



On the Subject

FDA 2016 Year-in-Review

Veleka Peeples-Dyer, Vernessa T. Pollard, Michael W. Ryan,
Vanessa K. Burrows, Shelby Buettner and Anisa Mohanty

The enactment of the 21st Century Cures Act signaled the close of a multi-year bipartisan effort on Capitol Hill to grant the US Food and Drug Administration (FDA) new authorities to expedite product development and reform clinical trial design. FDA also issued important rulemakings and guidance documents throughout 2016, although the agency's publication of regulations and guidance documents increased after the enactment of the law. In the final days of 2016, FDA issued guidance to explain its interpretation of certain Cures Act provisions and to stake out legal positions before the start of the Trump administration.

This *Special Report* highlights notable FDA regulations, guidance and enforcement actions in 2016, as well as select developments in product promotion and communication of health care economic information to payors that occurred prior to the start of the Trump administration on January 20, 2017.

FDA's 2016 regulatory agenda was marked by a competing emphasis on loosening regulatory barriers to market entry for innovative treatments while expanding oversight of previously unregulated tobacco products, cybersecurity and pre-clinical research, among others. While changes can be expected under the Trump administration—starting with the delayed effective date for FDA regulations and guidance documents published in the *Federal Register* that did not take effect prior to January 20, 2017, and postponed notice-and-comment

rulemakings¹—FDA's areas of focus in 2016 offer insight and guidance for regulated entities as to agency priorities in 2017.

A. Incentives for Innovative Products, Treatments and Technology

The [21st Century Cures Act](#) was the most important piece of FDA legislation enacted in 2016. The bipartisan law encourages biomedical research investment and facilitates innovation in the discovery, development and review of medical products. The [medical device provisions](#) update the process for exempting certain Class I and II devices from premarket notification requirements, increase the number of diseases to which a humanitarian device exemption may be applicable, and speed the review process for breakthrough devices. The [drug provisions](#) of the law expedite review processes for certain drugs and encourage consideration of data other than data produced in randomized clinical trials to support approval. Additionally, the Act [streamlines clinical research](#) through efforts such as harmonization of human subject research protections and informed consent requirements across agencies.

The Act also funds cancer research, opioid abuse prevention and treatment, and mental health treatment while enhancing collaboration between agencies and in public-private partnerships. For a comprehensive look at the law's health care, FDA and other provisions, [click here](#).

B. Medical Devices—FDA Actions Respond to Technical and Global Changes

¹ Memorandum for the Heads of Executive Departments and Agencies from Reince Priebus, Assistant to the President and Chief of Staff, Regulatory Freeze Pending Review (Jan. 20, 2017), <http://www.politico.com/f/?id=00000159-be8f-da97-a9dd-becf15ae0001>.

In 2016, FDA issued three final and three draft medical device guidance documents of note. The agency's guidance on cybersecurity, classification of devices that are accessories, software changes and low-risk devices demonstrates that FDA is addressing new technologies and the risks, or lack thereof, posed by devices that incorporate such technologies. Additionally, FDA is taking steps to harmonize its evaluation of software as a medical device and its third-party review program for 510(k) premarket notifications with international quality and other standards, as demonstrated in two guidance documents discussed below.

1. *Postmarket Management of Cybersecurity*

FDA's final guidance on [Postmarket Management of Cybersecurity in Medical Devices](#) outlines FDA's recommendations for managing postmarket cybersecurity vulnerabilities in medical devices that contain software or programmable logic, software that is a medical device, devices that are part of an interoperable system, and legacy devices. The agency notes that cybersecurity risks that are not proactively addressed pose risks to health. As a result, manufacturers should remediate vulnerabilities to reduce the risk of patient harm if a device's cybersecurity vulnerability is exploited. FDA encourages manufacturers to address cybersecurity in all phases of the product lifecycle and to adopt the National Institute of Standards and Technology Framework for Improving Critical Infrastructure Cybersecurity.

The guidance announces FDA's expectation that manufacturers will implement and document cybersecurity risk management programs as part of compliance with the Quality System Regulation's provisions on complaint handling, quality audits, corrective and preventive actions, software validation and risk analysis, and servicing. The guidance also informs manufacturers as to when an enhancement or other change to a marketed device to address a cybersecurity vulnerability would trigger FDA's reporting requirements for device corrections and removals.

