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Practical cross-border insights into pharmaceutical advertising

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Expert Analysis Chapters

- 1** Advertising of Medical Devices and *In Vitro* Diagnostic Medical Devices in Europe Following the New EU Legislation
Adela Williams & Jackie Mulryne, Arnold & Porter
- 6** Global Trends in Regulatory Compliance Challenges in Advertising and Promotion
Dr. Lincoln Tsang, Katherine Wang, Kellie Combs & Daisy Bray, Ropes & Gray LLP

Q&A Chapters

- 12** **Australia**
Clayton Utz: Colin Loveday & Greg Williams
- 25** **Austria**
Herbst Kinsky Rechtsanwälte GmbH:
Dr. Sonja Hebenstreit
- 39** **Belgium**
Quinz: Olivier Van Obberghen, Pieter Wyckmans,
Nele Jonckers & Michiel D'herde
- 53** **Brazil**
Veirano Advogados: Renata Fialho de Oliveira,
Priscila Sansone, Livia Gândara & Roberta Medina
- 63** **Canada**
Marks & Clerk: Justin Smith
- 75** **Cyprus**
Harris Kyriakides: Eleni Neoptoleμου,
Munevver Kasif & Maria Constanti
- 85** **Denmark**
Jusmedico Advokatanpartsselskab:
Jan Bjerrum Bach & Lone Hertz
- 106** **England & Wales**
Arnold & Porter: Adela Williams & Jackie Mulryne
- 122** **Finland**
Roschier, Attorneys Ltd.: Mikael Segercrantz &
Johanna Lilja
- 135** **Germany**
Clifford Chance: Dr. Peter Dieners &
Ann-Cathrin Bergstedt
- 152** **Greece**
Kyriakides Georgopoulos Law Firm: Irene Kyriakides,
Dr. Victoria Mertikopoulou, Maria-Oraiozili Koutsoupia
& Aithra-Valentina Antoniadou
- 165** **Ireland**
Arthur Cox LLP: Colin Kavanagh & Bridget Clinton
- 180** **Italy**
Astolfi e Associati Studio Legale: Sonia Selletti &
Annalisa Scalia
- 194** **Japan**
Iwata Godo: Shinya Tago, Landry Guesdon &
Minako Ikeda
- 205** **Korea**
Lee & Ko: Hyeong Gun Lee, Eileen Jaiyoung Shin &
Hyun Ah Song
- 215** **Mexico**
OLIVARES: Alejandro Luna F. & Armando Arenas
- 227** **Poland**
Wardynski & Partners: Natalia Fałęcka-Tyszka &
Małgorzata Sokołowska
- 237** **Portugal**
Morais Leitão, Galvão Teles, Soares da Silva &
Associados: Fernanda Matoso & Alessandro Azevedo
- 248** **Sweden**
Mannheimer Swartling Advokatbyrå:
Camilla Appelgren & Emmie Montgomery
- 260** **Switzerland**
Wenger Vieli Ltd.: Frank Scherrer & Ines Holderegger
- 272** **Turkey**
Sezekkaplan Lawyers: Ufuk Sezekkaplan
- 282** **USA**
Arnold & Porter: Daniel A. Kracov, Mahnu V. Davar &
Abeba Habtemariam

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Arnold & Porter



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1 General – Medicinal Products

1.1 What laws and codes of practice govern the advertising of medicinal products in your jurisdiction?

Prescription Drugs

In the U.S., prescription drug advertising is primarily governed by the Federal Food, Drug, and Cosmetic Act (FDCA) and U.S. Food and Drug Administration (FDA) regulations and guidance. In certain circumstances, the U.S. Federal Trade Commission (FTC), as well as individual states, retain jurisdiction over aspects of prescription drug advertising as well (e.g., guarantees, pricing claims, limited-time offers, etc.).

The FDCA sets out broad requirements for prescription drug promotion and authorises the FDA to promulgate related regulations. *See*, e.g., 21 U.S.C. §352(n). The FDA regulations expand on these requirements in the FDCA, adding details to the statutory framework. *See* 21 C.F.R. §202.1. The FDA has also developed various non-binding draft and final guidance documents relating to a variety of issues in prescription drug advertising, ranging from direct-to-consumer broadcast advertisements to appropriate risk communication in advertising and social media. The FDA has significant discretion in enforcing the FDCA and its implementing regulations to protect the public health of patients prescribed prescription drug products, although the breadth of the FDA's authority with respect to truthful and non-misleading claims that go beyond approved labelling has been called into question by First Amendment case law.

Non-Prescription Drugs

Most non-prescription or “over-the-counter” (OTC) drugs in the U.S. are sold under the terms of regulatory monographs sanctioning a range of specific ingredients, claims and directions for use permitted in such products, without requiring FDA approval. Some are switched from prescription to OTC status, and, more rarely, directly approved for sale OTC. While the FDA regulates the labelling of non-prescription drugs, it does not regulate the advertising; that responsibility largely rests with the FTC, with the exception of certain OTC drugs approved under new drug applications. The FTC has broad authority to address the deceptive or unfair advertising of such OTC drug products. Under 15 U.S.C. §§52–57, the dissemination of false or deceptive advertisements likely to induce the purchase of

food, drugs, devices, or cosmetics is unlawful and subject to enforcement by the FTC.

1.2 How is “advertising” defined?

“Advertising” includes any descriptive matter issued or caused to be issued by the manufacturer, packer, or distributor with respect to the drug. *See* 21 U.S.C. §352(n). Advertising, however, does not include “labelling” as defined in §321(m). *Id.* While “advertising” and “labelling” are legally distinct concepts under U.S. law, both advertising and promotional labelling are subject to specific FDA regulatory requirements, and both are required to be truthful and not misleading. Advertising is distinct from labelling in that it need not “accompany” the actual product either physically or textually. Nonetheless, various controversies have erupted over whether particular modes of dissemination of information about drug products are properly considered labelling or advertising under the FDCA, such as communications on the Internet.

1.3 What arrangements are companies required to have in place to ensure compliance with the various laws and codes of practice on advertising, such as “sign off” of promotional copy requirements?

While U.S. law does not impose specific requirements on manufacturers to put “sign off” procedures in place, both the FDA and the Department of Health and Human Services Office of Inspector General, which oversees the integrity of government healthcare programmes, have indicated that they expect manufacturers to have an internal review process to ensure that advertising and promotional materials comply with U.S. law and industry Codes of Practice. U.S. government authorities have indicated that they consider an internal, inter-disciplinary sign-off process for promotional materials (in which legal, scientific/medical, compliance and regulatory personnel take part) to be an important part of a manufacturer's compliance programme, and such processes have been required as part of enforcement settlements incorporating Corporate Integrity Agreements. Certain state laws may also arguably require corporate policies of this nature. Generally, once advertising materials are vetted through an internal process, they are then sent to the FDA through the process described in question 1.5.

1.4 Are there any legal or code requirements for companies to have specific standard operating procedures (SOPs) governing advertising activities or to employ personnel with a specific role? If so, what aspects should those SOPs cover and what are the requirements regarding specific personnel?

The industry codes promulgated by the Pharmaceutical Research and Manufacturers of America (PhRMA) and other organisations encourage the development of appropriate processes to maintain compliance, but in large part such SOPs are driven by the range of potential enforcement risks relating to drug promotion. Such SOPs generally govern the review of promotional materials for accuracy, balance, consistency with approved labelling, and compliance with other laws, such as the Anti-Kickback Statute, which would address the fraud and abuse aspects of payments and transfers of value associated with promotion, market research, and other commercial activities.

Under the terms of settlements with the Department of Justice and the states, and industry best practice, most pharmaceutical companies have established internal compliance frameworks, which require review processes and the reporting of violations for further investigation and action. Such SOPs should generally address issues such as (a) who participates in the review (typically commercial, regulatory, medical and legal or compliance representatives), (b) adherence to FDA and other applicable requirements and standards, such as appropriate balance and risk communication, (c) internal escalation processes when consensus cannot be reached on a promotional piece, and (d) submission to the FDA as required under applicable law.

1.5 Must advertising be approved in advance by a regulatory or industry authority before use? If so, what is the procedure for approval? Even if there is no requirement for prior approval in all cases, can the authorities require this in some circumstances?

As a general matter, prescription drug advertisements do not need prior approval by the FDA prior to dissemination. *See* 21 U.S.C. §352(n). However, upon initial dissemination, all advertisements must be submitted to the FDA Center for Drug Evaluation and Research Office of Prescription Drug Promotion (OPDP) using Form FDA 2253. *See* 21 C.F.R. §314.81(b)(3)(i). OPDP will also offer comments on advertisements submitted prior to publication, although that can significantly delay use of the materials. *See* 21 C.F.R. §202.1(j)(4). Manufacturers often submit to review proposed advertisements and promotional labelling intended for use in association with a newly approved drug. In the case of accelerated approval products, which are approved based upon surrogate markers for effectiveness with post-market study requirements, all promotional materials (including advertisements) intended for dissemination within 120 days of approval must be submitted to the FDA during the pre-approval period. *See* 21 C.F.R. §314.550. Post-approval, promotional materials for such “subpart H” products should be submitted 30 days prior to first use. In certain circumstances – such as under a consent agreement resulting from an injunction – pre-approval of advertising may be required as part of an enforcement action.

1.6 If the authorities consider that an advertisement which has been issued is in breach of the law and/or code of practice, do they have powers to stop the further publication of that advertisement? Can they insist on the issue of a corrective statement? Are there any rights of appeal?

The FDA responds to violations of its advertising regulations

through both informal and formal administrative processes. In instances where a manufacturer has voluntarily sought the FDA’s comments on a proposed advertisement (or promotional labelling), the FDA may provide a response in the form of suggested guidance through informal communication. In such cases, manufacturers are encouraged but not legally required to accept all of the FDA’s comments (though the FDA may take the position that it has placed the manufacturer on notice of a potential violation).

Where the FDA has determined that an advertisement may be or is false or misleading or otherwise violative, it may act by sending the manufacturer either an “untitled” letter or a Warning Letter. Generally, untitled letters set forth the FDA’s objections to a particular advertisement and the reasons as to why the Agency believes it may violate applicable laws or regulations. Such letters ask for a response from the manufacturer and results in a dialogue with the FDA to resolve the matter to the Agency’s satisfaction.

