
Guidance for Industry

Bioavailability and Bioequivalence Studies Submitted in NDAs or INDs — General Considerations

DRAFT GUIDANCE

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For questions regarding this draft document contact the CDER Office of Clinical Pharmacology at 301-796-5008 or OCP@fda.hhs.gov.

**U.S. Department of Health and Human Services
Food and Drug Administration
Center for Drug Evaluation and Research (CDER)**

**March 2014
Biopharmaceutics**

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Bioavailability and Bioequivalence Studies Submitted in NDAs or INDs— General Considerations

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Center for Drug Evaluation and Research
Food and Drug Administration
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<http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm>
Phone: 301-796-3400; Fax: 301-847-8714
druginfo@fda.hhs.gov*

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Guidance for Industry¹

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This draft guidance, when finalized, will represent the Food and Drug Administration's (FDA's) current thinking on this topic. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. You can use an alternative approach if the approach satisfies the requirements of the applicable statutes and regulations. If you want to discuss an alternative approach, contact the FDA staff responsible for implementing this guidance. If you cannot identify the appropriate FDA staff, call the appropriate number listed on the title page of this guidance.

I. INTRODUCTION

This guidance provides recommendations to sponsors and/or applicants planning to include bioavailability (BA) and bioequivalence (BE) information for drug products in investigational new drug applications (INDs), new drug applications (NDAs), and NDA supplements (referred to as the NDA BA and BE Draft Guidance).² This guidance contains advice on how to meet the BA and BE requirements set forth in 21 CFR part 320 as they apply to dosage forms intended for oral administration.³ The guidance may also be applicable to non-orally administered drug products when reliance on systemic exposure measures is suitable to document BA and BE (e.g., transdermal delivery systems and certain rectal and nasal drug products). The guidance should be helpful for applicants conducting BA and BE studies during the IND period for an NDA and also for applicants conducting BE studies during the postapproval period for certain changes to

¹ This guidance was developed by the Office of Clinical Pharmacology, Office of Translational Sciences, and the Office of New Drugs Quality Assessment, Office of Pharmaceutical Science, in the Center for Drug Evaluation and Research (CDER) at the U.S. Food and Drug Administration (FDA).

² BA and BE information for drug products in abbreviated new drug applications (ANDAs) and ANDA supplements are not the subject of this guidance. FDA has issued a separate draft guidance on this topic entitled *Bioequivalence Studies with Pharmacokinetic Endpoints for Drugs Submitted Under an ANDA* (December 2013) (ANDA BE Draft Guidance). The ANDA BE Draft Guidance, when finalized, will represent FDA's current thinking on this topic. Many guidances are referenced throughout this document. The guidance referred to in this footnote, as well as others referenced throughout the remainder of the document, can be found on the FDA Drugs guidance Web page at <http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm>. We update guidances periodically. To make sure you have the most recent version of a guidance, check the FDA Drugs guidance Web page.

³ These dosage forms include tablets, capsules, solutions, suspensions, conventional/immediate-release drug products, and modified (extended, delayed)-release drug products.

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28 drug products that are the subject of an NDA.⁴ This guidance document is not intended to
29 provide recommendations on studies conducted in support of demonstrating comparability or
30 biosimilarity for biological products licensed under section 351 of the Public Health Service
31 Act.⁵

32
33 When finalized, this guidance will revise and replace the parts of FDA's March 2003 guidance
34 for industry on *Bioavailability and Bioequivalence Studies for Orally Administered Drug*
35 *Products – General Considerations* (the March 2003 BA and BE Guidance) relating to BA and BE
36 studies for INDs, NDAs, and NDA supplements.⁶ Since the March 2003 BA and BE
37 Guidance was issued, FDA has determined that providing information on BA and BE studies in
38 separate guidances according to application type will be beneficial to sponsors and applicants.
39 Thus, FDA is issuing this NDA BA and BE Draft Guidance and, as previously noted, has issued
40 the ANDA BE Draft Guidance for ANDA and ANDA supplements.⁷

41
42 We recognize that this guidance cannot address every issue pertaining to the assessment of BA
43 or BE studies for INDs and NDAs, so we suggest sponsors and applicants contact the appropriate
44 review division for guidance on specific questions not addressed by this guidance.

45
46 FDA's guidance documents, including this guidance, do not establish legally enforceable
47 responsibilities. Instead, guidances describe the Agency's current thinking on a topic and should
48 be viewed only as recommendations, unless specific regulatory or statutory requirements are
49 cited. The use of the word *should* in Agency guidance documents means that something is
50 suggested or recommended, but not required.

51
52 **II. BACKGROUND**

53

⁴ *Bioequivalence* is a statutory term reflected in the Federal Food, Drug, and Cosmetic Act (FD&C Act) in section 505(j) (21 U.S.C. 355(j)), which requires ANDA applicants to demonstrate, among other things, that the proposed generic product is bioequivalent to its reference listed drug. Section 505(j)(2)(A)(iv) of the FD&C Act; see also section 505(j)(8) of the FD&C Act. There is no similar statutory requirement for an NDA applicant either under section 505(b)(1) or (b)(2) of the FD&C Act to demonstrate bioequivalence of its proposed product to another product. As a scientific matter, however, the same or a similar showing of the bioavailability of two products in the NDA context may be needed for the purposes of evaluating the safety or effectiveness of a product. For ease of the reader, we refer to such evaluations of the relative bioavailability for two or more products as an evaluation of bioequivalence in this guidance.

⁵ For information on these types of studies, see FDA's Drugs guidance Web page. See footnote #2 for information on accessing this Web page.

⁶ Revisions to the March 2003 BA and BE Guidance include (1) expansion of the section on modified-release products, (2) addition of a section on concomitant administration of drug products and combination drug products, (3) addition of a section on alcoholic beverage effects on modified-release dosage forms, (4) addition of an endogenous substance section, (5) addition of a section on drug products with high intrasubject variability, and (6) removal of references to BE studies conducted for ANDAs. The guidance also makes other revisions for clarification.

⁷ See footnote #2.

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54 BA assessment of formulations is a component of new drug development. The approaches of
55 evaluating BA and BE discussed in this guidance are designed to aid FDA evaluation of the
56 safety and effectiveness of a product that is the subject of an IND, NDA, or NDA supplement.
57 In this endeavor, we use the totality of information available in the submission, which includes,
58 among other things, information gathered using the principles of BE, exposure-response
59 evaluations, and clinical trial results. The evaluation of BE in the generic drug context, by
60 contrast, is used to support a determination that a generic product may be substituted for its
61 reference listed drug, and involves consideration of different types of data permitted in an
62 ANDA. Accordingly, the approaches discussed in this guidance may differ from similar
63 discussions of BE in the ANDA BE Draft Guidance. For example, this NDA BA and BE Draft
64 Guidance recommends assessment of the effect of food on BA using the approaches set forth in
65 FDA's 2002 guidance for industry on *Food-Effect Bioavailability and Fed Bioequivalence*
66 *Studies* (the 2002 Food-Effect Guidance). Fasting BE studies generally are sufficient, given the
67 totality of information we consider in evaluating INDs, NDAs, or NDA supplements. In
68 contrast, we recommend in the ANDA BE Draft Guidance fed and fasting BE studies that will
69 provide specific information to support a demonstration of BE under section 505(j) of the FD&C
70 Act, and in turn, to support substitutability. Even though the ANDA BE Draft Guidance revises
71 and replaces the parts of the 2002 Food-Effect Guidance pertaining to NDAs and ANDA
72 supplements, this NDA BA and BE Draft Guidance does not replace the 2002 Food-Effect
73 Guidance relating to studies for INDs, NDAs, and NDA supplements.⁸

74

75 **A. General**

76

77 Studies to measure BA and/or establish BE of a product are important elements in support of
78 INDs, NDAs, and NDA supplements. *Bioavailability* means the rate and extent to which the
79 active ingredient or active moiety is absorbed from a drug product and becomes available at the
80 site of action (21 CFR 320.1(a)). BA data provide an estimate of the fraction of the drug
81 absorbed, as well as provide information related to the pharmacokinetics of the drug.

