MEDSAFE
New Zealand Medicines and Medical Devices Safety Authority

Guideline on the Regulation of Therapeutic Products in New Zealand

New Medicine Applications

Edition 1.1

[2026 draft for consultation]

Contents

Abbreviations and definitions

Abbreviation or term	Definition
API	Active Pharmaceutical Ingredient
CMI	Consumer Medicine Information
CMN	Changed Medicine Notification
COR	Therapeutic Goods Administration Comparable Overseas Regulators process
CTD	Common Technical Document
EMA	European Medicines Agency
EU	European Union
GMP	Good Manufacturing Practice
FDA	United States Food and Drug Administration
INN	International Non-proprietary Name
OTC	Over-The-Counter
PHARMAC	Pharmaceutical Management Agency
NBE	New Biological Entity
NCE	New Chemical Entity
NMA	New Medicine Application
RFI	Request for Information
SMARTI	Medsafe's Therapeutic Product Database
SACN	Self-assessable change notification
TGA	Therapeutics Good Administration
WHO	World Health Organisation

1. When is a medicine a "new medicine"?

The term "new medicine" is defined in section 3 of the Medicines Act 1981 (the Act). In practical terms, a new medicine is defined as one of the following:

- a medicine for which Ministerial consent for distribution in New Zealand (NZ) has not previously been granted
- an approved medicine that has undergone a change or changes that has resulted in its referral to the Minister under section 24(5) of the Act
- a medicine that has previously been approved but has not been generally available in New Zealand during the five years immediately preceding the date on which it is proposed to become available.

A medicine is considered to have been "generally available" if, during the relevant five-year period one of the following has been met:

- the product has been sold or offered for sale in or export from New Zealand on one or more occasions, or the product has been advertised in New Zealand as available for sale
- the regulatory file for the approved medicine has been updated through a Changed Medicine Notification (CMN) (note that a Self-Assessable Change Notification (SACN) for a change in sponsor is not sufficient evidence that the medicine has been generally available)
- the product has been the subject of a submission made to the Pharmaceutical Management Agency (PHARMAC) for a tender.

1.1 Evidence that a medicine has been generally available

An applicant wishing to show that a product is not a new medicine because it has been "generally available" must support that claim by providing one of the following:

- evidence of one or more sales during the relevant period (eg, invoice)
- evidence of importation (eg, customs clearance form)
- evidence of listing in a sales catalogue or price list from the relevant period
- a statement identifying regulatory activity for the product, such as a CMN.

The claim must be supported by a declaration from a person in New Zealand that the evidence is genuine, and that any documents provided are true copies of the original documents. The original documents must be made available on request.

1.2 Previously approved medicine that has not been generally available

When a sponsor wishes to commence or re-commence distribution of a previously approved product that has not been generally available in New Zealand in the last five years, a New Medicine Application (NMA) must be submitted. Otherwise, the medicine may only be supplied as an unapproved medicine under section 29 of the Medicines Act 1981.

Applications must be accompanied by data to demonstrate the claimed safety, efficacy and quality. It may be acceptable to refer to data already held on file by Medsafe if the data meets expected standards.

Where the product details are identical to those submitted in the original application for consent, or in any subsequent CMN, it is sufficient to submit a declaration to that effect. Where the details differ, the difference should be detailed and supporting data provided in the same way as is required for a CMN. If the change(s) is such that the safety profile of the product may have been altered, the data package should include a report of post-marketing surveillance from other countries in which the product has been marketed.

1.3 Combination packs of currently approved medicines

A new combination pack containing two or more currently approved medicines packaged together constitutes a new medicine and the Minister's consent for its distribution must be obtained before it may be distributed. Section 2 of the Medicines Act 1981 provides a definition of package.

2. New Medicine Applications

An NMA is an application under section 20 or section 23 of the Medicines Act 1981 seeking the Minister's consent to distribute a new medicine. In practice, the power to approve medicines is delegated to a senior Ministry of Health officer, referred to as the Minister's delegate.

To facilitate administrative processing of applications, NMAs are divided into three categories as described in the following subsections.

Each unique product is the subject of a separate product approval and has its own separate entry in Medsafe's Therapeutic Products Database (SMARTI). A unique product is defined by its name, dose form, active ingredient(s), strength, flavour (if applicable) and classification.

An NMA must be submitted to obtain consent to distribute a new medicine. Reduced data requirements and evaluation fees apply to NMAs for products that are closely related to an existing approved product.

2.1 Application selection tools

Further assistance on selecting the correct NMA category may be made by reference to the following Appendices to this Guideline:

- Appendix 1: Application categorisation tool
- Appendix 2: Lower-risk medicine categorisation tool

2.2 New Higher-risk Medicine Applications

A **New Higher-risk Medicine Application** (NMA-H) is an application for Ministerial consent to distribute a under section 20 or section 23 of the Medicines Act 1981 a:

- new medicine containing a new active substance (ie, a new chemical, biological or biotechnological entity described as an innovative medicine application according to section 23A of the Medicines Act 1981)
- new fixed dose combination product containing a combination not previously approved with least one prescription medicine
- new medicine with a new route of administration or novel pharmaceutical form
- new biological or biotechnological medicine, including vaccines, blood products (ie, plasma-derived medicinal product), and biosimilars
- new medicine based on a parent product that was approved via a new higher risk medicine application

2.3 New Intermediate-risk Medicine Applications

A **New Intermediate-risk Medicine Application** (NMA-I) is an application for consent to distribute a new medicine that is not a new higher risk medicine and is a:

- generic prescription medicine containing Active Pharmaceutical Ingredients (APIs) of synthetic or semi-synthetic origin that have been previously approved by Medsafe
- generic medicine that is a Controlled Drug for which a prescription is required
- new medicine based on a parent product that was approved via a new intermediate risk medicine application
- prescription medicine with a new combination of excipients where it is intended that the new formulation will be marketed in addition to the existing formulation
- parenteral medicine (includes parenteral medicines that are classified as non-prescription or General Sales medicines)
- irrigation solution
- dialysis solution
- medical gas.

2.4 New Lower-risk Medicine Applications

A **New Lower-risk Medicine Application** (NMA-L) is an application for consent to distribute a new medicine that is not defined above as a higher-risk or intermediate-risk medicine, and that:

- may be supplied without a prescription (ie, an 'Over-The-Counter' OTC product), and
- is recommended for indications that are already well documented for the active ingredient(s), **and**
- is presented in a pharmaceutical form that is monographed in a pharmacopoeia, and **either**
- contains active ingredients that are the subject of a pharmacopoeial monograph or
- contains active ingredients that have a well-documented history of use in OTC products (eg, as evidenced by entries in Martindale, etc.) or
- has active ingredients that are contained in one or more other products marketed as OTC products in New Zealand.

Lower-risk medicines may include products required to be sterile (eg, eye drops).

A product containing a Controlled Drug for which a prescription is not required (eg, pholcodine linctus) is evaluated using the new lower-risk medicine assessment procedure, provided it meets the criteria listed above.

New Lower-risk Medicine Applications are further categorised into application types as detailed in section 10 of this guideline.

3. Applications containing a new active substance

A chemical, biological, or biotechnological active substance (also known as an API) is a **New Active Substance**, when it is:

- a chemical, biological or biotechnological substance for which Ministerial consent for distribution as a medicine in New Zealand has not previously been granted, or
- an isomer, mixture of isomers, an ester, a complex or other derivative, or a salt, of a chemical substance with Ministerial consent for distribution as a medicine in New Zealand but differing in properties with regard to safety and efficacy, or
- a biological or biotechnological substance for which Ministerial consent for distribution as a medicine in New Zealand has been granted, but differing in properties with regard to safety and efficacy due to a modified molecular structure (due to nature of the source material, or manufacturing processes)

New active substances are also known as New Chemical Entities (NCEs) or New Biological Entities (NBEs). New active substances need to be classified by the Medicines Classification Committee before a new medicine containing that active substance can be granted consent. Sponsors are encouraged to submit a classification request prior to lodging an NMA to avoid delays.

It is possible for a generic or biosimilar medicine to contain a new active substance, if the innovator medicine containing the same active substance has not been previously granted consent for distribution in New Zealand.

3.1 Data protection for medicines containing new active substances

Under section 23B of the Medicines Act 1981, innovative medicines containing new active substances receive data protection for a period of five years from the date of approval (ie, publication of the consent notice in the *New Zealand Gazette*). This means that confidential information submitted with an NMA for a new innovative medicine cannot be referred to or relied upon by another application within five years following submission of the application, **and** within five years following approval of the innovative medicine. In practice, this means that NMAs for medicines containing the same API (generics or biosimilars) as an innovative medicine cannot be submitted until a data protection period has expired.

An exception to this is where innovative medicines have been submitted and/or approved in New Zealand based on evidence that is not considered confidential, or where a generic or biosimilar medicine does not need to rely on the innovative medicine's supporting information. This primarily includes medicines that have been developed as a generic medicine for an innovative medicine that has been approved overseas but not previously approved in New Zealand. In these cases, applications for medicines containing a new active ingredient may be supported by a combination of

bioequivalence data involving the global innovator and evidence to support the safety and efficacy of that innovator, which may include publicly available clinical trial data and/or evidence from published literature. Applicants who are unsure how data protection provisions may apply in such instances should contact Medsafe for advice.

4. Applications based on an approved parent product

An 'approved parent product' is a previously approved medicine where the safety, efficacy and quality of the product have been acceptably demonstrated, and that complies with current standards. NMAs that are based on a parent product are often referred to as line extensions.

For NMAs that include multiple products, the 'parent product' refers to the product upon which other products have been based on (typically the highest strength and/or the product used in a clinical/bioequivalence trial).

Where a new medicine is associated with a change in indications and/or dosing regimen approved for the parent product (e.g. a new strength that enables a higher dose required for an extended indication), a CMN for the change in indications or dosing regimen for the parent product must be submitted in parallel. Submission of that CMN should be clearly referenced in the NMA cover letter for the new medicine based on a parent product.

New parenteral medicines with a different fill volume (but same concentration) and/or container closure system compared to a parent product must be submitted via NMA under the most applicable category from the table below, and not via CMN.

The following table lists the types of new medicine applications that can be made are based on a parent product.

Table: NMA options for products that are based on a parent product

Category	**Product similarity criteria**
Additional name	• new and parent products are identical except for Module 1 aspects (e.g. labelling, data sheet)
Additional strength - Grade 1	• new and parent products have the same dose form • new product is a direct scale of parent product, or uses same excipient matrix • all other details identical to parent product except for labelling and specifications
Additional strength - Grade 2	• new and parent products have the same dose form • new product is not a direct scale of parent product • bioequivalence/clinical study not required • all other details identical to parent product except for labelling and specifications
Additional strength - Grade 3	• new and parent products have the same dose form

	• bioequivalence/clinical study not required • other details different from parent product
Additional strength - Grade 4	• new and parent products have the same dose form • bioequivalence/clinical study included • method and site of drug substance and drug product manufacture, specification parameters, test methods and packaging unchanged
Additional strength - Grade 5	• new and parent products have the same dose form • bioequivalence/clinical study included • other details different from parent product
Additional dose form - Grade 1	• new and parent products have different dose forms and the same or different strengths • bioequivalence/clinical study not required
Additional dose form - Grade 2	• new and parent products have different dose forms and the same or different strengths • bioequivalence/clinical study included

5. Abbreviated Applications

5.1 Abbreviated application overview

An abbreviated evaluation procedure is an option available for New Medicine Applications in which review of evaluation reports from Medsafe recognised regulatory authorities forms the basis of the evaluation. Therefore, it is essential that all relevant evaluation reports from the selected recognised regulatory authority are submitted to Medsafe are of high quality. The recognised regulatory authority evaluation reports must not use a reliance-based assessment, e.g. Therapeutic Goods Administration (TGA) COR pathway, as there will be insufficient detail in these reports for Medsafe to review. Although the abbreviated evaluation procedure places reliance on overseas evaluation reports, Medsafe undertakes an independent evaluation and makes an independent decision on whether and what type of consent should be granted for the distribution of the medicine in New Zealand.

