



## TECH TRANSFER AND QRM

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**VICE PRESIDENT– COMMISSIONING AGENTS, INC**

SAAPI Conference  
Bytes Conference Centre, Midrand  
Friday, Oct 6<sup>th</sup>, 2017



# COMMISSIONING AGENTS, INC.



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When you need to meet a higher standard.

# What is Technical Transfer?

## ISPE

The systematic approach that is followed in order to pass the **documented knowledge** and **experience gained** during development and/or commercialization to an appropriate, responsible, and authorized party

## ICH Q10

**Transfer of product and process knowledge between development and manufacturing, and within or between manufacturing sites to achieve product realization**

new product transfers during development through manufacturing

transfers within or between manufacturing and testing sites for marketed products

# Key References

ICH Q8R2

ICHQ10

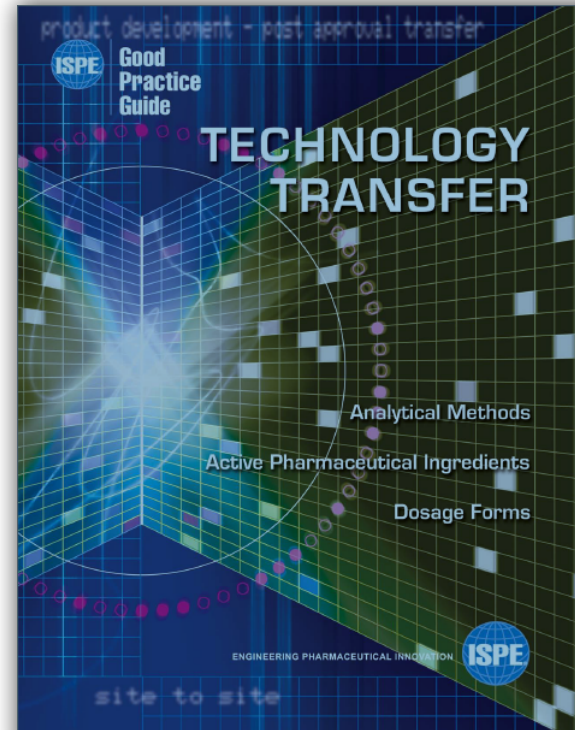
ISPE Tech Transfer Guide 2014

ISPE PQLI guides

WHO guide 2011

EMA annex 15

Draft annex 12- lifecycle management



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# Technical Transfer Examples

## **New product to the market**

Limit client risk yet maximize speed to market

## **Scale-up of an existing process**

Creative solutions typically required for implementation

## **Movement of production to new facility**

New can cost less. Like for like expected.

## **Process improvements**

Continual improvement to improve product cost a must

# Types of Technical Transfers: Risk Assessment

Each type of Tech Transfer comprises similar risk elements

Sending	Receiving	New Product	Same or Single Market	New or Multiple Market(s)	Existing Production Line	New Production Line	Equivalent Equipment	Equipment Change	>10x Scaleup	Process Change	New Process
Site 1	Site 1	No	Low	Med	NA	Med	Low	Med/High	High	Med/High	High
Site 1	Site 1	Yes	High	High	Low/Med	Med	Low	High	High	NA	High
Site 1	Site 2	No	Low	Med	Low	Med	Low	Med/High	High	Med/High	High
Site 1	Site 2	Yes	High	High	Med	Med	Low	High	High	NA	High

The risk assessment needs to include key cross-functional activities that comprise the boundaries of a TT

## Measures of Success of a TT program



**Does the approach promote the delivery of working equipment and automation, to achieve smooth transition to full scale operation?**

**Is the approach efficient in terms of effort (cost) and time (schedule)?**

**Is the program product/process focused, initiated with Process robustness ?**

**Will the approach be found acceptable by regulators?**

# The WHAT – Define Project Scope

## **Define the Project Scope and establish clear objectives with specific acceptance criteria.**

- > Proposed Registration and Launch Timings
- > Safety Information (MSDS, Fire & Health Hazards etc.)
- > Commercial needs (e.g. forecast Volume)
- > Cost of Goods
- > Tech transfer budget



# The WHO – Establish the Team

## Appoint a Team Leader and Form a cross functional project team

**CORE EXPERTISE:** Process Development, Manufacturing Operations - (manufacturing, engineering and maintenance, production QA, QC, Validation)

**SUPPORT EXPERTISE:** Regulatory affairs, EHS, Medical, Marketing, Supply Chain



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# The HOW – Establish the Plan

## Develop a Comprehensive Execution Plan that captures:

- > Goals and timing
- > Facility fit and regulatory strategy
- > Process tech transfer requirements
- > Managing documentation
- > Effective Team Communications
- > Roles and Responsibilities
- > Project schedule and resource requirements & tracking team performance

# Documentation Hierarchy

**TT Master plan**

**Subplans**

**TT Risk Assessment**

**Process Robustness study**

**TT SOP/protocols/Templates/reports**



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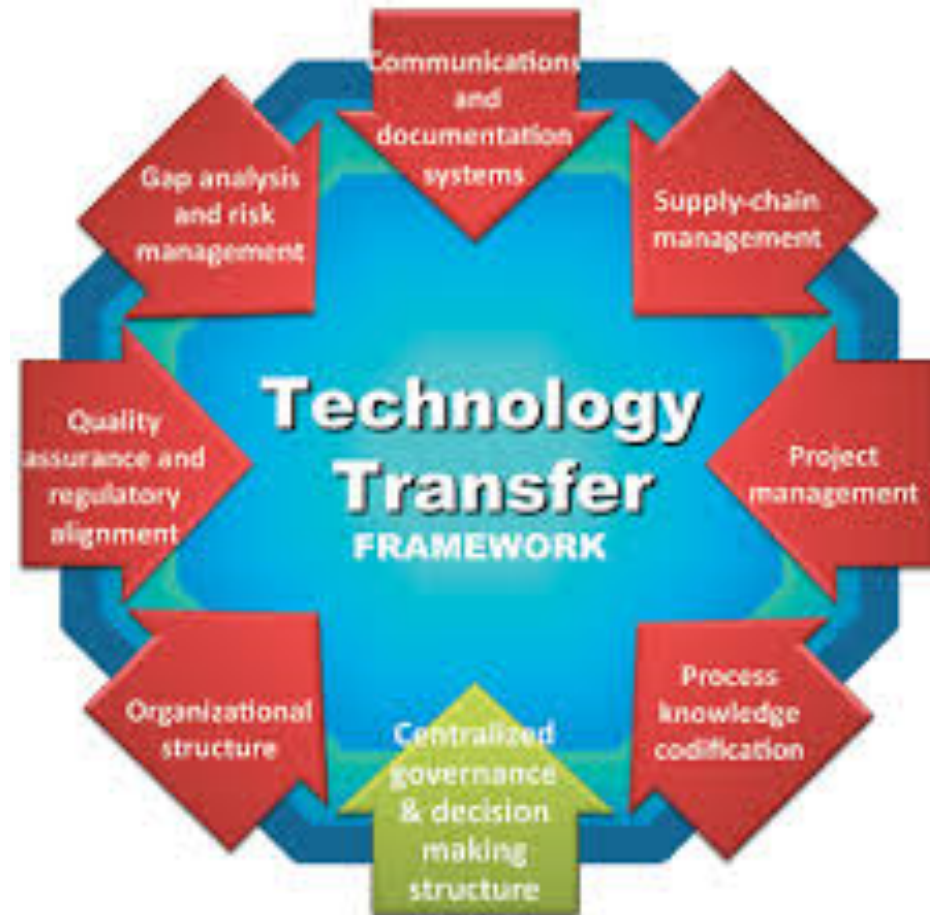
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# CAI Tool Box

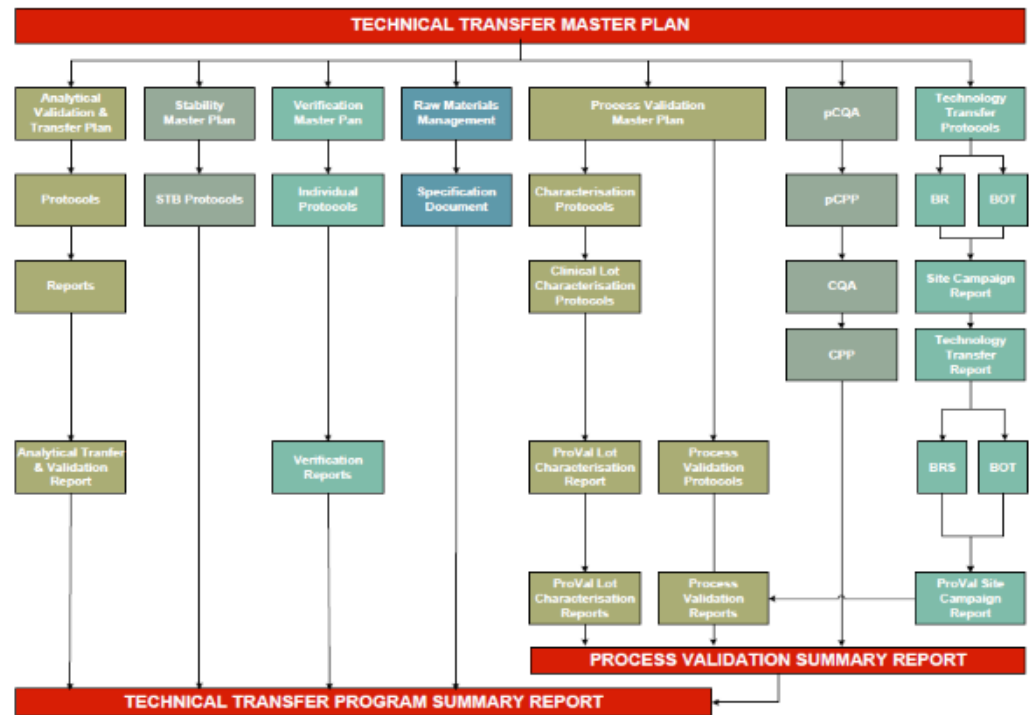
- **Program Management Plan**
- **Technology Transfer Plan**
- **TT Project Execution Plan**
- **Lifecycle Phase Checklist**
- **Subordinate plans/Reports**
  - CQV
  - Cleaning
  - Materials Mgt/Control
  - Supply Chain
  - Analytical Methods Validation
  - PQS
- **PM tools**
  - Schedule/Action/Decision logs



