Procter & Gamble
Pharmaceuticals Canada, Inc.
Post Office Box 355, Station "A"
Toronto, Ontario
Canada M5W 1C5
(416) 730-4711 phone
www.pgpharma.com

October 6, 2008

Ms. Sylvie Dupont,
Secretary,
Patented Medicine Prices Review Board
Box L40, Standard Life Centre
333 Laurier Avenue West, Suite 1400
Ottawa, Ontario K1P 1C1

Re: PMPRB Notice & Comment, August, 2008
Draft Revised Excessive Price Guidelines

Dear Ms. Dupont,

In response to the PMPRB's Notice & Comment on the Draft Revised Excessive Price Guidelines released on August 20, 2008, Procter & Gamble Pharmaceuticals Canada Inc. offers the attached submission containing its comments, observations and recommendations. This submission should be considered as a supplement to the response provided by Rx&D on behalf of its member companies, which Procter & Gamble Pharmaceuticals Canada Inc. fully supports.

While aspects of the Draft Revised Excessive Guidelines deal with some longstanding issues associated with the current Guidelines, there is still significant work to be done. The Guidelines for establishing the maximum non-excessive prices of patented medicines must be transparent as well as easily and equitably applied. An overriding principle must be that an identical average transaction price that is deemed non-excessive in one market cannot be subsequently considered excessive by simply redefining what constitutes a "market". Doing otherwise is counterintuitive. Nevertheless, this situation exists in the current Guidelines and continues in the Draft Revised Excessive Guidelines.

This situation will lead to inappropriately low prices for newly improved medicines, which will have the unintended consequence of discouraging innovation. The PMPRB, working together with stakeholders, can develop a solution to this issue, as well as other issues raised by the Draft Revised Excessive Guidelines as detailed in this submission.

Procter & Gamble Pharmaceuticals Canada Inc. believes that the co-operative approach between PMPRB and its stakeholders has resulted in some important steps forward. There is definitely more to be done. For this reason, and in consideration of the associated judicial review, we urge the Board to delay both the implementation of the Draft Revised Excessive Guidelines and the August 18th, 2008 Communiqué on proposed reporting related to third party agreements until these issues are resolved. We also support a continuation of dialogue between the PMPRB and its stakeholders, all of whom are committed to developing a solution together.

Yours truly,

Andy McClenaghan
Country Manager
Procter & Gamble Pharmaceuticals Canada Inc.

PMPRB Notice & Comment, August, 2008
Draft Revised Excessive Price Guidelines
Submission from Procter & Gamble Pharmaceuticals Canada Inc.

De-Linking Methodology and Any Market Reviews

While discussions of a proposed de-linking methodology offered hope for an end to a longstanding issue with the current guidelines, that of addressing the problem of average selling price fluctuation and its impact on subsequent allowable pricing, the proposed approach applies only in specific exceptional circumstances and places the onus on patentees to provide evidence of its applicability in each case. Given that these fluctuations are not unusual and are very likely to increase with the new proposal to report all benefits, the de-linking methodology should address this situation as standard practice to ensure that the CPI-adjustment methodology does not unreasonably impact on allowable pricing and certainly doesn't trigger an investigation as a result of its mechanics. Case in point, examples presented to patentees during the PMPRB information sessions on September 9, 2008 almost consistently showed a medicine's MNE price dropping from year to year until the national ATP finally exceeded the national MNE and an investigation was commenced.

Specific issues with the methodology are as follows:

- According to the Draft Revised Excessive Price Guidelines,

  > [...] the MNE price may be "de-linked" from the ATP of the previous three years such that it may increase up to the previous highest non-excessive ATP. (p.35)

  By way of example, the Draft Revised Excessive Price Guidelines document offers the following

Previous highest non-excessive ATP:	$10.00
Price in 2007:	$ 8.00
Price in 2008:	$10.00

  > [...] the MNE price would be determined by the previous highest non-excessive ATP (no matter in what year the drug product was sold at that price) [...]

