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Sylvie Dupont
Secretary of the Board
Patented Medicines Prices Review Board
Box L40, 333 Laurier Avenue West, Suite 1400
Ottawa, ON K1P 1C1

August 25, 2006

Dear Ms. Dupont:

Janssen-Ortho appreciates the opportunity to provide input on the Discussion Guide for the Consultations on the Board's Excessive Price Guidelines. This letter and attached document constitute our written response on this matter. We look forward to further discussion at the Board's Consultations on the Excessive Price Guidelines in November.

Should you have any questions pertaining to this response, please contact Kimberly Robinson at 416-382-4823.

Sincerely,

Penny Albright
Vice President, Government and Health Economics

Janssen-Ortho Response to the Discussion Guide for Consultations on the Board's Excessive Price Guidelines

We appreciate the opportunity to provide input into potential changes to the Guidelines. The collaborative approach the PMPRB is taking during this consultation is refreshing in the current climate of increased compliance activities and, in particular, hearings.

In general, we believe the PMPRB's guidelines and practice should better reflect the original intended mandate of Parliament "to protect consumers and contribute to Canadian Health Care by ensuring that prices charged by manufacturers for patented medicines are not excessive". We also believe the Board should exercise discretion, where appropriate, in the application of the Guidelines, rather than applying them rigidly and automatically resorting to the hearing process in cases where introductory prices are clearly not excessive in the context of the *Act* factors. We agree with Rx&D that prices should not be considered excessive under the *Act* unless they exceed the threshold of the range of international prices and the CPI-adjusted therapeutic class. The recent increase in compliance activities, particularly hearings, has negatively impacted the effectiveness and efficiency of the PMPRB process, and is inconsistent with the approach envisioned by Parliament when it established the Board. As an example, Janssen-Ortho is actively involved in three hearings for medicines whose prices are within the range of international and therapeutic class prices and which are recognized as providing significant clinical benefits to patients.

The existing guidelines and their application lead to uncertainty about launch prices and more generally about the business climate for innovative pharmaceuticals in Canada. Moreover, protracted timelines for completion of introductory price reviews and investigations paralyze parts of patentees' business, thereby exacerbating the uncertainty associated with the products at issue and the resource allocation decisions that have to be made in respect of these products. Many aspects of the existing guidelines are unfair to innovators, specifically:

- lack of consistency between the guidelines and the *Patent Act* ;
- lack of willingness to exercise discretion, where appropriate, in the application of the guidelines;
- lack of consistency between the PMPRB and Health Canada as to what constitutes a substantial improvement in safety and/or efficacy; and;
- increasing reliance on a hearing process that appears biased against patentees, and does not provide a robust appeal process.

The lack of fairness, consistency and predictability in the price regulation process create a difficult and uncertain business climate. Decisions that have resulted in Canadian drug prices well below the international median have created a highly

restrictive environment for the innovative industry. This is further exacerbated when PMPRB fails to recognize the value of incremental innovations that provide moderate benefits to patients. Much of modern medicine has progressed forward through incremental improvements. Despite the innovation necessary for such products, no price premium is allowable for incremental innovations in Canada, which may lead manufacturers to choose not to launch products here, thus putting our patients at a disadvantage versus their international counterparts.

As stated above, we believe the PMPRB should discharge its mandate in a manner more consistent with the *Patent Act,* and should reserve the hearing process for cases of egregious pricing excesses. We are extremely concerned that the application of the Guidelines to date has led to Canadian prices that fall well below the international median, on average, and do not believe this was the intent of Parliament when they established the PMPRB. Janssen-Ortho supports Rx&D in their position that the spirit of the *Patent Act* directs that prices should only be considered excessive when they exceed the range of international prices, and we urge the Board to support Board staff in more active negotiation of prices within the full range of non-excessive prices.

However, we understand the place of guidelines in facilitating this process. We offer the following recommendations for a revised four-category system to replace the existing guidelines, while stressing that any guidelines developed by the Board should provide guidance only, rather than being rigidly applied as if they have the force of law.

