

Editorial

The Continuing Dilemma of Drugs With Black Box Warnings

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The package insert (PI) for a prescription agent remains a primary source for certain information about a marketed drug in the United States and provides a template for safe and rational use based on data collected primarily in premarketing trials. However, because safety data are of a dynamic nature and subject to change based on postmarketing surveillance, the PI may be revised several times during the marketing life of a drug. When new safety data are of a most significant nature, the Food and Drug Administration (FDA) requires that a Black Box warning be added to or revised in the PI to alert clinicians that this information is considered critical. Black Box warnings are the strongest warning the FDA requires and typically details safety data (eg, adverse events, drug interactions) but may also include information regarding restrictions for use or distribution. Notification of Black Box warning additions and other safety information are posted by the FDA in several areas of their Web site (eg, *Med-WATCH*, Safety, News).¹ In addition, there is a free Web site dedicated to providing a list of drugs with Black Box warnings.² Since 2005, approximately 14% of safety labeling changes have been related to Black Box warning additions or revisions.³

In an ideal world, changes in safety labeling information for

drugs, particularly Black Box warnings, would be based on data that are available from published controlled trials. In reality, changes to such safety data are not always observed in controlled trials first, but may come to light as a mixture of data types—including, but not limited to, sentinel event reporting, postmarketing study or surveillance, voluntary adverse event reporting, or other clinical or non-clinical scenarios. Often, this information is not readily available in published form at the time of labeling revisions. The FDA is often challenged with an important mission—promoting safe medication practices through labeling changes in the face of varying levels of data.

Recently, the California Department of Health issued a letter addressing concerns pertaining to the safe use of medications whose labeling contains Black Box warnings in regards to compliance and licensing for general acute care hospitals in that state.⁴ It is essential for all health care professionals to be familiar with Black Box data as these drugs may be associated with significant risk or require specific monitoring/handling to optimize efficacy and/or safety.

The dilemma of Black Box warnings continues to be multifold. Several questions need to be continually evaluated and assessed regarding this topic in an effort to promote safe medication processes.

How do we learn and disseminate information about Black Box data in an efficient and timely manner to both prescriber and patients? How do we ensure that these data remain imbedded in information available at the point of patient care? Should health care facilities formalize a specific Black Box policy? Is Black Box warning information included in informed consent documents or preprinted order forms? How are sufficient safety practices implemented with full acceptance from clinicians and the scientific community when little published evidence may be available regarding the event at the time of notification? If a health care site uses a medication in a manner that is not consistent with a boxed warning, what evidence-based process is being documented?

Hospital Pharmacy is interested in hearing from practitioners regarding the issue of Black Box warnings and safe medication practices. Share your experiences and questions with us at hospitalpharmacy@drugfacts.com.

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