82

83 *Bioequivalence* means the absence of a significant difference in the rate and extent to which the
84 active ingredient or active moiety in pharmaceutical equivalents or pharmaceutical alternatives
85 become available at the site of drug action when administered at the same molar dose under
86 similar conditions in an appropriately designed study (21 CFR 320.1(e)). Studies to establish
87 BE between two products are important for certain formulation or manufacturing changes
88 occurring during the drug development and postapproval stages. In BE studies, the exposure
89 profile of a test drug product is compared to that of a reference drug product.

90

91 **B. Bioavailability**

92

93 BA for a given formulation provides an estimate of the relative fraction of the orally
94 administered dose that is absorbed into the systemic circulation. BA for orally administered drug
95 products can be documented by comparing a systemic exposure profile to that of a suitable
96 reference product. A profile can be generated by measuring the concentration of active

⁸ Accordingly, we are in the process of revising the 2002 Food-Effect Guidance.

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97 ingredients and/or active moieties over time and, when appropriate, active metabolites over time
98 in samples collected from the systemic circulation. Systemic exposure profiles reflect both
99 release of the drug substance from the drug product and a series of possible presystemic/systemic
100 actions on the drug substance after its release from the drug product.

101
102 FDA's regulations at 21 CFR 320.25 set forth guidelines for in vivo BA studies. As provided in
103 this regulation, the reference product for BA studies should be a solution, suspension, or
104 intravenous (IV) dosage form (21 CFR 320.25(d)(2) and (3)). The purpose of conducting a BA
105 study with an oral solution as a reference is to assess the impact of formulation on BA.
106 Conducting a BA study with an IV reference enables assessment of the impact of route of
107 administration on BA and defines the absolute BA of the drug released from the drug product.
108
109

110 **C. Bioequivalence**

111
112 As noted previously, both BA and BE focus on the release of a drug substance from a drug
113 product and subsequent absorption into systemic circulation. As a result, we recommend that
114 approaches to determining BE generally follow approaches similar to those used for BA.
115 Demonstrating BE involves a more formal comparative test that uses specific references with
116 specified criteria for comparisons and predetermined BE limits for such criteria.

117
118 *1. Preapproval Changes*

119
120 BE documentation can be useful during the IND period to compare (1) early and late
121 clinical trial formulations; (2) formulations used in clinical trials and stability studies, if
122 different; (3) clinical trial formulations and to-be-marketed drug products, if different;
123 and (4) product strength equivalence, as appropriate. In each comparison, the new
124 formulation, formulation produced by the new method of manufacture, or new strength is
125 the candidate, or test product and the prior formulation, prior method of manufacture, or
126 prior strength is the reference product. The decision to document BE during drug
127 development is generally left to the judgment of the sponsor, using the principles of
128 relevant guidances (in this guidance, see sections II.C.2, Postapproval Changes, and
129 III.D, In Vitro Studies) to determine when changes in components, composition, and/or
130 method of manufacture suggest that further in vitro and/or in vivo studies be performed.

131
132 *2. Postapproval Changes*

133
134 In the presence of certain major changes in components, composition, manufacturing site,
135 and/or method of manufacture after approval, FDA recommends that in vivo BE be
136 demonstrated for the drug product after the change in comparison to the drug product
137 before the change. Under section 506A(c)(2) of the Federal Food, Drug, and Cosmetic
138 Act (FD&C Act) (21 U.S.C. 356a(c)(2)), certain postapproval changes that require
139 completion of studies must be submitted in a supplement and approved by FDA before
140 distributing a drug product made with the change.

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142 Information on the types of recommended in vitro dissolution and in vivo BE studies for
143 immediate-release and modified-release drug products approved as NDAs for specified
144 postapproval changes is provided in the following FDA guidances:
145

- 146 • *SUPAC-IR: Immediate Release Solid Oral Dosage Forms: Scale-Up and*
147 *Postapproval Changes: Chemistry, Manufacturing, and Control; In Vitro*
148 *Dissolution Testing, and In Vivo Bioequivalence Documentation*
- 149 • *SUPAC-MR: Modified Release Solid Oral Dosage Forms: Scale-Up and*
150 *Postapproval Changes: Chemistry, Manufacturing, and Controls, In Vitro*
151 *Dissolution Testing, and In Vivo Bioequivalence Documentation*

152
153 3. *BE Considerations*
154

155 BE studies are usually conducted using a crossover design. For such studies, intrasubject
156 variability should be considered when determining the study sample size. In cases when
157 a parallel design is necessary to evaluate BE, consideration should be given to total
158 variability, including intersubject variability instead of just intrasubject variability.
159

160 A test product might fail to demonstrate bioequivalence because it has measures of rate
161 and/or extent of absorption compared to the reference product outside acceptable higher
162 or lower limits. For example, when the test product results in a systemic exposure that is
163 significantly higher than that of the reference product, the concern is the typically limited
164 experience from a safety standpoint for higher systemic concentrations. When the test
165 product has a systemic exposure that is significantly lower than that of the reference
166 product, the concern is potentially a lack of therapeutic efficacy of the test product.
167 When the variability of the test product is greater than the reference product, the concern
168 relates to both safety and efficacy, because it may suggest that the performance of the test
169 product is not comparable to the reference product, and the test product may be too
170 variable to be clinically useful.
171

172 When BE is not demonstrated, the sponsor should demonstrate that the differences in rate
173 and extent of absorption do not significantly affect the safety and efficacy based on
174 available dose-response or concentration-response data. In the absence of this evidence,
175 failure to demonstrate BE may suggest that the test product should be reformulated, or
176 the method of manufacture for the test product should be changed, or additional safety or
177 efficacy data may be needed for the test product. In some cases, conclusions of BE based
178 on the peak drug concentration (C_{max}) and area under the plasma concentration time curve
179 (AUC) between the test product and the reference product may be insufficient to
180 demonstrate that there is no difference in safety or efficacy if the systemic concentration-
181 time profiles of the test product and the reference product are different (e.g., time to reach
182 peak drug concentration (T_{max}) is different). For example, differences in the shape of the
183 systemic concentration profile between the test and reference products could imply that
184 the test product may not produce the same clinical response as the reference product. In
185 such cases, additional data analysis (e.g., partial AUCs), exposure-response evaluation, or
186 clinical studies may be recommended to evaluate the BE of the two products.

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187

188 III. METHODS TO DOCUMENT BA AND BE

189

190 Under FDA's regulations, applicants must use the most accurate, sensitive, and reproducible
191 method available to demonstrate BA or BE of a product (21 CFR 320.24(a)). As noted in 21
192 CFR 320.24, several in vivo and in vitro methods can be used to measure BA and to establish
193 BE. These include, in general order of preference, pharmacokinetic (PK) studies, in vitro tests
194 predictive of human in vivo BA (in vitro-in vivo correlation), pharmacodynamic (PD) studies,
195 studies with clinical benefit endpoints, and other in vitro studies. In addition, where in vivo data
196 are appropriate to demonstrate BA, our regulations provide guidelines on specific types of in
197 vivo BA studies (see 21 CFR 320.25 through 320.29). This guidance predominantly focuses on
198 the use of PK studies to document BA or BE.

199

200 A. Pharmacokinetic Studies

201

202 1. General Considerations

203

204 FDA's regulations generally define BA and BE in terms of rate and extent of absorption
205 of the active ingredient or moiety to the site of action.⁹ For in vivo studies, the
206 regulations also provide for use of PK measures in an accessible biological matrix such as
207 blood, plasma, and/or serum to indicate release of the drug substance from the drug
208 product into the systemic circulation.¹⁰ BA and BE frequently rely on PK measures such
209 as AUC to assess extent of systemic exposure and C_{max} and T_{max} to assess rate of systemic
210 absorption. PK-based comparisons to describe relative BA or make BE determinations
211 are predicated on an understanding that measuring the active moiety or ingredient at the
212 site of action is generally not possible and on an assumption that some relationship exists
213 between the efficacy/safety and concentration of the active moiety and/or its important
214 metabolite(s) in the systemic circulation. A typical study is conducted as a crossover
215 study. The crossover design reduces variability caused by patient-specific factors, thereby
216 increasing the ability to discern differences because of formulation.

