Wyeth

October 6, 2008

Ms. Barbara Ouellet
Executive Director
Patented Medicine Prices Review Board
Box L40
Standard Life Centre
333 Laurier Avenue West, Suite 1400
Ottawa, Ontario
K1P 1C1

Dear Ms. Ouellet,

As a leading pharmaceutical manufacturer in Canada, Wyeth Pharmaceuticals has been an active participant, since the commencement almost 2½ years ago, of PMPRB's discussions with stakeholders related to proposed changes to the excessive price guidelines. Wyeth is pleased to continue to be engaged in this discussion process.

The attached document is Wyeth's response to the Notice and Comments package released August 20, 2008.

Thank you for the opportunity to comment on this important issue.

Sincerely,

Adam Coote
Vice-President, Market Access and Communication
Wyeth Canada

WYETH'S RESPONSE TO THE

PATENTED MEDICINE PRICES REVIEW BOARD'S

NOTICE AND COMMENTS PACKAGE

"Draft Revised Excessive Price Guidelines"

[Released for comments August 20, 2008]

INTRODUCTION

Wyeth appreciates the opportunity to continue to be a participant in these very important discussions. Since the beginning of the Patented Medicine Prices Review Board (PMPRB)'s consultation process with stakeholders in 2006 concerning potential revisions to the *Excessive Price Guidelines*(EPG), Wyeth has made several written submissions as well as had representation at the Bilateral Meeting held in Toronto in September/2007.

Wyeth is fully supportive of Canada's Research-Based Pharmaceutical Companies formal response, on behalf of its members, to the PMPRB's latest request for comments on the PMPRB's Notice and Comment package, *Draft Revised Excessive Price Guidelines* (N+C), released August 20, 2008.

This submission provides Wyeth's response to selected sections of the N+C which are of particular relevance to our Company.

Wyeth remains uncertain as to the PMPRB's rationale behind this very extensive review of, and significant proposed changes to, the EPG. While acknowledging that some aspects of the current EPG are in need of revision, Wyeth does not believe that existing EPG are so broken as to require such extensive changes as being proposed by the PMPRB in this N+C. In the PMPRB 2007 Annual Report, it was acknowledged that the prices of patented medicines declined by 0.1% during a period when the Consumer Price Index (CPI) rose by 2.1%. The Annual Report further noted that, with the exception of 1992, price changes to patented medicines have been below CPI increases every year since 1988. The Annual Report states that "*... many patentees do not raise their prices by the full amount permitted under the Guidelines*", and that "*... in all jurisdictions (provinces and territories) average rates of price change were well below CPI-inflation*" for the years 2004 thru 2007.[1] On the basis of this information, it certainly appears that the existing guidelines are enabling PMPRB to effectively carry-out its mandate to insure the prices of patented medicines in Canada are not excessive.

We questions how the collection of the significant volume of additional price and sales data required to be submitted by patentees will further assist the PMPRB in its mandate of ensuring that prices of patented medicines are not excessive. Not only do we believe that this serves no

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[1] PMPRB Annual Report 2007, Figures 6 & 8

purpose to the PMPRB's mandate, but this adds a significant increased burden on patentees to gather and report expanded price and sales data. Such initiatives appear to clearly be outside of the PMPRB's initial mandate of ensuring that prices of patented medicines in Canada are not excessive.

For ease of cross-reference, Wyeth's responses have been organized to align with the sequence in which each issue is presented in the PMPRB's N+C.

ISSUE: Levels of Therapeutic Improvement

It is Wyeth's opinion that the PMPRB does not have a role in the therapeutic assessment of a new drug; rather, this role should remain within the mandate of Health Canada, which has exclusive responsibility for determining whether or not a new drug is safe and efficacious and can therefore be marketed in Canada. While acknowledging that their assessment of therapeutic improvement is for the sole purpose of undertaking the introductory price review test, the fact that the PMPRB does engage in such a review process would seem to be an unnecessary duplication of efforts, as well as create the potential for conflicting opinions between two governmental entities. (i.e. While the PMPRB's criteria for a Category 2 New Drug virtually mirror Health Canada's criteria for granting a Priority Review to a new drug, the PMPRB does not recognize Health Canada's assessment; should these two government agencies assign a different category classification, as has occurred in the past, this could lead to considerable confusion in the public's mind about the safety and efficacy of the reviewed drug, as well as bring into question the reputation of both agencies.)

