DEPARTMENT OF HEALTH AND HUMAN SERVICES
FOOD AND DRUG ADMINISTRATION

DISTRICT OFFICE ADDRESS AND PHONE NUMBER	DATE(S) OF INSPECTION
New York District 158-15 Liberty Avenue Jamaica, New York 11433-1034 (718) 340-7000 Industry Information: www.fda.gov/oc/industry	10/5, 6, 7, 9/2015
	FEI NUMBER 3010943533

NAME AND TITLE OF INDIVIDUAL TO WHOM REPORT IS ISSUED

TO: Alfonse J. Muto, Co-Owner

FIRM NAME	STREET ADDRESS
Pine Pharmaceuticals	100 Colvin Woods Pkwy
CITY, STATE AND ZIP CODE	TYPE OF ESTABLISHMENT INSPECTED
Tonawanda, New York 14150	Outsourcing Facility

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DURING AN INSPECTION OF YOUR FIRM I (WE) OBSERVED:

OBSERVATION 1

There is a failure to thoroughly review the failure of a batch or any of its components to meet any of its specifications whether or not the batch has been already distributed.

a). An investigation into out of specification test results for the potency of Vancomycin Injectable was not thorough. Lot 989@2 was released and partially distributed on 6/30/15 at 90.17% (specification of (b) (4) %) as was lot 995@1 at 90.2% as was lot 996@2 at 90.65% with results obtained on 6/26/15. The entire batch for the three lots were stored in a freezer that lost power late on 6/26/15 and was out until 6/29/15. Samples for all three lots were retested for potency with respective results on 7/15/15 at 103.48, 86.01, and 104.1. Another lot, 1075@3 was found to be at 86.5% on 7/17/15 and was not released.

The shelf life is 45 days frozen. One of the firm's conclusions was not to recall lots 989@2, 995@1, and 996@2 despite all three lots just at the lower limit of the potency and not being stored frozen for almost three days. Additionally, retest results stated above were variable with a failing test result and a later lot, 1075@3, failed for potency yet the firm concluded there was no need to recall.

b). There have been several complaints concerning Bevacizumab (Avastin) syringes with crystalline structures seen on the needle. Dates of the complaint for this same defect were on 11/17/14, 7/30/15, 9/11/15 (three complaints that day) and 9/25/15 covering (b) (4) different lots. Each individual complaint was investigated, acknowledged the defect, and stated that "measures are being taken to prevent crystallization from occurring". Though complaints have been received over the past 11 months with most complaints occurring recently from the end of July throughout September, the firm has not fully instituted preventative or corrective actions. There is no written investigation addressing the reoccurrence of this defect; i.e. crystals on the Avastin needles.

SEE REVERSE OF THIS PAGE	EMPLOYEE(S) SIGNATURE	EMPLOYEE(S) NAME AND TITLE (*Print or Type*)	DATE ISSUED
	James A. Liubicich Mindy Chou	James A. Liubicich - Investigator Mindy Chou - Investigator	10/09/2015

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OBSERVATION 2

Aseptic processing areas are deficient regarding systems for maintaining any equipment used to control the aseptic conditions.

During processing of Bevacizumab 1.25mg/0.05mL lot 1740@2 on 10/05/15, we observed in the non-allergenic clean room the following: On the ISO 5 work area (in LAFW #1), there was clutter including a plastic bin containing various discarded articles as wrappers.

OBSERVATION 3

For each batch of drug product, there shall be appropriate laboratory determination of satisfactory conformance to final specifications for the drug product, including the identity and strength of each active ingredient, prior to release.

Released batches of the following products were tested for potency with testing methods that have not been validated: Vancomycin Intraocular Injection, Calcium Gluconate Topical gel, Ceftazidime Intraocular Injection, Mitomycin Ophthalmic Solution, and Moxifloxacin Intracameral Solution.

OBSERVATION 4

The labels and containers of your outsourcing facility's drug products do not include information required by section 503B(a)(10)(A) and (B).

Specifically,

The following information is not found on some of your drug product labels:

• The inactive ingredients, identified by established name and the quantity or proportion of each ingredient.

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Furthermore, the following information is not found on the container labels for some drug products you produce: Information to facilitate adverse event reporting: www.fda.gov/medwatch and 1–800–FDA–1088. Examples of drug product labels that do not contain this information include:

- Calcium Gluconate Ophthalmic Irrigation 1% (500ML) Solution
- Calcium Gluconate (PF) Inhalation 2.5% (5ML) Solution
- Calcium Gluconate Topical 2.5% (60GM) Gel
- Ceftazidime Preservative Free SDV for Intraocular Injection 22.5 MG/ML Injectable
- Mitomycin Solution for Ophthalmic Use0.02% (0.2 MG/ML)
- Moxifloxacin in BSS 150 MCG/0.1 ML Solution
- Vancomycin Preservative Free SDV for Intraocular Injection 10 MG/ML
- Vancomycin (Preservative Free) Prefilled Syringe for Intraocular Injection 0.4 ML, 10 MG/ML
- Vancomycin/Gentamicin Prefilled Syringe Solution for Intraocular Irrigation (TB Style Syringe) 1 MG-4 MG / 0.12 ML

OBSERVATION 5

Your outsourcing facility has not submitted a report to FDA identifying all products compounded during the previous six month period as required by section 503B(b)(2)(A). Examples of products that were compounded but not identified on the report submitted on June 29, 2015 include:

- Sodium Hydroxide 10% Solution
- Calcium Gluconate (PF) 10% Injectable
- (b) (4) Capsules
- Calcium Gluconate Ophthalmic Irrigation
- Calcium Gluconate (PF) Inhalation 2.5%

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