16 about that.

17 But that's the formal process but here itself
18 I would say if you'd like it on the website we ask that
19 you submit it here as well.

20 Finally, the third category we have so far is
21 Natural History Studies or Other Disease Specific
22 Background on Condition and Discussion of Unmet Medical

1 Need.

2 So in the case of let's say -- natural history
3 studies we understand that that can be retrospective,
4 prospective where survey studies are conducted. And if
5 they are published on a website and are publicly
6 available you may submit those website links to us.

7 You may also provide links to other publicly
8 available reports or other documents providing disease-
9 specific background on a condition and unmet medical
10 need.

11 As I mentioned earlier this is a pilot effort
12 so as we receive submissions, categories may be added,
13 revised or deleted as needed.

14 Now I'll go over some of our additional
15 resources that we have available for -- for folks. We
16 have our frequently asked questions document which is
17 on our website and it is really to provide a little bit
18 more information on the scope and the process overall.

19 Some high-level questions here -- there's more
20 in the actual document. What is patient experience
21 data? Who can provide these publicly available website
22 links that we're talking about? What types of the

1 resources will be included on the page? So what's in
2 scope and what may be out of scope here for this
3 particular web page that we have.

4 And we'll go over the process -- over our
5 process of how can you submit a publicly available link
6 to us? So with that and in keeping that in mind the
7 last question -- how can you submit a publicly
8 available link?

9 Well, we have a PFDD resources email -- email
10 where we ask you to submit your resource itself. But
11 along with that we ask that you include a cover page as
12 part of your report or the resource that you are
13 submitting containing the information to provide a
14 little bit more -- greater transparency.

15 The cover page may be included within the
16 report of the resource that you're submitting to us so
17 it could be -- if it's a report it could be a first or
18 second page itself or it can be housed on the same
19 website link as your actual resource.

20 So if you have a report on a page you can have
21 the cover page as a second link there so that it is
22 both in the same place.

1 Some things that we ask that you include on --
2 in your cover page -- the title of the resource,
3 authors or collaborators -- so if you've worked with
4 consultants or other scientific writers, we ask that
5 you disclose that.

6 Funding -- funding received or granted, if
7 any. And if you have not received any funding we ask
8 that you include a brief statement on that as well.
9 Diversion date -- please include a statement that the
10 resource has not been revised or modified after the
11 time it has been shared with the FDA and also a
12 statement that the resource can be linked from our
13 website -- FDA website, so just giving us permission to
14 link to your page, that's very important to us.

15 So just -- these are some high-level steps. I
16 talked about the web page itself, some categories, some
17 additional resources we have. If you have other
18 questions please feel free to reach out to us and email
19 us. This is a pilot so as we are modifying -- as we go
20 through and issue this we'll modify the webpage and the
21 process as we go. If you have any feedback please do
22 let us know.

1 If you see that something's missing or just
2 general feedback on how we're communicating this please
3 let us know. If you have a resource -- I don't think I
4 showed the email address. We have
5 PFDDresource@fda.hhs.gov. For more information we have
6 CDER's patient focused home page and then our patient
7 focused email log so a lot of folks are probably
8 already with but just feel free to email us.

9 And then with that, thank you all and I will
10 now slowly move us into Session I discussions for
11 today. So for Session I we're going to be talking
12 about Opportunities for Patient Stakeholders and
13 hearing the FDA's perspective.

14 Our moderator for Session I will be Sara
15 Eggers so I'll ask Sara Eggers and our panelists for
16 Session I to please come up and take their seats, thank
17 you.

18 MS. EGGERS: Good afternoon, it's a pleasure
19 to be here moderating this session today. The session
20 is -- this first session is seeking to gain FDA's
21 perspective on opportunities for patient stakeholders
22 to develop information related to patient experience

1 that would provide helpful data and information to
2 support patient focused drug development in a specific
3 disease area.

4 In some cases, this work product could be well
5 suited for submission as a proposed draft guidance. In
6 other cases, it may be more appropriate or more helpful
7 submitting other forms of work products and we are
8 going to get into that today.

9 We'll first discuss what patient experience
10 data may be particularly helpful to inform medical
11 product development and regulatory decision-making
12 broadly.

13 Again, we'll be getting FDA's perspective on
14 the types of information on patient experience data to
15 collect and measure and talking about various formats
16 for effectively sharing that information.

17 There are two important presentations --
18 helpful presentations, I found them helpful that we
19 will have first. Theresa Mullin will come up first and
20 present on the range of opportunities that external
21 stakeholders have to contribute to their expertise and
22 information regarding patient experience.

1 And then Keith Flanagan will come up and give
2 a very helpful primer on guidance and the guidance --
3 and guidance development. And then after those two
4 presentations I'll come back up and we will engage our
5 panelists. Can we first before the first speak, can we
6 have everyone go through and introduce yourself on the
7 panel?

8 MS. LAPTEVA: Hello, my name is Larissa
9 Lapteva and I'm the Associate Director in the Division
10 of Clinical Evaluation, Pharmacology and Toxicology in
11 the Office of Tissues and Advanced Therapies in the
12 Center for Biologics Evaluation and Research.

13 MS. LOWY: Hi, I have a shorter title. I'm
14 Naomi Lowy, I'm Associate Director for Regulatory
15 Science in the Office of Drug Evaluation I.

16 MS. MCCUNE: Hi, I'm Susan McCune and I'm the
17 Director of the Office of Pediatric Therapeutics in the
18 Office of the Commissioner.

19 MS. MULDOWNNEY: My name is Laurie Muldowney
20 and I'm the Associate Director for Medical Policy in
21 the Office of Translational Science.

22 MS. MULLIN: Theresa Mullin, CDER.

1 MS. PAPADOPOULOS: Elektra Papadopoulos,
2 Clinical Outcome Assessments Staff.

3 MR. UNGER: I'm Ellis Unger, I'm Director of
4 Office of Drug Evaluation I in the Office of New Drugs
5 in CDER.

6 MS. EGGERS: Thank you very much and now if
7 Theresa could come back up.

8 MS. MULLIN: Thanks Sara. So again, I alluded
9 to this a little bit before and we're having this
10 workshop today and you look at all these provisions in
11 Section 3002 and all the kinds of guidance we're going
12 to be providing about how to collect information and
13 how to submit and there are many opportunities.

14 And what we struggled with a little bit when
15 we think about guidance is that guidance to industry --
16 we do guidance for industry, has a much narrow purpose
17 and so we thought that we wanted to have a discussion
18 around all the ways that the patient community and
19 stakeholders that are interested in developing patient
20 experience data could contribute and not have people
21 take away the message that it's just guidance.

22 The only thing that's useful to submit to FDA

1 is guidance -- that's the last thing we would want you
2 to think because there are so many other opportunities
3 and many that may really serve as a better vehicle for
4 the kind of information that you could provide.

5 So, so first of all just an observation that
6 in parallel with our expanded efforts in this we're
7 trying to ramp up in our efforts here in patient
8 focused drug development.

9 We know we've heard from a number of -- of
10 patient and disease advocacy groups and others and
11 companies too that they substantially are trying to
12 increase their own efforts in this area.

13 And a number have asked us how can they help -
14 - and what can they do? Sometimes those groups are
15 even led by regulated industry or supported by industry
16 or they're supported by, you know, patient's resources
17 and other sources of funding, but they want to know how
18 they can help and we think there's a lot of help that's
19 needed so we're trying to come up with an overview of
20 what might be -- not exhaustive, but just ideas of the
21 kind of things that occur to us that could be helpful.

22 And it might really depend how they contribute

1 -- probably depends on your expertise and your
2 perspective and where your own relative strengths lie
3 as an organization or as a collective -- a
4 collaborative of organizations.

5 But for example, we note that groups have
6 typically got access and expertise in the -- access to
7 patients and expertise in what patients are living with
8 when they're living with their disease or people who
9 are caring for patients with a disease.

10 They also -- they have especially good access
11 to clinical disease experts -- people who perhaps have
12 experience doing trials and knowing what it's like to
13 enroll people with that disease in trials and the
14 issues that they may face. They may have good access
15 and you may have that as part of your collaborative
16 academic experts who have a great depth of knowledge in
17 that disease area.

18 Drug developers who have particular interest
19 in that disease as a target for development of drugs
20 and generally we find that many external groups have
21 great communications and outreach expertise which --
22 you know FDA's trying to build its bench there but

1 we're always sometimes described as a culture of
2 introverts so we may not necessarily have the same
3 strengths that you all may in those areas.

4 And honestly, we're just aware of other things
5 -- other patient access related issues, whether it's
6 access to trials or access to therapies that are
7 approved and other issues that you know about or can
8 help flag and -- and provide insight about.

9 So here are some of the areas -- I'm going to
10 name a number of areas I'm going to talk a little bit
11 more about a few of them that have been identified in
12 discussing this with my leadership, also just helping
13 to contribute to this list from -- from the perspective
14 of the Senate Director and the Senate for Drugs as
15 well.

16 But the first and the most -- maybe the
17 earliest way that groups have contributed is by gaining
18 additional support for research in a given disease area
19 and this is through advocating for increased funding,
20 making those who have funding aware of the need.

21 And I mentioned in a meeting that -- it was
22 Patients as Partners meeting that was held last Friday

1 that maybe in addition to basic research which has long
2 been one targeted area of need for research, there's
3 probably a lot of applied research that's needed --
4 questions that are related to a particular disease area
5 and understanding the experience of patient's --
6 patient's experienced data is another type of research
7 opportunity.

8 You can also help people with the disease for
9 example providing and making sure that they have access
10 to the durable medical equipment like wheelchairs that
11 they may need as their disease progresses.

12 Outside groups are particularly well-
13 positioned sometimes to develop natural history studies
14 and these can be extremely helpful -- not only to
15 inform future research and the design of that research,
16 but also as a basis for recruiting patients into those
17 studies so that patients in a given disease area are
18 clinical trial ready and that just helps with
19 development expediting development of drugs.

20 Some groups have also formed patients' Centers
21 of Excellence. If you have the resources and
22 experience that gets built over time there was a

1 presentation I heard last week by the Addario Lung
2 Cancer Association, David LeDuc described his
3 Association's work with others in California and in the
4 west to develop Centers of Excellence for treatment of
5 lung cancer.

6 It was very impressive to hear about their
7 journey over several years but this is something that
8 might be within your reach depending on your interest
9 and your resources.

10 Also, venture philanthropy may be helpful
11 focused on a given disease area where groups who are
12 watching that area can see that certain products in the
13 pipeline are really looking like winners and you help
14 expedite development to get them over the finish line.

15 Here are some other areas that may be just
16 closer to the ones we often talk about here in
17 relationship to FDA and the first has participation in
18 our policy development and responding and giving us
19 your input to our meetings and workshops and also with
20 your request comments.

21 Coordination of work among the patient
22 advocacy groups, communication and education and

1 outreach and that's a variety of things -- I'll say
2 more about that in a minute, convening meetings and
3 workshops that could be done and really address more
4 quickly and in more detail, needs that are out there
5 that FDA may not have the bandwidth to get to or we're
6 not getting to as rapidly as you may want to or be able
7 to do.

8 And in addition, you -- groups can contribute
9 to guidance development and they can submit new or
10 enhancements to existing guidance. So in terms of
11 participating in our guidance and policy development --
12 we're -- we're planning a lot of meetings, as you may
13 know.

14 In fact, you might know if you want to get a
15 parking pass here or something we should look into
16 that, you know, actually FDA employees have a hard
17 enough time finding parking -- I shouldn't say that.

18 But we are going to have and we have been
19 having a lot of meetings related to patient focused
20 drug development issues. And these meetings -- there's
21 just no doubt that the meetings are not really anywhere
22 near as good if we don't have the inclusion of the

1 patients and people in the community -- it makes the
2 meetings the most -- provide the most insight for us
3 and the most valuable if we get strong participation.

4 And external groups are really important to
5 help us get participation of people in their community
6 and that includes all those groups I mentioned earlier
7 that have access -- they have access to. They can help
8 us get rich participation in these meetings. They
9 could also help us identify issues up front that we
10 ought to be addressing in these meetings and in making
11 sure that we are really increasing the value and
12 maximizing what we learned in these -- our meetings, so
13 it's an opportunity.

14 We also see an opportunity for helping
15 coordinate across groups. If there are more than one
16 advocacy group or more than one stakeholder group in a
17 given disease area sometimes groups don't know what
18 others are doing, they have limited resources. It
19 would be really great to minimize the you know,
20 duplication of efforts that unintended duplication or
21 conflicting work that might be going on by increasing
22 the awareness within that disease community and trying

1 to align their efforts and so they move forward more
2 and there's less of -- kind of I'll call it a kind of
3 inefficiency that they may experience from efforts
4 going on -- different efforts that are not coordinated
5 as well as they could be.

6 Communication, education and outreach -- here
7 again, building on that expertise that we see most
8 groups have in terms of being able to communicate to
9 their stake -- their own stakeholders, their own
10 constituents as well as to others -- groups can conduct
11 surveys of the community to collect that kind of
12 comprehensive representative input and -- and we
13 anticipate that the guidance we're going to be
14 developing and issuing in June, the draft guidance,
15 will be very helpful in terms of suggesting ways to go
16 about doing that.

17 But you can do those kinds of surveys of the
18 community to better understand what it's like to live
19 with your disease, the available treatments and
20 accessing and participating in trials and perhaps other
21 issues of concern.

22 If the group has -- we also think it would be

1 very helpful to educate communities about the drug
2 development process and the medical product device and
3 biologic development process so people are aware of
4 what kinds of research have to be done.

5 What kind of questions have to be answered
6 about safety and efficacy and being able to manufacture
7 a drug once you've developed an experimental compound?
8 Can you manufacture it in a consistent way so it
9 delivers with the benefits that were observed in
10 clinical trials?

11 And what kinds of timeframes are involved with
12 that and then when are opportunities to get involved
13 and -- and help with developing tools and so on to --
14 to run effective programs -- drug development programs?

15 We also think the groups can conduct that
16 other kind of outreach and in a number of other venues
17 we've talked about the need for a general cultural
18 change across the whole drug development, you know,
19 ecosystem and probably healthcare delivery as well.

20 And this is again where our communication of
21 what's going on here in the voice of the patient and
22 drug development. More needs to be done to implicate

1 this message and understanding in -- in regulators
2 around the world, academic researchers, regulated
3 industry and in healthcare delivery -- so there's a lot
4 of work to do with just trying to continue to reinforce
5 the message and external stakeholders are very good at
6 helping with that.

7 In terms of convening meetings, certainly the
8 externally led patient focused drug development
9 meetings are one type and they are extremely helpful
10 and we are committing again the guidances we'll be
11 developing will maybe help with other types of work
12 that groups may want to convene.

13 If you have particular scientific and
14 technical capabilities in your organization or access
15 to them, you may want to convene meetings and go after
16 other scientific and technical issues that are creating
17 uncertainties in drug development and could you benefit
18 from additional discussion among a workshop of experts
19 from different backgrounds and industry academia,
20 government agencies and so on to just further structure
21 what is it that is not understood, needs to be better
22 understood, focusing data collection and so on to

1 reduce that uncertainty to help advance drug
2 development in that area, or related to that issue.

3 And finally, contributing to guidance -- I
4 mean patient groups. So the FDA is developing guidance
5 -- I have two flavors -- I'm going to be very
6 simplistic here but there are two flavors of guidance
7 that I think of that we might develop and one is sort
8 of a disease focused guidance.

9 And the guidance we might develop in a disease
10 area will tend to be intended to address and provide a
11 broad treatment of issues in that disease area. It
12 won't get into lots of specifics within sub-groups.
13 It'll have broader coverage.

14 And if we have a methodological guidance that
15 we might put out -- maybe statistical methods or
16 pharmacological methods and so on -- then again, it's
17 going to be a general treatment of the methodologic
18 issues and it'll cover a range of study settings,
19 patient populations and so on.

20 And so there would be a -- a way to enrich
21 those guidances would be to -- and external
22 stakeholders would be perhaps well positioned to -- to

1 work to develop more specific use cases or scenarios.
2 For example, in the case of a disease guidance where
3 you tailor that guidance or you suggest additional
4 considerations or particular considerations related to
5 an important sub-population who has that disease, maybe
6 it's related to patient age or the severity, you know,
7 stage of disease, the severity of co-morbidities that
8 they may experience or other considerations, that are
9 very important considerations, within a given disease
10 area and are not going to get treated in any depth in a
11 general guidance document.

12 Similarly, methodological guidance would be
13 able to be enriched by examples of considerations where
14 that method may not be particularly applicable to a
15 certain sub-population or a certain study setting.

16 Maybe looking at variations in economic or
17 cultural contexts that are relevant to people with that
18 disease, language ability, literacy, numeracy and so on
19 or mobility. So issues related to these kinds of
20 considerations could be further explored by an external
21 group and that could be added to help further, you
22 know, kind of adjust or refine the approach someone

1 might take and include received information like that.
2 We can try to figure out how to integrate it maybe as
3 an annex to guidance that we developed that's more
4 general.

5 Here are some examples of questions that we
6 thought up at our -- again external groups are better
7 positioned perhaps -- might be very well positioned to
8 address that would be extremely interesting to us and
9 we'll be probably elaborating on some of these in our -
10 - our session in a few minutes.

11 The first is the one we've been talking about
12 a lot and it's just so central -- which is, what are
13 the disease impacts that matter most to patients, you
14 know, and how does that vary by socio-demographic
15 factors, you know, by subgroups -- maybe a pediatric
16 population or a geriatric population or other
17 populations that have a major co-morbidity along with
18 that disease of interest, stages of severity or other
19 like circumstances that can affect what's most
20 important.

21 How does that -- how attitudes toward or
22 tolerance of risks and uncertainties about side effects

1 may vary by sub-population. Again, same kinds of just
2 repeating similar kinds of sub-populations by culture,
3 severity and other circumstances that are important to
4 understand.

5 How well do the most commonly studied
6 endpoints in current clinical trials align with the
7 things patients are saying matter the most to them --
8 the impacts are the things they care about the most and
9 how does that value what might be a better way to go
10 about what studying -- what matters most?

11 In our currently conducted trials excluding
12 patients who really want to be participating because
13 the enrollment criteria exclude them -- not
14 intentionally but that's the way it works out, what
15 might be done about that?

16 Our current trial protocol is intolerable or
17 otherwise not workable for patients with the disease
18 who would like to participate in the trial might
19 otherwise be eligible. How can you measure and
20 increase the likelihood of the patient enrollment and
21 likelihood of patients for staying in trials in a given
22 disease area?

1 What challenges do patients face when they're
2 trying to adhere to a prescribed regime of treatment
3 and again probing more into how does that vary by
4 patient sub-population and ideas maybe for how to
5 address this?

