Use of Results

FMCS publishes this information in the agency's annual report, to inform the public about the arbitration services program and certain national trends in arbitration.

IV. The Official Record

The official records are electronic records.

Dated: May 14, 2025.

Alisa Zimmerman,

Deputy General Counsel.

[FR Doc. 2025–08912 Filed 5–19–25; 8:45 am]

BILLING CODE 6732–01–P

FEDERAL RETIREMENT THRIFT INVESTMENT BOARD

Notice of Board Meeting

DATES: May 29, 2025 at 10:00 a.m. ET.

ADDRESSES: Telephonic. Dial-in (listen only) information: Number: 1–202–599–1426, Code: 529 856 22#; or via web: *https://www.frtib.gov/*.

FOR FURTHER INFORMATION CONTACT: James Kaplan, Director, Office of External Affairs, (202) 864–7150.

SUPPLEMENTARY INFORMATION:

Board Meeting Agenda

Open Session

1. Approval of the April 22, 2025, Board Meeting Minutes
2. Approval of the November 14, 2024, ETAC Meeting Minutes
3. Monthly Reports
   (a) Participant Report
   (b) Investment Report
   (c) Legislative Report
4. Quarterly Reports
   (c) Metrics
5. OPE Office Presentation

Closed Session

6. Information covered under 5 U.S.C. 552b(c)(9)(B) and (c)(10).

Authority: 5 U.S.C. 552b(e)(1).

Dated: May 15, 2025.

Dharmesh Vashee,

General Counsel, Federal Retirement Thrift Investment Board.

[FR Doc. 2025–09009 Filed 5–19–25; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2025–N–1110]

Dihydropyrimidine Dehydrogenase Deficiency and the Use of Fluoropyrimidine Chemotherapy Drugs; Establishment of a Public Docket; Request for Comments

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice; establishment of a public docket; request for comments.

SUMMARY: The Food and Drug Administration (FDA or Agency) is announcing the establishment of a docket to solicit public comment for information on dihydropyrimidine dehydrogenase (DPD) deficiency and the use of fluorouracil and capecitabine (both fluoropyrimidine chemotherapy drugs). The purposes of the docket establishment are to foster Agency transparency and to solicit input on the currently available information on DPD deficiency and the use of fluorouracil and capecitabine.

DATES: Submit either electronic or written comments by June 20, 2025.

ADDRESSES: You may submit comments as follows. Please note that late, untimely filed comments will not be considered. Electronic comments must be submitted on or before June 20, 2025. The *https://www.regulations.gov* electronic filing system will accept comments until 11:59 p.m. Eastern Time at the end of June 20, 2025. Comments received by mail/hand delivery/courier (for written/paper submissions) will be considered timely if they are postmarked or the delivery service acceptance receipt is on or before that date.

You may submit comments as follows:

Electronic Submissions

Submit electronic comments in the following way:

- *Federal eRulemaking Portal: https://www.regulations.gov*. Follow the instructions for submitting comments. Comments submitted electronically, including attachments, to *https://www.regulations.gov* will be posted to the docket unchanged. Because your comment will be made public, you are solely responsible for ensuring that your comment does not include any confidential information that you or a third party may not wish to be posted, such as medical information, your or anyone else's Social Security number, or confidential business information, such as a manufacturing process. Please note that if you include your name, contact information, or other information that identifies you in the body of your comments, that information will be posted on *https://www.regulations.gov*.
- If you want to submit a comment with confidential information that you do not wish to be made available to the public, submit the comment as a written/paper submission and in the manner detailed (see ''Written/Paper Submissions'' and ''Instructions'').

Written/Paper Submissions

Submit written/paper submissions as follows:

- *Mail/Hand delivery/Courier (for written/paper submissions):* Dockets Management Staff (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.
- For written/paper comments submitted to the Dockets Management Staff, FDA will post your comment, as well as any attachments, except for information submitted, marked and identified, as confidential, if submitted as detailed in ''Instructions.''

