DELEGATED ACT ON THE DETAILED RULES FOR A UNIQUE IDENTIFIER FOR MEDICINAL PRODUCTS FOR HUMAN USE, AND ITS VERIFICATION

NOVEMBER 2011 CONCEPT PAPER SUBMITTED FOR PUBLIC CONSULTATION

RESPONSE FROM THE UK

Consultation Topic 1: Characteristics and technical specifications of the unique identifier.

Policy option n°1/1: Leaving the choice of the technical specification to the individual manufacturer

Policy option n°1/2: Harmonisation through regulation

The UK would prefer the delegated act to specify the technology to satisfy the requirements of the Directive, and for these technologies to be harmonised across the Community. We strongly believe that harmonisation is the only viable option that will meet the principles of better regulation, particularly transparency and efficiency.

Leaving the choice of system to the individual manufacturer will substantially increase the burden on the "downstream" supply chain, and it will also mean that any other player in the supply chain required to verify the unique identifier will need an array of identifier readers.

Advantages of a single unified system include:

- Member States will have a common understanding, and sight of, the technology required to read the identifier.
- Industry will have a common understanding of the format of the identifier, and the expectations of Competent Authorities when applying for marketing authorisations.

2.1. Regulation of the composition of the serialisation number

2.1.1. Manufacturer product code and pack number

Consultation item n°2: Where do you see the advantages and disadvantages of the approach set out in point 2.1.1.?

The proposal is that the serialisation number should include a manufacturer product code (which includes a prefix of the country) and a unique identification number of the pack.

Ideally the manufacturer product code should be a single code for a product from a manufacturer identifying the country. There needs to be clarity about the country identified in the code and whether it refers to the country of origin, importation or final destination. The increasing global nature of the pharmaceutical manufacturing chain creates difficulty in identifying the 'country' of manufacture for this purpose and increasing numbers of medicines are imported into the EU from third countries. However, all batches require QP certification before release and hence the most

appropriate and consistent country code would be that of the site of batch release to the intended market.

The physical size of what has to be affixed to each pack is a consideration for small packs of medicines and could have a significant effect on pack design, and therefore costs, which will add to the cost of medicines purchased by national healthcare schemes.

The paper suggests that serialisation numbers will be randomly generated. It is not clear how or by whom:

- will the manufacturer/MAH generate the number as part of the manufacturing process, or
- will an organisation (e.g. GS1) issue a block of unique codes to the manufacturer/MAH.

The information contained in the carrier of the serialisation number should be as simple as possible (for example, just the manufacturer's ID and unique identifier). Any additional information (such as reimbursement codes, batch numbers and expiry dates) could be linked to the unique identifier through the repository system. Information held in the repository system (such as batch number, expiry date) could be retrieved when the medicine is scanned.

This more simple mechanism could mean that a linear barcode could be used to verify pack authenticity, which would reduce technology costs. Any additional requirements for individual Member States could be retrieved from information held about the medicine in the repository database. This could also allow for inclusion in and access from the repository of information required by a Member State for other purposes, such as patient safety.

As medicines are increasingly manufactured outside the EU for a global market the system also needs to take account of developments such as serialisation requirements in India, otherwise we are in danger of having a multiplicity of international requirements. The system selected by the EU should not add complexity through additional (or conflicting) serialisation numbers. It should be possible to agree to a single system to fulfil all regulatory requirements. This is particularly relevant to the UK because a significant proportion of medicines supplied within the national health service is manufactured in third countries and imported.

2.1. Regulation of the composition of the serialisation number

2.1.2. Additional product information

Batch number and expiry date

Consultation item n°3:
Where do you see the advantages and disadvantages of the approach set out in points (a) and (b) of point 2.1.2? Please comment.

The requirement for holders of distribution authorisations to record the batch numbers of, at least, medicines subject to the safety provision feature, suggests that the inclusion of the batch number in the serialisation number would be useful.

The inclusion of batch number and expiry date into the serialisation feature could prove useful in providing traceability in particular where such information is relevant to administration (such as is the case with vaccines) or handling (such as recording of batch numbers at wholesale level).

However, as stated above, it is not necessary for the information to be held in the serialisation feature as it could be linked with the unique identifier through the repository. This approach could also serve to reduce the costs of implementing this technology.

However, both batch number and expiry date should also be presented in a human readable form as this information will be relevant to patients, healthcare professionals and members of the general public, if a medicine has to be recalled.

2.1. Regulation of the composition of the serialisation number

2.1.2. Additional product information

National reimbursement number

Consultation item n°4:
Which of the two options set out under point (c) of point 2.1.2 is in your view preferable? Where do you see advantages and disadvantages? Please comment.

