

**CENTER FOR DRUG EVALUATION AND
RESEARCH**

APPLICATION NUMBER:
022460Orig1s000

PROPRIETARY NAME REVIEW(S)



**Department of Health and Human Services
Public Health Service
Food and Drug Administration
Center for Drug Evaluation and Research
Office of Surveillance and Epidemiology**

Date: June 11, 2010

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Subject: Proprietary Name Review

Drug Name(s): Jalyn (Dutasteride and Tamsulosin Hydrochloride) Capsules
0.5 mg/0.4 mg

Application Type/Number: NDA 022460

Applicant: GlaxoSmithKline

OSE RCM #: 2010-999

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EXECUTIVE SUMMARY

This review summarizes DMEPA's evaluation of the proposed proprietary name, Jalyn, for Dutasteride and Tamsulosin Hydrochloride capsules. Our evaluation did not identify concerns that would render the name unacceptable based on the product characteristics and safety profile known at the time of this review. Thus, DMEPA finds the proposed proprietary name, Jalyn, acceptable for this product.

1 BACKGROUND

1.1 INTRODUCTION

This review responds to a request from GlaxoSmithKline on May 7, 2010, for an assessment of the proposed proprietary name, Jalyn, regarding potential name confusion with other proprietary or established drug names in the usual practice settings. Additionally, the Applicant submitted an independent name analysis conducted by the Drug Safety Institute (subsidiary of Brand Institute, Inc.) for the name Jalyn and the analysis was evaluated as part of this review.

The Applicant also submitted container labels which will be reviewed under separate review (OSE Review #2009-1981-1).

1.2 REGULATORY HISTORY

The Applicant initially submitted the proposed proprietary name, Flodart, for review. However, DMEPA objected to the name Flodart (b) (4). The Applicant submitted a second proposed proprietary name, (b) (4), which was also found unacceptable (b) (4). Subsequently, the Applicant submitted a third proposed proprietary name (b) (4), which was found unacceptable (b) (4). The Applicant has submitted a fourth proposed proprietary name, Jalyn, for review.

1.3 PRODUCT INFORMATION

Jalyn is a combination of dutasteride, a 5 α -reductase inhibitor, and tamsulosin hydrochloride, an alpha-adrenergic blocker, and is indicated for the treatment of symptomatic benign prostatic hyperplasia in men with an enlarged prostate. The usual adult dose is one capsule by mouth once a day. It will be available in bottles of 30 and 90 capsules.

2 METHODS AND MATERIALS

Appendix A describes the general methods and materials used by the Division of Medication Error Prevention and Analysis (DMEPA) when conducting a proprietary name risk assessment for all proprietary names. Sections 2.1, 2.2, and 2.3 identify specific information associated with the methodology for the proposed proprietary name, Jalyn.

2.1 SEARCH CRITERIA

For this review, particular consideration was given to drug names beginning with the letter ‘J’ when searching to identify potentially similar drug names, as 75% of the confused drug names reported by the USP-ISMP Medication Error Reporting Program involve pairs beginning with the same letter.^{1,2}

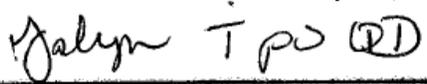
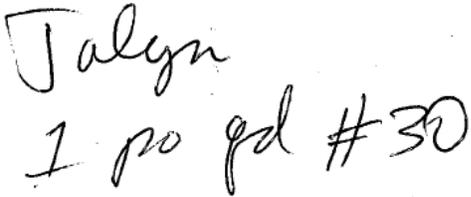
To identify drug names that may look similar to Jalyn, the DMEPA staff also considers the orthographic appearance of the name on lined and unlined orders. Specific attributes taken into consideration include the length of the name (5 letters), upstrokes (two, capital letter ‘J’, lowercase letter ‘l’), down strokes (one, lower case ‘y’), cross strokes (none), and dotted letters (none). Additionally, several letters in Jalyn may be vulnerable to ambiguity when scripted (See Appendix B). As a result, the DMEPA staff also considers these alternate appearances when identifying drug names that may look or sound similar to Jalyn.

When searching to identify potential names that may sound similar to Jalyn, the DMEPA staff search for names with similar number of syllables (2), stresses (JAY-lyn, jay-LYN), and placement of vowel and consonant sounds. Additionally, the DMEPA staff considers that pronunciation of parts of the name can be misinterpreted (See Appendix B). The Applicant’s intended pronunciation is ja’ lin. However, names are often mispronounced and/or spoken with regional accents and dialects, so other potential pronunciations of the name are considered.

2.2 FDA PRESCRIPTION ANALYSIS STUDIES

In order to evaluate the potential for misinterpretation of the proposed proprietary name in handwriting and verbal communication of the name, the following inpatient and outpatient medication orders and verbal prescription was communicated during the FDA prescription studies.

Figure 1. Jalyn Prescription Study (conducted on May 20, 2010)

HANDWRITTEN MEDICATION ORDER	VERBAL PRESCRIPTION
<p><u>Inpatient Medication Order:</u></p> 	<p>Jalyn Dispense #30 Take 1 PO QD</p>
<p><u>Outpatient Medication Order:</u></p> 	

¹ Institute for Safe Medication Practices. Confused Drug name List (1996-2006). Available at <http://www.ismp.org/Tools/confuseddrugnames.pdf>

² Kondrack, G and Dorr, B. Automatic Identification of Confusable Drug Names. Artificial Intelligence in Medicine (2005)

2.3 EXTERNAL PROPRIETARY NAME RISK ASSESSMENT

For this product the Applicant submitted an external evaluation of the proposed proprietary name. The Division of Medication Error Prevention and Analysis conducts an independent analysis and evaluation of the data provided, and responds to the overall findings of the assessment. When the external proprietary name risk assessment identifies potentially confusing names that were not captured in DMEPA's database searches or in the Expert Panel Discussion, these names are included in the Safety Evaluator's Risk Assessment and analyzed independently by the Safety Evaluator to determine if the potentially confusing name could lead to medication errors in the usual practice settings.