2. *Software as a Medical Device*

FDA released, as a draft guidance, a document produced by the International Medical Device Regulators Forum

(IMDRF)²—[Software as a Medical Device \(SAMD\): Clinical Evaluation](#). The guidance defines SAMD as software intended to be used for one or more medical purposes that perform these purposes without being part of a hardware medical device. Mobile apps that meet this definition are considered SAMD. The guidance explains that a clinical evaluation is the assessment and analysis of clinical data pertaining to a medical device to verify its safety, effectiveness and performance. For SAMD, a clinical evaluation that generates adequate scientific evidence to (1) create transparency and (2) assure confidence in the SAMD's clinical validity for the SAMD's intended purpose and indications of use may provide reasonable assurance of safety, effectiveness and performance. The guidance assists manufacturers, FDA and international regulators by explaining relevant clinical evaluation methods and processes that can be used to generate clinical evidence for SAMD; the required level of clinical evidence for different types of SAMD; and categories of SAMD where independent review may be required to provide users with confidence in the SAMD's clinical validity. Although FDA has yet to issue guidance on clinical decision support (CDS) or the application of medical device Quality System Regulation principles for medical apps and software, the draft SAMD guidance lays the groundwork for future guidance clarifying the boundaries of FDA's regulatory oversight for CDS and its expectations for medical software quality management systems.

3. *Classification of Devices That Are Accessories*

FDA's final guidance on regulation of accessories to medical devices explains how FDA plans to interpret new language in the 21st Century Cures Act that permits the agency to classify an accessory based on the *accessory's* intended use, not the classification of the *device* with which the accessory is intended to be used.³ In [Medical Device Accessories – Describing Accessories and Classification Pathway for New Accessory Types](#), FDA notes that some accessories to a Class III device may pose lower risks than the parent device and could be regulated as Class I or II devices (*i.e.*, software products that meet the definitions of (1) software as a medical device and (2) an accessory). Similarly, an accessory to a

² FDA representatives participate in the IMDRF, which is a voluntary group of medical device regulators from Australia, Brazil, Canada, China, Europe, Japan, Russia, Singapore and the United States.

³ Pub. L. No. 114-255, § 3060(c) (amending 21 USC § 360c(b), FDCA § 513(b)).

Class II device could be regulated as a Class I device. As a result, the guidance instructs manufacturers on the *de novo* classification process. Manufacturers may use that process to request Class I or II classification of low- to moderate-risk accessories of a type that has not previously been classified, cleared or approved. To determine the appropriate classification of the accessory, FDA will examine the risks imposed by the accessory's impact on the parent device, as well as unique risks of the accessory alone.

The final guidance also clarifies what devices FDA will consider accessories. FDA will classify an article as an accessory if the article is marketed as intended for use with a parent device and is intended to support, supplement and/or augment the performance of a parent device. As such, FDA generally will not consider mobile phones and computer monitors used to view medical data to be accessories unless the phone or monitor is specifically intended for use with a device.

4. 510(k) Requirements for Modified Devices

Rather than addressing software changes that necessitate the submission of a 510(k) in FDA's long-awaited draft guidance, [Deciding When to Submit a 510\(k\) for a Change to an Existing Device](#), FDA issued a separate draft guidance focused on infrastructure, architecture, core algorithm and other software changes. In [Deciding When to Submit a 510\(k\) for a Software Change to an Existing Device](#), FDA clarifies, and provides a flow chart to help manufacturers decide, when a software change to an existing device requires a new 510(k). FDA's device regulation, 21 CFR § 807.81, provides that premarket notification is required for modifications that could significantly affect the device's safety or effectiveness, and for a major change or modification in the device's intended use. The guidance sets forth FDA's interpretation of this regulation.

