CASE AUTH/2957/5/17

VOLUNTARY ADMISSION BY ASTELLAS UK

Omission of prescribing information

Astellas Pharmaceuticals (Astellas UK) voluntarily admitted that promotional materials which referred to both Betmiga (mirabegron) and solifenacin (Vesicare) only contained prescribing information for Betmiga. In addition, promotional material which referred to both Advagraf (tacrolimus prolonged release capsules) and Prograf (tacrolimus capsules) did not contain prescribing information for the latter.

Whilst the voluntary admission was made under the self-regulatory system, given the potential impact on patient safety, the companies had informed the Medicines and Healthcare products Regulatory Agency (MHRA) which was advised that the PMCPA was dealing with the matter as a complaint under the Code.

As Paragraph 5.6 of the Constitution and Procedure required the Director to treat a voluntary admission as a complaint, the matter was taken up with Astellas UK.

Astellas UK explained that during its investigation of the issues with prescribing information in another case, Case AUTH/2939/2/17, its urology marketing team uncovered four promotional items for Betmiga, on 15 February 2017, which also referred to solifenacin but only contained prescribing information for Betmiga; all four items were withdrawn on the same day. A further item was subsequently discovered by the urology marketing team and withdrawn.

Astellas UK stated that the voluntary admission for Case AUTH/2939/2/17, submitted on 21 February 2017, should have included this additional issue. However, aside from an email to healthcare compliance on 17 February, the urology marketing team did not further raise the issue with the healthcare compliance team or those involved in drafting the voluntary admission for Case AUTH/2939/2/17 and the healthcare compliance team did not action the email from urology until May. Whilst there was no excuse for this, Astellas UK explained that the healthcare compliance team was extremely busy in February and March 2017 preparing for the April PMCPA audit.

Astellas UK submitted that it had identified a further 46 Betmiga items which also referred to solifenacin but only contained the prescribing information for Betmiga. These dated back to 2013 and were all withdrawn before the issue of lack of Vesicare prescribing information was identified. Astellas UK noted that many of these items were certified and recertified without this issue being identified.

In addition, during this investigation, a further 25 promotional items for Vesomni (tamsulosin/ solifenacin) were identified that referred to Vesicare (solifenacin), outside of it being a component of Vesomni, without inclusion of the Vesicare prescribing information. All of this material had already been withdrawn.

Astellas UK also submitted that a review of material produced by other brand teams had identified that detail aids for Advagraf (tacrolimus prolonged release capsules) which referred to Prograf (tacrolimus capsules) did not contain the prescribing information for the latter; the withdrawal of both items was initiated immediately on discovery of this issue.

Astellas UK considered that this issue constituted multiple breaches of the Code. In addition, given the potential to impact patient safety, Astellas UK considered that this matter reduced confidence in the industry and brought the industry into disrepute, in breach of Clause 2.

The detailed response from Astellas UK is given below.

The Panel agreed with Astellas UK that this matter should have been included in its voluntary admission, Case AUTH/2939/2/17. The Panel considered that given the importance of patient safety, this should have been an absolute priority. The amount of time between Astellas UK first discovering the problem on 15 February 2017 and the healthcare compliance team taking action on 8 May 2017 was totally unacceptable. The explanation that the healthcare team was extremely busy preparing for the April PMCPA audit did not justify the delay.

The Panel was very concerned to note that in addition to the five items in use, a further 46 Betmiga items, which referred to solifenacin but did not contain its prescribing information, were identified which dated back to 2013. A further 25 promotional items for Vesomni (tamsulosin/ solifenacin) were identified that referred to Vesicare (solifenacin) alone and failed to provide its prescribing information. All of these items had already been withdrawn before this matter was identified.

The Panel further noted that two detail aids for Advagraf (tacrolimus prolonged release capsules) which referred to Prograf (tacrolimus capsules) did not contain its prescribing information. These items were withdrawn upon discovery.

The Panel ruled breaches of the Code in relation to each item subject to the voluntary admission which did not include the requisite prescribing information.

Failing to provide the requisite prescribing information was a serious matter. The Panel was very concerned that the company's systems including certification and, in relation to some

materials, recertification had not picked up these errors sooner. Overall, high standards had not been maintained and a breach of the Code was ruled.

