Meeting Minutes
EECA CAB and Medicines Patent Pool
May 28, 2015, Saint-Petersburg, Russian Federation

The meeting participants

Medicines Patent Pool:
Esteban Burrone | Head of Policy

EECA CAB:

	Name	Organization	Country
1	Aleksandra Volgina	ECUO	Ukraine
2	Aibar Sultangaziev	Partners network association	Kyrgyzstan
3	Aleksandrs Molokovskis	Association HIV.LV	Latvia
4	Anahit Harutyunyan	Positive People Armenian Network	Armenia
5	Vitaliy Tkachuk	All-Ukrainian Network of PLHIV	Ukraine
6	Dzmitriy Proskurnin	Together against hepatitis	Belarus
7	Dmitriy Sherembey	Patients of Ukraine	Ukraine
8	Elena Lavrenchuk	CREDINTA	Moldova
9	Igor Kilchevskiy	CREDINTA	Moldova
10	Liliya Kurbatova	PLHIV Community Advisory Board	Kazakhstan
11	Mari Chokheli	OSI-Georgia	Georgia
12	Natalia Vershinina	ENPUD	Russia
13	Svetlana Prosvirina	Status-plus	Russia
14	Sergey Biryukov	AGEP'C	Kazakhstan
15	Timur Abdullaev	European TB Coalition	Uzbekistan
16	Irina Evdokimova	E.V.A.	Russia
17	Grigoriy Vergus	ITPCru	Russia
18	Tatyana Khan	ITPCru	Russia

Модератор: Sergey Golovin.

MPP Presentation

The question about whether a certain drug is patented in a certain country is not an easy one, because there can be more than one patent for a certain drug. Very important countries in terms of patents are China and India, because China is the largest producer of active pharmaceutical ingredients (API), and India is a large producer of generic drug products.

The mandate of the Medicines Patent Pool (MPP) is voluntary licensing. A voluntary license is an agreement between two companies, when one company gives certain rights for a patented product to another company. MPP tries to negotiate voluntary licenses from the perspective of public health. It is not easy because the other party is a commercial company with commercial interests.

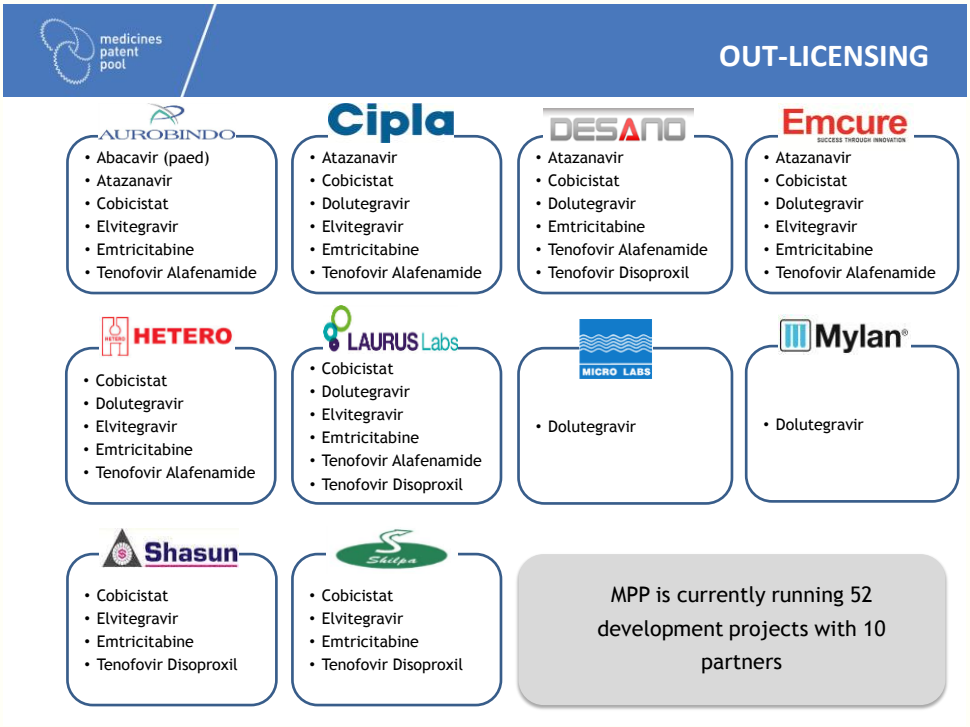
There is a possibility of royalties as an incentive for companies to conclude voluntary license agreements, but not all MPP licenses have royalties. Usually, royalties are used as incentives for brand companies to include more middle-income countries into license agreements. The main idea is to ensure generic competition, which ultimately brings the prices down.