The abbreviated evaluation process is a quicker process than the standard evaluation process, provided responses to any Medsafe questions are submitted within the established timeframes. This is reflected in the application fee and indicative timelines. Target timeframes for the abbreviated evaluation procedure are described on the Medsafe website.

The abbreviated evaluation procedure can be used for applications that have been subject to non-standard approval pathways overseas, for example, conditional marketing authorisations (European Medicines Agency (EMA)) or provisional approval (TGA). However, their acceptance for the abbreviated procedure will be determined on a case-by-case basis at screening based on the assessment process followed by the recognised regulatory authority, the quality and extent of the evaluation reports available, and any conditions/requirements of approval stipulated by the recognised regulatory authority.

Line extensions can use the abbreviated evaluation procedure but must meet the criteria for line extension abbreviated applications described in section 5.2 of this guideline.

The abbreviated evaluation process is not applicable to Lower-risk New Medicine Applications or CMNs, except for CMNs referred under Section 24(5)(a) (refer to the Guideline on the Regulation of Therapeutic Products in New Zealand: Changed Medicine Notifications and Non-notifiable Changes). Regardless, Medsafe strongly encourages applicants to consider providing recognised regulator evaluation reports and evidence of approval if these are available at the time of submission.

Applications that are not eligible for the abbreviated evaluation process should be submitted via the standard evaluation process, by submitting a full dataset for assessment as required by the Medicines Act 1981 and as described in Appendix 3 of this guideline.

5.2 Eligibility criteria

To be eligible for the abbreviated evaluation process the medicine must meet all of the following criteria:

- The medicine is an intermediate-risk or higher-risk medicine that has current marketing authorisation granted by a recognised regulatory authority and the marketing authorisation has been granted within ten years immediately prior to the submission date to Medsafe.
- If the medicine is a generic or biosimilar medicine, the innovator or reference product must be identical to that approved for New Zealand (Note: to determine if the medicine can be considered identical, refer to the essential similarity data requirements that are described in Guideline on the Regulation of Therapeutic Products in New Zealand: Bioequivalence of medicines).
- The medicine is not pending deferral of marketing authorisation, or has not had marketing authorisation rejected or withdrawn by a recognised regulatory authority for quality, safety, or efficacy reasons.
- The medicine has not been subject to any regulatory action that may or has resulted in a suspension or revocation of the market authorisation by a recognised regulatory authority.
- The medicine has the same formulation as the product currently approved by the recognised regulatory authority.
- The medicine has the same dosage and indications as the product initially approved by the recognised regulatory authority (does not apply to generic or biosimilar medicines that must be aligned with the NZ innovator).
- The medicine has a current market authorisation issued by the recognised regulatory authority.
- The medicine has undergone **NO MORE THAN FIVE** of any of the following types of significant change that have been approved by the recognised regulatory authority, preferably **with** the regulatory authority assessment reports available:
    - change to formulation, specific to excipient components/composition only
    - addition of a new active ingredient manufacturing site* and/or significant changes to active ingredient manufacturing process* that would be considered as “Active ingredient manufacture – G5 or G6” change for CMN Form A products or “Active ingredient method of manufacture – G4” change for CMN Form B products (Note: CMN Forms A and B can be found on the Forms and Templates page of the Medsafe website under Medicines –(Changed Medicine Notification Forms))
    - significant changes in finished product method of manufacture that would be considered as a "Finished product manufacture – G3 or G4” change for CMN Form A products, and “Finished product manufacturing process – G4” changes for CMN Form B products
    - addition of a new active ingredient or finished product testing site*

- addition of a new finished product manufacturing site
- addition of a new primary packing site
- extension of active ingredient* or finished product shelf-life (multiple extensions for either the active ingredient or the finished product will be considered as one change as subsequent changes supersede earlier ones)

* *For active ingredients that are the subject of a Drug Master File (DMF) or Certificate of Suitability (CEP), these changes are not considered significant as Medsafe does not routinely review DMFs during the abbreviated evaluation process.*

If there are no regulatory authority evaluation reports for any significant changes, then an abbreviated application can only include a maximum of three significant changes.

Applications with more than two significant changes that have regulatory authority evaluation reports, or with significant changes that do not have regulatory authority evaluation reports will incur additional fees. The additional fees will be equivalent to the fees charged if the change(s) was submitted to Medsafe as a Changed Medicine Notification**.**

Table: Fee calculations for abbreviated applications with significant changes

Types of abbreviated applications with significant changes	**Fees**
Abbreviated application with up to two significant changes that have overseas assessment reports	Abbreviated application fee
Abbreviated application with more than two significant changes that have overseas assessment reports	Abbreviated application fee plus additional fee(s) for the third or more significant change
Abbreviated application with significant changes that do not have overseas assessment reports (up to a maximum of three allowed)	Abbreviated application fee plus additional fee for each significant change without an overseas assessment report
Abbreviated application with a mixture of significant changes that do or do not have overseas evaluation reports	Abbreviated application fee plus additional fee(s) for the third or more significant change with an overseas evaluation report and for each significant change without an overseas evaluation report

A significant change that includes consequential changes can be counted as one change, providing that all changes were assessed and approved by the overseas regulatory authority at the same time as one application (eg, where a new finished

product manufacturing site is consequentially registered as a finished product testing and primary packing site all changes would be considered as one significant change).

If the medicine has had a number of non-significant changes (ie, changes not listed above) approved by the recognised regulatory authority then, depending on the number and complexity of these changes, the changes together may be considered a significant change. This will be determined by Medsafe during screening.

If the number and nature of the changes no longer fulfils the intent of the abbreviated evaluation process, then Medsafe reserves the right to re-route any application to the standard evaluation process.

If an additional strength of the medicine has been approved by the recognised regulatory authority after initial approval of the medicine, then it can be included in an abbreviated application but will incur an additional fee and will be considered a significant change. The additional fee will be the same as that applied to additional strengths submitted concurrent with parent NMAs as described in Medsafe's fee schedule. The additional strength must have the same indication as the parent product if it is included in an abbreviated application. There must be a recognised regulatory authority report for the additional strength, otherwise it will require a separate application after the abbreviated application for the parent product has been approved by Medsafe.

Abbreviated applications for new medicines based on an approved parent product (line extensions) must meet the following additional criteria:

- Parent product approved by the recognised regulatory authority must be identical to that approved in New Zealand.
- The proposed indication is identical to that approved by the recognised regulatory authority.
- The assessment performed by the recognised regulatory authority is comparable to what would be performed by Medsafe for a line extension. If the recognised regulatory authority reports are considered too brief, then the new medicine application may not be accepted as an abbreviated application.
- Indications/dosage should be the same as the parent product. If there are differences, this is only justifiable if there is no product available in New Zealand that is able to meet the proposed indications/dosages and these are currently approved indications/dosage in NZ (generally for paediatric, or lower or higher strengths that are for different indications).

5.3 Abbreviated application data requirements

The application must be supported by a complete dataset as required by the Medicines Act 1981 and the Guidelines on the Regulation of Therapeutic Products in New Zealand (GRTPNZ), consisting of Modules 1, 2, 3, 4, and 5 (as applicable). The dataset should be consistent with the product details that are approved by the overseas regulatory authority at the time of the NMA submission to Medsafe. For Module 1 information requirements for abbreviated applications, such as the need to provide a table of regulatory history, refer to appendix 1.

The original dossier submitted to the recognised regulatory authority must be in Common Technical Document (CTD) format and the dossier submitted to Medsafe must be updated to incorporate the supporting data for any changes approved by the recognised regulatory authority.

The recognised regulator evaluation report(s) must be in English, correspond to the CTD structure and be a complete record of the assessment (redacted reports are not acceptable). Any evaluation reports that have been translated must be certified translations. **The recognised regulator evaluation reports must not be based on a reliance approval process, e.g. TGA COR pathway**. In such cases, the abbreviated application should be based on the original approval upon which the overseas reliance assessment was based. The following overseas regulatory authority reports and approval documentation must be provided:

- All interim and final evaluation reports that have been completed by the overseas regulatory authority for the medicine assessment (eg, EMA day 70/80, day 120, day 180, and day 210 reports) and any reports for subsequent changes/variations for which reports are available.
- All questions raised by the recognised regulatory authority during the medicine assessment or change/variation assessment, the company's responses to these questions, and the subsequent assessment by the overseas regulatory authority of the responses to these questions.
- Evidence of the recognised regulatory authority approval of the medicine and any subsequent changes/variations that are also being sought for approval by Medsafe. Evidence for applications approved in Europe can be either a marketing authorisation or notification from the authority of either a closed Centralised Procedure, Mutual Recognition Procedure, or Decentralised Procedure.
- If the abbreviated application was subject to a joint regulatory authority work sharing process (eg, Access Consortium) then evaluation reports must be submitted from all the regulatory authorities that contributed to the assessment of the medicine. All regulatory authorities associated with the work sharing process must be Medsafe Recognised Regulatory Authorities (refer to section 5.4 of this guidance).
- The Risk Management Plan(s) approved the recognised regulatory authority.

In addition to evaluation reports, any correspondence with the recognised regulatory authority relevant to approval of the application and any documentation of involvement of relevant committees (e.g. TGA's Advisory Committee on Medicines (ACM) and FDA Vaccines and Related Biological Products Advisory Committee (VRBAC)- FDA) is encouraged to be provided.

Some regulatory authorities may prefer to provide their evaluation reports directly to Medsafe, rather than to the sponsor. In this situation, it is the responsibility of the sponsor to organise the regulatory authority to provide its reports to Medsafe. Medsafe can provide a letter to the sponsor that can be forwarded on to the regulatory authority advising how to submit their reports directly to Medsafe.

Medsafe reserves the right to re-route any application to the standard evaluation process if the application does not fulfil the intent of the abbreviated evaluation process.

Once an abbreviated application has been submitted, changes cannot be made to the application based on subsequent changes/variations that have been approved by an overseas regulatory authority. These changes should be notified to Medsafe via a Changed Medicine Notification after consent has been granted for the distribution of the medicine in New Zealand.

Although an abbreviated application is based on overseas regulatory authority approval of a medicine, Medsafe reserves the right to request modifications to any part of the dossier (e.g. finished product specifications, shelf life) during the evaluation process, including to the indications and dosage information, or other data sheet sections.

5.4 Recognised regulatory authorities

For the purposes of the abbreviated evaluation process, Medsafe recognises the following regulatory authorities:

- Australian Therapeutic Goods Administration (TGA) (excluding applications approved upon appeal)
- European Medicines Agency (EMA) (centralised procedure only)
- European Union (EU) member states (decentralised procedure only)
- Health Products and Food Branch of Health Canada
- Singapore Health Sciences Authority (HSA)
- UK Medicines and Healthcare products Regulatory Agency (MHRA)
- Swissmedic
- United States Food and Drug Administration (FDA) .

6. Provisional consent applications

Provisional consent, under section 23 of the Medicines Act 1981, may be granted when it is desirable that the medicine be sold, supplied, or used on a restricted basis. Provisional consent is only granted for a period not exceeding two years and will then expire. Prior to expiry an application for renewal of provisional consent (refer to section 6.1 of this document) or for full consent under section 20 of the Medicines Act 1981 should be made.

Conditions may be imposed on provisional consent for a medicine. These may relate to the person to whom the medicine may be sold or supplied, the area in which the medicine may be distributed, or other conditions (eg, post-approval activities that are required of the sponsor). All conditions are included in the *New Zealand Gazette* notice.

Provisional consent is ideally suited to medicines still undergoing clinical development and/or assessment but where it is desirable that patients have early access. It is anticipated that the medicine will be used on a restricted basis until which time that the risks and benefits have been fully quantified and full consent can be granted.

In exceptional circumstances provisional consent may also be appropriate for the following situations:

- Medicines that will only be supplied in very limited circumstances for a period not exceeding two years.
- To address a stock shortage where the potential short-term replacement medicine has a safe history of use overseas, but there is limited data or time available for submission under section 20 of the Medicines Act 1981.
- Where conditions restricting the prescription and/or supply of a medicine are required on an ongoing basis.