Instructions: All submissions received must include the Docket No. FDA–2025–N–1110 for ''Dihydropyrimidine Dehydrogenase Deficiency and the Use of Fluoropyrimidine Chemotherapy Drugs; Establishment of a Public Docket; Request for Comments.'' Received comments, those filed in a timely manner (see **ADDRESSES**), will be placed in the docket and, except for those submitted as ''Confidential Submissions,'' publicly viewable at *https://www.regulations.gov* or at the Dockets Management Staff between 9 a.m. and 4 p.m., Monday through Friday, 240–402–7500.

- Confidential Submissions—To submit a comment with confidential information that you do not wish to be made publicly available, submit your comments only as a written/paper submission. You should submit two copies total. One copy will include the information you claim to be confidential with a heading or cover note that states ''THIS DOCUMENT CONTAINS CONFIDENTIAL INFORMATION.'' FDA will review this copy, including the claimed confidential information, in its consideration of comments. The second copy, which will have the claimed confidential information redacted/blacked out, will be available for public viewing and posted on *https://www.regulations.gov*. Submit both copies to the Dockets Management Staff. If you do not wish your name and contact information be made publicly available, you can provide this information on the cover sheet and not

in the body of your comments and you must identify the information as ''confidential.'' Any information marked as ''confidential'' will not be disclosed except in accordance with 21 CFR 10.20 and other applicable disclosure law. For more information about FDA's posting of comments to public dockets, see 80 FR 56469, September 18, 2015, or access the information at: *https://www.govinfo.gov/content/pkg/FR-2015-09-18/pdf/2015-23389.pdf*.

Docket: For access to the docket to read background documents or the electronic and written/paper comments received, go to *https://www.regulations.gov* and insert the docket number, found in brackets in the heading of this document, into the ''Search'' box and follow the prompts and/or go to the Dockets Management Staff, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852, 240–402–7500.

FOR FURTHER INFORMATION CONTACT: Clara Lee, Oncology Center of Excellence, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 32, Rm. 3138, Silver Spring, MD 20993, 240–402–4809, or Marianela Perez-Torres, Center for Devices and Radiological Health, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 66, Rm. 3554, Silver Spring, MD 20993, 301–796–1489.

SUPPLEMENTARY INFORMATION:

I. Background

Fluorouracil and capecitabine are fluoropyrimidine chemotherapy drugs used to treat patients with various solid tumor malignancies. Fluorouracil injection was initially approved in the United States in 1962 and capecitabine tablets were approved in 1998. These drug products (and their generic equivalents) are currently approved for multiple oncology indications and are components of standard of care treatment regimens in a variety of cancers and treatment settings.

Fluorouracil and capecitabine (a prodrug of fluorouracil) are metabolized in the body by the dihydropyrimidine dehydrogenase (DPD) enzyme to nontoxic metabolites that are excreted in the urine. The DPD enzyme is encoded by the *DPYD* gene.[i] Patients with certain homozygous or compound heterozygous variants in the *DPYD* gene known to result in complete or near complete absence of DPD activity (complete DPD deficiency) will have higher amounts of fluorouracil in the blood and are at increased risk for acute early-onset toxicity and serious, including fatal, adverse reactions (*e.g.,* mucositis, diarrhea, neutropenia, and neurotoxicity). Patients with *DPYD* variants resulting in partial DPD activity (partial DPD deficiency) may also have an increased risk of serious, including fatal, adverse reactions.

