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Drug Giveaways Likely To Meet Resistance From Doctors, Potential Problems At CMS

By Paul Goldberg

Drug giveaway programs recently announced by two biotech companies created an appearance of limiting the cost of cancer drugs, but are likely to run into resistance from physicians, and could face regulatory problems.

After its agent Vectibix (panitumumab) was approved for third-line treatment of metastatic colorectal cancer on Sept. 27, Amgen Inc. announced that patients would be expected to pay no more than 5 percent of their adjusted gross income in co-payments.

Earlier this week, as Avastin (bevacizumab) received FDA approval for

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In Brief:

NCI's Greenwald Promoted To Rear Admiral; Niederhuber To Be Sworn In As NCI Director

PETER GREENWALD, director of the NCI Division of Cancer Prevention, has been promoted to Rear Admiral (08), Assistant Surgeon General, in the U.S. Public Health Service Commissioned Corps. The promotion doesn't change Greenwald's responsibilities at NCI, but may provide opportunities for him to promote common interests of PHS and NIH, including the recruitment of Corps clinicians, training, and collaboration, he said. NCI Director **John Niederhuber** recommended Greenwald for the promotion. "The NIH mission of research and training of scientists and the PHS Commissioned Corps primary mission as a uniformed service prepared for rapid response and deployment for urgent public health situations to some degree are interlocked," Greenwald said to The Cancer Letter. "In the long run, there is the potential for NIH and the Department of Defense to strengthen their ties as the Walter Reed Army Medical Center is merged with the National Naval Medical Center into the Walter Reed Military Medical Center to be located on the Naval Medical Center grounds across the street from the NIH. The leaders of these organizations already have been thinking about this, and I certainly would volunteer to help make this a success, in addition to my NCI duties." . . . **JOHN NIEDERHUBER** will be sworn in as NCI director on Oct. 18, at 11 a.m. EDT. HHS Secretary **Michael Leavitt**, NIH Director **Elias Zerhouni**, and **Phillip Sharp** of the MIT Center for Cancer Research, are scheduled to give remarks. To view a Webcast of the swearing-in, see http://videocast.nih.gov. . . . **SUSAN BAND HORWITZ**, Distinguished Professor and co-chairman of the Department of Molecular Pharmacology and the Falkenstein Professor of Cancer Research at the Albert

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Giveaways May Affect ASP For Vectibix And Avastin

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first-line treatment of advanced lung cancer, Genentech Inc. said it would limit the overall per-patient billing for Avastin to $55,000 per year.

By capping costs and aggressively pricing Vectibix, Amgen appears to have positioned itself to capture market share from the ImClone Systems Inc. biologic Erbitux (cetuximab).

The Genentech program allowed the company to demonstrate restraint while announcing an approval of an expensive drug regimen. However, the company's gesture can't be fully assessed, because it's unknown who would qualify for the program. Also, according to Genentech's numbers, the median drug bill for patients taking Avastin for lung cancer would total about $56,000.

Now, Centers for Medicare and Medicaid Services will have to determine whether the drugs given away through these programs should be factored into Average Sales Price. "If it does enter the ASP calculation, it will be almost impossible to sustain the program, as physicians' reimbursement will likely enter a downward cycle and make administering the drug unaffordable for oncology practices," Morgan Stanley said in a research report on Vectibix.

If CMS decides to include free drug in the derivation of the average, factoring in zeroes for every package given away, the agency's calculation of ASP would decrease as the giveaway program grows. As a result, doctors would continue to pay the manufacturer's price, yet reimbursement from Medicare would keep falling.

It appears that neither Amgen nor Genentech obtained an advisory opinion from the HHS Office of the Inspector General before launching the access programs. Such opinions aren't required. However, players in the rapidly expanding and legally ambiguous field of administering multi-million-dollar patient assistance programs often request OIG opinions to lower the risk of prosecution under federal fraud and abuse laws.

Amgen declined to state whether CMS agreed to exclude free drug from the ASP calculation.

"Once a patient reaches the cap, he or she will become eligible to receive free drug through the Safety Net Foundation [a foundation set up as a non-profit that administers aid to patients]," Christine Regan, an Amgen spokesman, said in an e-mail. "The drug donations to the Safety Net Foundation are not discounts and are not contingent upon future purchases, and thus are not included in ASP."

Genentech officials said the company consulted with CMS and OIG over the past four months.

