

Data integrity decides the week's enforcement, as guidance stacks up

This week regulators leaned on data integrity as the deciding factor: the CHMP moved to revoke avacopan (Tavneos) over trial-data reliability, and the FDA warned Huons over a fabricated logbook. Alongside enforcement, a dense run of guidance landed — formal-meeting procedures for OTC monograph drugs, two finalised bioequivalence guidances, and revised Ph. Eur. microbiology methods — while the TGA opened GMP inspection outcomes to public disclosure and the FDA paused Complete Response Letter releases.

Nine signals • traced to primary sources • selected by iFeed

FDA Schedules Public Hearing on Real-World Delivery Framework for Future Psychedelic Therapies

FDA's hearing notice, published July 14, seeks "feedback and perspectives on issues associated with the potential future therapeutic use of drug products containing a psychedelic drug substance in supervised and supportive settings", but explicitly states it "is not seeking comment on" either "the safety or effectiveness of any particular drug product" or "the scheduling status of any substance under the Controlled Substances Act." FDA finalized its separate psychedelic clinical-trial-design guidance the same day, splitting trial design and delivery infrastructure into two distinct regulatory tracks running years apart on the same drug class.

WHY IT MATTERS

Sponsors developing psilocybin-, DMT- or MDMA-class therapeutics are currently designing Phase 3 programs and REMS-style risk-mitigation strategies without knowing what post-approval delivery infrastructure FDA will ultimately require. This hearing is the first formal, dated signal of how FDA plans to build that record, and its explicit scope tells sponsors what not to spend comment bandwidth on.

WHAT TO CHECK

1) Sponsors with active or planned psychedelic INDs should register for oral comment by August 21, 2026 or submit written comments by October 5, 2026. 2) Regulatory and market-access teams should begin scenario-planning REMS and site-certification models now, using the hearing's four topic areas as the likely skeleton of any eventual framework. 3) Track this alongside the same-day finalized clinical-investigations guidance. 4) Watch for interagency signals (HHS, DEA) given FDA's statement that scheduling questions implicate other agencies' authorities.

FDA warning letter to Huons Co. (South Korea) cites fabricated logbook pages, OOS manipulation, and aseptic airflow failures

FDA's June 15, 2026 warning letter to Huons Co., Ltd. states plainly: "Pages were removed from your logbook and replaced with newly fabricated pages. Your microbiology team leader admitted to using a knife to remove completed pages from the logbook." The letter also documents an invalidated out-of-specification result: "Your firm prepared a second sample using glassware marked for disposal to mimic the original failed sample. This second sample met acceptance criteria. Your firm still used the passing hypothesis test results as justification to invalidate the original test result." A recall (March 25) and Import Alert 66-40 (April 3) both preceded the letter by months, FDA had already acted on the product risk before the public letter caught up.

WHY IT MATTERS

A microbiology team leader admitting to cutting completed logbook pages out with a knife and replacing them, combined with smoke studies showing turbulent airflow in an ISO 5 aseptic filling area, is fabrication and unproven sterility assurance at the same site in the same letter, a benchmark case for data-integrity training and for any sponsor assessing this site as a supplier.

WHAT TO CHECK

Any sponsor sourcing sterile injectables from this facility should already be assessing exposure, Import Alert 66-40 blocks admission of its products, and the June 15 letter adds a 15-working-day FDA response clock on top of that. Audit CMO logbook and chain-of-custody controls specifically for physical tamper-evidence (sequentially numbered, bound pages that can't be removed and replaced) and reconcile instrument/camera timestamps against paper records during supplier audits, not just at initial qualification. Re-screen your own OOS SOPs and recent invalidations for the exact pattern FDA rejected here, hypothesis-testing a failed result down to an unconfirmed cause like 'contaminated glassware' without documented root cause. Use FDA's required remediation list (3-year retrospective OOS review, independent contamination risk assessment, dynamic smoke studies with video, a qualified CGMP consultant under 21 CFR 211.34) as a benchmark for what credible remediation should look like when you evaluate this or comparable sites later. Pull this letter into data integrity and CAPA training now, physically razored-out logbook pages are a rare, concrete teaching example.