6 In addition, post-approval -- how well is the
7 current labeling communicating information that
8 patients need to know in order to use drugs safely and
9 effectively -- and this is another area which we think
10 a lot of valuable contributions could be made and
11 insights that would allow -- it would be information
12 that would inform FDA in terms of future actions and
13 perhaps future policies. So I'll stop there, but this
14 is just to give -- it's certainly not exhaustive but
15 it's meant to give -- be illustrative of the kinds of
16 things we think external groups are especially well
17 positioned to help us with and I'll turn it over to
18 Keith.

19 MR. FLANAGAN: Thanks Theresa. So this is
20 sort of what is guidance 101 or 001 -- just kind of the
21 very basics -- we're going to talk about what is
22 guidance, a little bit about the -- a little bitty bit

1 about the substance, the process, some practical
2 considerations and then give you some big picture
3 context.

4 So a guidance document represents FDA's
5 current thinking on a regulatory issue. The guidance
6 is prepared for FDA staff, industry, external
7 stakeholders and the public. We issue a draft,
8 consider public comment then finalize the guidance.

9 Guidance may/should be updated as the science
10 in the field progresses. It's not legally binding but
11 shows one way to achieve the regulatory goal. Industry
12 may take an alternative approach that complies with
13 relevant statutes and regulations and FDA staff may
14 depart from guidance documents with the appropriate
15 justification and supervisory concurrence.

16 So substantively what type of information is
17 most useful and relevant for guidance development? In
18 a nutshell -- information that could bring in the
19 patient's perspective to specific drug development and
20 regulatory challenges -- Theresa's slides 35, 36 and 37
21 give you a little more detail on that and panelists
22 will dive down into the weeds momentarily.

1 Procedurally what are the main windows for you
2 to provide input concerning guidance? And the four
3 main windows are as follows: First you can suggest
4 that FDA revise or withdraw existing guidance
5 documents. That's not the focus of today's discussion
6 but it's very important.

7 Sometimes instead of blazing a path forward we
8 need to refine, update, just fix, correct, our prior
9 work that's hanging out there.

10 Second, you can comment on a draft guidance
11 that FDA has issued. Third, the topic of today's
12 meeting -- you can submit drafts and proposed guidance
13 documents for us to consider.

14 And last, you can suggest specific issues on
15 which FDA should undertake guidance development,
16 explain why a guidance document is needed and in that
17 case, it's most helpful if you can provide information
18 that's useful and relevant in the guidance development.

19 So just a few practical considerations --
20 first, considering FDA's role and responsibilities, if
21 you send us a draft guidance to consider, we should not
22 and won't rubber stamp it or just act as a mere

1 conduit;

2 If we find that the proposed guidance content
3 is ripe then FDA might develop it into a guidance of
4 our own. It will be informed by your input but
5 ultimately FDA needs to make their regulatory
6 decisions.

7 Second bullet point their concerns novelty and
8 complexity and difficulty. Not every issue is easy,
9 right? So sometimes internally we can agree or all of
10 us can agree on 80% of a given issue but the 20% of it
11 may be very difficult to resolve.

12 In those cases, we sometimes want to issue a
13 policy about the 20% promptly and work on the remaining
14 20% that needs to be deferred until the science is
15 better developed, circumstances change and so on. We
16 may potentially do a separate guidance on it later.

17 Third thing -- we go on regulatory issues and
18 issues related to specific submissions. Sometimes FDA
19 gets jammed up by legal or regulatory issues or issues
20 related to specific submissions that you can't see on
21 the outside and we can't talk about.

22 But the point is delay or omission of a key

1 sub-issue does not mean that we are ignoring or
2 rejecting your suggestions. It means additional work
3 or information is needed to arrive at a good answer or
4 we have some other interim road block at the moment.

5 And then finally after you send in a proposed
6 draft guidance for FDA's consideration, naturally
7 you'll be curious concerning its status. So we were at
8 capacity to provide status updates on demand.

9 And in fact, that takes us away from a focus
10 on the substantive work. We also cannot communicate
11 one policy to one party before another and we have
12 certain procedures we have to follow before
13 communicating official policies to the public.

14 And finally, just to give you some -- a little
15 bit of big picture context, we are working on a pilot
16 project to develop and issue bulleted guidances
17 rapidly. That means bullet points on critical elements
18 of drug development.

19 It means focusing on need to know rather than
20 nice to know stuff. We're very strongly committed to
21 expanding our issuance of disease indication specific
22 guidance. For example, the Division of Neurology

1 Products recently developed five so Ellis and -- that's
2 from Ellis and Naomi's ODE and they may be able to
3 comment on what we found -- what kind of input we found
4 most helpful.

5 A focus on the critical elements, streamlines
6 or guidance development process makes it faster and
7 your input can be very helpful in that regard.

8 That's it Sara.

9 MS. EGGERS: Thank you very much Keith and
10 Theresa. I'm going to moderate this discussion from my
11 chair right here because yes, it is possible to have a
12 bowling injury and I have one. It hurts to stand for a
13 long time so I will be sitting here but I think I can
14 see everyone on the panel and I can see over there and
15 you as well.

16 The second thing I'll do before I'll start is
17 I'm going to do a favor for my colleagues and I'm going
18 to give the disclaimer on behalf of all of us that the
19 -- that the discussion we have and the perspectives we
20 share are our own and do not necessarily reflect the
21 position of our employer, the U.S. Food and Drug
22 Administration. Let's see how closely I got to the

1 standard disclaimer on that one -- because this is
2 really complex stuff we're talking about and it's still
3 evolving and things are moving along.

4 What we want to do first is focus on expanding
5 upon what Theresa presented about how and why patient
6 experience data can complement what we know internally
7 and what we can get from the science and the scientific
8 means about -- that can inform drug development and
9 regulatory decision-making more -- more generally.

10 So we're looking for examples of areas where
11 patient experience data might be particularly helpful
12 and then some of your insight into why for that.

13 Theresa had a long list of things including patient
14 experience with disease, clinical trial consideration,
15 et cetera.

16 And so I will, to prompt our discussion, keep
17 it moving. We'll go through some of those areas. I'd
18 like to first start with talking collectively about
19 patient experience with disease and disease burden.
20 Here we might need chief complaint as we're talking
21 about it, you know what is most impactful and
22 burdensome to patients as well as the broader impacts

1 of the disease and condition.

2 And so I'm going to ask Laurie to kick it off
3 and see if you can elucidate some types of -- of
4 experience insight that might be particularly helpful
5 for patients and patient stakeholders and why.

6 MS. MULDOWNNEY: Sure I can get started. Well
7 I think one of the important things that needs to be
8 considered is first what is the drug development
9 landscape in that disease of interest and really
10 thinking about the unmet need before you are
11 determining what type of information and ooh, that
12 determines that information is going to be most helpful
13 to us.

14 And I'm sort of -- I have spent some time in
15 the rare disease space so I'm thinking in the rare
16 disease space where, you know, there are often times
17 when there is nothing available -- there are no
18 available treatments, there's really nothing even in
19 the pipeline so the need is large.

20 And we have very little understanding and not
21 well documented natural history. So then we're going
22 to just -- we're really talking about what are the most

1 bothersome signs and symptoms of this disease, what
2 would be important to patients/caregiver input on what
3 they are seeing.

4 And I'm thinking a sort of specific example I
5 think where a patient input was really helpful -- and
6 you know, with a group of diseases that inborne areas
7 of metabolism that can result in substrate deposition
8 and it can lead to organ enlargement. And you know, we
9 were looking for, you know, what were the symptoms of
10 this you know, how can we sort of, you know, that's a
11 biomarker for measuring that organ and with what's
12 clinically meaningful to patients and we were able to
13 actually get a lot of patient input on a variety of
14 things including how potentially spleen enlargement
15 could result in bloating, generalized abdominal pain,
16 inability to bend over, and inability to button pants -
17 - so certain things like that that really took a lot of
18 context from the patients for us to understand which
19 was really helpful.

20 I think if in the position that there are
21 treatments available then you have to sort of identify
22 you know, where all those remaining on that need so

1 there's certain sub-populations that haven't been met
2 by the treatments that are available or they're
3 residual signs or symptoms of the disease that are not
4 addressed through the current treatments as well.

5 And sometimes this also could be related to
6 adverse events, or other side effects of the treatments
7 that are available potentially really impacting
8 compliance and maybe that's not as -- you know, it's
9 really obvious to the patients and to the patient's
10 family but it may not be blatantly obvious to us.

11 We're thinking well there's this drug in
12 clinical trials, you know, this is what it showed but
13 then after the fact, you know, maybe we come to learn
14 that patients really aren't staying on the therapy the
15 way that we think they are because of side effects that
16 they're experiencing.

17 So those types of things -- so again I think
18 it really first is what is that landscape? What are
19 the unmet needs and then, you know, the patients and
20 the caregivers, you know, there's so much rich
21 information that can really only be obtained by those
22 groups so that's really what we're -- what we're

1 looking for.

2 MS. EGGERS: Thank you Laurie. We're going to
3 go to Susan a lot -- Susie, because of your rich
4 experience and perspective on pediatric considerations
5 so I'd like you to weigh on this as well.

6 MS. MCCUNE: Well thank you very much and as
7 you said what you're going to hear from my discussion
8 today is really going to highlight some of the unique
9 issues related to the pediatric patients and their
10 families.

11 One of the things that we talk about in terms
12 of bothersome signs and symptoms is related to the fact
13 that pediatric patients may actually appreciate
14 symptoms very differently. Something that an adult
15 might not think is important may be critically
16 important and bothersome, especially to an adolescent,
17 especially related to body image or related to
18 invincibility.

19 In addition, some of the things that may
20 impact their ability to function in school -- go to
21 certain classes or participate with their friends.
22 Also, on the family scenario something that keeps the

1 entire family up at night in terms of coughing -- that
2 might not be quite as problematic to the patient, maybe
3 terribly problematic to the parents and the other
4 siblings who can't function the next day because
5 they've been up all night.

6 So those are just some very brief highlights
7 but something to consider in terms of -- of all of
8 these bothersome signs and symptoms that may be very
9 uniquely different in the pediatric population.

10 MS. EGGERS: Great, thank you. Go ahead
11 Naomi.

12 MS. LOWY: So I just had a comment on the
13 flipside you were talking about -- the coughing. We
14 actually had our patient focused drug development
15 meeting in this room a year ago for patients with
16 autism. And one of the, I think, most interesting
17 things we learned at that meeting was something that's
18 stimming -- which are these repetitive movements in
19 patients with autism and we're talking about the fact
20 that there are drug developers who are developing drugs
21 to reduce stimming and the patients who were at the
22 meeting said, "No, we don't -- that decreases our

1 anxiety, please don't develop drugs to reduce
2 stimming," that that's -- they like that behavior.

3 So what may be a bothersome symptom to others,
4 may not actually be bothersome to the patient
5 themselves so from that perspective it's crucial that
6 we understand what the patient perspective is.

7 MS. EGGERS: Okay, thank you. Yeah, go ahead
8 Ellis?

9 MR. UNGER: I mean this question is about the
10 chief complaint and I remember many years ago when I
11 was an investigator in IH, I'd be confronted with
12 patients with various types of cardiovascular disease
13 and they'd come in and they'd say I have these 7
14 symptoms.

15 And I always say, "Okay, well tell us if we
16 could only fix one, which one would you like us to
17 fix?" And they would -- they could come up with one.
18 Sometimes there was a tie. Then you could say, "Okay,
19 if we could fix that, what would be the next thing?"

20 So in other words, they could prioritize the
21 multiple symptoms that they were experiencing and I've
22 -- again my opinion, I've been a proponent of end

1 points that prioritize based on what an individual
2 patient says when they get enrolled in the trial.

3 So you -- we say to you these are the 6
4 symptoms in asthma that patients tend to have or these
5 are the ones in heart failure or whatever they are.

6 We say we want you to put them in an order
7 because we're going to -- we're going to weight your
8 response based on what you said was important to you.
9 There are scales -- there's one I like to talk about
10 for prostatism -- those are generally elderly men who
11 have trouble passing their urine and there's a scale
12 called -- I love this -- it's the IPSS, International
13 Prostate Symptom Scale or Score.

14 So it asks you know, I don't know -- 13-14
15 questions. Well if you look at those questions, some
16 of them would be relevant to a given patient but others
17 are not. And what happens is you get a huge signal --
18 excuse me, you get a huge amount of noise that can
19 drown out the signal.

20 Because if the only problem that they have is
21 they have to get up three times at night and it's
22 driving their spouse crazy and their spouse is going to

1 kill them -- that's what they care about.

2 So in terms of how the public could help us --
3 I think the public could help us if they could say,
4 "Look, these are the symptoms." If we were to adopt an
5 approach like this for some diseases -- not all
6 diseases lend themselves to this approach.

7 But for diseases that do, if you could tell us
8 well these are the symptoms that bug us, okay -- this
9 is what's important to a boy who has Duchenne Muscular
10 Dystrophy.

11 Then we could construct end points that allow
12 all of those various aspects to be considered.

13 MS. EGGERS: Okay, thank you, go ahead Laurie.

14 MS. MULDOWNNEY: Yeah, I just want to follow on
15 that for a second and I think this was from another
16 patient focused drug development meeting actually and a
17 disease that you know, had a laundry list of
18 devastating symptoms associated with it.

19 And you know it was -- you know, no cognitive
20 declines, seizures, and the list went on and on. But
21 family members described the loss of language as being
22 just critical -- that both for the patient and for the

1 families and that was really important and helpful
2 information.

3 And now sometimes we're constrained by the
4 mechanism of action of the drug that you're creating
5 and we don't expect that it's going to impact what may
6 be the most bothersome sign and symptom but it's -- but
7 to at least have those things sort of identified and
8 that should be part of that decision-making when you're
9 deciding what the end point hierarchy might be.

10 MS. EGGERS: Then you have the issue of
11 finding that intricate balance between the science and
12 the realities of the drug development, and what's
13 really important to -- to patients and their families.
14 Okay, let's move on to talk about natural history of
15 disease or condition and how -- what the patient
16 stakeholders and working with patients can do to
17 provide insight that might be particularly useful.

18 I'm going to ask Larissa to begin that one.

19 MS. LAPTEVA: Thank you. So the previous
20 discussion about the chief complaint and the clinical
21 manifestations of the disease is probably a nice segue
22 to the topic of the natural history studies because

1 good understanding and comprehensive knowledge about
2 disease's natural history is really foundational and
3 fundamental to any successful project development
4 program whether it be a drug or biologic or a medical
5 device.

6 In order to treat any disease effectively one
7 needs to understand its symptoms and its science and
8 the sequence of symptom appearance and the rate of the
9 disease progression, and all the important to patient
10 manifestations and not only that but also molecular
11 mechanisms that underlie those clinical manifestations.

12 And all of this needs to be learned and
13 observed and this observational knowledge accumulation
14 can be done so conducting natural history studies in
15 which I believe our patients could really play a
16 central role in helping to collect those data about the
17 natural histories of their diseases.

18 A well-designed natural history study not only
19 designed by investigators but could really be helped by
20 patient input where patients could potentially be
21 treated as equal partners in the trial design.

22 And in the design of the natural history study

1 I think really is a golden opportunity to collect
2 credible data prospectively and sometimes
3 retrospectively because those data could be extremely
4 helpful in product development.

5 Now natural history studies in general could
6 be very informative for many aspects of one's disease -
7 - they could provide a whole range of phenotypic
8 manifestations as well as shed light on various
9 genotypes of the disease they could help to understand
10 and better evaluate variability in the disease
11 presentation not only inter patient variability which
12 is different among patients with the same disease but
13 those that are intra patient variability which is how
14 the disease changes and progresses within the same
15 patient during the course of progression of the
16 condition.

17 But in addition to that predictive factors,
18 clinically and laboratory we will love the word
19 biomarkers which is a very general term I think, but
20 predictive markers of what is important for the disease
21 and how you could predict different changes in the
22 condition that could be identified through the natural

1 history studies.

2 Clinical end points outcome measures that
3 could then potentially be used and product development
4 could also be obtained and identified from the data
5 resulting from the natural history studies.

6 Well, in addition sometimes it is important to
7 remember that untreated diseases have their own
8 background risks and when we look potentially for a
9 risk tolerance with product development it is important
10 to remember that there are some background risks that
11 may be there that are maybe even more significant than
12 the potential risks from a newly developed therapy, so
13 natural history studies do provide that information.

14 And from the perspective of product
15 development as was mentioned earlier, natural history
16 studies are important -- and we've seen it time and
17 again in different development programs. They are an
18 important support for recruitment in clinical trials
19 and the recruitment in product development programs.

20 I think all of these various beneficial
21 features of natural history studies really apply to any
22 disease or any condition in any development program yet

1 I think they're particularly needy for poorly-defined
2 syndromes -- for categories of patients with rare
3 diseases.

4 And this is where one could potentially
5 envision really an opportunity for patient communities
6 to help with designing natural history study to help
7 with recognition and really indication of the important
8 manifestations for specific diseases or conditions.
9 How does data need to be collected? How the study
10 visits may need to be scheduled? How, perhaps, certain
11 poor outcomes could be expected or could be prevented
12 with interventions at different stages of the disease.

13 Patients -- we're always talking about how
14 well patient's position. I think in this case,
15 patients are really best positioned to help with the
16 data collection and design of natural history studies.

17 So this is something where we could
18 potentially envision the draft guidance development for
19 natural history study design in the various conditions
20 and diseases.

21 And it's also, I think, important to remember
22 that patient participation in natural history studies

1 go far beyond just, you know, putting together a
2 guidance and sending it to us.

3 It's really, you know, having a patient
4 representative of two or more being part of the
5 research team to not only help design natural history
6 studies but also help to conduct them because they are
7 the best to understand the nuances of data collection,
8 to understand the nuances of how symptoms should be
9 monitored.

10 And at the end even to help with the
11 interpretation of the data that have been collected
12 through natural history studies. So I just want to
13 make one last comment.

14 Sometimes when in product development it is
15 infeasible or difficult to advance a COA for various
16 reasons to include comparative placebo arms, natural
17 history studies could be used as potential control and
18 compare it to our data and I'm sure you've heard about
19 folks talking about a platform trials where natural
20 history studies could really be one important
21 contributing feeder into those platform developments
22 where a natural history study did a -- particularly for

1 a small patient populations, could really speed up our
2 product development, thank you.

3 MS. EGGERS: Thank you Larissa, yes, Susie?

4 MS. MCCUNE: So thank you, I just wanted to
5 add on to Larissa's comment about variability and just
6 remind folks about genetic polymorphisms and particular
7 sub-types of disease where -- especially in the
8 pediatric population the disease manifestations may be
9 more severe in the pediatric population and the serious
10 or life-threatening manifestations may be different in
11 the pediatric population than they are in the adult
12 population. So I think those are critically important
13 things to consider as you're talking about natural
14 history studies.