  The approach outlined in the Draft Revised Excessive Price Guidelines is not consistent with the interpretation presented during the PMPRB's information sessions on September 9, 2008. Examples provided by Board Staff during these sessions showed the ***CPI-adjustment methodology being applied to the previous ATP*** to establish the de-linked MNE. While neither approach is ideal, the CPI-adjusted approach presented at the information sessions provides at least some degree of consideration for price changes implemented for non-benefit customers during a benefit period. The Draft Revised Excessive Price Guidelines' approach expects companies to freeze prices to all markets during the benefit period, the timeline of which could extend over several years depending upon the type of benefit, thereby creating a disincentive to offer any benefits. Although somewhat better, the CPI-adjusted approach presented at the information sessions has significant shortfalls as demonstrated by the following example presented by Board Staff during the PMPRB sessions. The example applies CPI to the national ATP ($9.50 in year 5), which occurs in a year impacted by benefits, to calculate the "de-linked" national MNE ($9.69).

(4) De-linking - example four - variable uptake of one benefit in one market

	Wholesaler	Pharmacy	Hospital	Nat'l ATP (N-ATP)	Nat'l MNE price (N-MNE)	Notes
year 1	$10.00	$10.00	$10.00	$10.00	$12.00	N-ATP less than N-MNE, no class of customer higher than N-MNE
year 2	$10.00	$10.00	$9.00	$9.67	$10.20	N-ATP less than N-MNE, no review at the level of any market
year 3	$10.00	$10.00	$8.00	$9.33	$9.86	N-ATP less than N-MNE, no review at the level of any market
yeaer 4	$10.00	$10.00	$7.00	$9.00	$9.52	N-ATP less than N-MNE, no review at the level of any market
year 5	$10.00	$10.00	$8.50	$9.50	$9.18	N-ATP exceeds N-MNE, triggers investigation criteria Patentee provides evidence that fluctuation in Hospital class due variable uptake of a bulk offer Previous highest ATP in Hospital class is $10.00, no excessive pricing Review at the level of any market Prices in Wholesale and Pharmacy did not increase, no excessive pricing
year 6	$10.20	$10.20	$8.50	$9.63	$9.69	N-ATP less than N-MNE, no review at the level of any market

In order to accurately reflect market realities (i.e. that prices to other customers do not remain stagnant during the benefit period) and to minimize the disincentive to offer benefits, the MNE should be fully delinked from the ATP and should be allowed to rise with the changes in the CPI. In the example above, the full delinking would allow the non-excessive MNE of $12.00 to increase using the PMPRB's CPI-adjustment methodology thereby recognizing that prices in other markets increase during benefit periods. In addition, this approach eliminates the potential for false triggering of the investigation criteria as a result of volume shifts between discounted and non-discounted markets.

Another approach, which would tie CPI increases to non-excessive prices charged in a market rather than to MNEs is found in the redefined MNE proposed by the Working Group on Price Tests. According to the Working Group's recommendation:

> ***Revised Definition of the MNE Price***
> The WGPT proposed that the definition of the MNE price should be changed from what is currently contained within the existing Guidelines, such that the MNE price is determined by the highest non-excessive market-specific MNE price. For example, in the introductory period a drug product has a national MNE price established by the price tests of $9, a pharmacy price of $10, a wholesaler price of $9, and a hospital price of $6. In the subsequent period, if the prices in all markets increase by CPI (assuming 2%), and the pharmacy price increases to $10.20, this price should represent the MNE price for all markets (i.e., the national market). Therefore, the MNE price for all markets (i.e., the national market) is established by the highest non-excessive market-specific MNE price.
>
> Report of the Working Group on Price Tests to the Patented Medicine Prices Review Board, July 2008, page 4
> http://www.pmprb-cepmb.gc.ca/english/View.asp?x=1087&mp=808#11

Using this definition for the de-linking methodology, rather than the overly complicated approach being proposed, is transparent in its simplicity, takes into account market reality and most importantly addresses the longstanding issue of a price lower than a calculated

maximum price having the potential to be considered excessive. Using the information session example presented above, the national MNE price in year 6 would be the highest market price of $10.00 adjusted by the PMPRB's CPI-adjustment methodology, thus accounting for actual price changes that may have been implemented in other markets during the benefit period. As with the CPI-adjusted MNE approach, this approach also eliminates the false triggering of the investigation criteria resulting from shifts in sales mixes.

