The Compulsory Licence for Nexavar
A Landmark Order

S SRINIVASAN

The compulsory licence issued to Natco for manufacture of the anti-cancer drug Nexavar is a landmark decision on many grounds – the first one in India since the 2005 amendment to the 1970 Patents Act and the first in the world issued to a private party. There are some ambiguities in the order, but the door is now open for issue of CLs for a number of patented drugs that are not being worked.

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S Srinivasan (*sahajbrc@gmail.com*) is associated with LOCOST, Vadodara and All-India Drug Action Network.

The order awarding a compulsory licence (CL)[1] to Natco, a Hyderabad-based pharmaceuticals company, by India's patents controller office is a landmark one. This order comes almost exactly seven years after amendments to the Patents Act 1970 were passed in April 2005 in Parliament.

The Issue and the Order

Before the CL grant was awarded, the tosylate ester of sorafenib was sold under the brand name Nexavar by its innovating company, Bayer, and medically used for extending the life of certain kinds of kidney and liver cancer patients by about four to five years and six to eight months, respectively. If one uses Bayer's branded version Nexavar of sorafenib, it costs the patient Rs 2.80 lakh per month for 120 tablets (or Rs 33.65 lakh per year) whereas the generic version of the same was being offered by Natco for Rs 8,880 for a month's dosage; and has been marketed in India for Rs 30,000 for a month's dosage by Cipla. Independently, Bayer's case against Cipla and also Natco, for alleged infringement of the patent on sorafenib is a matter under dispute before the Delhi High Court, the run-up to which itself was eventful because it led to the clarification by the courts that you cannot link licensing by the drugs controller for manufacture and marketing of a medicine to its patent status. Bayer tried all kinds of legitimate, if a bit creative, tactics in the matter so that the CL application was derailed in its early stages, well before the patents controller would give a final order. But that was not to be. In the event the Delhi High Court declares, in the *Cipla vs Bayer case*, that Bayer's sorafenib is not patentable, the Natco CL Order will be a bit superfluous but nevertheless a landmark event and a portent of things to come.

A First Time

Issuing a CL is a means of promoting generic competition and deterring squatting on (intellectual) property by the patent holder without benefit to society at large. India's Patents Act provides for it under Section 84 (if initiated by a private party), 92 (notification by government that a CL needs to be issued for public non-commercial use, national emergency or extreme urgency), 92A (CL for generic exports) and 100 (for government use).

Till 12 March 2012 nothing much had been done in the post-2005 era of product patents, in terms of using these provisions; but this order is a precedent and more CLs are likely to follow. Most other countries which had issued CLs on medicines – like Thailand, Malaysia, Indonesia, Cameroon, Eritrea, Zambia, Brazil, et al – had issued them only for government use. The Natco CL is the first time a patent has been issued to a private party, and for an anti-cancer drug at that. India is one of the few countries where issuing CLs for local manufacture is meaningful, because Indian industry has the capacity to back it up by actually manufacturing the medicines so licensed.

The Logic in the Order

The 12 March 2012 order of the patents controller relies primarily on the interpretation of Section 84 (1) (a, b and c) of the Patents Act in the light of facts presented in the case by both parties:

> (1) At any time after the expiration of three years from the date of the [grant] of a patent, any person interested may make an application to the Controller for grant of compulsory licence on patent on any of the following grounds, namely: (a) that the reasonable requirements of the public with respect to the patented invention have not been satisfied, or (b) that the patented invention is not available to the public at a reasonably affordable price, or (c) that the patented invention is not worked in the territory of India.

The availability of Nexavar was shown to be sufficient for only 2% of

those getting these specific cancers and therefore reasonable requirements of the public were not satisfied. The high price ruled out affordability.[2] And Nexavar was shown not to be "worked" in India. Therefore Natco was eligible for the CL, especially after Natco's earlier request for a voluntary licence was rejected by Bayer.