Warning Letters are generally issued when either a manufacturer has failed to comply with the FDA’s requested action in an untitled letter, or where the FDA has determined that a violation has in fact occurred, particularly instances in which the violation is particularly egregious. Warning Letters set forth the particular reasons why the FDA believes the promotional material has violated the applicable laws or regulations. Warning Letters serve as notice for the manufacturer that the FDA may take further enforcement action. Warning Letters also serve as formal notice to an officer of a corporation that a violation of the FDCA has occurred, in the event that subsequent enforcement action is taken against the corporation or an individual officer. Such letters often seek specific corrective action, such as through advertising to correct the violative material or letters to healthcare practitioners.

In the last several years, the FDA has significantly curtailed its use of Warning and untitled letters in this area, focusing on cases involving investigational products, significant safety issues, or clearly false and misleading claims. It is generally believed that this change in enforcement posture is partially a result of changes in First Amendment case law, which, as discussed herein, significantly limits the FDA’s ability to deem truthful and non-misleading information as violative.

At the time that an untitled letter or a Warning Letter is issued, the prescription drug to which the violative advertisement refers to can be deemed potentially misbranded. Since distribution of an adulterated or misbranded drug can be a criminal act, manufacturers are required to withdraw and/or correct the violative advertising to the satisfaction of the FDA. Manufacturers may dispute the allegations in the untitled or Warning Letter, or seek to negotiate the scope of required corrective action with the FDA. However, subject to exceptions, the current case law generally does not deem Warning Letters to be final agency action, making it difficult to sue the FDA immediately upon receipt of a Warning Letter. Companies may pursue informal and formal dispute resolution processes, and ultimately could attempt to sue the FDA if they believe the Agency’s enforcement theory is arbitrary and capricious or not authorised by law, e.g., unconstitutional under First Amendment speech protections. The FDA has the option of pursuing further enforcement actions at any time, such as seeking an injunction against the company in question, or pursuing a criminal action. Such measures can also be pursued against responsible corporate officials. Third parties may also take action against companies, such as by bringing action under the False Claims Act alleging that a violative promotional activity induced claims for payment for the product under government healthcare programmes.

1.7 What are the penalties for failing to comply with the rules governing the advertising of medicines? Who has responsibility for enforcement and how strictly are the rules enforced? Are there any important examples where action has been taken against pharmaceutical companies? If there have not been such cases, please confirm. To what extent may competitors take direct action through the courts in relation to advertising infringements?

A prescription drug is considered “misbranded” if an advertisement fails to satisfy the requirements of the FDCA and FDA regulations. *See* 21 U.S.C. §352(n). The FDCA prohibits the introduction of a misbranded drug into interstate commerce or the misbranding of a drug already in interstate commerce. *See id.* at §331(a), (b). Further, violative advertising can be used by the FDA and other government authorities to show that a manufacturer intended a prescription drug to be used for an unapproved use, subjecting the manufacturer to potential enforcement based on distribution of an unapproved drug. *See* 21 U.S.C. §321(p) (defining a new drug as one whose composition has not been recognised by qualified experts as safe and effective for the intended use); 21 U.S.C. §355(a). Potential consequences for misbranding violations include injunction proceedings, which may result in a consent agreement restraining company conduct, civil penalties, seizure proceedings, and even criminal prosecution. FDCA. *See* U.S.C. §§331, 333. As noted earlier, except with respect to extremely grave violations, the FDA will typically issue an untitled or Warning Letter to a manufacturer prior to pursuing these sanctions.

The FDA is responsible for the enforcement of the FDCA and FDA regulations, although the FDA must work with the Department of Justice to seek judicial review and action. *See* 21 U.S.C. 337(a). In the U.S., manufacturers are also under increasing scrutiny for advertising practices from various other parties, including state attorneys, and general and private plaintiffs such as payors and consumer groups, under a broad variety of legal theories. Unlike most criminal laws, the FDCA’s criminal provisions prohibiting distribution of an unapproved new drug or a misbranded drug provide for “strict liability” for misdemeanour violations. In the context of prescription drug promotion and advertising, this means that the government need only prove beyond a reasonable doubt that: (1) a manufacturer caused a drug to be shipped into U.S. interstate commerce; (2) a manufacturer disseminated an advertisement; and (3) the advertisement was untruthful, misleading, or otherwise violative of the requirements of the FDCA. Further, additional penalties attached to knowing or intentional violations of the FDCA and the government may use violative advertising materials as evidence of unlawful intent. As discussed earlier, recent enforcement of FDCA criminal provisions governing advertising and other promotional activities has led to massive civil and criminal fines. These provisions also provide for liability of individuals who either actively participated in the violation or were in a position to prevent or correct the violation from occurring under the so-called “Park Doctrine”. *See United States v. Park*, 421 U.S. 658 (1975) (holding that an individual may be held criminally responsible under the FDCA for acts committed by his subordinates, if he was in a position to prevent or correct a violation of the FDCA from occurring and failed to do so).

Such cases continue to be pursued – often resulting in settlements in the hundreds of millions or even billions of dollars. However, as noted, the current First Amendment “free speech” case law has made it more difficult for the FDA to bring actions based solely on a theory that unapproved use information is *per se* unlawful without demonstrating that such communications are

actually false and misleading. This has resulted in an enforcement shift to focusing on cases that also include alleged violations of non-speech-related laws, such as the Anti-Kickback Statute.

While the FDCA does not provide for a private right of action by competitors for violations of the FDCA, the Lanham Act permits claims for false advertising and unfair trade practices. *See* 15 U.S.C. §1051, *et seq.* A competitor has standing under the Lanham Act to challenge false or misleading advertising if such competitor believes that it is likely to be damaged. *See id.* at §1125(a)(1)(B). Often, competitors report potentially violative promotional material to regulatory authorities, including, but not limited to, the FDA, the U.S. Department of Health and Human Services Office of Inspector General, state attorneys general, and other regulatory and enforcement entities. The FDA also has an initiative to encourage healthcare professionals to report potentially violative promotional practices to the FDA through its so-called “Bad Ad” Programme, which seeks to help healthcare providers recognise false or misleading advertising and report it to government authorities.

1.8 What is the relationship between any self-regulatory process and the supervisory and enforcement function of the competent authorities? Can and, in practice, do, the competent authorities investigate matters drawn to their attention that may constitute a breach of both the law and any relevant code and are already being assessed by any self-regulatory body? Do the authorities take up matters based on an adverse finding of any self-regulatory body?

While the FDA regulates the advertising of pharmaceutical products, professional organisations, such as the PhRMA and the American Medical Association (AMA), provide additional guidance for the healthcare community and pharmaceutical manufacturers. *See* question 4.2. While the FDA welcomes complaints regarding pharmaceutical advertisements and materials through OPDP, for prescription drugs, there is no general mechanism for resolving complaints through trade associations.

While typically used for issues involving the promotion of OTC drugs and other consumer products rather than prescription products, manufacturers may file a complaint with the National Advertising Division (NAD) of the Better Business Bureau Advertising Self-Regulatory Council regarding competitor advertising. The NAD is a self-regulatory body intended to provide an alternative to litigation for resolving disputes regarding advertising claims. The NAD may review any national advertisements, regardless of whether that advertisement is targeting consumers, professionals or business entities. In a NAD proceeding, a NAD attorney evaluates the express and implied messages communicated in a challenged advertisement and, after a briefing period, determines whether the advertiser has given a reasonable basis to support those messages. When reviewing health-related claims, the NAD requires competent and reliable scientific evidence, similar to the FTC’s standard. The initial burden of proof is on the advertiser. If the NAD finds that an advertiser has provided a reasonable basis for its claims, the burden then switches to the challenger, who must either prove that the advertiser’s evidence is fatally flawed or provide new, stronger evidence. While an advertiser may choose not to cooperate with NAD proceedings or comply with the NAD’s decision, the NAD may forward the case to the FTC or applicable regulatory body for action. While the NAD’s referral does not automatically result in a formal regulatory response, the potential for increased scrutiny often deters advertisers from refusing to cooperate with the NAD.

1.9 In addition to any action based specifically upon the rules relating to advertising, what actions, if any, can be taken on the basis of unfair competition? Who may bring such an action?

As stated in question 1.7, the Lanham Act provides standing to a competitor to bring a false advertising claim if such a competitor believes that it is likely to be damaged. 15 U.S.C. §1125(a)(1)(B). In addition, there is a wide array of potential federal and state antitrust and unfair competition laws that may be relevant to competitor activities.

2 Providing Information Prior to Authorisation of Medicinal Product

2.1 To what extent is it possible to make information available to healthcare professionals about a medicine before that product is authorised? For example, may information on such medicines be discussed, or made available, at scientific meetings? Does it make a difference if the meeting is sponsored by the company responsible for the product? Is the position the same with regard to the provision of off-label information (i.e. information relating to indications and/or other product variants not authorised)?

Manufacturers generally may not promote, advertise, or otherwise commercialise unapproved new drugs or unapproved uses of new drugs until they are approved by the FDA. The FDA regulations provide that: “A sponsor or investigator, or any person acting on behalf of a sponsor or investigator, shall not represent in a promotional context that an investigational new drug is safe or effective for the purposes for which it is under investigation or otherwise promote the drug. This provision is not intended to restrict the full exchange of scientific information concerning the drug, including dissemination of scientific findings in scientific or lay media. Rather, its intent is to restrict promotional claims of safety or effectiveness of the drug for a use for which it is under investigation and to preclude commercialisation of the drug before it is approved for commercial distribution.” 21 C.F.R. §312.7(a).