After the Safety Evaluator has determined the overall risk associated with the proposed name, the Safety Evaluator compares the findings to their overall assessment with the findings of the proprietary name risk assessment submitted by the Applicant. The Safety Evaluator then determines whether the Division's risk assessment concurs or differs with the findings. When the proprietary name risk assessments differ, the Division of Medication Error Prevention and Analysis provides a detailed explanation of these differences.

3 RESULTS

3.1 DATABASE AND INFORMATION SOURCES

The database searches yielded a total of seven names as having some similarity to the name, Jalyn.

Six names were thought to look like Jalyn. These include: Foltx, Galzin, (b) (4), Jenloga, Zagam and Zosyn. The remaining name, Javlor***, was thought to sound like Jalyn.

Additionally, DMEPA staff did not identify any United States Adopted Names (USAN) stems in the proposed proprietary name, as of May 19, 2010.

3.2 CDER EXPERT PANEL DISCUSSION

The Expert Panel reviewed the pool of names identified by DMEPA staff (see Section 3.1 above) and noted no additional names thought to have orthographic or phonetic similarity to Jalyn. However, the Expert Panel noted that the proposed name sounded like a female name which could be a concern since the drug's pregnancy risk rating is Category X.

DDMAC had no concerns regarding the proposed name from a promotional perspective, and did not offer any additional comments relating to the proposed name.

3.3 FDA PRESCRIPTION ANALYSIS STUDIES

A total of 49 practitioners responded. Seventeen (n=17) respondents interpreted the name correctly as 'Jalyn', with correct interpretations occurring in inpatient (n=6) and outpatient medication orders (n=11). The most common misinterpretation occurred with the first letter in the inpatient and outpatient written studies. The inpatient study respondents misinterpreted the first letter 'J' as a 'T' (n=3) and the outpatient study respondents misinterpreted 'J' as a 'Y' (n=4), 'F' (n=5), 'Z' (n=3), 'T' (n=1) or 'G' (n=1). In the voice study, the majority of the participants misinterpreted the combination letters '-lyn' as '-lin' (n=8), '-lan' (n=2), '-lind' (n=1), '-liv' (n=1), '-len' (n=1), or '-lick' (n=1). None of the responses in any of the studies identified a currently marketed drug name.

*** This document contains proprietary and confidential information that should not be released to the public.

3.4 EXTERNAL NAME STUDY

In the proposed name risk assessment submitted by the Applicant, Drug Safety Institute (DSI) found the name acceptable. They identified and evaluated a total of 20 names thought to have some potential for confusion with the name Jalyn. Two of the 20 names (Galzin and Zosyn) were also identified by the Division of Medication Error Prevention and Analysis staff searches or Expert Panel Discussion.

The remaining 18 names (Alinia, Aralen, Atryn, Calan, Dalgan, Focalin, Inulin, Jantoven, Januvia, Juven, Mezlin, Nalfon, Saline, Symlin, Talwin, Valium, Velban, and Zevalin) were not identified by the Division of Medication Error Prevention and Analysis staff. These 18 names will be evaluated in the Safety Evaluator Risk Assessment.

3.5 COMMENTS FROM THE DIVISION OF REPRODUCTIVE AND UROLOGIC PRODUCTS (DRUP)

3.5.1 Initial Phase of Review

In response to the OSE May 24, 2010 e-mail, DRUP had no objections to the proposed proprietary name, Jalyn.

3.6 SAFETY EVALUATOR RISK ASSESSMENT

Independent searches by the primary Safety Evaluator identified two additional names, Salagen and Zolyse, which were thought to look similar to Jalyn and represent a potential source of drug name confusion. Thus, 27 names were evaluated for their potential similarity to Jalyn.

4 DISCUSSION

4.1 PROMOTIONAL REVIEW

DDMAC did not find the name Jalyn promotional.

4.2 SAFETY EVALUATOR RISK ASSESSMENT

DMEPA identified a total of 27 names as having some potential similarity to the proposed name, Jalyn. We did not identify any other aspects of the name that would function as a potential source of error. Thirteen of the 27 names were not evaluated further for the following reasons: 7 names lacked orthographic and/or phonetic similarity to Jalyn (see Appendix D); one name was not a drug name (see Appendix E); four names were proprietary names for discontinued products with no generic equivalent available (see Appendix F); one name was withdrawn by the Sponsor (see Appendix G).

Failure Mode and Effects Analysis was then applied to determine if the proposed name, Jalyn, could potentially be confused with any of the remaining 14 names and lead to medication errors. This analysis determined that the name similarity between Jalyn and all of the identified names was unlikely to result in medication errors for the reasons presented in Appendices H and I.

5 CONCLUSIONS AND RECOMMENDATIONS

The Proprietary Name Risk Assessment findings indicate that the proposed name, Jalyn, is not vulnerable to name confusion that could lead to medication errors nor is it considered promotional.

However, if any of the proposed product characteristics as stated in this review are altered prior to approval of the product, DMEPA rescinds this Risk Assessment finding and the name must be resubmitted for review. In the event that our Risk Assessment finding is rescinded, the evaluation of the name on resubmission is independent of the previous Risk Assessment, and as such, the conclusions on re-review of the name are subject to change. If the approval of this NDA is delayed beyond 90 days from

the signature date of this review, the proposed name must be resubmitted for evaluation. If you have further questions or need clarifications, please contact Karen Townsend, OSE Project Manager, at 301-796-5413.

