Българска Асоциация за Лекарствена Информация (БАЛИ)
Bulgarian Association for Drug Information (BADI)

Statement of Bulgarian Association for Drug Information (BADI) regarding proposal for a

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[REGULATION OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL laying down Union procedures for the authorisation and supervision of medicinal products for human use and establishing rules governing the European Medicines Agency, amending Regulation (EC) No 1394/2007 and Regulation (EU) No 536/2014 and repealing Regulation (EC) No 726/2004, Regulation (EC) No 141/2000 and Regulation (EC) No 1901/2006Document subtitle]

Abstract

[High level expert team with a long expertise in the pharmaceutical life cycle management of the Bulgarian Association of Drug Information (www.badibg.org) has prepared that statement]

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Българска Асоциация за Лекарствена Информация (БАЛИ)
Bulgarian Association for Drug Information (BADI)

Date: June 26, 2023

Statement of Bulgarian Association for Drug Information (BADI) regarding proposal for a

REGULATION OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL

laying down Union procedures for the authorisation and supervision of medicinal products for human use and establishing rules governing the European Medicines Agency, amending Regulation (EC) No 1394/2007 and Regulation (EU) No 536/2014 and repealing Regulation (EC) No 726/2004, Regulation (EC) No 141/2000 and Regulation (EC) No 1901/2006.

GENERAL COMMENTS TO THE AMENDING DOCUMENTS

- General aspects: In principle, the Bulgarian Association for Drug Information welcomes the revision of the general EU pharmaceutical legislation and, in this context, the "Pharma Package" published by the European Commission on April 26, 2023.
- A review of the regulatory framework after more than twenty years makes sense and is necessary in order to adapt the above listed regulations to the current state of science and technology, to check certain procedures for their "readiness" and thus to reduce bureaucracy, so that drugs ultimately get to patients faster and patients of the EU and can be brought.
- In addition, we very much welcome the fact that the European Commission has tested the system of some directives and regulations.
- We also welcome the fact that tried and tested procedures and exceptions have been incorporated into the new regulations during the pandemic.
- Regulatory procedures, such as the introduction of the Rolling review, used for temporary emergency approvals should be part of the authoisation procedures, as Rolling review was the procedure used for the fast track COVID 19 approval and obvious was very efficient.
- No many parallel structures at the competent authorities s must be created that would increase the risk of excessive bureaucracy.
- **Minimization of the existing incentive system**
  The elements of the current regulatory framework that have been most critical to the sustainability and competitiveness of the industry and have helped foster innovation are the regulatory document. protection (RDP) provisions. The development of a market-ready product is lengthy and very expensive. Only a 15-20% active ingredients or investigational medicinal products are ultimately approved as medicinal products in general. It is therefore successful products (blockbusters) also largely bears the investment costs of other products that have not brought the desired success, like marketing authorisation.

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Against this background, the BADI regulatory ***experts sees it as critical if a revision of the legal framework results in the minimization of the existing incentive system*** of the innovative pharmaceuticals in the EU.

Many aspects need to be specified in more concrete terms by delegated legal acts to be issued by the Commission, and reference is made to guidelines to be drawn up.

The new legislative proposals contain a number of aspects which, in our view, have a critical impact on access to and the availability of medicines as well as the competitiveness and innovative ability of the European pharmaceutical industry, especially SME companies.

The Commission has argued that document protection can be extended by fulfilling various requirements, which in total theoretically offer the possibility of achieving a total of ten years of document protection (+ 2 years of marketing protection) (cf. Art. 81).
The requirements to be met - the market launch of an innovative product within a period of two years (three years for SMEs) (Art. 81) – depends on the competent authority.
The processing times of the responsible authorities can sometimes be several years, which means that companies cannot launch their products in a timely manner.

Digitalisation of the submission
The digitization of the submission of applications for regulatory procedures is already a matter of course for the pharmaceutical industry (eAF, eCTD).
The EMA and the national authorities have initiated further digitization projects that enable more efficiency in process management for applicants and regulatory authorities (web-based eAF for variations and ePI in the Product Lifecycle Management (PLM) portal, eCTD 4.0).

The structured presentation of the regulatory information by the IDMP/SPOR project also contributes to efficient drug life cycle management.