CONTENTS

1.	<b>SUMMARY</b>	2
2.	<b>PURPOSE</b>	2
3.	<b>SCOPE</b>	2
4.	<b>RESPONSIBILITIES</b>	2
4.1	Technical Transfer Core Team	2
4.2	Technical Transfer Extended Teams	2
4.3	Research and Development (R&D)	2
4.4	Technical Department	2
4.5	Operations	2
4.6	Quality Assurance (QA)	2
4.7	Regulatory Affairs (RA)	2
4.8	Operations Sites (PFI and JP)	2
5.	<b>DEFINITIONS</b>	2
6.	<b>ABBREVIATIONS</b>	2
7.	<b>TECHNOLOGY TRANSFER PHASES &amp; ASPECTS</b>	2
7.1	Feasibility	2
7.2	Planning	2
7.3	Technology Transfer Plan	2
7.4	Technology Transfer Implementation	2
7.5	Raw Materials	2
7.6	Environmental Health and Safety	2
8.	<b>PROCESS AND EQUIPMENT DESCRIPTION</b>	2
9.	<b>QUALIFICATION AND VALIDATION STRATEGY</b>	2
9.2	Analytical Method Validation and Transfer	2
9.3	Stability Testing for BAC2	2
9.4	Additional Studies	2
10.	<b>TRANSFER STAGE</b>	2

# Technology Transfer Master plan

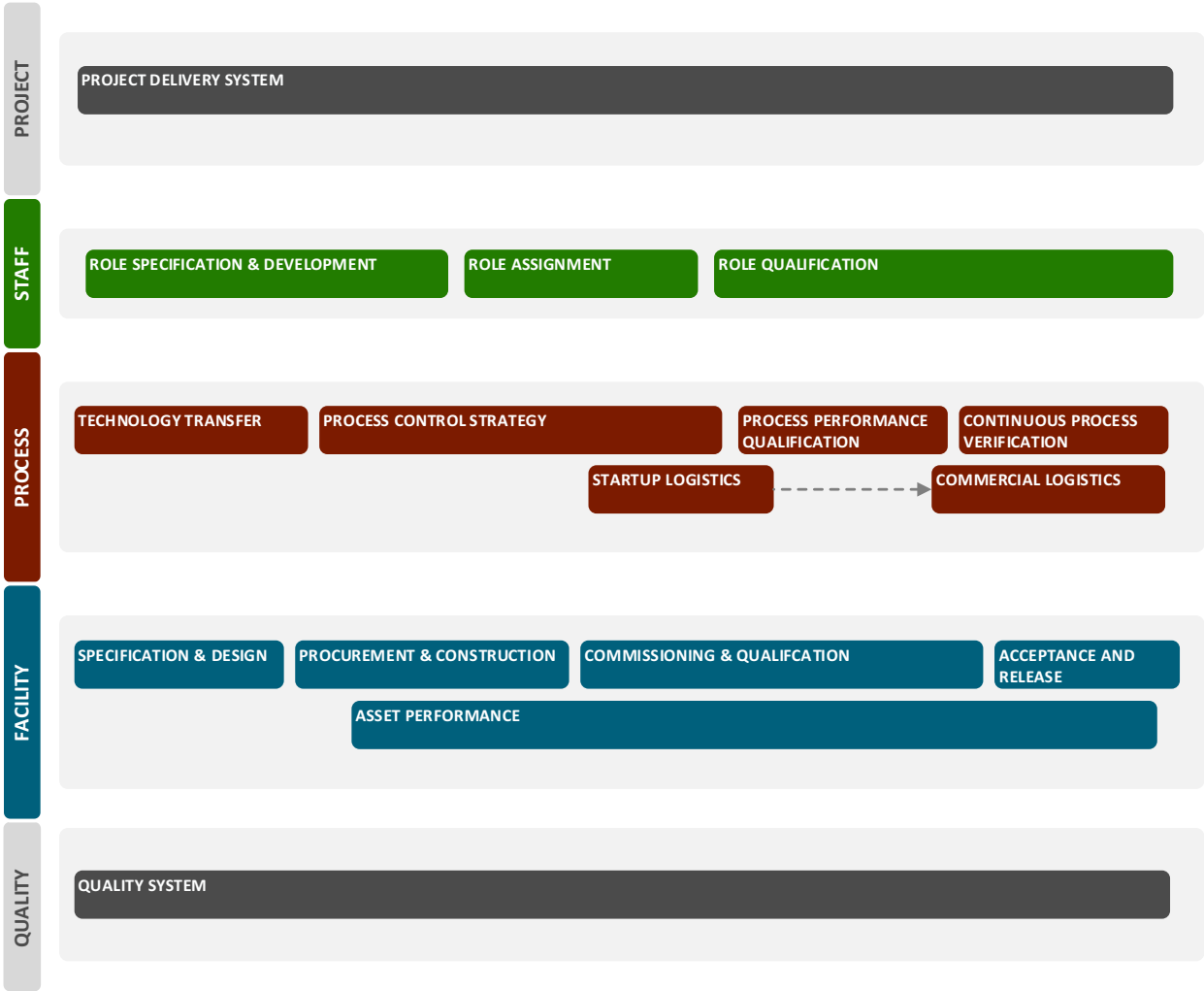


# TT Checklist

Dev = Development, Mfg = Manufacturing, Eng = Engineering, Reg = Regulatory, QA = Quality Assurance, Anl = Analytical, Val = Validation, Legal = Legal, PM = Project Management, Log = Logistics, EH&S = Environmental, Health, and Safety, Dis = Function  
 E-E = Existing Drug to Existing site, E-N = Existing Drug to New Facility, N-E = New Drug to Existing Facility, N-N = New Drug to New Facility.

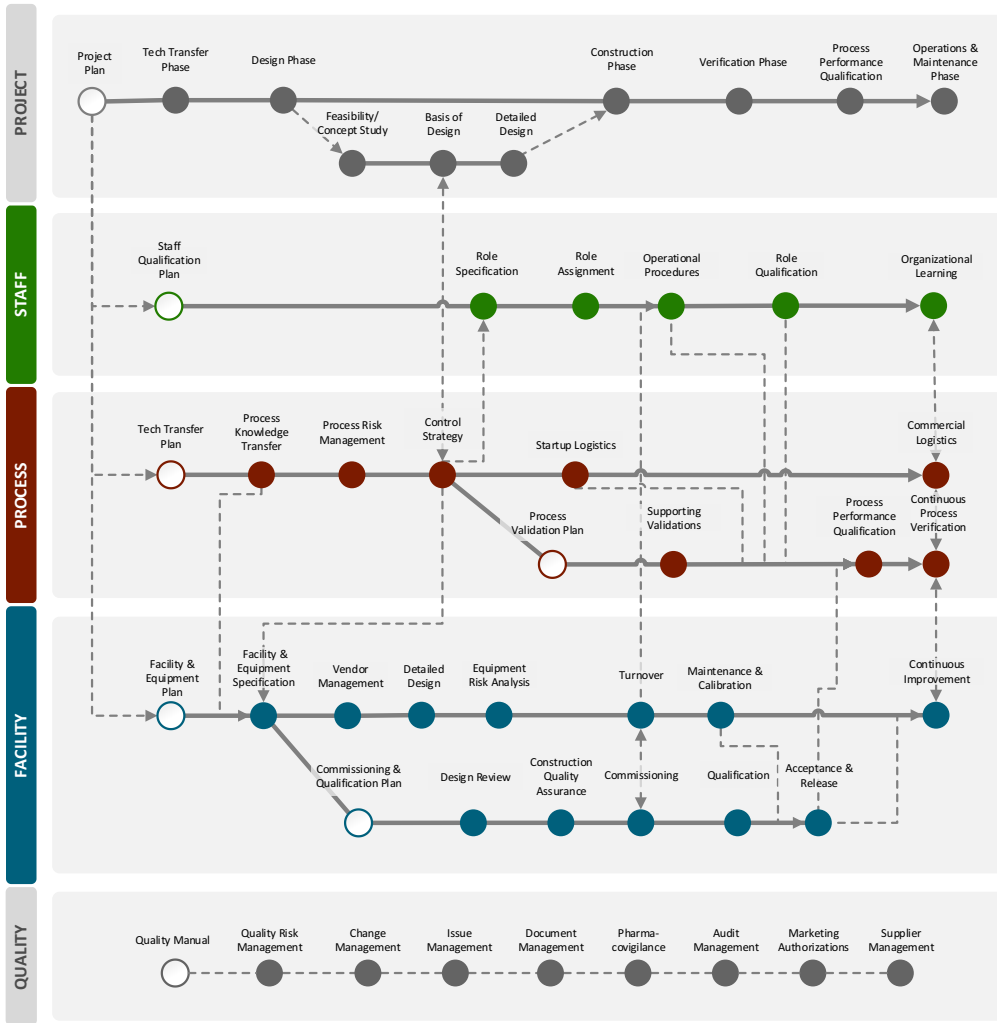
Type	PROJ	Activity	Phase	Dis	Deliverable	Ref	Project
E-E	<input type="checkbox"/>	Technical Development	Prior to Transfer or Feasibility	Dev, Mfg, Eng, Reg, QA	Go/No-Go Decision		
E-N	<input type="checkbox"/>	Initial Process Description					
N-E	<input type="checkbox"/>	Initial Product Description					
N-N	<input type="checkbox"/>	Dosage and Delivery Materials (consider European/Japanese/United States Pharmacopoeia or Multi-compendia) Specifications Method Development Instrumentation Needs Process / Product Development Reports Development History Report Manufacturing Monograph					
E-E	<input type="checkbox"/>	Write Confidential Disclosure Agreement (CDA)	Feasibility	QA, Legal	Approved CDA		
E-N	<input type="checkbox"/>	Approve CDA					
N-E	<input type="checkbox"/>						
N-N	<input type="checkbox"/>						
E-E	<input type="checkbox"/>	Evaluate Facility and Utilities	Feasibility	Dev, Mfg, Eng, Reg, Anl	Feasibility Assessment Report		
E-N	<input type="checkbox"/>	Evaluate Equipment					
N-E	<input type="checkbox"/>	Evaluate Process Capability					
N-N	<input type="checkbox"/>	Evaluate Technical Capacity Evaluate Analytical Capabilities Evaluate Regulatory Implications Evaluate Material Logistics					
E-E	<input type="checkbox"/>	Assess Quality Systems Assess Prior Regulatory Inspections	Feasibility	QA/Val	Audit Report		





**Our Solution.**

**The Chemistry of Full Scale Operations (FSO)<sup>TM</sup>**



**Our Solution, in Detail.**  
**The Chemistry of Full Scale Operations (FSO)<sup>TM</sup>**



# Summary

- **TT subset of Product Realization**
- **Knowledge Transfer is a key element to all TTs**
- **Upfront work to define complexities, resource needs, and understand business/regulatory strategy allows for smoother and more successful TT**
- **Risk management enables a more streamlined lifecycle effort**
- **Solid understanding of company's quality management system essential to defining requirements and flexibility that will be allowed**



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# QUALITY RISK MANAGEMENT



# References

**ICH Q9 “Quality Risk Management”**

**FDA Guidance on Process Validation**

**ICH Q8 (R2) “Pharmaceutical Development”**

**ASTM E2500**

**IEC 60812**

Analysis techniques for system reliability – Procedure for failure mode and effects analysis (FMEA)

## Risk Management is Universal across all Industries

### Common Elements

What can go wrong?