With regard to unapproved new drugs, manufacturers may: (1) provide limited, balanced information to healthcare providers or patients in connection with *bona fide* clinical trial recruitment communications (which cannot make claims of safety or effectiveness about the investigational product and generally are subject to IRB review); (2) provide information to investors or securities regulators to comply with securities law requirements and/or to facilitate information about securities offerings and required material disclosures; (3) provide information about investigational drugs (and unapproved uses of approved drugs) and the status of clinical development programmes to payors (*see*, FDA, Drug and Device Manufacturer Communications with Payors, Formulary Committee, and Similar Entities – Questions and Answers (June 2018) available at <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/drug-and-device-manufacturer-communications-payors-formulary-committees-and-similar-entities>) in connection with *bona fide* reimbursement and coverage discussions according to specific parameters set forth in FDA guidance; and (4) provide information to healthcare providers as part of *bona fide* “scientific exchange” – i.e. non-promotional, scientific or educational communications between a company’s non-commercial medical or scientific staff and a licensed healthcare provider that are not intended to promote the investigational product.

The concept of “scientific exchange” is highly fact-specific, and the FDA has issued several draft documents and policy positions that indirectly attempt to define its boundaries. In

all instances, communications about investigational products must be truthful and non-misleading, and in some cases, such as in the noted FDA payor communications guidance, the FDA has suggested that specific disclosures be made to ensure such communications do not violate regulations banning pre-approval promotion or false and misleading promotion.

With regard to unapproved uses of approved products (sometimes called “off-label uses”), the FDA has shown increased willingness to permit companies to provide truthful, non-misleading information about unapproved uses to healthcare providers or payors under certain circumstances. First, the FDA has clarified that certain types of product-related communications that are consistent with the approved labelling of FDA-approved products will not be policed by the FDA as inappropriate off-label promotion if they meet certain factors. These factors, which require a careful consideration of how the claim relates to the information in the package insert and known to the company and the FDA through pivotal studies, are spelled out in recent FDA guidance. Product claims that go beyond those “consistent with” the FDA-approved labelling pose heightened enforcement risks under the FDCA and other laws, though companies may avail themselves of *bona fide* scientific exchange communications if there is a legitimate need to communicate off-label information to physicians. *See*, e.g., FDA, Medical Product Communications That Are Consistent With The FDA-Required Labeling – Questions and Answers (June 2018) available at <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/medical-product-communications-are-consistent-fda-required-labeling-questions-and-answers>.

As noted, the analysis of what falls within the definition of “*bona fide* scientific exchange” is highly fact-specific and controversial. In analysing whether a particular communication is not subject to the general prohibitions against “pre-approval promotion”, the FDA will consider, among various factors, whether the communication: (1) is provided by scientific or medical personnel, free from commercial influence; (2) the information is truthful, balanced, and not misleading; and (3) the information is provided in response to an unsolicited request by a healthcare professional. While evidence that pre-approval information was provided at a scientific meeting or through a third party may support the case that a particular communication was not intended to be promotional, such evidence is not in and of itself dispositive to the analysis. The FDA will look to the degree of control and influence that a manufacturer has over a particular medical or scientific meeting to determine whether the pre-approval information can be “imputed” to a manufacturer. In a case where a manufacturer has significant control over the funding, content, or selection of attendees at a scientific meeting, the FDA may arguably apply the same rules to product-specific information discussed at the meeting as it would apply to employees of the manufacturer.

2.2 May information on unauthorised medicines and/or off-label information be published? If so, in what circumstances?

Information on medicines that have not been approved by the FDA may be published so long as the publication is for the *bona fide* purpose of disseminating scientific information or findings. *See* 21 C.F.R. §312.7. Information on unapproved medicines may not be published for promotional or marketing purposes. *See* question 2.1 above.

2.3 Is it possible for companies to issue press releases about unauthorised medicines and/or off-label information? If so, what limitations apply? If differences

apply depending on the target audience (e.g. specialised medical or scientific media vs. mainstream public media), please specify.

See questions 2.1 and 2.2 above. While such press releases may disseminate new scientific findings and developments to the scientific community and investors, companies must scrupulously avoid suggesting in such releases that the product is approved or has been proven to be safe and effective, and they generally should not be distributed in a promotional setting, such as further distribution by company sales personnel. In general, a press release in the mainstream media is more likely to be seen as promotional. Investor communications are given more leeway (and are generally subject to Securities and Exchange Commission rather than FDA jurisdiction), although such communications should also be balanced and objective in reporting information, and refrain from stating safety or effectiveness. Further dissemination of an investor release in non-financial communications may be seen as promotional.

2.4 May such information be sent to healthcare professionals by the company? If so, must the healthcare professional request the information?

Manufacturers may send information to healthcare professionals about medicines that have not been approved by the FDA in very limited circumstances in which the information is distributed for scientific and not promotional purposes, and generally when the information has been solicited by the healthcare professional rather than cued by manufacturer personnel. Very limited communication of pipeline information – without claims regarding safety or effectiveness and clear caveats regarding unapproved status – are generally also low risk. See questions 2.1 and 2.2 above.

The FDA also permits “coming soon” advertisements within six months of the projected approval date; however, such advertisements may state only the proprietary and established name for the product without any information or suggestion regarding the indication. Such advertisements are not permitted for products bearing a “black box” safety warning, and should not be used if the company is also engaging in disease state advertisements in the same pre-approval period. See question 3.7 below.

2.5 How has the ECJ judgment in the *Ludwigs* case, Case C-143/06, permitting manufacturers of non-approved medicinal products (i.e. products without a marketing authorisation) to make available to pharmacists price lists for such products (for named-patient/compassionate use purposes pursuant to Article 5 of the Directive), without this being treated as illegal advertising, been reflected in the legislation or practical guidance in your jurisdiction?

This has not had an impact in the U.S., although there are extensive requirements in the U.S. governing communications to physicians and patients regarding unapproved drugs in relation to expanded access programmes, including compassionate use. Such communications must generally adhere to the same rules that apply to other clinical trial-related communications with study subjects, and should not be promotional in tone or intent. Various enforcement actions have focused on the use of clinical trials for purposes of “seeding” future prescribing by physicians. Moreover, manufacturers generally may not require payment for investigational drugs, although there are mechanisms for seeking FDA approval to obtain “cost recovery” with no profit from study subjects. This is rarely done given the burdensome process for obtaining such approval. See question 2.1 above for a

discussion of the dissemination of information regarding unapproved medicines to payor audiences.

2.6 May information on unauthorised medicines or indications be sent to institutions to enable them to plan ahead in their budgets for products to be authorised in the future?

Sending information on an unapproved drug to third parties for such purposes could be construed as commercialising the drug, which is not allowed under FDA regulations, although such submissions do occur with some frequency, typically with numerous caveats and disclaimers to prevent a suggestion that the product is being promoted as safe and effective. However, if such third parties are payors – i.e., sophisticated parties making coverage and reimbursement decisions for a covered population via a deliberative process, more extensive communications are permitted. See question 2.1 above. Such information may also be shared in response to *bona fide* unsolicited requests by government or private insurers, assuming the information is truthful, not misleading, and balanced.

2.7 Is it possible for companies to involve healthcare professionals in market research exercises concerning possible launch materials for medicinal products or indications as yet unauthorised? If so, what limitations apply? Has any guideline been issued on market research of medicinal products?

While pre-approval market research is generally permitted under appropriate consulting arrangements, the FDA and other government authorities will scrutinise such research activities where healthcare professionals are receiving above fair market value compensation or if the number of healthcare professionals surveyed is excessive in relation to the market research need. Payments made to healthcare professionals to induce them to prescribe a manufacturer’s products are prohibited under U.S. law. Consulting arrangements with such professionals must be for *bona fide* services, in writing, at a fair market value, and not intended to influence their prescribing decisions. An excessive audience for such research may indicate pre-approval “seeding” promotion rather than legitimate market research.

3 Advertisements to Healthcare Professionals

3.1 What information must appear in advertisements directed to healthcare professionals?

The FDA’s approach to regulation of advertising is based on its view that a manufacturer must present truthful, non-misleading information that adequately balances a prescription drug product’s benefits and risks to the intended audience. U.S. law also requires that a manufacturer provide its consumers with adequate directions for the intended use of its prescription drug products. Therefore, while the requirements for both consumer-directed and healthcare professional-directed advertising are generally the same under U.S. law, the FDA will closely scrutinise whether the content is presented in terms that the intended audience can understand, and the FDA has developed special guidance addressing the application of regulatory requirements to consumer-directed broadcast advertising, communications in social media, and other fora.

Advertising for prescription drugs is subject to requirements under the disclosure of risk and other information. An ad for

a prescription drug must include, in addition to the product's established name and quantitative composition, a "true statement" of information in brief summary "relating to side effects, contraindications and effectiveness" of the product with respect to the use or uses that the message promotes. 21 U.S.C. 352(n); 21 CFR Part 202. FDA regulations also specify that, among other things, the statutory requirement of a "true statement" is not satisfied if an ad for a prescription drug product is false or misleading with respect to side effects, contraindications or effectiveness, or if it fails to reveal material facts about "consequences that may result from the use of the drug as recommended or suggested in the advertisement". 21 CFR 202.1(e)(5).

FDA regulations specify that ads must present a fair balance between information relating to risks and benefits, which is achieved when the treatment of risk and benefit information in a promotional piece is comparably thorough and complete throughout the piece. 21 CFR 202.1(e)(5)(ii). The regulations identify 20 types of advertising communications that the FDA considers "false, lacking in fair balance, or otherwise misleading". 21 CFR 202.1(e)(6). These include, for example, representations or suggestions that a drug is more effective or safer than has been demonstrated by substantial evidence. The regulations also identify 13 additional types of advertising communications that "may be false, lacking in fair balance, or otherwise misleading". 21 CFR 202.1(e)(7). These include, for example, advertising communications that fail to "present information relating to side effects and contraindications with a prominence and readability reasonably comparable with the presentation of information relating to effectiveness of the drug". 21 CFR 202.1(e)(7)(viii).

In addition to specific requirements set forth in statutes and regulations, the FDA issued a draft guidance document setting forth its expectations for communication of risk information for prescription drugs and devices. *See*, FDA, Draft Guidance for Industry: Presenting Risk Communication in Prescription Pharmaceutical and Medical Device Promotion (May 2009 (<https://www.fda.gov/media/76269/download>)). While the guidance is not binding on the FDA, and does not replace the statutory and regulatory requirements, it is an important reflection of the Agency's current thinking on this topic.