Applications for provisional consent can be submitted either via the standard NMA route or the abbreviated procedure described in section 5 of this guideline, provided all associated eligibility criteria and data requirements are met. The acceptance of such applications is considered on a case-by-case basis.

6.1 Provisional consent application categories

There are two distinct categories under which applications for provisional consent can be submitted, and these differ according to their intended purpose and minimum data requirements. These categories are described below.

Clinical need

This category is intended for innovative or other medicines where there is an unmet clinical need and early access is desirable before full development is completed.

Minimum data requirements:

- The standard CTD dossier requirements for NMAs for full consent under section 20 (as described in Appendix 3) apply, except where some module 3-5 data may not yet be available.
- The NMA cover letter should include a justification for any data omissions and for why the application should be considered for provisional consent (i.e. how the medicine addresses an unmet clinical need).
- Appropriate supporting documentation should be included, such as the regulatory status in other jurisdictions and/or letters of support from relevant healthcare professionals.

Standard NMA timeframes apply to applications for provisional consent (clinical need). However, applicants may request priority review if they believe the criteria described below in section 7.1 are met.

Stock shortage

This category is intended for products needed to address or prevent an urgent stock shortage where continued supply of a medicine is clinically critical.

Minimum data requirements:

- Complete module 1 as described in section 8.2
    - The cover letter should include a justification for the category selection, supply and shortage details (e.g. critical timeframes), and Pharmac support letter attached (if applicable).
    - In most cases, approval of the medicine by a recongnised overseas authority (listed in section 5.4) is required and evidence of approval must be provided.
- Copy of the EDQM Certification of Suitability (CEP) if applicable.
- Drug substance specifications applied by the drug product manufacturer and batch data (3.2.S.4.1 and 3.2.S.4.4).
- Drug product qualitative and quantitative formulation, including quality standards (3.2.P.3.1).
- Description of drug product manufacturing process and controls (3.2.P.3.3).
- Drug product specifications and batch data for three consecutive commercial batches, ideally including any batch(es) supplied in New Zealand (3.2.P.5.1 and 3.2.P.5.4).
- Stability data (3.2.P.8).

While the above represents the minimum requirements, any additional supporting data (including module 3 and 5 sections) should also be included. If any of the above information is not available or the eligibility of a particular product for this NMA category is unclear, sponsors are encouraged to contact Medsafe to seek pre-submission advice.

Applications for provisional consent (stock shortage) will be assessed as a priority by default. Requests for formal priority review status are not required, and these applications will not count towards resource capacity when considering requests for priority review on the basis of significant clinical need (see section 7.1 below). However, the internal target timeframes will vary depending on the specific stock shortage situation and associated critical supply dates.

6.2 Renewal of provisional consent

It is the sponsor's responsibility to ensure that provisional consent does not expire for a medicine. Applications for renewal of provisional consent must be submitted at least three months prior to the expiry of provisional consent. This is necessary to allow sufficient time for administrative processing, evaluation of the renewal application, and publication of the *Gazette* notice. This applies to products where an application for conversion to full consent is underway and approval has not been granted within three months of expiry.

If an application is received less than three months before the expiry of provisional consent, there may be insufficient time to process a renewal of provisional consent and it will expire. A new provisional consent will then need to be granted before supply can resume.

Renewal of provisional consent is for a period of up to two years from the date of expiry ie, the current provisional consent expires on 30 October 2025 and the renewal of provisional consent is published on 22 August 2025, therefore provisional consent will now expire on 30 October 2027.

Applications for renewal of provisional consent must include the following documentation:

- Cover letter, including justification for renewal of provisional consent (e.g. ongoing stock shortage, planned or ongoing applications for conversion to full consent).
- Completed and signed NMA and Declarations and Commitments forms.
- Updated evidence of GMP compliance for any sites where existing evidence has expired.

No material changes can be made to the product as part of an application for renewal of provisional consent. These must be submitted separately via CMN.

6.3 Conversion from provisional consent to full consent

The sponsors of medicines with provisional consent should address the data deficiencies that were identified during the initial application to convert to full consent under section 20 of the Medicines Act 1981.

It is expected that a sponsor should generally submit an application for full consent as soon as practical or within a maximum of six years of provisional consent initially being granted.

If a medicine has any conditions relating to restrictions on supplying or prescribing the medicine that are required on an ongoing basis, it is not considered suitable for full consent and sponsors will need to continue to apply for renewal of provisional consent.

Provisional consent must be maintained during the period that the application is undergoing evaluation for full consent. The evaluation timeframes will not be adjusted to avoid renewal of provisional consent being required.

6.4 Data requirements for conversion from provisional to full consent

Provisional consent (clinical need)

- Complete module 1 as described in section 8.2
    - Cover letter should include a summary of additional supporting data submitted with the application and any CMNs submitted since the initial provisional consent was granted.
- Additional supporting data that has been produced since provisional consent was granted, that was not available in original dossier, or that addresses any conditions of provisional consent.
- If applicable, real world or surveillance clinical data should be included to support the medicine's ongoing positive benefit-risk profile.

Provisional consent (stock shortage)

- Complete CTD dossier, including a complete module 1 as described in section 8.2, regardless of what documentation was submitted with the initial provisional consent application.

Applications can be submitted either via the standard NMA route or the abbreviated procedure described in section 5 of this guideline, provided all associated eligibility criteria and data requirements are met.

7. Priority assessment of applications

7.1 Criteria for priority assessment

There are three eligibility criteria for granting priority assessment to a new medicine application. The criteria relate to medicines which address a significant clinical need, medicines which could deliver significant cost savings to the taxpayer, and medicines that are manufactured in New Zealand for export. The criteria are discussed below.

Changed Medicine Notifications are not eligible for priority assessment. Changed Medicine Notifications referred under section 24(5) of the Medicines Act 1981 can use the same eligibility criteria for priority assessments as NMAs.

(A) Significant clinical need

Requests for priority assessment on the basis of significant clinical need will be considered for applications for products containing new active substances or where alternative products are not available. Vaccines for the prevention of diseases are treated in the same way as other agents for the treatment of diseases. Cost saving does not constitute a significant clinical advantage, hence will not be taken into account when deciding whether a product meets the clinical criteria for priority assessment.

The sponsor of a medicine may request priority assessment if the medicine is indicated for the treatment or diagnosis of a serious, life-threatening or severely debilitating disease or condition for which other treatment options are limited. Sponsors may also request priority assessment to address an out-of-stock situation or withdrawal from the market of alternative medicines and it is essential that access to that treatment is maintained.

Medsafe has determined that there is resource capacity for up to four NMAs with priority assessment, on the basis of significant clinical need, to be undergoing evaluation at any one time. Requests for priority assessment based on significant clinical need will only be granted if there is resource availability. If an application is initially declined for priority assessment because Medsafe resource capacity has been reached, the application may still be eligible for priority assessment in the later stages of the assessment process (eg, Evaluation of Additional Information (EAI)) if evaluation resource becomes available.

Requests for priority assessment can only be made by the New Zealand sponsor or distributor of the product. These requests must be included in the NMA cover letter along with a suitable justification for how the proposed medicine meets the above criteria.

Sponsors are encouraged to provide support for claims of significant clinical need by submitting material such as letters of support from Pharmac, clinicians and consumer support groups.

(B) Significant potential cost savings

A request for priority assessment of a medicine on the basis of potential cost savings can normally only be made by or with support from Pharmac.

(C) Medicines manufactured in New Zealand for export

A request for priority assessment of a medicine that is to be exported should be made by the sponsor at the time the application for consent is lodged. The request should include the following information:

- a statement that the medicine (prescription or non-prescription) is being manufactured in New Zealand for export (it is not necessary for the medicine to be produced exclusively for export)
- a declaration that early approval of the medicine in New Zealand would facilitate access to the intended export market(s).

Applications given priority assessment under the "exported medicines" criterion will have a lower priority than applications granted a priority under criteria A or B.

The Manager, Product Regulation decides which applications are accepted for priority assessment.

8. Guide to preparing applications

8.1 Formats for New Medicine Applications

Applications for consent to distribute a new medicine must use the CTD format as described in the ICH Guideline "Organisation of the Common Technical Document for the Registration of Pharmaceuticals for Human Use"

The CTD format is comprised of:

- Module 1 Administration information and prescribing information for New Zealand
- Module 2 Overviews and Summaries of the Quality, Non-clinical and Clinical data
- Module 3 Quality
- Module 4 Non-clinical Study Reports
- Module 5 Clinical Study Reports

The expectation of the quality, safety and efficacy data is further described in the following ICH guidelines:

- ICH M4Q common technical document for the registration of pharmaceuticals for human use: Quality. Overall summary of Module 2 Module 3
- ICH M4S the common technical document for the registration of pharmaceuticals for human use: Safety. Nonclinical overview and nonclinical summaries of Module 2 organisation of Module 4
- ICH M4E the common technical document for the registration of pharmaceuticals for human use: Efficacy. Clinical overview and clinical summary of Module 2 Module 5: clinical study reports.

Depending on the type of application, all modules may not be required.

It is the applicant's responsibility to ensure the application is complete and contains sufficient evidence to attest to the safety, quality and efficacy of the medicine in accordance with international and national guidelines. The technical guidelines Medsafe refers to during an application assessment are described in Appendix 5 of this Guideline.

If a module or document is required but cannot be provided, or the information therein does not comply with the requirements outlined in the guidelines used by Medsafe, a robust scientific justification must be provided instead.

8.2 New Zealand Module 1 requirements

The administration and prescribing information for New Zealand consists of the following documents (as applicable for the particular type of product):

- cover letter

- completed NMA form(s)
- signed declaration and commitments form
- European Directorate for the Quality of Medicines & HealthCare (EDQM) Certificates of Suitability
- Good Manufacturing Practice (GMP) documentation
- labelling (see Labelling of Medicines and Related Products)
- information leaflet/package insert/Consumer Medicine Information (CMI) (See Requirements for Information for Prescribers and Consumersfile:///G:/Medsafe/regulatory/guidelines.asp)
- data sheet (see Requirements for Information for Prescribers and Consumers)
- copies of overseas evaluation report(s) and approval documentation.

Each New Medicine Application must be accompanied by an application form and a signed declaration form. A separate form should be completed for each separate medicine (name, dose form, drug substance, strength, classification and flavour as applicable).

8.3 General data requirements

An application for a new higher-risk medicine needs to be accompanied by an extensive dossier of supporting quality, safety and efficacy data**.** Safety and efficacy data is typically generated from randomised, placebo controlled clinical trials conducted in accordance with ICH Guidelines.

New intermediate-risk and lower-risk medicines usually contain active ingredients that are listed in a pharmacopoeia and claim indications for which there is sufficient supportive published literature. In general, the safety and efficacy can be demonstrated by reference to other approved medicines and as such are sometimes referred to as 'abridged' applications.

In some cases, a New Intermediate-risk or New Lower-risk Medicine Application may need to contain clinical documentation to support the proposed indications, and also possibly relevant toxicological and pharmacological documentation. This is generally applicable to New Intermediate-risk or Lower-risk Medicine Applications that include novel indications.

Applications to distribute biosimilar medicines need to be accompanied by non-clinical and clinical data as described in the EMA "Guideline on similar biological medicinal products containing biotechnology-derived proteins as active substance: non-clinical and clinical issues". Applications must also include a risk management plan covering the introduction of the product to New Zealand.

While an application for provisional consent need not contain the same detail of safety and efficacy data as that required for full consent, all available information should be included, along with an explanation of the type of data still being collected and when these data will be available.

When the product that is the subject of an NMA is closely related to an existing product, such as a new strength, the applicant is only required to submit data relevant to the introduction of the new product. The application must specify all differences between the new and existing products and provide data to support the safety, quality and efficacy of the new product. A complete dossier duplicating data already supplied by the applicant for an existing product is not required.

Different pharmaceutical forms and strengths or flavours of a medicine require separate application forms, but may be supported by reference to the same dossier of information.

