United States Food and Drug Administration

Targeted Mechanism of Action Presentations in Prescription Drug Promotion

OMB Control No. 0910-NEW

SUPPORTING STATEMENT

Part A. Justification

1. Circumstances Making the Collection of Information Necessary

Section 1701(a)(4) of the Public Health Service Act (42 U.S.C. 300u(a)(4)) authorizes the FDA to conduct research relating to health information. Section 1003(d)(2)(C) of the Federal Food, Drug, and Cosmetic Act (FD&C Act) (21 U.S.C. 393(d)(2)(C)) authorizes FDA to conduct research relating to drugs and other FDA-regulated products in carrying out the provisions of the FD&C Act.

The Office of Prescription Drug Promotion's (OPDP's) mission is to protect the public health by helping to ensure that prescription drug promotion is truthful, balanced, and accurately communicated. OPDP's research program provides scientific evidence to help ensure that our policies related to prescription drug promotion will have the greatest benefit to public health. Toward that end, we have consistently conducted research to evaluate the aspects of prescription drug promotion that are most central to our mission. Our research focuses in particular on three main topic areas: advertising features, including content and format; target populations; and research quality. Through the evaluation of advertising features, we assess how elements such as graphics, format, and disease and product characteristics impact the communication and understanding of prescription drug risks and benefits. Focusing on target populations allows us to evaluate how understanding of prescription drug risks and benefits may vary as a function of audience, and our focus on research quality aims at maximizing the quality of research data through analytical methodology development and investigation of sampling and response issues. This study will inform the first two topic areas, advertising features and target populations.

Because we recognize the strength of data and the confidence in the robust nature of the findings are improved through the results of multiple converging studies, we continue to develop evidence to inform our thinking. We evaluate the results from our studies within the broader context of research and findings from other sources, and this larger body of knowledge collectively informs our policies as well as our research program. Our research is documented on our home page, which can be found at: https://www.fda.gov/about-fda/center-drug-evaluation-and-research-cder/office-prescription-drug-promotion-opdp-research. The website includes links to the latest Federal Register notices and peer-reviewed publications produced by our office.

In 2014, OPDP conducted focus groups designed to provide insights on how consumers and healthcare providers (HCPs), including physicians, nurse practitioners, and physician

assistants, interpret the term "targeted" in prescription drug promotional materials. Although diverse views were voiced, there appeared to be some tendency toward the impression that products with promotional materials using this term would be safer and more effective than other similar treatments. OPDP is also now conducting a nationally representative survey regarding the ways in which consumers and primary care physicians (PCPs) interpret terms and phrases commonly used in prescription drug promotional materials, including assessment of impressions of the terms "targeted" and "targeted mechanism of action" (targeted MoA) (86 FR 24867). Building upon this line of research, the proposed study will investigate the influence of targeted MoA claims, graphics, and disclosures that provide context about a drug's targeted MoA, utilizing an experimental design with both consumer and HCP samples. The experimental approach described here is intended to complement and augment the prior research by facilitating assessment of causality. Specifically, the proposed study will explore how varied targeted MoA presentations affect consumer and HCP understanding of the MoA of a drug, perception of drug benefits and risks, attention to risk information, and interest in the drug.

2. Purpose and Use of the Information Collection

This research represents the final element of our three-prong strategy to understand the impact of targeted MoA claims in promotional materials on the risk and benefit perceptions and behavioral intentions of consumers and HCPs. This will allow us to provide operational advice to OPDP reviewers on how best to comment on promotional presentations that include targeted MoA claims. The objective is operational. We do not have a guidance planned on this topic at this time but once all data has been analyzed from each part of the strategic assessment of targeted MoA claims, those data may inform future guidance.

3. Use of Improved Information Technology and Burden Reduction

Burden will be reduced by recording data on a one-time basis for each respondent, and by keeping study procedures to 20 minutes. Both the consumer and HCP samples will self-administer the survey instrument via a computer. In addition to its use in data collection, automated technology will be used in data reduction and analysis.