How often does it happen?

How bad are the consequences?

Is the risk acceptable?

### Key Differences

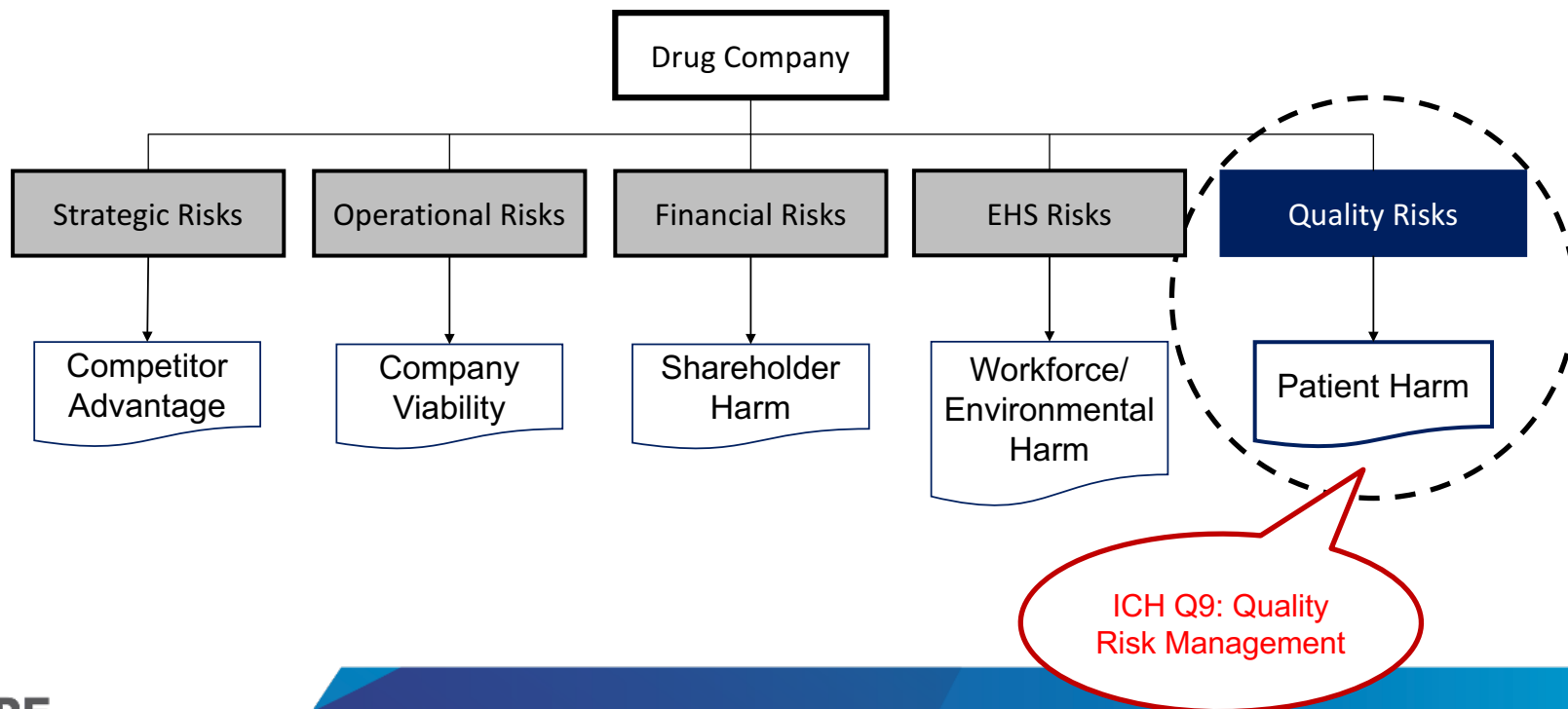
Risk criteria

Technology involved

Nature of the hazard

Whether the system is static or dynamic

# Risk Management In the Drug Industry



# Quality Risk Management ICH Q9

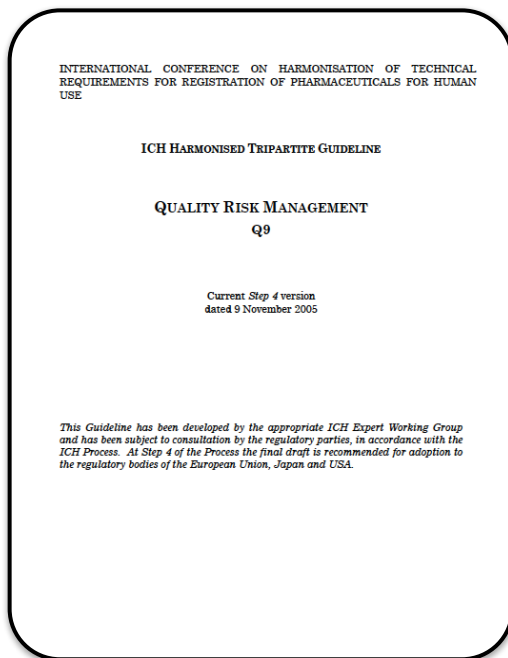
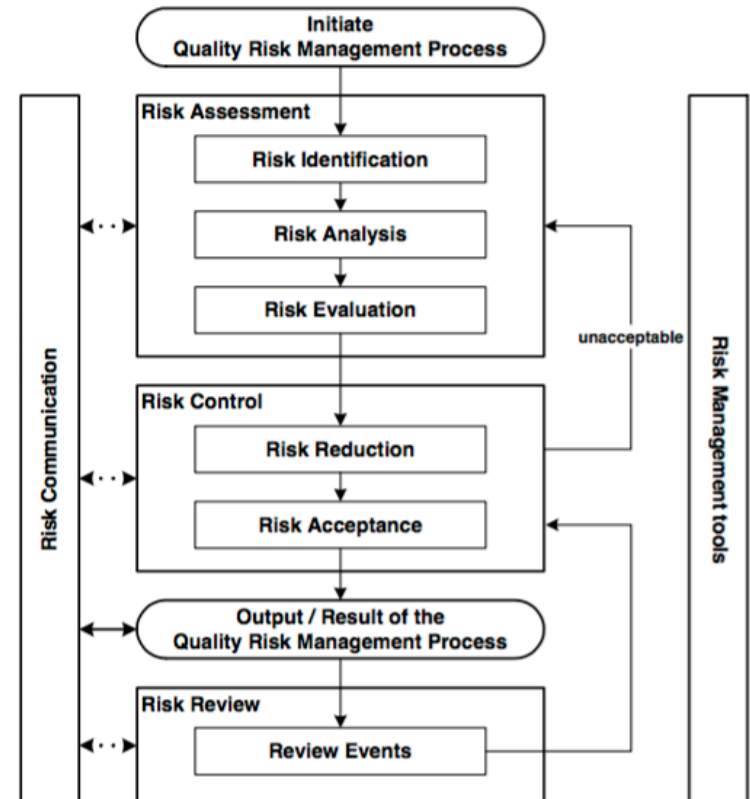


Figure 1: Overview of a typical quality risk management process



## ICH Q9: Primary Principle #1

**“Evaluation of the risk to quality should be based on scientific knowledge (of the product, process and clinical effects) and ultimately link to the protection of the patient”**

## ICH Q9: Primary Principle #2

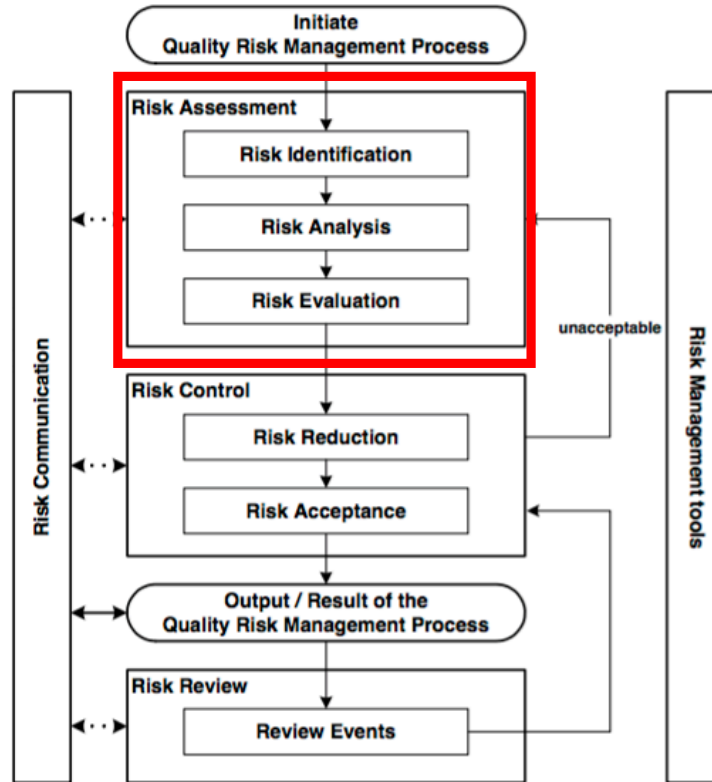
**“The level of effort, formality, and documentation of the quality risk management process should be commensurate with the level of risk”**