217

218 2. Pilot Study

219

220 If the sponsor chooses, a pilot study in a small number of subjects can be carried out
221 before proceeding with a full-scale BA or BE study. The pilot study can be used to
222 validate analytical methodology, assess PK variability, determine sample size to achieve
223 adequate power, optimize sample collection time intervals, and determine the length of
224 the washout period needed between treatments. For example, for conventional
225 immediate-release products, careful timing of initial samples may avoid a subsequent
226 finding in a full-scale study that the first sample collection occurs after the C_{max}. For
227 modified-release products, a pilot study can help determine the sampling schedule needed

⁹ 21 CFR 320.1(a) and (e).

¹⁰ See, e.g., 21 CFR 320.24(b)(1)(i). If serial measurements of the drug or its metabolites in plasma, serum, or blood cannot be accomplished, then measurement of urinary excretion can be used.

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228 to assess lag time and dose dumping. The results of a pilot study can be used as the sole
229 basis to document BA or BE provided the study's design and execution are suitable and a
230 sufficient number of subjects have completed the study.

231
232 3. *Full-Scale Study*

233
234 General recommendations for a standard BA or BE study based on PK measurements are
235 provided in Appendix A. Nonreplicate crossover study designs are recommended for BA
236 and BE studies of immediate-release and modified-release dosage forms. However,
237 sponsors and/or applicants have the option of using replicate designs for BE studies.
238 Replicate crossover designs are used to allow estimation of (1) within-subject variance
239 for the reference product, or for both the test and reference products, and (2) the subject
240 by formulation interaction variance component. This design accounts for the inter-
241 occasion variability that may confound the interpretation of a BE study as compared to a
242 non-replicate crossover approach. The recommended method of analysis for nonreplicate
243 or replicate studies to evaluate BE is average BE, as discussed in section IV.

244 Recommendations for conducting and evaluating replicate study designs can be found in
245 the FDA guidance for industry *Statistical Approaches to Establishing Bioequivalence*.

246
247 4. *Study Population*

248
249 Subjects recruited for BA or BE studies should be 18 years of age or older and capable of
250 giving informed consent. In general, BA and BE studies should be conducted in healthy
251 volunteers if the product can be safely administered to this population. A study in healthy
252 volunteers is likely to produce less PK variability compared with that in patients with
253 potentially confounding factors such as underlying and/or concomitant disease and
254 concomitant medications. Male and female subjects should be enrolled in BA and BE
255 studies unless there is a specific reason to exclude one sex. Such exclusions could be
256 related to the drug product being indicated in only one sex or a greater potential for
257 adverse reactions in one sex compared to the other. For example, oral contraceptives are
258 evaluated in female subjects because the indication is specific to females. If a drug has
259 the potential to be a teratogen, the drug product should be evaluated in male subjects.
260 Female subjects enrolled in the study should not be pregnant at the beginning of the study
261 and should not become pregnant during the study. In some instances (e.g., when safety
262 considerations preclude use of healthy subjects), it may be necessary to evaluate BA and
263 BE in patients for whom the drug product is intended. In this situation, sponsors and/or
264 applicants should attempt to enroll patients whose disease process is expected to be stable
265 for the duration of the study.

266
267 5. *Single-Dose and Multiple-Dose (Steady State) Testing*

268
269 This guidance generally recommends single-dose PK studies to assess BA and BE
270 because they are generally more sensitive than steady-state studies in assessing rate and
271 extent of release of the drug substance from the drug product into the systemic
272 circulation.

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273

274 FDA's regulations at 21 CFR 320.27 provide guidelines on the design of a multiple-dose
275 in vivo BA study. This regulation also identifies instances in which multiple-dose BA
276 studies may be required:

277

- 278 i. There is a difference in the rate of absorption but not in the extent of absorption.
- 279 ii. There is excessive variability in bioavailability from subject to subject.
- 280 iii. The concentration of the active drug ingredient or therapeutic moiety, or its
281 metabolite(s), in the blood resulting from a single dose is too low for accurate
282 determination by the analytical method.
- 283 iv. The drug product is an extended-release dosage form.¹¹

284

285 We recommend that if a multiple-dose study design is performed, appropriate dosage
286 administration and sampling be carried out to document attainment of steady state.

287

288 6. *Bioanalytical Methodology*

289

290 We recommend that sponsors ensure that bioanalytical methods for BA and BE studies
291 be accurate, precise, specific, sensitive, and reproducible. A separate FDA guidance,
292 *Bioanalytical Method Validation*, is available to assist sponsors in validating
293 bioanalytical methods.¹²

294

295 7. *Administration Under Fasted/Fed Conditions*

296

297 The BA or BE study should be conducted under fasting conditions (after an overnight fast
298 of at least 10 hours) except when tolerability issues are anticipated with fasting. In these
299 cases, we recommend that applicants conduct only a fed study. A separate FDA
300 guidance, *Food-Effect Bioavailability and Fed Bioequivalence Studies* is available to
301 assist sponsors.

302

303 8. *Moieties to Be Measured*

304

305 The active ingredient that is released from the dosage form or its active moiety and, when
306 appropriate, its active metabolites¹³ should be measured in biological fluids collected in
307 BA studies.

308

309 Measurement of the active ingredient or the active moiety, rather than metabolites, is
310 generally recommended for BE studies because the concentration-time profile of the
311 active ingredient or the active moiety is more sensitive to changes in formulation
312 performance than that of the metabolite, which is more reflective of metabolite formation,
313 distribution, and elimination. The following are instances when an active metabolite(s)
314 should be measured.

¹¹ 21 CFR 320.27(a)(3).

¹² See also 21 CFR 320.29.

¹³ See 21 CFR 320.24(b)(1)(i).

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- 315 • Measurement of a metabolite(s) is necessary when the active ingredient or the active
316 moiety concentrations are too low to allow reliable analytical measurement in blood,
317 plasma, or serum. In this case, the metabolite should be measured in lieu of the active
318 ingredient or active moiety. We recommend that the confidence interval approach be
319 applied to the metabolite data obtained from these studies.
320
- 322 • Measurement of a metabolite(s) is necessary in addition to the active ingredient or
323 active moiety if the metabolite is formed by presystemic metabolism and contributes
324 meaningfully to efficacy and/or safety. The confidence interval approach should be
325 used for all moieties measured. However, the BE criteria are only generally applied
326 to the active ingredient or active moiety. Sponsors should contact the appropriate
327 review division to determine which moieties should be measured.
328

329 9. *Pharmacokinetic Measures of Systemic Exposure*
330

331 This guidance recommends that systemic exposure measures be used to evaluate BA and
332 BE. Exposure measures are defined relative to peak, partial, and total portions of the
333 plasma, serum, or blood concentration-time profile, as described here:
334

335 • Peak Exposure
336

337 We recommend that peak exposure be assessed by measuring the C_{max} obtained directly
338 from the systemic drug concentration data without interpolation. The T_{max} can provide
339 important information about the rate of absorption. The first point of a concentration-
340 time curve based on blood and/or plasma measurements is sometimes the highest
341 concentration, which raises a question about the measurement of true C_{max} because of
342 insufficient early sampling times. A carefully conducted pilot study may help to avoid
343 this problem. Collection of an early time point between 5 and 15 minutes after dosing
344 followed by additional sample collections (e.g., two to five) in the first hour after dosing
345 may be sufficient to assess early peak concentrations. If this sampling approach is
346 followed, we consider the data to be adequate, even when the highest observed
347 concentration occurs at the first time point.
348

349 • Total Exposure (Extent of Absorption)
350

351 For single-dose studies, we recommend that the measurement of total exposure be:
352

- 353 – Area under the plasma, serum, or blood concentration time curve from time zero
354 to time t (AUC_{0-t}), where t is the last time point with a measurable concentration.
355
- 356 – Area under the plasma, serum, or blood concentration time curve from time zero
357 to time infinity ($AUC_{0-\infty}$), where $AUC_{0-\infty} = AUC_{0-t} + C_t/\lambda_z$. C_t is the last
358 measurable drug concentration and λ_z is the terminal or elimination rate constant
359 calculated according to an appropriate method.

