ABBOTT's NEW AND IMPROVED KALETRA: ONLY IN THE US … BUT WHAT ABOUT THE REST OF THE WORLD?

Briefing Note
Médecins Sans Frontières (MSF)
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Médecins Sans Frontières (MSF) is deeply concerned that Abbott's new version of the second-line fixed dose combination lopinavir/ritonavir – LPV/r, marketed as Kaletra, is not available in developing countries. The US Food and Drug Administration (FDA) approved a new version of LPV/r in October 2005 that has critically important advantages for patients in developing countries: lower pill count [down from six to four per day], storage without refrigeration, and no dietary restrictions. Some MSF projects have an urgent need for this drug, as no other boosted protease inhibitors – the cornerstone of second-line therapy - are practical to use in the hot climates of many developing countries, where refrigeration is not readily available.

New LPV/r is available in the US, but not in any developing countries and there is no publicized differential price or system of distribution for developing countries. If made accessible and affordable, the new and improved version of LPV/r could offer major benefits to patients across the developing world.

In 2005, approximately six percent of MSF patients that had been on treatment for three years were on second-line drugs, and in one MSF program that has access to viral load monitoring, after four years of treatment, 16% of patients needed a new combination. These data underline the acute and growing need for access to newer, field-adapted second-line drugs. But new LPV/r remains out of reach to MSF medical professionals and others working in developing countries. Without access to this drug, there is no practical solution for patients who no longer can benefit from older first-line drugs.

Because Abbott Laboratories is the sole producer of the new LPV/r and no generic versions have been internationally validated, MSF and others are dependent on the willingness of the company to make this urgently needed drug widely available.

MSF therefore calls on Abbott to:

- **Register the new version of LPV/r in developing countries and replace the old version of LPV/r with the new one, as they have already done in the US;**
- **Set an affordable differential price for the new formulation of LPV/r in developing countries, at the same level or lower than the price for the previous version ($500 per year per patient);**
- **Include middle-income countries as beneficiaries of the differential price; and**
- **Eliminate patent barriers to production of generic versions of new LPV/r for use in developing countries.**

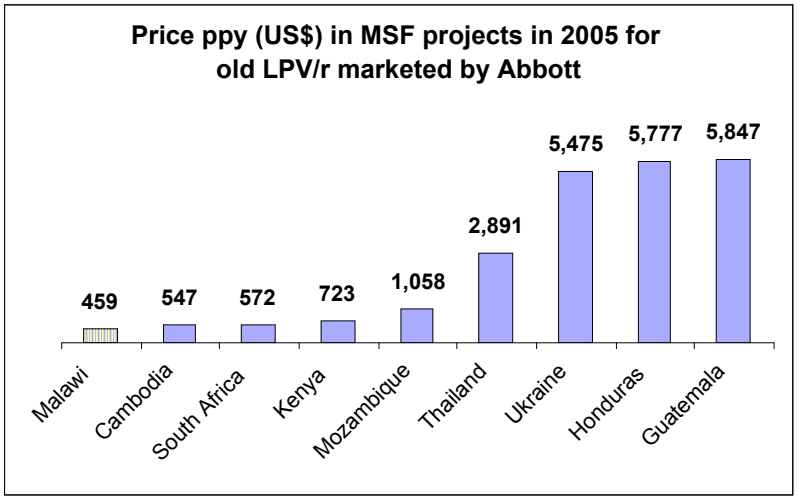
BACKGROUND

An Essential Medicine for Second-Line Treatment

Lopinavir/ritonavir (LPV/r) has been recognized as an essential medicine by the WHO,[i] as it is the only co-formulation that consists of a protease inhibitor (lopinavir) and booster (ritonavir) in the same pill. The WHO will include LPV/r in its revised recommendations[ii] as part of a second-line therapy once first-line treatment failure has occurred. Abbott Laboratories has been marketing the old formulation of LPV/r as Kaletra since 2000. But the old version of LPV/r has some serious drawbacks, as it requires refrigeration, comes with a high pill burden of six capsules per day and needs to be taken with food. Although second-line regimens including LPV/r are preferred in developing countries, they have not been an option in many places because of the the refrigeration requirement of the old formulation. The 14th WHO Expert Committee on the Use of Essential Medicines recommended the use of "*fixed dose combinations and the development of appropriate new FDCs, [which include] modified dosage forms,* ***non-refrigerated formulations*** …"[iii]

Price for Developing Countries Should Be the Same As, or Less Than, the Old Version

Since May 2002, Abbott has been selling the old formulation of LPV/r in Africa and Least Developed Countries for $500 per patient per year on an FOB basis (meaning that freight, insurance, customs handling, taxes and duties paid by purchaser). However, unlike other companies, Abbott does not offer differential prices in middle-income countries even though in these countries millions live on less than US $2 per day. As the chart below shows, middle-income countries are paying dearly for access to the old formulation of LPV/r.



The price of LPV/r in middle-income countries outside Africa is on average 7.4 times more expensive than in low-income countries (mean: $672 vs. $4,998). In some developing countries, the price for the old version of LPV/r is nearly as high as it was in the US ($6,944).

In Brazil, where the government has twice threatened to manufacture the drug at a lower cost under a compulsory license, Abbott Laboratories agreed to cut the price of old LPV/r formulation from $2,562 to $1,379 per patient/year, starting in March 2006[iv]. Although this is an improvement, Brazil will still have to pay nearly three times the price of the old formulation of LPV/r in Africa and least-developed countries.

In the Long Run, Alternate Suppliers Will Be Critical

There is currently some generic production of the old formulation of LPV/r, but the sources have not been internationally validated yet, and patents on the combination could block companies from marketing it in some countries. In addition, new patent obstacles may prevent the development of generic versions of the new formulation of LPV/r. Given the usual patenting strategies of multinational pharmaceutical companies, the new formulation of LPV/r is likely to be patent protected in drug producing countries for a new 20 year period, preventing generic competition.

Registration Should Be Immediately Sought For New Formulation

The old formulation of LPV/r (133/33.3 mg soft gel capsules) is registered in 54 countries and registration is pending in 14 others, covering 68 of the 69 countries eligible for Abbott's Access Program. But the new formulation of the drug has not been registered in any country except for the US. MSF calls on Abbott to register the new formulation of LPV/r (200/50 mg tablets) promptly and replace the old version with the new one in developing countries, as they have done in the US**.**

THE BOTTOM LINE:
The new formulation of LPV/r represents a significant improvement in second-line options for ARV treatment in developing countries. Abbott needs to make new LPV/r available throughout the developing world at an affordable price without further delay.

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[i] 14th edition, WHO Model List of Essential Medicines (revised March 2005)
[ii] Summary is available for consultation at http://www.who.int/3by5/mediacentre/news51/en/
[iii] 14th edition, WHO Model List of Essential Medicines (revised March 2005)
[iv] *http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=1&DR_ID=33054* Reported October 12, 2005