- Contract pricing, a standard practice within the industry, appears to be considered a lower list price in a specific market according to the Draft Revised Excessive Price Guidelines rather than a benefit offered to a specific customer or group of customers. Contract pricing represents a significant cause of average selling price fluctuation for which de-linking should be applied as standard practice. The presence of several contracts within a market or across different markets, each with a unique negotiated price, presents a significant challenge for patentees in their attempts to ensure that an average price overall remains in compliance with the guidelines.

  A scenario provided by the PMPRB Board Staff below in its information sessions on September 9, 2008 highlights the guidelines' inability to address this situation. First, because of the criteria excluding the de-linking option in cases where new customers are added post-introduction at lower prices, the de-linking provision is not available to the patentee in this example. There is no rationale for this arbitrary restriction offered in the guidelines, which in effect forces patentees to ensure sales to all classes are made at the list price in the first instance or face significant price limitations in the future. Second, even if this example met the criteria for de-linking, the option would not apply because the $9.00 hospital price is considered excessive. However, prices in a market ($8.00 - $9.00 in the example below) that are below the price deemed non-excessive for the product by the PMPRB cannot be considered excessive in subsequent reporting periods and certainly not when they represent the lowest price in the country. The staff's example points to a serious flaw in the methodology in this regard. A redefined MNE in this instance would address this situation.

(6) New customer class added post-intro - no benefits in that class

	Wholesaler	Pharmacy	Hospital	Nat'l ATP (N-ATP)	Nat'l MNE price (N-MNE)	Notes
year 1	$10.00	$10.00		$10.00	$12.00	N-ATP less than N-MNE, no class of customer higher than N-MNE
year 2	$10.00	$10.00	$8.00	$9.33	$10.20	N-ATP is less than N-MNE, no review at the level of any market
year 3	$10.00	$10.00	$9.00	$9.67	$9.52	N-ATP exceeds N-MNE, triggers investigation criteria Review at the level of any market Prices in Wholesale and Pharmacy did not increase, no excessive pricing ATP in Hospital in year 3 excessive as price increase more than CPI

- Unless the de-linking methodology is revised, there is a significant disincentive to providing benefits of any kind in any market. The proposed methodology and any market review penalizes patentees for offering incentives to their customers because it does not allow the price in the affected market ($9.00 in the example below) to bounce back to the regular price deemed non-excessive in other markets ($10.00). Instead, the methodology limits it to the CPI-adjusted price within the affected market (wholesaler). Again, this represents a serious flaw in the methodology because it considers a price excessive even though it is lower than a price the PMPRB has deemed not excessive.

(2) De-linking - example two - a benefit in one market - excessive pricing

	Wholesaler	Pharmacy	Hospital	Nat'l ATP (N-ATP)	Nat'l MNE price (N-MNE)	Notes
year 1	$9.00	$10.00		$9.50	$12.00	N-ATP less than N-MNE, no class of customer higher than N-MNE
year 2	$9.00	$10.00		$9.50	$9.69	N-ATP less than N-MNE, no review at level of any market
year 3	$8.00	$10.00		$9.00	$9.69	N-ATP less than N-MNE, no review at level of any market
year 4	$9.50	$10.00		$9.75	$9.18	N-ATP exceeds N-MNE, triggers investigation criteria Patentee provides evidence to meet de-linking conditions in Wholesaler class Previous highest ATP for Wholesaler is $9.00 ATP of $9.50 in Wholesaler class excessive

- While the PMPRB staff offered some examples of forms of evidence required to meet the de-linking criteria, there are no specifics included in the Draft Revised Excessive Price Guidelines. Given that this information is crucial to a company's ability to have its price bounce back when a benefit ends, the acceptable forms of evidence must be specified to ensure transparency of process and to avoid future disagreements as to the level of evidence required.

