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The International Comparative Legal Guide to:
Pharmaceutical Advertising 2010

A practical cross-border insight into pharmaceutical advertising

Published by Global Legal Group
with contributions from:

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Chapter 38

USA

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1 General - Medicinal Products

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

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. In certain circumstances, the U.S. Federal Trade Commission, as well as individual states, retain jurisdiction over aspects of prescription drug advertising as well (for e.g., guarantees, price reductions, and limited-time offers).

The FDCA sets out broad requirements for prescription drug advertisements and authorises the FDA to promulgate related regulations. *See* 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. FDA has also developed various non-binding 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. FDA has a broad mandate from Congress to exercise its discretion in enforcing the FDCA and its implementing regulations, to protect the public health of patients prescribed prescription drug products.

Non-Prescription Drugs

Most non-prescription or "over-the-counter" (OTC) drugs in the U.S. are sold under the terms of regulatory monographs providing a range of ingredients, claims and directions for use permitted in such products, without requiring FDA approval. While the FDA regulates the labelling of non-prescription drugs, it does not regulate the advertising; that responsibility largely rests with the Federal Trade Commission (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 advertisements likely to induce the purchase of food, drugs, devices, services, or cosmetics is unlawful and subject to enforcement by the FTC.

1.2 How is "advertising" defined?

"Advertising" includes any descriptive printed 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 arguably distinct from labelling in that it does "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 FDA and 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 advertising materials (in which legal, scientific/medical, compliance and regulatory personnel take part) to be an important part of a manufacturer's compliance programme. Generally once advertising materials are vetted through an internal process, they are then sent to FDA through the process described in question 1.4.

1.4 Are there any legal or code requirements for companies to have specific standard operating procedures (SOPs) governing advertising activities? If so, what aspects should those SOPs cover?

See question 1.3, above. Although in certain cases the government has specifically mandated promotional review processes as part of settlements involving Corporate Integrity Agreements, it is generally considered a best practice for companies to have SOPs in place governing compliance in advertising activities. Such SOPs generally encompass processes and standards in areas such as ensuring consistency with approved labelling, avoiding express or implied claims that could be considered false or misleading, substantiation of claims (generally subject to the substantial evidence standard), providing fair balance in the presentation of risk and benefit information, and submission of advertising materials to FDA.

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?

No, prescription drug advertisements generally do not need prior approval by the FDA prior to dissemination. *See* 21 U.S.C. §352(n). However, as a practical matter, a manufacturer generally submits for review proposed advertisements and promotional labelling intended for use in association with a newly-approved drug. And, in the case of accelerated approval products, all promotional materials (including advertisements) intended for dissemination within 120 days of approval must be submitted to the FDA during the preapproval period. *See* 21 C.F.R. §314.550. 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.

However, upon dissemination, all advertisements must be submitted to the FDA's Division of Drug Marketing, Advertising, and Communications (DDMAC) using Form FDA 2253. *See* 21 C.F.R. §314.81(b)(3)(i). DDMAC will also offer comments on advertisements submitted prior to publication. *See* 21 C.F.R. §202.1(j)(4).

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?

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

Where FDA has determined that an advertisement is false or misleading, it may act by sending the manufacturer either an "Untitled Letter" or a Warning Letter. Generally, Untitled Letters set forth FDA's objections to a particular advertisement and the reasons as to why the Agency believes it violates applicable laws or regulations. Such letters ask for a formal response from the manufacturer and results in a dialogue with FDA to resolve the matter to the Agency's satisfaction through requested corrective action.

Warning Letters are generally issued whether either a manufacturer has failed to comply with FDA's requested action in an untitled letter, or where a violation is considered particularly egregious. Like Untitled Letters, Warning Letters set forth the particular reasons why FDA believes an advertisement has violated the applicable laws or regulations. However, unlike Untitled Letters, Warning Letters serve as notice for the manufacturer that 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.