As a compromise between Wyeth's position, as noted above, and the current three category classification used by the PMPRB, the consensus recommendations of the Working Group on Therapeutic Improvement (WGTI) represented a positive step forward. While it is encouraging to note the proposed creation of a new category ("moderate improvement") and acknowledgement that there is a role for 'secondary factors' in the determination of the level of therapeutic improvement, it is disappointing that all of the consensus recommendations of the WGTI were not incorporated in the N+C. Wyeth encourages the PMPRB to reconsider its position, and include all of the consensus recommendations of the WGTI in the final recommended changes to the EPG.[2]

ISSUE: Introductory Price Test

In concert with the compromise noted in the previous section with respect to the proposal to create a new category which would recognize the "moderate improvement" brought by a new drug, Wyeth also notes that the PMPRB has accepted and incorporated in the N+C the recommendations of the Working Group on Price Tests (WGPT) related to the appropriate introductory price tests for each of the four categories of drug classifications.

Wyeth is, however, concerned, about the apparent inconsistency between the Board's position with respect to the reasonable relationship price test for new drugs, as stated on page 4 of the

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[2] Appendix 1

introduction to N+C versus what is presented in Schedule 5. The impact of this inconsistency, which effectively includes significant changes to the reasonable relationship price test without public consultation, will significantly impact the patentee's pricing strategy by introducing a new and unreasonable standard when launching a lower strength of an in-market drug. In the existing EPG, the introduction of a lower strength DIN at a price/unit equivalency to the in-market product would be deemed in compliance with EPG. This seems reasonable, and the PMPRB should consider amending the proposed reasonable relationship Different Strength Test accordingly.

Wyeth has also noted that the proposed EPG fails to recognize two scenarios in which the reasonable relationship test would be inappropriate. In the first instance, the current Compendium of Guidelines, Policies and Procedures (CGPG) allows the PMPRB to conduct a Therapeutic Class Comparison Test (TCCT) when a reasonable relationship test is not considered appropriate or adequate.[3] Such a situation could occur if the new DIN has a materially different therapeutic use or dosage regimen from other DINs of the same or comparable dosage forms of the medicine.

The second scenario considers the situation in which it is impossible or inappropriate to conduct the TCCT.[4] Under these circumstances, the PMPRB is allowed to undertake the introductory price review by assigning primary weight to the international median price for the same medicine in the PMPRB's identified reference countries.

Wyeth recommends that both of these provisions be incorporated into the proposed EPG.

ISSUE: Impact of Reporting Benefits (De-linking of the ATP from the MNE Price)

Wyeth has always found it perplexing that the same price for a drug can be deemed in compliance with EPG in one reporting period, and excessive in a subsequent reporting period. From our perspective, once set, the MNE should never go down in subsequent periods, and, in fact, should be eligible for appreciation based upon CPI rates. It was encouraging to note the PMPRB's initial willingness to consider changes to the existing methodology, both in the discussion paper released in January/2008, as well as the WGPT which devoted considerable time and energies to this topic.

While not a 'perfect solution', the 'de-linking' model ultimately recommended by WGPT seemed to be a reasonable compromise that satisfied the basic concerns of all stakeholders. It was somewhat surprising that the Board chose to only selectively include the consensus recommendations of the WGPT in this latest N+C. Wyeth is of the opinion that the "gap" and "dip" components of the WGPT's de-linking model are inseparable. By putting forth only the "dip" element of the model, the PMPRB has undermined the progressive impact of this proposed change, as well as introduced additional complicating factors to monitor and manage the prices of patented medicines.

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[3] Compendium of Guidelines, Policies and Procedures, Chapter 1, Section 8.3

[4] Compendium of Guidelines, Policies and Procedures, Chapter 1, Section 8.6

Wyeth is concerned that the PMPRB's view of the drug pricing and reimbursement environment in Canada does not recognize the variety and complexity of offers and benefits utilized by patentees to achieve success for their drugs in the marketplace. Programs offered by patentees could target different market segments, may or may not be taken up by some customers within a particular segment, could be multi-year contracts or only cover specific periods of a single year, could involve national or regional compassionate programs, or could be any combination of the above. While the examples of the de-linking model, as presented by the PMPRB during September briefing sessions with various stakeholder groups, provided useful insight as to how the PMPRB envisions this model being applied, these examples did not entirely capture the variety, complexity, timing and interrelationships of the offers and benefits employed by patentees. The examples did little to alleviate concerns about the workability of the de-linking model in the real world.

Not only does there continue to be a lack of clarity on the PMPRB's definition of "benefit related to a sales transaction", the PMPRB has gone on record by saying that it will not provide such clarity, and that it will be up to each patentee to ascertain whether or not a "benefit" relates to a sales transaction. Patentees will be faced with great uncertainty, at the time of the introduction of any particular program, as to whether or not the PMPRB will deem it to "qualify as a benefit" for purposes of applying the de-linking methodology. Such "uncertainty" could prove to be a significant disincentive to offer "benefit programs", to the detriment of the healthcare system in general, and, could ultimately, lead to higher drug prices for Canadians.