Regulatory Sandbox
When it comes to the design, that for the large number of SMEs and mid caps, the investment for the design of a playing field such as the regulatory sandboxes is usually not insignificant and a time-limited usability must often be positive for the development perspective when weighing the risk .

Dealing with Real World Evidence (RWE) and Real World Data (RWD) in the area of regulatory sandboxes should be presented in more detailed design of the Implementing Acts. This includes the concrete details of RWE/RWD for regulatory purposes.

Priority of antimicrobials
The proposed incentives for development of priority antimicrobials can stimulate the innovative pharmaceutical industry in addressing this unmet need. ***The data exclusivity vouchers can provide opportunity for companie***s to ensure stable market position and therefore could reduce the risk of delay in R&D process.

Understanding of unmet medical needs (UMN) and "high unmet medical need" (HUMN)

A thorough understanding of unmet medical needs (UMN) has led to the research, development and creation of new therapies that patients might not have reached.
Is of the opinion that the restrictive definition now proposed would have negative effects on the pharmaceutical industry on the long-term orientation of research and on patient access to new therapies.

The introduction of a concept such as that ***of "high unmet medical need" (HUMN)*** to define some orphan medicinal products (Art. 70 page 86)
Linking the HUMN approach to the Orphan Medicines Incentive Framework fails to recognize the fundamental challenges and shortcomings that contribute to the fact that that most of the rare diseases have no approved treatment.

These definitions exclude patient groups who still have UMN, because of limited access, despite the availability of a therapeutic option.

Compulsory licensing
Research and development (R&D) spending is not a measure of the value of a therapy. The suspension of document protection or market exclusivity when granting a compulsory license could have unintended consequences.

For some therapies with more than one indication, the question would be how to protect the indication that is still covered by intellectual property instruments while the other indication is subject to compulsory licensing.

Exploring alternatives to compulsory licensing to deal with public health emergencies without undermining the system of intellectual property rights and the attractiveness of the EU for business might lead to serious discrepancies.

The provision for SME

- The EU member states have different financial resources, they are giving different % of the budget for healthcare and they have different pricing and reimbursement systems. How will the innovative pharma companies, especially the smaller drug developers and ***producers enter into all markets*** and manage the complicated regulatory and reimbursement system of the EU member countries? It will put them in unfavorable position. Small and medium-sized firms and not-for-profit entities will benefit from a dedicated support scheme composed of regulatory, procedural and administrative support, which will also include a reduction, deferral or waiver of fees. In addition, the regulation facilitates the translation of robust research results, carried out by not for-profit entities, onto the label, allowing new promising therapeutic indications of off-patent medicinal products for unmet medical needs

  The **SME criteria** are set out in Commission Recommendation 2003/361/EC and are based on:

  - **the enterprise's size**:
    - fewer than 250 employees;
    - an annual turnover of not more than €50 million, or an annual balance-sheet total of not more than €43 million.

- **the ownership structure**, including any partnership or linkage. Types of enterprises (autonomous, partner, linked) correspond to relationships that enterprises could have with one another, and which may impact on the overall headcount and financial criteria of an enterprise.

Further information on how to determine whether an enterprise can qualify as an SME can be found in the European Commission user guide to the SME definition. Page 17 of the document

Conclusion
The Commission is to be authorized to define the format, content and amendment rules as well as the regulations that an applicant MAH should observe when using the certificates in the form of a delegated legal act.

The concrete impact of that legislation is difficult to be assessed at this point in time.

For reasons of planning and legal certainty, the colegislators should clear aspects in the current legislative process. In addition, coherence with other EU initiatives affecting the pharmaceutical industry and the competent authorities must be ensured, as the capacity of shortening the marketing authorization procedures.

CHAPTER I

SUBJECT MATTER, SCOPE AND DEFINITIONS:

Regarding list with Article 2 definitions (page 47) we have following comments

For the purposes of this Regulation, the definitions laid down in Article 4 of [revised Directive 2001/83/EC29] shall apply.

Comments: The following definitions are not enough clear which leads the risks of various interpretations. This in turn can cause misunderstanding and disputes.

'**similar medicinal product'** means a medicinal product containing a similar active substance or substances as contained *in a currently authorized orphan medicinal* product, and which is intended for the same therapeutic indication;

Comments: why that definition is address only to orphans ? Similar products is a terminology which is also use for parallel import reason

'similar active substance' means an identical active substance, or an active substance with the same principal molecular structural features (but not necessarily all of the same molecular structural features) and which acts via the same mechanism.

