Medicines & Healthcare products Regulatory Agency

MHRA
Regulating Medicines and Medical Devices

PHARMACOVIGILANCE INSPECTION REPORT

Pharmacovigilance System Name: Swedish Orphan Biovitrum AB

MHRA Inspection Number: Insp GPvP 27271/7235179-0001

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ABBREVIATIONS

ADR	Adverse Drug Reaction
AE	Adverse Event
CAP	Centrally Authorised Product
CAPA	Corrective and Preventative Action
DLP	Data Lock Point
EMA	European Medicines Agency
EU	European Union
GVP	Good Vigilance Practice
HCP	Healthcare Professional
ICH	International Conference on Harmonisation
ICSR	Individual Case Safety Report
MAH	Marketing Authorisation Holder
MedDRA	Medical Dictionary for Regulatory Activities
NCA	National Competent Authority
PIL	Patient Information Leaflet
PSMF	Pharmacovigilance System Master File
PSUR	Periodic Safety Update Report
PT	MedDRA Preferred Term
PV	Pharmacovigilance
PVA	Pharmacovigilance Agreements
QA	Quality Assurance
QMS	Quality Management System
QPPV	Qualified Person responsible for Pharmacovigilance
RMP	Risk Management Plan
SDEA	Safety Data Exchange Agreement
SmPC	EU Summary of Product Characteristics
SOP	Standard Operating Procedure
UK	United Kingdom
XEVMPD	eXtended Eudravigilance Medicinal Product Dictionary

SECTION A: INSPECTION REPORT SUMMARY

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Inspection type:	Statutory National Inspection
System(s) inspected:	Swedish Orphan Biovitrum AB, PSMF MFL 4935
Site(s) of inspection:	Remote inspection
Main site contact:	[redacted]
Date(s) of inspection:	11-14 August 2020
Lead Inspector:	[redacted]
Accompanying Inspector(s):	
Previous inspection date(s):	n/a
Purpose of inspection:	Inspection of pharmacovigilance systems to review compliance with UK and EU requirements
Products selected to provide system examples:	The inspection focussed on a review of the centrally authorised product [redacted]
Name and location of EU QPPV:	[redacted]
Global PV database (in use at the time of the inspection):	Sobi database: ARISg version 7.4 (commercially available) Global safety database for [redacted] held by Sanofi: Argus
Key service provider(s):	Global safety database and management of ICSRs for [redacted] managed by Sanofi. Signal management conducted in in partnership with Sanofi. Medical information services for [redacted] provided by [redacted]
Inspection finding summary:	01 Major finding 03 Minor findings
Date of first issue of report to MAH:	08 September 2020
Deadline for submission of responses by MAH:	12 October 2020
Date(s) of receipt of responses from MAH:	12 October 2020, a call to discuss responses was held with Sanofi on 12 November 2020. Subsequently, revised responses received from Sobi on 18 November 2020 and from Sanofi on 30 November 2020.
Date of final version of report:	02 December 2020
Report author:	[redacted]

SECTION B: BACKGROUND AND SCOPE

B.1 Background information

Swedish Orphan Biovitrum AB ('Sobi') was selected for routine inspection as part of the MHRA's statutory, national pharmacovigilance inspection programme. The purpose of the inspection was to review compliance with currently applicable EU and UK pharmacovigilance regulations and guidelines. In particular, reference was made to Regulation 726/2004/EC as amended, Directive 2001/83/EC as amended, Commission Implementing Regulation (EU) No 520/2012 and the adopted good pharmacovigilance practices (GVP) Modules. A list of reference texts is provided at Appendix I.

Sobi is an international biopharmaceutical company with four centrally authorised products for rare diseases marketed in the UK. Sobi operates a single pharmacovigilance system for all products but has established a partnership for the management of pharmacovigilance activities globally for [redacted] and [redacted] with Sanofi who holds licences for these products in non-EU territories, with the responsibilities of each party described in a safety data exchange agreement (SDEA), current version 1, dated 01 August 2019. The commercial arrangement for these products, and corresponding [redacted] was previously held with [redacted] who was acquired by Sanofi in 2018.

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As set out in the [redacted], Sanofi processes and reports ICSRs for [redacted] and [redacted] to EudraVigilance on behalf of Sobi. Signal management is conducted in partnership between Sobi and Sanofi. Data from the global safety database held by Sanofi is provided to Sobi who is responsible for producing and submitting EU PSURs.

