July 31, 2014

Ronald T. Piervincenzi, Ph.D.
Chief Executive Officer
U.S. Pharmacopeial Convention
12601 Twinbrook Parkway
Rockville, MD 20852-1790

Dear Dr. Piervincenzi:

The National Community Pharmacists Association (NCPA) appreciates the opportunity to provide comments regarding USP’s proposed new General Chapter <800> Hazardous Drugs—Handling in Healthcare Settings. NCPA represents the interests of America’s community pharmacists, including the owners of more than 23,000 independent community pharmacies. Together they dispense nearly 40% of all retail prescriptions, and employ more than 300,000 individuals, including over 62,000 pharmacists. According to a recent NCPA member survey, 88% of our members provide compounding services.

Per a letter dated July 10, 2014, and co-signed by 5 additional organizations, NCPA voiced our concern with Chapter <800> and respectfully requested that the chapter be numbered above <1000> in order to be classified as a general information chapter, imparting best practices.

Although there are many best practices included in the proposed chapter and NCPA agrees that employee safety must always be a top priority, the impact on our members and their patients is too great at this time and compliance would be extremely difficult if not insurmountable to the vast majority of NCPA members. As small business owners who provide vital compounds for their patients, our members would be one of the most impacted entities if Chapter <800> were to become enforceable. NCPA still maintains that position, and would like to expand on our concerns and recommendations below.

NCPA recommends that USP not rely on the National Institute for Occupational Safety and Health (NIOSH) list to determine which drugs are under the purview of Chapter <800>. The NIOSH list makes clear that some drugs defined as hazardous on the list may not pose a significant risk of direct occupational exposure because of the dosage formulation. In addition, with updating of the most recent NIOSH list currently underway, NCPA questions the timing of utilization of this list, especially as it relates to new classifications of hazardous drugs that may be considered for the new NIOSH list.
The “NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings 2012” document recommends that each organization create its own list using the NIOSH list as guidance. This document advises that practice-specific assessments should be conducted by individual facilities, which actually conflicts with the Chapter <800> proposal to utilize the entire list.

The NIOSH document does not discuss additional handling of hazardous drugs besides use of a ventilated cabinet. The additional storage and air quality requirements proposed in Chapter <800> will be extremely difficult for many independent community pharmacies to follow.

NCPA believes USP should have provided more background information and data as to why current regulations, guidelines, and standards (including current USP <797> and <795> requirements for PEC and PPE) are not sufficient for the handling of non-antineoplastic hazardous drugs. As mentioned above, a one-size fits all approach to requiring all drugs on the NIOSH list be held to the same Chapter <800> standards is extremely unrealistic and we recommend the Chapter distinguish between antineoplastic and non-antineoplastic drugs at a minimum.

The following line-by-line comments are a compilation of feedback/questions/concerns that NCPA members have submitted as well as NCPA comments based on direct discussions with members:

<table>
<thead>
<tr>
<th>Line #</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>38</td>
<td>USP is a drug standards body, not an environmental setting standards body.</td>
</tr>
<tr>
<td>39</td>
<td>Receipt/storage/dispensing/counting – this will be incredibly burdensome in every practice setting; what evidence is available to show there is legitimate risk from these actions with non-antineoplastic HDs?</td>
</tr>
<tr>
<td>39-46</td>
<td>As receipt of HD is listed, why aren’t third-party logistics (3PL) providers also listed as being held to this requirement?</td>
</tr>
<tr>
<td>50</td>
<td>Problem with acceptable level wording since there will always be some level of risk. The “no acceptable level of personnel exposure” statement combined with this chapter being under &lt;1000&gt; and thereby enforceable could open facilities up to violations of state pharmacy practice acts and undue litigation.</td>
</tr>
<tr>
<td>112</td>
<td>Propose different levels of NIOSH classification based on potential for AE from incidental environmental exposure; separation of hormones and other non-antineoplastic HDs from antineoplastic HDs.</td>
</tr>
<tr>
<td>115</td>
<td>Will be difficult to review every time a new dosage form is used.</td>
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<tr>
<td>136</td>
<td>Receiving and unpacking – is negative pressure required? How would hospitals and physician offices have negative pressure areas on their loading docks?</td>
</tr>
<tr>
<td>182</td>
<td>What are the requirements for labeling and packaging? Does it apply to bulk containers or to individual dispensing containers that patients receive? For example, what are the requirements for progesterone capsules vs. oral methotrexate tablets?</td>
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</tbody>
</table>
Undue burden on small business pharmacies to have three separate areas

Can our members create a "separate designated area" for unpacking in the same room (large room) that non-sterile compounding is being done in (but several feet away)?

How should the handling areas of hazardous and non-hazardous be separated? Does this mean yet another change of physical plant? Our members mix hazardous drugs with nonhazardous drugs on a daily basis, please clarify how you envision this happening.

Storage from antineoplastic HD separate from non-antineoplastic HD – then line 237 switches back to simply HD. What does HD refer to?

Define “separate” (rooms, areas, etc.)

Do our members need to open our traditional wholesale orders in a separate area too, in case there is spironolactone, methotrexate or medroxyprogesterone tablets in the order? Do these products require storage in the room with 12 air changes per hour? This would fall under the category of "too burdensome" for the vast majority of independent community pharmacies. What about long term care facilities and assisted living homes?