5.1 COMMENTS TO THE APPLICANT

We have completed our review of the proposed proprietary name, Jalyn, and have concluded that it is acceptable.

6 REFERENCES

1. ***Micromedex Integrated Index*** (<http://csi.micromedex.com>)

Micromedex contains a variety of databases covering pharmacology, therapeutics, toxicology and diagnostics.

2. ***Phonetic and Orthographic Computer Analysis (POCA)***

POCA is a database which was created for the Division of Medication Error Prevention and Analysis, FDA. As part of the name similarity assessment, proposed names are evaluated via a phonetic/orthographic algorithm. The proposed proprietary name is converted into its phonemic representation before it runs through the phonetic algorithm. Likewise, an orthographic algorithm exists which operates in a similar fashion.

3. ***Drug Facts and Comparisons, online version, St. Louis, MO*** (<http://factsandcomparisons.com>)

Drug Facts and Comparisons is a compendium organized by therapeutic course; it contains monographs on prescription and OTC drugs, with charts comparing similar products.

4. ***AMF Decision Support System [DSS]***

DSS is a government database used to track individual submissions and assignments in review divisions.

5. ***Division of Medication Errors Prevention and Analysis proprietary name consultation requests***

This is a list of proposed and pending names that is generated by the Division of Medication Error Prevention and Analysis from the Access database/tracking system.

6. ***Drugs@FDA*** (<http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm>)

Drugs@FDA contains most of the drug products approved since 1939. The majority of labels, approval letters, reviews, and other information are available for drug products approved from 1998 to the present. Drugs@FDA contains official information about FDA approved [brand name](#), [generic drugs](#), [therapeutic biological products](#), [prescription](#) and [over-the-counter](#) human drugs and [discontinued drugs](#) and “[Chemical Type 6](#)” approvals.

7. ***Electronic online version of the FDA Orange Book*** (<http://www.fda.gov/cder/ob/default.htm>)

The FDA Orange Book provides a compilation of approved drug products with therapeutic equivalence evaluations.

8. ***U.S. Patent and Trademark Office*** (<http://www.uspto.gov>)

USPTO provides information regarding patent and trademarks.

9. ***Clinical Pharmacology Online*** (www.clinicalpharmacology-ip.com)

Clinical Pharmacology contains full monographs for the most common drugs in clinical use, plus mini monographs covering investigational, less common, combination, nutraceutical and nutritional products. It also provides a keyword search engine.

10. Data provided by Thomson & Thomson's SAEGIS™ Online Service, available at (www.thomson-thomson.com)

The Pharma In-Use Search database contains over 400,000 unique pharmaceutical trademarks and trade names that are used in about 50 countries worldwide. The data is provided under license by IMS HEALTH.

11. Natural Medicines Comprehensive Databases (www.naturaldatabase.com)

Natural Medicines contains up-to-date clinical data on the natural medicines, herbal medicines, and dietary supplements used in the western world.

12. Stat!Ref (www.statref.com)

Stat!Ref contains full-text information from approximately 30 texts; it includes tables and references. Among the database titles are: Handbook of Adverse Drug Interactions, Rudolphs Pediatrics, Basic Clinical Pharmacology, and Dictionary of Medical Acronyms Abbreviations.

13. USAN Stems (<http://www.ama-assn.org/ama/pub/category/4782.html>)

USAN Stems List contains all the recognized USAN stems.

14. Red Book Pharmacy's Fundamental Reference

Red Book contains prices and product information for prescription, over-the-counter drugs, medical devices, and accessories.

15. Lexi-Comp (www.lexi.com)

Lexi-Comp is a web-based searchable version of the Drug Information Handbook.

16. Medical Abbreviations Book

Medical Abbreviations Book contains commonly used medical abbreviations and their definitions.

APPENDICES

Appendix A:

FDA's Proprietary Name Risk Assessment considers the potential for confusion between the proposed proprietary name and the proprietary and established names of drug products existing in the marketplace and those pending IND, NDA, BLA, and ANDA products currently under review by the Center. DMEPA defines a medication error as any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer.³

For the proposed proprietary name, DMEPA staff search a standard set of databases and information sources to identify names with orthographic and phonetic similarity and hold a Center for Drug Evaluation and Research (CDER) Expert Panel discussion to gather professional opinions on the safety of the proposed proprietary name. DMEPA staff also conducts internal CDER prescription analysis studies. When provided, DMEPA considers external prescription analysis study results and incorporate into the overall risk assessment.

The Safety Evaluator assigned to the Proprietary Name Risk Assessment is responsible for considering the collective findings, and provides an overall risk assessment of the proposed proprietary name. DMEPA bases the overall risk assessment on the findings of a Failure Mode and Effects Analysis (FMEA) of the proprietary name, and focuses on the avoidance of medication errors.

FMEA is a systematic tool for evaluating a process and identifying where and how it might fail.⁴ DMEPA uses FMEA to analyze whether the drug names identified with orthographic or phonetic similarity to the proposed proprietary name could cause confusion that subsequently leads to medication errors in the clinical setting. DMEPA uses the clinical expertise of its staff to anticipate the conditions of the clinical setting where the product is likely to be used based on the characteristics of the proposed product.

