

**FDA REQUESTED RECALL****JUL 26 2013**

Kristi Kubosh, Pharm.D, RPh
President/Pharmacist in Charge
NuVision Pharmacy, Inc.
4001 McEwen Road, Suite 110
Dallas, TX 75244

Dear Dr. Kubosh:

This letter is to request that you immediately initiate a recall of all lots of all sterile products produced at NuVision Pharmacy that are within expiry.

This request is based on the Food and Drug Administration's (FDA) findings during a recent inspection of the NuVision facility, during which FDA investigators observed poor sterile production practices that result in a lack of sterility assurance. If a drug product marketed as sterile contains microbial contamination, patients could be at risk for serious infections, which may be life-threatening. NuVision received adverse event reports of fever, flu-like symptoms, and soreness at the injection site associated with a methylcobalamin injection product, which NuVision subsequently recalled.

All sterile products produced at NuVision are adulterated within the meaning of section 501(a)(2)(A) of the Federal Food, Drug and Cosmetic Act (the Act) [21 U.S.C. § 351(a)(2)(A)], and those products that you produce and distribute without receiving patient-specific prescriptions are also adulterated within the meaning of section 501(a)(2)(B) of the Act [21 U.S.C. § 351(a)(2)(B)].

During a March 18 to April 16, 2013 inspection of the NuVision facility located at 4001 McEwen Rd, Suite 110, Dallas, TX 75244, FDA investigators documented poor sterile production practices that raise concerns about a lack of sterility assurance of NuVision's sterile drug products. The following are considered among the most objectionable conditions identified at NuVision:

1. Your firm's facility design was inadequate for the processing of aseptically filled, injectable products. HEPA filters covered less than one-half of the area in which sterile drugs are aseptically manipulated. Also, this ISO 5 area consisted of a table with inadequate protection to safeguard the sterile product from influx of lower quality air from the immediately adjacent ISO 7 clean room. Only a short curtain (approximately 30") was hanging from the ceiling. A meaningful physical barrier would be part of assuring that the ISO 5 zone is protected from microbial contamination risks generated by personnel movements and activities conducted near the area. Furthermore, your firm lacked assurance that the aseptic work area was supplied with clean unidirectional air of sufficient velocity to protect sterile components from microbial contamination during aseptic processing.

2. The facility lacked pressure gauges and you did not conduct routine differential pressure monitoring to assure proper air balance. The maintenance of the appropriate environmental conditions in order to perform aseptic processing requires a constant airflow from the “cleanest” (aseptic processing area) to the “dirtiest” part of the facility. Therefore your firm had no assurance that differential pressure remains sufficient at any given time such that the “dirtiest,” microbially-contaminated air did not flow into the aseptic processing area.
3. The ISO 5 area was not adequately sanitized or disinfected. Your firm used (b) (4) to clean the ISO 5 area and there was no documentation that sporicidal agents were used. Your firm did not perform any activity that would reliably remove microbial spores from the aseptic processing area. Therefore, there was an unacceptable risk of spores contaminating drug products during aseptic manipulations.
4. Your firm used (b) (4) some products. These (b) (4) can contribute particles, fiber, and chemical contamination to your injectable drug products. Therefore, these (b) (4) are unsuitable for use in a parenteral drug manufacturing process.
5. Some (b) (4) used for sterile (b) (4) are not suitable for pharmaceutical use or are not qualified for bacterial retention (e.g., (b) (4)). Therefore your firm had no assurance that these (b) (4) are capable of removing microorganisms that might be present in the (b) (4) product.
6. For injectable products that are (b) (4) sterilized, your firm used (b) (4) in which the user manual states “Caution: any liquids that are sterilized in this unit are for laboratory use only and not for use in direct patient contact.” Furthermore, your firm had not validated the use of these (b) (4) for product sterilization and did not maintain records of the use of (b) (4) indicators which were reportedly used in the first load each processing day. Therefore, your firm lacked basic assurance that the (b) (4) were capable of rendering the products sterile.
7. The media fill simulations conducted by your firm were inadequate. Media fills were not representative and did not simulate aseptic processing operations that personnel actually perform. In addition, in some instances, personnel who failed media fill studies were documented as having “passed” and allowed to perform aseptic operations. Therefore your firm had not demonstrated that staff was appropriately trained and capable of performing aseptic manipulations without contaminating injectable products.
8. Your firm labeled injectable products with beyond use dates (BUDs) ranging from 90 to 720 days. However, your firm had not performed adequate stability studies demonstrating that the components of the product are chemically and physically stable or that the product remained sterile for this period. Furthermore, your firm did not perform container-closure integrity testing and had no assurances that the container closure could maintain sterility of the injectable product.
9. Your firm relied upon sterility test methods other than those specified in the official USP chapter on sterility testing (*USP <71>*). However, your firm had not validated these methods to demonstrate that they are capable of detecting microbial contamination if present.