4. Efforts to Identify Duplication and Use of Similar Information

We conducted a literature search to identify duplication and use of similar information. We conducted a review of the scientific literature by locating relevant articles through keyword searches using popular databases such as PubMed and PsycInfo. We also identified relevant articles from the reference list of articles found through keyword searches. Based on this literature review, we found only two published articles that assessed the impact of exposure to MoA presentations in prescription drug promotion which highlights the importance of this study and the need for experimental research that examines the effect of targeted MoA presentations in prescription drug promotion among both consumers and HCPs.

5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this data collection.

6. Consequences of Collecting the Information Less Frequently

The proposed data collection is one-time only. There are no plans for successive data collections.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

There are no special circumstances for this collection of information.

8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

In the Federal Register of October 28, 2021 (86 FR 59736), FDA published a 60-day notice requesting public comment on the proposed collection of information. FDA received five comments that were Paperwork Reduction Act (PRA) related. Within the submissions, FDA received multiple comments that the Agency has addressed in this notice. For brevity, some public comments are paraphrased and, therefore, may not state the exact language used by the commenter. All comments were considered even if they were not fully captured by our paraphrasing in this document. One submission (ID number FDA-2021-N-1050-0002) was read and considered but was outside the scope of the research and is not addressed further. Comments and responses are numbered here for organizational purposes only.

(Comment 1) One comment stated that FDA has already investigated how HCPs and consumers interpret the terms "targeted" and "targeted mechanism of action."

(Response 1) Prior qualitative research[1] looked at how consumers and HCPs interpret the term "targeted" in prescription drug promotional materials. This initial qualitative research suggested that products using the term "targeted" may appear safer or more effective than other similar treatments but did not fully explore the implications of those interpretations. Robust empirical evidence is needed to understand how complex concepts, such as "targeted" and "targeted MoA," are interpreted or whether they lead to inaccurate inferences about a drug's efficacy and side effects when presented to consumers and HCPs in prescription drug promotion. The present research seeks to extend previous studies by investigating the effects of including a graphic and also by exploring whether the inclusion of a disclosure statement can help to clarify the information. It is possible that the presence of targeted MoA graphics affects the impressions of the product, which we are assessing in this study. It is also possible that any inflated perceptions consumers or HCPs may have based on the MoA claim or graphics can be adjusted by adding a disclosure. These are the questions this research is

[1] See Focus Groups to Investigate Specific Terminology in Prescription Drug Promotion (completed in 2014), available at https://www.fda.gov/aboutfda/centersoffices/officeofmedicalproductsandtobacco/cder/ucm090276.htm

aiming to address through an experimental design. We conducted a literature review, which found that only two published articles (O'Donoghue et al., 2014; Sullivan et al., 2018) have focused on assessing the impact of exposure to MoA presentations in prescription drug promotion. We also conducted a marketplace evaluation, which found that these types of presentations are widespread in the prescription drug promotion marketplace. Together, this preliminary work highlights the importance of this study and the need for experimental research that examines the effect of targeted MoA presentations in prescription drug promotion on both consumers and HCPs.

(Comment 2) Two comments proposed recruiting cancer patients rather than general population consumers because, according to one comment, cancer patients are more likely to be exposed to promotional materials regarding cancer products and may be more familiar with cancer-related terms than the general population. The comments also suggested that being diagnosed with a life-threatening illness may influence perception of risk/benefit and interest in a drug. One comment encouraged the Agency to look for ways to mitigate such bias, and the other specifically proposed that the Agency focus the research on a target consumer respondent sample of those who have had a cancer diagnosis and allow the screening criteria to straddle across multiple cancer diagnoses.

(Response 2) We chose a general population sample because of concerns about being able to recruit a sufficient number of participants if we selected a cancer-specific sample. However, we agree that in a future study, a small, carefully designed replication study with cancer patients could be valuable. We will also ask participants if they have been diagnosed with cancer and control for any impact that a diagnosis of prior cancer may have.

(Comment 3) One comment objected that access to the specific study stimuli and questionnaire was not provided.