- Contract pricing by its nature is lower than prices paid by other customers. Contracts can overlap from one period into the next and often continue on for extended periods, in fact throughout the life of a patent. As long as pricing under these contracts does not exceed a level previously accepted by the PMPRB as non-excessive, there should be no means under the guidelines that would consider the contract prices excessive. The notion that these prices could be excessive is counterintuitive and ignores the fact that the customer has negotiated the initial and subsequent discounted prices with the patentee and has accepted them.

Provision for Consideration of Shifts in Sales Volumes

A shift in sales volumes between a discounted and list price is a significant issue because it can cause the appearance of excessive pricing where none exists. The provision in the Draft Revised Excessive Price Guidelines to consider this issue is a welcome addition. According to these provisions,

> [...], when a patentee can demonstrate that a national increase in the ATP is due solely to a sales-mix shift and none of the prices for each class of customer and in each province/territory exceed the MNE price as determined by the CPI-Adjustment Methodology, the ATP will be considered to not be excessive. (page 18)

The requirement that the price to each class of customer and to each province be in compliance with the guidelines does not completely address the situation. Importantly, the provision as written assumes that the discounted price relates to an entire single market. In fact, only selected customers in several markets may have been offered the discount. Thus, a mix-shift can occur within a single market such that a market-based review would also point to excessive pricing even though no excessive pricing exists. In the following example using the hospital class to illustrate this point, although the non-excessive price to regular customers ($10.00) and to preferred customers ($3.00) has not changed over several years, sales volume between the two groups fluctuates. This mix of sales in this example pushes the hospital market's average selling price above its calculated MNE in each year. Taken a step further, the regular and preferred customer prices could also be in effect in other or all customer classes.

	Regular Customers (Hospitals)		**Preferred Customers (Hospitals)**		**Overall Average Price**	**MNE Price**
	Price	**Quantity**	**Price**	**Quantity**		
Year A	$10.00	2000	$3.00	500	$8.60	$8.60
Year B	$10.00	3500	$3.00	400	$9.28	$8.77
Year C	$10.00	5000	$3.00	400	$9.48	$8.95
Year D	$10.00	5500	$3.00	350	$9.58	$9.13

In order to fully address the mix-shift issue, the related provision must be revised to reflect consideration of shifts in sales volume at the discounted price versus the sales volumes at the regular price regardless of specific market. In addition, given the complexity of this issue, examples of how the PMPRB intends to apply the provision should be included in the final Revised Excessive Price Guidelines.

Revisions to the Alternate Review Methods for New Medicines

The current guidelines include specific direction when the prescribed primary test cannot be conducted on a new medicine or when it may not be inappropriate. The PMPRB's published new medicine review summaries demonstrate that these alternate price tests have often been relied upon in the past to determine the price status of a new medicine. Their removal from the Draft Revised Excessive Price Guidelines creates a serious gap in the price review methods that will be applied to new medicines. While the assumption may have been that the approach currently used will continue under the Draft Revised Excessive Price Guidelines, these omissions cause uncertainty and a lack of transparency as to the appropriate price review approach that will be used to determine compliance status in these instances.

Under the current guidelines, when a therapeutic class comparison test cannot be conducted, the new medicine's price is compared to the median of its international prices to determine compliance with the guidelines. This approach is generally used when there are no comparators identified or when comparable dosage regimens cannot be established but also when the staff considers the test not appropriate for a given situation (e.g. the only comparators are significantly older, low priced medicines, as was the case outlined in the published review of Alertec). According to the current guidelines:

> When it is inappropriate or impossible to conduct a Therapeutic Class Comparison Test, the Board Staff will give primary weight to the median of the international prices identified in an International Price Comparison Test (*Schedule 3*) to determine if the introductory price of the new DIN is excessive.

Similarly, when a reasonable relationship test cannot be conducted, the guidelines direct the staff to conduct a therapeutic class comparison test to determine compliance status. The current guidelines offer specific instances in this regard to account for differences in indication, therapeutic use and dosage regimens.