Is a negative pressure room required for unpacking? There are many environments such as hospitals or physician offices that would be impossible to manage.

The chapter does not indicate how non-HD ingredients that are used in compounds that also contain HDs should be handled.

This creates undue burden on pharmacies as most cannot meet this criteria. Is a negative pressure room to store HDs required? Is there evidence that storing closed containers of non-antineoplastic HDs in rooms that are not negative pressure has resulted in harmful exposure?

This will create insurmountable financial burden for most pharmacies.
Many of our members have spacious compounding labs inside a traditional pharmacy and many of these labs were built to conform to current USP standards. However, many are not built to contain a negative pressure area with 12 air exchanges per hour. The expense to accomplish this is very large. There is also the issue of external venting. Many of our members have no way to do this due to the physical constraints of their location or are located near business entities where external venting is questionable due to surroundings. For example, a pharmacy may be between two restaurants (sharing a wall) or across the parking lot from a day care center.

Where is a sink required to be? If the requirement is to place a sink in the C-SEC, it appears that this would be in violation of USP <797> in regards to not placing a sink in the buffer area of the C-PEC. Further clarification is required.

Separate room would be extreme burden for facilities who work with non-antineoplastic HDs

Will create financial burden for pharmacies. What is the added safety benefit of this surface requirement that would justify the expense, especially for non-sterile compounding?

Problems for 503B providers and 503A, redesign of facilities will be cost prohibitive.

Method must be used should be changed to “may.”

378 states “may” but 378 “requires” pass thru.

Does this apply for non-sterile compounding?

<PPE> should be sufficient for non-antineoplastic HDs. Recommend alternative to requiring negative pressure rooms and ASTM HD-attire for non-antineoplastic HDs.

Two gloves should be required only when HD requires it.

Administering – do patients need gloves as well, and if not why is their exposure considered acceptable?

Recommend changing “every 30 minutes” to “at completion of each compounding process” to avoid unnecessary disruptions.

<PPE> should be sufficient for non-antineoplastic HDs.

Can completed compounds come into the dispensing area? Can they be hung in the "will call" area with other prescriptions?
Certified powder containment hoods should omit requirement for respirator masks for non-antineoplastic HDs.

Special disposal should not be required for non-antineoplastic HDs.

Do non-antineoplastic HDs fall into this category?

Does this HD apply to all or just antineoplastic HDs?

<795> requirements for receiving should be sufficient.

When handling non-antineoplastic HDs, <795> + powder containment should be sufficient; need alternative to requiring an entire negative pressure suite.

What about antineoplastic HDs that aren’t in a coated table or capsule?

Can non-antineoplastic HDs be packaged in bottles, tubes etc. or do they need to be blister packed into unit dose?

Please provide evidence that <795> guidelines for cleaning glassware is not sufficient to remove residue for non-antineoplastic HDs to avoid cross contamination; need alternative.

Two pairs of gloves should be required only when HD requires it.

Is deactivating necessary for non-antineoplastic HDs?

Is this necessary for non-antineoplastic HDs?

Please clarify “routinely” during compounding.

Please clarify area under the work tray.

Is this necessary for non-antineoplastic HDs?

Is this necessary for non-antineoplastic HDs?

Are common marker HDs required for non-antineoplastic HDs?

Undue burden financially.

Liability for employers because changes in endogenous levels or exposure outside of work cannot be separated from exposure in the workplace nor prevented by the employer.

Is the intent to apply to all HDs?
This requirement is invasive and likely violates HIPAA and anti-discrimination laws; also doesn’t account for changes in age, life circumstances, drug therapy, etc.

The burden of proof on the employer to show that the future health was negatively impacted by the work related exposure is monumental and opens doors for legal actions by employees.

This section is too general and large in scope – how would one be deemed compliant?

We would like to reiterate the fact, as stated in our line-by-line comments above, that most NCPA members do not currently have the physical space to recreate/reformat their labs to comply with these requirements. Doing so would be completely prohibitive for some and cost-prohibitive for most. The unfortunate result is reduced patient access to compounded medications.

As stated in the aforementioned July 10, 2014, letter to USP, our members are currently held to regulations and guidelines from the Environmental Protection Agency (EPA) and the Occupational Safety and Health Administration (OSHA) which detail the handling of hazardous material, and although we appreciate the intent of the proposed chapter <800>, anything duplicative of currently enforceable rules can lead to confusion.

By placing this chapter above <1000>, our members will be afforded the opportunity to perform the appropriate analyses, including cost impacts and the impact upon the delivery of services to patients, and integrate best practices where appropriate. Given that no assessment of the financial impacts or the potential disruption to medication access has been conducted during the development of the proposed chapter <800>, we believe placing this chapter above <1000> to be the most prudent and appropriate course of action for USP. In addition, we recommend that a re-evaluation of implementation of the standards after a period of time occur, before consideration of renumbering the chapter.

While we respect the work of your expert committee and the merits behind the proposed chapter, we appreciate your thoughtful consideration of our comments.

Sincerely,

Ronna B. Hauser, PharmD
VP Pharmacy Affairs