Bayer's attempts to add to their arguments, aspects of Cipla's generic version of sorafenib, both in terms of its lower cost (Rs 30,000 per month to show affordability) and that the quantities produced by Cipla were many times more than Bayer (quoted by the company to show sufficiency) were firmly rejected as "two-faced" by the patents controller, as its suit against Cipla for patent infringement on sorafenib was still pending in the Delhi High Court, and was being actively pursued by Bayer. However, Bayer would be entirely at liberty to appeal against the order all the way up to the Supreme Court and it is quite possible that one of these higher juridical platforms of India may give Bayer an interim stay on the order and also reverse the grant of the CL. But for the moment, one may celebrate the order as a people's victory or cavil about the weak protection to intellectual property in India and how drug companies in India are "free loading" on innovations in the west.

At least two of the many issues raised by the order will be discussed for some time: the interpretation of the terms "affordability" and "working of the patent within India" – both terms not defined by the Act.

Affordability

"Affordability" is a term that is defined neither in the Patents Act nor in standard economics textbooks. It is usual to compare cost of consumption of the drug regimen to income levels of the patient – which is a bit inadequate because rarely do patients with complex diseases get prescribed a single medicine, nor are such medicines the only reasons for expenses for the patient. In the current case it is easily deduced that the cost Rs 2.8 lakh per month for the drug is an unaffordable figure for most people in a country with low per capita income figures. Indeed, the lower monthly costs of Rs 30,000 of Cipla and Rs 8,880 of Natco will also be considered unaffordable.[3] This of course calls for (a) some mechanism over time to determine the real cost of replicating a so-called innovator medicine under CL; and (b) what indeed is the cost of an innovator medicine? It is also clear that most innovator medicines under patent will be priced high especially if the innovators and/or CL applicants are private parties. Therefore it does not make sense to give CLs to a single applicant, at least for extended periods. Other eligible parties, with ability to "work the CL", must be granted CLs with relative ease, say within the period of a year.[4] In that way some competition among local CL licensees will be generated. It may even make Bayer think twice before issuing relatively lenient voluntary licences, even if only for export, so as to ambush Natco, which of course is a right confirmed by the order (read para 15m) that Bayer can give licences to other licensees to compete with Natco if need be. Ideally, it should also not be held against future eligible applicants for CL (for say sorafenib) for not having sought a voluntary licence or having refused one from Bayer. One also hopes that no injunctions will be given that stays the CL while Bayer goes on appeal against this order, which it is most likely to.

Section 90 (vii) of the Patents Act under "Terms and conditions of compulsory licences" says that

> ...In settling the terms and conditions of a licence under section 84, the Controller shall endeavour to secure ....that the licence is granted with a predominant purpose of supply in the Indian market and that the licensee may also export the patented product, if need be in accordance with the provisions of sub-clause (iii) of clause (a) of sub-section (7) of section 84.

The latter sub-clause is one of the markers for reasonable requirements of the public not being satisfied and reads: "a market for export of the patented article manufactured in India is not being supplied or developed". It is not clear therefore why Section 90 (vii) was not invoked nor suo motu spelled out in the order (para 15g), even if Natco voluntarily agreed to be satisfied with a CL only for the domestic market. Surely one of the reasons why such CLs are desirable is that India-made medicines find their way to needy persons abroad also as they are (and in this case is) less priced than the patentee's version. Sure there is a separate CL for export provision (Section 92A) but why cannot when every time a CL is granted in India under Section 84, it becomes a cause for hope in other underserved countries too by invoking Section 90 (vii)? Why go through more legal legwork and time as well as further burden the already overburdened patents controller's office when a CL licensee wants to export?

It is not clear why the patents controller had to specify (see order, para 15k) that Natco's product had to be visibly different from Bayer's in shape, colour, trade name and packaging, a condition sought by Bayer to be imposed on Natco. Or why the licensor (Bayer) "shall provide no legal, regulatory, medical, technical, manufacturing, sales, marketing or any other support to the Licensee (Natco)". This condition is neither specified nor suggested anywhere in Section 90 of the Patents Act.