Where a medicine has been evaluated and approved in Australia, Europe, Canada or the United States of America (USA), and the overseas approval documentation and evaluation reports are available, sponsors should provide copies of those reports along with an indication as to whether the supporting data submitted overseas was identical or not to the data submitted with the New Zealand application.

Additional information on the data requirements for specific application types is available in the appendices.

8.4 Formatting of documents

- All information in the dossier is to be in English, legible and easily located.
- Abbreviations and acronyms must be defined and included in a glossary.
- The documents must be numbered.
- Each part of the application must contain a detailed Table of Contents.

8.5 Older dossier formats

In exceptional circumstances Medsafe also accepts the EU format for the dossier as detailed in the European Commission's Rules Governing Medicinal Products in the European Union, Volume 2B: Notice to Applicants, 1998 edition. This format may be accepted in cases where the dossier has previously been assembled and submitted in that format to a regulatory authority in Europe or Australia and the product has not undergone significant post-approval modification.

Medsafe does not expect applicants to re-format such material to the CTD format. If an application dossier in EU format is available, this should be submitted unchanged **except** for "Part IA" (Administrative Data) which must be replaced with the New Zealand NMA form so that all information relevant to the New Zealand application is presented and that specific to EC administrative requirements is omitted. The accompanying "Part IB" documents (GMP documentation, data sheet, labelling, etc.) should be submitted as they are or adapted to New Zealand requirements, as appropriate.

The application must be accompanied by a complete dataset as required by the Medicines Act 1981 and the GRTPNZ, consisting of the equivalent data as described in CTD Modules 1, 2, 3, 4, and 5 (as applicable). The dataset must reflect the product details being sought for registration. In cases where the product details have been

changed post-approval, the original dossier must be updated with all changes incorporated.

A detailed Table of Contents must be provided with any dossier, regardless of the format, to assist Medsafe evaluators in their assessment. It is expected that a non-CTD format is cross-referenced to CTD format to assist with the location of information.

8.6 General requirements for applications based on a parent product

The name and TT50 file reference number of the parent product must be provided.

The relationship between the two products should also be detailed in the cover letter. Full access rights to the parent product must be provided if the parent product is owned by another sponsor.

The differences between the parent product and new product determine the type of application category and associated evaluation fee.

8.7 Format for Requests for Further Information responses

The only allowable exemption to using the CTD format is for responses to 'Requests for Further Information' (RFIs), but only when the additional information or data is limited in volume. It is important for all RFI responses that the additional information or data be cross-referenced to the outstanding questions/issues in the RFI letter in numerical order.

9. Selecting a product name

As New Zealand is a member state of the World Health Organization (WHO), Medsafe requires that sponsors take WHO resolution WHA 46.19 into consideration when proposing any new product name. In accordance with this resolution, proprietary names that are invented names must not be derived from International Non-proprietary Names (INNs) or include INN stems.

Medsafe's interpretation of the WHO resolution means that the following types of product names will not be considered acceptable:

- composite name consisting of part of the INN appended to a company identifier
- a name constructed to be essentially similar to the INN, but not the complete INN (e.g. middle letters or beginning or end syllables removed).

A product name that contains a complete INN together with a company name/identifier is acceptable and in accordance resolution WHA 46.19. For generic medicine, this is Medsafe's preferred option. If a company identifier is used, then this should be a well-recognised company identifier within New Zealand.

Further information on WHA 46.19 is available in Part 4 and Annex 5 of the WHO Guidance on the Use of International Nonproprietary Names (INNs) for Pharmaceutical Substances (https:/www.who.int/publications/m/item/guidance-on-the-use-of-inns)

In addition to ensuring compliance with resolution WHA 46.19, a proprietary name should be unambiguous and not misleading in anyway with regard to the nature, purpose, uses or effects of the product. A proprietary name should also not be easily confused any other product name consented in New Zealand.

Umbrella branding can be used in product names and refers to the marketing of medicines under the same brand name. The umbrella segment is the section of the product name that is used for more than one medicine to create a brand for a range of products. For further information and requirements for umbrella branding refer to Labelling of Medicines and Related Products (section 2.5) guideline of the GRTPNZ.

10. Categorisation of New Lower-risk Medicine Applications

New Lower-risk Medicine Applications are categorised as L1, L2 or L3 applications and further information about the categorisation criteria is described below. A flow chart is also available in Appendix 2 to assist with categorisation.

10.1 L1 application-clones

The L1 application category includes applications for 'clones'. The term 'clone' is used in relation to lower-risk medicines that are identical in all respects to a previously approved 'parent product', apart from the aspects detailed below.

Where a product is accepted as a 'clone', reduced supporting data is required that is limited to the proposed labelling, package insert, CMI and data sheet (where applicable), GMP (for finished product manufacturing, testing, and packing sites), and finished product specifications (specific for the product under evaluation).

'Clone' applications must comply with the following requirements:

- the 'clone' must be identical to the 'parent product' in all respects other than the product name and labelling. Note: the acceptability of the proposed name and labelling will be fully assessed as part of the evaluation of the 'clone' application
- the 'parent product' must have been previously approved and comply with all current regulatory requirements, including the Medsafe Label Statements Database
- the sponsor of the 'parent product' must authorise Medsafe to access the 'parent product' information
- if the sponsor of the clone is not the same as the 'parent product', the sponsor of the clone must hold a full copy of the supporting data from the dossier

The 'clone' application needs to include:

- a letter from the sponsor of the 'parent product' authorising Medsafe to access information on the 'parent product' to support the 'clone' application
- the cover letter for the application must include assurances that:
    - all quality aspects of the proposed 'clone' product are identical to the 'parent product', and that the sponsor will ensure that the 'clone' product will comply with all applicable regulatory requirements and
    - the 'clone' will comply with any specific conditions imposed by Medsafe on the 'parent product'
- marked up and clean copies of all 'clone' labels, package inserts, data sheet and CMI (where applicable) that comply with current regulatory requirements, including the Medsafe Label Statements Database

- copies of the most recently approved labels, package insert, CMI and data sheet (where applicable) for the 'parent product' (these must comply with current regulatory requirements, including the Medsafe Label Statements Database)
- evidence of current GMP certification for the finished product manufacturing, packing, and testing sites
- details of New Zealand site of batch release
- a copy of the finished product specification that is specific for the product under evaluation and includes the proposed clone name
- if a different pack size is proposed, an assurance that the container type is unchanged and the container material is unchanged.

10.2 L1 application – flavour/fragrance/colour variants

The L1 application category also includes extension applications for Flavour/Fragrance/Colour (FFC) variants, where the medicine meets all of the requirements applying to a 'clone' (refer section 10.1 of this Guideline) except for the inclusion of a different FFC.

A FFC extension application can only be submitted as an L1 application if it complies with the following:

- all of the requirements applying to 'clones', with the exception that the FFC may differ from the 'parent product'.

An FFC extension application must include all of the information and assurances required for a 'clone' application, together with the following:

- the cover letter for the application should include an assurance that all quality aspects, other than those directly related to the FFC, of the proposed 'clone' product are identical to the 'parent product', and that the sponsor will ensure that the 'clone' product will comply with all current regulatory requirements
- a copy of the raw material specifications for the 'parent product' FFC and the new FFC variant
- confirmation that any Proprietary Ingredients have been added to the Medsafe Proprietary Ingredient Register and the Medsafe reference number provided. (Note: new Proprietary Ingredients should be added to the Medsafe register following the process outlined in the "Ingredients in New Medicines and Related Products" guideline.)

10.3 L1 application – new pack size/classification

The L1 application category also includes NMAs for an additional pack size, where an active ingredient has been down-scheduled and/or the classification is dependent on pack size. The application must meet all of the requirements applying to other 'clone' applications except for the resultant change in pack size, classification statement and labelling.

An additional pack size/classification application can only be submitted as an L1 application if it complies with the following:

- all of the requirements applying to 'clones', with the exception that the pack size and classification may differ from the 'parent product'.

An additional pack size/classification application must include all of the information and assurances required for a 'clone' application, together with the following:

- the cover letter for the application should include an assurance that all quality aspects, other than those directly related to the pack size/classification change, of the proposed 'clone' product are identical to the 'parent product', and that the sponsor will ensure that the 'clone' product will comply with all current regulatory requirements.

10.4 L1 application - new combination pack

The L1 application category also includes NMAs for a new combination pack containing two or more previously approved 'parent products' when both products are contained within a fully labelled outer container (eg, carton). The container for each component of the combination pack must be unchanged from that previously approved, and the combination pack must not affect the stability or shelf life of each component. There cannot be any change to indications or dosage of any component of the combination. The application must meet all of the requirements applying to other 'clone' applications except for resultant labelling.

10.5 L2 and L3 applications overview

Applications for NMAs within the L2 and L3 categories are more complex than L1 applications and have different data requirements depending on the nature of the particular application. A summary of the data requirements for Lower-risk Medicine Applications are described in Appendices 3 and 4. Applicants submitting via the L2 and L3 categories should note the following requirements in addition to the generalised dossier requirements.

- Module 3 in CTD format is required to support the quality of the product. However, where all quality aspects of the product are identical to a 'parent product' that has been previously approved by Medsafe then the sponsor may provide an abbreviated Module 3 dossier. Where an abbreviated Module 3 dossier is submitted, the sponsor must provide:
  - a letter from the sponsor of the 'parent product' authorising Medsafe to access information on the 'parent product' to support the application
  - finished product specifications for the proposed product, specific for the product under evaluation, and stating the proposed clone name
  - evidence of current GMP certification
  - proposed labels
  - details of New Zealand site of batch release

- an assurance in the cover letter that all quality aspects are identical to the 'parent product', and identifying any areas of difference (note: dependent on the areas of difference additional information may be required).

- CTD Module 4 and Module 5 may be required for L3 applications to support the safety and efficacy of the product, and may also be required for L2 applications in exceptional circumstances.

10.6 L2 application – new generic or new strength of an existing product

L2 applications are for lower-risk medicines where the active ingredient, strength, combination, dose form, indications and directions for use are the same as a medicine previously approved in New Zealand.

The L2 route may also be used for a new lower risk medicine that is an extension of an existing lower risk product including:

- a new strength with no change in the administered dose of active ingredient.

10.7 L3 application

L3 applications are for lower-risk medicines, where safety and efficacy cannot be derived from the formulation alone.

The risk categorisation framework for NMAs in Appendix 4 details safety and/or efficacy data requirements for L3 applications.

Lower-risk medicines that should be submitted as L3 applications include:

- modified-release products (excluding enteric coated tablets/capsules)
- generic versions of a registered product where bioequivalence data are required or where a justification for not providing bioequivalence is required
- products that include a novel excipient or an excipient with a new route of administration
- products where the label claims equivalence with another product, which requires either bioequivalence data or a justification for not providing bioequivalence data
- formulation dependent topical products
- an application for a lower-risk medicine as a result of a change in scheduling for a particular product from the 'Prescription Only Medicine' schedule to a lower (OTC) schedule, where no such products are previously approved as a lower-risk medicine.