(Response 3) We have described the purpose of the study, the design, and the population of interest and have provided the questionnaire to numerous individuals upon request. We provided the disclosure language in the questionnaire. Our full stimuli are under development during the PRA process. We do not make draft stimuli public during this time because of concerns that this may contaminate our participant pool and compromise our research.

(Comment 4) Two comments suggested that the research assumes that all targeted MoA claims that do not include a discussion of off-target effects are misleading and also that it is misleading to suggest that targeted therapies are safer or more effective. The comments noted that this assumption would be overly broad and simplified and may result in biased results.

(Response 4) This research does not assume that any specific presentation is or is not misleading. Rather, this research aims to understand whether variations in MoA presentations of a targeted drug (e.g., presenting an inaccurate graphic depicting a drug's MoA without a disclosure relative to an accurate graphic depicting the MoA) may affect consumer and HCP perceptions of the drug. In this way, the research will provide more

information to help determine whether these audiences are misled by the tested presentations.

(Comment 5) Two comments focused on the proposed graphics. One expressed concern about the ability of a graphic to depict a targeted MoA accurately (particularly as it refers to the impact on off-target healthy cells) and to convey a truthful and non-misleading representation. The other comment proposed changes to the inaccurate graphic in terms of how it depicted healthy and cancer cells.

(Response 5) We tested candidate graphics in cognitive interviews to confirm that the audience interpreted the graphics as intended. The graphics were also reviewed by medical professionals, and we consulted with a doctoral-trained researcher who publishes extensively on the effects of graphic presentations in health communication and advertising.

(Comment 6) One comment noted that it is unclear what proportion of the sample will be oncologists versus PCPs with oncology experience. The comment also stated that while PCPs may have a role in the cancer patient's journey and may provide input along the way to diagnosis, as well as during the management phase of treatment, they are not routine decision makers for new treatments or treatment changes.

(Response 6) HCPs of all types are exposed to prescription drug promotion. Depending on location (e.g., rural areas) and type of clinical setting, some non-oncologists may consider oncologic prescription drugs to treat their patients. We agree that oncologists are the most relevant population to study in this research. However, we also want to know whether specific education and experience influence the processing of claims, graphics, and disclosures. We intend to use PCPs as a control group to understand whether specific advanced training influences the understanding of MoA claims, graphics, and associated disclosures. Further, including PCPs with oncology experience alongside oncologists has yielded useful data in prior studies (Boudewyns et al., 2021). The sample will be equally distributed across oncologists, PCPs with oncology experience, and nurse practitioners and physician assistants with oncology experience.

(Comment 7) One comment stated that the study should only recruit nurse practitioners and physician assistants who specialize in oncology.

(Response 7) We agree. Only nurse practitioners and physician assistants who specialize in oncology are eligible for the study.

(Comment 8) One comment noted that the instructions at the top of the questionnaire ask participants to "make your best guess" based on the web page they just viewed. The comment stated that respondents should not be asked to guess as their response and argued that these instructions undermine the importance of the participants' answers.

(Response 8) The instructions are displayed before perceived efficacy and risk questions where consumer participants are told, "Most people don't know how a prescription drug will affect them until they've taken the drug. But we'd like you to make your best guess based on the web page you just saw. Please answer the following questions based on what

you saw on the web page." HCPs are told, "Please answer the following questions based on what you saw on the web page rather than prior knowledge of this class of medications."

These instructions have been cognitively tested in prior studies as well as in the present study, and we found no evidence that these instructions undermined the perceived importance of participants' answers. Instead, the instructions helped to indicate that we wanted participants to form an opinion and that they did not need to base their opinion on prior knowledge to do so.

(Comment 9) One comment suggested that the recall questions (questions 6 through 11) and especially the "foil" responses could bias the responses to the questions that follow them and recommended locating the recall questions after other questions.

(Response 9) We always approach question ordering carefully, attempting to balance a number of considerations, including the reduction of bias from one question to another, the flow, and the importance of each item. In this case, we are prioritizing measures of specific claim comprehension over other more general questions in our questionnaire, which is why questions 6 through 11 are placed earlier in the questionnaire. Answering recall and comprehension questions first will allow consumers and HCPs to provide a more accurate response and will allow us to better understand whether the information was comprehended. We did not encounter any issues with recall questions influencing responses to questions found later in the survey during cognitive interviews.