Category 1 – Line Extensions

Category 1 designation should be limited to new strengths of an existing medicine that offers no benefits beyond dosing flexibility or improved titration. For these medicines, we believe the existing reasonable relationship test is adequate. However, new strengths of existing medicines, for example, immune system modulators and anti-convulsant medications, may be indicated for different uses in entirely different patient populations. In this instance, line extensions should be categorized as either moderate or substantial improvements, depending on their value, and the appropriate tests should be applied.

Category 2 – Substantial Improvement

Any medicine granted a priority review or notice of compliance with conditions by Health Canada should automatically be granted Category 2 status by PMPRB. The inconsistency between these two Federal Agencies in their assessment of what constitutes a substantial improvement is unacceptable and unfair. Health Canada relies on clinical specialists to conduct their reviews, and this level of clinical expertise is often not represented on the HDAP.

We believe the current test applied to Category 2 medicines (higher of international median or therapeutic class comparison) is adequate, with the caveat that the therapeutic class comparison test requires modification as outlined below, under Category 4.

Category 3 – Moderate Improvement

We believe medicines providing a moderate improvement should be reviewed in the context of "prices of other comparable medicines in other countries" as outlined in the *Patent Act*. We propose a test based on the median premium of the medicine under review over the appropriate therapeutic class in the PMPRB reference countries. A similar test wasapplied by the Board when approving prices for Humalog and Viread. Again, we propose this with the caveat that the therapeutic class comparison test must be modified, as outlined below.

Category 4 – little or no improvement

In general, we believe a therapeutic class comparison test is an adequate guideline for medicines providing little or no improvement, provided there is a clear distinction between medicines providing at least a moderate benefit and medicines falling into this fourth category. However, the current application of this test requires modification.

Comparative medicines and their appropriate dosages should be determined based on clinical use and the opinion of appropriate clinical experts. In addition, only patented brand name medicines with publicly available Canadian prices, clearly under PMPRB jurisdiction (i.e. this excludes non-patented and generic medicines), should be included in a therapeutic class comparison for a new medicine. The price of a new medicine should be compared to the CPI-inflated price of the therapeutic class. PMPRB reliance on the ODB or AQPP price lists does not account for PMPRB-allowable price increases. ODB, for example has had a price freeze in effect since 1993. Thus the PMPRB's approach inappropriately limits the price of new medicines.

Human Drug Advisory Panel (HDAP) Review and Composition

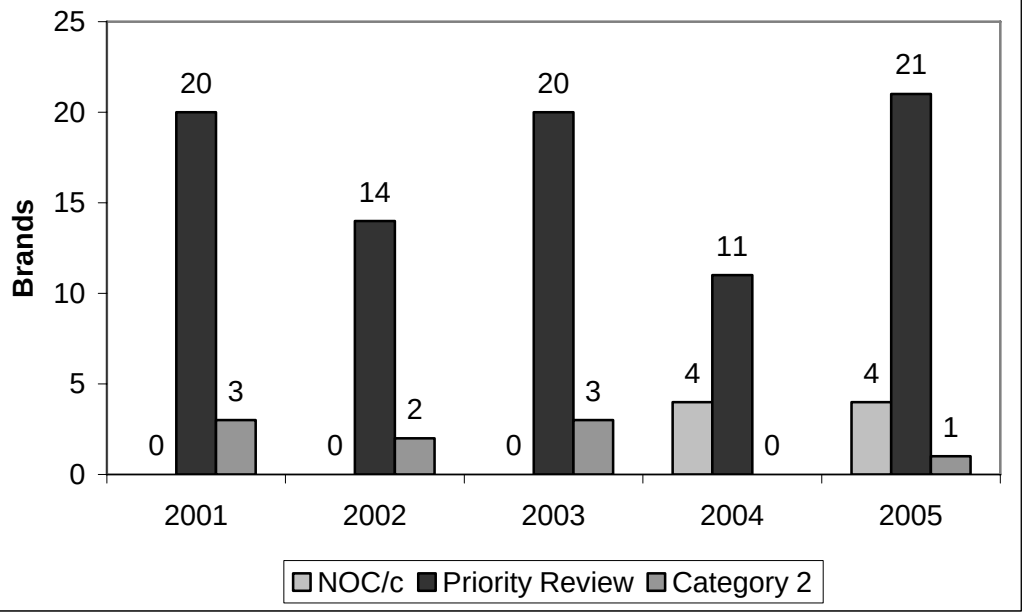
The HDAP reviews and evaluates scientific information, including submissions by patentees, on behalf of Board staff, and recommends categories for new medicines.