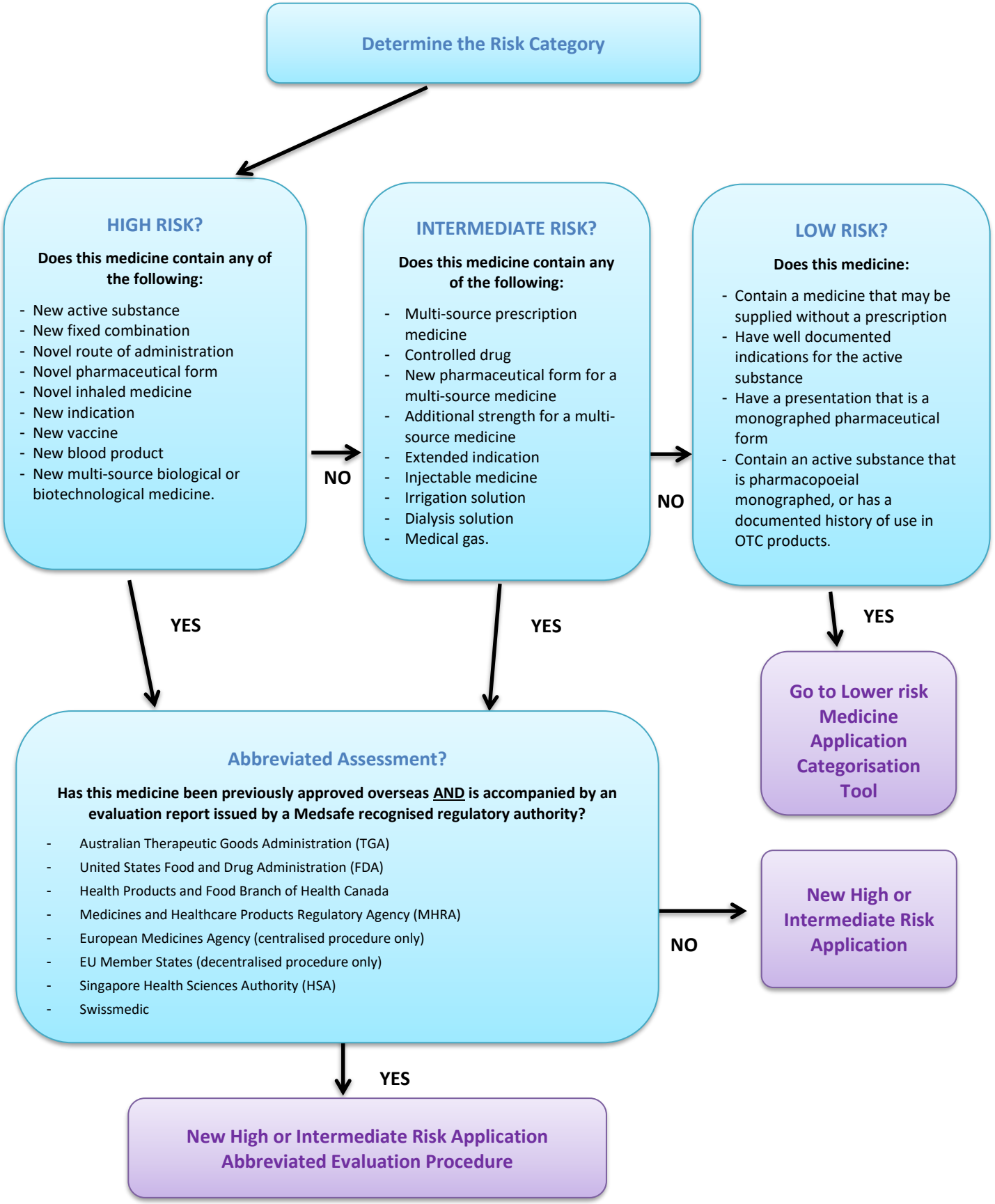
In general, lower-risk medicines should only contain active ingredients that have a long history of use in medicines. However, there are circumstances where a new lower risk medicine may contain an active ingredient that is a New Chemical Entity (NCE). To be eligible for assessment as a lower risk medicine all of the following conditions must apply to the medicine containing an NCE:

- The active ingredient is classified as an OTC medicine or has been confirmed by the Medicines Classification Committee (MCC) as suitable for general distribution (ie, agreed that the substance need not be scheduled).
- The overall presentation of the product is suitable for OTC sale, ie, indicated for self-limiting, self-diagnosed conditions and suitable for self-selection by consumers.
- The active ingredient is widely used in Australia, EU, Canada or the United Kingdom (UK) as an OTC medicine or in New Zealand as a food ingredient (including dietary supplements).

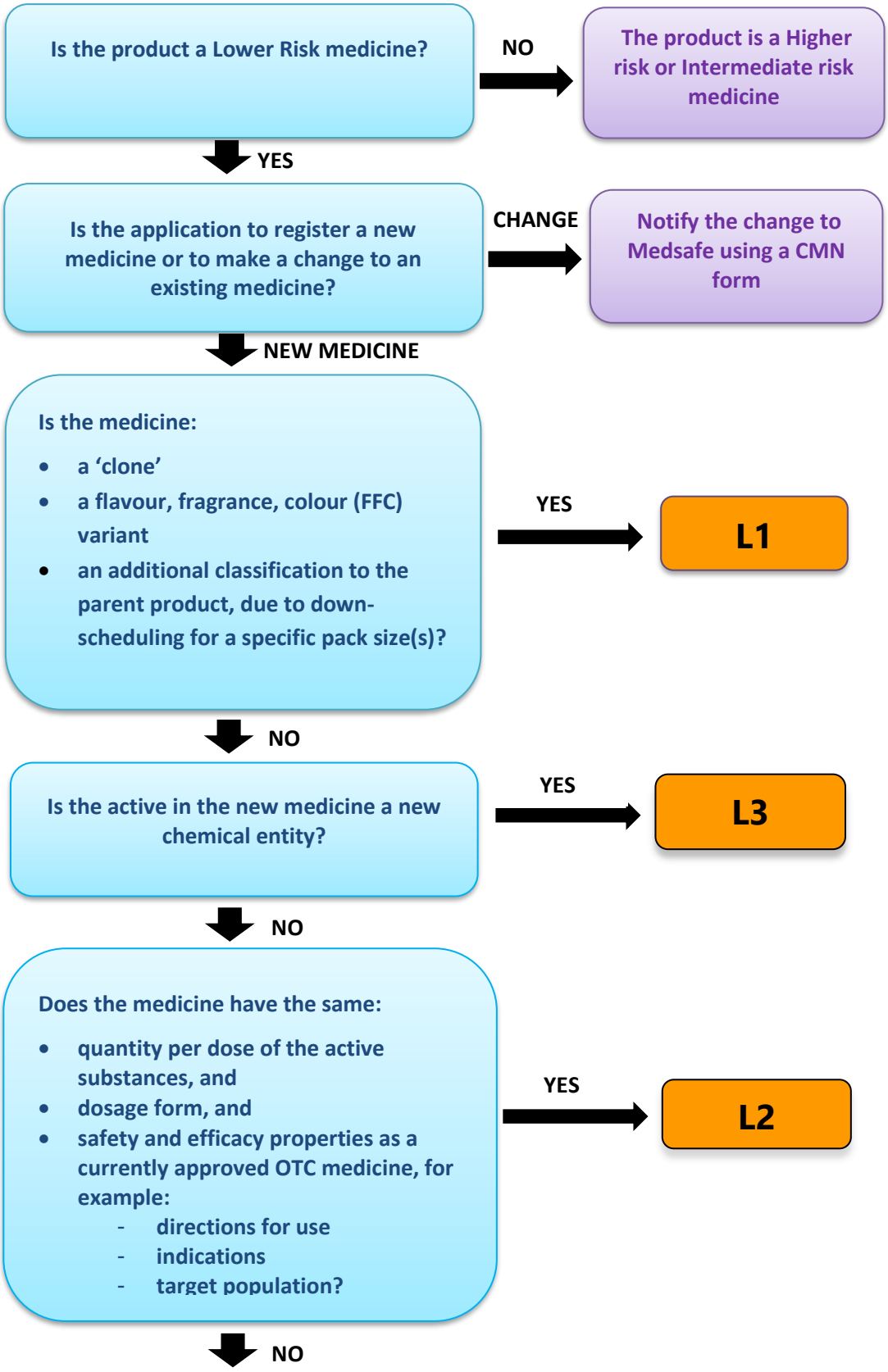
The L3 application route may also be used for a new lower-risk medicine that is an extension of an existing lower risk product to include:

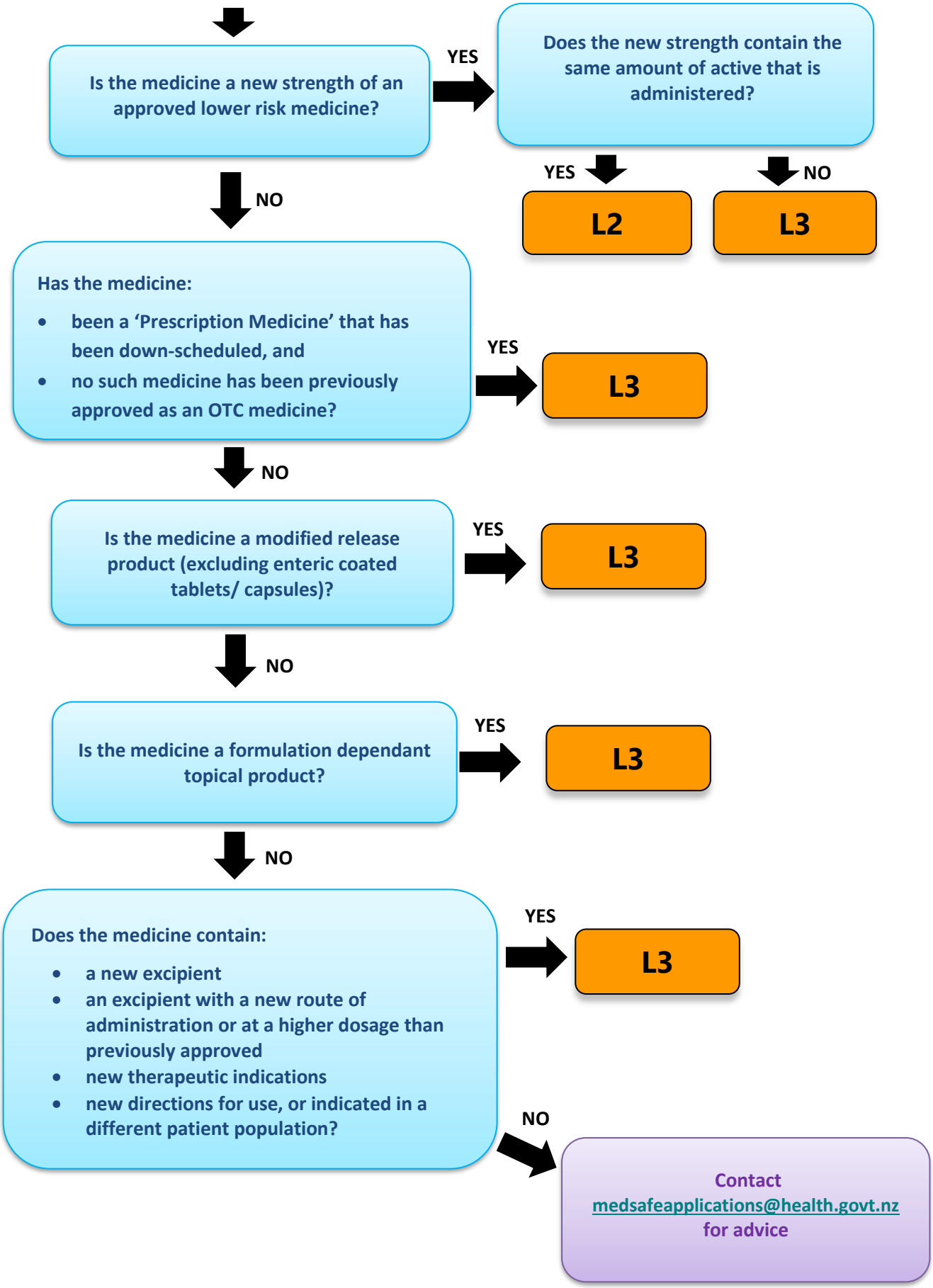
- new therapeutic indications
- new strengths that have a different administered dose of active ingredient compared to the existing product
- new dose forms
- new directions for use
- new combination products
- different patient populations

Appendix 1: Application categorisation tool



Appendix 2: Lower-risk medicine categorisation tool




Is the medicine a new strength of an approved lower risk medicine?
YES
Does the new strength contain the same amount of active that is administered?
YES
L2
NO
L3
NO
Has the medicine:
• been a 'Prescription Medicine' that has been down-scheduled, and
• no such medicine has been previously approved as an OTC medicine?
YES
L3
NO
Is the medicine a modified release product (excluding enteric coated tablets/ capsules)?
YES
L3
NO
Is the medicine a formulation dependant topical product?
YES
L3
NO
Does the medicine contain:
• a new excipient
• an excipient with a new route of administration or at a higher dosage than previously approved
• new therapeutic indications
• new directions for use, or indicated in a different patient population?
YES
L3
NO
Contact medsafeapplications@health.govt.nz for advice

Appendix 3: Summary of data requirements for New Medicine Applications

The data required to support a new medicine application depend upon the categorisation of the product:

- New Higher-risk Medicine (NMA-H)
- New Intermediate-risk Medicine (NMA-I)
- New Lower-risk Medicine (NMA-L)
- An application for provisional consent to distribute a new medicine

Please note that a non-prescription medicine does not automatically fall into the lower-risk medicine category. For example, a parenteral that is classified as a General Sales medicine is categorised as an intermediate medicine.