"Based on these discussions, we are confident that the program is consistent with relevant federal law and regulations and will not negatively affect Avastin's ASP," said Ed Lang, a company spokesman. "In addition, we are working with CMS to determine whether physicians will be able to separately bill for the Medicare administrative fees associated with the Avastin infusion."

Industry observers said that the CMS decision in these cases will turn on a definition of "inducement" for patients as they choose therapies.

Lawyers say that the government usually prohibits inducements to select a particular covered service. However, in the Amgen and Genentech programs, the benefits accrue to patients after they sign up for the programs, industry observers said. Vectibix patients could get free drug after spending 5 percent of their adjusted gross incomes on co-payments, and some Avastin patients could receive benefits after using $55,000 worth of the drug over a 12-month period.

It's unclear whether the CMS decision would have to be the same for both drugs, since Avastin is the only available drug in its class, and Vectibix is the second monoclonal antibody that binds to the epidermal growth factor receptor to be approved for third-line treatment of colorectal cancer.

Both programs are aimed at patients who do better

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and stay on the drug longer, said Deborah Schrag, a gastrointestinal oncologist and an outcomes researcher at Memorial Sloan-Kettering Cancer Center.

"In any survival curve, there is a tail, and they are really only subsidizing people who are at the tail," Schrag said to The Cancer Letter. "It sounds really generous, but I am not finding this to be so generous. These programs don't kick in at the start of therapy, but after patients have consumed a lot of drug. The number of patients who remain on these agents for long periods of time is modest. Lots of people start them, but relatively few continue them over many months."

Joshua Ofman, Amgen vice president for global coverage and reimbursement, said the company was taking a socially responsible position.

"We wanted to try to create a program for the product that was very positive," Ofman said to The Cancer Letter. "We priced the drug 20 percent less than the competition and at the same time developed what we think is a very innovative and industry-leading patient assistance program. I think there are very positive attributes here that demonstrate that Amgen took a very socially responsible position."

The company also gives out free drug to uninsured patients with the adjusted gross income of less than $75,000.

"Go See Tina"

The programs shift responsibility to physicians and their institutions, said Leonard Saltz, a gastrointestinal oncologist at Memorial.

"Who is going to administer this?" said Saltz, who has consulted for Amgen and has conducted sponsored research for Genentech, ImClone, and Bristol-Myers Squibb, a co-owner of Erbitux. "Who is going to determine what a patient's adjusted gross income is?

"Are the doctors going to take responsibility for getting tax returns for the last three years from patients? And if so, who is going to collate that? Who is going to take responsibility if those numbers are falsified or wrong? The Amgen cutoff is $75,000; suppose the patient makes $76,000 a year. Who is going to report? Who is going to take responsibility? Who is going to verify?

"What if it changes? What if the person had a bad year, but makes $100,000 the next year? What if the person is able to shift their income so that it appears that he had a bad year? So you are getting this 'free drug.'

"How are you getting it? Who is shipping drug free to what pharmacy that's storing it and knowing not to bill for it. Is it kept for that individual patient? Will every patient at Memorial Sloan-Kettering need his or her own private stash? How will we have our billing people figure out when to stop sending bills, because most of our charges are bundled anyway? How would you know when to start billing again?

"When you have a 'free drug,' will the doctor be expected to administer it free of charge, or will there be administration fees? And how will you submit charges for administration fees if you don't submit a charge for the drug?

"You want me to keep going?...

"Are we discriminating in favor of large and fat people if we have a flat out-of-pocket expenditure? Because a small, thin person will reach their dollar limit much later in their care than a large, fat one. It's not on a per-meter-squared basis. It's on a dollar-per-year basis.

"While I am tirading, if we are worried about cost-containment on this Amgen drug, what about the others? What about the massive amount of money that people spend on Neulasta (pegfilgrastim) and Aranesp (darbepoetin alfa)?

"If this is the proposed model on how we as a society are going to cope with this, obviously, this is going to need to extend to multiple drugs. So, imagine you have a patient on a five-drug regimen plus expensive antinausea medicines, and plus expensive growth factors.

"Will there be individual and different caps on each one, and who is going to keep track? You are going to need full-time financial advisors per patient.

"The bottom line is, the drugs are costing too much, and this is not the way to deal with the problem," Saltz said.

There are ethical problems, too.