The PSMF for the Sobi pharmacovigilance system is located in Sweden and therefore the supervisory authority is the Swedish Medical products Agency (MPA) who last inspected Sobi in 2018.

The inspection focussed on a review of [redacted], a recombinant [redacted] product used to treat haemophilia A. [redacted] was authorised centrally in the EU as a new active substance on 18 November 2015 and accordingly is subject to additional monitoring.

B.2 Scope of the inspection

The inspection included a review of specific pharmacovigilance activities for [redacted]; namely the collection and collation of safety data, signal detection and management, PSUR production and submission, and the partnership between Sobi and Sanofi for the conduct of these activities. Personnel from Sobi and Sanofi, participated in video calls in order to participate in the inspection.

The inspection was performed remotely using video call interviews and document review (including outputs from the global safety database and listings of product complaints). The topics reviewed during the inspection are highlighted in the Pharmacovigilance Inspection Plan (attached as Appendix II).

B.3 Documents submitted prior to the inspection

The company submitted a PSMF [redacted] dated 02 April 2020) to assist with inspection planning and preparation. Specific additional documents were also requested by

the inspection team and provided by the company prior to the inspection and are listed on document request sheet A which is filed with the inspection documentation.

B.4 Conduct of the inspection

In general, the inspection was performed in accordance with the Inspection Plan.

A closing meeting was held via video call to review the inspection findings on 14 August 2020.

A list of the personnel who attended the closing meeting is contained in the Closing Meeting Attendance Record, which will be archived together with the inspection notes, a list of the documents requested during the inspection and the inspection report.

SECTION C: INSPECTION FINDINGS

C.1 Summary of significant changes and action taken since the last inspection

Not applicable as this was the first MHRA pharmacovigilance inspection of the company.

C.2 Definitions of inspection finding gradings

Critical (CR): a deficiency in pharmacovigilance systems, practices or processes that adversely affects the rights, safety or well-being of patients or that poses a potential risk to public health or that represents a serious violation of applicable legislation and guidelines.

Major (MA): a deficiency in pharmacovigilance systems, practices or processes that could potentially adversely affect the rights, safety or well-being of patients or that could potentially pose a risk to public health or that represents a violation of applicable legislation and guidelines.

Minor (MI): a deficiency in pharmacovigilance systems, practices or processes that would not be expected to adversely affect the rights, safety or well-being of patients.

Comment: the observations might lead to suggestions on how to improve quality or reduce the potential for a deviation to occur in the future.

The factual matter contained in the Inspection Report relates only to those things that the inspection team saw and heard during the inspection process. The inspection report is not to be taken as implying a satisfactory state of affairs in documentation, premises, equipment, personnel or procedures not examined during the inspection.

Findings from any inspection which are graded as critical or major will be shared with the EMA, other EU competent authorities and the European Commission.

C.3 Guidance for responding to inspection findings

Responses to inspection findings should be clear, concise and include proposed actions to address both the identified deficiency and the root cause of the deficiency. Consideration should also be given to identifying and preventing other potential similar deficiencies within the pharmacovigilance system.

Responses should be entered directly into the table(s) in section C.4. The following text is intended as guidance when considering the information that should be entered into each of the fields within the table(s). 'Not applicable' should be entered into the relevant field if the requested information is not appropriate for the finding in question.

Root Cause Analysis Identify the root cause(s) which, if adequately addressed, will prevent recurrence of the deficiency. There may be more than one root cause for any given deficiency.
Further Assessment Assess the extent to which the deficiency exists within the pharmacovigilance system and what impact it may have for all products. Where applicable, describe what further assessment has been performed or may be required to fully evaluate the impact of the deficiency e.g. retrospective analysis of data may be required to fully assess the impact.
Corrective Action(s) Detail the action(s) taken / proposed to correct the identified deficiency.
Preventative Action(s) Detail the action(s) taken / proposed to eliminate the root cause of the deficiency, in order to prevent recurrence. Action(s) to identify and prevent other potential similar deficiencies should also be considered.
Deliverable(s) Detail the specific outputs from the proposed / completed corrective and preventative action(s). For example, updated procedure/work instruction, record of re-training, IT solution.
Due Date(s) Specify the actual / proposed date(s) for completion of each action. Indicate when an action is completed.

Further information relating to inspection responses can be found under 'Inspection outcomes' at: https://www.gov.uk/guidance/good-pharmacovigilance-practice-gpvp

C.4 Inspection findings

C.4.1 Critical findings

No critical findings were identified from the review of pharmacovigilance processes, procedures and documents performed during this inspection.