3.2 Are there any restrictions on the information that may appear in an advertisement? May an advertisement refer to studies not mentioned in the SmPC?

Advertisements generally must adhere to the terms of approved labelling, including consistency with respect to indication, dosing, mechanism of action, endpoints, and other aspects of labelling. However, it is possible to make certain claims relating to or expanding upon aspects of approved labelling if such claims are properly substantiated. As noted earlier, the FDA clarified in 2018 that it would permit companies to make claims consistent with the FDA-approved labelling of an approved drug product under certain conditions set forth in the guidance.

3.3 Are there any restrictions to the inclusion of endorsements by healthcare professionals in promotional materials?

While healthcare professionals may provide endorsements in promotional materials, the claims made by the endorser are treated as claims by the manufacturer, and thus are subject to the same rules. Thus, the statements made by the endorser should be consistent with approved labelling, truthful and not misleading, balanced, and generally representative of the experience of the average physician, unless otherwise clearly stated. A

mere disclaimer is generally insufficient. Endorsers who act on behalf of a company may be subject to enforcement by the FDA, in addition to enforcement against the manufacturer. Ensuring transparency in advertising (including social media) with respect to the financial or other relationship between the physician endorser and the manufacturer can be particularly important.

3.4 Is it a requirement that there be data from any, or a particular number of, "head to head" clinical trials before comparative claims may be made?

It has generally been the FDA's position that any advertising claim that represents or suggests that one drug is safer or more efficacious than another drug must generally be supported by substantial evidence. *See* 21 C.F.R. §202.1(e)(6)(ii). Substantial evidence of safety and efficacy generally consists of at least one, and often more, adequate and well-controlled clinical investigations comparing the products in a matter consistent with, and supportive of, the comparative claims. *See id.* at §202.1(e)(4)(ii). As noted earlier, the FDA's recent guidance on consistency with labelling and communications with payors provides companies with an ability to communicate some comparative safety and efficacy information where it is either consistent with the approved FDA labelling and substantiated by substantial evidence or, in the case of healthcare economic information provided to payors, substantiated by competent and reliable scientific evidence.

3.5 What rules govern comparative advertisements? Is it possible to use another company's brand name as part of that comparison? Would it be possible to refer to a competitor's product or indication which had not yet been authorised in your jurisdiction?

Prescription drug advertisements may not be false or misleading, and may not otherwise misbrand the product. *See* 21 C.F.R. §202.1(e)(6). Under FDA regulations, a comparator advertisement is false or misleading if it: "[c]ontains a drug comparison that represents or suggests that a drug is safer or more effective than another drug in some particular when it has not been demonstrated to be safer or more effective in such particular by substantial evidence or substantial clinical experience". *Id.* at §202.1(e)(6)(ii). Such an advertisement may also suggest uses that are not approved for the approved product, or present a false or misleading comparison. There is no reason *per se* why a company's brand name cannot be used in such a comparison, subject to considerations such as the limits of "fair use" of intellectual property rights.

3.6 What rules govern the distribution of scientific papers and/or proceedings of congresses to healthcare professionals?

Scientific papers and other clinical information provided to doctors must meet the requirements of the FDCA. Scientific information that is provided as part of a prescription drug product promotion must generally be consistent with the product's FDA-approved label, and must not be untruthful or misleading. Therefore, manufacturers are limited in their ability to provide doctors with scientific or clinical information about unapproved new drugs or unapproved uses of approved drugs. *See* question 2.1. The FDA has taken the position that manufacturers may, under certain circumstances, provide healthcare professionals with information about unapproved uses of approved drugs in certain non-promotional contexts.

However, the FDA has provided in guidance documents that reprints of scientific journal articles that discuss unapproved uses

of approved products may lawfully be distributed in a non-promotional manner if certain criteria are met. These criteria generally relate to the credibility and independence of the publication, the truthfulness of the information, and the potential risk posed to patients and consumers who could rely on that information. While the guidance does not replace the requirements set forth under statutes or FDA regulations, it is a useful guide on the Agency's current thinking on this topic. *See*, FDA, Guidance for Industry: Distributing Scientific and Medical Publications on Unapproved New Uses – Recommended Practices (February 2014) available at <https://www.fda.gov/media/88031/download>. Another guidance addresses the dissemination of risk information that may be inconsistent with approved labelling. Guidance for Industry: Distributing Scientific and Medical Publications on Risk Information for Approved Prescription Drugs and Biological Products – Recommended Practices (June 2014) available at <https://www.fda.gov/media/88674/download>.

3.7 Are “teaser” advertisements (i.e. advertisements that alert a reader to the fact that information on something new will follow, without specifying the nature of what will follow) permitted?

FDA regulations allow the use of “reminder” advertisements (which only mention the name of the drug and not its use) for approved drugs, as well as “help-seeking” advertisements (which encourage individuals with a particular condition to see a doctor without mentioning a specific product). *See* 21 C.F.R. §202.1(e). For an unapproved product, within certain limitations the FDA has permitted the use of either “Institutional Promotion” or “Coming Soon Promotion”. With an “Institutional Promotion” advertisement, the manufacturer may state the drug company name and the area in which it is conducting research, but not the proprietary or established drug name. In “Coming Soon” advertisements, the manufacturer may state the drug name, but not the area in which the company is conducting research. Such options are not available for drugs bearing “black box” safety warnings.

3.8 Where Product A is authorised for a particular indication to be used in combination with another Product B, which is separately authorised to a different company, and whose SmPC does not refer expressly to use with Product A, so that in terms of the SmPC for Product B, use of Product B for Product A's indication would be off-label, can the holder of the MA for Product A nevertheless rely upon the approved use of Product B with Product A in Product A's SmPC, to promote the combination use? Can the holder of the MA for Product B also promote such combination use based on the approved SmPC for Product A or must the holder of the MA for Product B first vary the SmPC for Product B?

In general, if a product is promoted in an unapproved combination, claims about the safety or effectiveness of the combination use are treated like any other off-label product claim and subject to the same rules as single product off-label promotion noted in the responses above. The FDA may consider the combination product use a new use for each of the products being promoted in combination. Combination product claims will be regulated under the rules that apply to each of the product categories. So, for example, if one product is a prescription drug and a second product promoted in combination with that product is a diagnostic test, the FDA can apply the standards for prescription drug approval and promotion to the claims made about the drug to the drug and those governing medical devices or laboratory tests to the test. In order for a company to lawfully promote two

products in combination, the manufacturers of each product would need approval from the FDA for the intended combination use – the labelling of each product would generally need to reference the other and there would need to be substantial clinical evidence presented to the FDA and included in the approved labelling to substantiate the safety and effectiveness of the combination use. As noted, non-promotional communications – such as scientific exchange communications through which scientific journal reprints that report on the results of studies or real-world use of combination uses (for example, in oncology) may be disseminated – may be permitted in compliance with FDA guidance.

4 Gifts and Financial Incentives

4.1 Is it possible to provide healthcare professionals with samples of medicinal products? If so, what restrictions apply?

Prescription drug sampling is a highly regulated practice in the U.S. Drug samples may be distributed to healthcare professionals licensed to prescribe the sampled drug under the Prescription Drug Marketing Act and implementing regulations. FDA regulations allow samples to be distributed by: (1) mail or common carrier; or (2) direct delivery by a representative or detailer. *See* 21 C.F.R. §§203.30, 203.31. Under either form of distribution, the licensed practitioner must execute a written request and a written receipt. *Id.* When distribution occurs through a representative, the manufacturer must conduct, at least annually, a physical inventory of all drug samples in the possession of each representative. *Id.* at §202.31(d). The manufacturer must also maintain a list of all representatives who distribute samples and the sites where those samples are stored. *Id.* at §202.31(e). Drug samples may not be sold, purchased, or traded. *See* 21 U.S.C. §353(c)(1). Similarly, drug samples cannot be provided to healthcare professionals with the understanding that those professionals will seek reimbursement for the samples from public or private insurance schemes. However, under certain conditions, drug samples may be donated to a charitable institution. *See* 21 C.F.R. §203.39. Additional restrictions apply to the dissemination of any product that is a controlled substance. In certain circumstances, free drug products, not labelled as samples, may also be provided as part of patient assistance programmes, ensuring continuity of care. However, the provision of such free products should be evaluated carefully under fraud and abuse and pricing laws.

4.2 Is it possible to give gifts or donations of money to healthcare professionals? If so, what restrictions apply? If monetary limits apply, please specify.

Under the U.S. Anti-Kickback Statute, it is generally unlawful to offer any type of remuneration directly or indirectly to any person or entity in a position to purchase, lease, order, or prescribe (or influence the purchase, lease, order, or supply) a service or item reimbursed by a state or federal healthcare programme if even one purpose of the remuneration is to increase utilisation of products or services reimbursed under those schemes. *See* 42 U.S.C. §1320a-7b(b). Safe harbours apply to, among other types of payments or discounts, *bona fide* personal services, such as consulting arrangements undertaken for fair market value compensation.

Moreover, under the U.S. Foreign Corrupt Practices Act (FCPA), manufacturers who are issuers of shares on U.S. stock exchanges may not offer any type of remuneration directly or indirectly to any ex-U.S. government official with the intent of

improperly influencing an official decision to obtain or retain business or gain an unfair advantage. *See* 15 U.S.C. §78dd-1. U.S. authorities have interpreted these statutes very broadly. Under the FCPA, “government official” includes employees of government-run healthcare institutions or businesses over which foreign governments have control. Under both the Anti-Kickback Statute and the FCPA, “remuneration” is interpreted very broadly, and there is generally no *de minimis* exception. Pharmaceutical manufacturers must, therefore, carefully scrutinise sales and marketing practices involving gifts, donations, or other forms of remuneration that may be given to medical professionals and/or facilities.

