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Division of Dockets Management, HFA-305
Food and Drug Administration
U.S. Department of Health and Human Services
5630 Fishers Lane, Rm 1061
Rockville, MD 20852

RE: Docket Number FDA-2010-N-0568

Dear Colleagues:

On behalf of the North American Quitline Consortium (NAQC), I would like to thank FDA for the opportunity to provide comments on the proposed rule on required warnings for cigarette packages and advertisements. NAQC strongly supports the FDA's regulatory efforts in this area. It is our hope that the final rule will include nine effective warning statements and graphics as well as a cessation resource: 1-800-QUIT-NOW. Such a final rule will have a significant, positive impact on the health of millions of Americans for years to come.

In its proposed rule, FDA requests comments on the proposed warnings and also on the selection of an appropriate smoking cessation resource as described in Section 1141.16 of the Tobacco Control Act. As a national organization with an expertise in cessation services, NAQC's comments focus exclusively on the selection of an appropriate cessation resource. To that end, NAQC recommends:

1) FDA should select 1-800-QUIT-NOW as the smoking cessation resource under Section 1141.16 of the Tobacco Control Act;

2) Every warning for cigarette packages and advertisements should include 1-800-QUIT-NOW and its numeric equivalent (1-800-784-8669). In addition, the telephone numbers should be clearly identified as a quitline; and

3) FDA should replace the criteria for the tobacco cessation resource and in their place require the provision of information and services that comply with the most current version of the U.S. Public Health Services Guideline on Treating Tobacco Use and Dependence.

Information supporting these recommendations follows.

Overview of Quitlines and NAQC

A quitline is a health service that offers telephone support – information, counseling, medication and other support – for people who want to quit using tobacco. Quitline services generally include telephone counseling along with a range of services such as: mailed materials, referrals to other cessation services, taped messages or web programs, the provision of nicotine replacement therapies (NRTs) and other medications or assistance in obtaining them, and language- or culturally-appropriate services directed toward specific populations within states. In North America, quitlines exist in all 50 states, the District of Columbia, Puerto Rico and Guam as well as all 10 Canadian provinces, Nunavut and the Yukon; and Mexico. A snapshot of the services available in each state is shown on the map at http://map.naquitline.org.
NAQC is a non-profit professional organization that aims to maximize the access, use and effectiveness of quitlines; provide leadership and a unified voice to promote quitlines; and offer a forum to link those interested in quitline operations. It is comprised of over 400 quitline professionals at state and provincial health departments, quitline service provider organizations, research institutes and national organizations in the United States and Canada. The Consortium enables professionals from these organizations to learn from each other and to improve the quality of quitline services.

RECOMMENDATION ONE: FDA should select 1-800-QUIT-NOW as the smoking cessation resource under Section 1141.16 of the Tobacco Control Act.

In its proposed rule, FDA requests comments on the selection of an appropriate smoking cessation resource as described in Section 1141.16 of the Tobacco Control Act. NAQC recommends that FDA select 1-800-QUIT-NOW as the appropriate cessation resource. The basis for this recommendation is twofold: 1) research supports selecting a telephone-based resource to ensure that smokers have greatest access to the cessation resource that appears on cigarette packages and advertisements; and 2) of all telephone-based resources, 1-800-QUIT-NOW is the only public sector resource with a history of providing high quality evidence-based cessation services across the nation.

In selecting a cessation resource to include as part of the warning on cigarette packages and advertisements, FDA should seek one that is accessible to as many Americans as possible, especially smokers. National statistical analyses show that telephones are fairly ubiquitous in the U.S. A recent report from the Federal Communications Commission found that the penetration for telephones in U.S. households is over 95%.1 Although the penetration varies somewhat for income, age, gender and number of people in a household, the penetration remains over 90% for all groups. For households with an income under $15,000 per year, penetration is 94.0% whereas for those over $50,000 per year, penetration is 98.2%. Similarly, for households with an unemployed head of household, penetration is 94.7% whereas for those employed, it is 96.8%. For households headed by a person under age 25, penetration remains high at 93.1%. For households headed by a person over 55, penetration is 96.6%.