According to the guidance, changes to strengthen cybersecurity and restore the device to its most recently cleared specifications likely do not require a 510(k). However, a new 510(k) is likely required for software changes that:

- Introduce a new cause of a hazardous situation (the potential for exposure to physical injury or damage to health) that could result in significant harm and that is not effectively mitigated in the most recently cleared device

- Modify an existing cause of such a hazardous situation that is not effectively mitigated
- Introduce a new hazardous situation that is not effectively mitigated
- Modify an existing hazardous situation that is not effectively mitigated
- Create or require a new risk control measure for such a hazardous situation
- Modify an existing risk control measure for such a hazardous situation
- Significantly affect clinical functionality or performance specifications directly associated with the device's intended use

The guidance does not apply to software changes in certain low-risk mobile applications for which FDA intends to exercise its enforcement discretion. A summary of both draft guidance documents is available [here](#).

5. General Wellness Products

FDA published a final guidance titled [General Wellness: Policy for Low Risk Devices](#), in which the agency announced that it would not (1) examine low-risk general wellness products to determine if they were devices under the Federal Food, Drug, and Cosmetic Act (FDCA), or (2) require such products to meet pre- and postmarket requirements for devices. General wellness products are low-risk products that promote a healthy lifestyle, such as products that claim to promote sleep management or track sleep trends. FDA's guidance explains which general wellness products will fall under the guidance, provides many examples of such products, states the types of devices that are not low risk and would not qualify under the policy, and includes a framework with questions to determine whether a general wellness product falls under the guidance. See a summary of the guidance [here](#).

6. International Harmonization: FDA's 510(k) Third-Party Review Program and the Medical Device Single Audit Program

FDA has statutory authority to accredit or recognize third parties to review premarket notification (510(k)) submissions. Under the program, third-party review organizations conduct a

premarket review that is the equivalent of the FDA's review of a 510(k) submission. The third-party review organizations recommend the initial classification of certain devices to FDA, specifically, Class I and II devices, except (1) Class II devices intended to be permanently implantable, life sustaining or life supporting; (2) devices that require clinical data; and (3) combination products or 510(k) reviews that require multi-center consultation.

In 2016, FDA attempted to harmonize its 510(k) third-party review program with the IMDRF's Medical Device Single Audit Program (MDSAP) by issuing draft guidance that cross-referenced international standards in IMDRF documents. The IMDRF documents form the basis of the MDSAP, which was designed to provide one audit that would cover FDA's Quality Systems Regulation, ISO 13485, and other quality management system requirements. FDA's [510\(k\) Third Party Review Program](#) draft guidance tracks IMDRF documents to the extent permitted by mandatory language in the FDCA and FDA regulations. The guidance describes FDA's requirements and recommendations for the recognition of a third-party organization to conduct a 510(k) review. The draft guidance also replaces a 2013 draft guidance document and, when finalized, will supersede all or part of two other guidance documents.⁴

C. Increasing Oversight of Early Stage Research

FDA and the US Department of Health and Human Services (HHS) issued several proposed and final rules and guidance documents designed to solicit additional information, strengthen quality requirements, and provide recommendations on data used to support bioequivalence or biosimilarity.

1. Clinical Trials

The HHS final rule, [Clinical Trials Registration and Results Information Submission](#), requires the sponsor or designated principal investigator to submit to ClinicalTrials.gov certain clinical trial registration and results information for drug, biological and device products, and for pediatric postmarket

⁴ The draft guidance replaces one draft guidance on third-party review—the 2013 draft guidance Accreditation and Reaccreditation Process for Firms under the Third Party Review Program; Part I. When finalized, the draft guidance will supersede two final guidance documents on third-party review: (1) the 2001 final guidance Implementation of Third Party Programs Under the FDA Modernization Act of 1997, and (2) the 2004 final guidance Third Party Review of Premarket Notifications, with the exception of [Appendices 2–4](#) of the 2004 guidance document.

surveillance of a device. The rule is generally consistent with the European Medicines Agency's regulatory efforts to encourage clinical trial transparency. The rule requires sponsors or designated principal investigators to submit information for unapproved, uncleared or unlicensed products. In addition to modifying initial and ongoing reporting deadlines, the rule also broadens the type of results information that must be reported. The rule does not apply to Phase I drug trials or small feasibility device studies. The rule took effect prior to the Trump administration, although affected parties have an additional 90 calendar days after the January 18, 2017, effective date to comply.