# Risk Assessment

Figure 1: Overview of a typical quality risk management process

## Risk Assessments

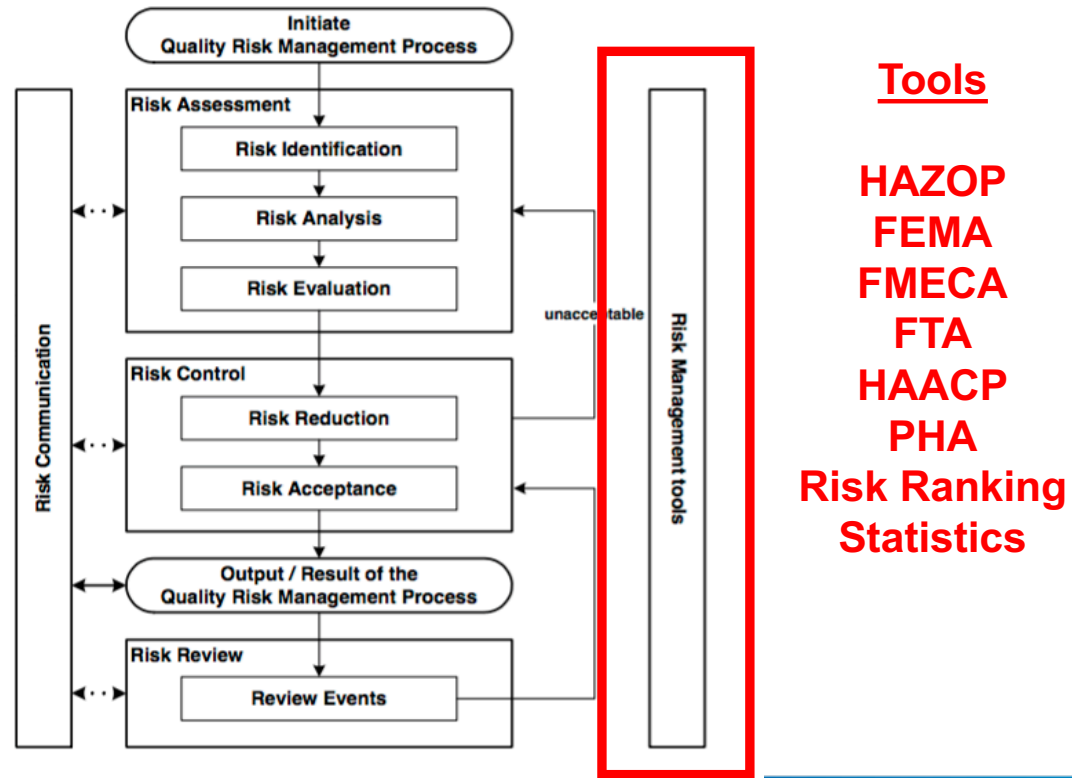
HAZOP  
FEMA  
FMECA  
FTA  
HAACP  
PHA  
Risk Ranking  
Statistics





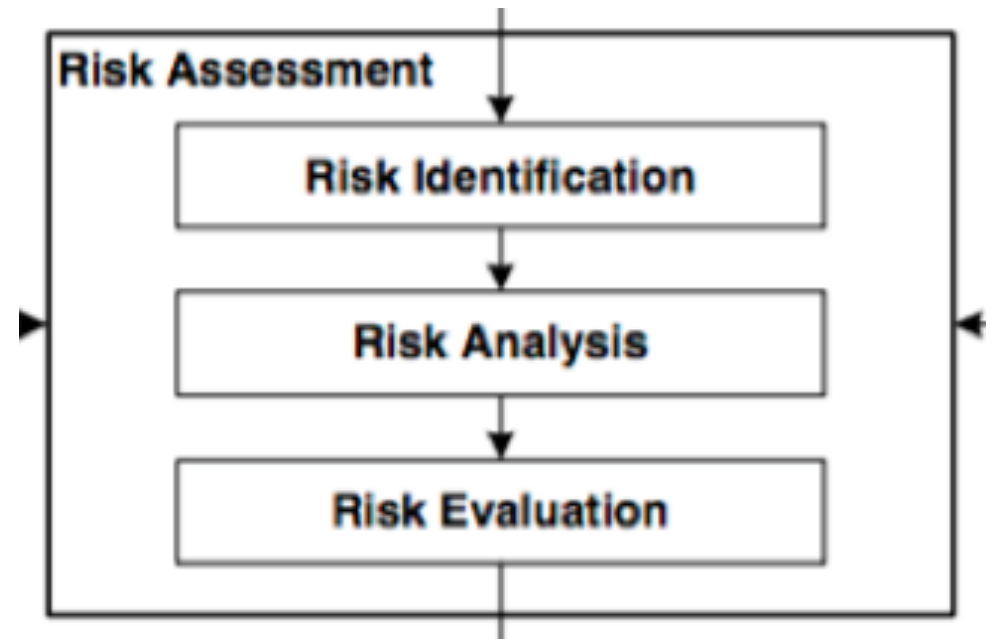
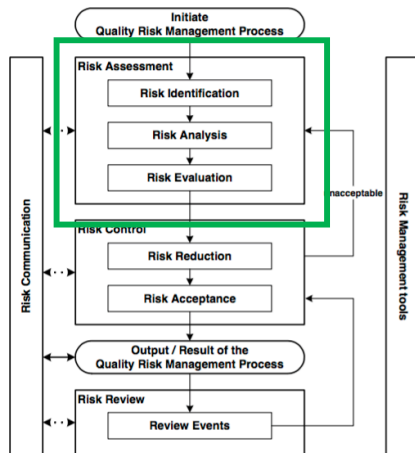
# Risk Management Tools

Figure 1: Overview of a typical quality risk management process



# Risk Assessment

Figure 1: Overview of a typical quality risk management process





# RISK ASSESSMENTS

# QRM Tool Selection

Murray, K. and Reich, S.

“Quality Risk Management (QRM) Tool Selection: Getting it Right First Time.”

Pharmaceutical Engineering,  
July/August 2011, Vol. 31 No. 4.



# Risk Assessment Options

## **Failure Modes Effect Analysis**

(FMEA / FMECA)