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- 360
361 – For drugs with a long half-life, truncated AUC can be used (see section VII.D,
362 Long-Half-Life Drugs).

363
364 For steady-state studies, we recommend that the measurement of total exposure be the
365 area under the plasma, serum, or blood concentration time curve from time zero to time
366 tau over a dosing interval at steady state ($AUC_{0-\tau}$), where tau is the length of the dosing
367 interval.

- 368
369 • Partial Exposure

370
371 For orally administered drug products, BA and BE can generally be demonstrated by
372 measurements of peak and total exposure. For certain classes of drugs and under certain
373 circumstances (e.g., to assess onset of an analgesic effect), an evaluation of the partial
374 exposure could be used to support the performance of different formulations by providing
375 further evidence of therapeutic effect. This guidance recommends the use of partial AUC
376 as a partial exposure measure. The time to truncate the partial area should be related to a
377 clinically relevant PD measure. We also recommend that sufficient quantifiable samples
378 be collected to allow adequate estimation of the partial area. For questions on the
379 suitability of the PD measure or use of partial exposure in general, we recommend that
380 sponsors and/or applicants consult the appropriate review division.

381
382 10. *Comparison of PK measures in BE studies*

383
384 An equivalence approach is recommended for BE comparisons. The recommended
385 approach relies on (1) a criterion to allow the comparison, (2) a confidence interval for
386 the criterion, and (3) a BE limit. Log-transformation of exposure measures before
387 statistical analysis is recommended. This guidance recommends use of an average BE
388 criterion to compare systemic exposure measures for replicate and nonreplicate BE
389 studies of both immediate- and modified-release products. For additional information on
390 data analysis, refer to Appendix A and to the FDA guidance for industry on *Statistical
391 Approaches to Establishing Bioequivalence*.

392
393 B. **Other Approaches to Support BA/BE**

394
395 In certain circumstances, other approaches are recommended to support a demonstration of
396 BA/BE. Below are some general considerations regarding these other approaches. Sponsors
397 should consult FDA's guidances for industry for additional information on these methods as
398 well.¹⁴

399
400 1. *In Vitro Tests Predictive of Human In Vivo BA*

401 1.

¹⁴ See footnote 2.

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In vitro-in vivo correlation (IVIVC) is an approach to describe the relationship between an in vitro attribute of a dosage form (e.g., the rate or extent of drug release) and a relevant in vivo response (e.g., plasma drug concentration or amount of drug absorbed). This model relationship facilitates the rational development and evaluation of extended-release dosage forms. Once an IVIVC is validated, the in vitro test serves as a surrogate for BA and/or BE testing, as well as a tool for formulation screening and setting of the dissolution/drug-release acceptance criteria.

Specifically, in vitro dissolution/drug-release characterization is encouraged for all extended-release product formulations investigated (including prototype formulations), particularly if in vivo absorption characteristics are being defined for the different product formulations. Such efforts may enable the establishment of an IVIVC. When an IVIVC or association is established (21 CFR 320.24(b)(1)(ii)), the in vitro test can serve not only as a quality control specification for the manufacturing process, but also as an indicator of how the product will perform in vivo.

Additional information on the development and validation of an IVIVC can be found in the FDA guidance for industry *Extended Release Oral Dosage Forms: Development, Evaluation, and Application of In Vitro/In Vivo Correlations*.

2. *Pharmacodynamic Studies*

PD studies are not recommended for orally administered drug products when the drug is absorbed into systemic circulation and a PK approach can be used to assess systemic exposure and evaluate BA or BE. PK endpoints are preferred because they are generally the most accurate, sensitive, and reproducible approach. However, in instances where a PK endpoint is not possible, a well-justified PD endpoint can be used to demonstrate BA or BE.

3. *Comparative Clinical Studies*

Clinical endpoints can be used in limited circumstances, for example, for orally administered drug products when the measurement of the active ingredients or active moieties in an accessible biological fluid (PK approach) or PD approach is not possible. Because these circumstances do not occur very often, use of this approach is expected to be rare.

4. *In Vitro Studies*

Under certain circumstances, BA and BE can be evaluated using in vitro approaches (e.g., dissolution/drug-release testing) during the preapproval and postapproval phases (see 21 CFR 320.24(b)(5) and (6)). For example, orally administered drugs that are highly soluble and highly permeable, and for which

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447 the drug product is rapidly dissolving, documentation of BE using an in vitro
448 approach (dissolution/drug-release studies) may be appropriate based on the
449 Biopharmaceutics Classification System.¹⁵

450
451 The following FDA guidances provide recommendations on the development of
452 dissolution methodology, setting specifications, and the regulatory applications of
453 dissolution testing:

- 454
- 455 • *Dissolution Testing of Immediate-Release Solid Oral Dosage Forms*
 - 456
 - 457 • *Extended-Release Oral Dosage Forms: Development, Evaluation, and*
458 *Application of In Vitro/In Vivo Correlations*

459
460 In addition, we recommend that sponsors consult other FDA guidances for
461 additional information on when in vitro data may be appropriate to demonstrate
462 BA or BE of a product.

463

IV. DOCUMENTING BA AND BE FOR VARIOUS DOSAGE FORMS

464 This section summarizes the recommendations for documenting BA and BE studies based on the
465 specific dosage forms and whether these evaluations occur preapproval or postapproval.

466

A. Solutions and Other Solubilized Dosage Forms

467 For oral solutions, elixirs, syrups, tinctures, or other solubilized forms, in vivo BA and/or BE are
468 generally self-evident and a requirement of in vivo data for a product may be waived (21 CFR
469 320.22(b)(3)). In such instances, the applicant would be deemed to have complied with and
470 fulfilled any requirement for in vivo data.¹⁶ Although a comparative study is not necessary,
471 characterization of the pharmacokinetics of the drug is required (21 CFR 314.50(d)(3)). In
472 addition, in vivo BE studies that compare different solution formulations are waived based on the
473 assumptions that release of drug substance from the drug product is self-evident and that the
474 solutions do not contain any excipients that significantly affect drug absorption. However, there
475 are certain excipients that may alter the BA (e.g., sorbitol may reduce the BA of drugs, and
476 vitamin E may enhance the BA) in amounts sometimes used in oral liquid dosage forms. In this
477 case, evaluation of in vivo BA and/or BE may be required.

478

B. Immediate-Release Products

479 Included in this discussion are capsules, tablets (including conventional, buccal, chewable, orally
480 disintegrating, and sublingual dosage forms), and suspensions.

¹⁵ See the FDA guidance for industry on *Waiver of In Vivo Bioavailability and Bioequivalence Studies for Immediate-Release Solid Oral Dosage Forms Based on a Biopharmaceutics Classification System*. This document provides complementary information on the Biopharmaceutics Classification System (BCS).

¹⁶ See 21 CFR 320.22(b)(3).

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487

488 1. *Preapproval Changes*

489

490 For BA and BE studies, we recommend a single-dose, fasting study be performed. Under
491 certain circumstances, multiple-dose BA studies (see section III.A.5) and/or food effect
492 studies may be necessary (See the FDA guidance for industry *Food-Effect Bioavailability*
493 and *Fed Bioequivalence*). Unconventional dosage forms (buccal, chewable, orally
494 disintegrating, and sublingual dosage forms) should be administered according to
495 intended label use/instructions. In addition, a BA study may be needed with the
496 unconventional dosage form swallowed intact to assess the impact of accidental
497 swallowing of the intact product. Sampling should adequately capture the T_{max} and C_{max}
498 in addition to total exposure.

499

500 We recommend that in vitro dissolution be evaluated for all orally administered products.
501 In vitro dissolution test conditions could be the same or different for unconventional
502 compared to conventional dosage forms. If differences in dissolution data exist, they
503 should be discussed with the appropriate review division.