Medsafe's data requirements for new medicines are set out below. Dossiers are assessed for conformity with these requirements.

Formatting of the data in the dossier should follow the Common Technical Document requirements as described in ICH guideline M4(R4) "Organisation of the Common Technical Document for the registration of pharmaceuticals for human use".

Module 1

The following table summarises the Module 1 data requirements for new medicine applications, depending on the application's categorisation.

Table 1. Summary of Module 1 data requirements based on application type

Module 1		Higher risk	Intermediate risk	Lower risk
1.0.1	Letter of application	Mandatory	Mandatory	Mandatory
1.0.2	Responses to questions for information	Not required	Not required	Not required
1.1	Comprehensive table of contents	Mandatory	Mandatory	Mandatory
1.2.1	Application form	Mandatory	Mandatory	Mandatory
1.2.2	Pre-submission details	Not required	Not required	Not required
1.2.3	Patent certification	Not required	Not required	Not required

1.3.1	Data sheet and package insert	Data sheets are Mandatory	Data sheets are Mandatory	Data sheets may be required
1.3.2	Consumer medicine information	Desirable	Desirable	Desirable
1.3.3	Human embryo/embryonic stem cell declaration	Mandatory	Mandatory	Not required
1.3.4	Label mock-ups and specimens	Mandatory	Mandatory	Mandatory
1.4	Information about experts & expert declarations	Mandatory	Mandatory	Not required
1.5.1	Literature-based submission documents	May be required. Refer to Module 1 requirements.	May be required. Refer to Module 1 requirements.	May be required. Refer to Module 1 requirements.
1.5.2	Orphan drug designation	May be required. Refer to Module 1 requirements.	May be required. Refer to Module 1 requirements.	Not applicable
1.5.3	Genetically modified organisms consents	May be required	May be required	Not applicable
1.5.4	Additional trade name declarations	Not required	Not required	Not required
1.5.5	Co-marketed medicines declarations	May be required	May be required	May be required
1.6	Drug and plasma master files and certificates of suitability	May be required	May be required	May be required
1.7	Good manufacturing practice	Mandatory	Mandatory	Mandatory
1.8	Compliance with meetings and pre-	Not applicable	Not applicable	Not applicable

	submission processes			
1.9	Individual patient data declaration	May be required	May be required	Not applicable
1.10	Overseas regulatory status	Mandatory	Mandatory	Mandatory
1.11	Summary of biopharmaceutic studies	Mandatory	Mandatory	Optional
1.12	References to paediatric development program	Optional	Optional	Not required
1.13	Information relating to pharmacovigilance	Mandatory	Mandatory	Not required
Annex I	Antibiotic resistance data	May be required	May be required	Not required
Annex II	Overseas evaluation reports	Desirable/ Mandatory for abbreviated route	Desirable/ Mandatory for abbreviated route	Desirable

Good Manufacturing Practice (GMP) certification or other evidence of GMP compliance must be provided for each finished product manufacturing, testing and packing site and the certification: (a) must relate to the product (or product class) and activity concerned, (b) must be issued by authorities recognised by Medsafe, and (c) must not be due to expire by the time the product is likely to be approved for distribution in New Zealand.

For prescription medicines appropriate evidence of GMP (in the form of a GMP certificate) must be provided (or have been provided previously) for each active ingredient manufacturing site.

The labelling must comply with the New Zealand Medicines Regulations 1984 and Guidelines (see Labelling of Medicines and Related Products guideline). In limited circumstances a labelling exemption may be requested according to the criteria set out in section 2.2 of the Labelling of Medicines and Related Products guideline .

If applicable, the labels must allow easy discrimination between the different strengths of the product.

If any excipients in the product are unsuitable for particular patient populations, appropriate information or warnings must be included on the label (or, when space on the label does not permit, in an information leaflet/package insert) and also in the data sheet.

The draft data sheet must comply with the NZ Medicines Regulations and Guidelines (see Requirements for information for prescribers and consumers).

In the case of a generic prescription medicine or a biosimilar, the data sheet must be consistent with that of the corresponding innovator product.

If applicable, any package insert/information leaflet supplied with the product must be consistent with the New Zealand product details and the data sheet.

Additional Module 1 requirements for abbreviated applications

Applicants submitting applications for new medicines that meet the eligibility criteria for an abbreviated application will need to provide documentation describing the product and the history of the product's evaluation and approval by the recognised regulatory authority.

The following information must be submitted.

1. A covering letter requesting that the application be evaluated using the abbreviated process.
2. A complete Module 1 completed specifically for New Zealand registration. Applicants should use the NMA form posted on the Forms and Templates page of the Medsafe website.
3. A table of contents for the dossier to provide easy reference to the submitted information.
4. A table which sets out the events in the regulatory history of the product occurring from the date of the application for consent lodged with the recognised overseas regulatory authority through to the date of the application for consent to distribute in New Zealand. If applicable, this table should include any post-approval variations that have been approved by the regulatory authority and are being sought for consent as part of the NMA. Information in the table should be presented in chronological order under the following headings.
    a. Date of the event.
    b. Event description (eg, type of application, request for further information, post-approval variation(s)).
    c. Summary of event (e.g. brief description of correspondence with the recognised regulatory authority (with dates, name and designation of author)), or a brief description of the change notified in a post-approval variation).
5. A copy of the approval letter and approved product details, including any attachments from the recognised regulatory authorities.

6. A copy of the evaluation reports from a recognised regulatory authority that has approved the product (this must include all interim and final evaluation reports that have been completed).
7. A copy of requests for information issued by the recognised regulatory authority that has approved the product, along with the responses to such requests, and the subsequent assessment of the responses by the regulatory authority.
8. Evidence, if required, of the relevance of the submitted biostudy reference product to the New Zealand market reference product in line with the New Zealand Regulatory Guidelines for Medicines (NZRGM). For biosimilars, relevance of the reference product used in characterisation, non-clinical, and clinical studies to the New Zealand reference product.
9. If applicable, details of the reason for and outcome of, any referral to arbitration by the Coordination Group for Mutual Recognition and Decentralised procedures (CMD(h)).
10. Finalised labelling and packaging copies approved by the recognised regulatory authority and the proposed New Zealand labelling and packaging.
11. A copy of the drug substance specifications applied by the drug product manufacturer and approved by the regulatory authority.
12. A copy of the drug product release and expiry specifications approved by the regulatory authority.

Module 2

Module 2 summarises the information that will be provided in the quality (Module 3), nonclinical (Module 4) and clinical (Module 5) modules of the dossier.

There is no single ICH guidance document that explains the content of Module 2 for the registration of pharmaceuticals for human use. The ICH M4 guidelines for Modules 3, 4, and 5 include a section on the information that must be provided in Module 2.

Table 2. Summary of Module 2 data requirements based on application type

Module 2		Higher risk	Intermediate risk	Lower risk
2.1	Table of contents	Mandatory	Mandatory	Mandatory
2.2	Introduction	Mandatory	Mandatory	Mandatory
2.3	Quality overall summary	Mandatory	Mandatory	Mandatory
2.4	Nonclinical overview	Mandatory	Mandatory	Not required
2.5	Clinical overview	Mandatory	Mandatory	Desirable
2.6	Nonclinical overview	Mandatory	Mandatory	Not required

2.7	Clinical overview	Mandatory	Mandatory	Not required

Modules 3, 4, and 5

Module 3 includes the chemical, pharmaceutical and biological data relevant to the application. Formatting and data requirements for Module 3 are described in ICH M4 guidance "M4Q(R1) The Common Technical Document for the registration of pharmaceuticals for human use: Quality – M4Q(R1)". A brief overview of Module 3 data requirements, including those specific to New Zealand are provided below, under Table 3.

Module 4 includes the pharmacologic, pharmacokinetic, toxicological data relevant to the application. Formatting and data requirements for Module 4 are described in ICH M4 guidance "M4S(R2) The Common Technical Document for the registration of pharmaceuticals for human use: Safety – M4S(R2)".

Module 5 includes the clinical data relevant to the application. Formatting and data requirements for Module 5 are described in ICH M4 guidance "Revision of M4E guideline on enhancing the format and structure of benefit-risk information in ICH: Efficacy – M4E(R2)".

Table 3. Summary of data requirements for Modules 3, 4 and 5 based on application type.

	Higher risk	Intermediate risk	Lower risk
Module 3: Quality	Mandatory	Mandatory	Mandatory
Module 4: Nonclinical	Mandatory	Mandatory	Not required
Module 5: Clinical	Mandatory	Mandatory	May be required depending on specific application types
Module 5.3.1: Reports of biopharmaceutic studies	May be required	May be required	May be required
Module 5.3.2: Pharmacokinetic studies using human biomaterials	May be required	May be required	May be required

Composition

The dose form and formulation must be adequately justified and be appropriate for the medicine concerned. All of the ingredients must be acceptable for use in human

medicines and be compatible with each other. Dose delivery must be consistent within clinically acceptable limits.

If relevant, any antioxidants and any chemical or anti-microbial preservatives included in the product must be adequately justified and their effectiveness must be established.

Adequate measures must be taken to ensure that any animal-derived ingredients (eg, gelatin, magnesium or calcium stearate, stearic acid) used in the product are free from transmissible spongiform encephalopathies (TSE) contamination.

Different strengths of the product must be readily distinguished (eg, by differences in size, colour, shape, markings, etc).

If tablets are scored, evidence that the tablets split evenly must be provided. If a tablet is not intended to be divided, or has not been proven to be capable of providing a divided dose, then the "Presentation" and "Dosage and Administration" sections of the tablet's data sheet should contain the following statement: "Do not halve tablet".

The primary (immediate) and secondary (outer) packaging and packaging materials, closures, induction or tamper-proof seals, pack sizes, any dosing device, and any desiccant or cotton wool contained in the package must be appropriate for the product.

If the New Zealand Medicines Regulations 1984 require the product to be in a safety container, it must be so packaged. The current legislative definition of safety packaging in New Zealand is blister strip packaging (Regulation 2 of the Medicines Regulations 1984). In addition, Medsafe requires all anti-depressants, marketed as a solid oral dose form, to be contained within safety packaging.

Manufacture of active ingredients

For prescription medicines, unless previously submitted and approved, a satisfactory Drug Master File (DMF) or a European Pharmacopoeial Commission "Certificate of Suitability" (CEP) issued by the European Directorate for the Quality of Medicines (EDQM), must be submitted from each supplier of bulk active ingredient.

For lower-risk medicines, Certificates of Analysis for representative batches of active ingredient that are issued by the finished product manufacturer are sufficient instead of a DMF or European Pharmacopoeial Commission CEP.

The DMF must describe in detail: the "route of synthesis", each step in the manufacturing and purification process, the reaction conditions and in-process controls for each step, the quality control of starting materials, reagents, catalysts, solvents and any isolated intermediates, as well as any subsequent processing (eg, milling) of the bulk substance.

The DMF must also provide proof of chemical and stereochemical structure of the substance (and of any significant impurities) using appropriate physical, chemical and spectroscopic methods.

Where relevant, adequate evidence of the crystalline form produced, and control thereof must be provided.

Manufacture of finished products

The manufacturing, sterilisation (if any) and packaging processes, the equipment used, and batch sizes must be described in detail, appropriate and justified.