In addition, the product characteristics provide the context for the verbal and written communication of the drug names and can interact with the orthographic and phonetic attributes of the names to increase the risk of confusion when there is overlap or, in some instances, decrease the risk of confusion by helping to differentiate the products through dissimilarity. Accordingly, the DMEPA staff considers the product characteristics associated with the proposed drug throughout the risk assessment because the product characteristics of the proposed may provide a context for communication of the drug name and ultimately determine the use of the product in the *usual* clinical practice setting.

Typical product characteristics considered when identifying drug names that could potentially be confused with the proposed proprietary name include, but are not limited to; established name of the proposed product, proposed indication of use, dosage form, route of administration, strength, unit of measure, dosage units, recommended dose, typical quantity or volume, frequency of administration, product packaging, storage conditions, patient population, and prescriber population. Because drug name confusion can occur at any point in the medication use process, DMEPA staff considers the potential for confusion throughout the entire U.S. medication use process, including drug procurement, prescribing and ordering, dispensing, administration, and monitoring the impact of the medication.⁵ DMEPA provides the product characteristics considered for this review in section one.

The Division of Medication Error Prevention and Analysis considers the spelling of the name, pronunciation of the name when spoken, and appearance of the name when scripted. DMEPA also compares the spelling of the proposed proprietary name with the proprietary and established name of existing and proposed drug products

³ National Coordinating Council for Medication Error Reporting and Prevention. <http://www.nccmerp.org/aboutMedErrors.html>. Last accessed 10/11/2007.

⁴ Institute for Healthcare Improvement (IHI). Failure Modes and Effects Analysis. Boston. IHI:2004.

⁵ Institute of Medicine. Preventing Medication Errors. The National Academies Press: Washington DC. 2006.

because similarly spelled names may have greater likelihood to sound similar to one another when spoken or look similar to one another when scripted. DMEPA staff also examines the orthographic appearance of the proposed name using a number of different handwriting samples. Handwritten communication of drug names has a long-standing association with drug name confusion. Handwriting can cause similarly and even dissimilarly spelled drug name pairs to appear very similar to one another. The similar appearance of drug names when scripted has led to medication errors. The DMEPA staff applies expertise gained from root-cause analysis of such medication errors to identify sources of ambiguity within the name that could be introduced when scripting (e.g., “T” may look like “F,” lower case ‘a’ looks like a lower case ‘u,’ etc). Additionally, other orthographic attributes that determine the overall appearance of the drug name when scripted (see Table 1 below for details). In addition, the DMEPA staff compares the pronunciation of the proposed proprietary name with the pronunciation of other drug names because verbal communication of medication names is common in clinical settings. If provided, DMEPA will consider the Applicant’s intended pronunciation of the proprietary name. However, DMEPA also considers a variety of pronunciations that could occur in the English language because the Applicant has little control over how the name will be spoken in clinical practice.

Table 1. Criteria used to identify drug names that look- or sound-similar to a proposed proprietary name.

Type of similarity	Considerations when searching the databases		
	Potential causes of drug name similarity	Attributes examined to identify similar drug names	Potential Effects
Look-alike	Similar spelling	Identical prefix Identical infix Identical suffix Length of the name Overlapping product characteristics	<ul style="list-style-type: none"> Names may appear similar in print or electronic media and lead to drug name confusion in printed or electronic communication Names may look similar when scripted and lead to drug name confusion in written communication
	Orthographic similarity	Similar spelling Length of the name Upstrokes Down strokes Cross-strokes Dotted letters Ambiguity introduced by scripting letters Overlapping product characteristics	<ul style="list-style-type: none"> Names may look similar when scripted, and lead to drug name confusion in written communication
Sound-alike	Phonetic similarity	Identical prefix Identical infix Identical suffix Number of syllables Stresses Placement of vowel sounds Placement of consonant sounds Overlapping product characteristics	<ul style="list-style-type: none"> Names may sound similar when pronounced and lead to drug name confusion in verbal communication

Lastly, the DMEPA staff also considers the potential for the proposed proprietary name to inadvertently function as a source of error for reasons other than name confusion. Post-marketing experience has demonstrated that proprietary names (or components of the proprietary name) can be a source of error in a

variety of ways. Consequently, DMEPA considers and evaluates these broader safety implications of the name throughout this assessment and the medication error staff provides additional comments related to the safety of the proposed proprietary name or product based on professional experience with medication errors.

1. Database and Information Sources

DMEPA staff conducts searches of the internet, several standard published drug product reference texts, and FDA databases to identify existing and proposed drug names that may sound-alike or look-alike to the proposed proprietary name using the criteria outlined in Section 2.1. Section 6 provides a standard description of the databases used in the searches. To complement the process, the DMEPA staff use a computerized method of identifying phonetic and orthographic similarity between medication names. The program, Phonetic and Orthographic Computer Analysis (POCA), uses complex algorithms to select a list of names from a database that have some similarity (phonetic, orthographic, or both) to the trademark being evaluated. Lastly, the DMEPA staff review the USAN stem list to determine if any USAN stems are present within the proprietary name. The individual findings of multiple safety evaluators are pooled and presented to the CDER Expert Panel.

2. CDER Expert Panel Discussion

DMEPA conducts an Expert Panel Discussion to gather CDER professional opinions on the safety of the proposed product and the proposed proprietary name. The Expert Panel is composed of Division of Medication Errors Prevention (DMEPA) staff and representatives from the Division of Drug Marketing, Advertising, and Communications (DDMAC). The Expert Panel also discusses potential concerns regarding drug marketing and promotion related to the proposed names.

The primary Safety Evaluator presents the pooled results of the DMEPA staff to the Expert Panel for consideration. Based on the clinical and professional experiences of the Expert Panel members, the Panel may recommend the addition of names, additional searches by the primary Safety Evaluator to supplement the pooled results, or general advice to consider when reviewing the proposed proprietary name.

