



May 29, 2015

The Honorable Fred Upton, Chairman
The House Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Frank Pallone, Ranking Member
The House Committee on Energy & Commerce
2322A Rayburn House Office Building
Washington, D.C. 20515

The Honorable Joseph Pitts, Chairman
The House Committee on Energy & Commerce
420 Cannon House Office Building
Washington, D.C. 20515

The Honorable Gene Green, Ranking Member
The House Committee on Energy & Commerce
2470 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Diana DeGette
The House Committee on Energy & Commerce
2368 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairmen Upton and Pitts, Ranking Members Pallone and Green, and Ms. DeGette:

On behalf of the 30 million men, women, and children affected by one of the nearly 7,000 known rare diseases, the National Organization for Rare Disorders (NORD) thanks you and the Energy and Commerce Committee for your continuing support of the rare disease community.

We welcome the opportunity to provide comments on the 21st Century Cures Act (H.R.6) recently passed with unanimous support by the Committee on Energy and Commerce. It is our hope that these comments will permit the House to consider the rare disease patient community's perspective on a number of the provisions as opportunities to amend the legislation continue.

Overall, we are very encouraged by the progress made within this version of the bill, and we are supportive of the majority of provisions that directly influence the rare disease patient community contained within.

We are especially heartened by the additional funding proposed for the National Institutes of Health (NIH) and the Food and Drug Administration (FDA). The FDA is a woefully underfunded agency, and adding more responsibilities requires the appropriate resources for implementation and effective management of these promising new programs. We thank the Committee for including the Cures Innovation Fund in Chairman Upton's amendment attached to the bill.

Below are our comments on specific sections within the bill.

Title I - Discovery:

Subtitle A – National Institutes of Health Funding: NORD thanks the Committee for its commitment to the NIH, and we wholeheartedly support both the additional \$1.5 billion in discretionary funding for each of the next three years and the \$2 billion “NIH Innovation Fund” authorization for each of the next five years.

The rare disease patient community relies on the NIH to conduct or fund much of the essential basic and translational research on rare diseases. This research lays the groundwork for therapeutic development for neglected diseases with inadequate or no treatment. The additional funding in this bill will help restore the NIH purchasing power lost over the last ten years. We hope the Committee continues its commitment to the NIH by continually increasing the NIH budget to at least keep up with medical inflation in 2019 and beyond.

Subtitle B – National Institutes of Health Planning and Administration: NORD thanks the Committee for requiring rare and pediatric diseases and conditions to remain a top priority at the NIH as it undergoes a strategic planning process. Coupled with a requirement for the NIH to consult with patient advocacy groups in its development of the strategic plan, we believe this provision will allow rare disease research to remain one of the NIH’s greatest strengths.

Subtitle E – Promoting Pediatric Research Through the National Institutes of Health: We thank the Committee for the inclusion of the “National Pediatric Research Network” section and the “Global Pediatric Clinical Trial Network Sense of Congress” section. NORD has been a supporter of the National Pediatric Research Network since its inception in 2013 as we believe a network and database of pediatric diseases, many of which are rare, will better coordinate pediatric research across the United States. The establishment of a “Global Pediatric Clinical Trial Network” will take this goal even further by facilitating pediatric clinical trials across the world.

Subtitle G – Facilitating Collaborative Research: Sec.1123. Data on Natural History of Diseases: NORD strongly supports this provision on the establishment of natural history data registries with a particular focus on rare diseases. If enacted, we would welcome the opportunity to engage in public/private partnerships with the relevant federal agencies implementing and overseeing this provision.

We believe rare disease natural history data registries are central to understanding a disease and its symptoms, and catalyzing research and drug development in neglected diseases. Because each disease affects people differently, scientists must study many cases to develop a thorough understanding of its natural history. This poses a special challenge for rare diseases, where collecting longitudinal natural history information has been limited by the small number of cases available for study.

To address this challenge, NORD has created a powerful, web-based registry platform. This enables the collection of high quality, natural history data for disease-specific research, with a focus on cross-disease analysis. We look forward to working with the Committee and regulators

in the development of this public/private partnership, and we fully support the enactment of this provision.