504

505 2. *Postapproval Changes*

506

507 Information on the types of in vitro dissolution and in vivo BE studies needed for
508 approved immediate-release drug products when postapproval changes are made is
509 provided in an FDA guidance for industry entitled *SUPAC-IR: Immediate Release Solid*
510 *Oral Dosage Forms Scale-Up and Postapproval Changes: Chemistry, Manufacturing,*
511 *and Controls, In Vitro Dissolution Testing, and In Vivo Bioequivalence Documentation*.
512 We recommend that for postapproval changes, the in vitro or in vivo comparison be made
513 between the post-change and pre-change products.

514

515 C. **Modified-Release Products**

516

517 Modified-release (MR) products include extended-release (controlled-release, sustained-
518 release)¹⁷ and delayed-release products.

519

520 Extended-release (ER) products are dosage forms that are designed to extend or prolong the
521 release of active ingredient or active moiety from the drug product and may allow a reduction in
522 dosing frequency as compared to when the drug is administered in an immediate-release (IR)
523 dosage form. These drug products can be developed to reduce fluctuations in plasma
524 concentrations when compared to an IR product. ER products can be capsules, tablets, granules,
525 pellets, or suspensions.

526

527 Delayed-release (DR) drug products are dosage forms that release active ingredient or active
528 moiety at a time later than immediately after administration (i.e., these drug products exhibit a
529 lag time in quantifiable plasma concentrations). Typically, coatings (e.g., enteric coatings) are

¹⁷ For the purpose of this guidance, the terms *extended*, *controlled*, and *sustained* are used interchangeably.

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530 used to delay the release of the drug substance until the dosage form has passed through the
531 acidic medium of the stomach. Generally, DR products are treated as IR products. However, if
532 the DR product has complex release characteristics, the relevant review division should be
533 contacted for additional guidance.

534
535 If the drug product is an ER product, the following recommendations apply.
536

537 1. *Preapproval: BA and BE Studies*

539 FDA's regulations at 21 CFR 320.25(f) address the purpose of a BA study for an
540 extended-release product, which is to determine if certain delineated conditions are met.¹⁸
541 This regulation also provides that "the reference material(s) for such a bioavailability
542 study shall be chosen to permit an appropriate scientific evaluation of the extended
543 release claims made for the drug product."¹⁹ Appropriate reference products may include
544 (1) a solution or suspension of the active drug ingredient or therapeutic moiety, (2) a
545 currently marketed non-controlled-release drug product containing the same active drug
546 ingredient or therapeutic moiety and administered according to the dosage
547 recommendations in the labeling of the non-controlled release drug product, and (3) a
548 currently marketed ER drug product subject to an approved full NDA containing the
549 same active drug ingredient or therapeutic moiety and administered according to the
550 dosage recommendations in the labeling of currently marketed ER product.²⁰

551
552 In general, the PK profile of the ER product may not match that of the approved IR
553 product (e.g., T_{max} is different) or, in some cases, to another ER product. In such a case,
554 establishing similar PK profiles using C_{max} and AUC may not be sufficient to show that
555 the ER product is bioequivalent to the IR product. Thus, additional safety or efficacy
556 studies or PK/PD assessments may be recommended. This guidance recommends that the
557 following BA studies and food effect BA studies be conducted for an ER drug product
558 submitted as an NDA for the scenarios described below:

559
560 New ER formulation comparison to an already-approved IR product

- 561
562 • For drugs with linear pharmacokinetics over the therapeutic dose range: A fasting
563 study should be conducted comparing the ER product administered as a single
564 dose at the highest strength to the IR reference administered over the least
565 common time interval to achieve equivalent total dose as for the ER product.²¹ If

¹⁸ 21 CFR 320.25(f)(1).

¹⁹ 21 CFR 320.25(f)(2).

²⁰ 21 CFR 320.25(f)(2)(i), (ii), and (iv). We recommend that a sponsor seeking to use as a reference product "a currently marketed extended release drug product subject to an approved full new drug application containing the same active drug ingredient or therapeutic moiety and administered according to the dosage recommendations in the labeling proposed for the extended release drug product," under 21 CFR 320.25(f)(2)(iii), consult with the Agency before commencing such a study.

²¹ For example, when a 150-milligram (mg) ER product administered once daily (QD) is being developed that gives an approved 50-mg IR reference product administered three times a day (TID) or a 75-mg product administered two times a day (BID), a comparison of the 150-mg ER product administered as a single dose could be compared to

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566 for safety reasons the highest strength cannot be used, a lower strength may be
567 acceptable.
568

- 569 • For drugs with nonlinear pharmacokinetics over the therapeutic dose range: At a
570 minimum, a single dose of the highest and lowest strengths of the ER product
571 should be compared to their corresponding IR references administered over the
572 ER dosing interval. If the relative BA of intermediate ER strengths cannot be
573 inferred based on the above studies, a single-dose fasting study for the
574 intermediate strength(s) of the ER product should be compared to the
575 corresponding IR reference administered over the ER dosing interval.
576
- 577 • When the ER strengths are not proportionally similar in composition, a single-
578 dose fasting dosage strength equivalence assessment study²² or a dosage strength
579 proportionality study²³ for the ER product should be conducted.
580
- 581 • A single-dose food-effect study should be conducted on the highest ER strength
582 (see the 2002 Food-Effect Guidance).
583
- 584 • A steady state study should be conducted on the highest strength of the ER
585 product compared to an approved IR reference dosed to achieve equivalent total
586 dose as for the ER product.
587

588 New ER product (ER_{new}) comparison to an approved ER product (ER_{old}) with a different
589 dosing interval (i.e., where ER_{new} and ER_{old} have unequal dosing intervals)
590

- 591 • The recommendations are the same as outlined in the previous section
592 (Development of a new ER formulation given an already approved IR product)
593 except for the choice of the reference product. In this case, the reference product
594 could be either the approved ER_{old} or IR product.
595

596 New ER product (ER_{new}) comparison to an approved ER product (ER_{old}) with the same
597 dosing interval
598

- 599 • A single-dose fasting BE study on the highest strength of the ER_{new} product
600 compared to the ER_{old} product. If ER_{new} and ER_{old} are of different strength, then

either the 50-mg IR reference product administered TID or 75-mg IR reference product administered BID. In this case, the least common time interval is 24 hours.

²² If three strengths, 10, 25, and 50 mg, are being developed for a new ER dosage form, the dosage strength equivalence study should be conducted using 5×10 mg, 2×25 mg, and 1×50 mg to achieve constancy of dose.

²³ If three strengths, 10, 25, and 50 mg, are being developed for a new ER dosage form, the dosage strength proportionality study should be conducted using 1×10 mg, 1×25 mg, and 1×50 mg to achieve constancy of dose and the dosage strength proportionality study should be conducted using 1×10 mg, 1×25 mg, and 1×50 mg.

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601 comparison of ER_{new} versus ER_{old} should be made based on dose using the highest
602 strengths.

- 603
- 604 • A single-dose, food-effect study should be conducted on the highest ER_{new}
605 strength.

606

 - 607 • When the ER_{new} strengths are not proportionally similar in composition, a single-
608 dose fasting dosage strength equivalence assessment study or a dosage strength
609 proportionality study²⁴ for the ER_{new} product should be conducted.

610

 - 611 • In some cases, BE between the new and old ER products may not be sufficient to
612 ensure that there is no difference in safety or efficacy if the PK profiles of the two
613 ER products do not match (e.g., T_{max} is different). Additional data analysis or
614 clinical studies may be needed to ensure that the two products are clinically
615 equivalent.

616

617 2. *Postapproval Changes*

618

619 Information on the types of in vitro dissolution and in vivo BE studies for ER drug
620 products approved in the presence of specific postapproval changes are provided in an
621 FDA guidance for industry *SUPAC-MR: Modified Release Solid Oral Dosage Forms:*
622 *Scale-Up and Postapproval Changes: Chemistry, Manufacturing, and Controls; In Vitro*
623 *Dissolution Testing, and In Vivo Bioequivalence Documentation*. We recommend that
624 for postapproval changes, the in vitro or in vivo comparison be made between the post-
625 change and pre-change products.