2. Good Laboratory Practice

FDA's proposed rule on [Good Laboratory Practice for Nonclinical Laboratory Studies](#) would amend the Good Laboratory Practice regulations to require a complete quality system approach when nonclinical laboratory studies are intended to support product applications or submissions. The rule aims to ensure the quality and integrity of data used to support FDA regulatory decisions. Additionally, the proposed rule would alter responsibilities for animal welfare and encourage entities to reduce, refine and replace animal use in testing. The proposed rule also would address requirements for nonclinical research involving tobacco products. See a detailed summary of the proposed rule [here](#).

D. New Product Approval Pathways and Decreasing Barriers for Generic Product Market Entry

1. Citizen Petitions to Delay Approval of NDAs, ANDAs and BLAs

In a November 2016 final rule, [Amendments to Regulations on Citizen Petitions, Petitions for Stay of Action, and Submission of Documents to Dockets](#), FDA revised its procedural regulations to implement the statutory requirement⁵ that such petitions not be used to improperly delay approval of pending Abbreviated New Drug Applications (ANDAs), 505(b)(2) New Drug Applications (NDAs) or Biologics License Applications (BLAs) submitted under § 351(k) of the Public Health Service Act (PHS Act). The final rule provides that FDA must not delay approval of these applications unless the agency receives a

⁵ 21 USC § 355(q).

written citizen petition⁶ or a petition for stay of action,⁷ and determines the delay is necessary to protect the public health.

FDA has [expressed concerns](#) that the statutory requirement does not discourage the submission of petitions that are intended primarily to delay approval of a competitor's drug and do not raise valid scientific issues.⁸ Additionally, several antitrust and unfair competition cases have challenged the use of citizen petitions filed by drug manufacturers in order to delay approval of competitor products.⁹

2. Bioequivalence Recommendations for Specific Products

FDA announced the availability of several draft [Product-Specific Bioequivalence \(BE\) Recommendations](#) for the development of generic drug products. A generic drug is bioequivalent to a reference listed drug if there is no significant difference between the generic drug and the listed drug in the rate and extent of absorption. FDA's intent in publishing the draft guidances is to facilitate the availability of generic drugs and to aid the generic drug industry by identifying the most appropriate methodology for developing drugs and generating evidence that supports ANDA approval. The draft guidances list the number and types of recommended studies that FDA advises applicants to use to demonstrate BE for particular drugs.

3. Biological Products and Biosimilars

In its draft guidance, [Implementation of the "Deemed to be a License" Provision of the Biologics Price Competition and Innovation Act of 2009](#) (BPCIA), FDA explains its interpretation of statutory language declaring that applications for biological products approved under an NDA or ANDA on or before March 23, 2020, shall be "deemed to be a license" for a biological product under § 351 of the PHS Act on March 23, 2020. The draft guidance provides that, as of March 23, 2020, all approved NDAs and ANDAs for biological products will be replaced by BLAs. FDA notes that the transition period will

affect protein products and products such as insulin, insulin mix and insulin analog products.

Any NDAs or ANDAs for biological products pending or tentatively approved (as the result of unexpired periods of patent or exclusivity protections) on March 23, 2020, may be resubmitted under § 351 of the PHS Act. FDA will not approve any NDAs or ANDAs for biological products on or after March 23, 2020. On March 23, 2020, FDA will also remove NDAs and ANDAs for biological products from *Approved Drug Products with Therapeutic Equivalence Evaluations* (Orange Book). Additionally, unexpired periods of exclusivity associated with approved NDAs for biological products will end, and any patents listed in the Orange Book will not be relevant for determining the time of approval of an NDA under FDCA 505(b)(2) or of an ANDA. The draft guidance provides recommendations for sponsors of development programs for proposed protein products.

In a separate guidance implementing BPCIA, [Clinical Pharmacology Data to Support a Demonstration of Biosimilarity to a Reference Product](#), FDA provides specific recommendations on the design and use of clinical pharmacology studies to support a demonstration of biosimilarity to an FDA-licensed reference product. Biosimilarity means a biological product is highly similar to the reference product and there are no clinically meaningful differences between the biological product and the reference product in terms of the product's safety, purity and potency. The guidance discusses critical considerations for the use of clinical pharmacology studies to support biosimilarity. The guidance also addresses the development of clinical pharmacology data and critical topics that sponsors should discuss with FDA. For example, FDA explained that clinical pharmacology studies should be conducted in healthy subjects when safe and ethical, as such studies are considered more sensitive in evaluating product similarity and are likely to produce less variability than a study in patients with disease and medication factors.