Title II – Development:

Subtitle A – Patient-Focused Drug Development: NORD strongly supports the Committee’s efforts to strengthen the patient’s voice within the FDA drug development process by creating a structured framework for the incorporation of patient experience data. While we are in full agreement with the spirit of the provision, we would still suggest a few changes to the language in order to craft a more effective and inclusive provision.

First, we would recommend striking the term “new drug approval process” and replacing it with “new drug review process”, or something similar. We do not want to see patient experience data only being used at the conclusion of the development process when the drug is approved, and as the language is currently structured, this may be the case.

Second, the term “patient experience data” is backwards looking, only taking the patients prior experience into account. “Patient preference data” should also be included. In the current Patient-Focused Drug Development Initiative, a common question asked at the meetings is “Would you be willing to participate in a hypothetical clinical trial if there were risks involved” and “what would you look for in an ideal treatment”. Both of these questions are incredibly valuable when taking into consideration the patients’ perspectives rather than solely their experience with the disease.

Finally we are encouraged to find a correction from the previous language which would have excluded the biopharmaceutical industry from this process.

Overall, we support this provision and would welcome its enactment, though we do believe there are several changes that need to be made in order to truly capture the power and importance of the patient perspectives and engagement in the drug development process.

Subtitle B – Qualification and Use of Drug Development Tools: In our previous comments, we regarded this section as overburdensome to the FDA due to the rigid qualification timelines laid out in the language. Now that the new language reflects the FDA’s input, we believe this language may be successful in codifying an extremely important program while also providing the FDA with the needed flexibility.

Establishing an appropriate clinical endpoint can be especially difficult for studies involving rare diseases. All clinical trials must have agreed-upon clinical endpoint(s), intermediate clinical endpoint(s) (ICE), or surrogate endpoint(s) for FDA approval. We are pleased that the Committee has chosen to address the development of Biomarkers and surrogate endpoints, and we encourage Congress to continue its involvement by ensuring the FDA implements this program expeditiously and appropriately.

Subtitle C - FDA Advancement of Precision Medicine: We have supported the prior iterations of this provision, and we voice our support for this version as well. This provision aims to signal

to the Food and Drug Administration (FDA) that it can use extrapolated data and information previously used in the approval of a drug from the same sponsor when approving a new therapy that incorporates or utilizes the same or similar genetically targeted platform technologies.

This is critically important to accelerating the development of treatments and cures for the numerous devastating rare diseases or subsets of rare diseases that otherwise have little hope of a treatment or cure due to their extremely small population size. By allowing the FDA to use previously accepted data, this provision will help facilitate the development and approval of therapies for these diseases.

We support the language for several reasons. First, the language clarifies that only the sponsor that generated the original data may extrapolate that data for future uses unless they grant permission for its use elsewhere. Second, this language does not bind the FDA in its review processes, and instead codifies the existing flexibility in the data they are allowed to accept. We are supportive of this provision and support its enactment.

Subtitle E – Expediting Patient Access: Sections 2082 and 2083 - Expanded Access Policy: NORD supports these expanded access provisions, and believes they will provide greater transparency for patients and their health care providers and provide companies with greater clarity on FDA’s current thinking on expanded access. We thank the Committee for including these provisions throughout the 21st Century Cures process, and we encourage its inclusion in the final 21st Century Cures Act.

Subtitle F - Facilitating Dissemination of Health Care Economic Information: Section 2102 - Facilitating Responsible Communication of Scientific and Medical Developments: NORD recently joined with ten other patient and provider organizations in a May 12th letter calling for the inclusion of a provision that would require the FDA to issue guidance on the dissemination of off-label information.

With only 350 rare diseases with an FDA-approved treatment, the vast majority of rare diseases are treated off label. To quote the May 12th letter,

"The Food and Drug Administration (FDA) currently requires manufacturers to present specific clinical trial information to bring products to market, and the FDA is responsible for creating a tailored product label reflecting how that product has been studied and how it should be used. Unfortunately, many patients suffer from diseases where there are no FDA approved products or for which their specific clinical needs fall outside of the narrow product label. As a result, the current FDA policy around dissemination of off-label product information is inefficient and restricts the free flow of information available about these treatments."

We strongly support this provision, and we support its enactment.

