

PROJECT INFORM / Positions For 1990 and beyond

1. We advocate the immediate implementation of *Parallel Track*. We urge that the *AIDS Clinical Research Committee* be convened within 30 days and the following critically needed drugs be reviewed for parallel track access:

ddC GM-CSF FOSCARNET
(Rationale: see Appendix 1)

2. We urge accelerated development of several promising experimental treatments.

Many treatments have shown dramatic promise of efficacy in laboratory, animal, or phase 1 studies yet seem to be going nowhere. What's lacking may be money, personnel, powerful backers, or urgency. Whatever the cause, the system is not doing an adequate job. Only the best-funded and best-connected drugs truly seem to find the "fast track" supposedly available for AIDS drugs. The 10 products/concepts we recommend for immediate action:

Interleukin 2	HPMPC	Protease inhibitors
TIBO derivatives	TAT inhibitors	Gallo's KS drug
GLQ-223	OI drugs	HIV-IG
Combination therapies		

(Rationale: see Appendix 2.)

3. We see (at least) four key unmet funding needs in the War on HIV which demand attention:

- A. "The AIDS Manhattan Project"
 - B. "The Immune System Reconstruction Project"
 - C. "The Early Intervention Mandate"
 - D. "The AIDS Education Project"
- (Program detail in Appendix 3)

4. We urge an immediate reform of the *AIDS Clinical Drug Development Committee*.

This group greatly influences which drugs are developed and which are overlooked. Its membership represents a narrow spectrum of scientific thought and virtually all of its members have lucrative consulting contracts with pharmaceutical companies, raising questions about their ability to objectively understand the work of others. While we do not question anyone's integrity or good intentions, we do question the intellectual influences and biases that such contracts inherently bring. We propose three key changes, outlined in Appendix 4.

5. We call for the creation of a *Rapid Claims Investigation Unit* within *NIAID* to quickly investigate the endless "breakthroughs" reported in the media throughout the world.

The media's interest in new "miracle" cures must be met with an effective means of evaluating such claims. *NIAID* needs to establish an official unit with the budget and authority to investigate publicized claims speedily and thoroughly, so that the *HIV* community isn't misled by unsupported claims or ineffective products, nor is it deprived of rapid confirmation of new approaches which might truly offer benefit. The claims unit should be balanced so as not to represent a single narrow, viewpoint of medical orthodoxy. It must include community representatives, community physicians, and experienced investigators.

6. We urge improved access to clinical trials and access programs for currently underserved populations.

There are three elements for increasing health care equity for all populations fighting *HIV*:

A. *Improved outreach for clinical trials.*

This might be accomplished with newspaper and other print media ad (in all appropriate languages). Community clinics must be provided with extensive print media, at the appropriate reading levels, explaining trials and how to access them.

B. *Improved access to trials.*

Greater attention must be paid to the (1) location of such trials (put them near the affected communities); (2) transportation must be provided or reimbursed; child care must be provided or reimbursed to permit participation by those with parenting responsibilities; (3) night clinics must be opened to permit participation by people who work in the daytime; (4) confidentiality provisions must be increased; and (5) third party reimbursement must be guaranteed for all costs associated with participation in clinical studies

C. *Improved access to Parallel Track programs*

This will require outreach efforts to community clinics and health centers, where additional resources must be provided to meet the added demands of participation in a parallel track. Moreover, educational programs must be initiated to inform both doctors and patients in underserved communities of their opportunities under *Parallel Track*.

Appendices

Appendix 1 (drugs for Parallel Track):

ddC: ddC is a promising drug from Hoffman-LaRoche with properties similar to AZT and ddI. It is the only well understood option for people who have failed these other drugs. Much more is now known about ddC than was known about ddI when it was released in 1989. ddC may offer special advantages over the others and may work especially well in com-

ination with AZT. The current ddC program supported by Hoffman-LaRoche is unconscionably narrow and restrictive, the most elitist expanded access program yet. Much of this restriction is due to the necessity in that program to fail both AZT and ddI before being permitted access to ddC. As ddI is not yet an approved drug or standard therapy, we do not accept failure on ddI to be a legitimate precondition for seeking access to ddC, as the current program requires. This is a bad precedent for Hoffman-LaRoche and a terrible precedent for drug regulation in general.

GM-CSF: This immune modulating drug from Schering-Plough has been shown to effectively increase white blood cell production in clinical studies. Access to it would allow patients to continue use of critically needed toxic drugs like AZT, gancyclovir, and chemotherapy for KS and lymphoma without fear of severe white cell depletion. We advocate that any patient who repeatedly has a neutrophil count of less than 750 per cc., whether due to HIV or to drug side effect, be allowed access to GM-CSF at the discretion of their physician.