The UK does not have a reimbursement system that relies on product codes and there would be no benefit to the UK in including reimbursement numbers in the coding of the serialisation number. As with other aspects of the proposed identification regime, we believe this information could be held in the repository/ies and retrieved from there as required rather than held in the unique identifier on each pack. This approach would meet the needs of Member States who currently make use of such codes, exempt those that do not, and provide the flexibility for other Member States to implement such a system should they wish to do so in the future.

2.2. Regulation of the technical characteristics of the carrier

2.2.1. Linear barcode

2.2.2. 2D-Barcode

2.2.3. Radio-frequency identification (RFID)

Consultation item n°5:
Please comment on the three concepts described under point 2.2. Where do you see the benefits and disadvantages of each of the three concepts. What are the costs for each concept? Please quantify your reply, wherever possible, by listing for example:

- costs for reading devices for the different carriers;
- costs for adapting packaging lines of medicines packaged for the EU market.

If a decision is made to include several fields of information in the serialisation feature, and not the minimum necessary (and using a retrieval mechanism for accessing additional information required as suggested above), it is unlikely that linear barcodes would provide a satisfactory mechanism because they may not be capable of carrying sufficient information to manage the multiplicity of packs across Europe.

Use of linear barcodes is widespread, including in healthcare systems. However, whilst the 2D barcode is increasingly used in retail environments, and presents the opportunity to store substantially more information than linear barcodes, the technology required to read 2D barcodes

is not currently widely available in the pharmaceutical manufacturing, wholesale, and retail sectors. Nor is it routinely used in hospitals where medicines are often dispensed to patients on wards or other healthcare settings where medicines are supplied in the UK, such as GP clinics.

The use of RFID is likely to be substantially more expensive than other options and, importantly from the point of view of quality of medicines, the radiation risks to products have not been fully established.

More generally, the introduction of serialisation is likely to have a significant effect on packing line speed, in particular if randomisation codes are integrated *in situ* and applied as part of the manufacturing process rather than applied to batch packaging ahead of final assembly. There may be technical barriers to the application of barcodes containing contemporaneously randomised information on pharmaceutical packing lines, and feedback from industry will be particularly important in this respect.

The system must provide both resilience and reliability – especially as whatever model is adopted will need to accept information from the act of scanning and also be able to feedback instantly - at least a confirmation that the product scanned has been recognised. The supply of potentially life saving medicines should not be dependent on the reliability of any computer network on which the repository is based. This needs to be reflected in the delegated act.

Whichever carrier is chosen, a means for dealing with contingencies for failure of the technology is essential so that manual reading can be undertaken without holding up time-critical and high volume processes. Linear barcode formats are commonly associated with human-readable digits whereas 2D barcodes and RFID usually are not.

Consultation Topic 2:
Modalities for Verifying the Safety Features

Consultation item n°6:
Regarding point 1 (policy option n°2/1), are there other points of dispensation to be considered? How can these be addressed in this policy option?

Consultation item n°7:
Please comment on the three policy options set out in points 1 to 3. Where do you see the benefits and disadvantages? Please comment on the costs of each of these policy options. Quantify your response, wherever possible.

This applies in particular to the:

- **number of wholesale distribution plants;**
- **costs for adapting such plants;**
- **duration of scanning of the serialisation number;**
- **number of pharmacies, including hospital pharmacies;**
- **number of medicinal products dispensed by pharmacies and a hospital pharmacy.**

There is an assumption in all the options provided in the Concept Paper that medicines subject to the safety feature provision and therefore included in the repository system must, at some point,

be checked out. The UK does not accept that this is the only possible model and indeed, such a model may not be able to take account of the important criteria set out on the face of the Directive. In particular, Article 54a(2)(d) emphasises that "When establishing those modalities, the particular characteristics of the supply chains in Member States, and the need to ensure that the impact of verification measures on particular actors in the supply chains is proportionate, shall be taken into account".

There is also an assumption that verification of the serialisation feature is mandatory at point of dispensing. Article 54(o) of the Directive does not mandate scanning at the point of dispensing. It requires that the safety features should enable the authenticity of individual packs (and evidence of tampering) to be verified and enable individual packs to be identified, but it does not mandate this practice. The agreed use of these terms in drafting the Directive were intended to protect the interests of Member States for whom mandatory scanning at the point of dispensing would present significant challenges.

The UK argued strongly during the negotiations of the Directive to ensure that scanning at the point of dispensing would not be mandatory because of the very significant challenges this would pose for healthcare providers in the UK. For example:

- there are around 11,000 community pharmacies in England which would all require at least one scanner;
- there is a large number of wide-ranging healthcare professionals and other organisations authorised to supply medicines to the public in the UK such as GP practices, optometrists, physiotherapists, dentists etc;
- over 900 million NHS prescription items are currently dispensed annually in the UK, with the average number of items dispensed per pharmacy per month being around 6,500;
- systematic check-out of the serialisation number at the point of dispensing would be problematic where contents of the pack are used to supply more than a single patient;
- many non-prescription medicines are made available to the public in supermarkets and other general stores. If some non-prescription medicines become subject to the safety feature requirement because of evidence of counterfeiting they too will have to have to be connected to the system and be provided with the scanners.