> When the above methodology [RRT] is not considered adequate or appropriate, the Board Staff may conduct a Therapeutic Class Comparison Test (*Schedule 2*) to determine if the introductory price of the new DIN is excessive. This could be relevant if, for example, the new DIN has a therapeutic use or dosage regimen that differs materially from the other DINs of the same or comparable dosage forms of the medicine.

There are also specific directions with regard to modified release formulations of an existing medicine. For example, the current guidelines recognize that it is not appropriate to use the reasonable relationship test to review the price of a tablet dosed on a once weekly basis against the price of a tablet of the same medicine administered once daily. According to the current guidelines:

> Drug products with modified release formulations are ordinarily considered Category 1 new drug products (line extensions), and are therefore subject to the Reasonable Relationship Test. However, the Reasonable Relationship Test may not be appropriate when the use of a modified release formulation provides a lower price per treatment to the consumer than the conventional release formulation.
>
> Specifically, where a patentee can demonstrate that the price per treatment of a modified release formulation is less than the price per treatment of the conventional release formulation of the same or comparable dosage form of the same medicine, the Board Staff may consider such information as evidence that the Reasonable Relationship Test is not adequate or appropriate.
>
> Under such circumstances, a Therapeutic Class Comparison Test will be conducted but ordinarily it will be restricted to comparing the modified release presentation to the conventional release presentations of the same or comparable dosage form of the same medicine from the same patentee.

The same alternate test language as it relates to the applicability of the prescribed primary test method, be it the therapeutic class comparison or the reasonable relationship test, must be included in the Draft Revised Excessive Price Guidelines to avoid confusion, uncertainty, and the potential for numerous disagreements between patentees and the staff of the PMPRB.

Revised Reasonable Relationship Test

Although there is no mention in the Notice & Comment discussion paper of a change to the price tests applied to new medicines, a small but very significant change to the Reasonable Relationship Test has been included in the Draft Revised Excessive Price Guidelines. This revision was not the subject of any of the consultations held over the past two years and was never highlighted by the PMPRB or any stakeholder as an issue of concern. As such, we question the PMPRB's rationale and motivation for this revision.

The current guidelines allow a new lower strength DIN to be priced up to the price per unit (i.e. tablet, capsule, mL, etc) of the higher strength existing DIN. For example, a new 25 mg tablet of an existing medicine can be priced up to the $1.00 price per tablet of its existing 50 mg counterpart. This approach recognizes that different strengths of a medicine are not priced equally on a $/mg basis, much the same as the smaller size versus larger size of any commodity. A review of current prices of multiple DINs of most medicines will bare this out. In fact equitable per mg pricing among DINs is an anomaly rather than the norm in Canada and in other countries for that matter.

According to the Draft Revised Excessive Price Guidelines, the new 25 mg tablet in the previous example is limited to the $/mg of the existing higher strength DIN (i.e. forced to a price of $0.50). This approach does not reflect market reality and in addition, perpetuates the unnatural $/mg relationship to all subsequent new DINs of the medicine by virtue of the linear relationship methodology applied when there are at least two existing DINs. The different strength test approach proposed in the Draft Revised Excessive Price Guidelines incorrectly assumes that the price of a tablet is based only on the cost of the active ingredient it contains. In fact, the price reflects many factors including research into the new strength's effectiveness, research aimed at developing treatments for Canadians with specific needs in whom the higher strengths are not appropriate (e.g. paediatric patients, patients with renal impairment, etc) in addition to the fixed costs associated with manufacture of the tablet itself, regardless of the amount of active ingredient it contains. Thus, while a lower strength tablet will generally carry a lower price than the corresponding higher strength, reflecting the lower amount of active ingredient, the price relationship between the two is not typically represented by an equal price per mg.