While the HDAP members are recognized experts in evidence-based medicine, their reviews are often limited by lack of specific clinical expertise in relevant therapeutic areas. This could be remedied by expanding the membership of the panel to include more members with varied clinical backgrounds, and by routinely

seeking expert feedback from an identified roster of clinical consultants when the Panel cannot provide expertise in a particular therapeutic area.

In order to guide the HDAP in their reviews, a cross-functional team, including members from industry and clinical experts, should be struck to develop guidelines for determining what constitutes a moderate and a substantial improvement in safety and/or efficacy. Under the current guidelines, this determination is left to the discretion of the HDAP and often appears to be uninformed by the opinion of clinical experts in relevant therapeutic areas, thereby inappropriately limiting access to category 2 designation. For example, most drugs granted a priority review or notice of compliance with conditions, indicating an unmet Canadian need, are not judged by the HDAP to provide substantial improvements over existing medicines. (see table 1, below)

Table 1: NOC/c, Priority Review and Category 2 Classification



Inconsistent and Inflexible Application of the Guidelines

The current guidelines, as written, provide significant flexibility in applying secondary tests to medicines in cases where the primary tests may be inadequate. In the past, it appears Board Staff would draw on this flexibility to negotiate fair prices with manufacturers, while in recent months there has been more reluctance to apply flexibility in application of the tests.. The example of

two Janssen-Ortho medicines approved for sale in recent years highlights this point.

In 2003, a Janssen-Ortho product indicated for overactive bladder consisting of an existing medicine offered in a new and unique dosage form was classified as Category 1 by the Board. However, given the unique nature of the medicine, its price was deemed to be within guidelines based on an international price comparison.

CONCERTA® (methylphenidate hydrochloride extended release) tablets is an existing medicine offered in a new and unique dosage form similar to that of the product noted above. It was reviewed as a category 1 medicine by PMPRB staff and its price is below the median international price. Unlike the product above, CONCERTA's price was deemed excessive. In 2006, Janssen-Ortho received a notice of hearing related to the introductory price for CONCERTA®.

As noted above, this inconsistency leads to uncertainty in launch prices and lack of confidence in the PMPRB and more generally the Canadian business climate for innovator companies.

Issue 1. Is the current approach to the categorization of new patented medicines appropriate?

The current approach to categorization of medicines inappropriately limits access to category 2 designations. In particular, many new medicines recognized by Health Canada as providing substantial improvements and thus granted priority review and/or a Notice of Compliance with Conditions, are not granted PMPRB Category 2. This may arise from the fact that the Human Drug Advisory Panel (HDAP) often does not have specific clinical expertise in the relevant therapeutic area. The obvious solution to this problem is to automatically grant Category 2 designation to any product granted a priority review or NOC/C by Health Canada.

In cases where Health Canada has not designated a product as outlined above, the HDAP should engage clinical experts in the scientific review of medicines for which the manufacturer is seeking a Category 2 or 3 designation.

Question 1.1: Are the new patented drug categories and their definitions appropriate?

There are many issues with the current categories and definitions as outlined in our responses, below.

Question 1.2: Is it important to distinguish a medicine that offers "moderate therapeutic improvement" from a medicine that provides "little or no therapeutic improvement?" If yes, why is it important? It not, why not.

The current definitions cannot recognize the incremental innovations in clinical benefit offered by new, state of the art medicines, as no distinction is made between medicines offering moderate, some or no benefits. Much innovation in pharmaceutical science is incremental, while still significant, and it is crucial to allow manufacturers to benefit from their investment in incremental innovations.