Wyeth suggests that there are still many significant, unresolved questions associated with implementing the de-linking model, as presented in the N+C, to move forward with it at this time. Wyeth also recognizes your "sense of urgency" to address these de-linking issues, and encourages the PMPRB to convene a Working Group to do so as soon as possible – though the Board feels some urgency, it would be preferable to arrive at a comprehensive, thoroughly thought through and applicable solution rather than put in place processes that will prove detrimental in the long run. Wyeth further suggests that the full consensus recommendations of the WGPT on this issue be the starting point for the commencement of discussions by the newly constituted Working Group.

ISSUE: Any Market Price Review

While the PMPRB has the statutory right to conduct price reviews in any market[5], in practice, price reviews have been conducted at a national level. In its Annual Report for each of the past several years, the PMPRB has stated that in all Canadian provinces and territories, "average rates of price changes were well below CPI-inflation". With this backdrop, Wyeth is unclear as to why the PMPRB has introduced such a significant additional administrative burden (i.e. monitoring/assessing ATP in multiple markets) on both patentees and Board Staff when the majority of prices *in any market* are in compliance.

With respect to the PMPRB's introductory price review for a new patented medicine, Wyeth is concerned that the proposed methodology, to conduct an introductory price review for each of

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[5] Patent Act, Section 80 & 83

three classes of customers (hospital, pharmacy and wholesaler), does not recognize the reality of launching a new drug into the marketplace. One simple example to illustrate Wyeth's concern would be the scenario in which a new drug may be initially sold at catalogue price to a single class of customers (i.e. wholesalers). Subsequent to the initial launch, a temporary discounted price (i.e. in the form of a compassionate use program, etc.) may be offered to this class of customers for a specified period (i.e. 3 months). Assuming that the catalogue price satisfies the PMPRB's non-excessive price guidelines, this price would become the introductory MNE; as a result of the introductory pricing program, the ATP would be less than the MNE. In a subsequent reporting period, the new drug is launched to a different class of customer (i.e. hospitals), at the original catalogue price. Under the proposed guidelines, the introductory price to hospitals, although equivalent to that charged to wholesalers, would be deemed excessive by the PMPRB (national ATP greater than national MNE). It does not seem reasonable that the same ATP can be deemed in compliance for one class of customer, and excessive for another.

The draft Guidelines indicate that the PMPRB will conduct 'any market reviews' for existing drug products only "where price variability in different markets appears to be an issue". While this infers that such reviews will be carried out on an exceptional basis only, the Guidelines also include a provision that 'in any market' reviews would be used to assess pricing in the event of sales-mix shifts. In addition, during briefing sessions facilitated by Board Staff in September, it was noted that 'in any market' reviews would be a component of applying the proposed de-linking methodology. Wyeth is very concerned that 'in any market' reviews will become the norm rather than the exception; this will significantly impact ongoing monitoring by patentees to ensure compliance with EPG.

Wyeth suggests that there are still many issues surrounding the implementation of 'in any market' price reviews, not the least of which is the methodology to determine excess revenues. Wyeth strongly recommends that the implementation of this proposed change to the EPG be deferred until such time as the outstanding issues can be thoroughly addressed, and appropriate methodology put into place to determine the basis for calculating excess revenues.

ISSUE: Re-setting the MNE Price

Wyeth has noted that there no longer appears to be an opportunity to request re-benchmarking the MNE for a drug which had been sold at a discounted price under a Special Access Program or as an Investigational New Drug following its commercial launch at a higher price, upon receipt of the Notice of Compliance. To address this matter, Wyeth recommends that the PMPRB incorporate Sec. 4.2 of the current Chapter 1 (EPG) of the CGPG, into the new EPG.

OTHER COMMENTS

As stated in earlier submissions, I would like to reaffirm our position that public and third party drug plan payers are not a class of customer. The PMPRB has acknowledged on numerous occasions that its mandate is to ensure that ex-factory prices of patented medicines are not excessive. By definition, an ex-factory price is that which appears on the commercial invoice to the first customer billed when the merchandise has left the manufacturer's shipping dock. At no time does Wyeth directly ship to and invoice public and private drug plan payers; therefore, any payments to them with respect to listing or cost-sharing agreements do not, and should not, fall

within the *Patented Medicines Regulations* to determine net revenues for PMPRB reporting purposes. Wyeth further contends that, should patentees be required to include such payments in price and sales data reporting to the PMPRB, patentees would find themselves in a legal 'no win' situation: should they choose not to report these payments to the PMPRB, they would be deemed in non-compliance with reporting regulations, and potentially subject to fines and penalties; should they report these payments to the PMPRB, they may be found in breach of confidentiality clauses in the agreements with the payers, prosecuted and subject to fines. Confidentiality of the reporting to the PMPRB itself could be breached should one of the provincial plans request information about another province's pricing level from the PMPRB which would then provide its opinion. The consequences of being faced with such a conundrum will undoubtedly be to inhibit patentees from entering into such agreements, and will therefore increase costs in the healthcare sector even without any new price increases being introduced. It is also important to note that some of those agreements with provinces are not voluntary and therefore any interference by the Board in respect of those confidential arrangements could be deemed to be outside of the federal jurisdiction in health care but infringing on the provincial one.