In the case of advanced therapy medicinal products, for which the principal molecular 29 [Name of revised Directive 2001/83/EC, date (OJ L XX, XX.XX.XXX, p. X).] EN 48 EN structural features cannot be fully defined, the similarity between two active substances shall be assessed on the basis of the biological and functional characteristics*;*

Comments: the thext "same principal molecular structural features (but not necessarily all of the same molecular structural features)" is contradictive

'significant benefit' means a clinically relevant advantage or a major contribution to patient care of *an orphan medicinal product* if such an advantage or contribution benefits a substantial part of the target population;

Comments: why that definition is address only to orphans ? Significant benefit could be addressed to any innovative product not just the orphans.

(8) 'clinically superior' means that a medicinal product is shown to provide a significant therapeutic or diagnostic advantage above that provided by an orphan medicinal product in one or more of the following ways;

Comments: Why that definition is address only to orphans ?" Clinically superior" is often use for HTA purposes for an innovative product.

(a) greater efficacy than an authorised medicinal orphan medicinal product in a substantial part of the target population;
(b) **Comments: Why** that definition is address only to orphans?

(b) greater safety than an authorised medicinal product in a substantial part of the target population;

Comments : How the terms "greater safety" and "substantial part" could be specified and determined?

(c) in exceptional cases, where neither greater safety nor greater efficacy has been shown, demonstration that the medicinal product otherwise makes a major contribution to diagnosis or to patient care.

Comments: How the term "a major contribution to diagnosis or to patient care." Could be specified because the interpretation will be subjective

Article 3

Centrally authorised medicinal products

Unclear definitions

2. Any medicinal product not listed in Annex I, may be granted a centralised marketing authorisation in accordance with this Regulation, if the product meets at least one of the following requirements:

(a) the applicant shows that the medicinal product constitutes a significant therapeutic, scientific or technical innovation or that the granting of marketing authorisation in accordance with this Regulation is in the interest of patients' health at Union level, including as regards antimicrobial resistance and medicinal products for public health emergencies;

Comments: constitutes a significant therapeutic, scientific or technical innovation – the term "significant" that need more clarification in order to avoid many misinterpretations.

Regarding Art 4

"Point (b), first subparagraph, shall not apply to those parts of summary of product characteristics and package leaflet referring to indications, posologies, pharmaceutical forms, methods or routes of administration or any other way in which the medicinal product **may be used which were still covered by a patent or a supplementary protection certificate for medicinal products** at the time when the generic medicinal product was marketed and where the applicant for the generic medicinal product has requested not to include this information in their marketing authorisation."

Comments: we could suggest an official EU Data Base to be created for the Product under Patent and supplementary protection certificates like in the USA – Orange Book FDA. Orange Book Data Files | FDA

Such data base does not exist and that is a serious challenge for the generic and biosimilar industry and for the PIPs as well and many obstacles could be overcome.

CHAPTER II

GENERAL PROVISIONS AND RULESs ON APPLICATIONS:

Centralised procedure

On the part of the applicant, this requires good and intensive preparation of the application for approval, since the evaluation of the application can also be ended 90 days after validation if the application is not of sufficient quality/maturity from the point of view of the authority.
The strengthening of the scientific support of the EMA and the national authorities is therefore of great importance for the applicants and will improve the quality of the applications.
It should be made clear in which specific cases the quality of the applications is not sufficient to avoid disputes during the procedure. Facilitate decisions and accelerate patient access to innovative therapies and also increase the attractiveness of obtaining approval in Europe.

The interference in the general freedom of the pharmaceutical company. This is because it does not take into account whether the company has the necessary infrastructure in the Member State concerned (local branches, logistic) that can carry out the activities for the introduction and marketing of a medicinal product.
This procedure should not be carried out without consultation with the pharmaceutical companies and that the legal text be adapted accordingly. However, it must be ensured that the EMA and the

national authorities have sufficient capacity and efficient procedures for this task in order to avoid delays before the application is submitted.
The scope of the central procedure (Art. 3 in connection with Annex I) has been revised. Regarding Annex I leaves it unclear whether medicinal products with indications such as autoimmune diseases, immune deficiency, viral diseases, which have only been included in Annex I of Regulation (EU) No. 726/2004 since May 20, 2008, shall continue to be centrally approved. We see hybridomas and monoclonal antibodies are also not listed in Annex I. Additional explanation is necessary.