Introducing mandatory scanning at the point of dispensing will require a huge financial outlay to provide the necessary scanners and high speed, high capacity, resilient connectivity to the repositories at all healthcare outlets. The additional ongoing costs of the technology and time taken to comply with the requirements throughout the healthcare system and beyond will be reflected in increased prices and increased professional fees.

The UK believes that the Commission must meet the obligation on the face of the Directive that the approach must be proportionate to the risk that counterfeits represent. There is currently no evidence to suggest that the risk from counterfeits in the EU warrants the establishment of a regime that the proposals in the Concept Paper implies. Furthermore, the UK does not believe that the proposed approach takes account – as required – of the particular characteristics of the supply chains in the UK or the impact of the verification measures on particular actors in those supply chains.

In order to meet the criteria set out on the face of the Directive the regime that the Commission proposes will have to be sufficiently flexible to:

- allow identification of individual packs of medicines and ensure their authenticity as required as they move through the supply chain;
- meet the obligation for wholesale dealers to undertake the check mandated for medicines subject to the safety feature in Article 80 (ca);
- not rely on "checking out" at any point in the supply chain as the sole means to ensure medicines are not deemed to be counterfeit;
- not mandate scanning at the point of dispensing;
- permit those Member States that want or need to mandate scanning at the point of dispensing (eg for reimbursement or fraud purposes).

The regime could, for example allow spot-checking at Wholesale Dealer level but not again later in the supply chain. This would better address the requirement for proportionality in the application of point of supply scanning. However, the UK has some 1,800 wholesale dealer licence holders. Introducing the scanning operation may still present a significant burden to high volume operations. The adoption of scanning technology may present a significant burden to low volume operations. In addition, wholesale dealers will have to break open shipping packs to verify the products contained within.

Policy option n°2/1:
Systematic check-out of the serialisation number at the dispensing point

The UK cannot support this option. We do not see that systematic checking out of the system has to be built into the system to allow checking for counterfeits. We do not believe that the Commission has the right under the Directive provisions to propose a scheme that mandates checking out at point of dispensing. Because of the diversity of medicines supply in the UK. such a regime would introduce disproportionate costs on the UK national health system which contravenes requirements on the face of the Directive. Neither does this option provide the means for wholesale dealers to comply with Article 80(ca).

Policy option n°2/2:
As in policy option n°2/1, but with additional random verifications at the level of wholesale distributors

The same arguments to those provided for policy option 2/1 apply to the pharmacy level check out. The random verifications proposed here should apply throughout the supply chain in order to meet the criteria on the face of the Directive.

Policy option n°2/3:
As in policy option n°2/1, but with additional systematic verification by the wholesale distributors

The UK cannot support systematic checking at any point in the supply chain. Such a regime would not meet the criteria set out on the face of the Directive for proportionality, and the need to ensure that the regime takes account of different national supply chains and economic operators.

Consultation Topic 3:
Provisions on the Establishment, Management and Accessibility of the Repositories System

Policy option n°3/1:
'Stakeholder governance'

Policy option n°3/2:
EU governance

Policy option n°3/3:
National governance

Consultation item n°8: Please comment on the three policy options set out in points 1 to 3. Where do you see the benefits and disadvantages? Please comment on the costs of each of these policy options. Please quantify your reply, wherever possible. This applies in particular to the estimated one-off costs and running costs for a repositories system. Where possible, please provide information on past experiences with a repositories system at individual company level and at national level (taking into account the experiences of Member States and companies).

A repository system solely governed by its “stakeholders” (industry) would carry a risk that the system could easily become fragmented. There would also be a potential conflict of interest between those holding the information and those using it.

Policy options 2 and 3 seem to present the best opportunity for harmonisation, which will be essential given the scope of the project.

EU governance would present a particular advantage for ensuring harmonisation across Member States, but could also be complex and expensive.

National governance could present advantages for local oversight, in particular meeting the needs of a Member State, whilst ensuring an acceptable degree of harmonisation to an agreed common database standard. However, it is not clear from the Concept Paper what Member States will be expected to put in place in order to meet the obligation that national repositories should be governed by official national bodies established by Member States. The UK would be concerned to ensure that any such regime was proportionate.