Although access to and use of the Internet is growing, it is not nearly as accessible as telephones, and Internet use is low in many groups with high rates of smoking. The Pew Research Center’s Internet and American Life Project conducted a survey of over 2,000 adults from April 29-May 30 2010.2 They found that 79% (+/- 2%) of American adults use the Internet. Use by African Americans was lower than other racial/ethnic groups (71%). Access decreased with increasing age; those under 30 had very high access (95%) whereas those over 65 had low (42%). Additionally, access varied significantly by income and education levels. For those with incomes under $30,000, only 63% had access to Internet. For those with less than a high school education or only a high school education, access was low (52% and 67%, respectively).

Research supports selecting a telephone-based resource such as 1-800-QUIT-NOW to ensure that smokers have greatest access to the cessation resource that appears on cigarette packages and advertisements. Since many current smokers have lower income and lower education levels than non-smokers, it is more likely that they have access to a phone as opposed to the Internet.

B. In 1992, after research demonstrated that telephone-based counseling for tobacco cessation is an effective treatment, the California Department of Health launched the first statewide telephone counseling service to help smokers quit. By the mid-1990’s, Massachusetts, Arizona and Oregon also had launched quitlines. The number of states and provinces in North America offering quitline services for smokers and other tobacco-users increased exponentially in the late 1990’s. In the U.S., this increase in quitlines was driven, in large part, by the influx of funds from the states’ Master Settlement Agreement with the tobacco industry; in Canada, a six-province pilot study funded by Health Canada helped drive adoption of this new intervention.

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According to the U.S. Public Health Service Clinical Guideline on Treating Tobacco Use and Dependence and the Cochrane Review, recognized around the world as the gold standards for treatment of tobacco use, proactive telephone counseling is recommended for smoking cessation interventions.\textsuperscript{4} Research demonstrates that the impact of quitlines in the U.S. has been extensive and impressive. Data from NAQC's most recent annual survey of quitlines\textsuperscript{5} shows that in fiscal year 2009,\textsuperscript{6} U.S. quitlines received over 1.04 million calls (up from 650,000 in FY 2008), enrolled 1.2 percent of all U.S. smokers, and provided evidence-based services (counseling or medications) to 0.7 percent of all U.S. smokers. It is noteworthy that some states enrolled nearly 10\% of smokers and provided services to over 7\% of smokers. The median budget for state quitline services has increased from $622,000 in 2005 to $1.7 million in fiscal year 2009. On average, states invested $3.55 per adult smoker in quitline services (counseling and medications).

The existing U.S. network of state and territorial quitlines is connected through a national toll-free portal, 1-800-QUIT-NOW, established by the U.S. DHHS in 2004. Any tobacco user in the U.S. can call 1-800-QUIT-NOW to receive free, effective help with quitting from his or her state quitline. Since its establishment, over 3 million calls have been routed to state quitlines through 1-800-QUIT-NOW. \textbf{NAQC recommends 1-800-QUIT-NOW as the cessation resource that should be selected to appear on warnings because of all telephone-based cessation resources, it is the only public sector resource with a history of providing high quality evidence-based cessation services across the nation.}

\textbf{RECOMMENDATION TWO:} Every warning for cigarette packages and advertisements should include 1-800-QUIT-NOW and its numeric equivalent (1-800-784-8669). In addition, the telephone numbers should be clearly identified as a quitline.

In its proposed rule, FDA indicates that a cessation resource may appear on some or all warnings. The purpose of the Tobacco Control Act is to curb the significant adverse consequences of tobacco use. By including a cessation resource on all cigarette packages and advertisements, FDA would best help achieve Congress’ stated purpose for the Act.