Another main objective of MPP is to promote development of fixed-dose combinations (FDC). There can be patents on single pills belonging to different companies, and there can be patents on combinations as well.

List of Licenses Concluded:

Abacavir (ABC) (paediatric)	ViiV Healthcare	1st line paediatric	February 2013
Atazanavir (ATV)	Bristol Myers Squibb	2nd line adult	December 2013
Cobicistat (COBI)	Gilead Sciences	New ARV	July 2011
Darunavir (DRV)	National Institutes of Health	3rd line	September 2010
Dolutegravir (DTG	ViiV Healthcare	New ARV	April 2014
Elvitegravir (EVG)	Gilead Sciences	New ARV	July 2011
Emtricitabine (FTC)	Gilead Sciences	1st and 2nd line	July 2011
Lopinavir (LPV) (paediatric)	AbbVie	1st line paediatric	December 2014
Raltegravir (RAL) (paediatric)	MSD (Merck in the US and Canada)	3rd line paediatric	February 2015
Ritonavir (RTV) (paediatric)	AbbVie	1st line paediatric	December 2014
Tenofovir alafenamide (TAF)	Gilead Sciences	New ARV	July 2014
Tenofovir disoproxil fumarate (TDF)	Gilead Sciences	1st line adult	July 2014

List of Generic Producers which have taken licenses from MPP:



Question: you refer to darunavir (DRV) as a third-line drug. Is it rather not a second-line drug?

Answer: DRV is currently a third-line drug, but WHO says that if it becomes available as an FDC with ritonavir, and if the price comes down, then it can become a second-line drug.

Question: are there any generic companies which have taken licenses for lopinavir/ritonavir (LPV/r) and DRV?

Answer: for LPV/r, several companies have requested sub-licenses on LPV/r from us, and the info will become public soon once those licenses are announced. In terms of DRV, the patents which currently exist do not appear to be blocking the development of generics.

Continued presentation

Many of the MPP licenses are for new products. Another focus of the MPP work is pediatric licenses. WHO recommends certain drugs for different age groups; however, the list of drugs which are being bought by different countries is completely different. Usually, the recommended drugs do not exist in formulations which are suitable for these age groups. MPP has launched an initiative with UNITAID, Drugs for Neglected Diseases and CHAI to work for the development of paediatric formulations. To be able to do that, we need licenses for all these drugs.

Question: Are you conducting negotiations with AbbVie regarding a VL for the adult form of LPV/r?

Answer: not yet, but we would like to initiate such negotiations, if the company agrees.

Question: How could Aurobindo register and sell their drug in Kazakhstan despite the fact that Abbvie has a patent there?

Answer: There are many mysteries with patents. We know about situations when companies are ok with the procurement of generics, but in other situations they choose to exercise their intellectual property rights. The companies can choose either to enforce the patents or not to enforce them. Also many countries enable registration of products even if there are patents (there is no patent linkage).

Question: to what extent does the Pool influence the content of the licenses concluded?

Answer: every license has terms and conditions under which generics are allowed to sell the drugs. Commercial licenses are concluded based on commercial interests and they are most often confidential. MPP tries to make their licenses pro-access, with more countries covered and less

restriction. The licensees can file patent oppositions, they can terminate the license agreement if they want to, they can sell to countries which issue compulsory licenses, and they can combine the drugs with other antiretrovirals. MPP, however, does not negotiate the price. Fixing the price is usually not a good idea. Competition is what drives the price down.

Presentation Continued

In the past, it took about 8 years from the moment when the drug was first approved by FDA until the moment when there were at least 2 generic drugs on the market. The MPP believes this time lag can be reduced. Now we are reaching the moment when the West uses the best drugs, whereas the rest of the world uses drugs which are not bad, but not as good. In the US, efavirenz is no longer standard of care. Dolutegravir (DTG) was approved by FDA in 2013. If the same pattern is used, access to generic DTG will be possible in 2020 at the earliest.

Question/comment: there is information that Aurobindo has recently submitted an application for the generic version of DTG to FDA.

