

June 20, 2007

Reference No.: INSL07001

The Honorable Jay Inslee
United State House of Representatives
Washington, DC 20515

Dear Representative Inslee:

On behalf of the Plasma Protein Therapeutics Association (PPTA), I am writing today to express our support for H.R. 1956, the Patient Protection and Innovative Biologic Medicines Act of 2007. PPTA is the association that represents the manufacturers of plasma protein therapies. These lifesaving therapies, which are either plasma-derived or recombinant, are used to treat a variety of diseases and serious medical conditions. PPTA members produce more than 80 percent of the plasma protein therapies for the United States market and more than 60 percent of such therapies for global consumption.

Manufacturers of plasma protein therapies extract a number of proteins, including blood clotting factor, immunoglobulin, alpha-1 antitrypsin, and albumin, from human plasma through the fractionation process. Because of its human origin, complexity, and richness in therapeutically useful proteins, human plasma is a unique biological material that serves a very small, fragile patient population. Blood clotting factor is necessary to treat individuals with life-threatening, chronic and congenital bleeding disorders, including hemophilia and von Willebrand's Disease. Albumin, which is the largest protein fractionated from plasma, is generally used in the surgical setting as a blood volume replacement therapy to treat burns and shock. Physicians use intravenous immunoglobulin to treat patients with primary immune deficiency disease, secondary immune deficiency diseases, such as pediatric HIV and B-cell chronic lymphocytic leukemia; idiopathic thrombocytopenic purpura, which is an autoimmune bleeding disorder, Kawasaki disease, bone marrow transplantation, neuropathies, and multiple sclerosis. Alpha-1 antitrypsin is used to treat patients suffering from genetic emphysema.

PPTA applauds your decision to exempt plasma-derived therapies from the abbreviated U.S. Food and Drug Administration (FDA) approval process for similar biological products that would be implemented by H.R. 1956. This treatment of plasma-derived therapies is consistent with the approach the European Medicines Agency (EMA) has taken with such therapies. In its *Guideline on Similar Biological Medicinal Products*, EMA, however, expressly excludes both plasma-derived therapies and their recombinant analogs, collectively known as plasma protein therapies, from an abbreviated approval process because of their "complex and variable physico-chemical,

biological and functional characteristics.” While this guidance document from the EMEA is not legally binding *per se*, it does reflect “the current scientific consensus” in the EU. While PPTA supports H.R. 1956, especially its treatment of plasma-derived therapies, PPTA respectfully requests that you make a minor amendment to this legislation as currently drafted to also exempt recombinant blood clotting factor.

A significant majority of blood clotting factor in the U.S. market is recombinant. Recombinant blood clotting factor is genetically engineered in a laboratory environment where the human clotting factor gene is isolated and inserted into non-human cells, which are then grown in a cell culture. The manufacturers of recombinant blood clotting factor harvest this therapy from the fluid in which this cell culture is suspended. Although this manufacturing process differs from that of plasma-derived blood clotting factor, both types of this critical therapy must be treated equally.

According to the FDA, plasma protein therapies, including blood clotting factor replacement therapy, are not therapeutically equivalent, pharmaceutically equivalent, or bioequivalent. While the marketplace includes several brands of plasma protein therapies in each respective class of drugs, none are listed in the FDA’s Orange Book. Moreover, plasma protein therapies are not interchangeable. Because of important clinical and manufacturing differences, an individual patient may tolerate or react to one plasma protein therapy better than the other therapies in the same class in the marketplace. For example, before prescribing blood clotting factor replacement therapy, physicians must consider factors beyond clinical indications, including the patient’s underlying medical condition, and previous reactions by the patient to such therapy. Moreover, because treatment with blood clotting factor is generally for the duration of the life of a patient, there are higher risks of immunogenicity for those patients using this therapy. Recent evidence suggests both plasma-derived and recombinant clotting factor may be immunogenic.

Although the patient population for chronic bleeding disorders is small, these diseases are quite debilitating. Most often, patients requiring blood clotting factor, either plasma-derived or recombinant, must infuse themselves frequently with the appropriate blood clotting factor replacement therapy in order to maintain an acceptable quality of life. This fragile patient population must have access to the most appropriate therapy that best suits their individual needs.

PPTA is very grateful for your recognition of the critical nature of plasma-derived therapies for these patients and urges you to give the same consideration to recombinant blood clotting factor replacement therapy as H.R. 1956 moves forward in the Committee on Energy and Commerce.

Sincerely,



Julie Birkofer
Vice President
PPTA North America