Subtitle I - Orphan Product Extension Now; Incentives for Certain Products for Limited Populations:

Section 2151 - Extensions of Exclusivity Periods for a Drug Approved for a New Indication for a Rare Disease or Condition: We are pleased to see this provision in the 21st Century Cures Act, and we reiterate our support for this provision. As mentioned above, the vast majority of rare disease patients are treated off-label, often causing various problems in patient access to care and reimbursement. This proposal would create an incentive for placing rare disease conditions on the label, thus greatly increasing the likelihood insurance would cover the therapy for the rare condition. We encourage the Committee to include this provision within the final legislation.

While we are supportive of this provision, we encourage the Committee to continue to discuss incentives for the development of re-purposed therapies that do not have remaining patent life. The discussion around dormant therapies is incredibly important, as many therapies that lack remaining patent life could be incredibly valuable for rare disease patients.

Section 2152 - Reauthorization of Rare Pediatric Disease Priority Review Voucher Incentive Program: NORD thanks the Committee for including the reauthorization of this critical program in the introduced bill. We believe this program has been very successful in attracting pharmaceutical interest in rare pediatric diseases, and by incentivizing therapeutic development in rare pediatric diseases by awarding priority review vouchers, this program does not carry the fiscal concerns for the government or health care system that other pharmaceutical incentives carry.

While we are encouraged by the inclusion of this provision, we are disappointed with and eager to help improve or sharpen some important specifics of the provision's language. First, this provision only reauthorizes the program through December 2018, less than three years away. This is problematic because we believe any incentive program will only be effective if it ensures stability and predictability for the pharmaceutical industry. Companies are unlikely to enter the rare pediatric disease therapeutic area in hopes of gaining a priority review voucher if they have no idea if the voucher program will be in existence once their therapy qualifies. This greatly and possibly entirely dilutes the incentives of this program.

Second, December 2018 is misaligned with future opportunities to reexamine and possibly reauthorize this program. We believe this program should be permanently reauthorized to ensure long-term stability of this program. If permanent reauthorization is not instituted, NORD suggests that there should be at least a seven year reauthorization to allow this program to be reexamined in PDUFA VII negotiations. We were encouraged to see a 2022 termination date in the third discussion draft, but December 2018 is entirely misaligned with any other reauthorization opportunities and could be extremely problematic for the potential reauthorization of this program.

One option to address stability concerns is to allow therapies that have received a rare pediatric disease designation during the voucher program's existence to receive the voucher later on even if the program has expired. NORD is currently reviewing this proposal, and would welcome further discussion on its efficacy.

We are also disappointed with the language that states, "The disease is a serious or life-threatening disease in which the serious or life-threatening manifestations primarily affect

individuals aged from birth to 18 years...". It is our understanding that this language attempts to address concerns in the rare disease community about the FDA interpretation of "primarily affecting a pediatric population", but we believe the above language misses the mark for a variety of reasons.

While we are relieved to see the removal of the "serious and life-threatening" requirement from the latest text, we believe the addition of the "serious or life-threatening" stipulation to qualify for the voucher opens an additional door to interpretations that may exclude some deserving treatments for rare pediatric conditions from the program. We do not believe this new stipulation is needed, and would ask the Committee to remove this language from the bill.

In the same regard, we remain concerned that the current language might exclude deserving rare pediatric conditions from the program by overly relying on prevalence data rather than incidence or morbidity data. The language referenced above, specifically the "serious or life-threatening manifestations primarily affect individuals aged from 0-18", could allow the FDA to again circumvent the clear intent of the provision by using the phrase, "primarily affect" to restrict voucher eligibility to those diseases in which more than 50 percent of individuals currently affected with severe manifestations are between birth and 18 years of age. Instead, we believe the FDA should use morbidity data in determining what diseases qualify for the program.

Finally, we recognize concerns about diluting the economic power of the voucher through the awarding of too many vouchers, but we reject the notions that annual caps or an early termination date are solutions. We hope this conversation continues on the best path forward, but we implore the Committee to steer away from annual caps.

We again thank the Committee for the inclusion of this reauthorization within the 21st Century Cures Act, but we hope to continue to work with the Committee to find a consensus on the language and length of reauthorization.

Subtitle L – Priority Review for Breakthrough Devices: We would like to reiterate our support for the establishment of a breakthrough pathway for medical devices. This provision would greatly benefit the rare disease community in need of innovative therapies, and we support its continued inclusion within the 21st Century Cures Act.