At the time that an Untitled Letter or a Warning Letter is issued, the prescription drug to which the violative advertisement refers is deemed adulterated or misbranded. Since distribution of an adulterated or misbranded drug is a criminal act, manufacturers are required to withdraw and/or correct the violative advertising to the satisfaction of FDA. Manufacturers may dispute the allegations in the Untitled or Warning Letter, or seek to negotiate the scope of required corrective action with FDA.

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? To what extent may competitors take direct action through the courts?

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 FDA and other government authorities to show that 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). *See also* Information, *United States v. Warner-Lambert*. Crim. No. 04-10150 (D. Mass. May 13, 2004) (charging Pfizer subsidiary Warner-Lambert with, among other things, a criminal violation of the FDCA for unlawful distribution of a new drug based upon evidence that Warner-Lambert promoted the drug Neurontin for unapproved uses). Potential penalties 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, FDA will typically issue an untitled or Warning Letter to a manufacturer prior to pursuing these sanctions.

FDA is responsible for the enforcement of the FDCA and FDA regulations, although 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., the regulation of prescription drugs advertising has become a public health priority and in addition to close oversight provided by FDA, manufacturers are under increasing scrutiny for advertising practices from various parties, including state attorneys general and private plaintiffs such as payors and consumer groups, under a broad variety of legal theories. Congress has also pursued a range of investigations relating to prescription drug advertising. 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 misdemeanor 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) that the advertisement was truthful, misleading, or otherwise violative of the requirements of the FDCA. Further, additional penalties attach 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). For example, in a 2007 case against the Purdue Frederick Company, the prosecutors charged the CEO, Chief Medical Officer, and Chief Legal Officer with strict liability misdemeanour violations of the FDCA for failing to prevent or correct their subordinate employees from violating the FDCA misbranding provisions. *See* Information, *United States v. Purdue Frederick Company*, Crim. No. 1:07CR0029 (W.D. Wv. May 10, 2007).

Note that while the FDCA does not provide for a private right of action by healthcare professionals, or consumers, other statutes, such as the Lanham Act, do. *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). Increasingly, competitors report potentially violative promotional materials, to regulatory authorities including, but not limited to, FDA, the US Department of Health and Human Services Office of Inspector General, state attorneys general, and other regulatory and enforcement entities. FDA has also recently launched an initiative to encourage healthcare professionals to report potentially violative promotional practices to FDA through its so-called "Bad Ad Program", which seeks to help healthcare providers recognise false or misleading advertising and report it to government authorities. *See* FDA, Press Release; 'Bad Ad Program' to Help Health Care Providers Detect, Report Misleading Drug Ads (May 11, 2010) (http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Surveillance/DrugMarketingAdvertisingandCommunications/ucm209384.htm).

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 Pharmaceutical Research and Manufacturers of America (PhRMA) and the American Medical Association (AMA), provide additional guidance for the healthcare community and pharmaceutical manufacturers. *See* question 4.2. While there is some overlap between complaints raised with the regulatory agencies and professional organisations, each agency and organisation has its own mechanism to report such issues. For example, the FDA welcomes complaints regarding DTC advertisements and materials through DDMAC. Also, the AMA works with the various state medical boards to report complaints regarding violations of the AMA's Code of Ethics. One instance where a professional organisation reports complaints to the FDA is the PhRMA Office of Accountability. The PhRMA Office of Accountability is responsible for receiving comments from the general public and health care professionals regarding DTC advertisements. The PhRMA Office of Accountability issues periodic reports to the public regarding the nature of the comments and provides a copy of each report to the FDA.

Under settlements with the Department of Justice and the states, and developing industry best practice, pharmaceutical companies have established internal compliance frameworks, which encourage the reporting of violations for further investigation and action. In addition, companies operating under Corporate Integrity Agreements with the HHS OIG must report such violations.

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 1.6, 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).