Other issues related to the repositories system

4.1. Information of a commercially sensitive nature

Consultation item n°9: Please comment on point 4.1. Are there other items of information which should be taken into consideration when addressing the issue of commercially sensitive information in the delegated act?

It is not clear in the Concept Paper what information will be made available to different parties involved in the supply chain. There is clearly a need to ensure that the regime can protect

commercially sensitive information about products from others who may have an interest in exploiting the data for their own ends. However, we agree that there is a strong case for regulatory authorities to have access to all the information held in the repository for supervision, control and inspection/enforcement activity.

4.2. Protection of personal data
4.3. Re-packaging of medicinal products

Consultation item n°10: Please comment on points 4.2 and 4.3. What aspects should be taken into consideration in the delegated act?

We assume that as there is no need for storage of personal data there is thus no danger that a particular medicine can be linked to a particular patient.

Re-packers would need to have access to certain information in order to carry across into the new serialisation feature. This would vary from country to country as Member States may have different requirements for information held in the repository. The linkage between the original serialisation and re-packaged serialisation would need to be maintained in the repository for traceability.

Any systems introduced should not have the effect of impeding parallel trade.

Consultation Topic 4:
Lists Containing the Medicinal Products or Product Categories Which, in the Case of Prescription Medicines Shall Not Bear the Safety Features, and in the Case of Non-Prescription Medicines Shall Bear the Safety Features

Identification criteria

Consultation item n°11:
Which approach seems the most plausible from your view? Can you think of arguments other than those set out above? Can you think of other identification criteria to be considered?

We question the implications for the “black” and “white” lists at a European level if a Member State chooses to extend in their territory the scope of application of the unique identifier to all prescription medicines for the purposes of reimbursement or pharmacovigilance (article 54(a)5)?

There will also be problems arising because the classification of medicines is not harmonised across the EU. For example, in the UK many medicines that remain subject to medical prescription elsewhere in the EU have been re-classified to non-prescription status. They are therefore unlikely to be subject to the safety feature provision when supplied for the UK market. However, if purchased for export to another Member State, the distributor will become responsible for applying the required safety feature (not simply replacing a pre-existing safety feature). The regime will need to take account of the need for these distributors to obtain access to the source of unique identifiers in these circumstances.

In terms of the identification criteria that could be used, identification by brand name could make it easier to specify particular products, and exclude others falling into the same therapeutic class or

active substance. However, restricting identification to brand name alone, without reference to approved (INN) name, could make it difficult to include generic versions of the medicine, should that be required. None of the options will meet all requirements and so we have concluded that a case-by-case approach to identification of medicines to be included within the scope of the safety feature would be preferred and the most adaptable.

More generally, whichever identification criterion is used it may be necessary to distinguish in the lists whether the safety feature provision applies to all pack sizes and all strengths/ presentations.

The lists should be dynamic and flexible and not rely on complex legal procedures to update. For this reason we would suggest that if it is possible to do so within the provisions of the Directive, these lists should not be annexed as a part of the delegated act, but published on the Commission's website. This would enable them to be updated quickly as necessary.

Applying the classification criteria

Consultation item n°12:
Please comment on the quantified approach set out above.

In terms of applying the classification criteria, there are difficulties inherent in establishing a price limit as the price of medicines varies significantly across Member States. Furthermore, the initial price limit set (€2) in the preamble to this section, seems very low and would apply to the majority of products on the market, which the UK considers to be disproportionate in terms of the costs of inclusion of these medicines and the risks of counterfeiting .

We disagree with the classification that low volume products necessarily present a low risk of falsification. Profitability is obviously a significant factor and low volume, high value products are quite likely to be perceived to offer good margins. However, whatever approach is adopted, it will be important to ensure that it can take proper account of submissions made for exclusion from the scope of the safety feature for particular categories of medicines such as low priced prescription generic medicines.

In summary, this is an area in which we believe we need to retain some flexibility. The proposed model could be developed and then further refined with experience. There would necessarily need to be a mechanism for including products on either list which would not be included on the basis only of an assessment by such a model.

Consultation Topic 5:
Other Issues

Consultation item n°13: Please raise any other issue or comment you would wish to make which has not been addressed in the consultation items above.

We note that the Directive prohibits any extension of the scope of the safety feature – especially the unique identifier – beyond medicines specified at EU level except for purposes of reimbursement or pharmacovigilance. For Member States that have no mechanism for using the technology for reimbursement purposes the unique identifier could, if it were permitted to apply it

to any medicine, provide information useful for other purposes. This could include reducing medication errors arising from “picking” the wrong medicine to dispense against a prescription. We note that the legal interpretation of “pharmacovigilance” in the context of this provision does not extend to “for the purposes of reducing human error”. Thus Member States are prevented from using this technology to fulfil broader health-related aims which may have made the regime overall more attractive and cost efficient.