September 23, 2019

Paul Bedard
Vice President & General Manager, Hematology & Neurology
Bayer HealthCare Pharmaceuticals
100 Bayer Boulevard
Whippany, NJ 07981

Re: Voluntary Recall of Two Lots of Kogenate® FS Antihemophilic Factor (Recombinant) in the United States

Dear Paul,

We are writing to follow up on our prior letters concerning Bayer's recent voluntary recall of two lots of Kogenate® FS Antihemophilic Factor (Recombinant) in the United States. We appreciate that Bayer has shared certain information with us related to its recall strategy, explanation for how the product was mislabeled and subsequently distributed, and preliminary answers to questions about medical consequences. However, Bayer's explanations and its management of the recall to date have not done what's needed to allay the understandable concerns of the bleeding disorders community – an unknown number of whom have, due to Bayer's actions, taken the wrong drug, in the wrong dosage, on the wrong dosing schedule, after the drug's expiration.

On August 9th, Bayer sent a letter to our organizations explaining the errors and failures that allowed the product mixup and mislabeling to occur (Bayer letter). Based on information conveyed in the Bayer letter, it is clear that Bayer violated a number of FDA Current Good Manufacturing Practice (CGMP) regulations, resulting in Bayer's distribution of a drug that was adulterated within the meaning of 21 CFR 210.1. The list of apparent violations includes:

- **Failing to meet quality control standards,** as set forth in 21 CFR 211.22(a). Bayer's August 9th letter describes a chain of human errors that resulted in the product mixup and mislabeling. *Four* separate individuals/processes had to fail in order for the product mixup and mislabeling to occur. It then took Bayer months to discover these failures. This cascade of human errors, compounded by the delay in discovering Bayer's quality control failures, is deeply concerning and strongly suggests that Bayer failed to meet the personnel training and qualifications requirements of 21 CFR 211.25 as well as the requirements of 21 CFR 211.22(a).
- **Maintaining a deficient facility setup,** in violation of 21 CFR 211.42 and 21 CFR 211.130 (requiring design and construction of facilities and operations, including labeling operations, in such a manner as to preclude mislabeling and product mixups). Bayer reports that it kept multiple, different products – expired *and* non-expired – in a single cold storage area.
- **Violating equipment identification requirements** set forth in 21 CFR 211.105. While storage cabinets were "tagged to identify its [sic] content," those tags were not distinct enough to prevent a cabinet of expired Jivi from being transported to the vial labeling area as part of the Kogenate labeling process.

As you can imagine, Bayer's distribution of adulterated product is extremely concerning not only for affected individuals and families, but also for anyone who survived or may now be reliving the hemophilia community's devastating experience with tainted blood products in the 1980s. We are lucky insofar as current information suggests that the events of 2019 will not prove as dire as that earlier history. Still, the circumstances surrounding the Bayer recall underscore the need for

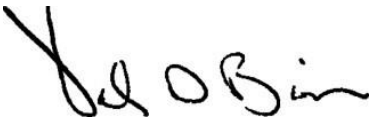
all parts of the bleeding disorders community – manufacturers, regulators, patients and families, national organizations, and more – to re-dedicate ourselves to vigilance and to unswerving defense of product safety.

Accordingly, NHF and HFA propose that Bayer work with our organizations on several levels, including to:

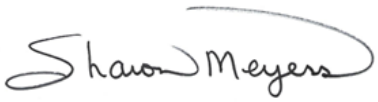
- Convene a Product Safety Summit in first quarter 2020. We ask that you continue your conversations with our senior staff as they work toward finalizing a timetable, agenda, and other details for this summit;
- Follow up on your letter of August 22nd, in which Bayer said it would share information about patients under 12 years of age who received the mixed-up product and adverse events reported to Bayer. Bayer also said that it would "inform the community of any safety signals that emerge through continued monitoring." Please advise us of the timeframe within which you expect to complete your evaluation. Please share any interim or preliminary data that you can make available at this time; and
- Consider establishing a patient portal on your website where you can post safety updates on an ongoing basis.

We look forward to your prompt response with answers to these questions, and to continuing our conversations about a Product Safety Summit. Please contact Michelle Rice, Chief External Affairs Officer for NHF (mrice@hemophilia.org) and Kim Isenberg, Vice President – Policy, Advocacy and Government Education at HFA (k.isenberg@hemophiliafed.org) as we continue our discussions.

Sincerely,



Val Bias
Chief Executive Officer
National Hemophilia Foundation



Sharon Meyers, M.S., CFRE
Interim President & CEO
Hemophilia Federation of America

Cc: Werner Baumann, CEO