"Physicians are not comfortable delving into people's finances," said Schrag. "We want to treat the rich and poor alike. Physicians would feel very intrusive asking people about their adjusted gross income at the end of their lives.

"What are docs supposed to do? Do I have to have a little clicker with me in clinic to know when my patient is getting close to their cap? Start gathering your tax returns, start filling out this application paperwork to try to get you into this SafetyNet Foundation.

"When people are anxious about being restaged or getting close to having conversations about hospice and best supportive care, that's a very traumatic time in people's lives. And yet, as a physician, you are referring them to the front office to deal with some billing manager.

"The way physicians handle this discomfort is to say, 'Go see Tina. She will help you figure out the money aspects of this.' That's why people hire Tina, this very firm, nice, smiling woman. These access programs are not easy or simple to negotiate."

Vectibix vs. Erbitux

At least for now, the price may be one of the more meaningful known differences between Vectibix and Erbitux.

A month of Erbitux costs about $10,000. A month of Vectibix, $8,000.

Erbitux is a chimeric antibody, Vectibix, humanized. "I think Amgen should be complimented on the fact that they priced it lower than Erbitux," said Mace Rothenberg, a gastrointestinal oncologist at Vanderbilt-Ingram Cancer Center. "They could have said, 'This is a fully human antibody. It's an advantage over the currently available chimeric antibody. Therefore, we should charge a premium.' But they didn't. They said, 'We are second on the market. We have to have something that allows us to get our foot in the door.'"

The agents are approved for the same indication, but based on different endpoints.

"The good news for our patients is that there are now choices and there is competition," said Neal Meropol, a gastrointestinal oncologist and a population scientist at Fox Chase Cancer Center. "The big missing piece of data in panitumumab right now is combination with chemotherapy. Those data are forthcoming, but right now we have abundant data regarding the combination of cetuximab with chemotherapy and very little data with panitumumab plus chemotherapy."

The administration schedules are different: weekly infusions for Cetuximab, and every two weeks for Vectibix. "However, there are recent data suggesting that every other week dosing of cetuximab may provide a similar pharmacokinetic profile to weekly dosing and maybe we will be able to someday move to every-other-week dosing of cetuximab as well," said Meropol.

According to product labels, severe allergic reactions occurred in 3 percent of patients receiving Erbitux and in 1 percent of patients receiving Vectibix. Yet, without a head-to-head study, there is no way to know whether there this is a real difference.

Moral Hazard

Amgen's patient assistance program, like many assistance programs for oral drugs reimbursed through Medicare Part D, aims to limit the patients' responsibility to make co-payments.

However, health researchers say that co-payments can prevent patients from overusing the system. "If you eliminate co-pays completely, people are going to consume all kinds of stuff they probably shouldn't," said Schrag. "It's one of the reasons why Medicare is so religious and strict about co-pays."

Health insurance can insulate consumers from financial consequences of their decisions, creating what economists call a "moral hazard."

"Co-pays have the potential to contribute an added degree of rationality to practice," said Meropol. "To the extent to which moral hazard can result in waste and inappropriate use of medical technologies the presence of co-pays can moderate that effect."

Though the Vectibix payment cap applies across the board, it will likely have greatest impact on the working poor and poor retirees who don't have co-pay insurance—people who aren't poor enough to get Medicaid assistance, but not rich enough to have additional coverage for what Medicare classifies as out-of-pocket expenses. According to industry figures, about 12% of Medicare patients have no co-pay support and would rapidly receive free drug.

"Those are the groups of patients this should provide the benefit for: Medicare beneficiaries who don't have supplemental insurance, and the uninsured, but also who don't have a cap on their out of pocket expenses in commercial health plans," Ofman said. "Hopefully this program does help this type of patients. But it's very early to tell who is going to be participating."

According to Amgen, the median duration of response to Vectibix was 17 weeks. At $2,000 a week, this adds up to $34,000 worth of Vectibix. For a Medicare patient, the government would pick up everything but $6,800.

"The really poor are buffered," said Schrag. "The really poor people get the stuff paid for by the state Medicaid programs. It's upsetting to people to have the really poor people not able to get stuff.

"The problem is that it gets the lower middle class. It gets the working poor; it gets the cops and firemen and public school teachers and home health aides, and people who work at Starbuck's, and janitors. People like that also tend to be proud. These are not the kind of people who mention to the doctor that this is a hardship. All the cops and firemen I take care of are proud people."

