Public consultation on the draft guidelines on compounding of medicines

Organisation name

APHS Pharmacy Group

Contact information

Stuart Giles

[redacted]

APHS

Your Pharmacy Partner

Your Pharmacy Partner

Responses to consultation questions on the draft guidelines on compounding of medicines

1. Do the draft guidelines clearly differentiate between simple compounding and complex compounding?

Greater differentiation and clarity between simple compounding and complex compounding and between those compounding (manufacturing) activities which are to be regulated by the PBA and those manufacturing activities which will be regulated by the TGA would be beneficial.

The two areas where further clarity is required are the reconstitution of sterile preparations and the manufacture of quantities in excess of that required by a single patient for a single episode of treatment.

Sterile preparations: It is unclear as to whether the term 'sterile preparations' in the definition of complex compounding includes the reconstitution of ARTG listed preparations such as freeze dried powders for eye drops and freeze dried powders for parenteral administration.

Quantities: While the board has indicated that it discourages batch preparation, it is unclear as to what extent a pharmacist can manufacture quantities of medicines in advance for one or a number of individuals.

APHS supports regulation of compounding aligned with the level of risk associated with the preparation. As this necessitates varying levels of regulation, we believe it is imperative that the profession is provided clarity as to the practices to which levels of regulation will apply.

The definitions and commentary provided within the guidelines which can be used by the profession to determine the nature of the manufacturing process (simple or complex) and the application of the relevant regulations, rely upon a number of independent variables, some of which are vague. These variable include but not limited to:

- the quantity being compounded (unit of issue, batch)
- the likely delay between compounding and utilisation (immediate use, manufacture in advance of regularly supplied products)
- the resources and equipment required (specific equipment and/or facilities)
- competence of the persons involved (expected of all pharmacists, specific competencies)
- the method of preparation (reconstitution, extemporaneous dispensing, compounding, manufacture)
- the nature of the pharmaceutical formulation (sterile products, micro dose, modified-release formulations)
- perceived occupational risk from handling the substance (cytotoxics, hormones)
- the identification of the user (individual patient, specific patient, multiple persons)
- the purpose of supply (identified need, veterinary)

- the evidence base for the product (ARTG listed, reputable reference, pharmacist's sound judgement)
- where the preparation occurs (pharmacy, TGA approved facility)
- the existence of comparable products (e.g. preparation of paediatric doses less than 25mg per unit of issue of products for which ARTG listed adult dose forms exist in higher doses)
- the extent or method of distribution of the product (from the premises of manufacture, by wholesale, interstate)

Because of the lack of specificity of the definitions distinguishing between simple and complex compounding can only be made on a case-by-case basis.

The current *TGA Consultation on Options for Reform of the Regulatory Framework for Pharmacy Compounding* uses the same definition for complex compounding as is used in these draft PBA guidelines, and the TGA options include the possible requirement for licensing of premises in which complex compounding is undertaken. The pharmacy profession faces the likely introduction of two regulatory frameworks, with potential for overlap, and lack of clarity in the definition which would be used to determine which regulations are applicable.

The uncertainty in the definitions, the applicable regulations and the responsible agency will likely mean the enforcement of compounding regulations will be difficult.

Greater specificity in the definitions would be beneficial and consideration could be given to adopting a check list to differentiate between simple compounding, complex compounding and manufacturing. This could be a variation of the table presented as Appendix 1 (General Guideline on Compounding and Manufacturing Activities) from Health Canada's *Policy on Manufacturing and Compounding Drug Products in Canada*. For a check list of this nature to be of maximum benefit, it would be useful for different terms to be adopted to describe the preparation of products that are listed on the ARTG, which are prepared in facilities subject to TGA regulation and terms which describe preparation of products not ARTG listed and not requiring TGA regulated facilities.

4. Is there any content that needs to be changed, added or deleted in the draft guidelines?

The draft Guidelines state "Only medicines for parenteral administration with a shelf life of up to 24 hours should be compounded by a pharmacist for use by a specific patient."

APHS believes the minimum practical shelf life should be applied to aseptically prepared parenteral products and accept that 24 hours is an acceptable, although arbitrary duration in most circumstances (allowing for chemical stability). There are however, some situations where a 24 hour shelf life is not practical. Some ambulatory patients are administered chemotherapy drugs via continuous infusion of up to 24 hours duration. Such infusion cartridges are prepared in controlled environments such as laminar flow hoods, isolators and CDSCs and to accommodate the time needed for distribution to the patient, are allocated a shelf life of up to 48 hours. Similarly, aseptically prepared parenteral nutrition solutions may be allocated a shelf life of up to 48 hours in situations where, based on the flow rate, the infusion volume will last in excess of 24 hours.

APHS believes a 24 hour shelf life for all aseptically prepared preparations is too restrictive and would support a shelf life of up to 48h for preparations compounded in approved facilities with validated procedures.

7. Do you have any other comments on the draft guidelines?

APHS supports regulation of compounding aligned with the level of risk associated with the preparation and use of the individual compounded preparation. Any regulation should be applicable in a consistent manner in all jurisdictions and in all practice settings and to all practitioners.

The draft guidelines propose that "to manipulate a commercially available product in accordance with the manufacturer's instructions, in order to produce a product in a ready-to-administer form" is to be classified as compounding and, furthermore, that compounding of "sterile preparations" is to be considered complex compounding with the associated requirement for demonstration of competence.

Clarification is required in relation to the application of these guidelines to a range of scenarios, such as the reconstitution of a sterile vial of freeze dried powder to prepare eye drops, withdrawal into a syringe of a measured dose from an ampoule, the transfer of a measured dose of solution from an ampoule to a large-volume parenteral solutions and the addition of a diluent to a vial for the purpose of reconstitution.

For example, the aseptic transfer of an ARTG registered and commercially available sterile product such as 2ml of B group vitamins from an ampoule to a commercially available ARTG registered sterile infusion fluid may be captured by the above criteria as complex compounding. This process and numerous similar simple aseptic transfers including the reconstitution of freeze dried sterile powders parenteral use, is frequently undertaken on the wards of hospitals and in other health care settings by nurses and other health professionals.

The draft guidelines also propose that the manipulation of monoclonal antibodies by pharmacists be classified as complex compounding however, this task is also undertaken in certain circumstances on wards by nurses and others.

While accepting the need for the application of guidelines commensurate with the risk, it is incongruous that tasks which can be undertaken by nurses on the wards of hospitals are to be classified as complex when undertaken by a pharmacist.

End of submission