3. FDA Prescription Analysis Studies

Three separate studies are conducted within the Centers of the FDA for the proposed proprietary name to determine the degree of confusion of the proposed proprietary name with marketed U.S. drug names (proprietary and established) due to similarity in visual appearance with handwritten prescriptions or verbal pronunciation of the drug name. The studies employ healthcare professionals (pharmacists, physicians, and nurses), and attempts to simulate the prescription ordering process. The primary Safety Evaluator uses the results to identify orthographic or phonetic vulnerability of the proposed name to be misinterpreted by healthcare practitioners.

In order to evaluate the potential for misinterpretation of the proposed proprietary name in handwriting and verbal communication of the name, inpatient medication orders and/or outpatient prescriptions are written, each consisting of a combination of marketed and unapproved drug products, including the proposed name. These orders are optically scanned and one prescription is delivered to a random sample of the 123 participating health professionals via e-mail. In addition, a verbal prescription is recorded on voice mail. The voice mail messages are then sent to a random sample of the participating health professionals for their interpretations and review. After receiving either the written or verbal prescription orders, the participants send their interpretations of the orders via e-mail to DMEPA.

4. Comments from the OND review Division or Generic drugs

DMEPA requests the Office of New Drugs (OND) or Office of Generic Drugs (OGD) Regulatory Division responsible for the application for their comments or concerns with the proposed proprietary name and any

clinical issues that may impact the DMEPA review during the initial phase of the name review. Additionally, when applicable, at the same time DMEPA requests concurrence/non-concurrence with DDMAC's decision on the name. The primary Safety Evaluator addresses any comments or concerns in the safety evaluator's assessment.

The OND or OGD Regulatory Division is contacted a second time following our analysis of the proposed proprietary name. At this point, DMEPA conveys their decision to accept or reject the name. The OND or OGD Regulatory Division is requested to concur/not concur with DMEPA's final decision.

5. Safety Evaluator Risk Assessment of the Proposed Proprietary Name

The primary Safety Evaluator applies his/her individual expertise gained from evaluating medication errors reported to FDA, conducts a Failure Mode and Effects Analysis, and provides an overall risk assessment of name confusion. Failure Mode and Effects Analysis (FMEA) is a systematic tool for evaluating a process and identifying where and how it might fail.⁶ When applying FMEA to assess the risk of a proposed proprietary name, DMEPA seeks to evaluate the potential for a proposed proprietary name to be confused with another drug name because of name confusion and, thereby, cause errors to occur in the medication use system. FMEA capitalizes on the predictable and preventable nature of medication errors associated with drug name confusion. FMEA allows the Agency to identify the potential for medication errors due to orthographically or phonetically similar drug names prior to approval, where actions to overcome these issues are easier and more effective than remedies available in the post-approval phase.

In order to perform an FMEA of the proposed name, the primary Safety Evaluator must analyze the use of the product at all points in the medication use system. Because the proposed product is has not been marketed, the primary Safety Evaluator anticipates the use of the product in the usual practice settings by considering the clinical and product characteristics listed in Section one. The Safety Evaluator then analyzes the proposed proprietary name in the context of the usual practice setting and works to identify potential failure modes and the effects associated with the failure modes.

In the initial stage of the Risk Assessment, the Safety Evaluator compares the proposed proprietary name to all of the names gathered from the above searches, Expert Panel Discussion, and prescription studies, external studies, and identifies potential failure modes by asking:

“Is the proposed proprietary name convincingly similar to another drug name, which may cause practitioners to become confused at any point in the usual practice setting?”

An affirmative answer indicates a failure mode and represents a potential for the proposed proprietary name to be confused with another proprietary or established drug name because of look- or sound-alike similarity. If the answer to the question is no, the Safety Evaluator is not convinced that the names possess similarity that would cause confusion at any point in the medication use system, thus the name is eliminated from further review.

In the second stage of the Risk Assessment, the primary Safety Evaluator evaluates all potential failure modes to determine the likely *effect* of the drug name confusion, by asking:

“Could the confusion of the drug names conceivably result in medication errors in the usual practice setting?”

The answer to this question is a central component of the Safety Evaluator's overall risk assessment of the proprietary name. If the Safety Evaluator determines through FMEA that the name similarity would not ultimately be a source of medication errors in the usual practice setting, the primary Safety Evaluator eliminates the name from further analysis. However, if the Safety Evaluator determines through FMEA that

⁶ Institute for Healthcare Improvement (IHI). Failure Mode and Effects Analysis. Boston. IHI:2004.

the name similarity could ultimately cause medication errors in the usual practice setting, the Safety Evaluator will then recommend the use of an alternate proprietary name.

DMEPA will object to the use of proposed proprietary name when the primary Safety Evaluator identifies one or more of the following conditions in the Risk Assessment:

- a. DDMAC finds the proposed proprietary name misleading from a promotional perspective, and the Review Division concurs with DDMAC's findings. The Federal Food, Drug, and Cosmetic Act provides that labeling or advertising can misbrand a product if misleading representations are made or suggested by statement, word, design, device, or any combination thereof, whether through a PROPRIETARY name or otherwise [21 U.S.C 321(n); See also 21 U.S.C. 352(a) & (n)].
- b. DMEPA identifies that the proposed proprietary name is misleading because of similarity in spelling or pronunciation to another proprietary or established name of a different drug or ingredient [CFR 201.10.(C)(5)].
- c. FMEA identifies the potential for confusion between the proposed proprietary name and other proprietary or established drug name(s), and demonstrates that medication errors are likely to result from the drug name confusion under the conditions of usual clinical practice.
- d. The proposed proprietary name contains an USAN (United States Adopted Names) stem.
- e. DMEPA identifies a potential source of medication error within the proposed proprietary name. For example, the proprietary name may be misleading or, inadvertently, introduce ambiguity and confusion that leads to errors. Such errors may not necessarily involve confusion between the proposed drug and another drug product.