D. Greater Emphasis on Improving Postmarket Product Safety

FDA issued an increasing number of warning letters for medical device reporting and complaint handling, *i.e.*, underreporting and inadequate corrective and preventive

⁶ 21 CFR § 10.30.

⁷ 21 CFR § 10.35.

⁸ FDA, Report to Congress, Eighth Annual Report on Delays in Approvals of Applications Related to Citizen Petitions and Petitions for Stay of Agency Action for Fiscal Year 2015 (July 29, 2016).

⁹ See, e.g., *In re: Prograf Antitrust Litig.*, Civ. No. 1:11-cv-02242 (D. Mass. Feb. 3, 2016); *In re: Suboxone (Buprenorphine Hydrochloride and Naloxone) Antitrust Litig.*, No. 13-MD-2445, 2017 WL 36371 (E.D. Pa. Jan. 4, 2017).

actions.¹⁰ Agency warning letters also focused on sterility issues, active pharmaceutical ingredients and data integrity,¹¹ process validation and quality management systems. Additionally, FDA issued several rules and guidance documents aimed at improving product safety.

1. Medical Device Reporting

FDA finalized its [Medical Device Reporting for Manufacturers](#) guidance with significant changes from the 2013 [draft guidance](#). In the 2013 draft, the agency sought adverse event reports from the contract manufacturer and the specification developers. In the 2016 final guidance, FDA reversed its position and stated that a contract manufacturer that does not distribute or market the device would not have a medical device reporting obligation. The final guidance also removed language from the 2013 draft guidance advising manufacturers to report a malfunctioning device even if the user intervened before any harm to the patient occurred.

2. Postmarketing Safety Reporting for Combination Products

The combination product and constituent part industries have struggled with overlapping regulatory frameworks and postmarketing safety reporting (PMSR) requirements, which FDA has said can result in inconsistent and incomplete PMSR. FDA's [final rule](#) on PMSR for combination products clarifies the requirements that apply to combination products and their constituent parts (drugs, devices and/or biological products that are part of a combination product). The rule states that a combination product applicant must comply with the PMSR requirements for the combination product it is marketing, and that a constituent part applicant must comply with PMSR

requirements for the constituent part it is marketing. Combination and constituent part applicants must follow the PMSR requirements applicable to the product based on the application type under which the product or part received marketing authorization. Combination product applicants also must submit reports based on the constituent parts in the combination product. The rule does not apply to investigational combination products or to combination products for which FDA has not received marketing authorization.

3. Risk Evaluation and Mitigation Strategy (REMS)

The draft guidance, [FDA's Application of Statutory Factors in Determining When a REMS Is Necessary](#), clarifies how FDA will determine whether a REMS is required to ensure that the benefits of a drug outweigh its risks. The agency is statutorily required to consider six factors when making such a determination, which is a complex, drug-specific inquiry. The factors also influence the type of REMS that FDA requires. The guidance reviews each of the six factors in detail and notes that FDA will also consider whether a REMS would impose burdens on patient access and the health care delivery system. [Click here](#) to access McDermott's in-depth analysis on this topic.

4. Compounding Pharmacies

FDA continued its push to implement the Drug Quality and Security Act by issuing a slew of draft and final guidance documents for compounding pharmacies in 2016:

- Electronic drug reporting for compounding outsourcing facilities under FDCA 503B (draft)
- Compounding and repackaging of radiopharmaceuticals by state-licensed nuclear pharmacies, federal facilities and outsourcing facilities (two separate draft guidances)
- Insanitary conditions at compounding facilities (draft)
- Compounded drugs that are essentially copies of commercially available drugs under FDCA 503A and 503B (two separate draft guidances)
- The definition of a facility under FDCA 503B (draft)
- Hospital and health system compounding (draft)
- Pharmacy compounding under FDCA 503A (final)

¹⁰ See, e.g., [Warning Letter](#) from Steven E. Porter, Jr., Los Angeles District Director, US Food and Drug Admin., to Thomas F. Greny, President, General Medical Company (June 2, 2016); [Warning Letter](#) from Steven E. Porter, Jr., Los Angeles District Director, US Food and Drug Admin., to David H. Medoff, Director, TriMed, Incorporated (June 30, 2016).

