

§ 320.32 Procedures for establishing or amending a bioequivalence requirement.

(a) The Food and Drug Administration, on its own initiative or in response to a petition by an interested person, may propose and promulgate a regulation to establish a bioequivalence requirement for a product not subject to section 505(j) of the act if it finds there is well-documented evidence that specific pharmaceutical equivalents or pharmaceutical alternatives intended to be used interchangeably for the same therapeutic effect:

- (1) Are not bioequivalent drug products; or
- (2) May not be bioequivalent drug products based on the criteria set forth in § 320.33; or
- (3) May not be bioequivalent drug products because they are members of a class of drug products that have close structural similarity and similar physicochemical or pharmacokinetic properties to other drug products in the same class that FDA finds are not bioequivalent drug products.

(b) FDA shall include in a proposed rule to establish a bioequivalence requirement the evidence and criteria set forth in § 320.33 that are to be considered in determining whether to issue the proposal. If the rulemaking is proposed in response to a petition, FDA shall include in the proposal a summary and analysis of the relevant information that was submitted in the petition as well as other available information to support the establishment of a bioequivalence requirement.

(c) FDA, on its own initiative or in response to a petition by an interested person, may propose and promulgate an amendment to a bioequivalence requirement established under this subpart.

[57 FR 18000, Apr. 23, 1992]

§ 320.33 Criteria and evidence to assess actual or potential bioequivalence problems.

The Commissioner of Food and Drugs shall consider the following factors, when supported by well-documented evidence, to identify specific pharmaceutical equivalents and pharmaceutical alternatives that are not or

may not be bioequivalent drug products.

(a) Evidence from well-controlled clinical trials or controlled observations in patients that such drug products do not give comparable therapeutic effects.

(b) Evidence from well-controlled bioequivalence studies that such products are not bioequivalent drug products.

(c) Evidence that the drug products exhibit a narrow therapeutic ratio, e.g., there is less than a 2-fold difference in median lethal dose (LD₅₀) and median effective dose (ED₅₀) values, or have less than a 2-fold difference in the minimum toxic concentrations and minimum effective concentrations in the blood, and safe and effective use of the drug products requires careful dosage titration and patient monitoring.

(d) Competent medical determination that a lack of bioequivalence would have a serious adverse effect in the treatment or prevention of a serious disease or condition.

(e) Physicochemical evidence that:

(1) The active drug ingredient has a low solubility in water, e.g., less than 5 milligrams per 1 milliliter, or, if dissolution in the stomach is critical to absorption, the volume of gastric fluids required to dissolve the recommended dose far exceeds the volume of fluids present in the stomach (taken to be 100 milliliters for adults and prorated for infants and children).

(2) The dissolution rate of one or more such products is slow, e.g., less than 50 percent in 30 minutes when tested using either a general method specified in an official compendium or a paddle method at 50 revolutions per minute in 900 milliliters of distilled or deionized water at 37° C, or differs significantly from that of an appropriate reference material such as an identical drug product that is the subject of an approved full new drug application.

(3) The particle size and/or surface area of the active drug ingredient is critical in determining its bioavailability.

(4) Certain physical structural characteristics of the active drug ingredient, e.g., polymorphic forms, conformers, solvates, complexes, and crystal

modifications, dissolve poorly and this poor dissolution may affect absorption.

(5) Such drug products have a high ratio of excipients to active ingredients, e.g., greater than 5 to 1.

(6) Specific inactive ingredients, e.g., hydrophilic or hydrophobic excipients and lubricants, either may be required for absorption of the active drug ingredient or therapeutic moiety or, alternatively, if present, may interfere with such absorption.

(f) Pharmacokinetic evidence that:

(1) The active drug ingredient, therapeutic moiety, or its precursor is absorbed in large part in a particular segment of the gastrointestinal tract or is absorbed from a localized site.

(2) The degree of absorption of the active drug ingredient, therapeutic moiety, or its precursor is poor, e.g., less than 50 percent, ordinarily in comparison to an intravenous dose, even when it is administered in pure form, e.g., in solution.

(3) There is rapid metabolism of the therapeutic moiety in the intestinal wall or liver during the process of absorption (first-class metabolism) so the therapeutic effect and/or toxicity of such drug product is determined by the rate as well as the degree of absorption.

(4) The therapeutic moiety is rapidly metabolized or excreted so that rapid dissolution and absorption are required for effectiveness.

(5) The active drug ingredient or therapeutic moiety is unstable in specific portions of the gastrointestinal tract and requires special coatings or formulations, e.g., buffers, enteric coatings, and film coatings, to assure adequate absorption.

(6) The drug product is subject to dose dependent kinetics in or near the therapeutic range, and the rate and extent of absorption are important to bioequivalence.

[42 FR 1635, Jan. 7, 1977. Redesignated and amended at 57 FR 18001, Apr. 28, 1992]

§ 320.34 Requirements for batch testing and certification by the Food and Drug Administration.

(a) If the Commissioner determines that individual batch testing by the Food and Drug Administration is necessary to assure that all batches of the

same drug product meet an appropriate in vitro test, he shall include in the bioequivalence requirement a requirement for manufacturers to submit samples of each batch to the Food and Drug Administration and to withhold distribution of the batch until notified by the Food and Drug Administration that the batch may be introduced into interstate commerce.

(b) The Commissioner will ordinarily terminate a requirement for a manufacturer to submit samples for batch testing on a finding that the manufacturer has produced four consecutive batches that were tested by the Food and Drug Administration and found to meet the bioequivalence requirement, unless the public health requires that batch testing be extended to additional batches.

[42 FR 1635, Jan. 7, 1977. Redesignated at 57 FR 18001, Apr. 28, 1992]

§ 320.35 Requirements for in vitro testing of each batch.

If a bioequivalence requirement specifies a currently available in vitro test or an in vitro bioequivalence standard comparing the drug product to a reference standard, the manufacturer shall conduct the test on a sample of each batch of the drug product to assure batch-to-batch uniformity.

[42 FR 1635, Jan. 7, 1977. Redesignated at 57 FR 18001, Apr. 28, 1992]

§ 320.36 Requirements for maintenance of records of bioequivalence testing.

(a) All records of in vivo or in vitro tests conducted on any marketed batch of a drug product to assure that the product meets a bioequivalence requirement shall be maintained by the manufacturer for at least 2 years after the expiration date of the batch and submitted to the Food and Drug Administration on request.

(b) Any person who contracts with another party to conduct a bioequivalence study from which the data are intended to be submitted to FDA as part of an application submitted under part 314 of this chapter shall obtain from the person conducting the study sufficient accurate financial information to allow the submission of complete and