15 MS. EGGERS: Thank you, and this -- those are
16 two lovely reminders to all of us here that -- that
17 patient experience data includes experience and that we
18 have to -- we have to move along the drug development
19 knowing -- trying to know as much as we can about the
20 science as well as as much as we can about what's
21 important about the priorities that are important to
22 people, so thank you for those examples.

1 Does anyone else have anything about natural
2 history they want to contribute? Okay, clinical end
3 points and meaningful outcomes -- this is one that we
4 expect would have a lot of interest by stakeholders in
5 -- in discussing further.

6 This is information that could come from
7 patients and external stakeholder groups about -- that
8 could help inform the selection development and use of
9 -- of clinical end points and outcome measures. So
10 Ellis, you started off something that was related -- do
11 you have any more you'd like to say about -- about how
12 patient input could help with end point?

13 MR. UNGER: Sure, I mean there's sometimes
14 when it's -- when it's pretty obvious what the right
15 end point is. If you're developing a drug to prevent
16 migraine headaches, you count migraine headaches --
17 that's a pretty good end point.

18 It's not very controversial but if you're
19 developing a drug for heart failure --

20 MS. EGGERS: Um-hmm.

21 MR. UNGER: It's very different and I don't
22 think we've done a very good job collectively. The FDA

1 and the medical community at developing end points for
2 diseases -- well heart failure's a good example of such
3 a disease where we haven't done such a great job.

4 So you know, we approve drugs based on numbers
5 of deaths, times of death or time to hospitalization
6 and we can congratulate ourselves because if the drug
7 beats placebo then we feel like well the drug must be
8 effective if it keeps you out of the hospital, it keeps
9 you from dying, that's great.

10 But if you take two patients -- both of whom
11 will live exactly 10 years and both of whom will be
12 hospitalized in exactly one year -- one could be living
13 a very fine existence and be happy. The other one
14 could be miserable and unhappy and that's a lot of
15 information that we're essentially leaving on the
16 table.

17 And there needs to be a way to extract that
18 information because that's obviously what's important.
19 And we have a way of measuring a patient's function in
20 heart failure. We say we want you to walk for 6
21 minutes and we're going to get out a yardstick and see
22 how far you walked and farther is better.

1 So that's done, but you know, that's not what
2 patients go -- a heart failure patient doesn't get up
3 in the morning and say, "I want to see how far I can
4 walk today in 6 minutes, I've got my fancy watch."
5 That's not what matters to them. What matters to them
6 may be that you know, they can't walk up that flight of
7 stairs to get into their daughter-in-law's condo
8 anymore so they can't go and visit anymore -- that's
9 what matters, right? That's what matters.

10 So we need ways to extract that information
11 and we're very -- we're very sensitive to the need to
12 do that. So once again, for some diseases -- not all,
13 but for some diseases, we really need to know what's
14 important to patients.

15 So all of it is fairly obvious -- heart
16 failure -- I mean if you've treated heart failure --
17 I've treat heart failure, it's pretty obvious what's
18 important. But for diseases that are you know, less
19 common where we don't have medical expertise here, we
20 really don't -- we don't have a clue -- I didn't say
21 that, but we don't have experts in every -- in every
22 aspect of medicine, we can't.

1 We just can't and the diseases are rare and
2 the doctors are rare so we need -- we need help. And I
3 think that's where all of you can come in.

4 MS. EGGERS: Alright, thank you -- Elektra,
5 from your -- from your perch in clinical outcome
6 assessment staff.

7 Ms. Papadopoulos: Thank you, so I think it's
8 first important to understand that the term "patient
9 centricity" is not equivalent to or synonymous with a
10 patient reported outcome. And so the definition I like
11 to share is the patient centered outcomes is one that
12 Dr. Donald Patrick presented in 2013 where he defined
13 patient centered outcome as an outcome that is
14 important to patient's survival functioning or feelings
15 as identified or affirmed by patients themselves or
16 judged to be in patient's best interest by providers
17 and/or caregivers when patients cannot report for
18 themselves.

19 On the other hand, a patient reported outcome
20 is a measurement based on a report that comes directly
21 from the patient about the patient's health condition
22 without amendment or interpretation of the response by

1 clinician or anyone else.

2 And so from this we can see that patient
3 reported outcomes are really just one category of
4 clinical outcome assessments and clinical outcome
5 assessments include several different types which can
6 be used to measure clinical benefit including how
7 patients feel, function or survive.

8 So, I'll, you know, give an example. Patient
9 centrality -- patient reported outcomes can actually
10 lack patient centrality if they assess things that
11 aren't important to patients. And so this is why it's
12 so critical to obtain the patient input and voice when
13 developing patient reported outcomes.

14 And conversely outcome assessments that are
15 not patient reported are often the most appropriate
16 depending on the disease, the target population, you
17 know, other types of outcome assessments might be used.

18 For example, drugs can be approved on the
19 basis of clinician report or caregiver reports or other
20 types when the patients cannot report for themselves
21 such as young children or those with cognitive
22 impairment.

1 And so -- just touch on a couple of anecdotes.
2 In some areas, for example in the realm of
3 ophthalmology where appearing in some rural public for
4 that -- what's being captured and measured often
5 doesn't really truly reflect the patient experience so
6 the snow and eye chart that we, you know, that we've
7 seen used doesn't really capture the full patient
8 experience and so patients are interested in something
9 called "functional vision" which goes beyond the visual
10 acuity test but reflects how patients really use vision
11 in daily lives to interact with the world.

12 And so one, as an example, was a gene therapy
13 that was approved for a specific inherited retinol
14 dystrophy and the primary end point captured this
15 concept of functional vision and actually served as the
16 basis for approval and basically consisted of an
17 obstacle course that patients completed in different
18 lighting conditions.

19 I -- I find that fascinating. So it used a
20 clinical outcome assessment -- performance outcome
21 assessment to really capture that patient centric
22 concept of functional vision.

1 In other areas that we're seeing a lot of
2 interest are the use of activity monitoring devices and
3 these have been proposed in chronic diseases like
4 chronic obstructive pulmonary disease, you know,
5 patients with chronic arthritis and others to really
6 get a sense of what patients are doing in their daily
7 lives and really to understand their activity -- their
8 mobility for example in their natural environments
9 outside the clinic.

10 And oftentimes patient reported outcomes are
11 used in conjunction to accompany these, you know,
12 activity monitoring end points to understand, you know,
13 what effort is actually being expended and what
14 symptoms patients might be experiencing as they're
15 going about their activity and so we see these methods
16 used in conjunction with each other.

17 MS. EGGERS: Okay, thank you. Susan, we want
18 the pediatric perspective on this.

19 MS. MCCUNE: Thank you very much. This is
20 really important because if you look at the drugs that
21 have been approved and that are studied in the
22 pediatric population -- approximately 40% of the time

1 those trials fail.

2 And the question is -- is it truly that the
3 drug does not work in the pediatric population or do we
4 just not have the right end points or potentially the
5 right dose for pediatric patients?

6 In terms of clinically meaningful end points,
7 they may differ substantially in pediatric patients.
8 So Ellis talked about the 6-minute walk time, but if
9 you have a 5-year-old and you put them on the path and
10 tell them to walk, they're usually walking somewhere
11 behind you and it's a little bit hard to -- to do those
12 tests.

13 In terms of pulmonary function tests, they
14 just may not be able to follow the instructions and may
15 not be able to do those kinds of tests. In terms of
16 clinical outcome assessments or patient reported
17 outcomes, it's really critically important that
18 patients and parents together develop reported outcomes
19 that are important for pediatric patients.

20 In terms of as snapshot in time -- a lot of
21 neural developmental outcome measures are coming to the
22 clinic at the age of 18 months or two years for a test

1 where they have to be tested all day. It doesn't take
2 into account the fact that they've been in the car all
3 morning -- that they have a cold, they haven't had
4 their juice and they really don't want to do the test
5 that you want them to do.

6 So in terms of pediatric populations, having
7 the capability of having parent or patient or even
8 clinician reported outcomes through the spectrum of
9 their development as opposed to a snapshot in time
10 would be critically important.

11 And then something that I think we don't
12 really take into account enough is what's important to
13 patients and parents in terms of timing of things. An
14 example that came up was talking to a parent about what
15 amount of time would be important for them to forestall
16 the onset of the disease if they were giving a
17 preventive drug.

18 And most of the clinicians in the room said,
19 "Oh, six months would be a good amount of time." And
20 the parents said, "I'm sorry, I have a 5-year-old and
21 every week that goes by that they can be
22 developmentally more mature is important for me."

1 Now the answer might have been different if
2 that had been an adolescent patient and it would not
3 have made such a difference in terms of the
4 developmental milestones.

5 But clearly, understanding what the impact of
6 that pediatric patient is -- and I'll just make one
7 comment that I hadn't planned on making to Ellis about
8 migraines and this is totally a personal story.

9 So my son had migraines starting at the age of
10 7 and while having migraines and treatment and not
11 having migraines is a good end point, the problem with
12 the pediatric trial was that the placebo rate was
13 incredibly high and they couldn't show a difference in
14 terms of the treatment.

15 Well the end point was really whether you had
16 migraine symptoms at 4 hours. Well my son had classic
17 migraines so he would wake up in the morning, feel
18 horrible, would throw up, then would tell me he was
19 going to go to sleep.

20 He would sleep for about 20 minutes, wake up,
21 throw up, sleep for 2 hours, wake up and it would be
22 gone.

1 So I can tell you that he absolutely would
2 have been a placebo responder in that trial. So I
3 think, you know, understanding the population that you
4 know, maybe migraine is a little bit different in the
5 pediatric population than it is in the adult
6 population.

7 So every time we think about doing pediatric
8 trials, really understanding what those -- what those
9 end points are and how they might be different and how
10 we might be able to capture them more successfully in
11 the clinical trial setting.

12 MS. EGGERS: Thank you Susie, that's also a
13 reminder that it's not always so much what we should be
14 using as an end point but how much of that end point we
15 need to see -- how much change we need to see in that
16 end point before we say that that's appropriate as an
17 end point or that's meaningful as an end point. I'm
18 going to turn to Larissa for perspective from the
19 biologics.

20 MS. LAPTEVA: Thank you. I actually would
21 like to expand a little on what Ellis and Elektra said
22 earlier and this is really about using different the

1 end points in different therapeutic areas.

2 And what we clinically observed with some of
3 the practices which maybe a feasible approach -- it may
4 not be a bad approach but is an approach that is not
5 uncommon is that for conditions for diseases that are
6 not well described, poorly defined syndromes.

7 Many of them may have very different
8 etiologies and very different disease courses yet they
9 may have a common end stage disease course and, if a
10 clinical end point or an outcome measure is developed
11 based on the manifestations in that very late disease
12 course or disease stage, then such an outcome measure
13 could potentially be applicable from one patient
14 population to another patient population.

15 What we see continuously is that people adopt
16 end points from one therapeutic area to another
17 therapeutic area and the situation was this -- is this.
18 These end points may be clinically meaningful and
19 they've saved many days from many drugs, yet what
20 sometimes is lacking is the sensitivity to change in
21 the individual conditions as well as difficulties with
22 discriminatory capacity of what happens was that the

1 end points in clinical trial in the population in which
2 that end point really didn't come up originally from
3 and which it wasn't developed.

4 So I think a real opportunity with use of
5 patient experience data for us today and in the
6 upcoming years, is to try to find those end points that
7 are early end points -- the end points that are
8 sensitive to change in specific conditions and that are
9 reflective of true clinical meaningfulness of the new
10 treatments that are specific for the disease.

11 Because the more sensitive to change and
12 predictive and discriminatory end points we have, the
13 better treatments we will eventually develop.

14 MS. EGGERS: Thank you Naomi, anyone else on -
15 - on meaningful outcomes? Okay, well we'll move on
16 because we have still quite a few more to cover and
17 then the next one is -- is patients and families'
18 perspectives on acceptable trade-offs of benefits and
19 risks. I think Susan, we'll start with the pediatric
20 perspective.

21 MS. MCCUNE: Thank you very much. I just
22 wanted to remind everyone upfront as we're going

1 through this discussion with respect to pediatric
2 patients that additional safeguards for children, which
3 is 21 CFR 50 Part -- sub-Part D must be considered when
4 pediatric patients will be enrolled in a clinical trial
5 unless the risk of an interventional agent are no more
6 than a minor increase over minimal risk.

7 The admission -- the administration of an
8 investigational -- sorry, agent, in children must offer
9 a prospect of direct clinical benefit to individually
10 enrolled patients. The risk must be justified by the
11 anticipated benefit and the anticipated risk benefit
12 profile must be at least as favorable as that presented
13 by acceptable alternative treatments.

14 And additionally, adequate provisions must be
15 made to obtain the permission of the parents and the
16 assent of the child. I just wanted everyone to kind of
17 have those as the ground rules from a pediatric
18 perspective.

19 MS. EGGERS: If that's your area in your
20 sphere, go look at that. Go look further in that
21 regulation statute. Theresa, would you like to comment
22 on this?

1 MS. MULLIN: Yeah, just to underline -- not on
2 what Susie had to say but just to underline the -- our
3 learnings from the patient focused meetings and other
4 work, CDER (inaudible) you know, work in looking at
5 patient preference, elicitation in some areas as well.

6 We know that the tolerance or acceptability of
7 risks in exchange for some described benefit can vary a
8 great deal within a patient population with a given
9 disease by you know, where they are, what the stage of
10 -- a stage of progression and perhaps even more so,
11 life circumstances and even prior experience with
12 treatment.

13 And an example of this that we had early on in
14 our work with patient focus was when non-cell -- non-
15 small cell lung cancer where we asked a question about
16 preferences of -- for treatment, and the patients who
17 were there who were for example there were a few
18 patients who were mothers of children who were probably
19 in their 30's or 40's -- they had children who were
20 still pretty young.

21 And they were feeling it was -- they would
22 undergo just about anything if it would give them a

1 little more time to be with their family and live
2 longer for their children. So for them and they hadn't
3 maybe undergone as many courses or different types of
4 treatment.

5 We also had some patients who were maybe in
6 their 60's or 70's or so and they had undergone
7 treatment previously and were at different stage of
8 their life and their willingness to accept very severe
9 at -- you know, very serious side effects to prolong
10 their live -- of the same amount of time was their
11 tolerance for finding that acceptable was much less --
12 much lower.

13 And so it was just to illustrate this. So
14 it's important in a given disease area that -- that we
15 understand that and that that kind of background and
16 context is very helpful if you were studying a disease
17 area to really understand in a given area perhaps,
18 which factors are most important to consider.

19 It might be able to do some -- some studies
20 and survey information to figure out which factors are
21 the most important in a given population of patients
22 affected by a disease to help -- to help guide and

1 improve the quality of work that's being done in that
2 area.

3 MS. EGGERS: Thank you Theresa, Larissa --
4 perspective on biologics?

5 MS. LAPTEVA: Yes, I would agree with
6 everything that the previous speakers have said and I
7 think that measuring trade-offs and patient preferences
8 for health outcomes is really a very important area and
9 this is the area where we're still largely lacking
10 systematic data collection and therefore systematic
11 knowledge on how and when certain trade-offs would need
12 to be made by patients or by their families.

13 And we probably all recognize the different
14 diseases would bring different trade-offs for people if
15 someone has a severe life-threatening and readily
16 progressive disease their trade-off for any given
17 treatment could potentially be different from someone
18 who has perhaps a chronic disease of mild severity with
19 waxing and waning course.

20 Another I think, aspect here to consider is
21 that different stages of product developments, trade-
22 offs are also going to be different for those who

1 participate in clinical trials and for those who use a
2 product -- a newly approved product to maybe a product
3 with sufficient history in clinical practice.

4 Because when somebody's starting say a
5 clinical trial which is an early trial with a new
6 product development and it could be any product could
7 be a drug product, could be a gene therapy or could be
8 a cell therapy or a biological device -- their trade-
9 offs will have to be made, potentially on some
10 theoretical knowledge of what will be anticipated in
11 terms of the benefits of that new investigational
12 therapy and the risks that may be known from previous
13 studies and maybe non-clinical studies.

14 Whereas somebody who has participated, say in
15 a clinical trial, for six months they have experienced
16 the product. Their trade-off of whether to continue
17 this product later may be very different because if
18 they've experienced some toxicity with the drug, they
19 have experienced the amount of benefit that they could
20 get with the product.

21 And so their understanding and their
22 preference for the health outcome again will be

1 different. And we still don't have a good methodology
2 to incorporate this in clinical trials and in product
3 development.

4 The science of these methods is out there and
5 it's been out there for a while and there has been a
6 number of methods that could be applied here yet we
7 still are waiting systematic data collection.

8 Now yet when somebody comes to the physician
9 and they are offered a new treatment, their trade-off
10 will again be different. It will be based on some
11 theoretical knowledge but on the knowledge that has
12 been accumulated about the product which now already
13 has known safety profile and efficacy expectations.

14 So at all of these different stages of
15 product's lifecycles, certain trade-offs would need to
16 be made by product users and we -- we don't -- we still
17 on many occasions don't understand what drives people
18 to choose one treatment over another.

19 Another aspect of this is to look at different
20 product categories. Since I represent CDER here I get
21 to talk about cell and gene therapies. When a drug
22 which is say an immediate release tablet and the whole

1 product can be taken and it's out of the system in 6
2 hours, that type of trade-off and potential for trying
3 the product -- for experiencing maybe potential
4 toxicity or maybe certain benefit again is going to be
5 very different from somebody for example, receiving a
6 cell therapy.

7 Risk tolerance may not necessarily be just or
8 be product specific, it will also be product delivery
9 related because some of these therapies -- gene
10 therapies for example could, could be delivered
11 specifically to certain tissues and that delivery could
12 potentially be much more traumatic than just taking an
13 oral pill.

14 So, so these are the types of trade-offs where
15 there are opportunities for us to understand better
16 from patient experience data. And if some of these
17 information and data could be sent to us -- not
18 necessarily maybe in the form of a guidance but perhaps
19 as summaries of questionnaires, or patient interviews
20 or some -- as some other form. It could be quite
21 informative for us to understand the trade-offs in
22 these different settings and incorporate them in

1 product development.

2 MS. EGGERS: Thank you Larissa. I'll put the
3 plug in for the methodological guidances that we are
4 developing that will touch upon those technical
5 methodological issues to, to gather that data. But
6 this shows how intricate -- how related all of these
7 guidances are.

8 Larissa brought up considerations on clinical
9 trials and that's another area that we think is -- is
10 potentially of great interest to patient stakeholders
11 and how they can contribute unique insight into
12 clinical trial development so I'd like to talk about
13 that for a few minutes.