¹¹ See, e.g., [Warning Letter](#) from Thomas J. Cosgrove, Director, Office of Manufacturing Quality, Office of Compliance, Center for Drug Evaluation and Research, US Food and Drug Admin., to Premchand Godha, Chairman & Managing Director, Ipca Laboratories Ltd. (Jan. 29, 2016); [Warning Letter](#) from Thomas J. Cosgrove, Director, Office of Manufacturing Quality, Office of Compliance, Center for Drug Evaluation and Research, US Food and Drug Admin., to Satish Mehta, Chief Executive Officer, Emcure Pharmaceuticals Ltd. (Mar. 3, 2016); [Warning Letter](#) from Ruth P. Dixon, District Director, New Orleans District, US Food and Drug Admin., to Chris Lemley, President & CEO, Apothea Supply, Inc. dba Apothea (Apr. 7, 2016); and [Warning Letter](#) from Francis Godwin, Acting Director, Office of Manufacturing Quality, Office of Compliance, Center for Drug Evaluation and Research, US Food and Drug Admin., to Zhang Jian, Owner, Xiamen Origin Biotech Co., Ltd. (July 19, 2016).

- The prescription requirement under FDCA 503A (final)

Of these guidance documents, the [Prescription Requirement Under Section 503A of the Federal Food, Drug, and Cosmetic Act](#) guidance may have the greatest impact on anticipatory compounding operations of compounding pharmacies. Under 503A, licensed compounding pharmacies that meet the statutory requirements are exempt from current good manufacturing practices, adequate directions for use, and FDA-approval for NDAs or ANDAs. The guidance distinguishes between (1) compounding after the receipt of a valid prescription for an identified individual patient, (2) anticipatory compounding before the receipt of a valid prescription for an identified individual patient, and (3) compounding for office use. FDA will determine that a prescription meets the FDCA 503A prescription requirement only if the identity of the patient is given and clear. Additionally, hospitals, clinics and health care practitioners that seek to obtain non-patient-specific compounded drugs must do so from an outsourcing facility registered under FDCA 503B.

The guidance notes that anticipatory compounding has an inherently greater chance of a production mistake or contamination. Limits on the quantity of drugs produced by anticipatory compounding help protect patients from such quality issues. As an interim compliance policy, however, the guidance provides a safe harbor for the limited quantities if the compounder holds no more than a 30-day supply of a compounded drug for distribution to fill prescriptions not yet received and the amount of the supply of the compounded product is based on valid prescriptions received for identified individual patients in a 30-day period over the past year.

E. Clarifying First Amendment Limitations on Drug and Device Advertising and Promotion

After several years of First Amendment challenges¹² to FDA's expansive application of off-label speech restrictions, the agency may be relaxing its pursuit of firms for certain promotional activities. FDA's Office of Prescription Drug

Promotion (OPDP) issued significantly fewer warning letters in 2016, possibly because of First Amendment litigation surrounding off-label communications. OPDP issued one [warning letter](#) alleging that a company failed to include *any* risk information associated with the use of its drug product. OPDP also issued a number of [untitled letters](#) citing the FDCA misbranding provision, that addressed the advertising and promotion of investigational drugs, adequate directions for use, and false or misleading presentations of risk.

FDA also took steps to reexamine policies regarding off-label promotion in the wake of significant court decisions affirming limitations on FDA's authority to prohibit truthful and non-misleading statements regarding off-label uses of prescription drugs and medical devices. FDA hosted a [two-day public meeting](#) in 2016 on Manufacturer Communications Regarding Unapproved Uses of Approved or Cleared Medical Products (off-label communications). The agency will accept public [comment](#) on the meeting until April 10, 2017. Prior to the start of the Trump Administration in 2017, the agency also issued three documents on product promotions: [Memorandum: Public Health Interests and First Amendment Considerations Related to Manufacturer Communications Regarding Unapproved Uses of Approved or Cleared Medical Products](#); [Draft Guidance: Medical Product Communications That Are Consistent with the FDA-Required Labeling—Questions and Answers](#); and [Clarification of When Products Made or Derived From Tobacco Are Regulated as Drugs, Devices, or Combination Products](#); [Amendments to Regulations Regarding "Intended Uses"](#) (final rule). The release of these documents, which purport to clarify FDA's view of First Amendment limitations on its authority, suggest that this topic will continue to be a focus for industry, regulators, legislators and public interest groups in 2017. See an analysis of the medical product communication draft guidance [here](#) and the final rule [here](#).