For medicinal products that do not fall within the scope of the centralized procedure and that are to be placed on the market in several Member States, the Mutual Recognition Procedure (MRP) or the Decentralized Procedure (DCP) must be used to obtain these authorisations.

In both procedures, the applicant determines the Member States in which authorization is to be sought. Article 36 number now gives the competent authorities of the Member States the competence to apply for legitimate reasons of public health to enter the MRP or DCP procedure.

The authority shall inform the applicant and the authority of the reference Member State responsible for the mutual recognition procedure of its application within 30 days of submission. We think that is involvement of the freedom of the MAH.

CHAPTER III

INCENTIVES FOR THE DEVELOPMENT OF 'PRIORITY ANTIMICROBIALS':

The emergence of drug-resistant microorganisms with new resistance mechanisms is a growing global health threat. The number of new innovative antibacterial agents is considered insufficient by the WHO to address the emergence and spread of antimicrobial resistance infections.
Therefore, the proposed incentives for development of priority antimicrobials can stimulate the innovative pharmaceutical industry in addressing this unmet need.

The data exclusivity vouchers can provide opportunity for companies to ensure stabile market position and therefore could reduce the risk of delay in R&D process. Ensuring registration and supply in the EU is a prerequisite for receiving a data exclusivity voucher, thus access to potential new antimicrobials to be granted for European patients.

Another positive approach in the proposed incentive is decreasing the link between financial return for developers of antibiotics from the volume of antibiotics consumed.

CHAPTER IV

POST-MARKETING AUTHORISATION MEASURES:

The updates are in line with overall strategy to maintain data transparency while reducing administrative burden. Imposed obligation to Marketing Authorization Holder to prepare and submit Risk Management Plans should be clearly justified by need for additional risk minimisation measures other justified on pharmacovigilance grounds.

Risk based approach in the procedures for examination of applications for variations will assess risk to public health and impact on quality, safety, and efficacy of the product.

Innovation is further stimulated by possibility of entity not engaged in an economic activity ('not-for-profit entity') to submit to the Agency substantive evidence for a new therapeutic indication that is expected to fulfil an unmet medical need.
The strategic aim to enhance security of supply and ensure medicines are s available to EU patients is further supported by clearly described roles and responsibilities of Supervisory Authorities.

The transparency and equity of high PV standards are ensured by clear description of inspection provision and Joint Audit program.

CHAPTER V

PRE-AUTHORISATION REGULATORY SUPPORT:

General comment:

The explanatory memorandum regarding the proposal for the regulation reads that a new directive, repealing and replacing Directive 2001/83/EC will be included in the proposed revision of the pharmaceutical legislation but the proposal of this revised directive has not been provided to us for discussion. In my opinion both documents (revised Directive 2001/83/EC and Proposal for a Regulation as mentioned above) should be revised and discussed in parallel.

Comment to art. 46 Update of risk management plans:

Point 1 of this article reads that "The marketing authorization holder of a medicinal product referred to in Art. 9 and 11 of [revised Directive 2001/83/EC] shall submit to the Agency a risk management plan and a summary thereof, where the marketing authorization for the reference medicinal product is withdrawn but the marketing authorization for the reference medicinal product is withdrawn but the marketing authorization for the medicinal product referred to in Articles 9 and 11 of [revised Directive 2001/83/EC] is maintained.
The risk management plan and the summary thereof shall be submitted to the Agency within 60 days of the withdrawal of the marketing authorization for the reference product by means of a variation in accordance with Art. 47.

Comments:

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In this point of time, it is not clear which products fall within this scope, what is the understanding for a reference product – is it the one referred to in the dossier or the European reference product? In addition, it is not clear how the MA holder of the medicinal product referred to in Art. 9 and 11 of [revised Directive 2001/83/EC] shall be informed about this in order to organize the drawing up of the RMP and submission of the variation within 60 days. A data base should be envisaged for the RMPs.