14 Naomi, do you have any perspectives you can
15 share about how input from patients on various aspects
16 of clinical trials could be helpful?

17 MS. LOWY: So I think that this is really a
18 unique area for patient input and one I think that we
19 would really all welcome. I don't know -- we do spend
20 a lot of time thinking about end points, chief
21 complaints, things like that but as far as how a trial
22 really should be conducted, I think there is a lot of

1 space there for help from all of you.

2 So when planning a new clinical trial
3 protocol, it may be helpful to look back in the
4 question that you had up there before that are there
5 clinical trials in a specific disease area that have
6 been excluding patients who do want to be enrolled?
7 And I think that's a really important question to
8 answer.

9 There may be historical reasons for including
10 certain patients but maybe the rationale really just is
11 not there. So I think that is worth revisiting. A
12 related question is -- are there clinical trial
13 protocols that are just not workable for some patients
14 who otherwise would be eligible to participate and what
15 could we do in those instances.

16 And what comes to mind is a study that was
17 published just last week in the New England Journal of
18 Medicine called the so-called "Black Barber Shop City."
19 I don't know if any of you have heard it but I see a
20 lot of shaking heads, but for those of you who haven't
21 heard of it -- it -- the premise of that study is that
22 black men have very high rates of blood pressure and

1 that barber shops are really uniquely popular setting
2 for African American men to go to.

3 So they set up this trial to treat
4 hypertension in black barber shops in California, in
5 L.A. and they brought a pharmacist into -- into the
6 barber shops and that serves -- that was where the
7 clinical trial was really conducted.

8 There were two groups of men, they were
9 randomized to either a group who they were given
10 information on hypertension and maybe encouraged to go
11 see their physician and another group who received that
12 plus they were actually treated with anti-hypertensives
13 and the results were really remarkable.

14 Both groups had decreases in their blood
15 pressure. The group clearly that was treated with the
16 anti-hypertensives dropped their blood pressure by
17 about 27 millimeters of mercury.

18 So I think -- I think that provides a really
19 unique perspective in how we can best accommodate
20 patients where patients are comfortable, where we can
21 find patients and also taking the results of that trial
22 and eventually adapting it to the real world if --

1 because we got such great results in that setting.

2 MS. EGGERS: Great, thank you Naomi.

3 MS. LOWY: Sure.

4 MS. EGGERS: Laurie?

5 MS. MULDOWNNEY: Sure, so to sort of follow on
6 what Naomi was saying you know, there's really the two
7 buckets when we're talking about who's actually
8 participating in the trial or two reasons why patients
9 may not be participating.

10 And the first related to eligibility criteria
11 and I'll go back to sort of the rare disease space --
12 for the most part the eligibility criteria that are
13 excluding patients in this space as if -- is often
14 related to the inability to sort of perform --
15 performance measure that might be that clinical outcome
16 that primary end point.

17 So I think where there can be input that's
18 valuable there as in helping us again -- it gets back
19 to end points, at identifying things. And Susie
20 touched on this a lot -- 6-minute walk tests, and
21 pulmonary function tests, and tests that are frequently
22 done but can't be done in that youngest age cohort.

1 And they're really, really challenging to
2 identify, you know, what can we measure. And parent
3 caregiver input can really be so -- so helpful in that
4 instance to try to identify other ways to measure
5 efficacy in those patient populations.

6 And then that second bucket is the enrollment
7 -- the eligibility criteria. It may be quite broad,
8 but it's -- but people aren't enrolling and sort of
9 identifying why. And you know, the -- a couple of
10 things I would say about that. You know one that I
11 think -- at least in my experience you know, often the
12 clinical trial designs are becoming more complex and
13 oftentimes in these really complicated multi-system
14 diseases, we're measuring a lot of things and we don't
15 always think about the burden that that has on patients
16 and caregivers.

17 And that can be really helpful information for
18 us to understand if it can offer for the drug company
19 for that matter to help narrow that focus to make -- to
20 try to make trials, you know, less burdensome but still
21 to be able to get the important information that we
22 need.

1 And then not so much necessarily enrollment
2 purposes, but Susie said something that reminded me of
3 a situation where you know, patients were coming from,
4 you know, all over the country to one or two centers
5 where they would stay for a day or two and get a litany
6 of tests -- many, many, many, neuro cognitive
7 assessments, any one of which might take three hours to
8 conduct.

9 And what we learned are you know, things that
10 we can learn from patients and caregivers is well my
11 son or daughter is always going to do better in the
12 morning. You know they know their kids, they know what
13 their disease variability is from day-to-day.

14 And so then you're really talking about the
15 quality of that data that you're getting and if you're
16 blind to you know, if you're not paying attention to
17 that you're not getting that input then that can be
18 really, you know, detrimental obviously to the quality
19 of the data that you're getting.

20 MS. EGGERS: Thank you Laurie. We could cover
21 these issues in a lot of depth but we do want to keep
22 moving on to talk another question about how -- what

1 formats are useful for people to submit this data? So
2 I'm going to go to the last one which is communicating
3 labeling information to patients.

4 So how FDA or sponsors -- how we communicate
5 information and I'm wondering if Ellis or Elektra has
6 any insights on -- to share on that and how patient
7 input or input from external stakeholders could be
8 useful?

9 MR. UNGER: Well we try very hard to do a good
10 job but it's hard, it's very hard to make labeling
11 understandable to patients. Labeling is really for
12 practitioners -- I'll say that, but it's the
13 practitioner who has to understand the label well
14 enough to be able to then transmit the information to
15 patients -- so it's a critical part of, you know, drug
16 approval and the drug.

17 And it's hard. I mean sometimes the -- I just
18 try to throw out many examples quickly. Sometimes the
19 end point can be very understandable but the numbers
20 aren't very clear. So if the end point is mortality --
21 disease has a 20% mortality rate and the drug reduces
22 mortality by 20% wow -- does that mean the mortality

1 rate goes from 20% to zero? No. It means it goes down
2 by 20% of 20%, 20% of 20% is 4% so there's really a 4%
3 reduction. So that's one way labeling can be unclear.

4 Another way is these end points that we have
5 some of them are not understood very well by many
6 people. So for major depression we use an end point
7 called the MADRS -- it's a 17-question scale.

8 And if I said to a psychiatrist that the drug
9 makes the MADRS go down by 3 points relative to placebo
10 -- do they actually know what that means? Can they --
11 can they talk to a patient in their office and say,
12 "Look, the MADRS went down by 3 points on average."
13 It's very difficult to translate into that -- translate
14 that into something that the patient can understand.

15 And we have to do better. We, we have to do
16 better. The guidance is really not focused on
17 labeling. Am I correct? The guidance is more about
18 end -- end points?

19 MS. EGGERS: The guidance that we're talking
20 about today is how patients can provide input on
21 relevant topics to drug development.

22 MR. UNGER: Okay, okay fine so labeling would

1 be included. So it would help -- and I'm thinking
2 outside the box here a little bit. But it would help
3 if we had input from patients on what, you know, what -
4 - not so much the label because the label is not for
5 them, but what information would they like to have from
6 their practitioner, okay, about what this drug -- what
7 they can expect from the drug, okay?

8 So that would be interesting and it's
9 something I don't think many of us have thought about
10 very much but there you go, food for thought.

11 MS. EGGERS: Thank you, anything to add
12 Elektra?

13 MS. PAPADOPOULOS: Well I, I really echo what
14 Ellis has said and I think the first step really to a
15 patient from my communication is going back and
16 measuring what matters to patients. For example, a
17 patient reported outcomes that are developed with
18 patient input would be more likely to use patient for
19 labeling which that resonates with the patients.

20 And so it's important to step back and ensure
21 that the instruments are developed at the outset -- at
22 the outset with an eye toward eventual labeling so that

1 they will be understood by -- not only by the patients,
2 but of course by the prescribers.

3 And I think you know, as Ellis said we really
4 need to be open to ways of making information and the
5 labeling more useful to prescribers so that they can
6 then better communicate with the patients and research
7 has shown that you know, patients who are engaged in
8 their healthcare actually have better outcomes so it's
9 extremely important.

10 And as part of the clear communication I think
11 it's important to communicate the concept that was
12 measured. What was the theme that was measured because
13 all too often we'll see the names of instruments put
14 into the label and nobody knows what was being measured
15 so it's fine to put the instrument name in but also
16 putting that concept in there and communicating what
17 the possible range in score is and what constitutes a
18 meaningful change within that score -- within the
19 meaningful change threshold within that score.

20 I want to say that there's also you know,
21 patient information that's approved by the FDA that
22 helps patients use the drug product safely and

1 effectively and FDA's also committed to further new
2 development of patient information and is proposing a
3 rule to require a new form of patient labeling -- the
4 patient medication information for human prescription
5 drug products.

6 And so this proposed rule would include
7 requirements for a patient medication information
8 development, FDA approval and distribution and the
9 information would be a clear and concise written
10 prescription drug product information presented in a
11 consistent and easily understood format to help
12 patients use their prescription drugs more safely and
13 effectively. So I just wanted to highlight that as
14 well.

15 MS. EGGERS: Thank you.

16 MS. PAPADOPOULOS: Okay.

17 MS. EGGERS: So that was a wealth of
18 information from our colleagues about what is important
19 and why. And we want to close this session by getting
20 some perspectives on what is the best and most
21 practical way for you to share this type of information
22 with FDA and others.

1 You'll recall Theresa had a couple slides up
2 and discussed the range of ways that stakeholders can
3 help. Guidance was one of them but there was a number
4 of other ways and so the -- the question is, is what's
5 most appropriate for one vehicular channel and when is
6 it more appropriate and more effective and efficient to
7 go another way?

8 So let's start by asking from the panelists
9 what type of information -- the stuff we were talking
10 about this afternoon so far, might be most suitable to
11 submit in the format of a proposed draft guidance? And
12 so I'll see if, if Ellis or Theresa want to start that
13 off -- Theresa go ahead.

14 MS. MULLIN: So I think, I think it's hard to
15 you know, kind of answer that question in absolute
16 terms Sara. So, but per what I was saying earlier when
17 I was presenting kind of an overview I think that it
18 could be that for example, for one of these perhaps,
19 bulleted guidances that Keith described, or disease
20 guidance where it alludes -- or it mentions enrollment
21 criteria or it mentions inclusion/exclusion criteria.

22 There are opportunities I think there to -- to

1 elaborate on that to do a sort of more deeper set of
2 considerations related to that. That might be an area
3 that could be developed by external stakeholder groups
4 to provide more of that breakout by sub-populations.

5 We have been talking about you know, various
6 ways to look at stage of progression of a disease,
7 pediatric patient considerations, maybe geriatric
8 patient considerations, other sub-groups that are very
9 important and they have particular issues that affect
10 their -- whether the enrollment criteria that are
11 standard, even work for them -- I was a meeting that
12 Annie Kennedy and PPND had recently and there was a
13 discussion about how few trials there were for boys
14 with DMD once they reached the sort of teen years.

15 And because they could no longer complete the
16 6-minute walk -- I'm sorry to keep -- we keep bashing
17 the 6-minute walk, but that's a standard measure that's
18 used.

19 And that was not something they were generally
20 able to do anymore. So there are things where you
21 could say what else is going on there, what other
22 criteria, maybe thinking of other approaches there that

1 would speak right to the enrollment criteria that might
2 be used for the inclusion/exclusion criteria that might
3 be used for a sub-population of maybe by age or
4 whatever, for a disease population -- so that's the
5 example I'd give.

6 MS. EGGERS: Thank you. Would anyone else
7 like to join in on this, we have Larissa?

8 MS. LAPTEVA: Yes, so as I indicated earlier I
9 think natural history study designs could potentially
10 be sent to us in the form of a draft guidance and also
11 various methodologies on how to measure and collect
12 patient preferences and that would include say
13 methodologies that could be collected for chronic
14 states versus for acute states because the trade-offs
15 there will be different.

16 I would fully support the different patient
17 sub-populations, pediatric, geriatric -- there will be
18 a challenge that will be presented particularly by
19 folks who actually have difficulties communicating --
20 those who may be deaf or blind.

21 You would still want to somehow get the
22 patient preference from those populations too. But

1 also, one of the reasons why patient experienced data
2 making such a -- what I would call delayed entry into
3 product development is because these methods are
4 typically very complex.

5 They are complexly difficult to measure. They
6 are very time consuming to incorporate in clinical
7 trial design. And so developing IT instruments -- this
8 is something that is probably universal would be you
9 know, one other potential aspect to which I think we
10 all could benefit.

11 And the overall draft guidance as we approach
12 it here multi-disciplinary and I'm sure that any draft
13 guidance that's sent to us, no matter what is the
14 topic, would probably need to be development by just
15 one patient advocacy organization but really, a -- a
16 team of experts, and -- and multi-disciplinary
17 contributors.

18 MS. EGGERS: Okay, so thank you, Theresa?

19 MS. MULLIN: So I just would like to add --
20 and just to show that FDA is not a monolith I -- I
21 would think that I'm not sure I completely agree with
22 what Larissa just said.

1 I mean I think guidance might be an
2 appropriate way to submit that information but it
3 certainly wouldn't be the only way you could submit a
4 natural history study or the kind -- all the
5 information described.

6 Maybe there's a form of that or a maturity of
7 that that would make it potentially you know, kind of
8 suitable for the guidance, but I think that there's a
9 wider swath of it that I could imagine could be
10 submitted just as research papers or other papers that
11 inform you know, policy development.

12 MS. LAPTEVA: I completely agree. I
13 completely agree this could be developed. All of these
14 different types of information could be submitted as
15 guidances or as part of data collection summaries --
16 other potential formats, I absolutely agree.

17 MS. PAPADOPOULOS: I would also add I think
18 it's really important when the patient experience data
19 is being submitted to indicate how you think this
20 information can be used in medical product development.

21 And so, not to just sort of give the data to
22 us but let us know what you think it should be used for

1 and it doesn't -- as has been mentioned does not always
2 need to be in the form of guidance, it can come in
3 different forms.

4 MS. EGGERS: So let's build on that and what
5 are the other types of areas? How can stakeholders
6 leverage those other areas beyond submission of
7 proposed draft guidance to really help inform -- to add
8 as much or greater value to -- to this area? Elektra
9 did you have other thoughts on that?

10 MS. PAPADOPOULOS: Well I -- I just wanted to
11 also highlight the need for a methodologic bigger way
12 conducting scientific research and the need to have
13 broad input from you know, scientific experts,
14 methodologists, disease experts, clinical experts,
15 measurement experts, drug developers, you know there's
16 a whole slew as well as the patients and the
17 caregivers.

18 I would much rather have a group, you know,
19 who has say limited funding maybe write off a smaller
20 project than try to boil the ocean, but really produce
21 high-quality, rigorous research which then you know,
22 maybe others could build upon.

1 MS. EGGERS: Thank you, others -- Naomi?

2 MS. LOWY: So, I think that there is an ideal
3 time and place for a guidance to be written but I would
4 say that our -- at least in my experience, some of our
5 biggest "aha" moments have been in direct interactions
6 with patients and meetings with them and advocacy
7 groups.

8 Having patients in the room directly tell us
9 some of these experiences, I think, has been more
10 impactful than maybe receiving a 30-page guidance. And
11 again, that's not to minimize the guidance but I think
12 that it is important to sort of figure out what kind of
13 impact we're trying to make and what -- what you're
14 trying to convey.

15 So, those sorts of interactions have been very
16 helpful. In our patient groups whom we have an
17 established relationship with, they've, you know,
18 they've gone to national or international meeting --
19 after the meeting they'll send us their slides or their
20 poster-presentation from that sort of to keep us
21 updated with what's going on.

22 I think that has been very effective and

1 certainly, you know, reports, white papers, those sorts
2 of things. So there is a huge spectrum of options
3 beyond.

4 MS. EGGERS: For our final minute we have --
5 oh Laurie and then Susie to close out with the
6 pediatrics.

7 MS. MULDOWNNEY: So I was just going to mention
8 that you know to keep in mind that one of our -- the
9 primary audiences for our guidance is industry. So if
10 you are doing these studies and have this information
11 and you know, I think Pujita gave some examples of how
12 this, you know, this resource -- this information
13 sharing resource will ultimately be used some day, but
14 that's an excellent way to get that information out to
15 industry, you know, maybe in conjunction with a
16 guidance.

17 You know, there's many ways that that could be
18 done.

19 MS. EGGERS: Thank you, Susie?

20 MS. MCCUNE: Well I was just going to pull it
21 together in terms of how all of those groups might come
22 together in a consortia so as an example the

1 International Neonatal Consortium is a group of
2 stakeholders from patient parent advocacy groups from
3 academia, from industry and from regulators around the
4 world -- over 100 individual institutions coming
5 together to have these conversations within the context
6 of protocols and end point definitions, so.

7 MS. EGGERS: Alright, well I want to thank the
8 panelists for being up here for an hour and a half and
9 providing really fantastic information. I love being
10 moderator because I learn a lot from you. It helps me
11 in our work and I'm going to see what's helping you. We
12 will take a break now for 15 minutes and then we will
13 all hear from the stakeholder perspective, so come back
14 at 3:15 please.

15 (Break)

16 MS. CHALASANI: Good afternoon everyone, my
17 name is Meg Chalasani and I work in CDER's Office of
18 Strategic Programs. I will serve as the Moderator for
19 our second session today which will really focus on
20 seeking input from our patient and other external
21 stakeholders on how best to communicate FDA's current
22 thinking on submitting proposed draft guidance relating

1 to patient experience data.

2 We had a really rich panel discussion earlier
3 and we're really hoping to build on that. I just want
4 us to take it a little bit more towards that proposed
5 draft guidance relating to patient experience data
6 scope.

7 So just a quick overview of the former --
8 we'll have a moderated panel discussion on what
9 questions would be really helpful for FDA to address in
10 its forthcoming guidance on guidance or guidance styles
11 through submission -- just how we call it internally,
12 followed by a facilitated audience discussion where
13 we'll really seek broader input from all of you in the
14 audience on the topics that we've been discussing
15 today.

16 So first I turn to our panelists to the right
17 of me and ask each of you to introduce yourselves.

18 MR. ALLEN: Hi, I'm Jeff Allen, President and
19 CEO, Friends of Cancer Research.

20 MR. BOUTIN: Marc Boutin, CEO of the National
21 Health Council which is a patient-led organization with
22 all stakeholders in health ecosystem represented

1 included the biopharmaceutical, generic, diagnostic,
2 family care-giving provider and insurance represented.

3 MS. KENNEDY: Good afternoon, I'm Annie
4 Kenney. I'm Senior Vice President of Legislation and
5 Public Policy for a Parent Project Muscular Dystrophy
6 or PPMD.