Any overages or ranges of quantities for the active ingredient(s) or any excipients must be appropriate and adequately justified.

If relevant, any sterilisation processes must be justified, and it must be established that harmful by-products are not formed during the sterilisation process.

Any overfill of the container(s) must be justified.

Any solvents or gases used in the manufacturing process must be of adequate quality.

If alternative processes are intended at some steps in the manufacture, these must have been justified and shown to yield finished product of equivalent quality.

The in-process controls (including temperatures, mixing times and speeds, and filter integrity), test methods and acceptance limits at each step in the manufacturing, sterilisation (if any) and packaging processes must be defined, appropriate and adequate to assure batch quality and unit-to-unit consistency.

If relevant, any processing (eg, neutralising, cleaning, washing, sterilisation) of the containers before filling must be adequately controlled.

If relevant, controls on sterility of the equipment, product and containers must be adequate throughout the process.

If sterilisation is by filtration, the bioburden of the product before filtration must be adequately controlled, the filter membrane pore size must be not more than 0.22 microns, and the integrity of the filter must be checked before and after use.

If sterilisation is by autoclaving or gamma irradiation, the equipment and procedures must be described in detail and adequately controlled.

If sterilisation of the product or container is by treatment with ethylene oxide, its use must be the only viable option and the residue level must be controlled to not more than 1 ppm in the product or 1 mcg/ml container volume, and any chlorohydrin residue must be controlled to not more than 50 ppm in the product or 50 mcg/ml container volume.

For a standard method of manufacture (as defined by EMA guidance) all critical steps in the manufacturing process (including any cleaning and/or sterilisation steps) must have been adequately developed and validated at each manufacturing site at either production scale or at pilot scale (10% of full scale or 100,000 solid dose units, whichever is the greater unless otherwise justified) using production scale equipment. For non-standard methods of manufacture (as defined by EMA guidance) validation at 100% of full production scale is required.

If only pilot scale validation has been completed, confirmation that full scale validation is scheduled for when commercial scale production commences must be

provided along with the process validation protocol that will be used for full scale validation.

Quality control of active ingredients

(a) Controls applied by manufacturer of bulk active ingredients

The active ingredient specifications applied by the manufacturer of the bulk active ingredient must be in accordance with a recognised pharmacopoeia (eg, Ph Eur, BP, USP) or, if non-pharmacopoeial specifications are applied, these must cover all of the relevant identity, organoleptic, physical (including crystalline form and particle size distribution, if applicable), chemical, stereochemical and microbiological quality parameters.

Justification must be given for the selection of any non-pharmacopoeial tests, test procedures, requirements and limits.

If certain tests are not carried out routinely, adequate justification must be provided.

Physical, chemical and microbiological test procedures (whether pharmacopoeial or not) must be self-validating or have been validated in accordance with pharmacopoeial standards or ICH guidelines.

All assay and related product/degradation product and residual solvent impurity level tests must have been validated (as appropriate) for specificity/selectivity, limit of detection, limit of quantitation, accuracy, precision, repeatability, linearity, stability of solutions, and robustness/ ruggedness in accordance with ICH guidance.

Proof must be provided that the related substance assay procedure is adequate to detect and control all of the related substance impurities actually or potentially present in the bulk substance produced using the intended manufacturing process.

Satisfactory representative batch analytical data must be supplied for typical batches of bulk active substance.

Any Certificates of Analysis submitted must have been signed.

If a "house" reference standard is used in the assays, characterisation and analytical data confirming its suitability for use must be provided.

(b) Controls applied by manufacturer of finished products

The active ingredient specifications applied by the finished product manufacturer in testing bulk active substance before use in manufacture of the finished product must be in accordance with a recognised pharmacopoeia (eg, Ph Eur, BP, USP) or, if non-pharmacopoeial specifications are applied, these must cover all of the relevant identity, organoleptic, physical (including particle size distribution, if applicable), chemical, stereochemical and microbiological quality parameters.

Justification must be given for the selection of any non-pharmacopoeial tests, test procedures, requirements and limits.

If certain tests are not carried out routinely, adequate justification must be provided.

Physical, chemical and microbiological test procedures (whether pharmacopoeial or not) must be self-validating or have been validated in accordance with pharmacopoeial standards or ICH guidelines in the testing laboratory(ies) used by the finished product manufacturer for routine quality control of the bulk active(s).

All assay and related product/degradation product and residual solvent impurity level tests must have been validated (as appropriate) for specificity/selectivity, limit of detection, limit of quantitation, accuracy, precision, repeatability, linearity, stability of solutions, and robustness/ ruggedness in accordance with ICH guidance.

Satisfactory representative batch analytical data generated by the finished product manufacturer(s) must have been supplied for typical batches of bulk active substance from each supplier.

Any Certificates of Analysis submitted must have been signed.

If a "house" reference standard is used in the assays, characterisation and analytical data confirming its suitability for use must be provided.

Quality control of excipients

The identity and quality of all excipients (including capsule shells and their constituents, and any gases used in filling vials or ampoules) must be controlled by either pharmacopoeial or appropriate in-house specifications.

Any non-pharmacopoeial specifications must be appropriate and adequately control identity, and physical, chemical and microbiological quality of the material.

Adequate measures must be taken to ensure that any ingredients of animal origin (eg, gelatin, magnesium or calcium stearate, stearic acid) used in the product are free from TSE contamination in accordance with EC and US guidelines.

Satisfactory representative batch analytical data must be provided for any excipients controlled by non-pharmacopoeial specifications.

Any Certificates of Analysis submitted must have been signed.

Quality control of packaging materials (primary packaging)

The packaging materials used (polymers, types of glass, etc.), containers, seals, closures and any delivery device(s) supplied with the product must be clearly defined, suitable for pharmaceutical use, and adequately controlled for identity, dimensions, physical and chemical properties, manufacturing defects, and sterility, as applicable.

Any plastic or rubber packaging/closure materials in contact with the product must be free from any leachable toxic impurities and must comply with Ph Eur and USP requirements for polymeric materials used in packaging of medicines.

Satisfactory representative batch analytical data must be provided for any primary packaging materials, containers and closures in contact with the product.

Any Certificates of Analysis submitted must have been signed.

Quality control of delivery devices

Any delivery device(s) supplied with the product must be clearly defined, suitable for pharmaceutical use and adequately controlled for identity, dimensions, physical and chemical properties, manufacturing defects, sterility, and dose delivery, as applicable.

Quality control of intermediate products

If there is an intermediate product, it must be controlled by separate, appropriate specifications that adequately control all relevant parameters.

Satisfactory representative batch analytical data must be provided.

Any Certificates of Analysis submitted must have been signed.

Quality control of finished products

The complete identity and quality of the finished product must be adequately controlled at release and throughout its shelf-life by appropriate pharmacopoeial or in-house specifications that cover all of the necessary organoleptic, physical, dissolution, chemical, microbiological and dose delivery parameters relevant to the dose form.

It must be clear which requirements apply at release and which apply throughout the shelf-life.

If applicable, any non-pharmacopoeial test procedures used as replacements for, or in addition to, the procedures in a pharmacopoeial monograph must be appropriate and have been justified.

If all specified tests are not carried out routinely, justification must be provided.

The test procedures used must be self-validating or have been adequately validated in accordance with pharmacopoeial requirements or ICH guidelines at each of the testing sites intended for routine quality control of the product.

All assay and related product/degradation product and residual solvent impurity level tests must have been validated (as appropriate) at each testing laboratory involved in the quality control of the product for specificity/selectivity, limit of detection, limit of quantitation, accuracy, precision, linearity, repeatability, stability of solutions, and robustness/ ruggedness.

Any lack of mass balance between assays and degradation products must be explained or discussed.

Satisfactory recent batch analytical reports must be provided for the final market formulation(s) of the product manufactured at each of the proposed manufacturing sites. For product manufactured using a standard method of manufacture (as defined by EMA guidance) batch analytical data can be at either production scale or at pilot scale (10% of full scale or 100,000 solid dose units, whichever is the greater unless otherwise justified). For product manufactured using a non-standard method of manufacture (as defined by EMA guidance) batch analytical data must be for provided for maximum production scale batches. Batch results must be included for

each specified test and all of the reported test results must comply with the specifications. If not, an adequate explanation or justification must be provided.

Any Certificates of Analysis submitted must have been signed.

Stability of active ingredients

The stability of the active ingredient(s) is normally described in the associated DMF(s) or 3.2.S.

The stability data submitted must have been produced in accordance with ICH guidelines and adequately establish that the bulk active substance packaged in the intended storage container and stored under the prescribed storage conditions will remain within specifications for the whole of the claimed shelf-life or retest period.

Stability of finished products

The stability of the market formulations of the finished product (or formulations that may reasonably be expected to have the same stability) packaged as intended for marketing must have been tested in accordance with ICH guidelines (including the ICH requirements for the number and sizes of batches used) unless otherwise justified.

Preferably, more than one batch of active substance should have been used in the manufacture of the stability batches.

The stability trial protocol, packaging, packaging orientation (if relevant), storage conditions and test procedures must be described in detail.

All of the stability-indicating organoleptic, physical, chemical and microbiological quality parameters relevant to the dose form and type of packaging must have been included in the testing schedule and have been monitored using appropriate, clearly defined, validated (in the testing laboratory used for the stability samples), stability-indicating test procedures.

Any changes in test procedures during the stability trials must be justified and results correlated.

At least 12 months data for storage under the recommended storage conditions must be available and be submitted with the application (unless otherwise justified).

The stability data should be updated before submission, to ensure all available stability data is provided.

Wherever relevant, results should be expressed quantitatively rather than as "complies" or "passes test".

If relevant, preservative levels or effectiveness must be monitored.

The results (and allowing for extrapolation within reasonable limits) must adequately support the proposed shelf-life under the recommended storage conditions (otherwise a shorter shelf-life may be granted until adequate stability data can be provided to support the proposed shelf-life).

If relevant, the stability of the product after first opening, reconstitution or dilution (as applicable) must have been investigated and shown to be adequate for the intended use of the product, and that described in the data sheet if applicable.

If relevant, adequate storage instructions and time-limits for use of the product after first opening or reconstitution or dilution must be stated on the draft product label, in any package insert, and in the data sheet.

Bioequivalence or biosimilarity

For generic products requiring bioequivalence data refer to Bioequivalence of medicines of the Guidelines on the Regulation of Therapeutic Products in New Zealand.

For biosimilars, extensive analytical comparability data are required. The reference product used for the comparability studies must be an innovator biological medicine that has consent for distribution in New Zealand. Biosimilar comparability data requirements are described by EMA and FDA guidance documents.

Appendix 4: Summary of data requirements for New Lower-Risk Medicine Applications

The lower risk medicine dossier documents matrix provides a summary of which documents are required for each application category. The matrix is expected to be used after a sponsor has determined the appropriate application category for their application and is intended to provide 'at a glance' an indication of which documents are to be provided.

The document requirements are described as:

M: where the stated document(s) are mandatory and are required to submit a valid application.

D: where the provision of the document(s) is dependent on regulatory requirements for the particular submission.

O: where the provision of the document(s) is optional. That is to say, there is no requirement or expectation from the regulator that the document(s) will be submitted with the application but that the document(s) could be provided where a sponsor considers the provision of the information may assist in the assessment of the application.

NA: where the document(s) are not relevant and should not be submitted with the application.

*: Where an asterisk is included, documents are to be provided to Medsafe if available.