2 Providing Information Prior to Authorisation of Medicinal Product

2.1 To what extent is it possible to make information available to health 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's variants not authorised)?

Manufacturers generally may not promote, advertise or otherwise commercialise unapproved new drugs until they are approved by FDA. However, in certain narrow circumstances, manufacturers may provide scientific information about unapproved new drugs to healthcare professionals through *bona fide*, non-promotional scientific exchange. For example, 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).

The analysis of what falls within the definition of "*bona fide* scientific exchange" is highly fact specific. In analysing whether a particular communication is not subject to the general prohibitions against "pre-approval promotion", FDA will consider 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. 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, FDA will apply the same rules to product-specific information discussed at the meeting as it would apply to employees of the manufacturer. For further discussion on regulation of scientific information, please *see* question 3.4 below.

Similar standards apply to the provision of off-label information on approved products (i.e. information relating to indications and/or other product's variants not authorised), based upon both the

concept of legitimate, non-promotional scientific exchange, as well a recognized but controversial sphere of "commercial speech" relating to such uses under the First Amendment to the U.S. Constitution. Current law permits manufacturers to provide information on developments relating to off-label uses in limited contexts, including legitimate scientific exchange and other non-promotional communications, in tailored responses to physician's *bona fide* unsolicited requests for information, and in the distribution of reprints of certain peer-reviewed articles in a manner consistent with FDA's Good Reprint Practices Guidance.

Great care must be taken to ensure compliance in distributing such information. In recent years there has been unprecedented U.S. government enforcement against pharmaceutical manufacturers for unlawful dissemination of information about unapproved new drugs or unapproved uses of new drugs. Criminal prosecutors have taken the position that the public health risks of pre-approval promotion and "off-label promotion" of unapproved uses of approved drugs are a top enforcement priority. Civil prosecutors and private plaintiffs have also found success bringing cases against manufacturers under a variety of civil fraud theories. In particular, the U.S. legal and enforcement framework has evolved to enhance cooperation between government authorities and private plaintiffs. In many cases, whistleblowers or "relators" under the U.S. False Claims Act bring instances of alleged unlawful manufacturer inducement of claims for government payment for off-label uses to the government. Such cases often result in huge civil and criminal settlements. In 2009, Pfizer's subsidiary Pharmacia paid a criminal fine of USD 1.3 billion to resolve allegations that the company promoted the pain drug Bextra for unapproved uses. The company paid an additional USD 1 billion to resolve a related civil case that alleged that this unlawful promotion defrauded government insurance programs. The civil case was brought to the attention of U.S. authorities by former employees of the company.

2.2 May information on unauthorised medicines 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 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 medicinal products which are not yet authorised? If so, what limitations apply?

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 may not be distributed in a promotional setting, such as further distribution by company sales personnel.

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

Manufacturers may send information to health 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. *See* questions 2.1 and 2.2 above.

2.5 May information 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. *See* question 2.1 above. Such information may be shared in response to *bona fide* unsolicited requests by government or private insurers, assuming the information is truthful and not misleading.

2.6 Is it possible for companies to involve health professionals in market research exercises concerning possible launch materials for medicinal products 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, FDA and other government authorities will scrutinise such research activities where health professionals are receiving compensation or if the audience 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 promotion rather than legitimate market research.

3 Advertisements to Health Professionals

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

While the statutes and regulations governing "promotional labelling" make a distinction between the information that is required to appear in advertisements directed to healthcare professionals versus patients and consumers, the advertising generally do not. Rather, 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 general requirements for both consumer-directed and healthcare professional-directed advertising are the same under U.S. law, FDA will closely scrutinise whether the content is presented in terms that the intended audience can understand.

Advertising for prescription drugs is subject to stringent requirements for 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 twenty types of advertising communications that 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 thirteen 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, FDA issued a draft guidance document in 2009, 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). While the guidance is not binding on FDA, and does not replace the statutory and regulatory requirements, it is an important reflection of the Agency's current thinking on this topic. The draft guidance can be found at http://www.fda.gov/downloads/drugs/guidancecomplianceregulatoryinformation/guidances/ucm155480.pdf. For further discussion of what information must appear in pharmaceutical advertisements, *see* questions 6.1 and 6.2 below.