## **Fault Tree Analysis**

## **HACCP**

## **Boston Matrix**

## **Ishikawa Diagram (Fishbone)**



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# FMEA / FMECA

**Assesses failure modes and looks to reduce impact or occurrence of failure**

**Relies on robust process understanding**

**Yields quantitative assessment of risks a risk priority number (RPN)**

**Methodical in nature, can be time consuming**

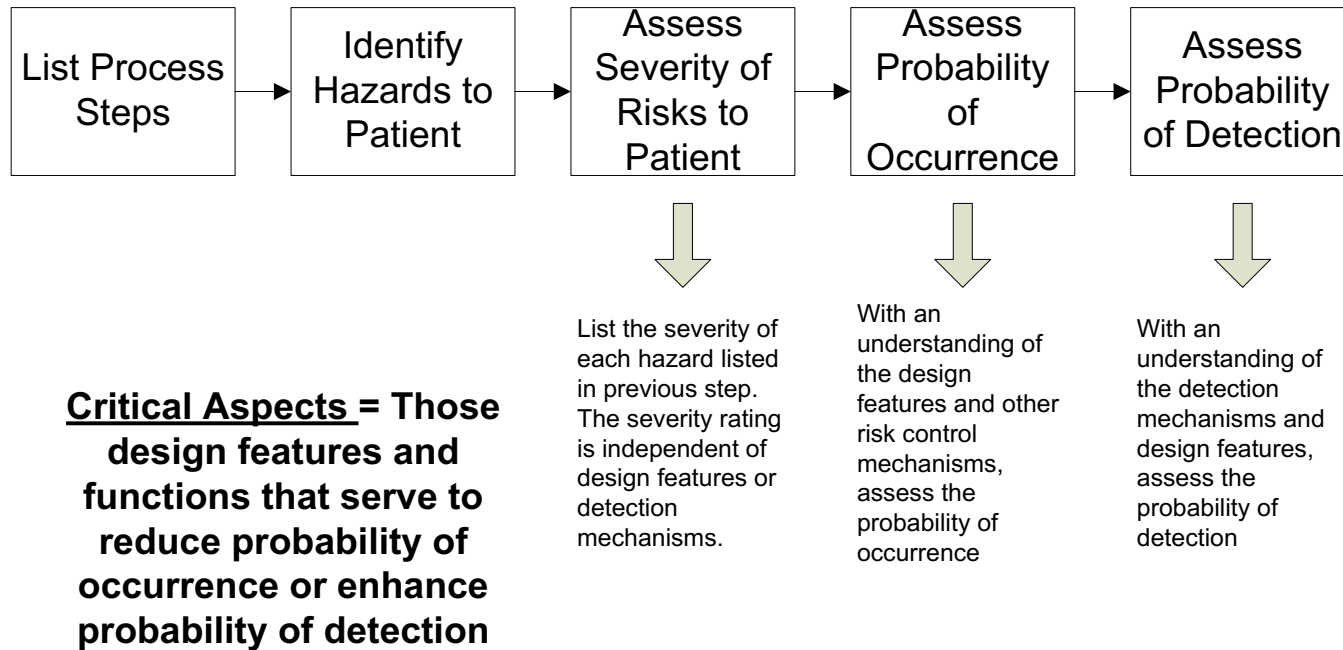
# FMEA / FMECA

Typically applied to an equipment or system boundary

**Level of effort may not be justified**

Use as deep dive for high risk items

# Process FMEA Example





# Scoring Options

## Use a 3 to 5 point scale (Quantitative)

1, 3, 5    1, 5, 10    1, 4, 7, 10    1, 10, 100

## Qualitative

Low, Med, High

Negligible, Low, Med, High, Unacceptable

## RPN Limits or Thresholds

Risk is Acceptable or Unacceptable

Grey Zone Suggested



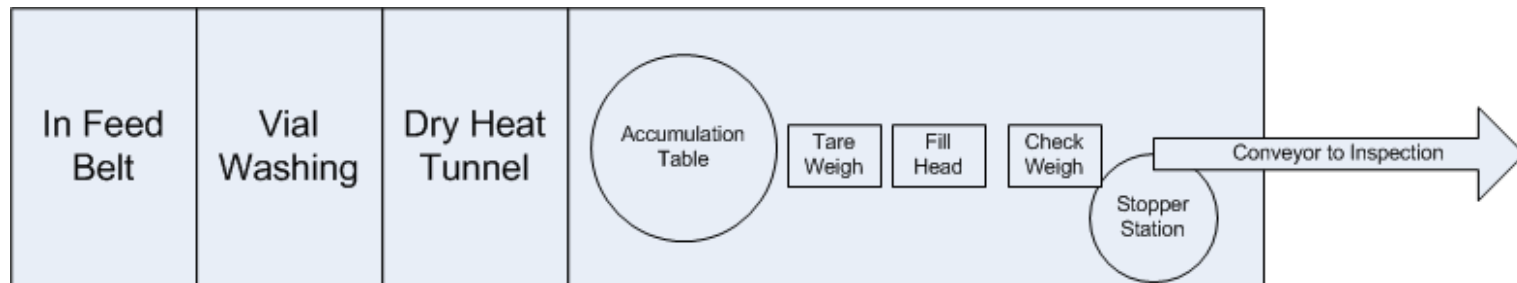
# Aseptic Filling Line - Isolator

**Isolator Sanitized with VHP**

**Product Transfer Line cleaned with CIP and sterilized with SIP**

**Filling Head parts cleaned in Washer and sterilized in Autoclave**

**Tubing Replaced each lot**



# Process Steps

Prepare Equipment

Load Vials

Wash Vials

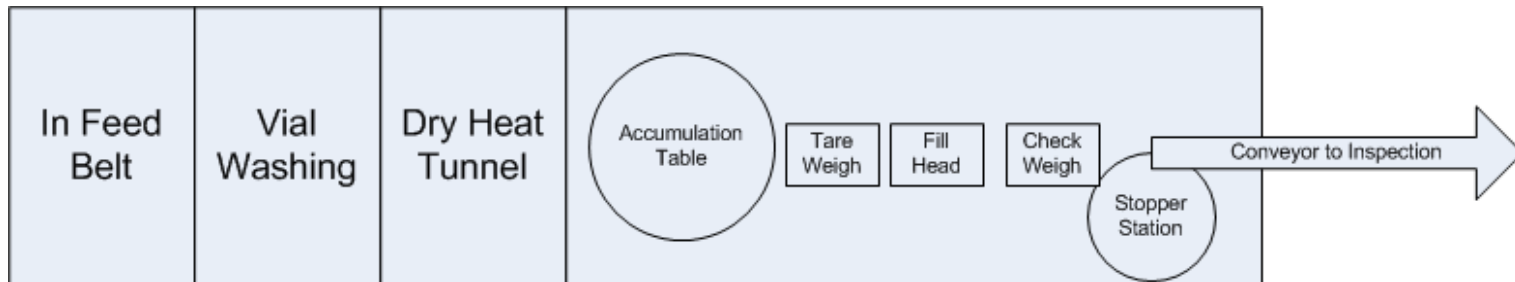
Depyrogenate Vials

Fill Vials

Weigh Vials

Stopper Vials

Convey Vials



# Hazards to Patient

## Wash Vials

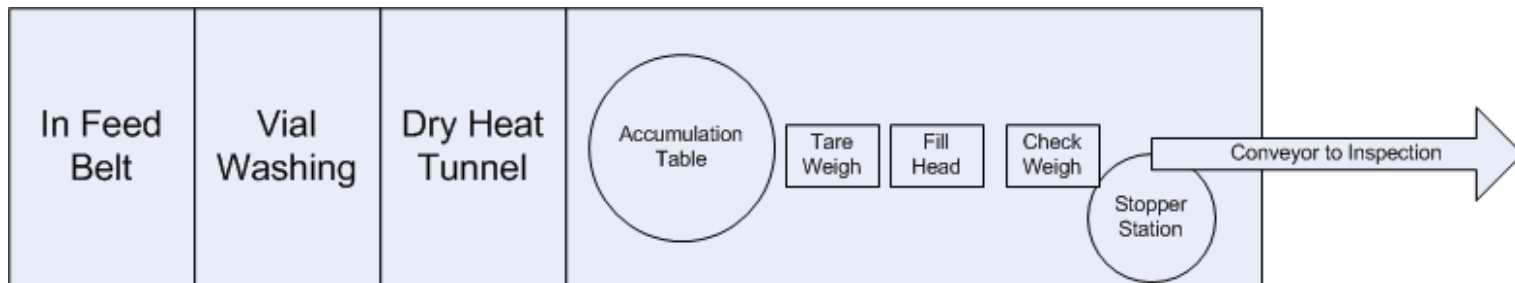
Dirty Vials not adequately Washed resulting in contaminated dose

Contamination from Water or Air ???

## Depyrogenation

Vials do not reach time at temperature resulting in endotoxin dose contamination

Contamination from Air???



# Example Output

Process Step	Hazard	Severity	Controls	Probability	Detectability	RPN
Wash Vials	Dirty Vial not Washed					
Depyro Vials	Endotoxin Contamination (Time at temp not reached)					
Depyro Vials	Microbial Contamination from Air					

# Example Output (Quantitative)

Process Step	Hazard	Severity	Controls	Probability	Detectability	RPN
Depyro Vials	Endotoxin Contamination (Time at temp not reached)	5	Automation control of belt speed, temperature control, airflow  Alarms associated with belt speed, low temperature, loss of airflow  Calibration of instruments	1	1	5