More importantly, the order (on how the product should look) is the preserve of the office of the drugs controller. If the latter cannot link patent status of a medicine to licensing for manufacture and marketing, para 15k would imply linking of a kind from the other side as it were, from the patents controller's office, even intruding into the drugs controller's sphere; and surely this might also imply a repeat of clinical trials of the product to generate safety data if the drugs controller were to take it literally. (However the latter may not happen in this case as Natco, according to para 4 of the order, has received a licence for manufacture and marketing of both the active pharmaceutical ingredient (API) and the formulation of sorafenib in April 2011.)

A related condition imposed by the order, in para 15 (c), is the one that says this CL is for "working the licence at only his own manufacturing facility" and shall not outsource, etc. This again is unnecessary – and again maybe an intrusion into the drugs controller's domain. How does it matter as long as the licensee, that is Natco, makes sorafenib any which

way in India as per terms specified by the drugs controller and the product is sold at not more than Rs 8,800?

A related issue is whether medicines manufactured under CL should be under price regulation. To us it is clear that it has ought to be, for the CL was granted with non-affordability of the original innovator's medicine as one of the criteria. If Cipla loses the infringement case in the Delhi High Court and decides not to appeal, it ought to be eligible for a CL and most likely would get one. Would the ceiling price of Rs 8,800 in the current order apply automatically to Cipla? Yes, we think it should, in the spirit of the CL being granted to Natco because of overpricing of the innovator medicine and resulting lack of accessibility and affordability. So Cipla would have to reduce its price from Rs 30,000 to Rs 8,880; and in case the Delhi High Court declares that Bayer is ineligible for its patent on sorafenib, the ceiling price would automatically apply to Bayer too. Or rather ought to. But that would take a special effort by the National Pharmaceutical Pricing Authority under the Department of Pharmaceuticals.

One may as well point out to another gratuitous provision in the order – namely para 15h – specifying that Natco provide free of cost medicine to 600 needy patients. At the risk of looking at a gift horse in the mouth, these kinds of administrative detailing and micromanagement sanctioning largesse (yes we understand it was first offered by Natco) are a waste of precious time and resources of the office of the patents controller apart from being a possible distorting factor in future rulings affecting such cases, apart from the patents controller contradicting himself (para 13 of the order) where he says he is not concerned with philanthropy (of Bayer), "no doubt appreciable".

The patents controller may have well spent some of his admirable intellectual resources wondering about the generous commissions being given to the trade (see page 56 of the order) and the fact that on paper Natco seems to be making less margins than those involved in distribution and retail; or even have spent his time worrying how the provisions of the CL can be stretched to generate more competition and better access to all patients.

Working of the Patent

The order discusses at length the meaning of the term "working of the patent", something not defined in the Patents Act, and has settled, for the time being at least, that importing a medicine patented in India cannot be considered the same as working the patent in India. The medicine has to be manufactured in India "to some reasonable extent." And "working the patent" does not mean only working on a commercial scale. Unfortunately for Bayer its arguments were not accepted that the scale of local production was not commercially viable. It is a moot point whether it would have been viable for Bayer if it had reduced its price and therefore increased its sales or to support its arguments, if Bayer had come clean on research and development costs to show how exactly it was unviable.

Looking at the arguments of the patents controller leading up to the order, it is not clear what is meant by the phrase that the medicine has to be manufactured in India "to some reasonable extent". Does this mean sales as a percentage of the potential demand? If so what percentage will be reasonable? And manufacture means manufacture of the formulations only, or formulations and the related API? Can the related API be imported and only its formulations made in India? If API is to be manufactured here in India and sold/used only locally, it may not be viable for an Indian company that is the recipient of the CL and hence such CL grants need to have an inbuilt provision for export of the formulation as well as the API. Again, even if the API were to be manufactured in India, what constitutes manufacture? Would a mere conversion from an intermediate that is one step before the final API, akin to import of semi-knocked down kits of cars that are then assembled in India, constitute manufacture? These questions are not theoretical as the API of sorafenib and its intermediates are manufactured by several Chinese companies who are willing to export. There appears to be even a manufacturer of sorafenib API in India.