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

Such endorsements in company advertising must meet the same standards as any other claims made in advertisements, and the fact that the endorsement may represent the personal views and experience of the healthcare professional generally does not except the claims made in the endorsement from the limitations of the approved labelling, or requirements for ensuring fair balance and substantial evidence in support of express and implied claims. In addition, an endorsement should reflect the honest opinions, findings, beliefs, or experience of the endorser, and advertisers should generally disclose connections between themselves and their endorsers that might materially affect the weight or credibility of the endorsement.

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

Any advertising claim that represents or suggests that one drug is safer or more efficacious that another drug must be supported by substantial evidence or substantial clinical experience. *See* 21 C.F.R. §202.1(e)(6)(ii). Substantial evidence of safety and efficacy generally consists of 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). Although in certain cases support consisting of less than two adequate and well-controlled studies – or conceivably a range of evidence drawn from a history of clinical experience – will suffice to support such claims, this is a very drug- and claim-specific determination, and in most cases FDA sets the bar for making comparative claims quite high, and the Agency often objects to such claims as unsupported.

3.4 What rules govern comparator 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 which had not yet been authorised in the USA?

Prescription drug advertisements may not be false, unbalanced, or misleading. *See* 21 C.F.R. §202.1(e)(6). Under FDA regulations, a comparator advertisement is false, unbalanced or misleading if it: "Contains 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). The fact that a comparison product has not yet been approved would not relieve a manufacturer of the requirements of §202.1(e)(6). Such an advertisement may also suggest uses that are not approved for the approved product, or present a false or misleading comparison.

3.5 What rules govern the distribution of scientific papers and/or proceedings of congresses to doctors?

Scientific papers and other clinical information provided to doctors must meet the requirements of the FDCA. Scientific information that is provided as part of prescription drug product promotion must generally be consistent with the product's FDA-approved label, and not 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. 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.

FDA has suggested in a January 2009 guidance document that reprints of scientific journal articles which discussed unapproved uses of approved products may lawfully be distributed as part of product promotion 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: Good Reprint Practices for the Distribution of Medical Journal Articles and Medical or Scientific Reference Publications on Unapproved New Uses of Approved Drugs and Approved or Cleared Medical Devices (January 2009) available at http://www.fda.gov/RegulatoryInformation/Guidances/ucm125126.htm.

3.6 Are "teaser" advertisements permitted, which alert a reader to the fact that information on something new will follow (without specifying the nature of what will follow)?

FDA regulations do not prohibit "teaser" advertisements as long as they relate to a drug which has been approved for marketing by the FDA. For example, FDA regulations allow the use of "reminder"

advertisements (which only mention the name of the drug and not its use) and "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 FDA has permitted 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.

4 Gifts and Financial Incentives

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

Prescription drug sampling is a highly regulated practice in the U.S., particularly where the drug in question has serious potential for abuse, misuse, or serious side-effects. 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 manufacture 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.

4.2 Is it possible to give gifts or donations of money to medical practitioners? If so, what restrictions apply?

Under the Federal 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 *bona fide* personal services, such as consulting arrangements undertaken for fair market value compensation.

Moreover, under the U.S. Foreign Corrupt Practices Act, manufacturers who are issuers of shares on U.S. stock exchanges may not offer any type of remuneration directly or indirectly to any non-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 U.S. Foreign Corrupt Practices Act, "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 Foreign Corrupt Practices Act, "remuneration" is interpreted very broadly, and there is generally no *de minimus* 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 www.phrma.org/code_on_interactions_with_healthcare_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/03/050503 RCPGPharmac.pdf; and (iii) The AMA Guidelines on Gifts to Physicians from Industry, available online at http://www.amaassn.org/ama/pub/category/4263.html. 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. As of January 2009, PhRMA has prohibited its members from providing any item of any value 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.