(Comment 10) One comment recommended using a consistent scale throughout the survey. Another suggested changing questions 12, 13, 14, 16, 17, 18, 19, 20, 22, and 23 to 7-point scales to add a midpoint.

(Response 10) We use true/false/don't know or yes/no/don't know response options for the comprehension questions and Likert-type scales for perceptions and opinion questions. Using one scale throughout the survey would not necessarily provide better data. For nearly all Likert-type questions, we use 6-point scales with the endpoints labeled. Some of these questions with Likert-type scales are validated questions; for these, we have maintained the response options from the validated measures. Other questions were altered from validated measures, and similarly we preferred to maintain the Likert-type scales that the original measure had. We will change question 5 from a 7-point to a 6-point scale to increase consistency. We will retain the 5-point scales with all response options labeled for the two validated scales for beliefs about medications and trust in prescription drug materials.

Regarding the inclusion of a midpoint, this is a matter of debate in the literature and has never been resolved. Based on input from cognitive interviews and in response to public comments, we will be adding a neutral point to the comparative efficacy and risk questions (i.e., questions 17 through 23), which will change these questions to be 7-point response options with endpoints and midpoint labeled.

(Comment 11) Two comments stated that the 6-point scales do not allow the respondent to pick neither agree/disagree/unknown. One comment noted that this is a concern for most 6-point scale questions but particularly for questions 17 through 23, which compare the study drug to other medications. The comments recommended either an anchored neutral middle point on the scale or a box for uncertain/do not know responses.

(Response 11) There are benefits and drawbacks to including a neutral or "no reaction" response in survey research, and the decision to use a neutral midpoint depends on the goal of the measures (Moors, 2008; Shapiro & Krishnan, 2001). For questions assessing comprehension of the MoA claim, we included a "do not know" option as this response would indicate some level of uncertainty about the MoA, and that uncertainty itself would be meaningful and actionable information. However, when assessing perceptions and attitudes about the claim, graphic, or disclosure, our objective is to force a selection. Inclusion of a neutral response option in these instances could potentially encourage satisficing--cuing participants to select a neutral response when there is uncertainty (Krosnick, 2018). For the comparative risk and efficacy questions (questions 17 through 23), we will include a midpoint based on results from cognitive interviews; however, these interviews did not point to the need to include a midpoint for the other questions.

(Comment 12) Questions 17 through 23 ask about the efficacy and risks of the study drug compared to other prescription drugs for the same indication. One comment contended that, without prior knowledge of the efficacy and risks of the prescription drugs on the market, it would be difficult for respondents to make a fully informed conclusion. Another comment asserted that the comparative risk and efficacy questions should be revised to establish a clear comparator, such as chemotherapy. Finally, a comment recommended removing these questions as consumers should not be assessing a drug's safety or efficacy compared to other drugs.

(Response 12) There are instances in the clinical setting when consumers will discuss the safety and risk information of a drug compared to others (e.g., if a patient switches from one drug to another, if a family member asks the consumer to talk to their doctor about another drug). We acknowledge that in a clinical setting, patients and HCPs may use additional information to make decisions about how a drug compares to another. However, the intent of questions 17 through 23 is to understand whether exposure to different presentations of the MoA claim, graphics, and disclosure results in different comprehension or perceptions, such as perception of comparative risks and efficacy. Except for the varied presentations, all participants will have the same level of information regarding the MoA of the drug. So we would expect that all participants would be equally informed of the drug, and differences among study conditions could be attributed to the experimental manipulations. Additionally, any subjective experiences outside the experiment setting should be evenly distributed across study conditions as a function of random assignment; therefore, they should not have any impact on the outcomes of the study. Still, cognitive interviews indicated that HCPs and consumers preferred that a midpoint be added to the response scale for these questions, which we added in the revised questionnaire. Based on cognitive interviews, we also revised the questions to include the phrase "compared to other similar prescription drugs that are for/treat bladder cancer."