While these questions need to be clarified in due course, it is generally accepted that opening up the market for manufacture by many local players in India – which this order does not grant because it gives a licence only to the applicant[5] – does eventually increase the manufacturing capability of the country; and India with its record of API manufacture, considerable backward integration can be expected to take place. It is therefore hoped that other CL applicants for sorafenib (and other such products in the future) will be granted CLs with relative ease, now that a case law is in place.

Over the last 20 years, multinational corporations (MNCs) in India have become mere traders and have closed most of their API and formulation manufacturing facilities in India. Some of India's top-selling MNC-owned medicine brands are made under contract manufacture. The interpretation of working the patent in the order is therefore likely to be seen as a well-deserved comeuppance.

A related move that is overdue from the patents controller's office is to see how many other patentees holding patents on overpriced vital medicines are not complying with the requirement for not working the patent locally (Form 27 of the Act even requires periodic reporting) and take suo motu cognisance by asking them why their patents should not be revoked and/or appropriate CLs awarded. At least the following medicine patents, among many, are likely to be under the scanner if such an action were to be taken: dasatinib, nilotinib, erlotinib, sunitinib, pegylated interferon, entecavir, and possibly other medicines like raltegravir, etravirine, rilpivirine, maraviroc – all useful in new types of resistant strains of HIV, hepatitis B and/or C, and various types of cancers.[6]

Ideally, of course if the Government of India could file for government use patents under Section 100 which applies to situations where "the government needs to manufacture, procure, distribute and sell the patented medicine on a non-commercial basis". But for that the Government of India will require supreme political will, apart from having to put in place a free or subsidised programme to supply such medicines.

NOTES

1 Available at http://www.ipindia.nic.in/ipoNew/compulsory_License_12032012.pdf, last accessed on 18 March 2012. The order hereafter.

2 As an aside, in November 2009, the UK's National Institute of Clinical Excellence (NICE) refused to approve sorafenib for use within the National Health Service in England because it felt increasing survival in liver cancer by six months did not justify its high price – around £2,500-3,000 per patient per month. For the gut-wrenching questions this move produces, see http://news.bbc.co.uk/2/hi/health/8367614.stm.

3 For issues in measurement of affordability, catastrophic spending and impoverishment, see Niëns, L M, et al, "Practical Measurement of Affordability: An Application to Medicines", *Bull World Health Organ*, 2012; 90: 219-27. See also the affidavit filed by KEI in the current case at http://keionline.org/sites/default/files/aff-jameslove_13Feb2012_as_Filed.pdf. See also "Access to Medicines, Vaccines and Technology", Chapter 3 of the *High Level Expert Group Report on Universal Health Coverage for India,* Planning Commission, New Delhi, November 2011. And see also for unaffordability of a range of medicines in India, Chapter 5 of *Impoverishing the Poor: Pharmaceuticals and Drug Pricing in India,* LOCOST/JSS, Vadodara/Bilaspur, December 2004. Also available online at: http://www.scribd.com/my_document_collections/2879052

4 The order (in 15d) says that the licence is non-exclusive, meaning CLs may be given to other applicants in the future.

5 There is also no provision in the Patents Act to throw open the CL to all other competent manufacturers in India with a single order like the current one.

6 Some of the medicines mentioned are courtesy the reporting on an RTI sought by Shamnad Basheer et al, reported at http://spicyipindia.blogspot.in/2011/04/non-working-of-patent-working-norms.html). See also Table 7 in Sudip Chaudhuri, "Multinationals and Monopolies: Pharmaceutical Industry in India after TRIPS", *Economic & Political Weekly*, 24 March 2012, Vol XLVII.