We acknowledge receipt of your response dated May 9, 2013, which describes corrective actions implemented to address our inspectional findings. Your response does not address the impact of the poor aseptic practices on sterile drugs produced and distributed prior to implementation of these corrective actions. In addition, your corrective actions are insufficient to address all of the objectionable practices found at your firm and to assure sterility. Consequently, your firm continues to lack basic assurance that the sterile drug product(s) that you produce conform to the basic quality standards that ensure safety, identity, strength, quality, and purity.

The FDA has determined that due to the lack of sterility assurance of NuVision sterile products, the sterile drugs distributed by NuVision present a risk of illness or injury to consumers. To date, NuVision has not initiated a recall of all of its sterile products that are within expiry. FDA action is therefore necessary to protect the public health and welfare.

FDA will classify this FDA Requested action as a Class I recall. A Class I recall is a situation in which there is a reasonable probability that the use of, or exposure to, a violative product will cause serious adverse health consequences or death. FDA recommends level A (100%) effectiveness checks be performed to the user level.

FDA's recall policy and guidance is found in Title 21 Code of Federal Regulations (CFR), Part 7. FDA's Dallas District Office will provide guidance in implementing and assuring the effectiveness of your recall of these products, including reviewing the proposed recall communication to your consignees. We are requesting that you work closely with the district office and that you provide any necessary information regarding the recall in a timely manner. Title 21 CFR, Part 7 provides for, among other things, publishing your recall in an upcoming issue of the weekly FDA Enforcement Report.

Please respond to this letter within two business days of receipt. Your response to this letter should be directed to:

Reynaldo R. Rodriguez, Jr, District Director
Dallas District Office
4040 North Central Expressway, Suite 300
Dallas, TX 75204
Phone 214-253-5201, Fax 214-253-5314

Please note that during our inspection of your contract testing laboratory, (b) (4), we learned that your sample, ascorbic acid 500mg/mL, lot number N03132013@18, failed its sterility test. It is unclear from (b) (4)'s records whether this sample is a sample of a finished product that was released for distribution, or if this sample is a sample of a component used in a preparation of another product that was released for distribution. However, because FDA is requesting that you recall all lots of all sterile products produced at NuVision Pharmacy that are within expiry, your recall should include this product, regardless of whether it is a finished product that was released for distribution or a component used in a preparation of another product that was released for distribution. In addition, during our inspection of (b) (4), we were unable to determine whether (b) (4) contacted you to alert you of this sterility failure. Please include in the above requested response an indication of whether (b) (4) alerted you to the sterility failure, and if so, any actions you took in response to this information.

Due to the seriousness of this situation, FDA is issuing a press release advising consumers of the FDA Requested Recall letter and again warning health care providers and distributors to discontinue use or sale of these products and of the health risk associated with the use of these products.

Failure to comply with this request can result in further regulatory action being taken against you, your firm, and the adulterated products distributed by your firm.

Sincerely,



Melinda K. Plaisier
Acting Associate Commissioner
for Regulatory Affairs

cc: Linda Baker, Director of Pharmacy
Brian Shields, Esq.