If DMEPA objects to a proposed proprietary name on the basis that drug name confusion could lead to medication errors, the primary Safety Evaluator uses the FMEA process to identify strategies to reduce the risk of medication errors. DMEPA is likely to recommend that the Applicant select an alternative proprietary name and submit the alternate name to the Agency for DMEPA to review. However, in rare instances FMEA may identify plausible strategies that could reduce the risk of medication error of the currently proposed name. In that instance, DMEPA may be able to provide the Applicant with recommendations that reduce or eliminate the potential for error and, thereby, would render the proposed name acceptable.

In the event that DMEPA objects to the use of the proposed proprietary name, based upon the potential for confusion with another proposed (but not yet approved) proprietary name, DMEPA will provide a contingency objection based on the date of approval. Whichever product, the Agency approves first has the right to use the proprietary name, while DMEPA will recommend that the second product to reach approval seek an alternative name.

The threshold set for objection to the proposed proprietary name may seem low to the Applicant. However, the safety concerns set forth in criteria a through e are supported either by FDA regulation or by external healthcare authorities, including the Institute of Medicine (IOM), World Health Organization (WHO), Joint Commission on Accreditation of Hospitals (JCOAH), and the Institute for Safe Medication Practices (ISMP). These organizations have examined medication errors resulting from look- or sound-alike drug names and called for regulatory authorities to address the issue prior to approval. Additionally, DMEPA contends that the threshold set for the Proprietary Name Risk Assessment is reasonable because proprietary drug name confusion is a predictable and a preventable source of medication error that, in many instances, the Agency and/or Applicant can identify and rectify prior to approval to avoid patient harm.

Furthermore, post-marketing experience has demonstrated that medication errors resulting from drug name confusion are notoriously difficult to rectify post-approval. Educational and other post-approval efforts are low-leverage strategies that have had limited effectiveness at alleviating medication errors involving drug name confusion. Applicants have undertaken higher-leverage strategies, such as drug name changes, in the past but at great financial cost to the Applicant and at the expense of the public welfare, not to mention the Agency's

credibility as the authority responsible for approving the error-prone proprietary name. Moreover, even after Applicants’ have changed a product’s proprietary name in the post-approval phase, it is difficult to eradicate the original proprietary name from practitioners’ vocabulary, and as a result, the Agency has continued to receive reports of drug name confusion long after a name change in some instances. Therefore, DMEPA believes that post-approval efforts at reducing name confusion errors should be reserved for those cases in which the potential for name confusion could not be predicted prior to approval. (See Section 4 for limitations of the process).

Appendix B: Letters with possible orthographic or phonetic misinterpretation

Letters in name, Jalyn	Scripted may appear as	Spoken may be interpreted as
Capital ‘J’	‘A,’ ‘D,’ ‘F,’ ‘G,’ ‘I,’ ‘L,’ ‘S,’ ‘T,’ or ‘Z’	g
Lower case ‘a’	any vowel	any vowel
Lower case ‘l’	‘i,’ ‘t,’ ‘e,’ or ‘b’	l
Lower case ‘y’	‘g,’ ‘p,’ ‘z’	a, e, or i
Lower case ‘n’	‘m,’ ‘r,’ or ‘v’	m

Appendix C: FDA Prescription Study Responses for Jalyn.

Inpatient Medication Order	Outpatient Medication Order	Voice Prescription
Jalyn	Jalyn	Jaylin
Yalyn	Talyn	Jailin
Yalyn	Jalyn	Jaylick
Yalyn	Talyn	J-lin
Jalyn	Jalyn	Jalin
Jalyn	Talyn	Jalin
Falyn	Jalyn	Javan
Zalyn	Jalyn	Jaylin
Jalyn	Jalyn	Jaylind
Falyn	Jalyn	Jaylin
Talyn	Jalyn	Jayliv
Jalyn	Jalyn	Jaylin
Jalyn	Jalyn	Jalin
Falyn	Jalyn	Jalen
Zalyn		Jalan

Falyn		
Zalyn		
Falyn		
Galyn		
Yalyn		

Appendix D: Proprietary names that lack convincing orthographic and/or phonetic similarities

Proprietary Name	Similarity to Jalyn
Alinia (DSI)	Sound and/or Look
Januvia (DSI)	Sound and/or Look
Mezlin (DSI)	Sound and/or Look
Nalfon (DSI)	Sound and/or Look
Saline (DSI)	Sound and/or Look
Velban (DSI)	Sound and/or Look
Zevalin (DSI)	Sound and/or Look

Appendix E: Name which is not a drug name

Proprietary Name	Similarity to Jalyn	Category
Jalyne	Sound and Look	Trademarked for clothing

Appendix F: Proprietary names for discontinued products with no generic equivalents available

Proprietary Name	Similarity to Jalyn	Status
Dagan (Dezocine)	DSI - Look and/or Sound	Discontinued
Inulin	DSI – Look and/or Sound	Discontinued
Zagam (Sparfloxacin)	Look	Discontinued
Zolyse (Chymotrypsin)	Look	Discontinued

Appendix G: Proprietary name withdrawn by the Sponsor

Proprietary Name	Similarity to Jalyn	Status	Alternate proposed name
(b) (4)	(b) (4)	(b) (4)	(b) (4)