Pharmaceutical manufacturers doing business in the U.S. should be familiar with the “guidelines” regarding relationships with physicians and other persons or entities in a position to make or influence referrals published by the following three entities: (i) the PhRMA Code on Interactions with Healthcare Professionals, available online at <https://www.phrma.org/en/Codes-and-guidelines/Code-on-Interactions-with-Health-Care-Professionals>; (ii) the HHS OIG Compliance Program Guidance for Pharmaceutical Manufacturers, 68 Fed. Reg. 23731 (May 5, 2003), available online at <http://oig.hhs.gov/authorities/docs/03/050503FRCPGPharmac.pdf>; and (iii) the AMA Guidelines on Gifts to Physicians from Industry, available online at <https://www.ama-assn.org/delivering-care/ethics/gifts-physicians-industry>. While the PhRMA and AMA Codes are voluntary, and do not take the place of statutory or regulatory provisions, U.S. authorities have encouraged manufacturers to comply, and most do so, certifying compliance to PhRMA. PhRMA prohibits its members from providing any item of any value that may be given in exchange for prescribing products or a promise to continue prescribing products, without consideration of their value. Even items intended for the personal benefit of the physician, including cash or cash equivalents, are inappropriate (except as compensation for *bona fide* services). So, for example, gift certificates, tickets to a sporting event, artwork, music, and floral arrangements would be prohibited under all three sets of guidelines.

Note that in many cases the U.S. Physician Payment Sunshine Act requires reporting and public posting on a government “Open Payments” website of payments or other transfers of value to prescribers and teaching hospitals. Certain states also prohibit gifts or transfers of value to healthcare providers, and institutional policies may also limit such activities.

4.3 Is it possible to give gifts or donations of money to healthcare organisations such as hospitals? Is it possible to donate equipment, or to fund the cost of medical or technical services (such as the cost of a nurse, or the cost of laboratory analyses)? If so, what restrictions would apply? If monetary limits apply, please specify.

Yes, it is possible to give donations and other items of value to healthcare organisations for legitimate charitable or educational purposes under certain limited circumstances. The Anti-Kickback Statute addressed above in question 4.2 applies to any remunerative relationship between the manufacturer and a person or entity in a position to generate federal healthcare programme business for the manufacturer. Such persons or entities would also include institutions such as hospitals or clinics. The OIG takes the position that goods and services provided by a manufacturer to a healthcare professional or institution that reduce or eliminate an expense the provider would otherwise have incurred (e.g., a business operational or overhead expense) implicates the Anti-Kickback statute if the arrangement is tied to the generation of federal healthcare programme

business. Therefore, manufacturers must refrain from providing any form of remuneration to a healthcare professional for operational or overhead expenses. It is possible to provide grants for *bona fide* research or other scientific/medical activities, but particular processes should be in place to ensure that decisions are made by medical affairs personnel, the amount is commensurate with the proposed research or other activity, and the grant is not for a promotional or other purpose that could be construed as an attempt to induce claims for the manufacturer’s products. Similar considerations apply to charitable donations made to institutions that are in a position to purchase, prescribe, use, or recommend the donor’s products. Note that such transfers of value, if given to a teaching hospital, may be reportable under the U.S. Sunshine Act. Outside the U.S., donations may also implicate the FCPA in cases where the donations are given with the intent to influence the official acts of foreign government officials, including employees of government-run medical institutions. No specific monetary limits apply to such gifts or donations, provided the gift or donation is otherwise lawful as outlined above.

4.4 Is it possible to provide medical or educational goods and services to healthcare professionals that could lead to changes in prescribing patterns? For example, would there be any objection to the provision of such goods or services if they could lead either to the expansion of the market for, or an increased market share for, the products of the provider of the goods or services?

Under U.S. law, it is generally unlawful for a manufacturer to provide healthcare professionals with any item of value that was intended to lead to changes in prescribing patterns in favour of that manufacturer’s products or services. U.S. law also limits the relationships a manufacturer may have with non-doctor third parties, such as pharmacies, insurers, consumers, and other entities, which are intended to refer patients or healthcare professionals to a manufacturer’s products or services.

4.5 Do the rules on advertising and inducements permit the offer of a volume-related discount to institutions purchasing medicinal products? If so, what types of arrangements are permitted?

To encourage price competition, the Federal Anti-Kickback statute contains both a statutory exception and regulatory safe harbour for discounts. *See* 42 U.S.C. §1320a-7b(b)(3)(A); 42 C.F.R. §1001.952(h). Both the statutory exception and regulatory safe harbour contain specific conditions that must be met. For example, all discounts must be disclosed and properly reported. Additionally, to qualify under the discount safe harbour, discounts must be in the form of a price reduction and must be given at the time of the sale (under certain circumstances the discount may be set at the time of the sale). *See* 42 C.F.R. §1001.952(h). Notably, the regulatory safe harbour provides that the term “discount” does not include: (i) cash payment or cash equivalents; (ii) supplying one good or service without charge or at a reduced charge to induce the purchase of a different good or service, unless the goods and services are reimbursed by the same federal healthcare programme using the same methodology and the reduced charge is fully disclosed to the federal healthcare programme and accurately reflected where appropriate to this reimbursement methodology; (iii) a reduction in price applicable to one payer but not to Medicare or a state healthcare programme; (iv) routine reduction or waiver

of any coinsurance or deductible amount owed by a programme beneficiary; (v) warranties; (vi) services provided in accordance with a personal or management services contract; or (vii) any other remuneration, in cash or kind, not explicitly described in the regulation. *See* 42 C.F.R. §1001.952(h). Recent changes to the safe harbours under the Anti-Kickback Statute should be considered, particularly with respect to certain reductions in price or other remuneration from a manufacturer of prescription pharmaceutical products to plan sponsors under Medicare Part D or pharmacy benefit managers (PBMs) under contract with them, and new safe harbours relevant to point-of-sale reductions in price on prescription pharmaceutical products (the latter protects certain PBM service fees).

4.6 Is it possible to offer to provide, or to pay for, additional medical or technical services or equipment where this is contingent on the purchase of medicinal products? If so, what conditions would need to be observed? Are commercial arrangements whereby the purchase of a particular medicine is linked to provision of certain associated benefits (such as apparatus for administration or the provision of training on its use) as part of the purchase price (“package deals”) acceptable? If so, what rules apply?

Under U.S. law, no gift or payment should be made contingent on the purchase of medicinal products that is reimbursable under U.S. government healthcare programmes. Similar limitations apply under certain state laws.

Although it may be possible to bundle medicines and other value or services provided to physicians in certain circumstances, particularly if the value or services are necessary for safe use of the medication, such value or services should not create an inducement for use of the product, and bundling activities may have an impact on drug pricing for government reporting purposes. Such factors must be carefully scrutinised in each specific arrangement. In general, supplying one good without charge or at a reduced charge to induce the purchase of a different good is not possible – unless they are reimbursed by the same federal healthcare programme using the same methodology and the reduced charge is fully disclosed to the federal healthcare programme and accurately reflected in the reimbursement methodology.

4.7 Is it possible to offer a refund scheme if the product does not work? If so, what conditions would need to be observed? Does it make a difference whether the product is a prescription-only medicine, or an over-the-counter medicine?

Yes. Such programmes are not typically used for individual patients who are prescribed prescription drugs, but given the high cost of certain treatments, such as gene therapies, increasingly we will see a guarantee of retreatment if an initial treatment fails. Moreover, as noted, such schemes are a definite focus in the context of manufacturer-payer agreements providing financial incentives based on the overall outcomes within the insured patient population. In addition to the difficulties of accessing sufficient data to facilitate such value-based arrangements, they pose a wide range of fraud and abuse, off-label promotion, and price reporting complexities. In the OTC space, such refund schemes are much more common, and are similar to the money-back guarantees seen for other consumer products. Such provisions are largely governed by FTC and state rules.

Safe harbour analysis is critical for any proposed warranty scheme involving a product for which federal healthcare

programme reimbursement is available; warranties can be considered value transfers that implicate the Anti-Kickback Statute. Importantly, there is a “warranty” safe harbour in the Anti-Kickback law that excludes certain warranty payments from the definition of “remuneration” under the statute. *See* 42 C.F.R. §1001.952(g).

Safe harbour protection is highly fact-specific and must be analysed based on the particulars of the specific warranty offer/arrangement.

4.8 Are more complex patient access schemes or managed access agreements, whereby pharmaceutical companies offer special financial terms for supply of medicinal products (e.g. rebates, dose or cost caps, risk share arrangements, outcomes-based schemes), permitted in your country? If so, what rules apply?

Yes, such value-based arrangements are increasingly common, and in fact companies are encouraged to discuss such arrangements with payors even prior to approval. Such arrangements can be complex to develop and administer, and implicate a wide range of legal concerns, including structuring them in a manner consistent with a safe harbour under the Anti-Kickback Statute, reflecting price concessions in government price reporting, ensuring that outcome measures are appropriate and consistent with labelling, privacy issues, antitrust considerations, and state laws governing Medicaid arrangements. That said, various models have been implemented across the industry, particularly for high-cost treatments such as gene therapies.

4.9 Is it acceptable for one or more pharmaceutical companies to work together with the National Health System in your country, pooling skills, experience and/or resources for the joint development and implementation of specific projects? If so, what rules apply?

Yes, this can vary from demonstration programmes under the Medicare programme involving multiple companies and intended to enhance quality of care, to Cooperative Research and Development Agreements (CRADAs) with the National Institutes of Health involving research on new treatments. In recent years, a particular focus is collaboration with the Department of Health and Human Services’ Biological Advanced Research and Development Authority (BARDA) on the development of vaccines, drugs, and other countermeasures for use in treating COVID-19.

4.10 May pharmaceutical companies sponsor continuing medical education? If so, what rules apply?

It is permissible for manufacturers to support the education of the medical community through sponsoring continuing medical education (CME); however, these relationships must be consistent with U.S. federal healthcare laws and applicable professional society guidelines. For example, if pharmaceutical manufacturers provide financial support for medical conferences or meetings other than their own, to avoid responsibility for any off-label content, control over the content and faculty of the meeting or conference must generally remain with the organisers. The FDA and OIG have set forth their expectations for manufacturer-supported CME in guidance documents. In particular, these authorities are concerned with financial relationships between manufacturers and CME providers that could transform otherwise beneficial, independent medical information into promotional vehicles for manufacturer

products (including unapproved uses of those products). See, e.g., FDA, Guidance for Industry, Industry-Supported Scientific and Educational Activities (December 2007) available at <http://www.fda.gov/downloads/RegulatoryInformation/Guidances/UCM125602.pdf>; OIG, OIG Compliance Program Guidance for Pharmaceutical Manufacturers (May 2003) available at <http://oig.hhs.gov/authorities/docs/03/050503FRCPG-Pharmac.pdf>; PhRMA Code on Interactions with Healthcare Professionals available online at <https://www.phrma.org/en/Codes-and-guidelines/Code-on-Interactions-with-Health-Care-Professionals>. Support for medical education must also be structured to comply with the Anti-Kickback Statute, the PhRMA Code, the FCPA and other applicable guidelines, since such support may result in an item of value being provided to healthcare professionals.