626

627 D. **Batch Size**

628

629 For pivotal BE studies, the test batch should be representative of the production batches.
630 Therefore, the size of the test batch should be at least 10% of the planned production batch size,
631 or a minimum of 100,000 units, whichever is larger.

632

633 V. **ADDITIONAL INFORMATION ON IN VITRO APPROACHES**

634

635 A. **In Vitro Studies Conducted in Support of a Waiver of an In Vivo BA or BE
636 Data Requirement**

637

638 As discussed above, FDA's regulations contemplate that if in vivo BA or BE data are required
639 for a product, a sponsor may seek a waiver of that requirement under certain circumstances.²⁵

²⁴ 21 CFR 320.21(b) (giving applicants the option of submitting information that "would permit FDA to waive the submission of evidence demonstrating in vivo bioequivalence") and 320.21(f) (requiring that the information submitted in support of a waiver request "shall meet the criteria set forth in § 320.22").

²⁵ 21 CFR 320.21(b) (giving applicants the option of submitting information that "would permit FDA to waive the submission of evidence demonstrating in vivo bioequivalence") & 320.21(f) (requiring that the information submitted in support of a waiver request "shall meet the criteria set forth in § 320.22.")

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640 For example, in some instances, in vivo BA or BE is self-evident based on certain characteristics
641 of the drug product (21 CFR 320.22(b)), and therefore, any in vivo data requirement has been
642 deemed to have been met. In other delineated circumstances, an in vivo BA or BE data
643 requirement may be waived, and in vitro data may be accepted in lieu of in vivo data (21 CFR
644 320.22(d)). For example, an in vivo data requirement may be waived for different strengths of
645 an immediate-release drug product under 21 CFR 320.22(d)(2) when (1) the drug product is in
646 the same dosage form, but in a different strength; (2) this different strength is proportionally
647 similar in its active and inactive ingredients to another drug product for which the same
648 manufacturer has obtained approval; and (3) the new strength meets an appropriate in vitro test
649 as outlined in the regulation.²⁶ In addition, for waiving higher strengths, linearity of the
650 pharmacokinetics over the therapeutic dose range should be demonstrated.

651
652 This guidance defines *proportionally similar* in the following ways:
653

- 654 • All active and inactive ingredients are in exactly the same proportion between different
655 strengths (e.g., a tablet of 50-mg strength has all the inactive ingredients, exactly half that
656 of a tablet of 100-mg strength, and twice that of a tablet of 25-mg strength).
- 657 • For high-potency drug substances (where the amount of active drug substance in the
658 dosage form is relatively low), (1) the total weight of the dosage form remains nearly the
659 same for all strengths (within $\pm 10\%$ of the total weight of the strength on which a BE
660 was performed), (2) the same inactive ingredients are used for all strengths, and (3) the
661 change in any strength is obtained by altering the amount of the active ingredients and
662 one or more of the inactive ingredients.
- 663 • Bilayer tablets are considered to be one formulation even though they consist of two
664 separate layers with different compositions. In assessing the proportional similarity of
665 the different strengths, all components of both layers should be proportionally similar.
666 The fact that only one layer is proportionally similar and the other is not clearly indicates
667 that the products (whole tablet) are not proportionally similar. This is relevant because
668 there can be interactions between the different tablet layers, which can differ across
669 different strengths because of the different size of the layers and the varying amounts of
670 excipients present in each layer.

671 Exceptions to the above definitions may be possible if adequate justification is provided and
672 discussed with the appropriate review division.

673
674 **B. In Vitro Studies Conducted in Support of Demonstrating BA or BE**

675
676
677
678²⁶ See also 21 CFR 322.22(d)(3) and (4) for additional bases for waiver. Also, FDA, for good cause, may waive a
requirement for the submission of evidence of in vivo bioavailability or bioequivalence if waiver is compatible with
the protection of the public health. For full NDAs, FDA may defer a requirement for the submission of evidence of
in vivo bioavailability if deferral is compatible with the protection of the public health (21 CFR 320.22(e)).

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679 FDA may determine that in vitro data are the most accurate, sensitive, and reproducible method
680 to demonstrate BA or BE in other contexts (21 CFR 320.24(b)(5) and (6)).²⁷ Below we provide
681 additional guidance on the conduct of such studies.

682

683 1. *Immediate-Release Formulations (Capsules, Tablets, and Suspensions)*

684

685 In vitro data can be used to compare formulations of drug products under certain
686 circumstances. If an applicant seeks to demonstrate the BA or BE of immediate-release
687 formulations for capsules, tablets, and suspensions using in vitro data, FDA recommends
688 that sponsors generate dissolution profiles for all strengths using an appropriate
689 dissolution method. If the dissolution results indicate that the dissolution characteristics
690 of the product are not dependent on the pH and product strength, dissolution profiles in
691 one medium are usually sufficient to support demonstrating BE. Otherwise, dissolution
692 data in at least three media (e.g., pH 1.2, 4.5, and 6.8) are recommended. The f_2 test
693 should be used to compare profiles from the different strengths of the product (see FDA
694 guidance for industry, *Dissolution Testing of Immediate Release Solid Oral Dosage*
695 *Forms*). An f_2 value ≥ 50 indicates a sufficiently similar dissolution profile to support a
696 biowaiver. For an f_2 value < 50 , discussion with the appropriate review division is
697 recommended to determine whether an in vivo study is needed. The f_2 approach is not
698 suitable for rapidly dissolving drug products (e.g., $\geq 85\%$ dissolved in 15 minutes or less).

699

700 • *Over-encapsulation of clinical trial formulations*

701

702 During the course of drug development, sponsors sometimes have to blind the
703 formulations that they use in the clinical trials. In certain situations, the only difference
704 between the to-be-marketed and clinical trial formulations is that the dosage form is put
705 into a capsule. This over-encapsulation is done mainly for blinding purposes. It may be
706 possible to support bioequivalence of the to-be-marketed and clinical trial formulations
707 using in vitro data only, provided that no other excipients are added to the capsule and the
708 dissolution profiles are comparable in three media: pH 1.2, pH 4.5 and pH 6.8.

709

710 • *Scale-up and postapproval changes*

711

712 Certain formulation changes in components and composition, scale-up, manufacturing
713 site, manufacturing process, or equipment can be made postapproval. Depending on the
714 possible impact of the manufacturing change on the release of the active ingredient from
715 the formulation and its BA, certain manufacturing changes for IR products can be
716 approved based solely on similarity of the dissolution profiles between the postchange
717 and prechange formulations. Information on recommendations for using in vitro
718 dissolution and in vivo BE studies for immediate-release drug products in such
719 circumstances is provided in FDA's guidance for industry on *SUPAC IR: Immediate-*
720 *Release Solid Oral Dosage Forms: Scale-Up and Post-Approval Changes: Chemistry,*
721 *Manufacturing, and Controls; In Vitro Dissolution Testing, and In Vivo Bioequivalence*

²⁷ In such instances, no waiver under 21 CFR 320.21 and 320.22 is necessary.

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722 *Documentation.* The same principles described in the guidance can be applied to
723 pre-approval changes in which the to-be-marketed formulation differs from the clinical
724 trial formulation.

725 2. *Modified-Release Formulations*

728 The use of in vitro data may be acceptable for modified-release drug products for which
729 specific postapproval changes are sought is delineated in the FDA guidance for industry
730 *SUPAC-MR: Modified Release Solid Oral Dosage Forms: Scale-Up and Postapproval*
731 *Changes: Chemistry, Manufacturing, and Controls; In Vitro Dissolution Testing, and In*
732 *Vivo Bioequivalence Documentation.* The same principles described in the guidance may
733 also apply to preapproval changes. Additional considerations for use of in vitro data are
734 described below.