The current guidelines make no provision for clinical benefits that flow from new delivery systems or innovative dosage forms of existing medicines. In many cases, PMPRB jurisdiction over a medicine is based on patents that pertain to novel delivery systems or dosage forms rather than the medicine itself; however, the current guidelines do not appropriately value the patented invention. In addition, it is significant to note that the currently proposed regulatory amendments to the *Patented Medicines (Notice of Compliance) Regulations* clearly indicate the Government's intention to allow such patents to be listed on the Patent Register maintained by Health Canada. The Regulatory Impact Analysis Statement supporting these proposed amendments confirms the Government's view that "novel dosage forms can offer significant therapeutic advantages over drugs with conventional release characteristics and are therefore worthy of the special protection provided by the *PM(NOC) Regulations*".

Issue 2: Is the current approach used to review the introductory prices of new patented medicines appropriate?

In recent months, the PMPRB has become increasingly rigid in its application of the guidelines and is resorting to price hearings for products whose prices are well within the range of international and therapeutic class prices. This is inefficient and inconsistent with Parliament's intentions in creating the Board. In addition, where hearings become necessary, there should be an established mechanism for appealing the merits of Board Orders. Under the current guidelines, the Board has undue power and manufacturers have too little recourse.

Question 2.1: Are the price tests currently used to review the prices of new medicines in the various categories appropriate for that category? Why? Why not? If not, how could these tests be amended to improve their appropriateness?

As outlined above, we proposed a modified set of categories and price tests to more fairly reward innovation.

Question 2.2: If you think that medicines that offer "moderate therapeutic improvement" should be distinguished from medicines that provide "little or no therapeutic improvement" what would the appropriate new test be?

As outlined above, we propose a test based on the median premium over the therapeutic class in the PMPRB reference countries, similar to that considered by the PMPRB when it approved prices for Humalog and Viread.

Question 2.3: For price review purposes, "comparable medicines" are medicines that are clinically equivalent. Do you have any suggestion as to principles or criteria that should be used in determining how to identify "comparable medicines" for the purpose of inclusion in the above price tests?

Comparative medicines and their appropriate dosages should be determined based on clinical use and the opinion of appropriate clinical experts. In addition, only patented brand name medicines with publicly available Canadian prices, clearly under PMPRB jurisdiction (i.e. this excludes non-patented and generic medicines), should be included in a therapeutic class comparison for a new medicine. In addition, the price of a new medicine should be compared to the CPI-inflated price of the therapeutic class. PMPRB reliance on the ODB or AQPP price lists does not account for PMPRB-allowable price increases.

Question 2.4: Under the current Guidelines, Board Staff compares the Canadian average transaction price of the new medicine to the prices of the

same medicine sold in the seven countries listed in the Regulations. However, Section 85(1) of the Patent Act states that the Board should take into consideration the "prices of other comparable medicines in other countries". Should the Guidelines address this factor?
If so, how could this factor be incorporated into the price tests for new medicines?

As outlined above, we believe the guidelines should address the prices of comparable medicines in other countries as it relates to medicines that provide a moderate therapeutic benefit. We propose for these medicines a test based on the premium of a new medicine over therapeutic class comparators in the PMPRB reference countries, similar to that considered for Humalog and Viread.

Issue 3: Should the Board's Guidelines address the direction in the Patent Act to consider "any market"?

Question 3.1: Given the price variations by provinces/territories and class of customer illustrated in the previous figures, is it appropriate for the Board to only consider an ATP calculated based on the total revenues from the sales for all provinces/territories and all classes of customer? Why? Why not?

The level of price variation by province/territory and class of customer does not appear to warrant reviewing prices at any level below the total Canadian aggregate level. Any regulation of ATP at the level of individual markets could eliminate preferred pricing, such as that routinely offered to institutional customers and proposed in Ontario's Bill 102.

Question 3.2: If the current ATP calculation is not appropriate, should the Board review the prices to the different classes of customers and/or the different provinces/territories for all DINs? Or should this level of review be done on a case-by-case basis, where there is significant variation in the prices charged?

Detailed price review by class of customer or region should be limited to exceptional cases.