The Panel noted its comments above and the failure of the company to treat this matter as a priority and include these matters in its voluntary admission in Case AUTH/2939/2/17. These failures brought discredit upon and reduced confidence in the pharmaceutical industry. In particular, the Panel was concerned about the volume of materials involved and that this error had occurred across business units. It was very difficult to understand how, and of concern that, these matters had not been picked up previously. It was crucial that health professionals and others could rely completely upon the industry for up-to-date and accurate information about their medicines. A breach of Clause 2 was ruled.

The Panel noted that had the investigation been appropriately followed up, the matters in this case would have been included in the voluntary admission in Case AUTH/2939/2/17. The Panel noted its comments above and its ruling of a breach of Clause 2 which would mean that brief details of this case would be the subject of an advertisement. The Panel noted that in Case AUTH/2939/2/17 Astellas had been reported by the Panel to the Code of Practice Appeal Board and by the Appeal Board to the ABPI Board. Additional sanctions had been imposed. These were ongoing. At the completion of this case the details would be available to both the Appeal Board and ABPI Board. The Panel decided, taking all the circumstances into account, not to report Astellas UK to the Appeal Board for it to consider in accordance with Paragraph 8.2 of the Constitution and Procedure.

Astellas Pharmaceuticals Limited (Astellas UK) voluntarily admitted that promotional materials which referred to both Betmiga (mirabegron) and solifenacin only contained prescribing information for Betmiga. Astellas still had exclusivity on the manufacture and marketing of solifenacin (as Vesicare) and considered that material which referred to solifenacin, even once, should also contain prescribing information for Vesicare. Betmiga and Vesicare were both indicated for the symptomatic treatment of overactive bladder syndrome.

Astellas UK also voluntarily admitted that promotional material which referred to both Advagraf (tacrolimus prolonged release capsules) and Prograf (tacrolimus capsules) did not contain prescribing information for the latter. Advagraf and Prograf were both indicated for the prevention of transplant rejection.

Whilst the voluntary admission was made under the self-regulatory system, given the potential impact on patient safety, the companies had copied the letter to the Medicines and Healthcare products Regulatory Agency (MHRA) which was informed that the PMCPA was dealing with the matter as a complaint under the Code.
As Paragraph 5.6 of the Constitution and Procedure required the Director to treat a voluntary admission as a complaint, the matter was taken up with Astellas UK.

VOLUNTARY ADMISSION

Astellas UK explained that during its investigation of the issues with prescribing information in Case AUTH/2939/2/17, its urology marketing team uncovered four promotional items for Betmiga, on 15 February 2017, which also referred to solifenacin but only contained prescribing information for Betmiga; all four items were withdrawn on the same day. An email to the UK healthcare compliance team on 17 February outlined what had been discovered and actions taken to date which included a deviation being raised for this omission. A further item was subsequently discovered by the urology marketing team and withdrawn on 17 February.

Given that the voluntary admission for Case AUTH/2939/2/17 was submitted on 21 February 2017, Astellas UK considered that this additional issue should have been included in that admission. However, aside from the email, the urology marketing team did not further raise the issue with the healthcare compliance team or those involved in drafting the voluntary admission for Case AUTH/2939/2/17 and the healthcare compliance team did not action the email from urology until 8 May. Whilst there was no excuse for this, Astellas UK explained that the healthcare compliance team was extremely busy in February and March 2017 preparing for the April PMCPA audit, in particular, revising policies and procedures.

Astellas UK submitted that as far as the functionality on Zinc allowed, it had identified a further 46 Betmiga items which also referred to solifenacin, but only contained the prescribing information for Betmiga (a list of items was provided). These dated back to 2013 and were all withdrawn before the issue of lack of Vesicare prescribing information was identified, mostly because updated versions of the items were to be introduced. With the latter in mind, Astellas UK noted that many of these items were certified and recertified without this issue being identified.

In addition, during this investigation, a further 25 promotional items for Vesomni (tamsulosin/solifenacin) were identified that referred to Vesicare (solifenacin), outside of it being a component of Vesomni, without inclusion of the Vesicare prescribing information. All of this material had already been withdrawn from use.

Astellas UK also submitted that a review of material produced by other brand teams had identified that detail aids for Advagraf (tacrolimus prolonged release capsules) which referred to Prograf (tacrolimus capsules) did not contain the prescribing information for the latter; the withdrawal of both items was initiated immediately on discovery.