The [21st Century Cures Act](#) expanded the audience to which health care economic information (HCEI) may be communicated to include payors and similar entities with expertise in health care economic analysis that select drugs for coverage or reimbursement. The law also broadened the types of analysis that may be shared (to include clinical data, inputs, clinical or other assumptions, methods, results and other components underlying or comprising the analysis, as well as separate or

¹² See, e.g., *United States v. Caronia*, 703 F.3d 149 (2d Cir. 2012) (holding that the government may not prohibit or criminalize truthful off-label promotional speech); *Amarin Pharma, Inc. v. FDA*, 119 F. Supp. 3d 196 (S.D.N.Y. 2015) (holding that the government may not pursue misbranding provisions under the FDCA for statements that were truthful and non-misleading); *United States v. Vascular Solutions, Inc.*, 181 F. Supp. 3d 342 (W.D. Tex. 2016); *United States v. Facticeau*, 2016 WL 4445741 (D. Mass. 2016) (addressing promotion of a device for intended uses not cleared or approved by FDA).

aggregated consequences from the represented health outcomes). Additionally, the Cures Act liberalized the previous requirement that HCEI “directly relate” to approved indications (now HCEI must only “relate” to such indications). Prior to the beginning of the Trump administration, the agency issued a draft guidance explaining FDA’s interpretation of the new HCEI provision with regard to HCEI communications to payors about approved drugs and communications to payors about investigational drugs and devices—[Drug and Device Manufacturer Communications with Payors, Formulary Committees, and Similar Entities – Questions and Answers](#). View a summary of the guidance [here](#).

F. Expanded Oversight of Tobacco Products

In one final and one proposed rule, FDA significantly expanded its authority over tobacco products in 2016.

1. *Deeming Rule*

In [Deeming Tobacco Products To Be Subject to the Federal Food, Drug, and Cosmetic Act, as Amended by the Family Smoking Prevention and Tobacco Control Act \[TCA\]; Restrictions on the Sale and Distribution of Tobacco Products and Required Warning Statements for Tobacco Products](#), FDA extended its jurisdiction over tobacco products that it deemed to be subject to the TCA, including cigars, hookah, pipe tobacco and e-cigarettes. The final rule imposes various requirements, such as regulatory submissions, warning statements and sales restrictions to minors.

2. *Nonclinical Laboratory Studies*

In the earlier-mentioned proposed rule, [Good Laboratory Practice for Nonclinical Laboratory Studies](#), FDA would expand the scope of its Good Laboratory Practice regulations to tobacco products. Nonclinical laboratory studies may address the relative toxicities of new- or modified-risk tobacco products. The rule proposes to exclude the use of a marketed tobacco product’s labeling to characterize the product if it is used as a control or reference article in a nonclinical laboratory study, because labeling of currently marketed tobacco

products does not provide the information required for full product characterization.

AUTHORS

For more information, please contact your regular McDermott lawyer, or:

Veleka Peeples-Dyer

+1 202 756 8639
vpeeplesdyer@mwe.com

Vernessa T. Pollard

+1 202 756 8181
vpollard@mwe.com

Michael W. Ryan

+1 202 756 8088
mryan@mwe.com

Vanessa K. Burrows

+1 202 756 8742
vburrows@mwe.com

Shelby Buettner

+1 202 756 8287
sbuettner@mwe.com

Anisa Mohanty

+1 202 756 8286
amohanty@mwe.com

For more information about McDermott Will & Emery visit www.mwe.com

IRS Circular 230 Disclosure: To comply with requirements imposed by the IRS, we inform you that any U.S. federal tax advice contained herein (including any attachments), unless specifically stated otherwise, is not intended or written to be used, and cannot be used, for the purposes of (i) avoiding penalties under the Internal Revenue Code or (ii) promoting, marketing or recommending to another party any transaction or matter herein.