We will also review these questions and make any necessary adjustments based on pre-testing results.

(Comment 13) One comment stated that the questionnaire does not take into account the HCP respondents' baseline understanding or expectations of targeted treatments.

(Response 13) We expect that any knowledge or expectations of targeted treatments that consumers and HCPs already have outside of the experiment setting should be evenly distributed across study conditions as a function of random assignment; therefore, observed differences between conditions are unlikely to be caused by these individual differences. However, we added an item that assesses HCPs' knowledge of targeted therapies for cancer treatments.

(Comment 14) One comment encouraged FDA to disseminate all final results of completed research related to this topic.

(Response 14) FDA's research is documented on our homepage, which can be found at https://www.fda.gov/about-fda/center-drug-evaluation-and-research-cder/office-prescription-drug-promotion-opdp-research. The website includes links to the latest Federal Register notices and peer-reviewed publications produced by our office. The Agency also anticipates disseminating the results of this study after the final analyses of the data are completed. The exact timing and nature of any such dissemination has not been determined, but dissemination of research results often occurs through presentations at trade and academic conferences, publications, articles, and postings on FDA's website.

(Comment 15) One comment recommended that certain populations, such as those who work in pharmaceutical marketing or for the U.S. Department of Health and Human Services (DHHS), be excluded from the study.

(Response 15) We agree. Participants will be excluded from participation if they work for a pharmaceutical, advertising, or market research company or are employed by DHHS.

(Comment 16) One comment recommended that participants who are unable to recall key elements of the stimuli, such as indication, risk elements, presence of claim, and presence of disclaimers, be excluded from the study because they are not able to appropriately assess the MoA presentations.

(Response 16) The fact that a consumer or HCP is not able to recall certain information does not mean they did not see that information or subconsciously process it (Ref. 6). Therefore, we do not plan to exclude anyone based on their self-reported recall of elements in the stimuli.

(Comment 17) One comment suggested that participants should be asked questions 30 through 34 as part of a pre-test and be stratified based on their responses.

(Response 17) Typically, stratified randomization is used if there are prognostic variables that correlate with outcome measures and researchers are concerned about such factors not being evenly distributed across groups (Friedman et al., 1998). We have no reason to

expect that the aforementioned factors would have a strong association with the outcome measures, nor do we have reason to believe that we will not achieve adequate balance of prognostic variables given the large sample size proposed for this study (Friedman et al., 1998). Random assignment will help to produce groups that are, on average, probabilistically similar to each other. Because randomization eliminates most other sources of systematic variation, we can be reasonably confident that any effect that is found is the result of the intervention and not some preexisting differences between the groups (Fisher, 1935). However, we have included questions 30 through 34 to assess the association of factors such as health literacy, prior cancer diagnosis, or familiarity with cancer treatment options with our outcomes and statistically control for those variables if necessary.

(Comment 18) One comment suggested that in order to ensure that differences in risk assessment across stimuli are due to the manipulation of MoA information, the prominence of the risk presentation should be standardized across the 12 versions of the stimuli and displayed in accordance with FDA's guidance document entitled "Presenting Risk Information in Prescription Drug and Medical Device Promotion."[2] The comment also encouraged the use of qualifiers to delineate which side effects are considered serious.

(Response 18) In creating the stimuli, we created one web page that was the basis for all the stimuli. The risk presentation was standardized across the experimental conditions, and we kept FDA's guidance in mind when displaying stimuli. Regarding the suggested use of qualifiers to delineate which side effects are considered "serious," we again note that we kept FDA's guidance in mind with respect to the risk presentation.

(Comment 19) One comment noted that the disclosure for patients should be reworded as follows to prevent implied bias: "[Drug X] delivers medicine directly to cancer cells and can also harm healthy cells."

(Response 19) We revised the statement to read "[Drug X] could also affect healthy cells." With this change, the consumer disclosure is consistent with the content of the disclosure shown to HCPs.