4.3 Is it possible to give gifts or donations of money to institutions 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?

The Federal Anti-Kickback statute discussed above in question 4.2 applies to any remunerative relationship between the manufacturer and a person or entity in a position to generate Federal health care business for the manufacturer. Such persons or entities would also include institutions. *See* OIG Compliance Program Guidance for Pharmaceutical Manufacturers, 68 Fed. Reg. 23731 (May 5, 2003). The OIG takes the position that goods and services provided by a manufacturer to a health care 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 health care 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 unlawfully induce claims for the manufacturer's products. Donations may also implicate the U.S. Foreign Corrupt Practices Act where the donations are given with the intent to influence the decisions of non-U.S. government officials.

4.4 Is it possible to provide medical or educational goods and services to doctors 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 doctors with any item of value which 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 harbor 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 harbor 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).

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?

Under U.S. law, no gift or payment should be made contingent on the purchase of medicinal products.

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?

The FDCA and FDA regulations do not specifically prohibit this practice with regard to prescription and over-the-counter medications. 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). The definition of warranty in the warranty safe harbour incorporates the Federal Trade Commission's definition of warranty which includes "any undertaking in writing... to refund, repair, replace, or take other remedial action with respect to such product in the event that such product fails to meet the specifications set forth in the undertaking." 15 U.S.C. §2301(6)(B). The warranty safe harbour only protects warranties on "items", so, a warranty on a combination of items and services does not technically qualify for protection. Safe harbour protection is available as long as the buyer complies with the standards of 42 C.F.R. §1001.952(g)(1)-(2) and the manufacturer or supplier complies with the following standards of 42 C.F.R. §1001.952(g)(3)-(4):

- The manufacturer or supplier must comply with either of the following two standards -- (i) The manufacturer or supplier must fully and accurately report the price reduction of the item (including a free item), which was obtained as part of the warranty, on the invoice or statement submitted to the buyer, and inform the buyer of its obligations under paragraphs (g)(1) and (g)(2) of this section. (ii) Where the amount of the price reduction is not known at the time of sale, the manufacturer or supplier must fully and accurately report the existence of a warranty on the invoice or statement, inform the buyer of its obligations under paragraphs (g)(1) and (g)(2) of this section, and, when the price reduction becomes known, provide the buyer with documentation of the calculation of the price reduction resulting from the warranty.
- The manufacturer or supplier must not pay any remuneration to any individual (other than a beneficiary) or entity for any medical, surgical, or hospital expense incurred by a beneficiary other than for the cost of the item itself.

4.8 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, control over the content and faculty of the meeting or conference must generally remain with the organisers. 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/03/050503FRCPGPharmac.pdf. PhRMA Code on Interactions with Healthcare Professionals, available online at www.phrma.org/code_on_interactions_with_healthcare_professionals/. Support for medical education must also be structured to comply with the Anti-Kickback Statute, the PhRMA Code, the Foreign Corrupt Practices Act and other applicable guidelines, since such support may result in an item of value being provided to healthcare professionals.

5 Hospitality and Related Payments

5.1 What rules govern the offering of hospitality to health professionals? Does it make a difference if the hospitality offered to those health professionals will take place in another country?

The provision of "hospitality," such as meals and social functions, to health professionals is governed by the Federal Anti-Kickback statute in addition to several professional organisation codes. In cases where hospitality is provided to health professionals employed by ex-U.S. government institutions, the U.S. Foreign Corrupt Practices Act 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 guidelines, 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 Foreign Corrupt Practices Act if ex-U.S. government officials were invited to participate or attend the event.

5.2 Is it possible to pay for a doctor 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, Foreign Corrupt Practices Act, and the professional guidelines noted above. In general, a manufacturer's financial support may be appropriate if: (i) the subsidy is 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.