4.11 What general anti-bribery rules apply to the interactions between pharmaceutical companies and healthcare professionals or healthcare organisations? Please summarise. What is the relationship between the competent authorities for pharmaceutical advertising and the anti-bribery/anti-corruption supervisory and enforcement functions? Can and, in practice, do the anti-bribery competent authorities investigate matters that may constitute both a breach of the advertising rules and the anti-bribery legislation, in circumstances where these are already being assessed by the pharmaceutical competent authorities or the self-regulatory bodies?

As noted in response to question 4.2, there is both a domestic and international framework prohibiting kickbacks or other corrupt payments to healthcare professionals and organisations. Within the U.S., subject to certain safe harbours, the U.S. Anti-Kickback Statute prohibits offering any type of remuneration directly or indirectly to any person or entity in a position to purchase, lease, order, or prescribe (or influence the purchase, lease, order, or supply) a service or item reimbursed by a state or federal healthcare programme if even one purpose of the remuneration is to increase utilisation of products or services reimbursed under those schemes. See 42 U.S.C. §1320a-7b(b). Internationally, under the FCPA, manufacturers who are issuers of shares on U.S. stock exchanges may not offer any type of remuneration directly or indirectly to any ex-U.S. government official with the intent of improperly influencing an official decision to obtain or retain business or gain an unfair advantage. See 15 U.S.C. §78dd-1. The Anti-Kickback Statute is enforced by the Department of Justice and Office of Inspector General of the Department of Health and Human Services, and the FCPA is enforced by the Department of Justice and Securities and Exchange Commission. There is an increasing enforcement focus on investigating patterns of kickbacks and corruption that involve both U.S. and ex-U.S. healthcare practitioners and institutions, particularly those with a government institution nexus. For example, Department of Justice settlements with Olympus Corporation of the Americas stemmed from an investigation that involved both domestic kickback and Latin American bribery allegations. See <https://www.justice.gov/opa/pr/medical-equipment-company-will-pay-646-million-making-illegal-payments-doctors-and-hospitals>.

5 Hospitality and Related Payments

5.1 What rules govern the offering of hospitality to healthcare professionals? Does it make a difference if the hospitality offered to those healthcare professionals will take place in another country and, in those circumstances, should the arrangements be approved

by the company affiliate in the country where the healthcare professionals reside or the affiliate where the hospitality takes place? Is there a threshold applicable to the costs of hospitality or meals provided to a healthcare professional?

Providing “hospitality”, such as meals and social functions to healthcare professionals, would be governed by the aforementioned federal Anti-Kickback Statute as well as state laws and industry codes. In cases where hospitality is provided to healthcare professionals employed by ex-U.S. government institutions, the U.S. FCPA may also be implicated. The guidelines set by OIG as well as PhRMA, the AMA and other professional organisations discussed above in question 4.2 would also be relevant. For example, under the PhRMA Code, a company may hold informational presentations that serve a valid scientific purpose and provide a “modest meal” by local standards. The company cannot, however, provide entertainment or a recreational outing and cannot pay for a spouse’s or guest’s meal. The AMA Guidelines provide that subsidies for hospitality should not be accepted outside of modest meals or incidental social events held as part of a conference or meeting. See also question 5.2.

The choice of country would not be a factor in the analysis under the Anti-Kickback Statute or under U.S.-based professional guidelines. Further, an ex-U.S. event could raise risks under the FCPA if government officials were invited to participate or attend the event. It is generally best practice to require approval by the local affiliate where the hospitality takes place, as well as the affiliate where the payment is originating, in order to ensure compliance with local requirements and fair market value. Finally, meal costs and other hospitality – even when permissible – must be tracked and reported under applicable transparency laws.

5.2 Is it possible to pay for a healthcare professional in connection with attending a scientific meeting? If so, what may be paid for? Is it possible to pay for his expenses (travel, accommodation, enrolment fees)? Is it possible to pay him for his time?

As with the provision of hospitality, travel and honorarium payments are items of value that implicate the Anti-Kickback Statute, FCPA, certain state laws, and the professional guidelines noted above. In general, a manufacturer’s financial support may be appropriate if: (i) the subsidy is sent directly to the conference sponsor; (ii) the sponsor uses the subsidy to create an overall reduction in conference registration fees for all attendees; and (iii) the physician does not receive the subsidy directly. Non-faculty professionals should not be paid for the costs of travel, lodging, or any other personal expenses. A manufacturer may, however, offer financial support to sponsors for modest meals or receptions so long as the meals and receptions are provided for all attendees. Funding should not, however, be offered to pay for the physician’s time associated with attending the conference and no direct or indirect payments (including reimbursements made directly to attendees or to their travel agencies) may be paid with the intention of influencing their prescribing behaviour or otherwise referring them to a manufacturer’s products or services. Finally, as noted earlier, lawful payments or reimbursements must be tracked and reported under transparency laws.

These limitations should be distinguished from *bona fide* personal services arrangements such as compensation for investigators to attend investigator or consultant meetings in a manner consistent with the terms for such arrangements under the Anti-Kickback Statute, where the payments are made at a fair market value for services rendered. See the answer to question 5.4 below. Note also that transparency reporting requirements may apply to such payments.

5.3 To what extent will a pharmaceutical company be held responsible by the regulatory authorities for the contents of, and the hospitality arrangements for, scientific meetings, either meetings directly sponsored or organised by the company or independent meetings in respect of which a pharmaceutical company may provide sponsorship to individual healthcare professionals to attend?

In instances where such meetings do not meet the FDA's and OIG's indicia for independence (*see* the guidance documents discussed in question 4.10), U.S. authorities will generally take the position that a supporting manufacturer is responsible for the content presented at such meetings, as well as any items of value offered to attendees.

5.4 Is it possible to pay healthcare professionals to provide expert services (e.g. participating in advisory boards)? If so, what restrictions apply?

Yes. As noted, U.S. regulations create a safe harbour to the Anti-Kickback Statute for "personal services", provided all of the requirements of the safe harbour are met. *See* 42 C.F.R. §1001.952(d). Manufacturers may enter into consulting agreements with physicians so long as the compensation reflects a fair market, a commercially reasonable value, there is a legitimate need for the services, and the arrangement does not take into account the past, present, or future prescribing or purchasing potential. As outlined in government regulations, as well as professional society guidelines, there are several factors that are relevant in identifying the existence of a *bona fide* consulting arrangement: (i) the agreement is in writing and specifies the nature of the services to be provided and the basis for the payment of those services; (ii) a legitimate need for the services has been identified (and documented) in advance of the request for services and entering into arrangements with prospective consultants; (iii) the criteria for selecting the consultants are directly related to the identified purpose and the persons responsible for selecting the consultants have the expertise necessary to decide if the consultant meets the criteria; (iv) the number of consultants retained is not greater than the number reasonably necessary to achieve the desired purpose; (v) the company maintains records of the services provided and makes appropriate use of the services provided; (vi) the venue and circumstances of any meeting with consultants is conducive to the consulting services provided and activities related to the services constitute the primary focus of the meeting, with any social or entertainment events clearly subordinate in terms of time and emphasis; and (vii) no payments are made for the consultant's spouse or significant other to attend the meeting. A similar analysis should be conducted to limit a manufacturer's exposure to liability under the FCPA, where the personal services are between a manufacturer and a government official or employee (such as a clinical investigator who is also employed by a government-run hospital).

A failure to comply with these requirements can result in severe civil and criminal consequences for a U.S. manufacturer, as well as responsible corporate officials. This is especially true where advertising and promotion issues converge with payment arrangements with healthcare professionals. Inappropriate advisory board activities, such as holding numerous advisory boards that were clearly for the purpose of disseminating off-label information and seeding prescribing as opposed to a genuine goal of receiving advice, have formed the basis for government enforcement, resulting in major settlements.

5.5 Is it possible to pay healthcare professionals to take part in post-marketing surveillance studies? What rules govern such studies?

While it is possible to compensate doctors to participate as investigators in clinical trials, the compensation must comply with the FDA regulations governing clinical research. Such studies should have a clear scientific/medical rationale, and should not constitute a "seeding" effort to market the product to physicians. Payments must also conform to the requirements under the Anti-Kickback Statute, including payments based on fair market value, and, where applicable, the FCPA.

5.6 Is it possible to pay healthcare professionals to take part in market research involving promotional materials?

Yes, if the market research is *bona fide* research (i.e., designed to achieve a legitimate commercial research question) and the payments are fair market value for the time required of the healthcare professionals. An excessive audience for such research may indicate pre-approval "seeding" promotion or kickbacks rather than legitimate market research.

6 Advertising to the General Public

6.1 Is it possible to advertise non-prescription medicines to the general public? If so, what restrictions apply?

Yes, non-prescription or OTC drugs may be advertised to the general public. As discussed above in question 1.1, advertisements for monograph non-prescription drugs are primarily regulated by the FTC, not the FDA. U.S. law prohibits the dissemination of non-prescription drug advertisements that are deceptive or otherwise misleading. *See* 15 U.S.C. §52. This prohibition applies to non-prescription drug advertisements. A "false advertisement" is defined as an advertisement "which is misleading in a material respect". *Id.* at §55. In determining whether an advertisement is misleading, several factors will be considered, including the representations made or suggested by word, design, device, or sound and any material facts omitted.