Table 1: Lower risk medicine dossier documents matrix

		L1	L2	L3
Mod. 1.0.1	Letter of Application (cover letter)	M	M	M
Mod. 1.0.2	Responses to screening questions	D	D	D
Mod. 1.0.4	Letters of Authorisation	M	D*	D*
Mod. 1.1	Table of Contents	M	M	M
Mod. 1.2.1	Lower Risk Medicine Form	M	M	M

		L1	L2	L3
	Lower Risk Medicine Declarations and Commitment Form			
Mod. 1.2.3	Patent certification	D	D	D
Mod. 1.3.1	Product Information / Data Sheet	D	D	D
Mod. 1.3.1	Pack Insert	D	D	D
Mod. 1.3.2	Consumer Medicine Information	D	D	D
Mod. 1.3.4	Mock-ups and labelling specimens	M	M	M
Mod. 1.4	Info on Experts & Expert Declarations	NA	D	D
Mod. 1.5	Category L1: Finished product specification	M	NA	NA
Mod. 1.5	Category L1: raw material specifications	D	NA	NA
Mod. 1.5	Lower Risk Medicine Evaluation Analytical Validation Summary	NA	D*	D*
Mod. 1.5.1	Literature-based submissions document	NA	D	D
Mod. 1.6	Drug and Plasma Master Files and Certificates of Suitability	NA	D	D
Mod. 1.7	GMP	D	D	D
Mod. 1.9	Individual Patient Data Declaration	NA	D	D

		L1	L2	L3
Mod. 1.10	Overseas Regulatory Status	O*	D*	D*
Mod. 1.11	Summary of Biopharmaceutic Studies	NA	D	D
Mod. 1.13	Information relating to pharmacovigilance	O	D	D
Mod. 1 Annex II	Overseas Evaluation Reports	NA	O*	O*
Mod. 2.	Quality, non-clinical, and clinical overall summaries	NA	D	D
Mod. 2.2	Introduction	NA	D	D
Mod. 2.3	Quality Overall Summary	NA	D	D
Mod. 2.4	Non-clinical Overview	NA	D	D
Mod. 2.5	Clinical Overview	NA	D	D
Mod. 2.6	Non-clinical Summary	NA	D	D
Module 2.7	Clinical Summary	NA	D	D
Mod. 3	Quality	NA	M	M
Mod. 4	Non-clinical	NA	D	D
Mod. 5	Clinical	NA	D	D
Mod. 5.3.1	Reports of Biopharmaceutic Studies	NA	D	D

Appendix 5: Technical guidelines

The technical data requirements for applications for consent to distribute new and changed medicines in New Zealand are closely aligned with those currently applying in the European Union. The European requirements are published by the European Commission (EC) as the *Rules Governing Medicinal Products in the European Union*. Various other documents have been published as additions and amendments to these Rules by the Committee for Proprietary Medicinal Products (CPMP) Working Parties as 'Notes for Guidance'. Medsafe also recognises the technical guidelines published by the United States Food and Drug Administration. These CPMP and FDA documents are listed on EMA and FDA Internet web sites and may be downloaded from there (see subsections 1.3.2 and 1.3.3 below).

The International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use (ICH) has also developed tripartite guidelines for use by regulatory authorities in the EU, USA and Japan. When these reach the final stage of adoption by the ICH they are normally adopted by the EC, USA and Japan as additions to, or replacements for, their guidelines.

Once ICH, CPMP or FDA guidelines are formally adopted and come into force in the EU or the USA they are recognised by Medsafe.

Medsafe also recognises relevant guidelines published in the British, European and United States Pharmacopoeia and, where relevant, the guidelines published by the World Health Organisation and the Australian Therapeutic Goods Administration (TGA).

While there are different administrative procedures applying in New Zealand and Australia, there is substantial harmonisation of the data requirements for evidence of quality, safety and efficacy of medicines and the grounds on which consent for distribution is granted in the two countries. Consequently, there are considerable similarities between the requirements of Medsafe and the Australian TGA. However, there are Australian-specific requirements for some aspects of the quality control and stability data that are not relevant to New Zealand. New Zealand has a cooler climate than Australia and, consequently, the same stability data may support a longer shelf life for room temperature storage in New Zealand (<25degC) than in Australia (<30degC).

It is recognised that, in some circumstances, a different approach from that described in a guideline may be appropriate. However, where an applicant chooses to submit a data package that does not meet the relevant guideline, that decision should be explained and justified in the dossier submitted in support of the application. The following situations are possible grounds for departing from current guidelines:

- scientific development
- circumstances unique to the product in question
- adoption by the company of an acceptable approach which had not previously been considered by Medsafe

- sufficient alternative studies having been conducted that satisfy the criteria of quality, safety and efficacy.

In assessing the chemical, pharmaceutical and biological data submitted with new medicine applications, Medsafe generally follows the technical guidelines published by the ICH, the European Commission and its Committee for Proprietary Medicinal Products (CPMP), and the United States Food and Drug Administration (FDA), as well as the technical guidance provided by the British, European, and United States Pharmacopoeia (which Medsafe regards as essentially equivalent and equally acceptable standards). Where appropriate, Medsafe also takes into considering the guidelines published by the World Health Organisation (WHO) and the Australian Therapeutic Goods Administration (TGA). Medsafe recognises these overseas guidelines from the dates on which they come into force internationally.

Medsafe expects toxico-pharmacological studies and clinical studies supplied in support of any new medicine application or changed medicine application to have been carried out in accordance with the internationally accepted standards of Good Laboratory Practice and Good Clinical Research Practice.

Where a product or ingredient is controlled according to a pharmacopoeial monograph, the specifications are to be updated to reflect any revisions to the monograph concerned. Where a pharmacopoeial monograph exists, this is considered to be the minimum requirements for the product or substance.

Guidelines and pharmacopoeia are constantly evolving as a result of scientific developments and harmonisation of the requirements of the major overseas regulatory authorities. Medsafe endeavours to keep abreast of such developments and keep its evaluation policies in line with "best international practice".

Where an ICH guideline exists for a particular aspect of a medicine (eg, impurity limits, validation of analytical procedures, stability) and has been adopted by the European, US and Japanese regulatory authorities, conformity to this guideline is the normal requirement for applications submitted to Medsafe. Applicants should ensure that the data in their application dossiers comply with these ICH guidelines. It is recognised, however, that older medicines may have been developed before publication of the ICH guidelines. The data packages for these products may not meet current ICH guidelines, but do meet earlier CPMP or FDA guidelines. In this situation, the available data should be submitted for evaluation. The data will be acceptable if they can be seen to be effectively equivalent, although not identical, to those which would meet the requirements of the ICH guidelines.

Where no ICH guideline exists for a particular aspect of a medicine, data will normally be acceptable if they comply with the requirements of the CPMP and/or FDA guidelines. These guidelines are generally equivalent in intent, if not always in their details.

The ICH, CPMP and FDA guidelines are listed on and available for downloading and printing from these organisations' web sites (see below).

ICH guidelines

The ICH has developed and published numerous guidelines relating to the quality, safety and efficacy of medicines.

ICH guidelines may also be obtained in electronic form (printable pdf format) via the Internet from the following address: http://www.ich.org and select "Publications" and "Guidelines".

CPMP guidelines

The European Commission (EC) has issued various directives relating to medicinal products. The Commission's CPMP and its veterinary equivalent (the CPVP) has applied these directives in developing a set of rules which have been published in series of volumes entitled *Rules Governing Medicinal Products in the European Union*. Volumes 2B, 3A, 3B and 3C contain information and references to guidance documents that are applicable to New Zealand.

- Volume 1 details European Union pharmaceutical legislation and EC directives and, therefore, is generally not relevant to applications submitted in New Zealand.
- Volume 2 is in 3 parts (A, B and C) and details the procedures for marketing authorisation in the European Union (Vol. 2A), the presentation and content of application dossiers, summaries of product characteristics and expert reports (Vol. 2B) and regulatory guidelines (Vol. 2C). Medsafe prefers that application dossiers submitted in New Zealand are in the EU format as described in Volume 2B.
- Volume 3 is also in 3 parts (A, B and C) and contains technical guidelines relating to the various sections of the dossier, namely: Quality and Biotechnology (Vol. 3A), Safety, Environment and Information (Vol. 3B), and Efficacy (Vol. 3C). Numerous other specific guidelines have been drafted or finalised by the CPMP Working Parties and issued as separate 'Notes for Guidance'.
- Volume 4 details the EC requirements for good manufacturing practices (GMP) for medicinal products for human and veterinary use.
- Volumes 5, 6, 7 and 8 detail European pharmaceutical legislation, regulatory procedures and technical guidelines for veterinary medicinal products.
- Volume 9 details European requirements for pharmacovigilance of both human and veterinary medicinal product.

The European Commission's *Rules Governing Medicinal Products in the European Union* may be downloaded in printable electronic form (pdf format) from the Internet site: http://ec.europa.eu/enterprise/pharmaceuticals/eudralex/eudralex_en.htm

Individual 'Notes for Guidance' may be obtained in printable electronic form (pdf format) from the following Internet site: http://www.emea.europa.eu/home.htm

FDA guidelines

The US FDA has published numerous guidelines dealing with all aspects of medicines.

FDA guidelines relevant to New Zealand requirements can be obtained in printable electronic form (pdf format) from the following Internet address:

http://www.fda.gov/cder/guidance/index.htm

FDA guidelines relating to biological and biotechnological products may be obtained from:

http://www.fda.gov/cber/guidelines.htm

Summary of major changes and rationale

Proposed changes	Rationale
Section 2.2 and 2.3 (New Medicine Application risk descriptions): Amendments to the descriptions of the types of applications that can be categorised as higher-risk or intermediate-risk, e.g. providing more detail description for a biological or biotechnological medicine.	To provide greater clarity to sponsors so that application types can be selected correctly.
Section 3.1 (Data protection for medicines containing new active substances): Addition of an explanation for when data protection is not applied to 'innovator' medicines	To provide clarity about what products receive data protection, particularly for products that are generics or biosimilars overseas, but are approved as innovators in New Zealand
Section 4 (Applications based on an approved parent product): • Addition of information on how to submit a line extension that is associated with a change in indications and/or dosing regime • Inclusion of parenteral products that have a different fill volume (same concentration) and/or container closure system as a line extension product. • Addition of an 'Additional name' category to the table describing NMA options for products that are based on a parent product.	To update Medsafe guidance with current Medsafe practices, and to create an abbreviated NMA option for line extensions that are identical to the parent product except for the product name.
Section 5 (Abbreviated Applications): • Amendment of section 5.1 (Abbreviated application overview) to reword and to include line extension applications and CMNs that have been referred under Section 24(5)(a) of the Medicines Act 1981	To extend the abbreviated procedure to include line extensions and CMNs that have been referred under Section 24(5)(a) of the Medicines Act 1981. To amend wording of eligibility criteria and revise the recognised regulatory authorities to align with the requirements proposed for the verification pathway.

• Update section 5.2 (Eligibility criteria) to exclude medicines that are pending deferral of overseas marketing authorisations, or have had their marketing authorisations rejected or withdrawn due to quality, safety, or efficacy reasons • Update section 5.2 'Eligibility criteria' to amend post-approval significant changes that can be included in abbreviated applications, specifically removing changes to indication(s) and/or dosage and administration information • Update section 5.2 (Eligibility criteria) to add criteria for abbreviated applications that are line extensions • Update section 5.3 (Abbreviated application data requirements) to clarify that recognised regulatory authority evaluation reports must not be based on a reliance approval process • Update section 5.3 to include Risk Management Plans • Update section 5.4 to remove the EU mutual recognition procedure as an overseas approval process for the abbreviated procedure.	Amending the significant changes that can be included in abbreviated applications, specifically to remove changes to indication(s) and/or dosage and administration information as the work required for this type of significant change, with or without recognised regulatory authority evaluation reports, is not compatible with abbreviated application timelines. To include Risk Management Plans as required documentation for abbreviated applications, where appropriate.
Section 6 (Provisional consent application): • Addition of section that describes the categories for provisional consent applications and associated data requirements • Update section 6.2 (Renewal of provisional consent) to include documentation requirements • Update section 6.3 (Conversion from provisional consent to full	To update Medsafe guidance with current Medsafe practice and provide clarity about data requirements for applications for: i) provisional consent, ii) renewal of provisional consent, and iii) conversion of provisional consent to full consent.

consent) to include data requirements.	
Section 7.1 (Criteria for priority assessment), part (A) Significant clinical need: addition of information explaining how to make a request for priority consent.	To provide clarity on how to make a request for priority assessment based on significant clinical need.