7 MS. MCCLEARY: Hi, I'm Kim McCleary, I'm
8 Director of FasterCures. We're a D.C. based center of
9 the Milken Institute and we work across diseases with
10 all the stakeholders in the ecosystem to identify and
11 breakdown barriers that add time and expense to the
12 process of getting promising therapies from the bench
13 to patients.

14 MR. MELMEYER: Hi everybody I'm Paul Melmeyer.
15 I'm the Director of Federal Policy at the National
16 Organization for Rare Disorders. We're a patient
17 advocacy organization that represents all 30,000
18 million Americans with a rare disease.

19 MS. PARISER: Good afternoon, I'm Anne
20 Pariser. I'm the Director of the Office of Rare
21 Diseases Research at NIH's National Center for
22 Advancing Translational Sciences or NCATS.

1 MS. PATRICK-LAKE: Hi, I'm Bray Patrick-Lake.
2 I'm the Director of Stakeholder Engagement at the Duke
3 Clinical Research Institute where I lead the Research
4 Together Program which brings patient and community
5 members together with other stakeholders in the design
6 and conduct of research.

7 MS. STROBEL: Hi, I'm Mary Jo Strobel. I'm
8 the Executive Director of the American Partnership for
9 Eosinophilic Disorders. We're a 501c3 patient advocacy
10 organization that serves patients with the eosinophilic
11 associated diseases.

12 MS. CHALASANI: Great, thank you all. First, I
13 want to provide you all with an opportunity to really
14 reflect on what we heard during our Session I, really
15 on the what types of patient experience data would be
16 really useful and in the practical ways to probably
17 share those with FDA and I'll really just ask you to
18 reflect on some of the topics that we've heard so far.

19 Perhaps we'll start on that end of the table
20 this time, Mary Jo?

21 MS. STROBEL: I thought it was -- it was
22 really helpful to be here in person and hearing the

1 perspective from the FDA. It's much different, we were
2 having conversation during break but when you receive
3 that information verbally versus reading something on a
4 document it's -- it's much different.

5 So my key takeaways from the first panel was
6 it was really helpful to hear about the various stages
7 when that patient experience data is helpful and why.
8 I think patient groups are well-positioned to
9 facilitate that and bridge that gap but may not know or
10 understand when that guidance is the best approach to
11 take or how to know maybe what already would be in the
12 works or has already been submitted to be able to build
13 upon.

14 Also, considering ways in which to collect
15 data outside of survey or formally design data capture
16 method. Some of the most insightful information may
17 come out of open-ended questions and discussion opening
18 up an avenue to collect that open-ended perspective.

19 Not just multiple-choice questions on the
20 survey for example, but really to facilitate that open
21 discussion really I think brings the most insightful
22 information forward.

1 MS. CHALASANI: Thank you, Bray?

2 MS. PATRICK-LAKE: I thought it was
3 particularly useful to go through the resources and
4 then also kind of see the stage gating of the guidance
5 and development as Mary Jo said kind of mapped to the
6 different phases of medical product development cycle.

7 But I really wanted to pick up on something I
8 think Elektra touched upon which is that everything
9 doesn't have to be a proposed draft guidance -- that is
10 pretty high buyer for a lot of patient groups and I
11 think the more we can do to help people understand the
12 types of patient experience data, clinical trials,
13 transformation initiative which is an FDA public-
14 private partnership is working on a framework to help
15 assess high-value, high-impact, opportunities mapped
16 with investment which could be time, resources, staff
17 member collaborators -- anything FDA could do something
18 taking that into consideration and moving that forward
19 or proposing its own road map to really help, I think,
20 the patient groups navigate what you can do -- what you
21 can do well, and who you should be doing it with would
22 be particularly useful.

1 MS. CHALASANI: Great, thank you, Anne?

2 MS. PARISER: I, I'm coming at this I guess --
3 a little bit difference perspective than everybody else
4 on the panel. I'm not representing a patient group but
5 rather a sister agency for FDA and we also spend a lot
6 of time thinking about patient experienced data
7 collections.

8 We heard natural history studies and registry
9 a number of times, so I guess I'm just throwing in a
10 plug here as we're also here to help and we have a
11 number of resources that we built over the years to
12 help you either get started or to further your data
13 collections and we do actually work closely with FDA on
14 a number of these.

15 But I'll just name a few. We have something
16 called the NCATS tool kit for patient focused therapy
17 development. That's a long name but if you Google
18 either NCATS tool kit or NAH patient tool kit, it will
19 take you to that and this is a collection of tools,
20 advice, documents that have actually been put together
21 mainly by patient groups -- experienced patient groups
22 over the years who have learned through their

1 experience and trial/error how to put some of these
2 data collections together.

3 And I'd urge everybody to please take a look
4 at that. You know you don't have to reinvent the
5 wheel. There's a lot of people that have been out
6 there who have done that and I just urge everybody to
7 seek out what exists already before you start your data
8 collections.

9 Data are good -- particularly for poorly
10 understood conditions such as rare diseases but good
11 data is even better so there's a lot of things that
12 have been looked at or exist. I would just urge you to
13 look at those and if you need any help finding that you
14 could contact me or Google this or contact our office
15 and we'd be happy to help.

16 MR. MELMEYER: well we at NORD are incredibly
17 pleased with the number of opportunities our patients
18 and patient organizations now have to participate
19 within FDA initiatives and I think that was quite well
20 highlighted by the wealth of opportunities discussed in
21 the first panel just before this one.

22 It does create the unique problem however in

1 that many patient organizations could be rather
2 overwhelmed with all the opportunities that are in
3 front of them and are not perhaps sure of which to take
4 and that kind of builds off of Mary Jo and Bray's
5 points and that could be most exacerbated within our
6 community because of the 270 organizations that are
7 rated as these patient organizations that focus on any
8 one single disease that are members of the National
9 Organization for Rare Disorders, the vast majority of
10 them have fewer than five full-time employees and many
11 actually don't have any full-time employees.

12 They have a volunteer Board of parents and
13 grandparents who are there working for their loved
14 ones. So thinking about how we can structure not only
15 the guidance we'll be talking about shortly, but all of
16 these opportunities to make sure that they're
17 accessible and are a benefit to kind of the full
18 breadth of organizations and their capabilities is
19 something that we're here to ensure.

20 MS. MCCLEARY: So first, I just have to say
21 wow. Annie and Marc and I were commenting after the
22 first panel concluded that it feels a little bit like

1 déjà vu but we've switched seats. Like we can remember
2 when we were up here saying these were all the rules
3 that patient experience could be useful and FDA was
4 listening intently, and obviously has taken it onboard
5 into the next level.

6 So it's very rewarding just to hear all of the
7 embrace.

8 MR. BOUTIN: Let's give FDA a big round.

9 MS. MCCLEARY: And I -- I also just want to
10 send up a huge thank you to Theresa's team and the
11 whole team and the Office of Strategic Programs because
12 I think maybe, you know, we talk about the outcomes of
13 the PFDD and the series of 24 meetings and now all the
14 externally-led meetings that are occurring and you
15 know, what we've learned.

16 But I think one of maybe the unseen outcomes
17 and takeaways from that effort and that initiative has
18 been the ability for FDA to gain both a vocabulary and
19 a venue to understand the patient experience from the
20 patient point of view in a setting that is outside a
21 single product discussion that is not really stressed
22 by that kind of immediate, sort of, you know, literally

1 life or death decision.

2 And it has freed up a conversation about all
3 of these different things from outcome measures to what
4 does meaningful change sound like to what should we be
5 putting on the labels so that those prescribers and
6 patients will understand what we mean by, you know, a
7 couple of points on the MADRS score.

8 So I feel like it's been a huge evolution and
9 now what we have the ability to do is kind of refine
10 from what the earlier colleagues on this panel have
11 said, the ways in which to kind of tailor and match
12 what the needs in a particular disease state are with
13 what the tools that FDA might be able to use and how to
14 -- how to put those things together so that you can
15 package up your patient experience in a way that would
16 really help to advance both the drug development
17 pipeline itself and also inform the decision-making at
18 the agencies level that will take place all along the
19 way.

20 I do have some specific comments but maybe
21 I'll just hold those.

22 MS. KENNEDY: So I agree with everything

1 that's been said previously but one of the things I'd
2 like to reflect on as I was listening to the previous
3 panel and then preparing for this panel yesterday was -
4 - I went back to Section 3001 and was looking at the
5 definitions in that section which I think are really
6 important to set the tone for what we're doing here.

7 And you know, if we look back a decade ago in
8 our community -- or not even that long ago, maybe even
9 5-6 years ago, I think when we engaged with industry
10 and we engaged with other stakeholders who sometimes
11 felt like if you weren't at the table you were on the
12 menu right?

13 But we really had as patients and patient op's
14 groups, you really had to make sure that you had a
15 space at the table so that you were a part of the
16 discussion. And so as we all engaged stakeholders in
17 the 21st Century Care's discussions that was very much
18 a part of the discussion -- how did we make sure that
19 we were broadening the definitions in the framework
20 around drug development and the drug development
21 lifecycle to ensure that we all were being recognized
22 as innovators and those that are now generating data

1 and sometimes were the ones that probably had the more
2 relevant data sometimes, that needed to be considered.

3 So you see that now in the definitions. But
4 those definitions and those discussions were never
5 intended to shift the responsibility away from
6 academics and researches and industry just to patients
7 and caregivers and patient advocacy groups -- but to
8 ensure that we all had a space together at that table.

9 And so I think that's really important for
10 this discussion today that we make sure that we're not
11 shifting the responsibility to patient advocacy groups
12 and patients and caregivers and saying, okay, well any
13 guidance or any of that patient experience data that
14 you're going to do that and fund that with your rock
15 and your bake sale and we'll do this piece.

16 Because within our community we've had very
17 successful collaborations with our industry partners in
18 figuring out how we're going to move that forward and I
19 think that's really important that we recognize that.

20 And then the other things is, you know, I was
21 really appreciative of that first panel and especially
22 Theresa's opening presentation where she really started

1 to lay the framework of what kinds of information are
2 really important and to really set some context.

3 And as a community we've done a lot of that.
4 We've done much of that and we talked a little bit
5 about, you know, we're going to talk today about
6 development of guidance to help inform how to bring
7 patient experience data in.

8 That panel talked a lot about the really
9 important impression that the PFDD meetings have made
10 on the individual panelists and their experiences, but
11 I think we also need to talk about many times it was --
12 just so submit that to us, send that to us, publish
13 that, send that to us -- what does that mean?

14 So if you're not outside of guidance and a
15 PFDD meeting how do you get published data to the FDA?
16 What is that pathway? What does that look like --
17 because I think some -- we need to maybe be considering
18 how time sensitive some of that information is and what
19 is the pathway for that and can that be done by a
20 patient advocacy group?

21 Can that be done by individual academics? Can
22 that just be done by industry? Does it have to come in

1 with a product submission? And so those are some of
2 the things I think we should be thinking about, may not
3 all get answered today, but things that questions are
4 coming out.

5 MS. CHALASANI: Thank you Annie, Marc?

6 MR. BOUTIN: So I want to join Kim and say
7 again, wow! So much work has been done in the last 5
8 years and for many of the patient advocates in the
9 room, some of us have been at this for 25 years. And
10 to see the speed and the acceleration change just in
11 the last 5 to 7 years is phenomenal, so kudos to the
12 FDA and to the work of the patient advocates in the
13 room to really make this happen.

14 I want to share two points that I think are
15 important -- one direct to, to the conversation we just
16 had and you've heard a number of people allude to this.
17 We need a roadmap.

18 When the patient community supported the
19 concept of this guidance on guidance, it wasn't so much
20 that we all necessarily wanted to go out and develop a
21 guidance for our disease area -- it was really we
22 wanted to have a meaningful roadmap on how to get

1 information out to the regulator and to the folks that
2 are going to be developing products.

3 And you expressed a number of different ways
4 in which that can be done. I think we have to think
5 about a framework that manages expectations. It
6 creates a hierarchy of what the need is so that any
7 individual organization can do two things.

8 They can assess where their disease is and
9 really identify where can they use the minimal
10 resources, which includes staff, volunteer and money,
11 and actually have the greatest impact and move the
12 development of new interventions for their condition.

13 They also need to be able to assess their own
14 capacities. You know, what do they have and what can
15 they bring to the table? As much of that as you can
16 put into the guidance will cause every organization to
17 take a step back and really work through that analysis.

18 Because what we don't want is everybody
19 rushing to submit a guidance that is not going to move
20 the field forward. And I think if you can call that
21 out in the guidance, go as far as you can. Many of our
22 organizations will work to develop tools to combine the

1 existing tools that already are out there to really
2 drive this point home so that we get the most
3 meaningful information out there that we absolutely
4 can.

5 Second point I'll say -- and how many people
6 in the audience are from industry? Okay, so we have a
7 good group of you from industry. I love you all to
8 death but I'm going to say to the FDA set the bar
9 really, really high.

10 Now this is a general comment but it's really
11 important. There are a lot of folks in industry that
12 are very taken on the concept of patient engagement,
13 patient centricity -- it's working through a lot of
14 your departments.

15 But when I meet with your heads of R&D some of
16 them really get it, a lot of them scratch their head
17 and say, "We do clinical trials. We engage patients."

18 Not quite what we mean. It's critical that
19 this gets embedded throughout the entire lifecycle of
20 drug development. And I hear folks from the FDA say
21 this repeatedly, but we need to drive that point home
22 so that we can push that into the culture of R&D, which

1 has a lot of challenges in terms of how they think
2 about this.

3 They're siloed for a specific reason or we
4 want great output. But we in the patient community
5 want to have the opportunity to work with them in the
6 beginning to shape their thinking so that they have
7 right insights and are shooting at the right targets.

8 Any opportunity you have -- and you've got 5
9 guidances coming out over the next few years. To drive
10 that point home would be terrific. I remember being in
11 an audience here at the FDA not too long ago when
12 somebody said, "Well, you know what? FDA is not Moses,
13 you're not coming down the mountain with tablets." On
14 this point be Moses, come down the hill with the
15 tablets and if we need to -- we're doing to hit those
16 people within the R&D department upside the head to
17 drive this point home -- it's critical, thank you.

18 MS. CHALASANI: Thank you Mike, and finally
19 Jeff?

20 MR. ALLEN: I -- yes, I thought that the
21 discussions during the first panel were, were terrific.
22 They group covered the gamut -- so to speak, of

1 opportunities and I think it was great to see how many
2 different perspectives from across the agency were --
3 were represented, so that's greatly appreciated.

4 I think that the opportunity here was really -
5 - and even the intention of this legislation of
6 including it either it be in 21st Century Care's or in
7 the user fees, was to try and facilitate next steps to
8 operationalize the patient focused drug development
9 programs that started with the 20 meetings.

10 And I think even the fact that that
11 opportunity is presenting itself shows that the -- the
12 patient focused drug development meetings were able to
13 be conducted in a meaningful way so that it could be
14 operationalized now and not just be baseline meetings
15 to learn more about how different conditions afflict
16 the different populations.

17 But to now and try and bring the entire field
18 forward in many of those areas -- so the concept around
19 guidance. I hope that we can use that as sort of a --
20 I don't know air quotes or a little bit loosely to some
21 degree because, you know, I think what -- as was
22 implied that the guidance may be a very high bar or

1 even an ultimate end game for what to do with some of
2 the information that was described earlier.

3 And hopefully though, by having that be the
4 focus as a potential vehicle -- that it's not the
5 potential vehicle, that there's other ways to
6 contribute to these processes.

7 And also, to add -- you know I think like Marc
8 said, this isn't just about the FDA but I think that
9 the desire that the community had in sort of
10 positioning this around guidance documents was -- was
11 helping the FDA be able to articulate different
12 methodological standards that could then be applied.

13 You know I don't think it's a surprise,
14 particularly, for all the folks that raised their hand
15 from industry that if the FDA speaks first, often they
16 will listen and be more comfortable to move in that
17 type of direction rather than just investing and trying
18 it first.

19 And some of that's true from our community
20 too. I think being able to understand the information
21 that would be useful, the methodological standards that
22 should be applied allows us to apply our resources and

1 be able to work within our communities to make sure
2 that we're developing the information that can be most
3 utilized and finally to lay the path forward.

4 And I think that one of the things that did
5 strike me that I hope that we can add to the discussion
6 here is -- aside from just a process on how to submit
7 this information once it's developed, some sort of
8 process very early on that would allow -- hopefully
9 even informal interactions with the different divisions
10 that we should be working with at the FDA to make sure
11 that we're joining developing key priorities here.

12 I don't think you -- the agency and the
13 experts at the agency want to receive information that
14 they're not interested in, nor do we want to produce it
15 if it's not going to be useful.

16 So I think having some ability to prioritize,
17 even for the FDA to be able to ask questions. You know
18 I think we heard that from many of the experts in the
19 first session that there were things that were clearly
20 on the front of their mind that having more information
21 on those topic areas would be really helpful.

22 So maybe even much like the major medical

1 center's layout -- the guidance documents that they
2 intend to pursue each year, even giving some sort of
3 idea in terms of burning questions that would be
4 helpful if more data were able to be supplied.

5 It could help many of our organizations focus
6 our efforts, inform the coalitions that would be needed
7 in order to create that information to bring it back to
8 the FDA ultimately.

9 MS. CHALASANI: Thank you Jeff, thank you all.
10 I think what I'm hearing is that we're on the right
11 track but there's still a lot of work to do,
12 particularly in helping to communicate more on what's
13 suitable and appropriate and especially practical at
14 what time for a lot of this information, great, thank
15 you all.

16 I do want to move a little bit more towards
17 the proposed draft guidance -- the guidance on
18 guidance, sorry, the forthcoming guidance. And so when
19 we had calls with our panelists, we asked them as FDA
20 is developing this guidance -- this forthcoming
21 guidance, and if it was to be formatted in a question
22 and answer format, what questions should FDA consider

1 addressing.

2 And we heard several common themes and I think
3 they started coming up already. The first one being
4 what types of information on patient experience might
5 be most suitable to submit in the format of proposed
6 draft guidance?

7 We heard this towards the tail-end of Session
8 I as well as during our introductory remarks right now.
9 And kind of along that line, if external stakeholders
10 do not plan to develop a proposed draft guidance --
11 whether it's for resources, the time considerations,
12 what are other ways to submit patient experience data
13 related information, including those types of
14 information identified above?

15 So really what is that range of formats and
16 methods? What is the process for planning and
17 developing a proposed draft guidance relating to
18 patient experience data to FDA? And is there a
19 recommended format or a list of topics for guidance
20 documents that an external stakeholder might develop
21 and submit?

22 Third, what is the process for submitting a

1 proposed draft guidance to FDA? There is actually a
2 clear statute for this. What will happen after
3 external stakeholders submit a proposed draft guidance
4 relating to patient experience data to FDA?