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 Act, where the payments are made at a fair market value for services rendered. *See* the answer to question 5.4, below.

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 doctors to attend?

In instances where such meetings do not meet FDA and OIG's indicia for independence (*see* the guidance documents discussed in Section 4.6), 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 doctors to provide expert services (e.g. participating in focus groups)? If so, what restrictions apply?

As noted, the Federal Anti-Kickback regulations create a safe harbour 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, commercially reasonable value, and there is a legitimate need for the services. 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. This is especially true where advertising and promotion issues converge with payment arrangements with healthcare professionals. For example AstraZeneca recently paid $520 million in April 2010 to resolve allegations that the company paid unlawful remuneration to healthcare professionals and consultants to promote the anti-psychotic drug Seroquel off-label. *See* Settlement Agreement Between United States and AstraZeneca, Inc., (E.D. Pa Apr. 27, 2010). In the AstraZeneca case, the government alleged that payments to healthcare professionals for clinical investigations, authorship of medical journal articles, promotional speaking, and other services, violated the Anti-Kickback Statute. *Id.*

5.5 Is it possible to pay doctors 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 trials. This includes a regulation requiring the disclosure of any financial arrangements between the clinical trial sponsor and the investigator that could cause, or be perceived as causing, bias. *See* 21 C.F.R. 54. Any such financial arrangement will be considered by the FDA when analysing the clinical trial. 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 with the requirements under the Anti-Kickback Statute and, where applicable, the Foreign Corrupt Practices Act.

The professional guidelines discussed in question 4.2 indicate that it is generally appropriate for doctors who perform *bona fide* services to receive reasonable compensation, including reasonable travel and lodging expenses. Token consulting arrangements are not appropriate to justify compensating a doctor for expenses. These guidelines do not delineate between scientific or market studies.

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

See question 5.5 above.

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, non-prescription drug advertisements are primarily regulated by the FTC, not the FDA. U.S. law prohibits the dissemination of non-prescription drug advertisements that are deceptive of 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 shall 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, 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. See, e.g. Draft Guidance, Brief Summary: Disclosing Risk Information in Consumer-Directed Print Advertisement (January 2004). *See* also, question 3.1. Reminder Advertisements and Help-Seeking Advertisements are not subject to these brief summary requirements however.

Broadcast Advertisements

While broadcast advertisements are subject to several technical requirements that differ from those of print advertisements, 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 include either a brief summary, as discussed above, or make "adequate provision... for the dissemination of the approved or permitted package labeling in connection with the broadcast presentation" (known as the "adequate provision" requirement). 21 C.F.R. §202.1(e)(1). In a Guidance Document, the FDA 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.

See FDA, Guidance for Industry: Consumer-Directed Broadcast Advertisements, (August 1999).

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.

6.4 Is it possible to issue press releases concerning prescription only medicines to non-scientific journals? If so, what conditions apply?

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 are 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. In some narrow circumstances, a manufacturer may distribute scientific findings to the lay media prior to approval. *See* questions 2.1 and 2.2 above.

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 promotion of unapproved new drugs or unapproved uses of approved drugs.

6.6 What, if any, rules apply to meetings with and funding of patient support groups, including any transparency requirement as regards the recording of donations and other support in corporate reports?

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. Such funding may implicate the Anti-Kickback Statute if such groups include prescribers as well, the Foreign Corrupt Practices Act, as well as state and federal tax laws. 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.

7 The Internet

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

FDA enforcement of internet advertising has increased dramatically over the past two years. While FDA is currently developing a policy to address promotion and advertising of prescription drugs on the Internet, numerous Warning and untitled letters have been issued to manufacturers whose Internet advertisements fail to conform with the FDCA and its implementing regulations. *See* http://www.fda.gov/cder/handbook/pol_guid.htm. In general, FDA has indicated that manufacturers must follow the same principles for communicating product risks and benefits on the internet (e.g., in YouTube videos), as they do in print and broadcast advertising, although there are various outstanding controversies regarding FDA's jurisdiction – and applicable rules – relating to company participation in areas such as social media.