The material in this publication may not be reproduced, in whole or part without acknowledgement of its source and copyright. *On the Subject* is intended to provide information of general interest in a summary manner and should not be construed as individual legal advice. Readers should consult with their McDermott Will & Emery lawyer or other professional counsel before acting on the information contained in this publication.

©2017 McDermott Will & Emery. The following legal entities are collectively referred to as “McDermott Will & Emery,” “McDermott” or “the Firm”: McDermott Will & Emery LLP, McDermott Will & Emery AARPI, McDermott Will & Emery Belgium LLP, McDermott Will & Emery Rechtsanwälte Steuerberater LLP, McDermott Will & Emery Studio Legale Associato and McDermott Will & Emery UK LLP. These entities coordinate their activities through service agreements. McDermott has a strategic alliance with MWE China Law Offices, a separate law firm. This communication may be considered attorney advertising. Prior results do not guarantee a similar outcome.

Office Locations

BOSTON

28 State Street
Boston, MA 02109
USA
Tel: +1 617 535 4000
Fax: +1 617 535 3800

DALLAS

3811 Turtle Creek
Boulevard, Suite 500
Dallas, TX 75219
USA
Tel: +1 972 232 3100
Fax: +1 972 232 3098

HOUSTON

1000 Louisiana Street, Suite 3900
Houston, TX 77002
USA
Tel: +1 713 653 1700
Fax: +1 713 739 7592

MIAMI

333 Avenue of the Americas, Suite 4500
Miami, FL 33131
USA
Tel: +1 305 358 3500
Fax: +1 305 347 6500

NEW YORK

340 Madison Avenue
New York, NY 10173
USA
Tel: +1 212 547 5400
Fax: +1 212 547 5444

ROME

Via Luisa di Savoia, 18
00196 Rome
Italy
Tel: +39 06 462024 1
Fax: +39 06 489062 85

SILICON VALLEY

275 Middlefield Road, Suite 100
Menlo Park, CA 94025
USA
Tel: +1 650 815 7400
Fax: +1 650 815 7401

BRUSSELS

Avenue des Nerviens 9-31
1040 Brussels
Belgium
Tel: +32 2 230 50 59
Fax: +32 2 230 57 13

DÜSSELDORF

Stadttor 1
40219 Düsseldorf
Germany
Tel: +49 211 30211 0
Fax: +49 211 30211 555

LONDON

110 Bishopsgate
London EC2N 4AY
United Kingdom
Tel: +44 20 7577 6900
Fax: +44 20 7577 6950

MILAN

Via dei Bossi, 4/6
20121 Milan
Italy
Tel: +39 02 78627300
Fax: +39 02 78627333

ORANGE COUNTY

4 Park Plaza, Suite 1700
Irvine, CA 92614
USA
Tel: +1 949 851 0633
Fax: +1 949 851 9348

SEOUL

18F West Tower
Mirae Asset Center1
26, Eulji-ro 5-gil, Jung-gu
Seoul 100-210
Korea
Tel: +82 2 6030 3600
Fax: +82 2 6322 9886

WASHINGTON, D.C.

The McDermott Building
500 North Capitol Street, N.W.
Washington, D.C. 20001
USA
Tel: +1 202 756 8000
Fax: +1 202 756 8087

CHICAGO

227 West Monroe Street
Chicago, IL 60606
USA
Tel: +1 312 372 2000
Fax: +1 312 984 7700

FRANKFURT

Feldbergstraße 35
60323 Frankfurt a. M.
Germany
Tel: +49 69 951145 0
Fax: +49 69 271599 633

LOS ANGELES

2049 Century Park East, 38th Floor
Los Angeles, CA 90067
USA
Tel: +1 310 277 4110
Fax: +1 310 277 4730

MUNICH

Nymphenburger Str. 3
80335 Munich
Germany
Tel: +49 89 12712 0
Fax: +49 89 12712 111

PARIS

23 rue de l'Université
75007 Paris
France
Tel: +33 1 81 69 15 00
Fax: +33 1 81 69 15 15

SHANGHAI

MWE China Law Offices
Strategic alliance with
McDermott Will & Emery
28th Floor Jin Mao Building
88 Century Boulevard
Shanghai Pudong New Area
P.R.China 200121
Tel: +86 21 6105 0500
Fax: +86 21 6105 0501