FDA Finalizes Guidance on Formal Meetings With OTC Monograph Drug Sponsors

FDA published the final guidance July 14, four years after its February 2022 draft, stating it "provides recommendations to industry on formal meetings between FDA and sponsors or requestors of over-the-counter (OTC) monograph drugs." The document codifies Type Y meetings into three categories, noting "there are three different categories of Type Y meetings and that generally FDA will grant one Type Y meeting per category," and for the first time extends formal-meeting rights to studies run under an IND "to conduct a clinical investigation to support a determination of whether an OTC monograph condition is generally recognized as safe and effective."

WHY IT MATTERS

OTC monograph sponsors have never had the codified, user-fee-backed meeting rights that Rx/ANDA sponsors get under PDUFA/GDUFA. This guidance gives them an enforceable meeting taxonomy and, via the companion OMUFA FY2026-2030 performance-goals letter, response-time commitments to hold FDA's Office of Nonprescription Drugs to, and it newly extends formal-meeting rights to pre-IND and IND-supported clinical studies run to back monograph safety/efficacy determinations, which changes how those sponsors plan clinical consultations.

WHAT TO CHECK

1) Map upcoming monograph-order or safety-driven label negotiations against the Type X/Y/Z taxonomy and request the meeting type matching your program stage. 2) Pull the 'OMUFA Performance Goals and Procedures FY2026-2030' letter and calendar FDA's response-time commitments against internal program timelines. 3) Any sponsor running or planning an IND-supported study to support a monograph safety/efficacy determination should use the newly explicit pre-IND meeting pathway rather than default IND pre-submission correspondence. 4) Update meeting-request SOPs to reflect the new hybrid (in-person core team / virtual non-core participants) format.

EDQM Publishes Revised Ph. Eur. Chapter 5.1.6 on Alternative Microbiological Methods

EDQM published the revised chapter in Ph. Eur. Supplement 13.2 on July 15, adopted by the European Pharmacopoeia Commission at its March 2026 session, with an implementation date of April 1, 2027. EDQM says "the description of technologies has been comprehensively updated to remove outdated methods no longer used in quality control and to incorporate modern approaches," and that although "the overall implementation framework remains unchanged, the revised text more clearly defines the respective responsibilities of suppliers and users" while introducing "a range of validation strategies based on a risk assessment, aimed at optimising implementation."

WHY IT MATTERS

Chapter 5.1.6 is the reference framework manufacturers cite when justifying replacement of classical growth-based compendial methods (sterility, bioburden, environmental monitoring) with rapid or alternative microbiological methods (RMMs). A revision changes the evidentiary bar validation packages must meet in front of assessors and inspectors, and the roughly 8.5-month runway to the April 2027 effective date makes this a real deadline for gap-assessment and revalidation work.

WHAT TO CHECK

Obtain the full revised chapter text in Ph. Eur. Supplement 13.2 and compare clause-by-clause against internal RMM validation protocols and SOPs. Map every RMM in use or in the validation pipeline against the new supplier/user responsibility split and build a gap-assessment and revalidation plan with 1 April 2027 as the hard deadline. Flag any method validated solely against the outgoing text for re-review, and register for EDQM's Microbiology Symposium (13-15 October 2026).

TGA Closes Consultation on Public Disclosure of GMP Inspection Outcomes

TGA's consultation paper, open for comment until it closed July 13, proposes publishing "manufacturer name, manufacturing site address, inspection date, type of inspection, scope of manufacturing activities inspected, whether the site was assessed as acceptable or unacceptable, and licence or certificate number" for both domestic and overseas sites. The paper draws one explicit line: TGA "is not proposing to publish confidential or commercially sensitive information," including details of individual companies' supply chains, but the separate question of retrospective publication, covering up to 12 months of inspections that already happened, is still unresolved and is the single highest-stakes design detail left open.

WHY IT MATTERS

This would materially change how much GMP compliance information about a specific named manufacturing site is publicly visible in Australia. For any manufacturer or CDMO supplying, or seeking to supply, the Australian market, an unacceptable inspection outcome tied to their name would become public, a reputational and commercial exposure that quality and regulatory leadership should be pricing in before the rule is finalized.