CHAPTER VI

ORPHAN MEDICINAL PRODUCTS:

The proposal contains some positive measures that would help streamlining and future-proofing the EU's regulatory system (EMA): examples include the changes to the EMA's committee structure, introduction of phased/rolling review of data and regulatory sandboxes to test innovative ideas and processes, and the possibility of the electronic patient information leaflet.
However, several other provisions, if agreed in their current form, would weaken the incentives system which enables pharmaceutical innovation, including in orphan diseases. These provisions will undermine the competitiveness of an industry that contributes more to the EU's trade balance than any other sector.

Orphan market exclusivity

The introduction of orphan designation validity limited to seven years (Article 66 (1)), compared to unlimited validity at present, should be carefully considered whether will achieve the Commission's aims to incite faster authorization of designated products having in mind amended definition of "significant benefit" (Article 2 (7)).

The requirement to prove a significant benefit for "a substantial part of the target population" seems will be harder to demonstrate a significant benefit than under the current regime, which does not include this added requirement as there is no clarity on what is considered" a substantial part" and how broadly or narrowly the "target population" will be regarded.

From this point of view, most probably, the companies will apply for orphan designation closer to the marketing authorization phase and this will not have a positive effect in terms of horizon scanning and the resulting resilience of health systems.

Although there are theoretical opportunities for extension of the period of market exclusivity up to 13 years cumulatively, reduction of the standard period of orphan market exclusivity to nine years, and the possibility to assess similar medicines during the last two years of orphan market exclusivity are significant limitations compared to the current regime (Article 71 (6)). This may have a negative effect on the sustainability of orphan drug development and, accordingly, impair patient access to necessary drug therapy in a timely manner.

Articles 71 and 72 of the Regulation propose a move from the current orphan market exclusivity (OME) approach, which provides a separate period of OME (10 years) is granted for each different orphan designated condition, towards a "Global Orphan Marketing Authorisation" (GOMA) system, whereby a company would only be granted one single OME period by active substance, with various possible extensions of that duration, applicable to the full product scope.

The proposal would reduce the baseline OME period from 10 years to 9 years. OMPs (by default addressing an unmet medical need) which fulfill the definition of High Unmet Medical Need will get 10 years OME; while well-established OMPs will get 5 years OME. Various extensions are possible.

High Unmet Medical Need

Orphan medicinal products would be considered as addressing unmet medical need as per Article 83(2) of the draft Directive. In addition, the European Commission proposes criteria for high unmet medical need (HUMN) in Art. 70 in the Regulation – if satisfied, the product would be eligible for longer orphan market exclusivity (10 years). These shall be met if there is either no treatment available or, if so, the treatment under development will bring in addition to the significant benefit exceptional therapeutic advancement and result in a meaningful reduction in mortality or morbidity.

Current debates over UMN or high UMN (HUMN) are part of a broader set of challenges related to the availability, accessibility, and affordability of innovative medicines and the long-term sustainability of health systems. It misses the patient perspective, and the acknowledgement of how new treatments are being discovered and developed with the potential to transform the lives of patients, the way companies like Pfizer think, manage and resource healthcare. In addition, unmet medical needs can evolve over time, it is not a static concept. Therefore, limiting incentives to treatments that fit a very narrow definition of UMN or HUMN today, risks excluding the development of important therapies for patients tomorrow. It will reduce the overall predictability for companies and disincentivize them from investing in R&D in the EU that may have addressed patients' unmet medical needs.

CHAPTER VII

PAEDIATRIC MEDICINAL PRODUCTS:

For medicinal products for children, in option A the 6-month supplementary protection certificate (SPC) extension is kept as a reward for all medicinal products completing a paediatric investigation plan ('PIP').
an extra reward benefiting products addressing unmet medical needs of children is added, yrcър consist of either 12 extra months of SPC extension or a regulatory protection voucher (duration 1 year), which could be transferred to another product (possibly of another company) against payment, allowing the receiving product to benefit from extended regulatory data protection (+1 year).

In option B, the reward for completing a PIP is abolished. Developers of every new medicinal product would continue to be obliged to agree with the EMA and conduct a PIP, but the extra costs incurred would not be rewarded.

In option C, like today, the 6-month SPC extension remains the main reward for completing a PIP. All options are complemented by a set of common elements aimed at simplifying and streamlining regulatory procedures and futureproofing the legislation
We think that there SPC extension should be also included in EU Patent and SPC Certificate for transparency of all stakeholders.

