Towards a Systematic Approach to REMS Design

Adam Kroetsch
Office of Program and Strategic Analysis
OSP, CDER, FDA
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Why do we need a systematic approach to REMS design?

A systematic approach to REMS design could help us...

- Document and communicate a "rationale" for each REMS.
- Comprehensively identify and anticipate failures.
- Address complexity of drug risk management.
- Reduce unnecessary variation in REMS design and tools.
- Increase predictability of review process.



REMS Design: Future State

Establish the Scope

- Characterize the <u>risk</u> that the REMS is trying to address and conditions for <u>safe use</u> of the drug.
- Establish the likely <u>context of use</u> for the drug.

Analyze the Problem

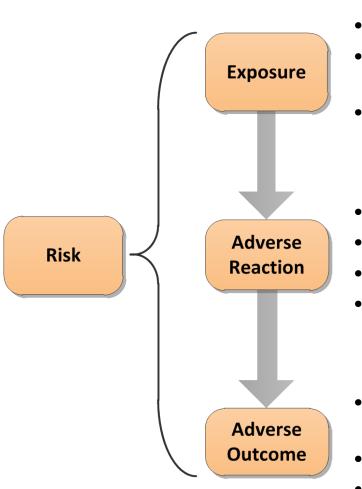
- Identify <u>failures</u> in safe use that might lead to patient harm.
- Identify <u>underlying causes</u> of those failures.

Specify Interventions

- Specify <u>key information / desired behaviors / process</u> changes to address underlying causes.
- Develop <u>interventions</u> to convey information/ behaviors.



Characterize the risk and safe use of the drug



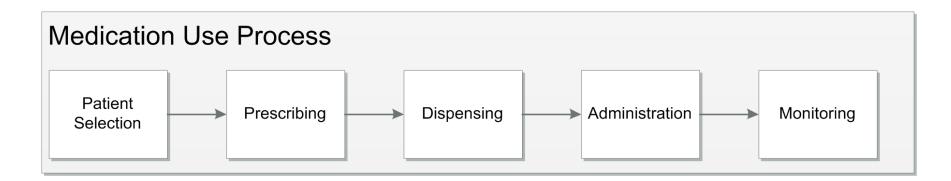
- How do patients become exposed to the risk?
- What is the relationship between exposure and the adverse reaction of concern?
- Can exposure be managed to reduce the likelihood of an adverse reaction? How?
- What is the adverse reaction (ADR) of concern?
- Can it be prevented, detected, or treated? How?
- What risk factors affect the likelihood of an ADR?
- Can they be prevented, detected, or treated? How?

- What are adverse outcomes that can result and how likely/severe are they?
- What factors affect their likelihood/severity?
- Can they be prevented, detected, or treated? How?



Establish the context of use

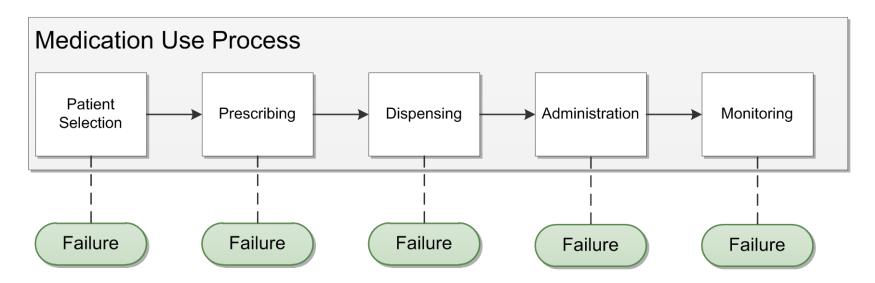
- Which patient populations that are likely to use the drug?
- In which healthcare <u>settings</u> is the drug likely to be prescribed?
- Which stakeholders will be involved in the patient's care?
- What is the <u>process</u> by which the patient is treated?