(Comment 20) One comment asserted that most promotional materials in the real world qualify MoA statements with language mirroring the labeling (e.g., "Pre-clinical studies demonstrate . . .") and recommended that the research materials be updated to include similar qualifying language.

(Response 20) The addition of such language may create an imbalance of information across the various experimental conditions and could confound interpretation of the results. As such, we did not include the qualifying language mentioned above.

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[2] The draft guidance for industry Presenting Risk Information in Prescription Drug and Medical Device Promotion (May 2009) is available on the FDA guidance web page at https://www.fda.gov/regulatory-information/search-fda-guidance-documents.

(Comment 21) One comment suggested that study participants should be allowed to refer back to the product website as often as needed rather than only being permitted to view it once.

(Response 21) As a practice, we often purposely do not permit study participants to refer back to the product website as often as needed for these types of studies. Rather, for this study, we will instruct participants to read the website carefully and alert them that they will be answering several questions about the content that they just saw and that they cannot return to the website. The goal of this study is not to assess participants' comprehension of verbatim information in the stimuli, for which repeated exposures to stimuli may be more appropriate in another study. Rather, the present study is interested in gist understanding of the information. Allowing for multiple exposures to the stimuli could potentially influence study outcomes and confound interpretation of the study results. A large literature supports presence of a "mere exposure effect" in social science research, where more exposure enhances processing and increases positive affect towards stimuli (Bornstein, 1989; Bornstein & D'Agostino, 1994).

(Comment 22) One comment recommended removing question 16 (i.e., risk-benefit tradeoff) for consumers because consumers may not have the experience or background to assess a drug's benefit-risk profile. The comment also suggested that this question ignores the role of prescribers in informing patients of the relevant risks and benefits of prescription medications.

(Response 22) We disagree that consumers do not form their own perceptions about risk-benefit tradeoffs after seeing direct-to-consumer (DTC) promotional materials and before any discussion with an HCP. Consumers often wish to participate in shared decision making with HCPs when selecting prescription drugs and may request specific prescription drugs from their HCPs based on promotions they have seen in the marketplace. Because the information consumers receive through DTC prescription drug promotion can impact these requests, it is important to investigate how the information in prescription drug promotional pieces impacts consumer attention, understanding, and perceptions. In addition, the purpose of these questions is to assess perceived benefit and risk based on the promotional material shown. The question includes instructions indicating that judgments should be reached based on the information on the prescription drug website. As such, we plan to ask participants about their perceptions of the risk-benefit tradeoff using question 16, which is a common and validated item in DTC research.

External Reviewers

In addition to the comments above, the following experts reviewed the study design, methodology, and questionnaires:

1. Andy King, Ph.D., Assistant Professor, Greenlee School Journalism/ Communication, Iowa State University

2. Jennifer Ball, Ph.D., Assistant Professor, Department of Advertising & Public Relations, Klein College of Media and Communication, Temple University

3. Mariam Alkazemi, Ph.D., Assistant Professor, Richard T. Robertson School of Media and Culture, Virginia Commonwealth University

9. Explanation of Any Payment or Gift to Respondents

General population consumers will receive points equivalent to approximately $1.50 once they complete the study. The incentive options allow panelists to redeem their points from a large range of gift cards, points programs, and partner products or services. HCPs will have the option to receive an incentive by check, gift cards, or electronic payments. Oncologists will receive an honorarium payment of $70 for completing the study. PCPs with oncology experience and nurse practitioners and physician assistants who specialize in oncology will receive an honorarium payment of $50 for completing the study.

Following OMB's "Guidance on Agency and Statistical Information Collections," we offer the following justification for our use of this incentive.

Burden on the respondent: As participants often have competing demands for their time and recently even more limited time due to pandemic challenges (e.g., lack of or limited childcare, increase in home or caregiving responsibilities, additional guidelines for sanitization between patients, potentially reduced staff in physician offices) incentives are used to encourage participation in research. When applied in a reasonable manner, incentives are not an unjust inducement and are an approach that recognizes the time burden placed on participants, encourages their cooperation, and conveys appreciation for contributing to this important study. The use of incentives treats participants justly and with respect by recognizing and acknowledging the effort that they expend to participate (Halpen et al., 2004; Russell et al., 2000). Incentives must be high enough to equalize the burden placed on respondents with respect to their time and cost of participation, as well as to provide enough motivation for them to participate in the study rather than another activity.