CHAPTER VIII

PHARMACOVIGILANCE:

Very positive approach, no challenges could be seen

The obligations of Marketing Authorization Holder are in line with revised Directive 2001/83/EC.
The data provision in Eudravigilance are clearly described ensuring precise information maintained in the database.
The Eudravigilance database shall be fully accessible to the competent authorities ensuring transparency of the information and further justifiable decision making process for CA.

European medicines web-portal and register of studies for environmental risk assessment maintenance is ensuring data transparency and objective evaluation, and will be consulted with relevant stakeholders, including patient and consumer groups, healthcare professionals and industry representatives.

The environmentally friendly development and production of medicinal product is a key priority, as well as environmental risk from use or disposal of medicinal products.

The Marketing Authorization Holder shall update any Information from Environmental Risk Assessment (ERA) without any delay.

The assessment of the periodic safety update reports shall be conducted by a rapporteur appointed by the Pharmacovigilance Risk Assessment Committee, ensuring availability of robust and up to date information with reduced administrative burden.
Collaboration with external organizations, like WHO, will enhance exchange of safety information and will help to timely provisions of any safety related actions. The international collaboration between member states will further enhance the harmonization of PV standards and public health protection.

CHAPTER IX

REGULATORY SANDBOX:

The concept of introducing the regulatory sandbox provisions will provide the Agency and the Member States with the opportunity to act in an agile and proactive way especially in times of health crisis or promising new therapies for unmet medical needs to support the development of new treatments while keeping the oversight and controlling mechanisms of the competent authorities without derogations.

This regulatory possibility could be defined as the topic covering one for the new legislative proposal – to provide at EU level a reduction of the regulatory burden and to provide a flexible regulatory framework which is attractive for innovations to be developed for the EU community.

However, this incentive would require specialized expert resources, expectedly knowledgeable about pharmaceutical development of advanced therapies. The sandbox design will be quite challenging for smaller competent authorities that struggle even with the daily procedure workload. If the Agency can provide additional support at expert resource level, the regulatory sandbox opportunities can be beneficial in times when dedicated attention is required for specific pharmaceutical development.

Setting up regulatory sandboxes offers a good option for the development and approval of innovative products.
It is essential that this principle be clearly defined in further regulations.

Comments:
The time limitation of the marketing authorization granted under the sandbox requirement may be a reason for the industry not to invest large amounts of financial means into a product that might not receive a long-term authorization. What would be the possibility of obtaining a permanent marketing authorization, possibly through post-authorization commitments or clinical pathways?

CHAPTER X

AVAILABILITY AND SECURITY OF SUPPLY OF MEDICINAL PRODUCTS:

While in the current legislation there is no preset timeline for the obligation of the marketing authorization holder of medicinal products that have obtained authorization through centralized or national procedures to notify the Member States concerned forthwith of any action taken by them to suspend the marketing of a medicinal product or to withdraw a medicinal product from the market, together with the reasons for such action if the latter concerns the efficacy of the medicinal product or the protection of public health and related to this, Member States shall ensure that this information is brought to the attention of the Agency and related Member states' competent authorities, the new Regulation sets definite timelines for the notification process.

This obligation of the MAHs to notify the competent authorities about their intentions to permanently or for preset timeline, can positively contribute to the planned cease of supply, however in times of health crisis, as we have observed in the Covid-19 pandemic situation, it is hard to predict in advance the abnormal market demand of a specific therapeutic group or the interruption starting material supply. On the other hand, the obligation for MAHs and distributors to provide the health authorities with actual information for the stock availability at different locations can help better distribution of the amounts without the need of stockpiling.

Manufacturers often experience a temporary disruption in supply of a medicinal product in each Member State due to insufficient planning of supply, facility capacity overload or delayed ingredients supply even in regular periods without specific health crisis.

While the legislation sets the obligation for MAHs to notify the Competent authorities for such disruptions for short periods exceeding two weeks generates big administrative burden both for the MAHs to report and generate prevention plans and for the competent authorities, especially the more short staffed ones that will be overloaded with incoming information from numerous MAHs. This data evaluation required for the possible reporting to the Agency of anticipated critical shortage will largely engage a lot of experts. (Art 121(1) point c)

As the anticipated workload to gather, evaluate, publish publicly the shortage lists, as well as the intense interaction with the Agency and MMSG will require dedicated units within the health authorities to meet the requirements of the proposed regulation.
Financial investments will also be required for the purposes of implementing the Regulation, specifically, the Agency to expand the scope of the ESMP. The Agency is expected to ensure that, where relevant, data is interoperable between the ESMP, Member States' IT systems and other relevant IT systems and databases, without duplication of reporting.