Of the patients who apply for help, many will drop off because of disease progression or side effects.

"Most people are going to get the drug for eight or nine weeks and have enough," she said. "It looks generous, but it's not that generous, and it could work

because cetuximab doesn't have anything comparable. It's great advertising, and it's a great PR plan."

It's unlikely that Genentech would face extreme exposure from imposing a $55,000 a year price cap. The company said it would announce the eligibility limit for the program sometime before it begins in January.

Based on clinical trial data, median progression-free survival in the approved lung cancer indication was 6.4 months. If a patient is treated through progression, at $8,800 a month, total treatment bill for Avastin would be $56,000.

"Half of the patients could receive more," said Genentech spokesman Lang. "This program will benefit those who do well on Avastin and exceed the six-month progression-free survival in lung cancer."

Megan Pace, another Genentech spokesman, said the program has been in development for a year and is now being discussed with patients and physicians. "We've just announced it, so we are in the process of talking with the physicians, but our hope is that it helps to enable physicians to treat these patients without additional concerns about expense," Pace said.

According to an analysis by Morgan Stanley, the program will have a "small" impact on Amgen's sales.

"Amgen's innovative plan addresses many of the patients most in need of aid, creates good public relations, and has little impact on current revenue expectations," the analysts wrote. "The program will allow Amgen to capture almost all of the economics of the short duration third-line colorectal cancer market while helping cap patient expense if the drug is ultimately successful in earlier stage patients with longer duration of therapy."

NCI Programs:

TCGA Project Selects First Three Cancers, Tissue Banks

NCI and the National Human Genome Research Institute selected the first three cancers that will be studied in the pilot phase of The Cancer Genome Atlas project: lung, brain (glioblastoma), and ovarian.

These cancers were selected because of the availability of biospecimen collections that met the project's scientific, technical, and ethical requirements. The biorepositories that will provide specimens are:

—Lung Cancer Tissue Bank of the Cancer and Leukemia Group B clinical trials group, housed at Brigham and Women's Hospital in Boston.

—The Brain Tumor Bank at M.D. Anderson Cancer Center in Houston.

—The Gynecologic Oncology Group tissue bank at Children's Hospital of the Ohio State University in Columbus.

NCI and NHGRI began TCGA in December 2005 as a three-year pilot project to test the feasibility of using large-scale genome analysis technologies to determine all of the important genomic changes involved in cancer. TCGA will consist of a Biospecimen Core Resource, Cancer Genome Characterization Centers, Genome Sequencing Centers, and a Principal Bioinformatics Resource.

NCI and NHGRI also selected the International Genomics Consortium, part of the Translational Genomics Research Institute, of Phoenix, to manage the Biospecimen Core Resource. The BCR will collect, store, process, and distribute biomolecules from cancerous and normal samples to the Cancer Genome Characterization Centers and Genome Sequencing Centers. The centers will be selected in coming months, the institutes said.

The three cancers were identified in a process that began in the fall of 2005 with a Request for Information from NCI and notification to NCI cancer centers.

NIH News:

NIH Funds Clinical Consortium

NIH funded grants for 12 academic health centers as part of its new Clinical and Translational Science Awards.

The following institutions will receive the first set of awards for nearly a five-year period: Columbia University Health Sciences; Duke University; Mayo Clinic College of Medicine; Oregon Health & Science University; Rockefeller University; University of California, Davis; University of California, San Francisco; University of Pennsylvania; University of Pittsburgh; University of Rochester; University of Texas Health Science Center at Houston; and Yale University.

The CTSA consortium will be led by the National Center for Research Resources. Funding for the initiative comes from redirecting existing clinical and translational programs, including Roadmap funds. Total first-year funding for the awards will be about $100 million. By 2012, the initiative is expected to provide a total of $500 million annually to 60 academic health centers.

A second Request for Applications for CTSAs has been issued for the next round of submissions to be made by Jan. 17, with awards expected in fall 2007.