Answer: Aurobindo has a direct bilateral license with ViiV and supplies API to ViiV. Aurobindo already had an agreement with ViiV, allowing Aurobindo to make and sell generics, which to the best of my knowledge covered the pre-existing licensing territory of ViiV (67 countries). When the MPP negotiated an agreement with ViiV, it covered over 120 countries. I understand that now Aurobindo also has the same geographical scope, which is great. Our negotiations resulted in improved licensing conditions with a broader geographical scope. Aurobindo has been the first to file for regulatory approval and we hope that our licensees will follow shortly. Experience tells us that having only one generic is not enough to really drive the price down, which is why we are working with our licensees to ensure that there will be many suppliers of generic dolutegravir as soon as possible.

Question: does MPP work with governments to make sure they can access the generic drugs?

Answer: every time we sign a license we send letters to all the governments of the countries which are covered by the license to inform them or the licenses. We also try to meet with governments when they come to the World Health Assembly and when we visit those countries. This is the area where we can improve our work with the help of the patient community to establish closer links with certain governments with whom we have so far had more limited interactions. Even if a license agreement is concluded, contracts can be amended and governments can still demand that their counties be included in the license if they so wish.

Question: which ministry do you work with in Kyrgyzstan?

Answer: to begin with, all our licenses include Kyrgyzstan. Until very recently, Kyrgyzstan has been a low-income country, so it has not been difficult to include Kyrgyzstan. We have concentrated our efforts on including more difficult middle-income countries, such as Ukraine. Every time we conclude license agreements, we inform the government of Kyrgyzstan about it. We go through the representative of Kyrgyzstan in Geneva and send letters to the Ministry of Health. We have never received a reply. As far as I know, Kyrgyzstan can buy generics of all the first- and second-line ARVs. At the last World Health Assembly, we met with representatives from Uzbekistan; they seemed to be interested in the work of MPP.

Continued presentation

Our adult licenses have up to 127 countries home to over 90% of all people living with HIV. Our peadiatric licenses cover up to 99% of all children living with HIV in the world. We have often heard people say MPP cannot do anything for middle-income countries (MICs); that is not really the case. Today, there are only 34 low-income countries in the world; so, we are managing to include a lot of MICs. However, some of the upper-middle countries are very difficult to include. For me, the most challenging and upsetting example of a country we often cannot include in our licenses is Ukraine.

To include more MICs in some licenses we have royalties. In other licenses, we split the public and the private markets. For a product like DTG, we managed to include Vietnam, Indonesia, India, and Philippines. In this license, even if the country is not included, companies can still supply to countries where there is no patent or where a patent is pending (most of Latin America, Thailand, Georgia). In this region, there is a Eurasian patent for DTG and there is also a patent in Ukraine.

Question: If we look at the WHO guidelines, they still do not recommend DTG as a first-line option. Could MPP maybe work with WHO to update the guidelines with respect to DTG?

Answer: in order to be able to recommend DTG, there should be cheap generics, and we need data on TB co-infection and on pregnant women. These studies are currently delayed. However, there are groups who are setting up such trials and that will be important to enable the experts meeting in the WHO guidelines to be able to recommend.

With respect to second-line drugs we need to continue to work on atazanavir (ATV) and LPV/r. Most of your countries can benefit from our ATV license, with the exception of Ukraine and Russia.

Question: any steps regarding DRV?

Answer: I do not see a role for MPP as far as access to DRV is concerned. We are now working with Janssen to develop the paediatric FDC DRV/r. This combination has been identified as a priority by WHO. For the adult form, the main problem is not DRV; it is RTV. There is still a pricing issue for DRV in some countries, but it is not because of patents, I believe it is because of low demand

Continued presentation

The underlying principle of our licenses is promoting competition. They are non-exclusive. No generic companies from EECA have applied for licenses, probably because companies need to meet certain quality standards, such as WHO prequalification or approval by a stringent regulatory authority (FDA etc).

Question: do you work with governments prior to concluding licenses?

Answer: we have been trying to do that, but we often focus on new drugs, and it is hard to get governments interested in new products they are not currently buying. When the license is public, they sometimes become more interested. As mentioned, the licenses can be amended, and we have already had such cases, for instance, we have managed to include Ukraine in our license for paediatric abacavir (ABC).

Question: do you work with international organizations, such as the Global Fund, UNDP etc? They should also be interested in generic drugs.

Answer: We have a patent database, and the Global Fund, UNDP and UNICEF use this database as a tool. Sometimes, they contact us in case they need to understand the patent status for certain drugs. In general, we work very closely with many of the leading procurement agencies and international organizations such as the GFATM, UNDP and UNICEF.

Comment: it would be great if this database also included information about the concluded license agreements.

Answer: right now, we are in the process of redoing the patent status database. We want to add information about both voluntary and compulsory licenses, data exclusivity, and the number of people living with HIV. We also want to simplify the process of downloading information.