5 So this gets at some of the managing
6 expectations that we heard about, early communication
7 to see if, you know, it's something that FDA even needs
8 getting at those kind of aspects.

9 And then the final question is something that
10 both Keith and Theresa mentioned earlier is how may an
11 external stakeholder submit proposed revisions to an
12 existing FDA guidance? You don't have -- you may not
13 have to start from scratch from it.

14 So I think these questions are on the right
15 track and based on the calls that I had with all of you
16 earlier, you agreed. So I do want to ask a few follow-
17 up questions and seek a little bit more -- a little bit
18 more input from folks.

19 I think we talked about one a lot. In the
20 interest of time I will go directly to the sub-question
21 for two. So is there a recommended format or a list of
22 topics for guidance documents that an external

1 stakeholder might develop and submit?

2 I think -- I would be interested in hearing
3 from panelists. How do we really find that right
4 balance of, you know, being -- providing guidance but
5 maintaining flexibility. So would a template be
6 helpful? Or would that be too restrictive or too
7 prescriptive? What are some of your thoughts on that?
8 I think I see Bray -- yeah.

9 MS. PATRICK-LAKE: Yeah, I mean I think you do
10 need that level of detail and the external resources
11 webpage, I think is -- that's a great start. I mean I
12 looked around in there and -- excuse me, there were --
13 I mean you can go back and you can look at the Voice of
14 the Patient as a model, but then really getting into
15 developing a meeting plan.

16 And I think also I'm envisioning some kind of
17 pyramid that shows, you know, what's the highest
18 standard, most rigorous as we start getting -- I mean
19 we have to have the methods where it would come out to,
20 but, you know, the where to start as the patient group
21 and then what you need to work through to get to this
22 level.

1 I think you're going to have to put it on
2 there even if it's just case examples because, you
3 know, again the capabilities of different groups and
4 the financial resources is key.

5 And then I also really want us to hit on that.
6 There were statements about -- think about the other
7 stakeholders in the space and we encourage
8 collaborations, but you're really going to have to put
9 that in bold I think with exclamation points if that's
10 really, you know, the consortium model is what we're
11 trying to achieve.

12 MS. CHALASANI: Sure, so really a question
13 that's going to get the who as well as -- I think the
14 examples you hit right on that I think would be really
15 helpful as well. Others that would like to chime in?
16 I see Anne or Kim and then Anne.

17 MS. MCCLEARY: So I think that "who" question
18 came up in our protocols. PPMD sort of set the pace
19 for these patient-led guidances and did a remarkable
20 job of -- we had over 80 people involved in developing
21 that draft guidance and that is -- as others have said,
22 maybe beyond the capabilities of some organization and

1 maybe there aren't 80 people studying a particular
2 condition especially in the rare diseases.

3 So what would the right consortia look like?
4 Does it have to be all of the patient organizations in
5 the space coming together? Would a single industry
6 sponsor be acceptable or would FDA be looking for that
7 industry participation to be spread among several
8 companies?

9 How could academics be involved when, you
10 know, that may be outside of what their purview is to
11 understand what regulatory guidance looks like?

12 So I think some, maybe for setting of what's
13 the minimum expected set of participants and then it
14 can build from there, but to give people an idea of
15 what they're shooting for would be really helpful.

16 MS. CHALASANI: Sure, thank you, Anne and then
17 Marc.

18 MS. PARISER: Yeah and in addition to that I
19 think also the "why" is important. I think we -- we
20 heard that several times earlier this afternoon and
21 again from this panel. We have a tremendous variety of
22 diseases -- there's about 7,000 or so different

1 diseases that have been described and they're all
2 various places along the spectrum of how well they're
3 understood or -- or how organized they are.

4 So I think it's very important to everybody --
5 you have to take a very close look at where you are.

6 Some of the diseases are very well described. Duchenne
7 Muscular Dystrophy -- there's been a lot of work there.

8 There's a lot of rare diseases in particular,
9 where we really are starting out. So what you're going
10 to be collecting and the level of complexity can be
11 very, very different but it can still be tremendously
12 useful. For example, we heard a lot about natural
13 history studies. Well maybe we're not quite ready for
14 that.

15 One of the first organizing activities is --
16 is a registry. A registry is a very broad term, it's
17 just really almost any data collection. But a
18 communication registry is often a place to start and
19 that can be of tremendous utility.

20 Now this may not be something you'd submit in
21 a guidance to FDA, but that could form the start of --
22 of organizing your research plan. It could put you in

1 touch with the pharmaceutical industry who may not want
2 to embark on a clinical development program if they
3 don't think they can enroll a trial.

4 But if you're able to unite the community like
5 this -- that could be a tremendous help in moving
6 things forward. So, so I'll go back to what I was
7 saying before -- look around very carefully. There are
8 consortia that exist.

9 We have a rare disease clinical research
10 network that has corrected longitude and observational
11 data. Some of them are 15 years long. Now, not all of
12 them have that but there may be something that already
13 exists -- is it something you can build on?

14 Especially for rare diseases as it tends to be
15 a small community, there aren't a lot of patients but
16 there also are not a lot of researchers so you can
17 often pull people together around one table to get
18 started and to see where you are.

19 So I'd urge everybody to do that first and
20 then decide what your first goal is that you're going
21 to build on.

22 MS. CHALASANI: And I think Marc you wanted to

1 address this.

2 MR. BOUTIN: So first Anne, I think you're
3 absolutely dead-on right. Whatever you do in the
4 preamble of this guidance should encourage a self-
5 assessment for any group that wants to do this about
6 their organizational capacities and where the disease
7 area is or we could get stuck in a lot of resources
8 being spent inappropriately and a lot of submissions to
9 FDA that may use a lot of FDA resources
10 inappropriately.

11 I actually think most of your best work in the
12 patient community is going to be submitted in other
13 ways. And so making that point really, really clear
14 and driving that home I think is critically important
15 for the patient community to do that assessment and
16 decide where they can have the greatest impact.

17 A couple of quick thoughts on this guidance --
18 can it be submitted in segments and sequentially?
19 Thinking about that can it be made bite-size? Maybe
20 some of the bites are submitted not as guidance but
21 eventually a package comes together and becomes a
22 guidance.

1 Recommending that to a lot of groups would
2 make a lot of sense. When you have this information on
3 your website, anything you can do to make it searchable
4 -- and for organizations to say, "These are the 28
5 things that are critically important to me," and to put
6 that into the website so that when anything new gets
7 put in, they're notified to go back and look, will help
8 make this a robust tool that can be functional not only
9 for sponsors but for the patient community that may not
10 realize that there are people in Europe and India and
11 China working on the same issue.

12 MS. CHALASANI: Several hands, I'll go to
13 Annie?

14 MS. KENNEDY: So we -- as has been referenced,
15 we did develop guidance for industry and the "why" was
16 because we wanted to accelerate therapy development in
17 the Duchenne space.

18 We had developed and funded research. We had
19 several natural history studies. We had funded so many
20 animal models we referred to it as the Duchenne zoo.
21 And we wanted to bring all the stakeholders together
22 and really look at our -- look at the space, assess the

1 space, and understand what we knew and bring it
2 together before the FDA.

3 So, but I think it's important to say that
4 that was not a guidance around patient preferences and
5 patient experience data. There was a section about
6 patient preferences because we had begun to embark on
7 patient preference studies so we analyzed the
8 methodologies that we had at that time been using in
9 our community and talked about benefit risk assessment
10 in Duchenne at that time.

11 And we also talked about what we called the
12 imperatives which was from the perspective of our
13 Community Advisory Board -- what was really important
14 for our community to ensure that regulators understood
15 about Duchenne.

16 So that was what was in the community-led
17 guidance that went before the FDA. That was probably
18 considered to be sort of a lightning-pace process. It
19 took 6 months for that to come together in 7 work
20 groups of over 80 individuals and stakeholders which
21 included academics and industry and researchers and the
22 patient community.

1 And we invited all of the Duchenne
2 organizations and individuals in the Duchenne space
3 that wanted to be a part of it. So convening the
4 community was really incredibly important.

5 But again, that wasn't related to focus on
6 patient experience data as we defined the clutch and
7 the patient experience data. We have been collecting
8 patient preferences, we have specific registry data and
9 peer Ode's that are in development in Duchenne and we
10 have been working to bring those into the FDA and
11 publish those and work in collaboration with the
12 relevant centers of the FDA to bring those in to the
13 FDA.

14 And we also worked with bio in collaboration
15 to develop a document and published it called, Key to
16 Considerations in Developing and Integrating Patient
17 Perspectives and Drug Development.

18 We used Duchenne as a case study but we looked
19 at other communities that were also doing this work to
20 look at what models and methodologies and what their
21 experiences were in integrating patient perspectives
22 throughout the drug development lifecycle, and again

1 talked to FDA around what were the considerations that
2 were important to FDA, what were the time points where
3 that data should come into the agency, and talked to
4 industry about those same things.

5 So we think that there are some of these other
6 models out there but guidance is a huge undertaking and
7 so we're not saying, don't do it. But I think from our
8 perspective we haven't seen guidance as the vehicle to
9 bring patient experience data in -- that to us is
10 needed to be a little bit more of an agile, iterative
11 process.

12 MS. CHALASANI: Sure, Annie, while you're on
13 the mic. Just since you're one of the folks on the
14 table that's been through this process I mean, 6 months
15 is already very efficient actually. But if answers to
16 this were out there for these questions would that --
17 would that be helpful or are there still some key
18 questions?

19 MS. KENNEDY: Oh, absolutely.

20 MS. CHALASANI: I mean answers are always
21 helpful. I mean the last panel from the FDA is gold.

22 MS. KENNEDY: That kind of information is

1 always helpful. The one thing I worry about though
2 with -- the one thing I worry about is if you put out a
3 list to stakeholders to say these are the kinds of
4 things we want to see in guidance.

5 You have to be very careful that it's not
6 interpreted as, "We want you to do guidance on these
7 things."

8 MS. CHALASANI: Yes, great.

9 MS. KENNEDY: I think I liked when Jeff said,
10 air quotes around that for -- you need to make sure
11 that it's not seen as a sort of edict.

12 MS. CHALASANI: Right --

13 MS. KENNEDY: That you need to be generating
14 guidance for us and that that is the preferred method
15 of communication with the FDA at this point.

16 MS. CHALASANI: Correct, and I think that's
17 what we were really trying to get at with that sub-
18 question underneath saying, "If you don't want to
19 submit it as proposed draft guidance," -- even if it is
20 that information that we talked about in Session I --
21 what are those other formats, but we really need to,
22 apparently, highlight them and communicate them and

1 find other ways to get that message across, okay.

2 Paul, I think I wanted to give you an opportunity as
3 well.

4 MR. MELMEYER: Yeah, I wanted to build-off a
5 couple of the points already made -- this is why we
6 also need to be very careful with the case study model
7 if FDA was to put forward a case study and let's say it
8 was -- PPND's process or some of the other guidances
9 that have been submitted to FDA.

10 I can imagine the vast majority of patient
11 organizations within our space would say you know,
12 "Holy Cow, I couldn't do that within 6 years let alone
13 6 months, so I'm just going to walk away from this and
14 not worry about it."

15 So if we were to go forward with a case study
16 model -- there would have to be a variety of case
17 studies that fit a variety of different resources that
18 patient organizations could put into the process.

19 I think it's also important to ask for whom is
20 this data being generated for. I would imagine for
21 many patient organizations who would be introduced to
22 this process they may think, okay so, you know, we're

1 submitting this draft guidance to FDA so this data is
2 specifically for FDA.

3 But in actuality this data may be most useful
4 to industry as they are developing therapies for their
5 specific diseases so that must be a point that is quite
6 clear to patient organizations as they're thinking
7 through what data should we be collecting in order to
8 participate within this process.

9 And one final point, patient organizations
10 within our space have to get particularly creative in
11 order to get things done -- just due to very small
12 resources and not resources that go around within rare
13 disease research and patient advocacy.

14 And for this reason, many patient
15 organizations that represent different diseases that
16 are kind of within the same space oftentimes partner
17 with each other on projects. We see this oftentimes
18 within research consortiums and other avenues.

19 And so if there's an opportunity for patient
20 organizations that technically represent different
21 diseases but perhaps are all within inborn errors of
22 metabolism or some other kind of subsets of rare

1 diseases.

2 If there's a way that they could partner
3 together on collecting this data and putting forward a
4 draft guidance, it would still be valuable to FDA, it
5 would still be valuable to industry -- that should be
6 well noted by FDA within its draft guidance.

7 MS. CHALASANI: Thank you Paul. Just really
8 quickly going back to your case studies and examples on
9 how it would be really helpful to have a range --
10 that's really a call of action to everyone in this room
11 and on the web and other folks as well.

12 We have a public docket that's open I think
13 until May 18th. If you could send us the resources and
14 the examples, that would be very, very helpful.
15 Earlier rather than later -- we have a very tight
16 deadline for drafting this guidance, but that would be
17 really helpful, Jeff?

18 MR. ALLEN: Just to add one thing and I don't
19 mean to keep harping on the early interaction but I
20 think it's really important in terms of determining the
21 scope.

22 FDA uses guidance documents to communicate the

1 agency's positions on a variety of things and that's
2 different than submitting data that would be valuable
3 for FDA processes or for things that they may want to
4 consider.

5 We also were involved with drafting a guidance
6 document a number of years ago -- I think it took us
7 more like 10 or 11 months, but I think what was
8 important about that and the area that we were looking
9 at was -- was multi-drug combinations for -- for two or
10 more novel drugs for use in combinations that were
11 otherwise unapproved.

12 And this was an issue that the oncology
13 community was sort of -- had the foresight to see that
14 this was the future for cancer treatment and a
15 perceived barrier.

16 And we could have very easily just pursued the
17 exact same publication that laid out a couple different
18 clinical development programs that could be followed
19 and that could have been informative as a publication.

20 And I think the reason that it became of
21 interest to FDA was that the FDA was frankly sort of
22 being identified as a barrier for novel, novel drug

1 combinations and I think this was a good venue for the
2 agency to put forth their thinking in saying well
3 here's the types of information that we could suggest
4 to clinical researchers on how to produce and ways that
5 would be acceptable from our vantage point and advice
6 that we would give you, so it was of interest to them.

7 The second point was this wasn't unique to
8 oncology as much as some of our efforts were focused on
9 that, one of the charges from the agency were yeah look
10 -- look more broadly.

11 So we brought in the infectious diseases
12 community that had frankly more experience than the
13 oncology community in multi-drug combinations. And the
14 ultimate guidance document that the agency put forth
15 was not specific to any of those diseases. There were
16 some things that needed to be addressed in there to be
17 specific as necessary.

18 But it was meant to be as encompassing as
19 possible. But you know my point is I think that it
20 would be important very early on to distinguish are
21 these topic areas things where the FDA could lay out
22 the agency's position on certain things versus ways in

1 which the external community can provide experience and
2 information back to the FDA for those -- for their use,
3 because I think those are different things.

4 And early is really important. I would only
5 imagine that -- that if any individual within the FDA
6 thought they themselves wanted to pursue some sort of
7 guidance document they would talk with their colleagues
8 and follow a procedure rather than drafting it and
9 submitting it to, you know, the center director or
10 whatever the case may be, you know, so it would be very
11 important from the same standpoint I think for external
12 groups to do the same.

13 MS. CHALASANI: Thank you Jeff. I think along
14 the lines of communicating FDA communication, kind of,
15 really going to that fourth goal at point about what
16 will happen after stakeholders submit a draft guidance
17 related to PED to the FDA.

18 So I'd really like our panelist's input on how
19 can FDA manage expectations and really keep
20 stakeholders informed on the practical considerations
21 that Keith kind of touched upon earlier.

22 You know, there may be things that we just

1 can't share. So what -- what are some of your thoughts
2 on that? Like how can FDA manage expectations, what's
3 realistic? That's Kim -- are you nodding your head or
4 Annie?

5 MS. MCCLEARY: I was just going to say that
6 you know some -- and it kind of goes to Jeff's point
7 about there should be a dialogue that proceeds
8 submission of guidance so that you are somewhat
9 confident that this is hitting at a time when FDA is
10 ready to think about what its position on a particular
11 disease area might be.

12 I mean otherwise you might be just submitting
13 it and this kind of a "thanks for sharing" opportunity,
14 or you get crickets because there isn't really any
15 perceived need within the agency to clarify something
16 that they don't have an urgency to act on.

17 So I think the response is going to be
18 somewhat dictated by how well you've matched what
19 you're doing to what FDA's needs are. Ultimately, I
20 think as Paul said, the real audience for this might be
21 industry but if, you know, we don't want to use the FDA
22 as a pass-through for every bit of information we want

1 to communicate to industry -- that's not a terribly
2 efficient use of limited resources here, so.

3 MS. CHALASANI: We're happy to be facilitators
4 but we do have day jobs, Marc and then Annie, sorry.

5 MR. BOUTIN: Even in our conversation here I
6 think we're lending the potential audiences and I think
7 we have to be disciplined about what is the audience
8 and what is the purpose. You know, again I'll go with
9 Jeff's air quotes, this really isn't a guidance per se.

10 In many respects it's very, very different and
11 I think a lot of patient organizations perceive this as
12 an opportunity to distribute information to a variety
13 of audiences and there's a lot of value in that because
14 there is no place to do that effectively currently.

15 If this is really going to be a guidance that
16 is informing FDA's thinking, it becomes much more
17 narrow. And to your bullet here -- the fourth bullet -
18 - having clarity on exactly what the process and the
19 timelines are are critical, but if this is the point of
20 managing expectations we're too late.

21 So being very clear on what the purpose for
22 this is because I'm hearing two different extremes

1 here. And it could be both, but being very clear what
2 it is and then when a patient organization starts to
3 consider this I think there's a lot of soul searching
4 they have to do to figure out if this is the right
5 pathway.

6 And there can be some opportunities to match
7 expectations there. But the expectations are going to
8 be set at the very, very beginning. If we're waiting
9 to this point, we probably waste a lot of resources.

10 MS. CHALASANI: Sure, so what I'm hearing is
11 the fourth bullet point should be the first or like
12 right after the first one, almost, Annie?

13 MS. KENNEDY: I guess the -- a couple of
14 things that came up make me think that this process is
15 cumbersome, right? So, we're talking about there could
16 be multiple stakeholders that are involved in
17 developing the guidance and my understanding is that
18 FDA doesn't necessarily -- if you have multiple
19 stakeholders developing a guidance, then there's not
20 necessarily one point of contact so that means that FDA
21 may need to develop a process for identifying one point
22 of contract that if there is going to be some type of

1 communication back and forth about the process, that
2 there's an agreement on what organization -- which
3 organization that is or who that's going to be if
4 that's representative and then disseminates the
5 information -- so that would be a new process that
6 would need to be established potentially.