WHAT TO CHECK

Manufacturing quality and regulatory affairs leads supplying the Australian market should identify every site with a TGA GMP inspection in the past 12 months and assess exposure if published retrospectively. Treat any open CAPA from a TGA inspection as newly time-sensitive, and build external/investor communication plans now rather than reacting after the rule takes effect.

EMA's CHMP recommends revoking avacopan (Tavneos) authorization over data integrity concerns

EMA's own statement frames this purely around whether the ADVOCATE trial can still support Tavneos's effectiveness claim, echoing FDA's April 2026 position that its Center for Drug Evaluation and Research (CDER) 'can no longer conclude that there is, or has ever been, a valid demonstration that Tavneos is effective', this after NEJM retracted the trial paper over findings that nine of 331 patients' outcomes were reassessed post-unblinding without two requesting authors' knowledge. That makes this post-market evidentiary forensics, not post-market safety surveillance: regulators re-auditing a pivotal trial's foundational integrity five years after approval rather than responding to newly observed adverse events. And because Amgen disputes the characterization and declined FDA's request for voluntary withdrawal, the case is becoming a live precedent for how much weight a sponsor's disagreement carries once two major regulators have moved to act on a data-integrity finding.

WHY IT MATTERS

A revocation triggered by data integrity concerns in the pivotal trial itself, not a new safety signal, means the question isn't whether the drug works, it's whether the evidence it was approved on can be trusted.

WHAT TO CHECK

1) Re-examine your own unblinding, database-lock, and outcome-adjudication procedures for tamper-evident controls, an auditable log of who reassessed which outcomes, when, and under what authorization, since an undisclosed post-unblinding reassessment is exactly what's alleged here. 2) If you sponsor or manage pivotal/confirmatory trials, confirm adjudication committee charters explicitly bar undisclosed reassessment after database lock, and that any such deviation triggers immediate escalation to sponsor QA/regulatory rather than discovery years later. 3) Track the European Commission's final decision and Amgen's July 29, 2026 FDA hearing-submission deadline as live regulatory-intelligence triggers, the outcome will signal how much a contested data-integrity finding can be slowed by sponsor pushback. 4) If any marketed product rests heavily on a single pivotal trial, run a tabletop exercise now on the contingency playbook: prescriber communication, alternative-therapy transition, and supply wind-down, mirroring what EMA is already requiring for current Tavneos patients.

FDA pauses Complete Response Letter releases after citizen petition, then posts 14 anyway

This is less a fight over whether rejection letters should be public than a demonstration of how fragile a transparency initiative built on discretionary agency practice really is: one citizen petition from an unnamed sponsor, filed through Covington & Burling, was enough to freeze a policy FDA had championed as 'radical transparency' since mid-2025. FDA's inability to execute that freeze consistently, an HHS spokesperson says the agency is merely 'evaluating the process and potential next steps,' yet FDA posted 14 new CRLs, including a third straight rejection of the Hengrui/Elevar liver-cancer combination, within days of confirming the pause, is the exact 'transparent process' gap that critics like Eva Temkin, formerly of FDA's Chief Counsel's office and now at Arnold & Porter, are pointing to. Expect the fight to shift from whether CRLs get published toward who gets advance notice and redaction rights before they do.

WHY IT MATTERS

FDA announced a pause on July 8 and then posted 14 rejection letters days later anyway, including a third straight rejection of the same liver-cancer combination, the agency's own actions after the announcement don't match the announcement, on a policy that exists specifically to show the industry why drugs get rejected.

WHAT TO CHECK

Do not treat 'FDA paused CRL releases' as a reliable operating assumption: the agency posted 14 new letters days after announcing the freeze, so confirm current posting status directly via FDA's CRL portal rather than assuming a pending rejection will, or won't, become public. If your company has a recent CRL on file, have regulatory counsel review it now for unredacted confidential commercial information, the petition specifically cites redaction failures in the Lykos Therapeutics and Stealth BioTherapeutics letters as grounds for its complaint. Track the regulations.gov docket for the petition; FDA's response is reportedly due by October 17, 2026, which is the window to weigh in, through counsel or a trade association, before any formal advance-notice or redaction-review process is finalized.