Question: is MPP involved into the development of the WHO treatment guidelines?

Answer: We are not involved in this process; however, WHO asks us about when to expect generic medicines. Our role is to make as many drugs as possible as affordable as possible in as many countries as possible.

Question: does MPP collect data about whether a particular license works in a given country?

Answer: for the new drugs and for the peadiatric formulations, this information will come later. For the drugs that are already on the market, the data says that 117 countries have bought 1st-line drugs from our generic partners. There has been 79 million US dollars in savings, which is equivalent of 625 000 1st line HIV treatment per patient per year. For the future, the total savings are estimated to be 1.4 billion US dollars before the patent expiry. 87% will come from the licenses MPP already has. The rest will come if we succeed with other licenses, such as the adult form of LPV/r. Here are some of the countries that have been able to benefit from access to more affordable generics.

Country	Product	Lowest price paid before MPP agreement (2010-2011)	Lowest price from MPP partners following MPP agreement (2011-12)	Lowest price from MPP partners (2013-14)
Azerbaijan	TDF/FTC	582	80	-
Belarus	TDF/FTC	577	77	67
Egypt	TDF/FTC	384	85	76
El Salvador	TDF/FTC	553	72	61
Georgia	TDF/FTC	657	88	-
Iran	TDF	577	48	48
Iraq	TDF	440	55	55
Paraguay	TDF/FTC	536*	-	86
Tunisia	TDF/FTC	358	118	95

TDF: Tenofovir disoproxil fumarate; TDF/FTC: tenofovir disoproxil fumarate / emtricitabine * 2012 price
Source: Analysis based on data from the WHO Global Price Reporting Mechanism

This data is public; we also get confidential reports from our licensees.

Comment: it is good you have this data, and it is important if you present this data at regional forums, such as the 5th Conference on AIDS in Eastern Europe and Central Asia. It is also important these new drugs are discussed and mentioned at these forums as options that could be recommended in the guidelines in the future, because these forums are attended by policy makers.

Comment from the MPP: there are representatives of the civil society in the committees of WHO; you could contact them when it comes to working with WHO.

Comment from the MPP: we also have to generate data that these drugs could also work in resource-limited settings. We think important that organizations like UNITAID are considering to getting involved and potentially funding those trials.

Question: who sets the priorities for MPP?

Answer: every year, we publish our priorities in terms of antiretroviral drugs to work on. First, we do this internally; then, we consult our external expert advisory group and WHO. The report is published on our website. We use two sets of criteria: medical criteria and market and intellectual property criteria (whether the drugs are patented in countries). Lamivudine (3TC), for instance, is very important clinically, but not patented. Maraviroc (MVC) is patented almost everywhere, but the clinical importance, according to WHO, is very low. We need to find drugs where these two sets of criteria match.

Our future priorities include improving the licenses we have (more countries, better conditions, clarifying language, and adding adult forms to peadiatric licenses).

Comment: Last time, we talked about potential priorities for the future work of MPP; for the current licenses, we do not see the immediate benefits for our region.

Question from the MPP: if you were to decide, what would be the priorities for you?

Answer: it would be working with WHO to include new drugs (DTG, DRV etc) into the treatment guidelines, and then moving into this direction. Our countries rely solely on the guidelines set by WHO. If the drugs are not included in the guidelines, it is highly unlikely our governments will fund them.

Comment from the MPP: the drugs the region is using today have been used for more than 10 years. The title of our annual report is "Working today for the treatment of tomorrow". WHO will not include TAF into its priorities if the generic version is not available; that is why we need to work now to make the generic version available.

Question/comment: our region has been held hostage to the World Bank classification. Is it possible for MPP to work on changing the paradigm used for access policies? We think there are other factors that need to be taken into consideration, such as the epidemic rate, policies related to drugs use and commercial sex work, and national HIV policies. Ukraine is usually deprived of the opportunity to receive quality generic drugs because Ukraine is a reference country for Russia. This is not ethical behavior.

Comment/proposal: MPP should reconsider such agreements as TAF, ABC, DTG and include Ukraine into these agreements, given the current political and humanitarian situation and given the fact that the income status of the country will soon be reconsidered.

Comment: other factors that should be taken into account include withdrawal of the GF programmes and deterioration of the economical situation. If needed, we could provide the necessary data.