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Appendix H: Proprietary names with differentiating product characteristics

Product name with potential for confusion	Similarity to Jalyn	Dosage Form/ Strength	Usual Dose	Differentiating product characteristics (Product vs. Jalyn)
Jalyn	NA	Capsule: 0.5 mg dutasteride/ 0.4 mg tamsulosin	One capsule by mouth (PO) daily	NA
Galzin (Zinc Acetate)	Look	Capsule: 25 mg, 50 mg	50 mg PO three times daily	Strength: 25 mg or 50 mg vs. 0.5 mg/0.4 mg Frequency: three times daily vs. once daily
Zosyn (Piperacillin Sodium/ Tazobactam Sodium)	Look	Injectable powder for solution: 2.25 g/vial, 3.375g/vial, 4.5 g/vial, 40.5 g/vial Injection solution: 2.25 g per 50 mL, 3.375 g per 50 mL, 4.5 g per 100 mL	3.375 g or 4.5 g intravenously every 6 hours for 7 to 14 days	Dosage form: injectable vs. capsule Strength: 2.25 g, 3.375g, 4.5 g, or 40.5 g vs. 0.5 mg/0.4mg Dose: 3.375 g or 4.5 g vs. 1 capsule Route: intravenous vs. oral Frequency: every 6 hours vs. once daily
Javlor ^{***} (Vinflunine)	Sound	Injectable: 50 mg/2 mL, 100 mg/4 mL, 250 mg/10 mL	320 mg/m ² intravenously over or 20 minutes every 3 weeks (can be decreased to 250 mg/m ² , 280 mg/m ²)	Dosage form: injectable vs. capsule Strength: 50 mg/2 mL, 100 mg/4 mL, 250 mg/10 mL vs. 0.5 mg/0.4mg Dose: 250 mg/m ² , 280 mg/m ² or 320 mg/m ² vs. 1 capsule Route: injectable vs. oral Frequency: every 3 weeks vs. once daily
Salagen (Pilocarpine Hydrochloride)	Look	Tablet: 5 mg, 7.5 mg	5 mg to 10 mg PO three or four times daily	Strength: 5 mg or 7.5 mg vs. 0.5 mg/0.4mg Frequency: 3 or 4 times daily vs. once daily
Atryn (Antithrombin Alfa)	DSI - Look and/or Sound	Injectable: 1750 units	Individualized to patient; Requires loading dose and maintenance dose; Dose calculation formula: units required = [desired – baseline AT-III level (expressed as % normal level based on functional AT-III assay)] × weight (kg)/1.4	Dosage form: injectable vs. capsule Dose: Individualized to patient vs. 1 capsule Route: intravenous vs. oral

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Calan (Verapamil Hydrochloride)	DSI - Look and/or Sound	Tablet: 40 mg, 80 mg, 120 mg	40 mg/day to 480 mg/day in 2 to 4 divided doses	Strength: 40 mg, 80 mg or 120 mg vs. 0.5 mg/0.4mg Frequency: 2 to 4 times daily vs. once daily
Focalin (Dexmethylphenidate Hydrochloride)	DSI - Look and/or Sound	Tablet: 2.5 mg, 5 mg, 10 mg	5 mg/mg to 20 mg/day in 2 divided doses	Strength: 2.5 mg, 5 mg, 10 mg vs. 0.5 mg/0.4mg Frequency: twice daily vs. once daily
Jantoven (Warfarin Sodium)	DSI - Look and/or Sound	Tablet: 1 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg, 10 mg	1 mg to 10 mg once daily	Strength: 1 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg, 10 mg vs. 0.5 mg/0.4mg
Juven (Over-the-counter Nutritional Supplement)	DSI - Look and/or Sound	Nutritional supplement	1 packet twice daily	Availability: OTC vs. Rx Frequency: twice daily vs. once daily
Symlin (Pramlintide Acetate)	DSI - Look and/or Sound	Injectable: 0.6 mg/1 mL, 1 mg/mL	Type I: 15 mcg to 60 mcg per dose 3-4 times daily Type II: 60 mcg to 120 mcg per dose 3-4 times daily	Dosage form: injectable vs. capsule Strength: 0.6 mg/1 mL or 1 mg/mL vs. 0.5 mg/0.4mg Dose: 15 mcg to 120 mcg vs. 1 capsule Route: subcutaneous vs. oral Frequency: 3-4 times daily vs. once daily
Talwin (Pentazocine Lactate) Talwin NX (Naloxone Hydrochloride/ Pentazocine Hydrochloride) – <i>Generics available</i> Talwin 50 (Pentazocine Hydrochloride) – <i>Discontinued with no generics available</i> Talwin Compound (Aspirin/ Pentazocine Hydrochloride) – <i>Discontinued with no generics available</i>	DSI - Look and/or Sound	Talwin: Injectable: 30 mg/mL Talwin NX: Tablet: 0.5 mg/ 50 mg Talwin 50: Tablet: 50 mg Talwin Compound: Tablet: 325 mg/12.5 mg	Talwin: 30 mg intravenously, intramuscularly or subcutaneously given once or every 2 to 4 hours Talwin NX: 1 tablet every 3 or 4 hours; increase to 2 tablets if necessary	Talwin: Dosage form: injectable vs. capsule Dose: 30 mg vs. 1 capsule Route: intravenous, intramuscular, subcutaneous vs. oral Talwin NX : Frequency: every 3 or 4 hours vs. once daily Modifier: “NX” required on prescriptions to differentiate from Talwin which will differentiate the products
Valium (Diazepam)	DSI - Look and/or Sound	Tablet: 2 mg, 5 mg, 10 mg	2 mg/day to 40 mg/day once to four times daily	Strength: 2 mg, 5 mg, 10 mg vs. 0.5 mg/0.4mg