In Brief:

NIH Funds 13 Pioneer Awards

(Continued from page 1)

Einstein College of Medicine of Yeshiva University, was elected to the Institute of Medicine. Horwitz, who was elected to membership in the National Academy of Sciences in 2005, is known for her pioneering work in elucidating the mechanisms of action of anti-tumor agents. Her pivotal research in the 1980s eventually led to the development of Taxol. In recent years, she has focused on the mechanisms of drug resistance. Horwitz received her B.A. from Bryn Mawr College and her Ph.D. in biochemistry from Brandeis University. She joined the Albert Einstein College of Medicine faculty in 1968, and became a professor in the Department of Molecular Pharmacology in 1980 and the co-chairman of that department in 1985. Horwitz was appointed Rose C. Falkenstein Professor of Cancer Research in 1986, associate director for therapeutics at the Albert Einstein Cancer Center in 2000, and Distinguished Professor in 2005. She is a past-president of the American Association for Cancer Research, and serves on the NCI Board of Scientific Advisors. . . . **NIH DIRECTOR'S PIONEER AWARDS** for 2006 were announced. Each awardee will receive $2.5 million in direct costs over five years. They are: **Kwabena Boahen**, associate professor of bioengineering, Stanford University; **Arup Chakraborty**, professor of chemical engineering, chemistry, and biological Engineering, Massachusetts Institute of Technology; **Lila Gerasch**, professor of biochemistry and molecular biology and chemistry, University of Massachusetts, Amherst; **Rebecca Heald**, associate professor of molecular and cell biology, University of California, Berkeley; **Karla Kirkegaard**, professor and chairman of microbiology and immunology, Stanford University; **Thomas Kodadek**, professor of internal medicine and molecular biology, University of Texas Southwestern Medical Center, Dallas; **Cheng Chi Lee**, associate professor of biochemistry and molecular biology, University of Texas Health Science Center, Houston; **Evgeny Nudler**, professor of biochemistry, New York University School of Medicine; **Gary Pielak**, professor of chemistry, University of North Carolina, Chapel Hill; **David Relman**, associate professor of microbiology and immunology and of medicine, Stanford University; **Rosalind Segal**, associate professor of neurobiology, Dana-Farber Cancer Institute; **James Sherley**, associate professor of biological engineering, MIT; and **Younan Xia**, professor of chemistry, University of Washington, Seattle. . . . **ROBERT NELSON**, associate professor of anesthesiology and critical care at Children's Hospital of Philadelphia, will join the FDA Office of Pediatric Therapeutics. He will provide guidance and advice on ethical issues on pediatric clinical trials and other pediatric issues. He will maintain his faculty appointments at the University of Pennsylvania School of Medicine. Nelson was chairman of the FDA Pediatric Advisory Committee for the past two years. He is director of the Center for Research Integrity established at CHOP to further the responsible conduct of pediatric research. He replaces **Sara Goldkind**, who will join the FDA critical path team. . . . **CORRECTION**: An item in last week's In Brief incorrectly identified **John Porter's** party affiliation when he served in Congress. He was a Republican from Illinois.

In the Cancer Centers:

Curiel Named SACI Director

TYLER CURIEL was named director of the San Antonio Cancer Institute, a collaboration of the University of Texas Health Science Center at San Antonio and the Cancer Therapy & Research Center. Curiel joined SACI from the Tulane University Medical School in New Orleans. "Dr. Curiel's leadership and scientific expertise is going to change the landscape of oncology in South Texas," said **Francisco Cigarroa**, president of the Health Science Center. "His arrival reflects the commitment of both the Health Science Center and the CTRC to expand what we are doing in academic oncology to better serve our region, the state and the world. One result will be more clinical trials testing more new groundbreaking treatments for cancer." SACI plans to apply for a renewal of its NCI Cancer Center Support Grant in October 2007. Curiel received his M.D. from Duke University and his M.P.H. from Harvard University. He completed an internship and residency in medicine at Yale University and was a clinical and research fellow in infectious diseases and medicine at Harvard Medical School and Massachusetts General Hospital. . . . **CITY OF HOPE** appointments: **Wendy Landier** was named clinical director of the Center for Cancer Survivorship, Division of Population Sciences, at City of Hope. Landier was clinical director of the Pediatric Survivorship Clinic at City of Hope. **Kimlin Ashing-Giwa** was appointed director of the new Center of Community Alliance for Research & Education and professor in the Division of Population Sciences. She was senior researcher and clinical psychologist at the University of California, Los Angeles. **David Horne**