# Critical Aspects

**Belt Speed Control, Indication, Alarm**

**Tunnel Temperature Control, Indication, Alarm**

**Airflow Velocity, Loss of Airflow Alarm**

**Acceptance Criteria driven by process requirements**

# Fault Tree Analysis

**Assumes a failure has occurred with a process or product**

**Evaluates sub-process steps and causal effects**

**Represented pictorially as a logic diagram**

**May be good for root cause analysis or for assessing impact of multiple factors**



# Fault Tree Analysis

**Graphical methodology that examines combinations of possible events with undesirable results**

**Human and System Failures**

**Good for integrated systems analysis, forcing us to think across system boundaries**

**Intended for assessing designs and processes for risk**

# Fault Tree Analysis

Start by picking the worst event results and work down to possible causes

Technique inherently encourages prioritization of events

Uses a set of symbols to depict actions and relationships

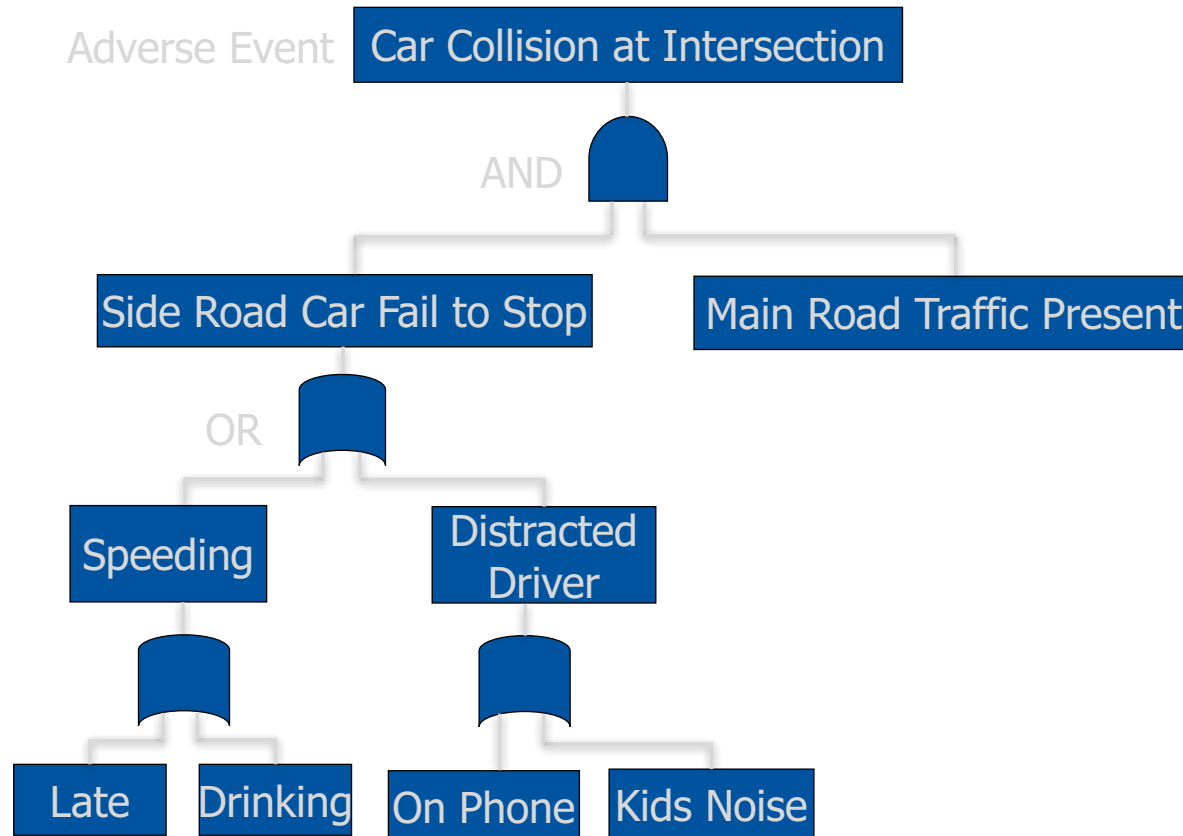


= “AND”: combination of events triggers fault



= “OR”: one of several possibilities triggers fault

# Standard FTA: Common Example



# Hazard Analysis and Critical Control Points (HACCP)

**Structured approach applying technical and scientific principles**

**Analyze, evaluate, prevent, and control the risk or adverse consequence(s) of hazard(s)**

**Considers design, development, production, and use of products**

# Hazard Analysis and Critical Control Points (HACCP)

Looks for physical, chemical, and biological hazards to process

Requires sufficient process understanding to identify critical control points

Focus is on lifecycle of product, not just manufacturing process