7.2 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 health professionals?

No specific level of security is required. Some prescription drug websites require the healthcare professional to register while others have no security at all. Such a security requirement would factor in regulator's overall analysis regarding the nature and purpose of the website, and the applicable rules for website content.

7.3 What rules apply to the content of independent websites that may be accessed by 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?

The FDA has yet to promulgate prescription drug advertising regulations specific to the internet. However, all restrictions and limitations discussed above on the promotion of prescription drugs would apply to the Internet. FDA would likely take 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.

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

See question 7.3.

8 General - Medical Devices

8.1 What laws and codes of practice govern the advertising of medical devices in the USA?

Like prescription medications, the FDCA and FDA govern the advertising of restricted medical devices. *See* 21 U.S.C. §352(q),(r). A restricted device is one in which the sale, distribution, and use of the device must be authorised by a licensed practitioner. Advertisements regarding all other devices are regulated by the FTC.

8.2 Are there any restrictions on payments or hospitality offered to doctors in connection with the promotion of a medical device?

The restrictions on hospitality offered to physicians in connection with the promotion of a medical device are similar to the restrictions placed on the promotion of pharmaceutical products. *See* question 4.6 above. There are a few notable differences, however.

The Advanced Medical Technology Association (AdvaMed) has issued its own Code of Ethics on the Interactions with Health Care Professionals specific to medical devices, available at www.advamed.org/MemberPortal/About/code/codeofethics.htm. AdvaMed developed a code independent of the PhRMA Code so that to address issues specific to the medical device industry. The FDA may require medical device manufacturers to train and educate physicians on the safe and effective use of particular devices. This type of interaction is much more prevalent in the medical device context. As a result, medical device manufacturers may generally fund product training and education programs and may provide physicians with hospitality in the form of modest meals and receptions subordinate in time to the training purpose. Manufactures may also pay for reasonable travel expenses and lodging associated with these training programs. As discussed in earlier sections, all items of value, including training, hospitality, and lodging, provided as part of medical device training or promotion must conform to the requirements of the Anti-Kickback Statute, professional codes, and, where applicable, the U.S. Foreign Corrupt Practices Act.

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?

The major developments this year have been a significant focus on Internet advertising and company involvement in Internet communications, and a more general FDA focus on enforcement in the promotional area, including threats of enforcement including executive liability under the Park Doctrine, as well as continuing large civil/criminal settlements under the False Claims Act and related laws.

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

As the Obama Administration and Congress continue to focus on combating fraud against government programs, ensuring safety of medicinal products, and preventing corruption, it is expected that government enforcement in the area of pharmaceutical and device advertising will only continue to increase. Programmes such as the "Bad Ad Program" (*see* question 1.6, above) indicate a willingness on the part of FDA and other government agencies to partner with healthcare professionals and consumers to aid in these enforcement efforts. Further, an increasing number of major cases against manufacturers are focusing on allegations of improper product promotion. These cases are often initiated by private parties (current or former employees, or healthcare professionals) who bring evidence of improper promotional practices to the government. Finally, Warning Letters for advertising and promotion of prescription drugs and medical devices have been on the rise, as FDA, together with other agencies, emphasises the need for industry to comply with FDA standards for risk communication, "consumer friendly messaging", and adequate application of FDCA concepts of "fair balance" to new media such as internet sites, sponsored-links, and social media outlets. Manufacturers based in the U.S., or wishing to market prescription drugs in the U.S., must be careful to stay abreast of these developments, as administrative, criminal, and civil sanctions continue to rise for advertising-related violations.

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

See question 9.1.

9.4 Has your national code been amended in order to implement the current version of the EFPIA Code of October 2007?

Not applicable.

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