735 • *Beaded capsules: lower/higher strength*

736 For ER beaded capsules where the strength differs only in the number of beads
737 containing the active moiety, a single-dose, fasting BA or BE study, as appropriate,
738 should be carried out on the highest strength. In vivo BA or BE of one or more lower
739 strengths can be demonstrated based on dissolution profile comparisons, with an in vivo
740 BA or BE study only on the highest strength (unless safety reasons preclude the
741 administration of the highest strength to healthy volunteers). The dissolution profiles for
742 each strength should be generated using the recommended dissolution method. If the
743 dissolution method has not been finalized, dissolution profiles should be generated in at
744 least three media (e.g., pH 1.2, 4.5, and 6.8). In vivo BE studies for higher strengths may
745 not be necessary based on (1) clinical safety and/or efficacy data on the proposed dose
746 and the need for the higher strength, (2) linearity of pharmacokinetics over the
747 therapeutic dose range, and (3) the same dissolution procedures being used for all
748 strengths with similar dissolution results. The f_2 test can be used to demonstrate similar
749 profiles among the different strengths of the product.

750 • *MR dosage forms: lower strength*

751 For MR dosage forms, when the drug product is in the same dosage form but in a
752 different strength and when (1) the drug exhibits linear pharmacokinetics, (2) the various
753 strengths are proportionally similar in their active and inactive ingredients²⁸ and (3) the
754 drug-release mechanism is the same, an in vivo BA or BE determination of one or more
755 lower strengths can be demonstrated based on dissolution profile comparisons, with an in
756 vivo BA or BE study only on the highest strength. The dissolution profiles for each
757 strength should be generated using the recommended dissolution method. If the
758 dissolution method has not been finalized, dissolution profiles should be generated in at
759

²⁸ If the formulations of all the strengths are not compositionally proportional, in vitro data can be submitted for the middle strength(s) if the following data are acceptable: (1) BA or BE data, as appropriate, for both the highest and the lowest strengths, and (2) in vitro multimedia dissolution comparison profiles using f_2 evaluation.

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763 least three media (e.g., pH 1.2, pH 4.5, and pH 6.8). The dissolution profile should be
764 generated on the test and reference products of all strengths using the same dissolution
765 test conditions.

766

767 **VI. SPECIAL TOPICS**

768

769 **A. Alcoholic Beverage Effects on MR Drug Products**

770

771 The consumption of alcoholic beverages may affect the release of a drug substance from an MR
772 formulation. The formulation may lose its MR characteristics, leading to more rapid drug release
773 and altered systemic exposure. This more rapid drug release may have deleterious effects on the
774 drug's safety and/or efficacy.

775 In vitro assessments of the drug release from the drug product using media with various alcohol
776 concentrations should be conducted. Based on the results of the in vitro assessments, an in vivo
777 BA study of the drug product when administered with alcohol may be needed.

779

780 **B. Enantiomers versus Racemates**

781

782 During development of a racemic drug product, the racemate should be measured in BA studies.
783 It may also be important to measure the individual enantiomers of the racemate to characterize
784 the pharmacokinetics of the enantiomers. For the development of a specific enantiomer, chiral
785 inversion should be assessed.

786 Measurement of the racemate using an achiral assay is recommended for BE studies.
787 Measurement of individual enantiomers in BE studies is recommended only when all of the
788 following conditions are met: (1) the enantiomers exhibit different PD characteristics, (2) the
789 enantiomers exhibit different PK characteristics, (3) primary efficacy and safety activity resides
790 with the minor enantiomer, and (4) nonlinear absorption is present (as expressed by a change in
791 the enantiomer concentration ratio with change in the input rate of the drug) for at least one of
792 the enantiomers. In such cases, we recommend that BE criteria be applied to the enantiomers
793 separately.

795

796 **C. Drug Products With Complex Mixtures as the Active Ingredients**

797

798 Certain drug products may contain complex drug substances (i.e., active moieties or active
799 ingredients that are mixtures of multiple synthetic and/or natural source components). Some or
800 all of the components of these complex drug substances may not be fully characterized with
801 regard to chemical structure and/or biological activity. Quantification of all active or potentially
802 active components in BA and BE studies may not be possible. In such cases, we recommend
803 that BA and BE studies be based on a select number of components. Criteria for component
804 selection typically include the amount of the moiety in the dosage form, plasma or blood levels
805 of the moiety, and biological activity of the moiety. When PK approaches are infeasible to
806 assess rate and extent of absorption of a drug substance from a drug product, PD, clinical, or in
807 vitro approaches may be appropriate.

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808

D. Long-Half-Life Drugs

809

In a BA or PK study involving an IR oral product with a long half-life (≥ 24 hours), adequate characterization of the half-life should include blood sampling over a long period of time. For BA or BE determination of a drug product containing a drug with a long half-life, a nonreplicate, single-dose, crossover study can be conducted, provided an adequate washout period is used. If the crossover study is problematic, a study with a parallel design can be used. For either a crossover or parallel study, we recommend that the sample collection time be adequate to ensure completion of gastrointestinal transit (approximately 2 to 3 days) of the drug product and absorption of the drug substance. C_{max} and a suitably truncated AUC can be used to characterize peak and total drug exposure, respectively. For drugs that demonstrate low intrasubject variability in distribution and clearance, a truncated AUC (e.g., $AUC_{0-72\text{ hr}}$) can be used in place of AUC_{0-t} or $AUC_{0-\infty}$. For drugs that demonstrate high intrasubject variability in distribution and clearance, AUC truncation should not be used. In such cases, we recommend that sponsors and/or applicants consult the appropriate review division.

824

E. Orally Administered Drugs Intended for Local Action

825

Documentation of BA and BE when the drug substance produces its effects by local action in the gastrointestinal tract can be achieved either by using pharmacokinetics, an acceptable PD end point, clinical efficacy and safety studies, and/or suitably designed and validated in vitro studies, as appropriate. For such cases, we recommend that sponsors and/or applicants consult the appropriate review division. Additional safety studies may also be recommended to characterize the local safety of the product. The in vitro studies should reflect important clinical effects or should be more sensitive to changes in product performance compared to a clinical study. To ensure comparable safety, additional studies with and without food may help to understand the degree of systemic exposure that occurs following administration of a drug product intended for local action in the gastrointestinal tract.

837

F. Combination/Coadministered Drug Products

838

Two or more active ingredients can be formulated as a single drug product, which is referred to as a combination drug product. Generally, the purpose of an in vivo BA study involving a combination drug product is to compare the rate and extent of absorption of each active drug ingredient or therapeutic moiety in the combination drug product to the rate and extent of absorption of each active drug ingredient or therapeutic moiety administered concurrently in separate single-ingredient preparations (21 CFR 320.25(g)).

839

For the purpose of defining BA or determining BE when required, this guidance recommends that the following studies be conducted for a combination drug product:

840

- A two-treatment, single-dose, fasting study of the combination drug product versus single-ingredient drug products administered concurrently as a single treatment or an approved combination product containing the same active ingredients. This study should

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- 853 use the highest strength of the combination product with matching doses of individual
854 drug products.
- 855
- 856 • Certain alternative study designs may also be acceptable depending on the specific
857 situation. For instance, in the case of a combination product consisting of two
858 components, a three-treatment study design comparing the combination drug product
859 versus single-ingredient drug products administered separately may be appropriate.
 - 860
 - 861 • A single-dose, food-effect study on the combination drug product.

862 BE studies for the combination product should include the measurement of systemic
863 concentrations of each active ingredient. The confidence interval approach should be applied to
864 each measured entity of the combination drug product and its reference product.

865 In specific cases, drug products are given in combination (not co-formulated) with the objective
866 of increasing the exposure of one of the drugs (subject drug). The second drug is not intended to
867 have a therapeutic effect and is given only to increase the systemic exposure of the subject drug.
868 When both the subject and second drug are new molecular entities, the BA of each should be
869 assessed separately. If a BE study is needed for the subject drug for any reason, the subject drug
870 should be administered with the second drug for both test and reference products. The
871 corresponding PK results, including confidence intervals for BE criteria, should be applied to the
872 subject drug. It is not necessary to measure the concentrations of the second drug. BE studies
873 that are needed for the second drug should be conducted only with the second drug; the subject
874 drug is not dosed with the second drug. When the combination includes a new molecular entity
875 and an approved product, only the BA of the new molecular entity should be assessed. It is
876 assumed that the BA of the approved product has been previously evaluated.