## From 21 CFR 123.6

**List the hazards that are reasonably likely to occur**

**List the critical control points for hazards**

**List the limits for each CCP**

**List the procedures, and frequency for monitoring CCP**

**List corrective action plans for deviations from CCP limits**

**List the verification procedures**

**Provide for a recordkeeping system that documents the monitoring of the CCPs**

# Boston Matrix

**80 / 20 Rule**

**Drive focus to area of most need**

**Drive focus to actions with most impact**

**Drives discussion**

**Documents decisions**



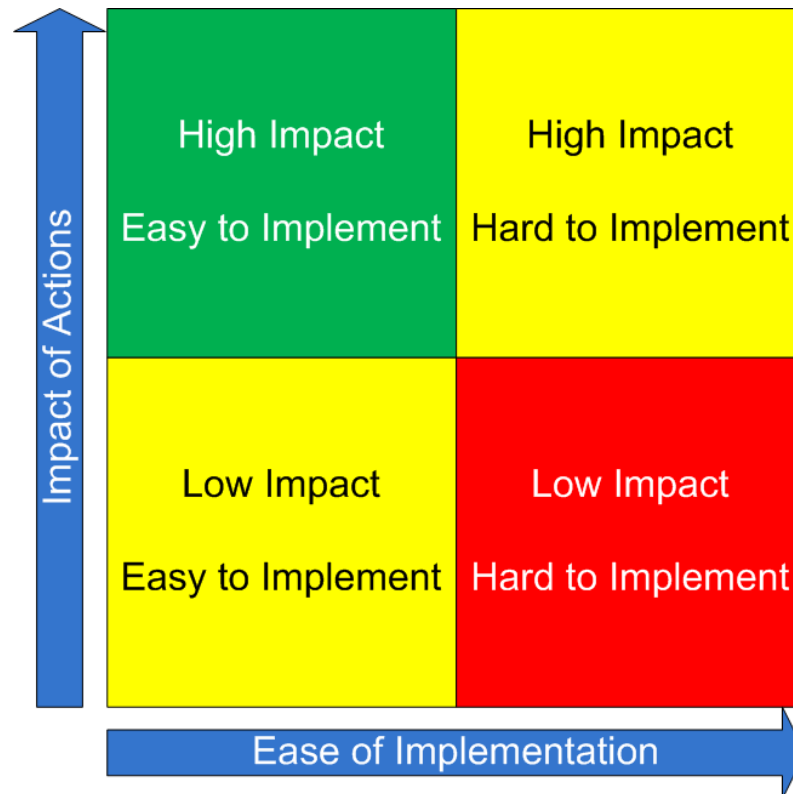
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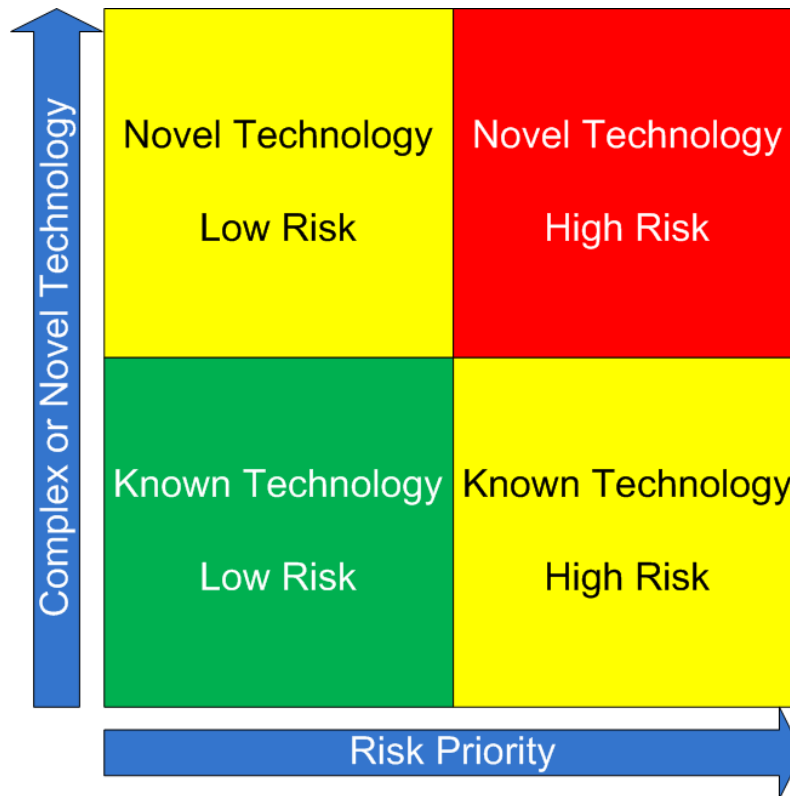
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# Response to Design Review





# FAT Planning



# Cause and Effect Diagram

**AKA: Fishbone or Ishikawa diagram**

**Widely used for Root Cause Analysis**

**Used to examine:**

Man, Method, Machinery, Materials

**Effective when output coupled with another tool**

# Sample Formulation Process

**Formulation Tank CIP/SIP**

**Buffer Prepared**

**Bulk Drug Substance Thawed**

**Buffer and Formulation Added to Formulation Vessel**

**Mixed and Sampled**

**Transferred to Filling Area**



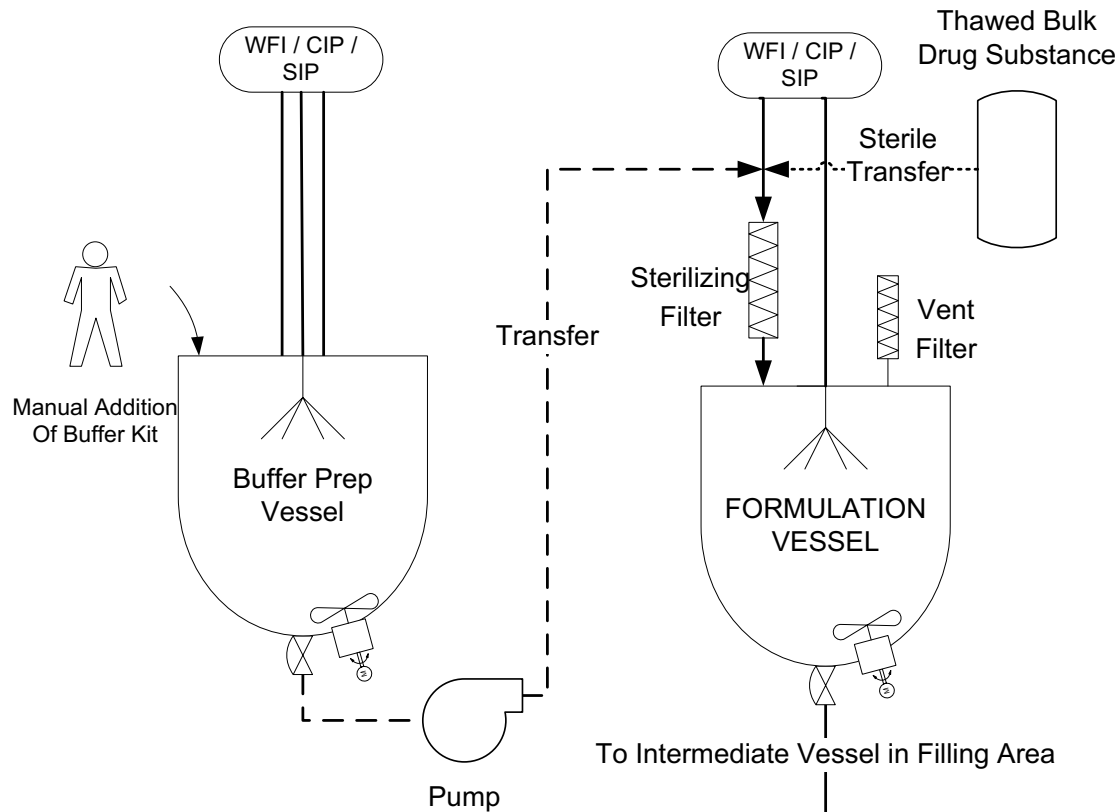
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# Formulation Process



# Hazards to Process

**Microbial Contamination**

**Protein Degrades or Denatures**

**Cross Product Contamination**

**Wrong Formulation**

**Endotoxin Contamination**

**Foreign Material Contamination**



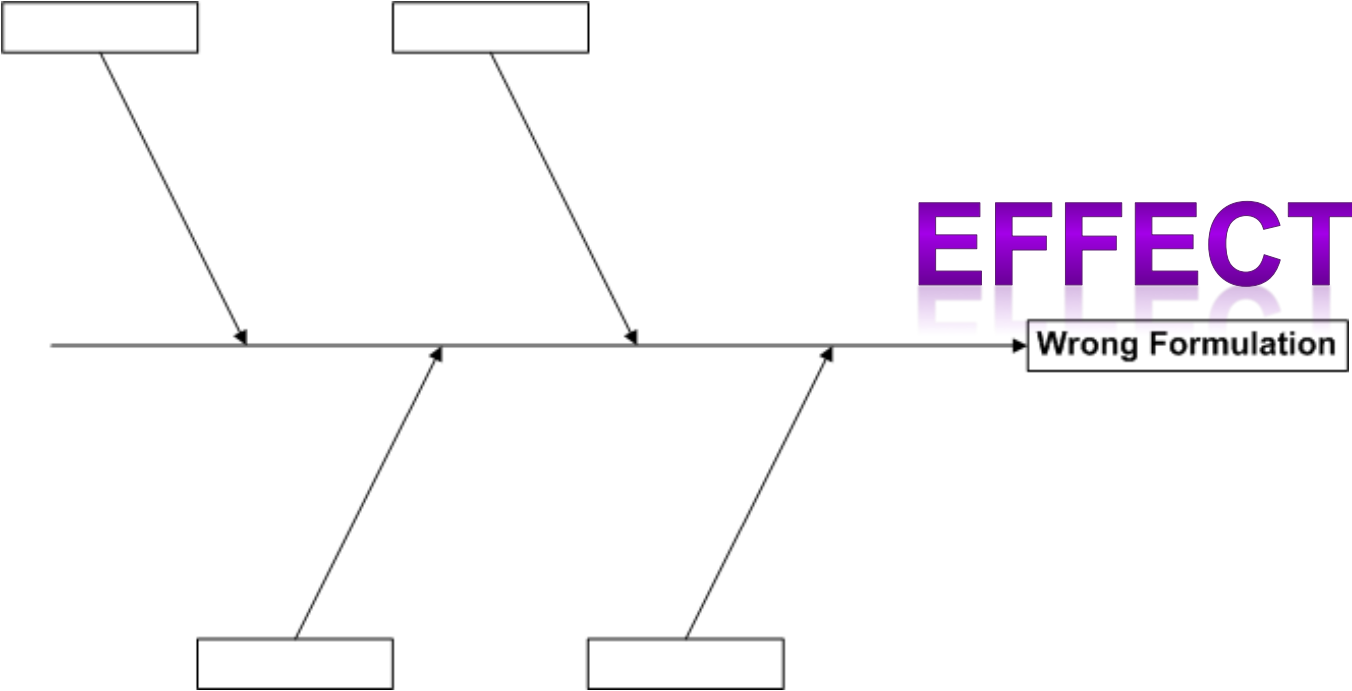
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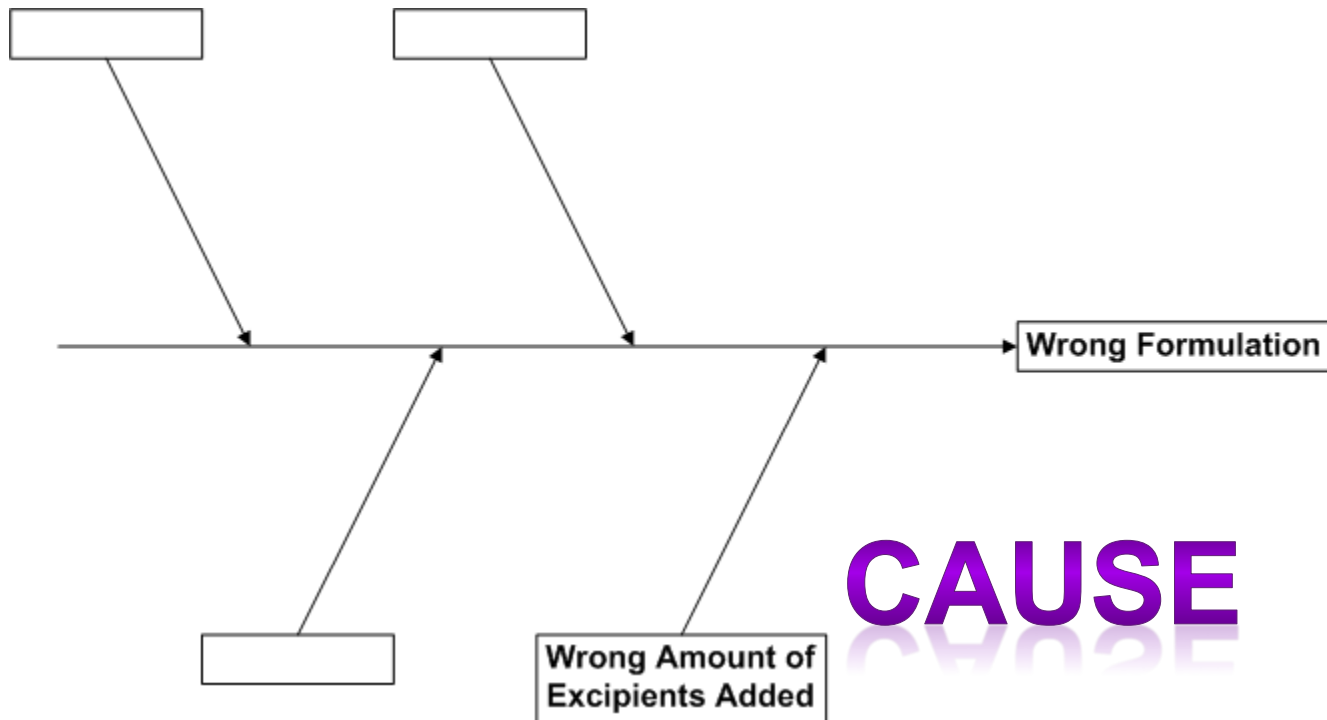
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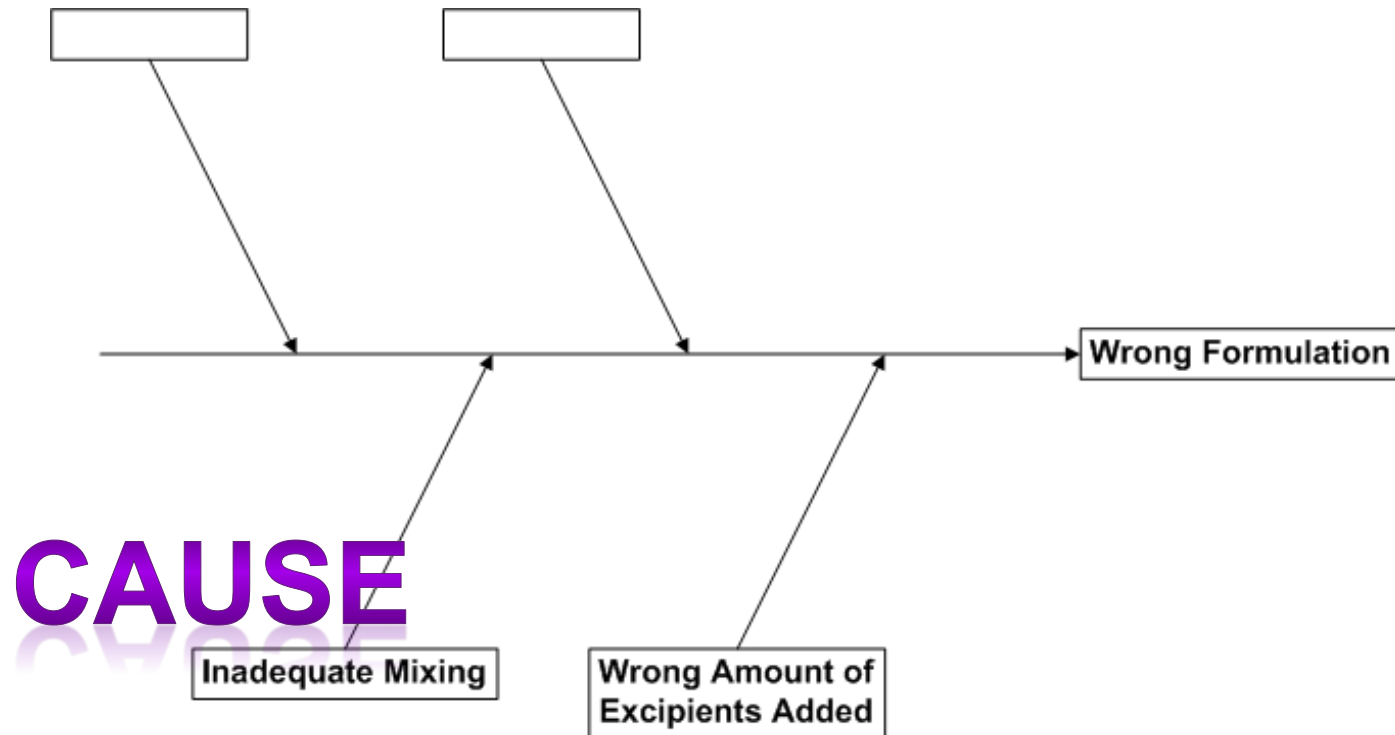
# Cause and Effect Diagram