Available evidence estimates that complete DPD deficiency is present in approximately 0.2% of the White population, and partial DPD deficiency is seen in approximately 3–5% of the White population.[ii] [iii] The rates of complete and partial DPD deficiency are not well-established in other populations, and variants may differ based on ancestry.[iv]

On January 16, 2025, the FDA Oncology Center of Excellence, in collaboration with the American Association for Cancer Research, held a public workshop [v] to hear from the oncology community and other interested parties on considerations for DPD deficiency testing for patients receiving fluoropyrimidine drugs as part of their cancer treatment regimen. During the workshop, the benefits and challenges of pretreatment DPD deficiency testing were discussed, and perspectives from patient advocates, practicing oncologists, pharmacists, pharmacogenomics experts, molecular geneticists, and clinical guideline development representatives were heard. The workshop presentations highlighted revisions in recent years to the FDA-approved labeling for fluorouracil and capecitabine products, the clinical use of genotypic and phenotypic test methods, the clinical data regarding efficacy and safety of fluoropyrimidine drugs in patients with different *DPYD* genotypes, the challenges related to the dosing of fluorouracil and capecitabine in the setting of potential partial DPD deficiency, current clinical and pharmacogenomic guideline recommendations, and patient perspectives on shared decision-making. Workshop speakers expressed the view that patients scheduled to begin treatment with fluorouracil or capecitabine should be informed of the potential risk of severe adverse reactions in the setting of DPD deficiency and the role of pretreatment testing, as is recommended in the Patient Counseling Information section of current FDA-approved labeling. Workshop speakers also expressed the view that the currently available data supporting avoidance of fluoropyrimidine use in the setting of complete DPD deficiency are relatively robust, but that dosage modification recommendations for consideration for use in the setting of partial DPD deficiency would need to address the varying contexts in which fluoropyrimidines are used (*e.g.,* with curative intent).

There is no FDA-authorized test intended to identify DPD deficiency or identify patients at risk for fluoropyrimidine-related toxicity at this time, and available tests intended to identify *DPYD* variants may vary in accuracy, reliability and design (*e.g.,* which *DPYD* variant(s) they are intended to identify). FDA encourages in vitro diagnostic (IVD) device sponsors to discuss with FDA any potential or planned IVD devices intended for the identification of DPD deficiency through the Agency's Q-Submission Program.[vi]

II. Request for Public Input on Information on DPD Deficiency and the Use of Fluorouracil and Capecitabine

FDA is seeking public input on information about DPD deficiency and the use of fluorouracil and capecitabine based on the following considerations:

- as reflected in current FDA-approved labeling, available data suggest that patients with complete DPD deficiency are at increased risk of life-threatening or fatal adverse reactions when treated with fluorouracil or capecitabine at the dosages recommended in the currently approved labeling; and
- some participants in the January 16, 2025, workshop advocated for FDA to consider undertaking efforts to revise fluoropyrimidine drug product labeling to recommend that all patients be tested for *DPYD* variants before treatment with fluorouracil or capecitabine due to the risks of life-threatening or fatal adverse reactions, most notably in patients with complete DPD deficiency, despite

[i] van Kuilenburg AB. Dihydropyrimidine dehydrogenase and the efficacy and toxicity of 5-fluorouracil. Eur J Cancer 2004;40:939–950.

[ii] Dean L, Kane M. Fluorouracil therapy and DPYD genotype. In: Pratt VM, Scott SA, Pirmohamed M, et al., editors. Medical Genetics Summaries. Bethesda, MD: National Center for Biotechnology Information (US); 2012.

[iii] Innocenti F, Mills SC, Sanoff H, Ciccolini J, Lenz HJ, Milano G. All You Need to Know About DPYD Genetic Testing for Patients Treated With Fluorouracil and Capecitabine: A Practitioner-Friendly Guide. JCO Oncol Pract 2020;16(12):793–798.

[iv] See endnote ii.

[v] *https://www.fda.gov/news-events/fda-meetings-conferences-and-workshops/fda-aacr-workshop-test-or-not-test-question-dpd-deficiency-and-weighing-potential-harms-01162025#event-materials* | FDA; accessed January 30, 2025.

[vi] See the draft guidance for industry and FDA staff: *Requests for Feedback and Meetings for Medical Device Submissions: The Q-Submission Program* (March 2024). When final, this guidance will represent FDA's current thinking on this topic. For the most recent version of a guidance, check the FDA guidance web page at *https://www.fda.gov/regulatory-information/search-fda-guidance-documents*.

uncertainties about the strength of the available evidence on the clinical management (*e.g.,* dosage modifications, monitoring recommendations) of patients whose test results purport to identify partial DPD deficiency.