FOSCARNET: Foscarnet is an antiviral drug effective against CMV and for acyclovir-resistant herpes, an increasingly common problem for which there is no other solution. We advocate release of Foscarnet to the physician of any patient who fails or cannot use gancyclovir, or who suffers acyclovir-resistant herpes.

Appendix 2 (products in need of development):

Interleukin-2: IL-2 showed great promise in studies at Stanford last year, yet new studies have moved at the pace of molasses. Instead of learning from the successful Stanford experience, NIAID continues testing it in a manner which has only produced failure in the past. IL-2's neglect exemplifies the overall neglect of immune restoration, without which the current path of antiviral therapy is essentially a dead end.

HPMPC: This powerful anti-CMV drug promises a better therapeutic index than all existing competitors. Although a product of Bristol-Meyers, there is little evidence of urgency about its development, despite the generally unsatisfactory character of existing CMV drugs.

Protease inhibitors: these drugs offer an entirely new angle of attack against HIV, and several companies have announced promising laboratory findings. Since then - we see no sign movement. We fear that patent concerns may eventually slow their development.

TIBO derivatives: This new type of antiviral may be far more effective than AZT in stopping production of reverse transcriptase. It has been nearly a year since exciting laboratory findings were published, but little seems to be happening in the U.S.

TAT protein inhibitors: Scientists have speculated on the broad therapeutic benefits possible from inhibiting the protein produced by the TAT gene on HIV. Despite this promise, we see no evidence of action.

Dr. Gallo's KS drug: This potential cure for KS may have astonishing properties, but long delays have already been experienced due to bureaucratic inefficiencies and manufacturing difficulties. Because of proprietary concerns, no one is being permitted to help speed its development, while the sponsor has no experience in working with the U.S. drug development process.

Combination therapies: Since 1986, preliminary studies have suggested that combining drugs which work in different ways and/or do different things will work better than single agents. Yet combination studies are still downplayed in favor of single-drug studies. We are well aware of the proprietary and regulatory obstacles involved here, but see little or no effort to solve these problems.

Drugs for opportunistic infections: Better control or prophylaxis of opportunistic infections obviously can extend the lives of people with HIV and improve the quality of their lives. Yet far too little is done in this arena, perhaps because of the lack of broad commercial markets.

GLQ-223: Perhaps the most potent of all the antivirals because of its ability to kill infected cells, this drug offers additive advantages to everything else under study. Yet, as the product of small unknown high technology company, its development has been hampered by a shocking degree of bias and has been stymied by dishonest misuse of laboratory data.

HIV-Immuno globulin: This promising form of passive immuno-therapy addresses the weakness of other such models. Yet Abbott Labs, the manufacturer sees it as a low priority item, despite very encouraging clinical results.

Appendix 3 (four unmet funding needs):

A. "The AIDS Manhattan Project:"

We urge that federal funds be set aside to pool the 30 best scientific minds, uniting multiple disciplines into a single working unit, provide them with the best possible facilities in a sequestered environment, and issue a single directive: advance the state of the art in *clinical AIDS care*. Today's programs are instead directed at the licensing of individual drugs, which no one believes to be the answer. This group must be given complete access to all IND drugs and procedures for use outside of existing protocols. To the maximum extent allowable by law, all regulatory restraints must be removed from this working group.

B. "The Immunity Reconstruction Project"

All the progress in the world made with antiviral drugs will not save one person currently having a full AIDS diagnosis until there is a way to restore their immune systems. Immuno-modulatory drugs must be examined and procedures developed for restoring the destroyed system. We have theoretical understanding of how to do this, but research is blocked by lack of product motive and by federal bans on fetal tissue research.

C. "The Early Intervention Mandate"

Inform everyone of what the well-connected already know: If you have ever been at risk, get tested; if you are tested positive, intervene. Provide universal access to the best proven therapies at all stages of infections.

D. "The AIDS Education Project"

Physicians, particularly those outside of major cities, have difficulty keeping up. Even academic centers are often a year or more behind the state of the art. Only the best-informed patients know how to interact with their physicians to produce optimal clinical results. Grants must be provided for the production of educational videos, print material, and public service announcements aimed at both physicians and all patient populations (in a manner they will accept).

Appendix 4 (reform of the ACDDC):

A. Require public declaration of the "potential for bias" statements that all members currently sign (they do sign such agreements, don't they?). It is not enough to have such statements in the private record.

B. Expand the committee to include patients and their advocates, community physicians, and a broader spectrum of researchers.

C. Require individuals to abstain from the decision-making process when their consulting relationships imply the appear of conflict of interest. This is made possible by the expanded membership.

D. Publish a record of the committee's proceedings.