# Cause and Effect Diagram

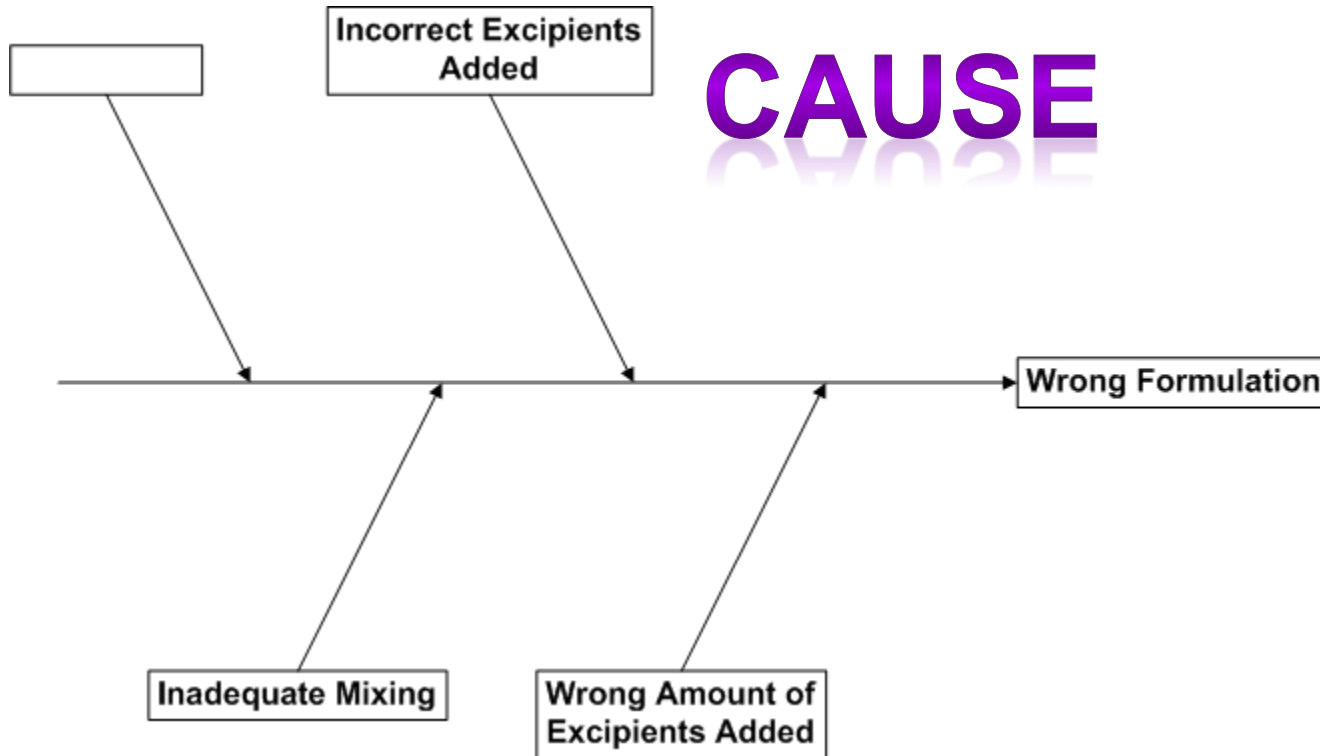


# Cause and Effect Diagram

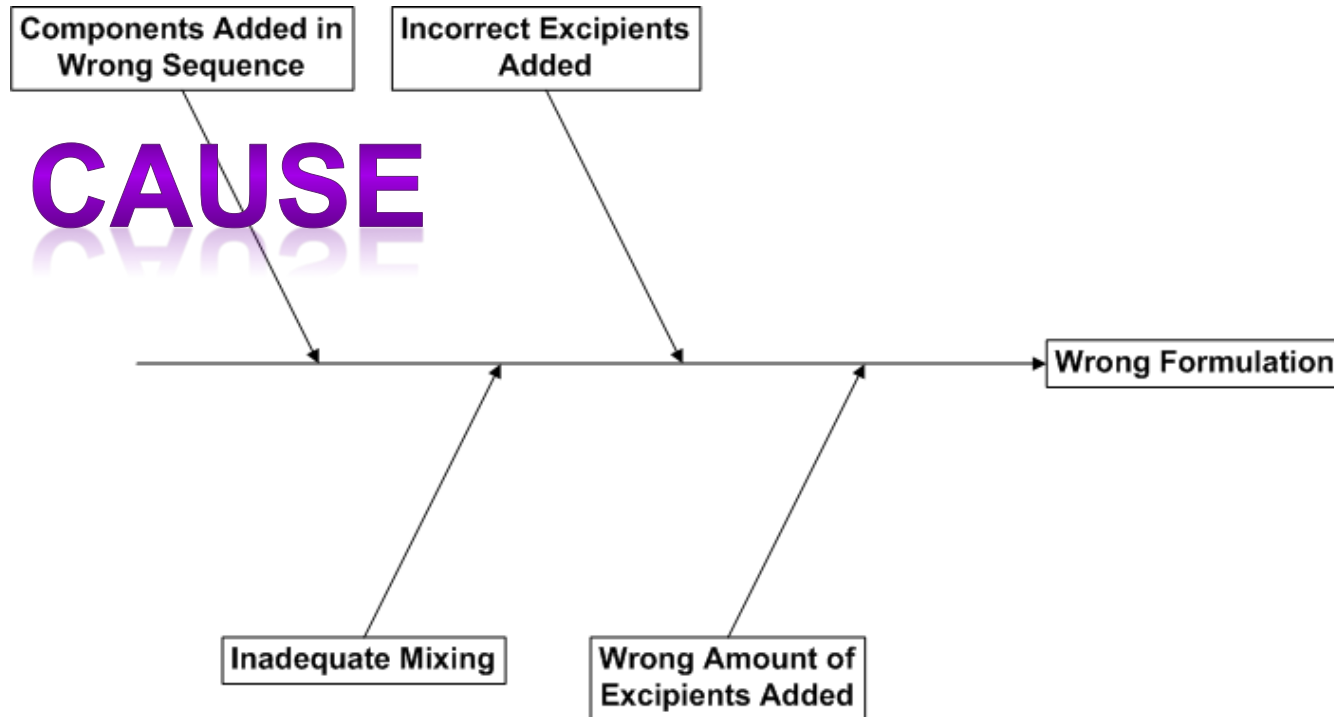




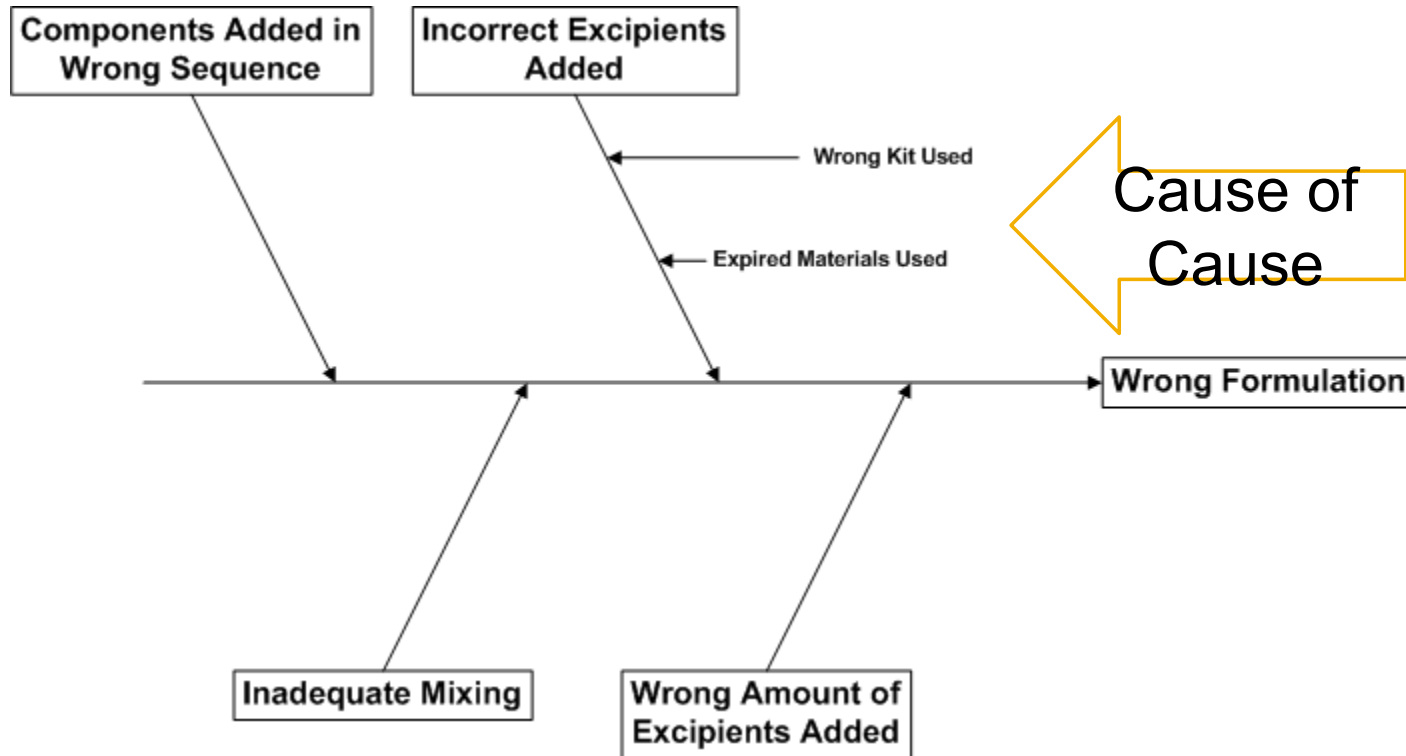
# Cause and Effect Diagram



# Cause and Effect Diagram



# Cause and Effect Diagram



# Work Shop



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# Cause and Effect

## Analyze one of the previously identified hazards

Microbial Contamination

Protein Degrades or Denatures

Cross Product Contamination

Wrong Formulation

Endotoxin Contamination

Foreign Material Contamination

**Identify at least three 1<sup>st</sup> Tier Causes**

**Identify at least six 2<sup>nd</sup> Tier Causes**

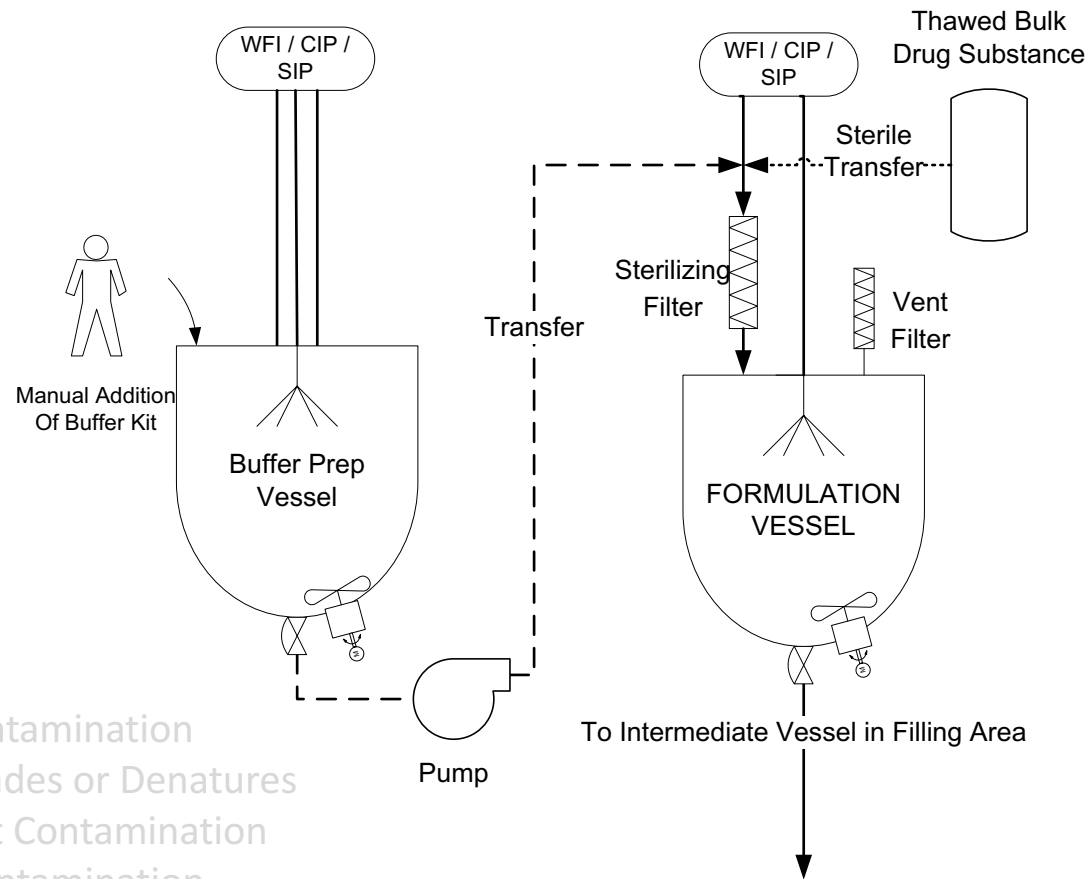


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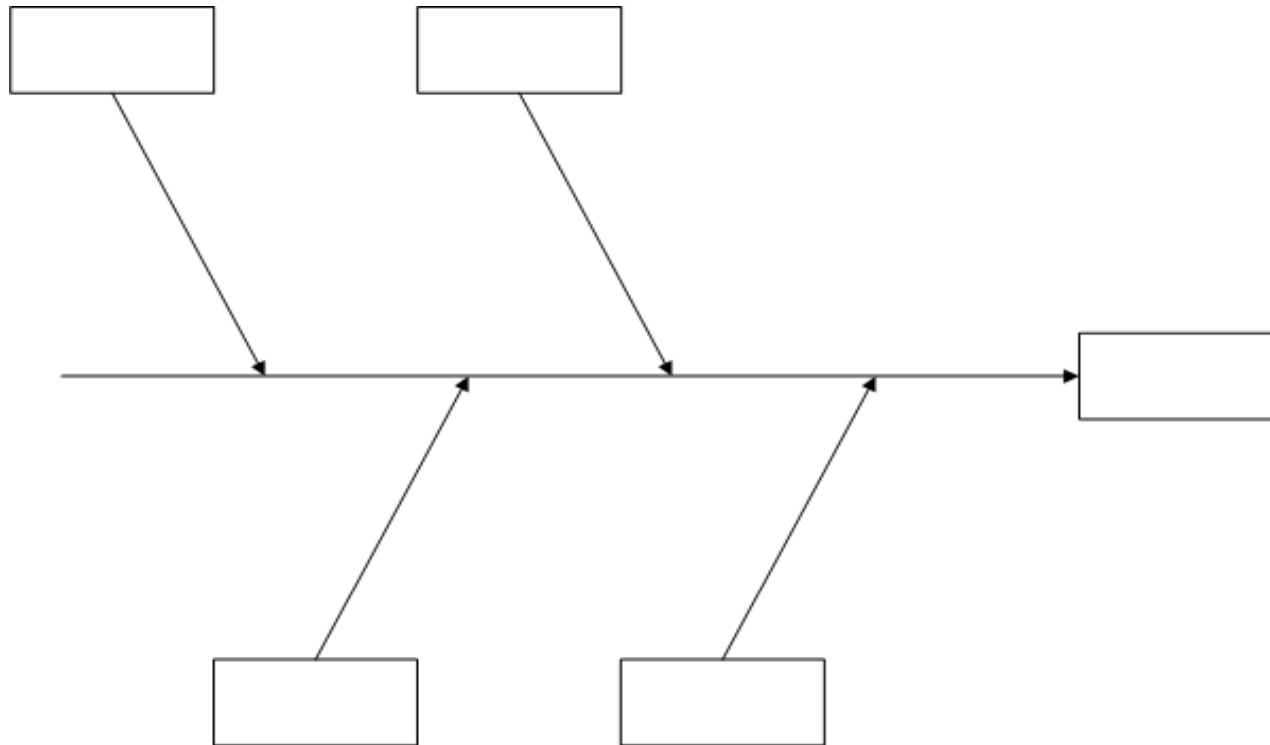
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Microbial Contamination  
 Protein Degrades or Denatures  
 Cross Product Contamination  
 Endotoxin Contamination  
 Foreign Material Contamination

# Cause and Effect Diagram



# Thank You!

**Timothy P. Howard, CPIP, PE**  
**Vice President**  
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