7 And then another question that's come up --
8 came up around our guidance is that we had submitted a
9 community-led guidance and then FDA broke into docket
10 for that to be submitted and then FDA developed a DAIS
11 draft guidance for industry in Duchenne and those were
12 two different documents -- so FDA's guidance looked
13 more like an empty egg guidance and then there was a
14 community-led guidance and both were very well-done,
15 robust, scientific documents but they were different
16 from one another.

17 And so there was a question of how do those
18 relate to one another, link to one another, refer to
19 one another? And I would imagine that something
20 similar will come up here and so there needs to be a
21 process for acknowledging that and setting expectations
22 around that so that the community and industry know

1 what to do with that.

2 And then related to that, if then the
3 community were to update their version of the guidance
4 at some point -- and especially related to patient
5 experience data, I would assume that gets updated
6 fairly regularly. How does the one get updated and
7 linked to the other, et cetera or does one sunset?

8 So just some questions or considerations
9 around that.

10 MS. CHALASANI: I think that's really helpful,
11 Anne?

12 MS. PARISER: So in a different -- in addition
13 to the use cases that you talked about which probably
14 need to be at very different stages, very mature
15 research on beginning stage.

16 Perhaps something like a decision tree or
17 pointing people in the direction of -- I have this
18 amount of data. It might help you identify where the
19 gaps are and where you need to then -- what should be
20 your next step. This may or may not lead to a guidance
21 but as Theresa's talk had a lot of other directions
22 this could be put to, it might be helpful.

1 If I have a lot of information on clinical
2 symptoms -- well maybe your next step is you want to
3 start developing an outcome measure.

4 MS. CHALASANI: Thank you Anne, Mary Jo, sure?

5 MS. STROBEL: Just to build on that. I think
6 any guidance issued would need to be very simple
7 language that could be easily understood by a patient,
8 an advocate, a lay person. I would say most -- many,
9 if not most, advocacy organizations that are serving
10 those for rare diseases are started at the kitchen
11 table and they are run by those who may have little or
12 no medical background.

13 So it would be really important that any
14 guidance is written and presented in a way that can
15 really be easily understood. Very clear sections would
16 be helpful as they're navigating -- planning
17 implementation, submission, post-submission, very
18 simplified so it's not so cumbersome, or intimidating
19 when they are embarking or assessing how to move
20 forward with that.

21 You had asked earlier if templates would be
22 helpful and I would say yes. Having sample questions

1 structured in a way that's going to help draw out what
2 is the most meaningful data for all parties is really
3 helpful, again thinking about who is accessing this.

4 The various channels that that information can
5 be captured -- again scalable -- what one group might
6 have a budget to -- and the support to host an in-
7 person meeting to bring the patients together, there
8 are many in the space that maybe they're only patient
9 engagement.

10 They've got the patient engagement but maybe
11 it's through social media and how would we -- how would
12 we address that and what are ways that that could be
13 harnessed and used and submitted?

14 MS. CHALASANI: I think Paul and then Bray.

15 MR. MELMEYER: Yeah, just to build off that
16 even further. In regards to managing expectations as
17 Marc was saying earlier that, you know, needs to be
18 addressed before the guidance is even really
19 considered.

20 And to have an open line of communication
21 between patient organizations or those who could be
22 pursuing these opportunities and those at FDA from the

1 very start is really key to insuring that patient
2 organizations are choosing the right way forward.

3 Perhaps they just raised \$10,000 they want to
4 spend it on something -- is it best to start a registry
5 or should I look into a guidance or should I hold a
6 scientific meeting with FDA. That can't really be
7 reflected in the guidance on guidance because that is
8 unique to that patient organization specifically and
9 that could be covered within, you know, an hour-long
10 conversation with FDA.

11 So ensuring within the guidance on guidance
12 that there is something to day that for your unique
13 circumstances, you're considering how to best engage
14 with FDA, how to contribute your patient-communities'
15 perspectives, you know -- this is who you talk to, this
16 is who you should be reaching out to -- to have that
17 conversation.

18 MS. CHALASANI: Sure, I think that goes along
19 with the earlier idea of a decision tree or Marc you
20 mentioned a framework kind of along those lines, Bray?

21 MS. PATRICK-LAKE: So I guess I want to go
22 ahead and just have the hard conversation about you

1 know what about when things go wrong? So right now,
2 we've got the early adapters and the people that are
3 open to this and pretty good at it but we know that not
4 every patient group is the same, not every industry
5 sponsor is the same and not every FDA reviewer or
6 division head is the same and their thinking.

7 So I wonder what happens when people submit.
8 So we're saying you shouldn't really be submitting
9 unless you've already kind of come to agreement that
10 there's a need. But we also heard FDA sometimes
11 doesn't think there's a need when patient groups think
12 there's a need.

13 So how do we work through, you know, is it
14 just a -- you get an email back that says thank you but
15 no thank you. Thank you, what you submitted we don't
16 find rigorous, thank you, you don't have the right
17 stakeholders -- you know what -- what do people get
18 back to choose for or do you get something back that
19 says, you know, this is what, you know, how you move
20 forward from here or what we really need or you know,
21 can we meet because we're discordant.

22 I mean I just -- I want to have a little more

1 conversation about what that looks like.

2 MS. CHALASANI: Sure and I think I'm going to
3 turn that question back to our panelists -- what would
4 be useful in that circumstance, Anne?

5 MS. PARISER: Well I mean FDA I suppose is not
6 the only player otherwise we're here for the guidance -
7 - but not the only player. So chances are if -- if
8 there's discordance I'm thinking it's probably
9 premature so you're probably going to need to go seek
10 additional help.

11 So again, NIH, the experts in the disease,
12 other patient groups -- that would probably be the next
13 step in seeking some help.

14 MS. CHALASANI: Paul?

15 MR. MELMEYER: And if there is discordance
16 hopefully FDA has a suggestion on what to do instead.
17 Perhaps they do disagree that it should be a guidance
18 that would be developed but you instead, in your
19 specific situation, you know, patient organization next
20 -- you should be doing this instead and therefore FDA
21 can still have a proactive productive suggestion for
22 the patient community to pursue that would still be

1 beneficial for drug development within their space.

2 MS. CHALASANI: Annie and then Marc.

3 MS. KENNEDY: So perhaps the process looks --
4 I mean to Jeff's point earlier, it looks similar to the
5 PFDD meeting process where what you're asking for
6 initially is an LOI right? So, and a brief description
7 of the effort and who you look to involve and the
8 identified need, and -- and then it's the beginning of
9 a conversation.

10 So you haven't gotten so far down the path
11 where there's been an investment of time and resources
12 that it's actually a great opportunity to begin a
13 relationship with the right people at FDA to really
14 help you do that assessment of your community and what
15 you're working towards.

16 And so it maybe at that point where you're
17 invited in to say, "Absolutely, let's talk about this,
18 and flush this out a little bit," and put you in touch
19 with people who that can help you navigate the next
20 steps.

21 Or it can be you know what -- the next steps
22 before you get to this might this this and let's help

1 point you in the direction of those kinds of resources.

2 MS. CHALASANI: I think that's a really good
3 idea, Marc and then Kim?

4 MR. BOUTIN: So Annie we're channeling exactly
5 the same idea. You might consider a requirement that
6 you register an intent to pursue a guidance first to
7 start that conversation.

8 My biggest concern here, I'll be really frank,
9 is a lot of resources are going to get wasted
10 developing guidances or diseases where the disease
11 either is not ready or the organization is not ready.
12 And there are too few resources in the patient advocacy
13 community to allow that to happen.

14 So I have a real concern here. What -- the
15 feed that I'm picking up is that your opportunity to
16 collect hopefully high-quality information and to
17 curate that and to make it public -- short of a
18 guidance, is really what the patient community was
19 looking for.

20 And to really beef that up and to connect it
21 to the guidance might be relevant. But it's probably
22 going to be relevant for a small percentage of -- of

1 disease areas where people are ready. And when they're
2 ready we absolutely want to encourage that.

3 But many in our world are going to need to get
4 ready. So it feels like the guidance on guidance is
5 sort of being over-weighted compared to the other
6 opportunity to share information through this web
7 portal.

8 And I think we may want to think about how we
9 reverse that and communicate that effectively to
10 communities so that we can use that portable -- portal
11 to get great information out there that builds on our
12 body of knowledge, curated appropriately, make it
13 searchable, get it to the relevant parties, encourage
14 collaboration and then when the time is right let's
15 move to the guidance.

16 MS. CHALASANI: Kim, if you want to build off
17 of that?

18 MS. MCCLEARY: Yeah, I think that's -- that's
19 really important and one thing I'm thinking about
20 sitting here is in some diseases where the kind of
21 standard of care is -- revolves around drugs, it's more
22 -- maybe more straightforward of who you work with but

1 so many of the conditions there's interplay between
2 biologics and drugs and devices.

3 And we -- we heard a lot in the PFDD meeting
4 series about supplemental oxygen and ventilation
5 machines and it's not clear like maybe it could be
6 diagnostics, or diagnostics paired with treatments and
7 how would a patient community know who to seek out and
8 how to involve other centers in that work and the
9 timing of when it makes the most sense as well. I
10 think that's important too.

11 That letter of intent process might help
12 clarify who the internal partners within FDA might need
13 to be.

14 MS. CHALASANI: Just to provide context for
15 externally-led patient focus drug development meetings,
16 our process starts with asking groups that are
17 interested in hosting a meeting to submit a letter of
18 intent to our office so that we can review and then
19 work with them to help support them in any way.

20 I do want to leave some time for the audience
21 facilitated discussion so I'm going to turn to my
22 panelists and just ask if there's any final concluding

1 remarks or anything you'd like to say, Kim?

2 MS. MCCLEARY: Another thought that came up is
3 and using Jeff's air quotes -- the guidance, you know,
4 even in the best of circumstances it takes six months,
5 probably longer than that if you're mortals.

6 There are certain circumstances though like
7 potentially, you know, how could a patient or an
8 external stakeholder submit information for an Adcom
9 meeting where there is potentially patient experience
10 data that could help inform a particular product
11 decision even if that data wasn't collected, you know,
12 about a specific product but just helping understand
13 what the trade-offs are?

14 And that may be a shorter timeline given PDUFA
15 timelines of when the deed is immediate, how could
16 there be maybe some accelerated pathways and there may
17 be PFDD meetings externally led where other communities
18 have information that they feel could be important to
19 bring to bear but they aren't specifically involved in
20 that meeting, so just a couple of very specific
21 instances.

22 MS. CHALASANI: Sure and I think our external

1 resources webpage that Pujita presented on may be
2 working in that direction and that it's entitled to a
3 resources -- resource for external stakeholders as well
4 as FDA staff, for example, preparing for an advisory
5 committee meeting. Any other -- Bray?

6 MS. PATRICK-LAKE: I just want to make one
7 more request. On the cover page I thought it was
8 great. A lot of good information but authors and
9 collaborations -- I was wondering if you could add
10 roles? I think it's important to really understand --

11 MS. CHALASANI: Sure.

12 MS. PATRICK-LAKE: What contributions are -- I
13 know it said financial, but I think, you know, is it a
14 patient group that got bolted on and they're you know,
15 not really driving the effort?

16 I think we want to elicit that and understand
17 who contributed.

18 MS. CHALASANI: Sure, I think that's really
19 helpful feedback, thank you, Paul?

20 MR. MELEYERS: Yeah and to build on that we
21 know that patient organizations are always very
22 cautious in approaching relationships with industry so

1 they'll want to know to what extent industry --
2 regulated industry, should be involved within
3 generation of this data so that they're -- they can
4 ensure that whatever data they generate will be looked
5 at by FDA in looking in the light that they'd like it
6 to be looked at.

7 MS. CHALASANI: Okay, helpful, thank you, what
8 else Marc?

9 MR. BOUTIN: So, really, I think everything is
10 Bray -- I'm glad you mentioned that. I had made a note
11 about that and forgot about it. I think it's critical
12 to say that it's okay for it to be funded, but there'd
13 need to be appropriate guardrails on how that works,
14 guaranteed independence, mission-related context for
15 the patient organizations.

16 So not just simply asking where the money
17 comes from because that will lead us to a certain set
18 of conclusions but understand where the money came from
19 being completely transparent about it and also what
20 governance independent mission drive was there? And
21 there are ways to get that that.

22 And organizations should be expected to

1 communicate that.

2 MS. CHALASANI: Okay, great. Unless there's
3 any final thoughts, I am going to open the floor for
4 the audience facilitated discussion. So a lot of the
5 same questions that I've been asking the panelists
6 here.

7 What would be helpful for FDA to address in
8 our guidance on guidance, now that we're using air
9 quotes? We do have few mic runners -- a couple of them
10 that are going to be walking around so please just
11 raise your hand and they'll bring a mic to you. I see
12 Dr. Roberts in the back over there.

13 MR. ROBERTS: Thank you, thank you for a great
14 discussion today. I'm Steve Roberts of the Tuberous
15 Sclerosis Alliance, and I just wanted to add a voice to
16 -- to some of the groups that are close to ready for
17 guidance.

18 That the guidance for guidance, maybe with a
19 capital "G" is important to some of the -- some of the
20 groups, so while it doesn't work for everybody, I just
21 didn't want to leave the discussion thinking we need
22 to, you know, take it really, really down because I

1 think I and maybe some others wouldn't be here if it
2 was a discussion about how to improve a -- a website
3 and sharing.

4 We're really interested in taking it to the
5 next level so I appreciate all the input on, on doing
6 that to help us do it the best way we can.

7 MS. CHALASANI: Sure, I see a hand.

8 MS. KENNEDY: Can I just make one remark
9 though. I think to that end and I mean disagree with
10 me if you disagree. This panel blew past the
11 guardrails of the statutory language where we opened
12 because the statutory language talks about how a person
13 seeking to develop incident proposed draft guidance
14 relating to patient experience data for consideration
15 by the Secretary.

16 And we're really talking about submitting
17 guidance for guidance so I think probably a lot of us
18 who have submitted guidance didn't just cover patient
19 experience data, but really looked at our ecosystem
20 around the scientific data, the natural history data
21 and brought it all together and I think that's how
22 we've been -- we've been using the big G and not just

1 looking at what patient experience data we have to
2 bring in.

3 So I think that's important to clarify though
4 today because we aren't just looking at how to bring
5 patient experience data forward, but what's new about
6 our disease condition and how to bring that forward.

7 MS. CHALASANI: Sara, I think you had --

8 MS. BRYSON: Okay, thank you first of all.
9 This was wonderful. I'm Dyan Bryson, I'm with Inspired
10 Health Strategies. And what we do is work with
11 pharmaceutical companies to help them become more
12 patient centered and help them develop strategies to
13 improve health outcomes as well as the bottom line.

14 And what I saw in this opportunity originally
15 it sounds like might not be the original intent, but it
16 could be an opportunity. Many companies really have
17 developed initiatives that had been effective but the
18 learning doesn't take place and the projects aren't
19 replicated because the education leaves the
20 organization or that person leaves that role that they
21 were in.

22 And there's nowhere to put all of these

1 programs that had been effective that pharma can learn
2 from which is seems like this is part of the intent and
3 isn't it possible for pharmaceutical companies to
4 submit -- and not everyone has good ones, but for
5 pharmaceutical companies or those of us who work with
6 them to submit initiatives that we have seen to be
7 effective?

8 MS. CHALASANI: Pujita, feel free to correct
9 me if I'm wrong but I do think the answer and FAQ's for
10 external resources website -- the "who" and in statute
11 also says the "who" and it really can be any
12 stakeholders, so I think that's the answer to your
13 question, okay I'm getting nods from my left here,
14 other folks, oh in the back?

15 UNKNOWN SPEAKER: Yes, since you're specific
16 about finding guidance from guidance, my thoughts about
17 it is -- guidance from guidance, probably really should
18 be most importantly to connect with the other -- the
19 other regulations in European countries.

20 They have those entities, all the nations in
21 Australia, there are so many other continents haven't
22 targeted it because they must already have such

1 (inaudible). They may ahead in this game so this is my
2 thoughts.

3 Have you tried communicating with them?

4 MS. CHALASANI: I don't know -- I don't know
5 the answer to your question but we can take it back. I
6 do know that one of our other commitments is a
7 repository that we have to develop and that's something
8 -- it may be the external resources webpage that we
9 presented that may grow into that.

10 It may be a separate effort to be decided. We
11 have a little bit more time on that. But we do
12 envision it to be disease specific and it may be
13 broader than just information that's collected for the
14 United States population so going towards that
15 facilitation and collaboration and consortia, all those
16 other themes that we heard.

17 Hopefully that kind of answers a little bit of
18 your question. Other folks -- I wanted to ask about
19 that sorry?

20 MS. PATRICK-LAKE: So I know on one of the
21 webpages it said, "See who else is working in the
22 space." Is there like a specific direction for

1 landscape analysis?

2 MS. CHALASANI: Sure, sorry I missed the
3 beginning of that question, Bray, would you mind re-
4 stating?

5 MS. PATRICK-LAKE: I'm just limited -- I know
6 that on one of the resources it was saying that you
7 should identify all the other people working in the
8 space but it didn't say like landscape analysis and I
9 don't know U.S. specific, I think, was his question
10 versus global --

11 MS. CHALASANI: There could be something --

12 MS. PATRICK-LAKE: But there was something
13 about who the other collaborators were.

14 MS. CHALASANI: Sure, we can take that back
15 and consider that, yes?

16 MR. MELMEYER: And I do believe there is a
17 patient engagement cluster between FDA and EMA --
18 perhaps that could be an opportunity for the cluster to
19 talk about international collaboration on this?

20 MS. CHALASANI: Yeah, that's a really great
21 suggestion, thank you.

22 MR. MELMEYER: Thanks.

1 MR. BAKER: I'm Jim Baker, I'm representing
2 FARE, the Food Allergy Foundation. I'm an allergist.
3 I've been involved in drug development my entire
4 career. And we're almost the opposite of many of the
5 organizations here in that we have an outbreak of a
6 disease that has multiple causes and the impact is very
7 different.

8 We have both pediatric and adult and we have
9 people who have an allergy to something like peanut
10 which is avoidable as compared to milk and egg which
11 make their lives much more difficult.

12 Obviously, we are not ready to go to guidance
13 yet and I think in particular for problems like this
14 that are emerging, we don't have any therapies that are
15 approved yet.

16 This is a very important thing. So the
17 concept of providing input to an Adcom or something in
18 another way that could have an impact for our
19 population is something that's very important and I
20 don't want to get lost in the fact that we outweigh the
21 (inaudible).

22 MS. CHALASANI: So really providing some

1 communication on the range of opportunities, other
2 folks -- I see a hand right there.