C.4.2 Major findings

MA.1 Periodic safety update reports

Requirements:

GVP Module VII (Rev 1)
VII.B.5.6.3. PSUR sub-section "Cumulative and interval summary tabulations from post-marketing data sources"

Finding MA.1 a)

Sobi had incorrectly included unrelated solicited and spontaneous events in PSUR summary tabulations of adverse drug reactions (ADRs) from post-marketing sources.

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i) The cumulative and interval summary tabulation for post marketing sources in [redacted] PSUR 11 (DLP 05 June 2020) incorrectly included events from solicited reports where reporter causality had been defined as 'unassessable' (i.e. unknown) and company causality was 'unreportable' (synonymous with unrelated per company conventions). Examples included:

- Case [redacted] was a serious solicited case received from a patient support programme (PSP) in the USA on 03 June 2019, reporting the serious event preferred terms (PTs), 'Rib fracture', 'Road traffic accident' and 'Back injury'. Source documentation stated, *"PT stated that he just left the hospital. He was in a car crash at the front of the car and the air bags did not deploy. He reports he broke two ribs and hurt his back*". The reporter causality was captured as 'unassessable' for all the events and the company causality assessment was 'not reportable' for all the events.

- Case [redacted] was a serious solicited case received from a PSP in Canada on 28 May 2018 and updated on 07 June 2018 to report the serious event PT, 'Chest injury'. Source documentation stated, *"Patient poked himself in the chest with a pencil*". The reporter stated the causal relationship to [redacted] was 'unknown' and the company assessment for the event was unrelated.

For the interval period for PSUR 11 (06 June 2019 – 05 June 2020), there were 48 serious events from solicited reports that met these criteria. Cumulatively, there were 87 serious events from solicited reports that met these criteria.

ii) The cumulative and interval summary tabulations for post marketing sources in [redacted] PSUR 10 (DLP 05 June 2019) and PSUR 11 (DLP 05 June 2020) incorrectly included adverse events from spontaneous reports where the reporter had explicitly stated that the event was unrelated to [redacted] Examples included:

- Case 2018BV000217 was a non-serious spontaneous case from the USA initially

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received on 19 April 2018, reporting the event PTs, 'Accident at work' and 'Limb injury'. Source documentation stated, *"forklift ran over his foot because the machinery malfunctioned"*. On the post-marketing safety event notification, it was stated that the patent assessed the event not to be related to [redacted].

- Case [redacted] was a serious spontaneous case from Japan initially received 05 October 2018, reporting the event PTs, 'Oesophageal varices haemorrhage' and 'Hepatic failure' with a fatal outcome. Source documentation stated, "*The patient's concurrent disease included varices oesophageal and end-stage hepatic cancer which was worsened from hepatitis C*". On the adverse event reporting form it was stated that the reporting physician assessed the events as not related to [redacted]

These examples did not qualify for expedited reporting to the EMA, and therefore accordingly are not relevant for including in aggregate reports as ADRs. The inclusion of all spontaneous reports, irrespective of reporter causality assessment, was introduced in PSUR 10 following transfer from Bioverativ processes to Sanofi processes.

Root Cause Analysis

[redacted]

Further Assessment

[redacted]

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[redacted]

Corrective Action(s)

[redacted]

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[redacted]

[redacted]	
Preventative Action(s)	
[redacted]	
Deliverable(s)	**Due Date(s)**
[redacted]	

Finding MA.1 b)

Two cases that should have been nullified prior to the DLP of [redacted] (05 June 2020) were incorrectly included in the cumulative and interval summary tabulation for post marketing sources:

- Case [redacted] was a non-serious spontaneous case from Portugal, first received 17 February 2020, and reporting the event PTs, 'Poor venous access' and 'Anti factor VIII antibody positive'. Follow-up information was received on 19 March 2020 confirming that [redacted] was not the product involved, however the case was not nullified until four months later on 07 July 2020.

- Case [redacted] was a serious spontaneous case from Spain, first received 18 February 2020, and reporting the event PTs, 'Vascular pseudoaneurysm thrombosis', 'Subcutaneous haematoma', 'Mass' and 'Anti factor VIII antibody positive'. Follow-up information was received on 20 April 2020 confirming that the suspect drug was not the company product, however the case was not nullified until three months later on 07 July 2020.