Data quality: OMB's guidance states that a "justification for requesting use of an incentive is improvement in data quality. For example, agencies may be able to provide evidence that, because of an increase in response rates, an incentive will significantly improve validity and reliability to an extent beyond that possible through other means." Several studies have demonstrated that monetary incentives help to increase response rates, particularly among hard-to-reach populations (Shaghagi, Moralejo, & Burgess, 2000), convert refusals, and reduce subsequent attrition (Pit, Vo, & Pyakurel, 2014; Singer & Kulka, 2002). Empirical studies have established that larger incentives (e.g., $100, $150) perform significantly better than smaller incentives (Church, 1993; Hsu et al., 2017; Shettle & Mooney, 1999; Martinez-Ebers, 1997). Providing low incentives can result in increased time and cost to recruit the required number of participants for the study as participants may agree to participate and then not show up or drop out early. Importantly, physicians are a difficult population to recruit for research (Asch et al., 2000; VanGeest, Johnson, & Welch, 2007), and their response rates have been decreasing in the

recent years. Additionally, there are only a limited number of physicians (particularly oncologists) in online panels. High nonresponse can risk our ability to achieve the target number of completes for the study. Therefore, it is critical to maximize the number who respond to ensure sufficient power to determine meaningful differences by experimental conditions. An underpowered study increases the chance for Type II error, which may result in erroneously rejecting hypothesized models (Cohen et al. 2003). As such, the honoraria are intended to recognize the time burden placed on participants, encourage their cooperation, and to convey appreciation for contributing to this important study. The use of modest incentives is expected to enhance survey response rates and reduce nonresponse bias.

Improved coverage of specialized respondents, rare groups, or minority populations: Incentives are also necessary to ensure a reasonable cross-section of participants, reflecting diversity in age, income, and education. Studies have shown that incentives can reduce nonresponse bias for key subgroups (Griffin et al., 2011; Groth, 2010; Lesser et al., 2001). Leverage-salience theory argues that monetary incentives can help to recruit people who otherwise might not be motivated to respond (e.g., people who do not care about the topic, lack altruistic motives for responding, have competing obligations) or are typically less likely to participate in research (Groves, Presser, & Dipko, 2004; Guyll, Spoth, & Redmond, 2003; Singer & Ye, 2013). Using incentives to bring in a cross section of consumers who otherwise may not participate can reduce nonresponse bias if these participants (for example, those less interested in the topic, men, minorities, high income) have different responses and feedback than those who would participate without incentives (Castiglioni & Pforr, 2007).

Below are incentive rates that have also been approved for online surveys with HCPs of similar length.

- $100 for PCPs and specialists for a 20-minute survey web mixed mode (OMB package #0990-0415)
- $75 for specialists and $55 for primary care providers (OMB package #0910-0730)

We are also providing incentive rates that have also been approved for online surveys with general population consumers of similar length.

- $7.50 for consumers from the general population for a 20-minute online survey (OMB package #0910-0695)
- $7.50 for consumers from the general population for a 30-minute online survey (OMB package #0910-0785)
- $1.50 for consumers from the general population for a 15-minute online survey (OMB package #0910-0885)
- $1.50 for consumers from the general population for a 20-minute online survey (OMB package #0910-0896)

Participants will be compensated only for surveys that they qualify for and complete. Incentive amounts are determined by participant type and the time commitment involved.

10. Assurance of Confidentiality Provided to Respondents

In preparing this Supporting Statement, we consulted our Privacy Office to ensure appropriate identification and handling of information collected.