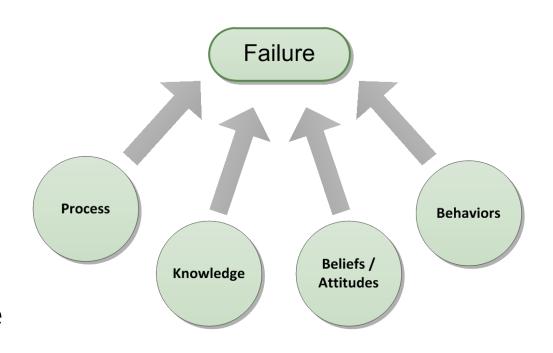
Identify possible failures

- What are the potential failures that could lead to unsafe use and patient harm?
- Where in the medication use process could these failures occur?



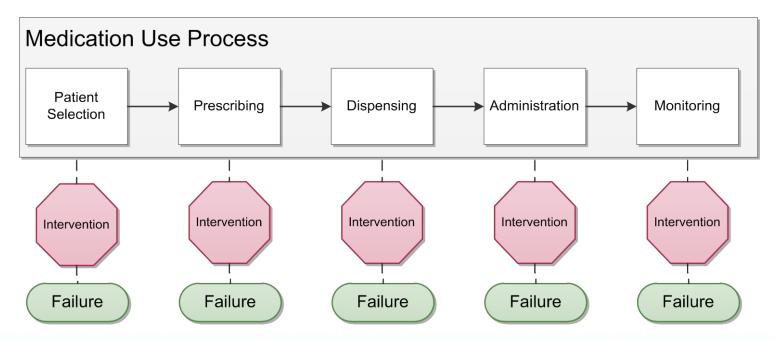


- How does the medication use process contribute to the failure?
- How do the knowledge, attitudes, beliefs, and behaviors of stakeholders contribute to the failure?





- What information, behavior changes, or process changes are needed to address the underlying causes of failure?
- What interventions can effectively convey information and implement changes?



Develop tools

Elimination / Substitution **Engineering Controls** Administrative Controls Training and Education

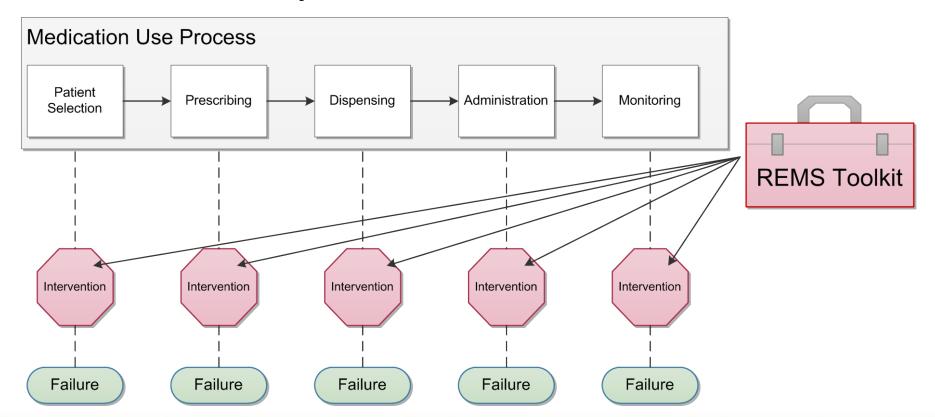


 When is it possible to use engineering or administrative controls?

 How do we balance tool "intensity" against access and burden considerations?



- What tools can we use from our REMS toolkit?
- How should they be customized to the individual REMS?





Practical Considerations

An effective approach should...

- 1. Work within the regulatory review process
 - Build an evidence base that permits informed decision-making
 - Consider time/resource and regulatory constraints
- 2. Focus on what's most important
 - Prioritize most important failures, root causes
 - Prioritize most effective/feasible interventions
- 3. Streamline to enhance efficiency
 - Share tools across programs (e.g., for similar risks, failures, and/or contexts of use)
 - Re-use analysis across programs
- 4. Design with evaluation in mind