Root Cause Analysis

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[redacted]

Further Assessment

[redacted]

Corrective Action(s)

[redacted]

Deliverable(s)	Due Date(s)
[redacted]	

Preventative Action(s)

[redacted]

Deliverable(s) Sobi response:	Due Date(s) Sobi response:

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C.4.3 Minor findings

MI.1 Signal management for biological medicines

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Finding MI.1 a)
Sanofi conducted biannual lot trending reviews for [redacted] which detailed the number of cases received per lot over a six-month period. A quantitative threshold of 10 cases with the same lot number received during the report period triggered further qualitative review of the reported cases and events. However, the following limitations were identified with this approach: i) There was no review of all cumulative cases received for a specific lot, thus covering the entire lifecycle of a lot (the unopened product had a shelf life of four years). For example, the lot review covering 01 October 2018 – 30 June 2019 (dated 18 October 2019) identified 11 cases for lot [redacted] and 9 cases for [redacted] received in this period. During the following review cycle (covering 01 July – 31 December 2019, report dated 20 March 2020), an additional 2 cases for lot [redacted] and 4 cases for [redacted] were reported but these were not evaluated in the context of the previous reporting period. ii) Lot-specific exposure data was not included in the review to identify whether there were any changes in the AE reporting rate for specific lots. Sobi are reminded of the guidance in section B.4. on signal management of GVP Chapter PII Product- or Population-Specific Considerations II: Biological medicinal products which states: "*Processes should be particularly sensitive to detect any acute and serious new risks that may emerge following a change in the manufacturing process or quality of a biological and important differences between batches of the same product (this is particularly important following a significant change to the manufacturing process given that the product name usually does not change).*"
Root Cause Analysis
[redacted]

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[redacted]

Further Assessment

[redacted]

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Corrective Action(s)	
[redacted]	
Deliverable(s) **Sobi response:**	**Due Date(s)** **Sobi response:**
[redacted]	
Preventative Action(s)	
[redacted]	
Deliverable(s)	**Due Date(s)**
[redacted]	

Finding MI.1 b)
The confirmed signal of Vascular Thromboembolic Events (VTEs) for [redacted] was not evaluated in the context of batch-specific exposure data following its detection in July 2019. The MAH stated in response to a document request *"As there was no potential signal identified from periodic manufacturing lot review, a separate batch specific analysis was not done"* for this signal. The six-monthly lot trending reviews conducted by Sanofi for [redacted] only considered the number of cases received per lot over a six-month period and did not include cumulative data. Therefore, the guidance in GVP PII.B.4. which states, *"In case of a signal any effort should be made to identify any common root cause such as batch"* was not demonstrably followed.

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This has been graded as a minor finding as this signal for [redacted] was evaluated based on other sources of data and ultimately confirmed following its evaluation.

Root Cause Analysis

[redacted]

Further Assessment

[redacted]

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Corrective Action(s)	
[redacted]	
Deliverable(s)	Due Date(s)
[redacted]	
Preventative Action(s)	
[redacted]	
Deliverable(s) Sobi response:	Due Date(s) Sobi response:
[redacted]	

MI.2 Follow-up of safety reports

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Finding MI.2 a)
A spontaneous report [redacted] was received in the UK on 23 June 2017 that described a patient who received Elocta for immune tolerance induction (ITI) (off-label use), from an HCP via Sobi representative. The case was invalid as no patient identifiers were provided in the report, however it was not followed up to obtain these details. The ARISg User Manual (v5.0 effective 31 March 2017, superseded by v6.0 on 16 November 2017), followed at the time by Sobi employees for the collection of [redacted] ICSRs and the conduct of follow-up to these reports, did not specify how to follow-up invalid reports of off-label use. In response to inspection document request N05, regarding whether attempts to obtain follow-up were made for the case, Sobi stated *"No follow-up was performed. Off label use with no AE reported does not require follow up as per Sobi conventions"*. The current work instruction [redacted] 'ARISg User Manual - Follow-up' (v1.0 effective 27 April 2020), states that for off-label use without associated AE (valid and invalid reports*): "No follow up required unless summarised in the Product Safety Information (PSI) aligned to the Risk Management Plan"*. However, there was no approved PSI for [redacted]. Off-label use of [redacted] for ITI has been specifically reviewed in [redacted] PSURs as a safety concern listed as 'missing information' in the RMP and only valid cases were included in this review in the PSUR for this off-label use of [redacted] As no follow-up was conducted to obtain patient identifiers for this case, this case remained invalid and was therefore not included in any PSURs.
Root Cause Analysis
[redacted]