6.2 Is it possible to advertise prescription-only medicines to the general public? If so, what restrictions apply?

Yes, DTC advertising is also allowed for prescription drugs. Under FDA regulations, "advertisements" subject to the FDCA fall into two categories: print advertisements; and broadcast advertisements. Print advertisements include "advertisements in published journals, magazines, other periodicals, and newspapers". Broadcast advertisements include "advertisements broadcast through media such as radio, television, and telephone communication systems". 21 C.F.R. §202.1(l)(1). Both types of advertisements may not be false or misleading and must present a fair balance between the efficacy of a drug and its risks. *Id.* at §202.1. Additional FDA requirements differ slightly depending on the type of advertisement.

Print Advertisements

The FDCA and FDA regulations require that all prescription drug advertisements discussing the effectiveness or indications of the drug must include a brief summary of side effects, contraindications,

and effectiveness (known as the “brief summary” requirement). *See* 21 U.S.C. §352(n); 21 C.F.R. §202.1(e). This brief statement must include all risk information contained in the approved labelling, including all side effects, contraindications, warnings, precautions, and adverse reactions. *See* 21 C.F.R. §202.1(e)(3)(iii).

To satisfy the brief summary requirement, manufacturers will usually reprint the relevant sections of the package insert. The package insert is directed at healthcare providers and may be difficult for consumers to understand. As a result, the FDA has suggested that manufacturers use consumer-friendly language on contraindications, warnings, major precautions, and frequently occurring side effects in print advertisements directed at consumers. As noted, two types of advertisements are not subject to the brief summary requirement:

- Reminder Advertisements.
- Help-Seeking Advertisements.

Broadcast Advertisements

While broadcast advertisements are subject to several technical requirements that differ from those of print advertisements, the FDA applies the same guiding regulatory principles to both types of ads, when determining whether a particular ad adequately communicates risks and benefits to consumers. *See* question 3.1 above.

A broadcast advertisement must include a statement of the most important risk information (known as the “major statement” requirement). A broadcast advertisement must also either include a brief summary, as discussed above, or make “adequate provision...for the dissemination of the approved or permitted package labelling in connection with the broadcast presentation” (known as the “adequate provision” requirement). 21 C.F.R. §202.1(e)(1). In a guidance, the FDA has indicated that a manufacturer can satisfy the adequate provision requirement by:

- providing a toll-free phone number for consumers to call for the approved labelling;
- referencing a printed advertisement or brochure that can be accessed with limited technology;
- providing reference to an Internet website that contains the requisite labelling; and
- advising consumers to ask doctors or pharmacists for more information.

6.3 If it is not possible to advertise prescription-only medicines to the general public, are disease awareness campaigns permitted encouraging those with a particular medical condition to consult their doctor, but mentioning no medicines? What restrictions apply?

While prescription drug advertisements are allowed in the U.S., a manufacturer may use “help-seeking” or disease-oriented advertisements focused on raising awareness of a particular condition and not addressing a specific brand. Such advertisements should not be framed so narrowly as to constitute *de facto* advertising for a specific product, and should be perceptually distinct from branded advertising.

6.4 Is it possible to issue press releases concerning prescription-only medicines to non-scientific journals? If so, what conditions apply? Is it possible for the press release to refer to developments in relation to as yet unauthorised medicines or unauthorised indications?

There is no prohibition on such press releases so long as the drug has received marketing approval from the FDA and the press release is otherwise compliant. Because such press releases

may be regulated as promotional materials, the information they contain must be consistent with the drug’s FDA-approved label and otherwise meet the requirements set forth for promotional materials under U.S. law. If the product is not approved, the information should make clear that the product is not approved by the FDA and should not include safety or effectiveness claims. In some narrow circumstances, a manufacturer may distribute material, new scientific findings, to the lay media prior to approval. *See* questions 2.1 and 2.2 above. Note that press releases relating to product developments may also be scrutinised under applicable securities laws. The FDA and the Securities and Exchange Commission frequently coordinate on matters involving prescription drug communications.

6.5 What restrictions apply to describing products and research initiatives as background information in corporate brochures/Annual Reports?

Although such materials are generally not considered promotional materials for specific products, in certain circumstances they may be used in that manner. There are no specific restrictions on product descriptions and research initiatives, other than the prohibition against the general prohibition on false and misleading promotion, including unlawful *promotion* of unapproved new drugs or unapproved uses of approved drugs. Note that laws governing the accuracy and transparency of securities disclosures may apply, and the FDA and the U.S. Securities and Exchange Commission frequently coordinate on matters involving prescription drug communications.

6.6 What, if any, rules apply to meetings with, and the funding of, patient organisations?

Prescription drug and medical device manufacturers may provide charitable funding to patient support groups. Such funding decisions should generally be made through a formal grant process. Funding to patient organisations may implicate the Anti-Kickback Statute if such groups include prescribers or the organisations have the ability to refer patients to physicians or otherwise influence prescribing. Notably, the OIG has published guidance and several advisory opinions that provide the Agency’s views as to when the Anti-Kickback Statute may be implicated through patient organisation support. The FCPA, as well as state and federal tax laws, may also be implicated in certain scenarios. Certain state laws require manufacturers to publicly disclose funding to such groups to state officials. Further, professional and industry guidelines (such as the AMA and PhRMA Codes discussed earlier) may require individual organisations and medical professionals to make public disclosures on a case-by-case basis. Note that PhRMA maintains industry principles on interactions with patient organisations (<https://www.phrma.org/en/Codes-and-guidelines/PhRMA-Principles-on-Interactions-with-Patient-Organizations>). Finally, industry funding of third-party organisations that provide financial assistance to patients has come under increased scrutiny in the U.S. in recent years out of a concern by regulators that such funding can steer patients to the funding company’s products.

6.7 May companies provide items to or for the benefit of patients? If so, are there any restrictions in relation to the type of items or the circumstances in which they may be supplied?

Within limits, items may be provided to patients via their physicians if the items are designed primarily for the education of

patients, are not of substantial value (generally \$100 or less) and do not have value to the healthcare professional outside of his or her professional responsibilities. For example, an anatomical model for use in an examination room is intended for the education of the patients and is therefore appropriate, whereas an iPad® may have independent value to a healthcare professional outside of his or her professional responsibilities, even if it could also be used to provide education to patients, and therefore is not appropriate. Items designed primarily for the education of patients or healthcare professionals should not be offered on more than an occasional basis, even if each individual item is appropriate. Moreover, certain items may be provided directly to patients if they are *de minimis* in value, generally relate to the medical treatment, and not intended as an inducement to seek a particular product. An example would be a very inexpensive container that permits the patient to maintain the proper temperature of a product.

6.8 What are the rules governing company funding of patient support programmes?

This is a complex area that implicates the Anti-Kickback Statute and various other fraud and abuse laws. Such patient assistance is generally based on financial need, and should not be structured in a manner that induces prescribing of the product. Numerous companies have encountered serious legal concerns due to a lack of controls in this area, including overly extensive or promotional patient assistance (writing appeal letters, going through patient files to address reimbursement issues, characterising the programme as a “white glove service”, etc.). Others have entered into major settlements due to funding of third-party patient assistance foundations in a manner that allegedly did not comport with HHS advisory opinions pertaining to foundation independence and information flow-back to the grantor.

7 Transparency and Disclosure

7.1 Is there an obligation for companies to disclose details of ongoing and/or completed clinical trials? If so, is this obligation set out in the legislation or in a self-regulatory code of practice? What information should be disclosed, and when and how?

Yes. Registration is required at clinicaltrials.gov for trials that meet the definition of an “applicable clinical trial” under relevant legislation. See <https://clinicaltrials.gov/ct2/manage-recs/fdaaa>. Applicable clinical trials include controlled clinical investigations, other than phase 1 clinical investigations, of drugs or biological products subject to FDA regulation, and generally include interventional studies (with one or more arms) of FDA-regulated drugs, biological products, or devices that meet one of the following conditions:

- The trial has one or more sites in the United States.
- The trial is conducted under an FDA investigational new drug application or investigational device exemption.
- The trial involves a drug, biologic, or device that is manufactured in the United States or its territories and is exported for research.

Extensive information on the parameters for, and ultimately the results of, the clinical trial must be provided, and the National Institutes of Health recently finalised rules expanding the results information requirement very substantially. See <https://www.federalregister.gov/documents/2016/09/21/2016-22129/clinical-trials-registration-and-results-information-submission>.

Notably, the FDA has begun sending notices of a violation of clinicaltrials.gov requirements.

7.2 Is there a requirement in the legislation for companies to make publicly available information about transfers of value provided by them to healthcare professionals, healthcare organisations or patient organisations? If so, what companies are affected (i.e. do these requirements apply to companies that have not yet been granted a marketing authorisation and/or to foreign companies), what information should be disclosed, from what date and how?

Yes. The Physician Payments Sunshine Act requires “applicable manufacturers” of drugs, devices, biologicals, or medical supplies covered under Medicare, Medicaid or the Children’s Health Insurance Program (CHIP), to report annually to the Centers for Medicare and Medicaid Services (CMS), in an electronic format, certain payments or other transfers of value to “covered recipients” – physicians and teaching hospitals. Early in 2022, reporting obligations were expanded to include data for physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anaesthetists, and certified nurse-midwives.

“Applicable manufacturer” is defined as an entity that operates in the U.S. and is “engaged in the production, preparation, propagation, compounding, or conversion of a covered drug, device, biological, or medical supply”. A “covered” product means that payment must be available under Medicare, Medicaid or CHIP and the product requires a prescription or premarket approval (devices). This includes products that are reimbursed separately or as part of a bundled payment. The Sunshine Act only requires applicable manufacturers to register with CMS and report payments to the agency if they have made reportable payments or transfers of value to “covered recipients” in the applicable calendar year.

The Sunshine Act applies to payments or transfers of value made by applicable manufacturers to “covered recipients”, who are defined to include: (1) physicians; and (2) teaching hospitals. Physician includes doctors of medicine and osteopathy, dentists, podiatrists, optometrists, and chiropractors, who are legally authorised to practise by the state in which they practise. Thus, the law applies to a physician who is licensed in the U.S., even if they maintain a licence or practice in a different country. This includes all physicians and fellows that have a current or active licence, regardless of whether they are enrolled with CMS or currently or actively seeing patients. Medical residents are not “covered recipients”. Payments to prospective employee physicians (e.g., recruiting costs), including travel, lodging and meals, are also reportable. *Bona fide* employees of an applicable manufacturer that are U.S.-licensed physicians are also exempt from the definition of covered recipient. Teaching hospitals are also covered recipients. CMS publishes a list of teaching hospitals once annually that will be available 90 days before the reporting year and will include tax identification numbers. CMS has clarified that hospitals not listed on the Open Payments teaching hospital list are not considered a teaching hospital covered recipient for purposes of Open Payments. Payment data is due to CMS each year by March 30, and must be posted on CMS’s “Open Payments” website in June.