Use of Comparator ATPs and Published MNEs

The Draft Revised Excessive Price Guidelines state that the comparator price used in the price test will be from a public source. There are noted exceptions whereby the use of published non-excessive ATPs will be used in cases where a patentee chooses to have a medicine's previous higher ATP published as the medicine's MNE and in cases where the comparators are sold by same patentee as the new medicine. These exceptions represent a double standard. In the case of the same patentee, the comparable medicine's average selling price incorporates benefits, discounts and other programs that are then forced on the new product during its introductory period and into perpetuity because of the guidelines governing the prices of existing medicines. If another patentee was introducing the new medicine that company would have the benefit of a review based on the comparable medicine's published non-excessive list price.

With regard to using the MNEs in cases where the company has chosen to have it published, a company unfortunate enough to introduce a new medicine in that therapeutic class will also be forced to adhere to a price that has potentially been depressed by discounts offered by another company. This approach imposes pricing schemes unrelated to the new medicine and from which recovery can take several years based on the PMPRB's CPI-adjustment methodology.

There is no justification for an approach that considers a MNE in a non-discounted market to be "non-excessive" but yet forces a price decrease on the new entry in a product line down to the national ATP of its comparator in order for it to be considered non-excessive. By doing so, the Board is crossing the line from determining price excessiveness to becoming an agent of price discount negotiations. For example, Market A for the existing comparator is non-excessive at $10 and Market B is at $6 because of a benefit being offered. The resulting national ATP for the existing product is $8. According to the guidelines, the same patentee is only allowed to introduce a new line extension at the comparator's market combined ATP of $8 even though the existing comparator is already considered non-excessive at $10. The new line extension priced at the same $10 is considered excessive because of the comparator benefit being offered in Market B. In addition, the benefit offered for the existing drug in Market B may be given in exchange for securing a hospital contract. The PMPRB should not require the price of the new line extension to reflect the national ATP because there is no guarantee that the new product would be awarded the same hospital contract as the existing comparator.

In the spirit of fairness and transparency, the introductory price of all new medicines should be reviewed against the published list price of the identified comparators. In terms of what list price should be used for comparison purposes, in keeping with the Board's decision with regard to Adderall XR and its identified comparator, it should be the medicine's highest published price in Canada.

Special Provisions for Certain Patentees

According to the Patent Act, a patentee is defined as "the person for the time being entitled to the benefit of the patent for that invention". The *Act* does not distinguish between companies with regard to the marketing of a patented medicine; it encompasses all companies selling medicines for which a patent pertains – a patentee is a patentee regardless of what sector of the industry it belongs to. Nor does the *Act* impose different pricing factors on specific patentees. As such, all patentees must be held to the same pricing standards outlined in the PMPRB's Excessive Price Guidelines, whether a brand name company or a generic company. The Draft Revised Excessive Price Guidelines create a two tier system whereby one group of patentees is held to a significantly higher standard than the other. This is clearly inconsistent with the intent of the *Patent Act* as it relates to patented medicines sold in Canada.

International Price Guideline – Exchange Rates

The Draft Revised Excessive Price Guidelines formalize the requirement that patentees reduce the price of a medicine that, over time, becomes non-compliant with the PMPRB's international price guideline as a result of the strengthening of the Canadian dollar. While some latitude is provided in terms of timing of the price decrease, we question the overall appropriateness of holding a Canadian patentee accountable for economic conditions in other countries. Just as Canadian companies do not adjust their prices to match a weakening of the Canadian dollar, neither should they be forced to decrease prices when the Canadian dollar becomes stronger. This provision could lead to continuous price decreases as a company targeting the previous exchange rate levels decreases its price in the next year only to find that the Canadian dollar has risen in that year. In addition, while price decreases are obviously met with no resistance from PMPRB guidelines or from public drug plans, a subsequent increase to the previous non-excessive level if the Canadian dollar weakens will be virtually impossible.

Unless there is a change in international prices in real terms, Canadian companies should not be required to adjust prices solely as a result of exchange rate fluctuations. Doing otherwise inappropriately imposes the economic conditions of other countries onto the Canadian market,

instils considerable uncertainty in the price review process and forces companies to live with the price decrease even after exchange rates return to previous levels.