3 MS. EISENHOWER: Hi, thanks, this has been
4 very helpful. My name is Jessica Eisenhower, I'm
5 General Counsel for a company called Corona, we're
6 collecting longitudinal observational data for -- since
7 2001 in autoimmune diseases.

8 And I sort of came into this thinking we were
9 going to be talking a little bit about how industry
10 could utilize existing registries and I was very
11 pleased to see all of the patient organizations
12 involved. And one of the questions for the FDA and
13 other may have been mentioned a little bit is -- is the
14 expectation that patient organizations will collaborate
15 with registries or other companies or whatnot that Anne
16 had sort of mentioned that already have methodologies
17 and designs in place?

18 Are the patient organizations expected to work
19 and collaborate with registries or and would the
20 expectation of desire of the FDA or is the FDA really
21 interested also in sort of the expertise that a company
22 like Corona and others can bring to the table even

1 though it might not be a patient organization because -
2 - and I'm also a little bit unclear as to whether the
3 FDA is asking for the PD rated information directly
4 from patient organizations or whether they are
5 expecting that information to come initially from the
6 organizations and registries but be reported by
7 industry -- so?

8 MS. CHALASANI: So really clearly stating or
9 communicating the "who" that I think we're talking
10 about would be really helpful in this guidance.

11 MS. SANTIAGO: Hi, I'm Kristen Santiago with
12 the Cancer Support Community and I do want to just
13 touch on the focus of patient experience data and the
14 expansion of the definition to include psychosocial and
15 physical impacts of an agent.

16 This is something that our organization is
17 really interested in understanding the full patient
18 experience beyond just what -- how the drug works so
19 trade-offs to work/life balance -- things like that.

20 And I think that there's an opportunity going
21 forward with patient focused drugs about when to either
22 in the checklist that's used when you're capturing, you

1 know, what patient experienced data was submitted to
2 really outline was there a psychosocial data submitted.

3 And then also potentially help define some of
4 the -- the psychosocial impacts could be that people
5 can submit in their guidance or other forms of sharing
6 that information, so thank you.

7 MS. CHALASANI: Thank you, other -- other
8 comments or questions that we should address?

9 MR. HO: Hi, I'm Calvin Ho from the Tuberous
10 Sclerosis Alliance. I wanted to build on the second to
11 last question and also on Anne and Paul's opening
12 remarks. So we've discussed that a lot of patient
13 advocacy groups don't really have the resources or the
14 expertise to collect very good data, but we need very
15 good data in order to make good decisions because bad
16 data is at best, useless, and at worst very misleading.

17 So I was wondering if we could brainstorm a
18 bit about how we can help patient advocacy groups, you
19 know, collect data that will be useful to FDA?

20 MS. CHALASANI: Sure, I think Theresa outlined
21 some of the other guidances that are part of the PFDD
22 series -- really those guidances 1 through 4, so those

1 methodological guidances and I see that those are going
2 to be targeted towards the methodology to really
3 collect representing and robust data -- that's took for
4 purpose, other comments, yeah?

5 MS. KENNEDY: The one thing I do want to say
6 is that I do want to caution people that it doesn't
7 actually -- it doesn't cost a lot of money to start
8 collecting resources if you have the ability to reach
9 patients.

10 And that many of our organizations, all --
11 most of our organizations started with almost nothing
12 and one or two parents that cared and found other
13 parents, and long before social media.

14 So now in the day and age of social media, you
15 can convene a community much quicker and there is a
16 resource now through NCATS called the tool kit, the NIH
17 tool kit and I think Anne referenced it a few minutes
18 ago -- where the community came together to identify
19 across the drug development lifecycle where all of
20 these resources were so that patient organizations
21 didn't have to reinvent the wheel but could do a quick
22 swat assessment and needs assessment to figure out

1 where your community was in the drug development
2 lifecycle, where the resources you needed to build
3 where.

4 And then plug into those tools and resources
5 that had been mapped out and invented before you came
6 along so that you could benefit from others who come
7 before you and didn't have to start from scratch. And
8 those this is where industry and patient groups and
9 government -- federal partners came together and
10 developed that tool kit together.

11 It was just launched a few months ago. So for
12 those streaming and those in the room, don't feel like
13 you're starting at zero because anybody can convene and
14 build a community and do any of the things we've been
15 talking about today and you don't have to start from
16 scratch.

17 The templates have been pushed out and shared
18 and we all publish this so that people can come behind
19 us.

20 MS. PARISER: Yeah, I would agree and don't
21 sell yourself short. You can do an awful lot with a
22 little and this is especially true in diseases for --

1 that are not -- that don't have a lot of research going
2 on or a lot of information right now.

3 A little bit of information can be a
4 surprisingly big push to a research agenda. So, you
5 know, take a look at the resources that exist, look at
6 what people have done -- even a small but thorough good
7 quality data collection can be extremely informative.

8 MS. CHALASANI: Thank you. I have permission
9 to go five minutes over so I'm going to take one or two
10 and that's it. Sorry, but we have the public docket
11 so.

12 INAUDIBLE NAME: Randy (inaudible) with the
13 (inaudible) Research Foundation so I'm familiar with
14 the rare disease community. Marc's comment -- and what
15 I'm hearing today is what I've heard for the past 15
16 years. You know, patient centricity, FDA guidance, I
17 think disease specific guidance, you know, is a good
18 idea.

19 But at the end of the day in order for this to
20 work we need to have a way that the patients and
21 regulators and the sponsors are at the table,
22 literally, when these kinds of final decisions are

1 being made as far as what's acceptable risk -- what's
2 success in an outcome.

3 So the guidance is not binding patient
4 engagement of companies is advice sponsors or you know,
5 doing applications, but we can do all the guidance we
6 want but if we don't have a point where people have to
7 come together during the process, it's hard to see
8 everyone adopting this in any kind of a reasonable
9 timeframe.

10 MS. CHALASANI: Okay, thank you. Okay, I
11 think with that we're going wrap Session II. I want to
12 thank all my distinguished panelists up here, thank you
13 so much for your expertise and your insights and
14 everyone in the audience as well.

15 And now I'd like to invite Pujita Vaidya for
16 the open public comment.

17 MS. VAIDYA: Thank you Meghana and all of our
18 panelists. So this wraps up our panel session. I know
19 some folks have meetings to run to at exactly 5 o'clock
20 so I'm going to try to keep this short.

21 This is the open public comment session so if
22 you're not -- if you don't know what the purpose is for

1 this -- it's really to allow an opportunity for those
2 who have not had a chance to speak to provide their
3 comments. We ask that you, during the -- during the
4 process we ask that you -- encourage you to note any
5 financial interests that are related to your comment
6 and if you do not have such interest you may state that
7 as well.

8 So we actually have 1, 2, 3, 4, 5 -- 5 people
9 signed up for this although I do know some of you have
10 already spoken so you may -- I don't know if you want
11 to take your names off, but let's jump to it really
12 quickly. First, we have Campbell Hutton from JDRF. If
13 you could find the mic -- okay great, and you have two
14 minutes for this, thank you.

15 MS. HUTTON: Good afternoon, I am Campbell
16 Hutton as you just said, Senior Director of Regulatory
17 Affairs for JDRF and I have no financial interest to
18 disclose.

19 JDRF is the leading charitable organization
20 funding type 1 diabetes research with a mission to
21 accelerate life-changing breakthroughs to cure, prevent
22 and treat the disease.

1 It was founded by parents of children with
2 type 1 diabetes and is led by a Board of people with
3 personal connections to the disease.

4 Type 1 diabetes or T1D is an autoimmune
5 disease in which insulin-producing cells in the
6 pancreas are destroyed by the body's immune system.
7 T1D can be diagnosed at any age. Its causes are not
8 fully known and there is currently no cure.

9 People with T1D must take insulin multiple
10 times a day to survive and given the shortcomings of
11 current treatment, typically spend many hours a day
12 with blood sugar too high or too low which can result
13 in serious complications and medical emergencies.

14 JDRF strongly supports FDA's convening of this
15 public meeting and the overall effort on patient
16 focused drug development. We applaud the resources and
17 energy the agency has put into fully integrating the
18 patient voice into decision-making.

19 12 years ago, JDRF embarked on an effort to
20 work collaborative with the agency to develop a pathway
21 for regulation of novel, complex medical devices called
22 artificial pancreas systems.

1 Through this collaboration a guidance was
2 developed and within a decade our patients saw the
3 first artificial pancreas system approved and available
4 in the U.S. These tools are now revolutionizing care
5 for people with T1D.

6 And we're thrilled to be able to engage again
7 with the agency on this -- on the very important focus
8 of this meeting -- patient experience data. We have
9 found that a multi-dimensional approach to patient-
10 focused drug development that incorporates patient
11 experience, scientific evidence and clinical knowledge
12 to develop a flexible, safe and effective regulatory
13 pathway can improve therapeutic options and health
14 outcomes for people with T1D.

15 Hemoglobin A1C is the accepted surrogate
16 efficacy outcome for T1D. Advances in technology have
17 now made it feasible to measure additional outcomes,
18 but these have not been consistently defined or used.

19 Over the past two and ½ years, JDRF and the
20 leading T1D clinical organizations and other research
21 funders have come to consensus on the definitions for
22 clinically meaningful outcomes beyond HBA1-C and the

1 consensus was published in diabetes care late last
2 year.

3 A patient preference study is also being
4 conducted to quantitatively understand how patients and
5 caregivers value these outcomes. We look forward to
6 continuing to work with the agency to incorporate the
7 consensus of patients, clinicians and researchers into
8 our refined regulatory pathway for T1D therapies so
9 that the risks and benefits are fully considered and
10 people with T1D can benefit from therapies that are
11 truly clinically meaningful in their daily lives.

12 We greatly appreciate the opportunity to make
13 these brief remarks to the agency today and look
14 forward to continuing to work with you on all the
15 elements we've highlighted, thank you.

16 MS. VAIDYA: Thank you Campbell, next we have
17 Jack Mitchell from National Center for Health, and if
18 you could please limit your response to two minutes
19 please, thank you.

20 MR. MITCHELL: Good afternoon, thank you for
21 the opportunity to speak. I'm Jack Mitchell, Director
22 of Health Policy for the National Center for Health

1 Research.

2 We perform original health research, promote
3 consumer oriented health policy and legislation and we
4 focus on patient centered research and treatment. We
5 do not accept any funding from any pharmaceutical or
6 medical device company so I have no conflicts to
7 report.

8 We thank FDA for convening this worthwhile
9 workshop and we comment the agency for listening to
10 patient advocacy groups and for elevating the profile
11 of its patient affairs and engagement office -- a
12 process now only a few months old.

13 However, patients who have been harmed by a
14 medical product or have concerns about safety and
15 efficacy issues, who are not represented by many of
16 these patient advocacy groups often feel they are not
17 always listened to by FDA.

18 They tell us that patients advocating for new
19 treatments who are often affiliated with industry seems
20 to get the bulk of FDA's attention. More than 80% of
21 the patient groups receive funding from some aspect of
22 the medical industry.

1 And I'm not here to bash industry support of
2 patient advocacy groups. It greatly and furthers the
3 critical medical research in this area and it focuses
4 the agency and the public's attention on these crucial
5 medical issues, but it doesn't include all the patients
6 out there -- many of whom we hear from.

7 These patients don't read the Federal
8 Register, they don't know they're allowed to submit
9 public comments to FDA, and they have no one
10 representing them.

11 They often ask us is it worthwhile to come to
12 a meeting like this at our own expense when we don't
13 even know the morning of the meeting that we're going
14 to be allowed to speak and if so, only for two minutes.

15 So these people deserve a voice at the table
16 too, independent voices -- we're not affiliated with
17 these groups and I'd like to advocate today for their
18 presence and inclusion in the effort -- the very good,
19 very worthwhile efforts you're making which we intend
20 to cooperate with.

21 Also, I'm happy to hear that CDER and other
22 centers are reforming the ways they do personal

1 meetings with patients because it's often hard for
2 these independent patients to get in here and talk to
3 somebody who can do more than listen to them.

4 And it shouldn't take a Congressional staff or
5 an intervention by a public health organization to get
6 these independent voices of patients in here to have
7 people listen to them at FDA.

8 Doctor Gottlieb has made every effort as far
9 as I can see to meet with patient groups and take on
10 their point of view. I know he's done that because
11 we've heard from those groups so we hope that the other
12 ranking officials at FDA and the rest of you will take
13 that as a cue and expand your efforts in that regard.
14 And with that I thank you for allowing us to express
15 our views.

16 MS. VAIDYA: Thank you so much Jack. Next, we
17 have Kristin Santiago -- no okay, we're done -- great.
18 James, sorry -- James Baker -- are you in the audience
19 -- Food Allergy Research Group? Okay, and then finally
20 Jessica Eisenhower? Okay, great, perfect. So that
21 wraps up our OPC -- open public comment session. I
22 will now turn it over to Theresa Mullin for closing

1 remarks.

2 MS. MULLIN: Thank you Pujita. Alright well
3 this was a fantastic meeting for us. I mean I have to
4 say I am so glad that we said, "Let's ask people if
5 they want to hear guidance be pro-related because it
6 was extremely helpful as usual, to hear from people
7 about what would be helpful for us to be putting in a
8 guidance document.

9 So I think one of the big takeaways for us
10 which is really helpful is that the guidance on
11 guidance shouldn't just focus heavily on guidance --
12 which is really what we wondered about that and then
13 where do we go after that -- that was really helpful.
14 The air quotes took a try seeing if they could figure
15 out how to do that and see if our Reg Councils and our
16 Chief Counsel's Office will let us put air quotes
17 around the guidance.

18 But the -- to talk -- maybe but my preliminary
19 -- and we'll get, you know, we're recording this and
20 we'll go back and we've all taken notes on this but it
21 sounds like one of the things we were hearing here is
22 talk maybe first and foremost about that wider set of

1 needs for patient experience data and opportunities to
2 -- to develop that kind of information and -- and that
3 while we may not welcome something that didn't look
4 like it should be a guidance as a guidance, but we
5 really would always welcome that kind of information.

6 I think I've never heard of anybody say it's
7 not extremely useful and helpful, but we could maybe
8 try to provide a roadmap -- I was hearing a roadmap for
9 external groups who may want to collaborate -- maybe
10 working on their own, maybe collaborating with others
11 with better -- you know the kinds of groups for example
12 listed in the statutory definition.

13 Develop a roadmap and mention maybe a decision
14 tree we could try, see what formats work to help think
15 through what their disease area needs are, how -- to
16 try to get a sense of what sort of the needs, what's
17 already been done, what are they and their partners or
18 collaborators able to do and what are they resourced to
19 do?

20 And then really try to look from there what
21 the opportunities are that might be a good fit for
22 them. I mean I think we would not want to be too

1 prescriptive or algorithmic about this. I think we're
2 too early in this whole undertaking to have algorithms
3 and recipes that are all, you know, the best recipe you
4 could have.

5 So I think we're not quite ready for that. It
6 sounds like we should also consider if there are ways
7 to get input from FDA without having -- admitting of
8 every -- of every time we would like to pre-anticipate
9 a lot of these questions in the guidance document --
10 that would be the point of it.

11 To try to lay out as much as possible in the
12 document, but maybe there are times when it -- it would
13 be really helpful to consult with or talk to somebody
14 FDA about what you have in mind or, or if we know of
15 other things but -- and we will be trying to put as
16 much of that as we can to identify where -- where those
17 resources are available.

18 I mean and Anne Pariser also mentioned the
19 NCATS information that would be extremely helpful. I
20 think we also want to make clear that we're not going
21 to orchestrate what groups do, or we're not going to
22 say your -- the ideal group has X, Y and Z on it --

1 that's just not our job.

2 And I think what it would be, you know, that's
3 -- we think the best efforts will come forward from you
4 looking around and seeing what's possible and who you
5 might, can and want to work with and that -- but we
6 heard that there's a concern that that kind of a --
7 groups be -- maybe if there's something desirable there
8 about a mix -- or you don't have to do it.

9 One part is not responsible for it. Patients
10 aren't the only parties or who are supposed to be doing
11 this -- that's just -- so we make sure that that's not
12 conveyed because that certainly wouldn't be our
13 intention to convey that.

14 Try to be really clear, if we can, about who
15 can submit to make sure groups understand we're not
16 looking for just a certain type of party to make
17 submissions going back again to all those different
18 types of organizations and stakeholders listed in the
19 statute.

20 We were told to try to set the bar high and
21 make sure the expectation and the desirability of
22 meaningful engagement with patients is clear, including

1 to industry. I don't remember who coined this -- it
2 might have been I heard this at a city meeting some
3 years ago. I don't know but patient centered drug
4 development as opposed to patient centered drug
5 development and so we -- we're not interested in just
6 getting the -- you know, the sort of the odor of
7 patient involvement, we want the real thing.

8 And also, I think one thing that a good
9 suggestion was to try to identify what kinds of roles
10 in our cover page. If you have ideas about what would
11 be a good couple of categories of rules and how they
12 might be defined that would be -- make sense to you as
13 people who might be putting information into those
14 cover sheets and what kinds of governance there might
15 be and descriptors that you think might be in simple
16 definitions that you think would be meaningful to
17 outside groups who would be submitting something to us.

18 We'd really welcome hearing that and getting
19 that in the docket as well, as well as any other ideas.
20 And I hope it's understood that we -- we always do
21 webcasts for these meetings because we know people
22 can't necessarily travel here.

1 And we've made that a practice in all the
2 patient focused meetings because patients can't travel
3 and a lot of people can't get here, not just because
4 they don't have resources but they are physically
5 unable sometimes or they can't leave home.

6 So I think that hopefully that a lot of these
7 folks have been able to participate in the webcast
8 today and we've made that a regular practice and submit
9 information to the docket if they have ideas.

10 And so with that I thank you so much today. I
11 can't tell you, this has been so helpful to us in
12 moving forward with writing this air quotes -- guidance
13 on guidance document and we'll be looking to get a
14 draft of this done before the end of the fiscal year.

15 Of course, the federal fiscal year ends in
16 September so that would be our -- our time frame for
17 trying to aim to get out a draft guidance. Again,
18 thank you so much and I hope that you're travels home
19 are without any incident so with getting home today so
20 thanks again for coming here today and being on the
21 webcast.

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CERTIFICATE OF NOTARY PUBLIC

I, KEVON CONGO, the officer before whom the foregoing proceeding was taken, do hereby certify that the proceedings were recorded by me and thereafter reduced to typewriting under my direction; that said proceedings are a true and accurate record to the best of my knowledge, skills, and ability; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this was taken; and, further, that I am not a relative or employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.



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I, HELEN VENTURINI, do hereby certify that this transcript was prepared from audio to the best of my ability.

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03/29/2018

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