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Further Assessment
[redacted]
Corrective Action(s)
[redacted]
Deliverable(s) / **Due Date(s)**
[redacted]

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Preventative Action(s)	
[redacted]	
Deliverable(s)	**Due Date(s)**
[redacted]	

Finding MI.2 b)
Product specific targeted questions were listed on 'Data Collection Tools' (DCT) (approved on 17 March 2020) to be used for the follow-up of reports of inhibitor development to [redacted] and thrombosis; both reactions that are listed as important identified and potential risks in the RMP for [redacted] respectively, (current approved version 3.0 dated 20 February 2019). However, the use of these DCTs was not formally documented in written procedures. During the inspection, it was verbally described by Sobi that a product safety information (PSI) document, which was referred to in SOPs and WIs as a product specific reference during case handling was under preparation and would describe the use of these DCTs.
Root Cause Analysis
[redacted]
Further Assessment
[redacted]
Corrective Action(s)
[redacted]
[redacted]

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Preventative Action(s)	
[redacted]	
Deliverable(s)	**Due Date(s)**
[redacted]	

MI.3 Quality management for signal management

The following deficiencies were identified in relation to the procedural documentation governing the signal detection and management activities at Sobi. GVP [redacted] (Rev 1), section B.5 on quality requirements for signal management describes the need for detailed procedures that clearly document roles, responsibilities and tasks. The below procedural deficiencies have been graded as minor as no deficiencies were identified in the actual activities reviewed during the inspection.

Finding MI.3 a)
There was no procedural documentation describing the activities, frequency and members of the joint Safety Surveillance Team (SST) whose function was a joint forum to review safety data for detection and validation of potential signals.
Root Cause Analysis
[redacted]
Further Assessment
[redacted]
Corrective Action(s)
[redacted]

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[redacted]

Deliverable(s)	Due Date(s)
[redacted]	

Preventative Action(s)

[redacted]

Deliverable(s)	Due Date(s)
[redacted]	

Finding MI.3 b)

The Sobi procedures used for signal detection for products other than [redacted], did not include any defined timeframes within which signal detection and evaluation steps should be completed to ensure that these activities are conducted in a timely manner.

Root Cause Analysis

[redacted]

Further Assessment

[redacted]

Corrective Action(s)

[redacted]

Deliverable(s)	Due Date(s)
[redacted]	

Preventative Action(s)

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Sobi response:	
[redacted]	
Deliverable(s)	**Due Date(s)**
[redacted]	

C.4.4 Comments

1. In accordance with the SDEA in place between Sanofi and Sobi for [redacted], Sanofi were responsible for full data entry of [redacted] cases and their submission to EudraVigilance as required. Per the SDEA, exchange of ICSRs was via CIOMS I form (or other agreed method such as outputs from study electronic data capture systems). These CIOMS I forms were generated following the creation and populating of cases in ARISg by Sobi staff through an accelerated workflow that, whilst ensuring all information was captured in the case narrative field, did not include medical assessment of the case causality or seriousness or MedDRA coding of the events. There was no exchange of source records for the purposes of verification of the final case versions prior to submission to EudraVigilance, in accordance with GVP Module VI (Rev 2) which states that *"Conformity of stored data with initial and follow-up reports should be verified by quality control procedures, which permit for the validation against the original data or images thereof. With regard to this, the source data (e.g. letters, emails, records of telephone calls, which include details of an event) or an image of the source data should be easily accessible"*. No discrepancies were identified by inspectors between source records received by Sobi and corresponding cases fully processed by Sanofi, however provision should be made to allow source records to be available to support QC of cases where required.

2. Section 9.2 'Medication errors' of [redacted] PSUR 11 (DLP 05 June 2020) did not state the number of relevant non-serious solicited reports that were assessed in the interval. It is acknowledged that an additional search was completed to identify all relevant ICSRs irrespective of causality and seriousness assessment, however the output from this search was not stated in the PSUR. The company should consider the transparency of this section (and any other relevant section where this may apply) with regards to the total number of relevant events, regardless of whether they meet the criteria for inclusion in the cumulative and interval summary tabulation.