FDA is interested in obtaining public input on the above considerations and any other related aspects on which interested parties would like to comment. Specifically, FDA is interested in information on the following topics:

1. What, if any, challenges have healthcare providers and patients encountered based on the current recommendation to consider testing for genetic variants of DPYD prior to initiating treatment with fluorouracil or capecitabine to reduce the risk of serious adverse reactions if the patient's clinical status permits and based on clinical judgment?

2. What factors are considered by healthcare providers when deciding whether or not to test patients for DPD deficiency prior to initiating treatment with fluorouracil or capecitabine? Which, if any, of these factors may result in a healthcare provider's decision to initiate treatment with fluorouracil or capecitabine without prior testing for DPD deficiency?

3. What factors are considered by healthcare providers in deciding whether or not to use a fluorouracil or capecitabine product in a patient with a complete DPD deficiency (*e.g.,* using a markedly reduced dosage regimen) based on currently available data and information?

4. What factors are considered by healthcare providers for determining dosing and monitoring approaches when using a fluorouracil or capecitabine product in patients with purported partial DPD deficiency based on currently available data and information?

FDA will consider all suggestions, recommendations, and comments; however, the Agency will not respond directly to the person or organization making the suggestion, recommendation, or comment.

Dated: May 13, 2025.

Grace R. Graham,

Deputy Commissioner for Policy, Legislation, and International Affairs.

[FR Doc. 2025–08960 Filed 5–19–25; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

[Document Identifier: OS–0990–0481]

Agency Information Collection Request; 30-Day Public Comment Request

AGENCY: Office of the Secretary, HHS.

ACTION: Notice.

SUMMARY: In compliance with the requirement of the Paperwork Reduction Act of 1995, the Office of the Secretary (OS), Department of Health and Human Services, is publishing the following summary of a proposed collection for public comment.

DATES: Comments on the ICR must be received on or before June 20, 2025.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

FOR FURTHER INFORMATION CONTACT: Natalie Klein, *Natalie.Klein@hhs.gov* or (240) 453–6900. When submitting comments or requesting information, please include the document identifier 0990–0481–30D and project title for reference.

SUPPLEMENTARY INFORMATION: Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Title of the Collection: For HHS/OASH Consultation Process, Institutional Review Board (IRB) Records.

Type of Collection: Reinstatement without changes.

OMB No. 0990–0481.

Abstract: The Office of the Assistant Secretary for Health (OASH), Office for Human Research Protections (OHRP) is requesting reinstatement of the Office of Management and Budget (OMB) information collection request, OMB No. 0990–0481, For OASH/HHS Consultation Process, Institutional Review Board (IRB) Records, with no changes, for a three-year period. The previous information collection was approved by OMB on February 14, 2022, and expired on February 28, 2025. The purpose of the collection is for OHRP to receive IRB records when an IRB or an institution requests an HHS consultation process for proposed research that is not otherwise approvable by an IRB involving, respectively: (1) pregnant women, human fetuses and neonates; (2) prisoners; or, (3) children, as subjects. The information that must be submitted to OHRP by an IRB or institution includes the research protocol, consent form, parental permission and child assent forms (if relevant), and other relevant IRB records (*e.g.,* IRB minutes). The Office of the Assistant Secretary for Health, on behalf of the Secretary of HHS, may determine that such research can be conducted or supported by HHS after consulting with experts and meeting other procedural requirements.

Likely Respondents: IRBs.

ANNUALIZED BURDEN HOUR TABLE

45 CFR part 46—HHS Consultation process provision	Respondent type	Number of respondents	Number of respondents	Average burden per response (in hours)	Total burden hours
subpart B, § 46. 207	IRBs	3	1	1	3
subpart C, § 46.306(a)(2) (iii) and (iv)	IRBs	3	1	1	3
subpart D, § 46.407	IRBs	4	1	1	4
Total					10