Subtitle M – Medical Device Regulatory Process Improvements: Sec.2227 - Humanitarian Device Exemption Application: NORD supports expanding the Humanitarian Device Exemption program to products that impact up to 8,000 patients rather than the 4,000 use cap currently in statute. The 4,000 patient limit is an arbitrary number having no scientific rationale, and expanding this valuable program to deserving rare disease patient populations is critical. NORD supports this provision, and we support its enactment.

Subtitle Q - Exempting from Sequestration Certain User Fees: NORD has always supported exempting user fees collected under the various user fee agreements from sequestration, and we are elated to see this provision included within Chairman Upton's amendment to the 21st Century Cures Act. These fees support a substantial portion of the FDA staff that reviews and approves

new therapies. Sequestration of these funds inevitably would lead to delays in the availability of many new drugs and devices that patients with rare diseases need.

Fees collected from the drug and medical device industries are essential in providing FDA with the resources it needs to promptly and efficiently review applications for new therapies, many of which are intended to treat patients with rare diseases. Regulated companies have been required to pay fees since 1992 so that FDA has the resources necessary to provide efficient product reviews.

Thank you for including this provision within the 21st Century Cures Act, and we support its enactment.

Title III: Delivery

Subtitle A – Interoperability: NORD thanks the Committee for including language on the interoperability of health data. NORD submitted comments to the Committee on July 21st in response to the Committee’s “Leveraging Technology to Advance the Discovery, Development, and Delivery of Better Treatments and Cures” white paper. At that time we called for greater coordination to ensure the interoperability of patient data. While we do not yet have comments on the language contained within the bill, we will continue to review the language and will look to provide the Committee with feedback on the language at a later date.

Subtitle B – Telehealth: We thank the Committee for its efforts on improving the telehealth landscape. As a member of the Advisory Board of the Alliance for Connected Care, NORD recognizes the importance of being able to access one’s physician outside of the hospital or doctor’s office.

Telehealth is especially important to the rare disease community, as many rare disease patients must travel far to see physicians who specialize in their disease or disease area. This distance is often prohibitive in accessing treatment, and can create insurance reimbursement issues as well. In addition, many patients with rare diseases have severe physical disabilities, thus making even a limited amount of travel difficult. Telehealth allows rare disease patients to receive consultation from qualified health care providers in their own home or community, thus greatly improving access to care and to the quality of life of the rare disease patient.

There are many regulatory hurdles physicians must overcome if they are to use telehealth. First, physicians face steep reimbursement challenges when practicing telehealth, especially within the Medicare and Medicaid programs, as telehealth is often only reimbursed for beneficiaries who are living in very rural areas. Public and private health insurance models are also not adequately reimbursing for the physician’s consultative services, which makes up the vast majority of telehealth services. It is also important that where appropriate rare disease patients have access to allied health professionals with expertise in telehealth.

Second, there is a lack of a standard definition of telehealth, thus creating different standards across health care practices and insurance plans. This exacerbates access and reimbursement issues, creating vast inequalities in accessing telehealth across the nation.

Finally, in order to facilitate a greater use of telehealth, the current medical licensure system must be reformed. Currently, State Medical Boards are responsible for setting licensing standards in each state, thus creating broad variation in application processes, fees, processing times, and requirements. Most states require a health care provider to be licensed within the state to practice telehealth there. Thus, to practice telehealth you are required to obtain a medical license in each state where patients are treated.

Together, these hurdles make practicing telehealth extremely difficult, thus greatly limiting access for rare disease patients who may not be geographically close to their rare disease specialist. We view the language contained within the bill as a good first step towards addressing these problems, but we hope the Committee will continue to work towards expanding telehealth services.

Thank you again for the opportunity to engage in this exciting and much-needed initiative. We look forward to working with you and the Energy and Commerce Committee to ensure the passage of the 21st Century Cures Act, and we are grateful for your recognition of these extremely important issues within the rare disease community.

For questions regarding NORD or these comments, please contact Paul Melmeyer, Associate Director of Public Policy at pmelmeyer@rarediseases.org or (202) 588-5700 ext. 104.

Sincerely,



Peter L. Saltonstall
NORD President and CEO