SECTION D: CONCLUSIONS AND RECOMMENDATIONS

D.1 Conclusions

The factual matter contained in the Inspection Report relates only to those things that the inspection team saw and heard during the inspection process. The Inspection Report is not to be taken as implying a satisfactory state of affairs in documentation, premises, equipment, personnel or procedures not examined during the inspection. It is recommended that you review whether the inspection findings also apply to areas not examined during the inspection and take appropriate action, as necessary.

The responses to the inspection findings, which include proposed corrective and preventative actions, do appear to adequately address the issues identified. No additional responses are required at this time. When the company has adequately implemented the proposed corrective and preventative actions, the pharmacovigilance system will be considered to be in general compliance with applicable legislation.

D.2 Recommendations

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Sobi is encouraged to share this inspection report with Sanofi as the partner to whom it has sub-contracted some pharmacovigilance activities for [redacted]. Where deficiencies are more broadly applicable to products and MAHs not subject to this inspection, appropriate CAPA should be proposed. Specific CAPA relating to Sanofi processes may be incorporated into this report or provided separately. Sobi and Sanofi should be able to demonstrate effective assessment and resolution of deficiencies that have been reported during any inspection.

The Lead Inspector has recommended that the next MHRA inspection is performed as part of the routine risk-based national inspection programme.

APPENDIX I REFERENCE TEXTS

- Regulation (EC) No. 726/2004 (Title II, Chapter 3), as amended
- Directive 2001/83/EC, as amended
- Commission Implementing Regulation (EU) No 520/2012
- Guideline on good pharmacovigilance practices (GVP)
- The Human Medicines Regulations 2012 (Statutory Instrument 2012 No. 1916)
- EMA/CHMP/ICH/544553/1998: ICH guideline E2C (R2) on periodic benefit-risk evaluation report (PBRER)

APPENDIX II PHARMACOVIGILANCE INSPECTION PLAN

MHRA INSPECTION NUMBER	Insp GPvP 27271/7235179-0001	**INSPECTION TEAM**	[redacted]
PHARMACOVIGILANCE INSPECTION OF	Swedish Orphan Biovitrum AB	**DATES**	11th – 14th August 2020

- An opening meeting will be held by video conference on **Tuesday 11th August, 9.30am (BST)**, led by the lead inspector. The agenda will be:
  - Review of the scope and arrangements for the inspection
  - Brief presentation by Sobi (20 min) with an overview of the company and pharmacovigilance system. The presentation should focus on the topics listed for inspection and any relevant ongoing remediation work in the pharmacovigilance system.
- A specific time will be agreed for an overview via video Conference of each topic to be covered preferably on day 1 or 2 of the inspection.
- The remainder of the inspection will consist of remote document review, written requests and ad hoc video/telephone clarifications with subject matter experts as required, at a pre-agreed time based on SME availability.
- Feedback on any non-compliance will provided during the closing meeting TC planned for the end of day 4 (time to be confirmed). All relevant personnel are welcome to attend the closing meeting.

The inspection will be focused on a review of specific pharmacovigilance activities listed below in relation to Elocta (efmoroctocog alfa)	
Topics for review	**Personnel** (Name & Job Title)
Topic 1 **Sources of safety data at Sobi** Including: - UK Non-interventional studies - UK Investigator initiated studies - Pharmacovigilance and safety data exchange agreements between Sobi and third parties in the UK for Elocta - Medical information - Product quality complaints - Transmission of ICSRs to Sanofi and reconciliation - Follow-up for UK safety relevant reports **Interview session – 10am 12 Aug** Please prepare a short (<20 min) presentation on the routes of receiving safety data for Elocta at Sobi, the transmission of ICSRs to Sanofi and the associated tracking and reconciliation processes with Sanofi.	**Presentation preferred on Day 2 (August 12) due to availability of SME** [redacted]

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Topic 2 **Periodic safety update reports** - Provision of data for PSURs including extraction of data for summary tabulations and specific searches from the safety database - PSUR authoring - Quality control **Interview session – 11.30am 11 Aug** Please prepare a short (<20 min) presentation on the company process of PSUR production, specifically around the provision and QC of data from the Sanofi global safety database for summary tabulations and ad hoc searches.	**Presentation preferred during the morning on day 1(August 11) due to availability of SME** [redacted]
Topic 3 **Ongoing safety evaluation** - Signal detection and management - Signal tracking **Interview session 1pm 11 Aug** Please prepare a short (<20 min) presentation on the joint Sobi/Sanofi signal detection and management process.	**Presentation preferred on day 1 (August 11)** [redacted]