The review of Schedule 6 of N+C reveals proposed changes to be imposed on patentees to address situations were the Canadian price of a patented medicine becomes 'excessive' through no fault of the patentee, merely as a result of a price change to the same drug in the PMPRB's basket of international reference countries. N+C has identified three such scenarios:

1. exchange rate variations;

2. a foreign regulator forcing price reductions; or

3. a drug product priced highest in the world is removed from the market.

The proposed changes would require the patentee to adjust the Canadian price downward by the end of the following year to be in full compliance with EPG, or be subject to a Voluntary Compliance Undertaking.

While the third scenario noted above may have been somewhat addressed during the WGPT discussions, in general, this proposed change has never appeared in any prior discussion document released by the PMPRB, and therefore has never been properly discussed with stakeholders. Wyeth believes it is unreasonable to hold a Canadian manufacturer accountable for events that occur in the international marketplace over which it has no control. Wyeth recommends the permanent removal of Section 5 from Schedule 6; alternatively, implementation of this proposal should be deferred until such time as the PMPRB has been able to engage all interested stakeholders in meaningful discussion on this matter.

CONCLUDING COMMENTS

Wyeth is very concerned about the proposed timelines for implementing the changes to the EPG. While we can appreciate that the discussion stage of this process has already been very lengthy,

the issues are very complex and there remain many unanswered questions, both from an interpretation perspective as well as a technical implementation perspective.

Wyeth believes that the implementation of the proposed revisions to EPG will add a significant burden to patentees, in terms of time and resources to gather and compile the additional data required to be reported, as well as more extensive monitoring activities of prices and sales data in multiple markets to ensure non-excessive pricing and full compliance with EPG. While the PMPRB has intimated that it has initiated changes that would streamline the reporting process and, in fact, reduce the burden on patentees, Wyeth is concerned that the PMPRB has failed to fully grasp the reality of how the proposed changes to EPG will adversely impact patentees.

As noted previously, one of the PMPRB's primary mandates is to work on behalf of the Canadian consumer to ensure the prices of patented medicines are not excessive. A simple litmus test is to ask the questions: by implementing the proposed changes to EPG, how will the PMPRB be in a better to carry out their mandate, and how will the consumer and healthcare system benefit from the proposed changes? For example, if one of the results of implementing the proposed revisions to EPG is that patentees will no longer offer compassionate and/or emergency drug release programs, as there is now a clear disincentive to do so, how does the consumer and healthcare system benefit from the inevitable increased costs they will face, or the lack of access to investigational medicines?

In summary, to reinforce the key messages presented by Wyeth in this submission:

1. while the existing EPG are in need of some revisions, the extensiveness of the changes being proposed by the PMPRB appears overly excessive, complicated, counter-productive to the Federal Government's *Cabinet Directive on Streamlining Regulation* (issued April 1, 2007) and are clearly a disincentive for manufacturers of patented medicines to continue to offer programs which benefit patients and the healthcare sector (i.e. compassionate drug programs, emergency release programs, disaster assistance programs or the Canadian Access to Medicines Regime);
2. the reasonable relationship test provisions of Sec. 8.3 (paragraph 2) and Sec. 8.6 of Chapter 1 of the existing CGPG should be re-instated and incorporated into the proposed changes to EPG;
3. the de-linking of MNE and ATP must be complete, as recommended by the WGPT; there must be assurances that the MNE will never go down;
4. the PMPRB should continue its historical practice of conducting price reviews at a national level; the concept of expanding price reviews 'in any market' beyond those currently practiced under the exist EPG should be abandoned;
5. public and private drug programs should not be considered as a 'class of customer'; payments made to these payers should not be included in price and sales data reporting to PMPRB. With respect to payments to public payers under listing or cost-sharing agreements, these funds go into the general revenue stream of the province and not directly back into drug programs, and therefore do not constitute a rebate to a specific payer.

Wyeth appreciates the opportunity to continue to be engaged in these discussions to revise the EPG. Wyeth encourages the PMPRB to recognize that continuing to adhere to the proposed timelines for implementing changes to the EPG could have a significant adverse impact on patentees, patients and other stakeholders. Wyeth strongly recommends that the PMPRB defer initiating any changes to the EPG until such time as the many outstanding issues have been fully addressed and resolved, and the methodology for implementing the final changes to the *Guidelines* have been established, tested and effectively communicated to the patentees who must comply with the new reporting requirements. In conjunction with the deferral of implementing these changes, Wyeth also encourages the PMPRB, at a minimum, to extend the current reporting requirements to all reporting periods in 2009.