This ICR does not collect personally identifiable information (PII) or information of a personal nature. While PII is collected at the subcontractor website (i.e., name, phone number, email address) it is collected so the individual can be compensated for their participation in various surveys. The individuals who provide their PII are voluntarily signing up to participate in surveys from many compantes, not just for the FDA. They are considered an existing pool of participants. Information is not collected on behalf of the FDA. Because the FDA does not collect PII or the information collection is not done on behalf of the FDA, the ICR is not subject to the Privacy Act of 1974 and the requirements of the Privacy Act such as displaying a Privacy Act Statement on a collection form do not apply.

Under the Freedom of Information Act (FOIA) (5 U.S.C. 552), the public has broad access to government documents. However, FOIA provides certain exemptions from mandatory public disclosure of government records (5 U.S.C. 552(b)(1-9)). FDA will make the fullest possible disclosure of records to the public, consistent with the rights of individuals to privacy, the property rights of persons in trade and confidential commercial or financial information.

11. Justification for Sensitive Questions

This data collection will not include sensitive questions.

12. Estimates of Annualized Burden Hours and Costs

12a. Annualized Hour Burden Estimate

FDA estimates the burden of this collection of information as follows:

Table 1.--Estimated Annual Reporting Burden

Activity	Number of respondents[1]	Number of responses per respondent	Total annual responses	Average burden per response[2]	Total hours
Pretest					
General population: pretest screener completes (assumes 75% eligible)	528	1	528	0.08 (5 min.)	42.2

Table 1.--Estimated Annual Reporting Burden

Activity	Number of respondents[1]	Number of responses per respondent	Total annual responses	Average burden per response[2]	Total hours
General population: number of completes, pretest	396	1	396	0.33 (20 min.)	130.7
HCP: pretest screener completes (assumes 60% eligible)	660	1	660	0.08 (5 min.)	52.8
HCP: number of completes, pretest	396	1	396	0.33 (20 min.)	130.7
Main Study					
General population: number of main study screener completes (assumes 75% eligible)	792	1	792	0.08 (5 min.)	63.4
General population: number of completes, main study	594	1	594	0.33 (20 min.)	196.0
HCP: number of main study screener completes (assumes 60% eligible)	990	1	990	0.08 (5 min.)	79.2
HCP: number of completes, main study	594	1	594	0.33 (20 min.)	196.0
Total					891

[1]As with most online and mail surveys, it is always possible that some participants are in the process of completing the survey when the target number is reached and that those surveys will be completed and received before the survey is closed out. To account for this, we have estimated approximately 10 percent overage for both samples in the study.

[2]Burden estimates of less than 1 hour are expressed as a fraction of an hour in decimal format.

12b. Annualized Cost Estimate

There are no capital costs or operating and maintenance costs associated with this collection of information. As a voluntary collection being administered at FDA's expense, we estimate no annualized cost to respondents.

13. Estimates of Other Total Annual Costs to Respondents and/or Recordkeepers/Capital Costs

There are no capital, start-up, operating or maintenance costs associated with this information collection.

14. Annualized Cost to the Federal Government

The total estimated cost to the Federal Government for the research is $526,321.00. This includes the costs paid to the contractor to assist with study design, questionnaire, and stimuli development, recruit a sample, collect and analyze data, write reports of work completed, and present findings. The task order was awarded as a result of competition. Specific cost information other than the award amount is proprietary to the contractor and is not public information.

15. Explanation for Programs Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

Conventional statistical techniques, such as descriptive statistics, analysis of variance, and regression models, will be used to analyze the data. See part B for detailed information on the design and analysis plan. The Agency anticipates disseminating the results of the study after the final analyses of the data are completed, reviewed, and cleared. The exact timing and nature of any such dissemination has not been determined, but may include presentations at trade and academic conferences, publications, articles, and posting on FDA's website.

Table 2.--Estimated Project Timetable

Task	**Estimated Completion Date**
FDA IRB review	December, 2021
30-day FRN publication	September, 2022
OMB Review of PRA package	October, 2022
Pretesting	November, 2022
Main Study Data Collection	March, 2023

17. Reason(s) Display of OMB Expiration Date is Inappropriate

FDA will display the OMB expiration date as required by 5 CFR 1320.5.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

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