Is some EU funding planned for implementation of the human resources and IT infrastructure investments for the connectivity level necessary for common EU actions?

Art 132 and Art 134– Role of MSSG and Role of the Agency – The measures proposed to MAHs may include recommendations on diversification of suppliers and inventory management. As well as The Commission, taking into consideration the information or the opinion, referred to in paragraph 1, or MSSG recommendations, may decide to adopt an implementing act to improve security of supply. The

implementing act may impose contingency stock requirements of active pharmaceutical ingredient or finished dosage forms, or other relevant measures required to improve security of supply, on marketing authorisation holders, wholesale distributors or other relevant entities.

Do these recommendations have any commitment/officially binding nature as they are related to the MAHs/Manufacturers' commercial strategies, production feasibility and company overall profitability?

CHAPTER XI

EUROPEAN MEDICINES AGENCY:

Furthermore, we support the restructuring of the EMA and the reduction to two standing committees (CHMP and PRAC) as a measure that can not only speed up decision-making within the agency, but at the same time ensure the quality, safety and efficacy of new medicines.

For products of high public health interest, the evaluation period can be reduced to 150 days (Art. 6). Even in the case of national approval procedures (MRP/DCP), the member states should ensure that the approval procedure is finalized within 180 days (Art. 30 RL-V).

The restructuring of the EMA must not be at the expense of efficiency and must continue to enable agile cooperation between experts. This must not delay the regulatory procedures and scientific advices and regulatory support to applicants.
It is also crucial that the transparency of the EMA remains at the highest level, both at standing committee (CHMP and PRAC) and working group level, to guarantee adequate reporting and information on the agency's processes and decisions.

The lack of essential provisions of the PRIME (PRIority MEdicines) program and the fact that the concept of “high unmet medical needs” (HUMN) only applies to orphan medicinal products (OMPs). That should be considered again.

If other relevant committees (e.g. HMPC, CAT, PDCO and COMP) have no longer have their own secretariat and budget and the authority to issue guidelines and everything is handed over to the CHMP and that might be a critical step.

Furthermore, EMA should offer the service of regulatory and scientific support not only to SMEs, but also to mid-caps, in order to facilitate the process and support the applicant for new developments.

The previous specialist committees. (HMPC, CAT, PDCO and COMP) may lose importance in the new EMA -structure and that this will affect the future of product development. The accumulated expertise should be used in the future for further drug development processes.

The approach "phased review" could involve unsustainable querying of complete datasets, which could also impact "standard" approval processes. pediatric medicines, herbal medicines, ATMP, orphans) could be counterproductive.

It is therefore imperative to ensure that the technical expertise of the current committees (such as HMPC, COMP, CAT and PDCO) is retained and fed into the working groups or scientific committees that EMA will set up.

CHAPTER XII

GENERAL PROVISIONS:

Maily financial penalties are envisaged here where in the form of fines or periodic penalty payments on the marketing authorisations holder granted under this Regulation if they fail to comply with any of the obligations laid down in Annex II in connection with the marketing authorisations.

CHAPTER XIII

DELEGATED AND IMPLEMENTING ACTS:

That chapter refers to many procedures and articles which should be elaborated in parallel with that document

CHAPTER XIV

AMENDMENTS TO OTHER LEGAL ACTS:

Amendments to Regulation (EC) No 1394/2007 Regulation (EC) No 1394/2007 which is on Amendments to Regulation (EC) No 1394/2007 Regulation (EC) No 1394/2007 is amended as follows: is amended here
Amendments to Regulation (EC) No 536/2014 Regulation (EC), obvious after its implementation in the period 2022 - 01.02.2023 many additional issues are find out which could be improved.

CHAPTER XV

FINAL PROVISIONS:

The implementation period is mentioned here:
This Regulation shall enter into force on the twentieth day following that of its publication in the Official Journal of the European Union. It shall apply from [Note to the OP:

Please insert the date of 18 months after its entry into force. The date should be identical to the date for the application of the Directive]. However,
Article 67 shall apply from [Note to the OP: Please insert the date of 2 years after the date of adoption/entry into force/application of this Regulation]

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