Comment from the MPP: we totally agree that the income status is not the only criteria that should be taken into account. There was an initiative at the GF called the Equitable Access Initiative which initially seemed to focus on tiered prices. Some civil society groups were unhappy with it and the process has been adapted; now, the process is aimed at developing treatment access criteria for countries transitioning from the GF programmes to national treatment programmes.

If EECA CAB has ideas about criteria, do send them to MPP.

MPP and potential expansion to TB

UNITAID has asked MPP to explore opportunities of working in the field of TB. For drug-sensitive TB, the drugs are relatively cheap, and the treatment duration is about 6 months. For multi-drug resistant TB (MDR-TB), the treatment is very complex and expensive. The immediate need is in MDR-TB. There are two dew drugs on the market: bedaquiline and delamanid. There are very few drugs in clinical development. The first role of MPP could be working with newer drugs and provide access to generic versions of such drugs as delamanid, sutezolid, bedaquiline etc. However, in TB what you need is not a new drug, but a new regimen. Bedaquiline and delamanid have not been tested together. This trial will take 3-4 years. Investigators need to share data about the new compounds at the earliest stages to come up with optimized regimens. This is a different role as compared to the role of MPP in HIV, where we work with drugs which are at late stages of development. We work with such organizations as the TB Alliance, The Union for TB and Lung Diseases, and MSF. They think MPP can play a role as part of a bigger alliance. There is a proposal developed by MSF called "Push, Pull, and Pool". The idea is to stimulate more and better drug development, and to initiate sharing of compounds at early stages of clinical trials.

Question: there is still an issue of pricing. Is it linked to patents? If it is not, we should still work on making the drugs more affordable.

Answer: my understanding is that for many MDR-TB drugs the price stays high because there are few suppliers and the demand is very limited and very fragmented between the drugs. Eventually, what you want is a perfect regimen available from many suppliers, which everyone buys. For most drugs, it is rather a market problem, not a patent problem.

Question: does MPP plan any work on bedaquiline in terms of patents?

Answer: in the short term, it could be one of the priorities. However, we would still need a phase 3 trial, because there are some concerns about side effects. I believe this trial is starting only now. We need data to see whether it is really a good drug. Janssen still has a patent for bedaquiline; if we were

to have a generic version, we would need to start negotiating with Janssen. One of the tragedies of TB is that companies are moving away from it; they are no longer interested in developing new drugs.

MPP and expansion into HCV

UNITAID has asked MPP to explore opportunities for expanding into HCV. MPP cannot work on HCV as a co-infection, because we work on access to specific drugs in specific countries. There are some revolutionary new HCV drugs, which represent a significant opportunity. The current prices for the new drugs are very high in certain countries, up to 84 000 USD per 12 weeks. The cheapest we have heard is Egypt (900USD per 12 weeks). There are some voluntary licenses concluded directly between companies without MPP. The license for SOF, SOF/LDV and GS-5816 covers 91 countries; the access programme of BMS includes the same 90 countries without Egypt. For daclatasvir (DAC), there is no license yet. There is no info about the availability of generic daclatasvir; there are some generic companies working on it. There have been companies asking BMS for a license; BMS indicated they would prefer to work through the MPP, but the MPP does not have a mandate yet.

Comment: we have heard that there is a generic company working on DAC, and that a product may be ready in autumn.

Continued presentation

Right now, MPP is not working in the field of HCV. If we were to work in it, our objectives would include having more countries being able to buy generics, improving the conditions of the licenses which have already been concluded (from the perspective of the public health), and working on other drugs such as drugs by AbbVie and Merck. We would try to persuade them to choose VL rather than tiered pricing approach. One of the opportunities is that MPP already has experience of working with these companies from the HIV field. There may still be time to convince the companies to allow generics in more countries. We have contacted some governments, and they said they could not buy the drugs at the current prices, but if there were generics, they would consider starting large-scale treatment programmes. Today, most people are paying out of pocket.

Some governments are negotiating prices directly; some civil groups are doing patent oppositions; some countries are considering compulsory licenses. Whatever the MPP does should be complementary to those activities.

The potential risks would be the following: the companies already have access strategies; companies might not be willing to change terms and conditions; the treatment programmes might not develop even if there is theoretical access to generics.

Our experience in HIV shows that even if the companies have access strategies, we have been able to push them further; we have also succeeded in improving the terms of the existing licenses. The question is when the license you get is good enough. It is a balance of doing something for some people or not doing anything because we still cannot help everyone.

Comment: Does MPP support advocacy aimed at changing patent laws?

Answer: MPP receives funds only on working with VLs; however, UNITAID as a funder may consider supporting such work.

End of the meeting.