Appendix I: Proprietary names with overlapping product characteristics but differentiating orthographic and phonetic characteristics

Proposed name: Jalyn (dutasteride/tamsulosin)	Strength 0.5 mg/0.4 mg	Usual dose: One capsule by mouth daily 30 minutes after meal
Failure Mode: Name confusion	Causes (could be multiple)	
<p>Foltx (Cyanocobalamin/ Folic Acid/ Pyridoxine) Tablet: 2 mg/2.5 mg/25 mg Dose: One tablet by mouth daily</p>	<p>The first letters ‘F’ and ‘J’ look similar when scripted; ‘o’ and ‘a’ look similar; both contain upstroke ‘l’; both are 5 letters in length</p> <p>Both products are available in a single strength so the strength may be omitted on a prescription; Both have overlapping route of administration (oral), dose (1 tablet/ capsule), same dosage form (tablet/capsule) and frequency of administration (daily).</p>	<p>Orthographic differences in the names minimize the likelihood of medication error in the usual practice setting.</p> <p><i>Rationale:</i></p> <p>Although the two products have similar product characteristics, the orthographic differences especially in the ending letters minimize the likelihood of medication errors. The differences of the upstroke ‘t’ in Foltx and the downstroke ‘y’ in Jalyn in addition to different ending letters (‘x’ vs. ‘n’) differentiate the name pair and minimize the risk of confusion.</p> <p style="text-align: center;">F O L T X J A L Y N</p>
<p>Jenloga (Clonidine Hydrochloride) Extended-release tablet: 0.1 mg Dose: 0.1 mg (1 tablet) at bedtime; titrate up to 0.6 mg in 2 divided doses in 0.1 mg weekly interval</p>	<p>Both names begin with the letter ‘J’; both contain an upstroke (‘l’) and a downstroke (‘g’ vs. ‘y’).</p> <p>Both products are available in a single strength so the strength may be omitted on a prescription; Both have overlapping route of administration (oral), dose (1 tablet or capsule), and dosage form (tablet/capsule).</p>	<p>Orthographic differences in the names and product characteristic difference minimize the likelihood of medication error in the usual practice setting.</p> <p><i>Rationale:</i></p> <p>Although the two products have similar product characteristics, the orthographic differences minimize the risk of confusion. The difference in the length of the names (7 letters vs. 5 letters), different ending letters (‘a’ vs. ‘n’), additional ‘n’ and ‘o’ in Jenloga, the upstroke ‘l’ immediately followed by the downstroke ‘y’ in Jalyn versus ‘o’ between the upstroke and downstroke in Jenloga, and two letters ‘en’ between the two upstrokes (capital ‘J’ and upstroke ‘l’) in Jenloga versus only one letter ‘a’ in Jalyn provide differentiation between the name pair and minimize the risk of confusion.</p> <p style="text-align: center;">J A L Y N J E N L O G A</p> <p>In addition to orthographic differences, the difference in dose and frequency of</p>

		<p>administration minimize the risk of confusion. Although the initial treatment with Jenloga is 0.1 mg at bedtime, the dose is titrated up in increments of 0.1 mg per day at weekly intervals up to the maintenance dose of 0.6 mg given in two divided doses. Therefore, the specific dose would need to be specified on prescriptions for Jenloga (0.1 mg to 0.6 mg). Additionally, the frequency of administration differences minimize the risk further since Jenloga is given in divided doses (morning and bedtime) versus Jalyn which is given once daily 30 minutes after meal.</p> <p>Thus, the combination of orthographic and product differences minimize the risk of confusion between Jenloga and Jalyn.</p>
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Application Type/Number	Submission Type/Number	Submitter Name	Product Name
NDA-22460	ORIG-1	SMITHKLINE BEECHAM CORP DBA GLAXOSMITHKLIN E	DUTASTERIDE/ TAMSULOSIN HYDROCHLORIDE

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/s/

JUDY J PARK
06/11/2010

CARLOS M MENA-GRILLASCA
06/11/2010

CAROL A HOLQUIST
06/11/2010



**Department of Health and Human Services
Public Health Service
Food and Drug Administration
Center for Drug Evaluation and Research
Office of Surveillance and Epidemiology**

Date: September 8, 2009

To: Scott Monroe, MD, Director
Division of Reproductive and Urology Products

Through: Carlos M Mena-Grillasca, RPh, Team Leader
Carol Holquist, RPh, Director
Division of Medication Error Prevention and Analysis (DMEPA)

From: Walter Fava, R.Ph., Safety Evaluator
Division of Medication Error Prevention and Analysis (DMEPA)

Subject: Proprietary Name Review

Drug Name(s): Flodart (Dutasteride and Tamsulosin Hydrochloride) Capsules
0.5 mg/0.4 mg

Application Type/Number: NDA 22-460

Applicant/Applicant: GlaxoSmithKline

OSE RCM #: 2009-1406

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EXECUTIVE SUMMARY

Flodart is the proposed proprietary name for the combination of Dutasteride and Tamsulosin Hydrochloride. This proposed name was evaluated from a safety and promotional perspective based on the product characteristics provided by the Applicant. We sought input from pertinent disciplines involved with the review of this application and considered it accordingly. Our evaluation finds that the proposed name, Flodart, (b) (4)
. Thus, we object to the use of the proposed proprietary name, Flodart, for the product and have provided comments in section 5.1.1 *Comments to the Applicant*, explaining our analysis.

(b) (4)

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/s/

WALTER L FAVA
09/07/2009

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