Astellas UK considered that this issue constituted multiple breaches of Clause 4.1, given that promotional material that referred to prescription only medicines failed to contain prescribing

information for such medicines. Astellas UK also considered that this amounted to a failure to maintain high standards, contrary to the requirements of Clause 9.1. In addition, given the potential to impact patient safety, Astellas UK considered that this matter reduced confidence in the industry and brought the industry into disrepute, in breach of Clause 2.

Astellas UK stated that it had treated this issue with the utmost seriousness; it recognized the gravity of the situation that had been uncovered and had addressed it as a priority. The company was appalled to, yet again, find itself making a voluntary admission about prescribing information. Astellas UK noted that investigation into the circumstances surrounding this case might result in disciplinary action for certain individuals.

RESPONSE

Astellas UK provided further documentation requested by the case preparation manager but otherwise made no further comment.

PANEL RULING

The Panel noted that during Astellas UK's investigation of the issues with prescribing information in a separate case, Case AUTH/2939/2/17, its urology marketing team uncovered four promotional items for Betmiga which referred to solifenacin (Vesicare) but only contained prescribing information for Betmiga. All four items were withdrawn on the day the errors were discovered (15 February 2017) and UK healthcare compliance was notified by email two days later on 17 February. A fifth item was subsequently discovered and withdrawn on 17 February. The Panel agreed with Astellas UK's submission that this matter should have been included in its voluntary admission, Case AUTH/2939/2/17, submitted on 21 February 2017. The Panel considered that given the importance of patient safety, this should have been an absolute priority. The amount of time that had elapsed between Astellas UK first discovering the problem on 15 February 2017 and the healthcare compliance team taking action on 8 May 2017 was totally unacceptable. The Panel did not consider that the explanation that the healthcare team was extremely busy in February and March 2017 preparing for the April PMCPA audit justified the delay.

The Panel was very concerned to note that in addition to those five items noted above a further 46 Betmiga items which referred to solifenacin but did not contain its prescribing information were identified which dated back to 2013. All of these items had already been withdrawn before this matter was identified.

In addition, the Panel noted that a further 25 promotional items for Vesomni (tamsulosin/solifenacin) were identified that referred to Vesicare (solifenacin) alone and failed to provide its prescribing information. All of these items had already been withdrawn before this matter was identified.

The Panel further noted that two detail aids for Advagraf (tacrolimus prolonged release capsules) which referred to Prograf (tacrolimus capsules) did not contain its prescribing information. These items had not already been withdrawn. Their withdrawal was initiated immediately upon their discovery.

The Panel ruled breaches of Clause 4.1 in relation to each item subject to the voluntary admission which did not include the requisite prescribing information.

Failing to provide the requisite prescribing information was a serious matter. The Panel was very concerned that the company's systems including certification and, in relation to some materials, recertification had not picked up these errors sooner. Overall, the Panel considered that high standards had not been maintained. A breach of Clause 9.1 was ruled.

The Panel noted its comments above and the failure of the company to treat this matter as a priority and include these matters in its voluntary admission in Case AUTH/2939/2/17. The Panel considered that these failures brought discredit upon and reduced confidence in the pharmaceutical industry. In particular, the Panel was concerned about the volume of materials involved and that this error had occurred across business units. It was very difficult to understand how, and of concern that, these matters had not been picked up previously. It was crucial that health professionals and others could rely completely upon the industry for up-to-date and accurate information about their medicines. A breach of Clause 2 was ruled.

The Panel noted that had the investigation been appropriately followed up, the matters in this case would have been included in the voluntary admission in Case AUTH/2939/2/17. The Panel noted its comments above and its ruling of a breach of Clause 2 which would mean that brief details of this case would be the subject of an advertisement. The Panel noted that in Case AUTH/2939/2/17 Astellas had been reported by the Panel to the Code of Practice Appeal Board and by the Appeal Board to the ABPI Board. Additional sanctions had been imposed. These were ongoing. The Panel noted that at the completion of this case its case report would be published in the normal way and details of this case would be available to both the Appeal Board and ABPI Board. The Panel decided, taking all the circumstances into account, not to report Astellas UK to the Appeal Board for it to consider in accordance with Paragraph 8.2 of the Constitution and Procedure.

Complaint received **23 May 2017**

Case completed **19 July 2017**