FDA finalizes two bioequivalence guidances: statistical approaches and PK-endpoint ANDA studies

This is less new policy than consolidation: FDA folded reference-scaled average BE methodology for narrow therapeutic index and highly variable drugs, plus population and modified-population BE statistics that used to live scattered across individual product-specific guidances, into one central Statistical Approaches guidance. The companion PK-endpoint ANDA guidance was trimmed accordingly and re-aligned to the October 2024 ICH M13A guideline, signaling FDA is synchronizing its ANDA statistical expectations with international standards rather than running a US-only framework. The practical shift for sponsors: methodology that used to get negotiated product-by-product inside individual reviews now has one final, publicly citable reference point.

WHY IT MATTERS

These finalize the statistical and study-design expectations generic manufacturers have been working from in draft form for up to four years; final guidance, not draft language, is what actually gets cited in a review deficiency letter.

WHAT TO CHECK

Audit any BE study design or statistical analysis plan built against the superseded February 2001 statistical guidance, or against the pre-final drafts (December 2022 for statistics, August 2021 for PK-endpoint), for gaps against the new estimands/intercurrent-events framework, sample size determination, and outlier-handling provisions before submitting. For narrow therapeutic index or highly variable drug programs, find the RSABE methodology in its new home, the Statistical guidance, not the PK-endpoint appendices where it used to sit, and reconcile it against any conflicting product-specific guidance for that molecule. Update internal SOPs, protocol templates, and any citation lists that still reference the 2001 guidance by name or the superseded drafts by docket. Cross-check protocol templates against the newly incorporated ICH M13A alignment points for immediate-release solid oral dosage forms. For traceability, the two dockets are FDA-2001-D-0197 (Statistical Approaches) and FDA-2013-D-1464 (PK-Endpoint ANDA Studies); comments remain open indefinitely under 21 CFR 10.115(g) (5), so flag any ambiguity in how the final text applies to a specific product class through that channel.

FDA files updated bioequivalence guidance for topical dermatologic corticosteroids, replacing 1995 original

This finalizes the October 2022 draft rather than introducing a new approach: the pharmacodynamic vasoconstrictor, or skin-blanching, assay comparing test and reference products via chromameter-measured AUEC0-24hr remains the core method. The bigger methodological overhaul relative to the 1995 original, a defined reference standard, an in vitro option when test and reference share identical inactive ingredients (Q1/Q2 sameness), nonlinear mixed-effects modeling for ED50 estimation, and a tighter method-qualification standard (variability capped at 15% CV for chromameter and operator qualification), was already telegraphed in that 2022 draft, so sponsors designing to it for the past four years shouldn't be surprised. What's genuinely new in this final version is narrower: added flexibility on which subjects can be used for chromameter and operator qualification versus pilot/pivotal enrollment, and a new exclusion criterion for history of hypopigmentation, meaning the event that matters most for governance purposes may simply be that the 1995 guidance is now formally superseded, which matters for any ANDA program still referencing it.

WHY IT MATTERS

This replaces three-decade-old bioequivalence testing guidance for one of the most genericized drug classes in dermatology; the exact methodology named here, not the retired 1995 version, is what generic sponsors will now be held to in review.

WHAT TO CHECK

Regulatory affairs and BE teams already designed to the 2022 draft don't need to redo core study design, but should check the two things that actually changed in this final version: subject eligibility rules for chromameter/operator qualification versus study enrollment, and whether protocols need history of hypopigmentation added as an exclusion criterion. Any program still citing or built against the 1995 original is now out of date and needs a full gap-check against current methodology: a pilot dose-duration study (reference product only, 7-9 application durations, 20-24 subjects, to establish ED50) followed by a pivotal study (test vs. reference, 3 selected durations, 40+ subjects, analysis restricted to 'detector' subjects). For ANDAs already submitted or under review, QA and regulatory affairs should assess whether a bridging justification or supplemental data package is needed given the final guidance's specific changes, and consider a Controlled Correspondence to FDA's Division of Bioequivalence III if the applicability of prior data is unclear. This is guidance, not a binding regulation, so deviations are technically permissible with justification, but treat non-conformance as a material review-delay risk in practice.