was appointed co-director of the new Synthetic and Biopolymer Chemistry Core, and professor of molecular medicine. He was professor of chemistry at Oregon State University. . . . **MICHAEL NISHIMURA** was named associate professor in the Department of Surgery and head of research at the Hollings Cancer Center at the Medical University of South Carolina. He will work on immune-based cancer therapies. Nishimura, known for developing the T-cell receptor gene transfer approach for treating cancer, was director of the surgical oncology laboratories in the Department of Surgery at University of Chicago. . . . **BRIAN ISSELL** was named to the new position of vice president of clinical research at Scripps Health. An academic oncologist and clinical researcher, Issell will lead a new clinical research department across the Scripps system. Scripps Health adds 100 new clinical trials a year among its five hospitals, the Scripps Clinic medical group, and Scripps Cancer Center. Issell was professor of medicine and director of the clinical trials unit at the Cancer Research Center of Hawaii, University of Hawaii. He also was director of the Cancer Research Center of Hawaii and chief of the Division of Oncology of the Department of Medicine at UH. Under his leadership, the Cancer Research Center of Hawaii was awarded a P 30 Cancer Center Support Grant and NCI designation as a cancer center. In Hawaii he also was principal investigator of the NCI-sponsored, Hawaii Minority-Based, Community Clinical Oncology Program and Cancer Information Service-Pacific. . . . **ROSWELL PARK Cancer Institute** signed a regional affiliation network agreement with Bradford Regional Medical Center of Bradford, Penn. Patients in the BRMC cancer care program will be able to enroll in RPCI clinical trials and BRMC medical staff will be able to participate in the RPCI continuing medical education activities. In December, BRMC will open a new medical oncology suite. A full-time medical oncologist will be recruited to provide services to patients at the BRMC Cancer Care Center and will also serve as a member of the RPCI faculty. . . . **M. D. ANDERSON Cancer Center** and **Baylor College of Medicine** have begun the Texas Medical Center Asthma and Allergic Diseases Cooperative Research Center, funded by a $5.6 million five-year grant from the National Institute of Allergy and Infectious Diseases. The principal investigators are **Yong Jun Liu**, professor and chairman of the Department of Immunology at M. D. Anderson, and **David Huston**, professor of immunology and director of the Biology of Inflammation Center at BCM. . . . **NEVADA CANCER INSTITUTE** received a $15 million gift from the Engelstad Family Foundation of Las Vegas to endow professorships and fellowships for research, screening, and treatment of lung cancer. Some of the funds will go to outreach and education for Nevada residents.

Funding Opportunities:
NIH Seeks More Pioneers

NIH opened a new round of competition for the Director's Pioneer Award. The program supports exceptionally creative scientists who take highly innovative and potentially transformative approaches to major challenges in biomedical research.

"We hope this opportunity stimulates even more investigators to send us their boldest, most imaginative concepts," NIH Director Elias Zerhouni said. "The Pioneer Award supports individual scientists rather than specific projects and allows recipients to pursue promising new research directions that could have unusually great impact. This program is one way we are exploring of funding scientists whose ideas might be too novel, span too diverse a range of disciplines, or be at too early a stage to fare well in the traditional NIH peer review process."

Each Pioneer Award provides $2.5 million in direct costs over five years. NIH funded 35 scientists in the first three years of the program, which is part of the NIH Roadmap for Medical Research. In September 2007, the agency expects to make between five and 10 new Pioneer Award grants.

Scientists at all career levels and engaged in any field of research may apply for the Pioneer Award.

The centerpiece of the streamlined, electronic application process is an essay on the investigator's vision for addressing a biomedical challenge, the importance of the problem, and the person's qualifications to engage in groundbreaking research. The application period opens on Dec. 1, and closes on Jan. 16.

Application instructions: http://grants.nih.gov/grants/guide/rfa-files/RFA-RM-07-005.html.

RFA-CA-07-501: NCI Limited Competition Supplements for Pilot Projects for Community Networks Program to Reduce Cancer Health Disparities. U01. Letters of Intent Receipt Date: Nov. 20; May 29; Application Receipt Date: Dec. 18; June 27. Full text: http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-07-501.html. Inquiries: Kenneth Chu, 301-496-8589; KC10D@NIH.GOV.

RFP N02-CM-77000-16: Support Services for the Pharmaceutical Management Branch, CTEP. Response Due Date: Nov. 2. Full text: http://www.fbodaily.com/archive/2006/09-September/20-Sep-2006/FBO-01146627.htm. Inquiries: Annmarie Keane, keanea@mail.nih.gov.

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