Applicable manufacturers must report to CMS “payments or other transfers of value” made to covered recipients, which the Sunshine Act broadly defines as “anything of value”. This could include a medical journal reprint, travel and lodging, meals, research grants, and any other payments or transfers of value unless otherwise exempt or excluded. Two types of payment reporting apply: (1) general payments; and (2) research payments. The final regulations explain the specific types of information that manufacturers must report to CMS for each payment or transfer of value.

Certain payments or transfers of value are excluded from reporting under the Sunshine Act. These include certain “indirect payments” or transfers of value. CMS defined an “indirect payment” as a payment or transfer of value made by a manufacturer to a physician or teaching hospital *through a third party or intermediary*, in which the manufacturer “requires, instructs, directs or otherwise causes” the third party to provide payment or transfer of value, in whole or in part, to a physician or teaching hospital. In other words, “indirect payments...are made to an entity or individual (that is, a third party) to be passed through to a” physician or teaching hospital. Although each payment arrangement must be carefully reviewed, the Sunshine Act does not require manufacturers to report indirect payments where the applicable manufacturer is “unaware” of the identity of the covered recipient during the reporting year or by the end of the second quarter of the following year. Under the final regulations, a manufacturer is unaware of the identity of a covered recipient if the manufacturer does not “know” the identity of the covered recipient. The definition of “know” provides that a person has actual knowledge of the information, acts in deliberate ignorance of the information, or acts in reckless disregard of the truth or falsity of the information.

In general, these requirements apply to foreign companies (including, in some cases, foreign affiliates that have a role in supporting U.S. products) who otherwise qualify as applicable manufacturers. Companies without approved or “covered” products subject to payment under government healthcare programmes, as outlined above, are not required to report under the Sunshine Act.

7.3 Is there a requirement in your self-regulatory code for companies to make publicly available information about transfers of value provided by them to healthcare professionals, healthcare organisations or patient organisations? If so, what companies are affected (i.e. do these requirements apply to companies that have not yet been granted a marketing authorisation and/or to foreign companies), what information should be disclosed, from what date and how? Are companies obliged to disclose via a central platform?

As noted above, the Sunshine Act provides for posting of such transfers of value on the CMS Open Payments website as a matter of law. In general, these posting requirements apply to foreign companies (including, in some cases, foreign affiliates that have a role in supporting U.S. products) who otherwise qualify as applicable manufacturers. Companies without approved or “covered” products subject to coverage under government healthcare programmes, as outlined above, are not required to report under the Sunshine Act.

7.4 What should a company do if an individual healthcare professional who has received transfers of value from that company, refuses to agree to the disclosure of one or more of such transfers?

While there are processes for physicians to review and dispute reported transfers of value directly with CMS (*see* <https://www.cms.gov/OpenPayments/Program-Participants/Physicians-and-Teaching-Hospitals/Review-and-Dispute.html>), and many companies have developed mechanisms for allowing physicians to review and reconcile payments prior to submission of Sunshine Act reports, if a transfer of value is accurate and otherwise required to be reported under the Sunshine Act, the physician may not refuse to permit such disclosure.

8 Digital Advertising and Social Media

8.1 How is Internet advertising regulated? What rules apply? How successfully has this been controlled?

The FDA has generally attempted to adapt traditional policies and concepts to such communications, with certain accommodations. The FDA has also developed certain draft and final guidance documents addressing aspects of Internet communications, including activities involving interactive media and when companies take on responsibility for content and must make submissions to the FDA, communications in character-limited settings such as Twitter, and correcting misinformation on the Internet. *See* <https://www.fda.gov/about-fda/center-drug-evaluation-and-research-cder/industry-using-social-media>.

8.2 What, if any, level of website security is required to ensure that members of the general public do not have access to sites intended for healthcare professionals?

Given that prescription medicines may be lawfully promoted to patients in the U.S., no specific level of security is required, although such security may be useful in certain circumstances in order to clearly delineate information intended for healthcare professionals *versus* lay audiences (for example, by placing “pop-ups” or “roadblocks” on the relevant web pages). Some prescription drug websites require the healthcare professional to register, while others have no special security at all. Such a security requirement would factor in a regulator’s overall analysis regarding the nature and purpose of the website, and the applicable rules for website content.

8.3 What rules apply to the content of independent websites that may be accessed by a link from a company-sponsored site? What rules apply to the reverse linking of independent websites to a company’s website? Will the company be held responsible for the content of the independent site in either case?

While the rules in this area are not entirely clear, the FDA has promulgated draft guidance to help companies determine when they are responsible for user-generated content on sites in which they participate or link, <http://www.fda.gov/downloads/drugs/guidancecomplianceregulatoryinformation/guidances/ucm381352.pdf>. In many cases, the FDA has taken the position that such links incorporate the content of linked sites (e.g., relating to off-label uses), unless steps are taken to create a buffer (e.g., at a minimum, a click-through disclaimer) indicating that the user is leaving the promotional, company-sponsored site.

8.4 What information may a pharmaceutical company place on its website that may be accessed by members of the public?

There are no general federal requirements governing what can be on the company website. Rather, the general requirements regarding promotion, scientific exchange, disclosures, and securities requirements apply, and many warning and untitled letters provide additional guidance on FDA areas of concern, particularly with respect to websites focusing on pipeline investigational products. Over the years, the FDA has sent numerous untitled and Warning Letters to companies who appear to be

promoting unapproved products on the web. Further, the FDA's "Bad Ad" Programme encourages physicians, patients, and competitor companies alike to inform the FDA of potentially violative advertising and marketing practices, which has driven many of the recent instances of FDA enforcement for web-based promotion over the past year. Independent of the promotion and advertising regulations, companies with ongoing Phase II and III clinical drug trials are required to place certain information about their policies supporting compassionate use and expanded access to investigational therapies on a public-facing website.

8.5 Are there specific rules, laws or guidance, controlling the use of social media by companies?

As noted, while the FDA has generally tried to apply its general approach to drug promotion to the social media context, the FDA has developed certain draft and final guidance documents addressing aspects of such communications, including activities involving interactive media and when companies take on responsibility for content and must make submissions to the FDA, communications in character-limited settings such as Twitter, and correcting misinformation on the Internet. *See* <https://www.fda.gov/about-fda/center-drug-evaluation-and-research-cder/industry-using-social-media>.

8.6 Are there any restrictions on social media activity by company employees using their personal accounts, including interactions with third parties through "likes", "applauds", etc.?

Such "likes" and similar actions, including forwarding company posts with additional messaging, may, subject to the context, be attributed to the employer as a promotional communication or subject recruitment. Thus, companies generally maintain policies regarding employees use of personal accounts to promote or discuss company products, often limiting or requiring prominent disclaimers with such communications. For example, while companies often allow employees to retweet or forward approved company tweets or posts, they are typically asked not to comment on the material with additional information.

8.7 Are there specific rules governing advertising and promotional activity conducted virtually, including online interactions with healthcare professionals, virtual meetings and participation in virtual congresses and symposia?

U.S. agencies generally apply the same standards to virtual activities, with adaptations for the setting. For example, companies in the U.S. have continued promotional speaker programmes during the COVID-19 pandemic, but have adapted the various rules relating to the number of attendees, the content, meals (by delivery), etc. Companies have also had to ensure their materials used in virtual detailing are adaptable to the virtual setting, and convey information in a truthful and non-misleading manner.

9 Developments in Pharmaceutical Advertising

9.1 What have been the significant developments in relation to the rules relating to pharmaceutical advertising in the last year?

A particular focus has been on speaker programmes, with the OIG issuing a Special Fraud Alert on the topic, and corresponding changes being made to industry codes to further restrict certain industry practices, *see* <https://oig.hhs.gov/documents/special-fraud-alerts/865/SpecialFraudAlertSpeakerPrograms.pdf>. Another continuing focus is the FDA's and OIG's enforcement efforts against companies making unlawful claims or engaging in fraud relating to products purported to be helpful in the treatment of COVID-19. (*See* Beware of Fraudulent Coronavirus Tests, Vaccines and Treatments | FDA (<https://www.fda.gov/consumers/consumer-updates/beware-fraudulent-coronavirus-tests-vaccines-and-treatments>) and Fraud Alert: COVID-19 Scams | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services (<https://oig.hhs.gov/fraud/consumer-alerts/fraud-alert-covid-19-scams/>)). More generally, companies in the field have been focused on compliance with the general rules governing pharmaceutical promotion in a remote context, and adapting those rules, such as ensuring fair balance, to virtual detailing, virtual medical education, virtual medical congresses, etc.

9.2 Are any significant developments in the field of pharmaceutical advertising expected in the next year?

We expect a continuation of recent FDA practices in this area, although it is possible that the Biden Administration will ramp up FDA promotional enforcement now that a new FDA Commissioner is in place.

9.3 Are there any general practice or enforcement trends that have become apparent in your jurisdiction over the last year or so?

Prior to the COVID-19 pandemic, an emphasis on pharmaceutical pricing had become particularly critical, and prosecutors have responded by focusing heavily on aspects of pharmaceutical manufacturer programmes that allegedly unlawfully blunt the impact of pharmaceutical pricing on patients or deter the use of generic products. Market access programmes, particularly those which seek to lower copay costs for patients without passing on savings to the government and those which provide free and valuable services to physicians or other healthcare providers will continue to be a focus of enforcement attention. The FDA has focused primarily on expanding its ability to approve complex generic products and biosimilars, thereby enhancing competition. In addition, the U.S. Congress is heavily focused on drug pricing, and in the coming years the debate over drug pricing legislation will continue, along with a focus on industry patenting practices.



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