877

878 **G. Endogenous Substances**

879 Drug products can be developed that contain compounds that are endogenous to humans (e.g.,
880 testosterone). When the endogenous compounds are identical to the drug that is being
881 administered, determining the amount of drug released from the dosage form and absorbed by
882 each subject is difficult. In most cases, it is important to measure and approximate the baseline
883 endogenous levels of the compound in blood (plasma) and subtract these levels from the total
884 concentrations measured from each subject after the drug product is administered. In this way,
885 an estimate of actual drug availability from the drug product can be achieved, and therefore BA
886 and BE can be assessed. Endogenous substances may have homeostatic processes that affect
887 their production and therefore impact their systemic concentrations. To reduce the complication
888 of these homeostatic processes and to potentially avoid the need for baseline correction, an
889 alternative approach might be to enroll patients in BA and BE studies with low or no production
890 of the endogenous substances instead of healthy volunteers.

891 Baseline concentrations of the endogenous substance produced by the body are measured in the
892 time period prior to study drug administration. Depending on the proposed indication,
893 subtraction of the time-averaged baseline or time-matched baseline from the post-dose

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898 concentration for each subject may be recommended. When the endogenous levels are
899 influenced by diet, strict control of the dietary intake of the compound prior to and during the
900 study may also be appropriate. To achieve a stable baseline, subjects should be housed at the
901 clinic for a sufficient time prior to the study and served standardized meals with similar content
902 of the compound to that of the meals served on the PK sampling day.

903
904 In either case, baseline concentrations should be determined for each dosing period, and baseline
905 corrections should be period-specific. If a negative plasma concentration value results after
906 baseline correction, this should be set to 0 prior to calculating the baseline-corrected AUC.
907 Pharmacokinetics and statistical analysis should be performed on both uncorrected and corrected
908 data as appropriate. Because of the complexities associated with endogenous compounds, we
909 recommend that sponsors and/or applicants contact the appropriate review division for additional
910 guidance.

911
912 **H. Drug Products With High Intrasubject Variability**
913

914 In addition to the traditional approach and the use of average BE using replicate designs, the use
915 of a reference-scaled BE approach using a replicate design can be considered. This approach
916 should be reserved for drugs that demonstrate a high intrasubject variability ($\geq 30\%$). The
917 reference-scaled average BE approach adjusts the BE limits of highly variable drugs by scaling
918 to the within-subject variability of the reference product in the study and imposes a limit of 0.8 to
919 1.25 on the geometric mean ratio.²⁹ The appropriate review division should be consulted when
920 planning the use of the reference-scaled BE approach.

921
922

²⁹ For general principles of the reference-scaled approach, refer to Davit B, Conner D. Reference-Scaled Average Bioequivalence Approach. In: Kanfer I, Shargel L, Eds. *Generic Drug Product Development – International Regulatory Requirements For Bioequivalence*. Informa Healthcare, 2010:271-272.

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APPENDIX A: GENERAL STUDY DESIGN AND DATA HANDLING

The following general approaches are recommended, recognizing that the elements can be adjusted for certain drug substances and drug products.

Study conduct

- The BA or BE study should be conducted under fasting conditions (after an overnight fast of at least 10 hours). If the BA or BE study needs to be conducted with food, a separate FDA guidance *Food-Effect Bioavailability and Fed Bioequivalence Studies* is available to assist sponsors.
- The test and reference products should be administered with about 8 ounces (240 milliliters) of water to an appropriate number of subjects.
- Generally, the highest marketed strength should be administered as a single unit. If warranted, to achieve sufficient bioanalytical sensitivity multiple units of the highest strength can be administered, provided the total single dose remains within the labeled dose range and the total dose is safe for administration to the study subjects.
- An adequate washout period (e.g., ≥ 5 half-lives of the moieties to be measured) should separate each treatment.
- The lot numbers of both test and reference listed products and the expiration date for the reference product should be stated. We recommend that the assayed drug content of the test product batch not differ from the reference product by more than +/- 5 percent. The sponsor should include a statement of the composition of the test product and, if possible, a side-by-side comparison of the compositions of test and reference listed products. In accordance with 21 CFR 320.38, and 21 CFR 320.63, samples of the test and reference listed product must be retained for at least 5 years. For additional information, please refer to the FDA guidance for industry on *Handling and Retention of Bioavailability and Bioequivalence Testing Samples*.
- Before and during each study phase, we recommend that subjects (1) be allowed water as desired except for 1 hour before and after drug administration, (2) be provided standard meals no less than 4 hours after drug administration, and (3) abstain from alcohol for 24 hours before each study period and until after the last sample from each period is collected.

Sample collection and sampling times

- We recommend that under normal circumstances, blood, rather than urine or tissue, be used. In most cases, drug or metabolites are measured in serum or plasma. However, in certain cases, such as when an assay of sufficient sensitivity cannot be developed for plasma, whole blood may be more appropriate for analysis. We recommend that blood samples be drawn at

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appropriate times to describe the absorption, distribution, and elimination phases of the drug. For most drugs we recommend that 12 to 18 samples, including a pre-dose sample, be collected per subject per dose. ***This sampling should continue for at least three or more terminal elimination half-lives of the drug*** to capture 90 percent of the relevant AUC. For multiple-dose studies, sampling should occur across the dose interval and include the beginning and the end of the interval. The exact timing for sample collection depends on the nature of the drug and the rate of input from the administered dosage form. The sample collection should be spaced in such a way that the maximum concentration (C_{max}) of the drug in the blood and terminal elimination rate constant (λ_z) can be estimated accurately.

Three or more samples should be obtained during the terminal log-linear phase to obtain an accurate estimate of λ_z from linear regression. We recommend recording the actual clock time when samples are drawn, as well as the elapsed time related to drug administration.

Subjects with pre-dose plasma concentrations

- If the pre-dose concentration is ≤ 5 percent of C_{max} value in that subject, the subject's data without any adjustments can be included in all PK measurements and calculations. We recommend that if the pre-dose value is > 5 percent of C_{max} , the subject should be dropped from all PK evaluations. The subject data should be reported and the subject should be included in safety evaluations.

Data deletion because of vomiting

- We recommend that data from subjects who experience emesis during the course of a study for immediate-release products be deleted from statistical analysis if vomiting occurs at or before 2 times median T_{max} . For modified-release products, subjects who experience emesis at any time during the labeled dosing interval should not be included in PK analysis.

Data submission and analysis

The following PK information is recommended for submission:

- Plasma concentrations and time points.
- Subject, period, sequence, treatment.
- Intersubject, intrasubject, and/or total variability, if available.
- For single-dose studies: AUC_{0-t} , AUC_{0-inf} , C_{max} , T_{max} , λ_z , and $t_{1/2}$.
- For steady-state studies: AUC_{0-tau} , C_{maxss} , T_{max} , C_{minss} (lowest concentration in a dosing interval), C_{trough} (concentration at the end of the dosing interval), C_{avss} (average concentration during a dosing interval), degree of fluctuation $[(C_{max}-C_{min})/C_{avss}]$, swing $[(C_{maxss}-C_{minss})/C_{minss}]$. C_{trough} should be measured for several dosing intervals to assess whether steady-state was achieved.

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- 1009 • In addition to the above information, clearance and volume of distribution should be
1010 reported for BA studies.

1011
1012 In addition, we recommend that the following statistical information be provided for AUC_{0-t} ,
1013 $AUC_{0-\infty}$, and C_{max} :

- 1014
1015 • Geometric means
1016 • Arithmetic means
1017 • Geometric mean ratios
1018 • 90 percent Confidence intervals (CI)

1019
1020 We also recommend that logarithmic transformation be provided for measures used for BE
1021 demonstration. An FDA guidance for industry, *Statistical Approaches to Establishing*
1022 *Bioequivalence*, is available.

1023
1024 **Rounding off of confidence interval values**

1025
1026 We recommend that applicants ***not round off*** CI values; therefore, to pass a CI limit of 80 to 125
1027 percent, the value should be at least 80.00 percent and not more than 125.00 percent.

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1029