According to the literature, warning labels on cigarettes and other tobacco products communicate the risks of smoking and have excellent recall with smokers.\textsuperscript{7} \textsuperscript{8} \textsuperscript{9} Literature also demonstrates that smokers who perceive greater smoking-related health hazards are more likely to consider quitting and to quit successfully.\textsuperscript{10} \textsuperscript{11} However, NAQC recommends that FDA require more than the communication of risks and health hazards on each and every warning. \textbf{We ask FDA to require that actionable information be provided to smokers on how to receive help with quitting.} Such a requirement will advance the use of labels and capitalize on the existing national portal number, 1-800-QUIT-NOW, and the U.S. DHHS website, www.smokefree.gov. Increased awareness of quitlines will result in a significant public health benefit by encouraging tobacco users to think about quitting and linking those who want to quit with effective, no-cost services.\textsuperscript{12} Research also shows that smokers

\textsuperscript{5} See 2009 NAQC Annual Survey results at http://www.naquitline.org/?page=survey2009
\textsuperscript{6} Fiscal Year 2009 was defined according to each quitline’s own fiscal year. For US quitlines, 95\% reported a fiscal year of July 1, 2008 – June 30, 2009.
may be more likely to attempt to quit when they know a quitline is available.\textsuperscript{13} The “insurance” of having a quitline available seems to give smokers confidence to make a quit attempt.\textsuperscript{14}

As discussed above, quitlines are effective cessation services as documented in numerous research studies and are recommended by the U.S. Public Health Services Clinical Guideline on Tobacco Dependence Treatment.\textsuperscript{15} Quitlines are available to all tobacco users in the U.S. These services are available at no cost to consumers in all 50 states, the District of Columbia, Puerto Rico and Guam.

The proposed rule and the research literature contain extensive support for the inclusion of cessation resources as part of the enhanced tobacco health warning labels. FDA describes the purpose of the warnings as “Specifically, the new required warnings are designed to clearly and effectively convey the negative health consequences of smoking on cigarette packages and in cigarette advertisements, which would help both to discourage nonsmokers, including minor children, from initiating cigarette use and to encourage current smokers to consider cessation to greatly reduce the serious risks that smoking poses to their health.” (pg 11). It acknowledges that research findings show that graphic health warnings not only are more noticeable and are more effective for educating smokers about health risks of smoking, but also increase motivation to quit smoking (pg 31, 34). For example, in Canada, smokers who quit smoking after the introduction of the graphic warnings were 2.78 times more likely to identify health warnings as their motivation for quitting than former smokers who quit before the graphic warnings appeared on packages. (pg 35).

Addiction has a serious impact on quitting. According to the proposed rule: “Nicotine addiction is another negative effect of cigarette smoking” (pg 20) .... “In addition to physical dependence, nicotine addiction also results in conditioned behavior in smokers in response to situations and environmental stimuli associated with cigarette use.” (pg 21) .... “As a result of nicotine addiction, only a minority of smokers can achieve permanent abstinence in an initial quit attempt.” (pg 21) .... The Institute of Medicine, considering data for 2004, found that although approximately 40.5 percent of adult smokers reported attempting to quit that year, only between 3 and 5 percent were successful.” (pg 22) .... “Adolescents also experience low success rates when attempting to quit. ... nicotine dependence can be rapidly established.... An analysis of data from the 2007 YRBS found that 60.9 percent of high school students who ever smoked cigarettes daily tried to quit smoking, but only 12.2 percent were successful.” (pg 22)

In Australia, graphic warnings increased attempts to quit but were not associated with short-term quit success (pg 35). These findings underscore the important effect of addiction on quit attempts. They also underscore the importance of including a cessation resource along with the required warning; by motivating smokers to quit (through the graphic warning) and then linking smokers with a cessation resource (1-800-QUIT-NOW), FDA may increase the likelihood of a successful quit for each smoker who views the warning.

Overall, international experience shows that including the quitline phone number as part of the health warning on cigarette packages clearly improves the effectiveness of the warning and the number of smokers seeking smoking cessation advice from the quitline.\textsuperscript{16} In Australia, graphic warnings and the quitline number were added to cigarette packs in 2006. Researchers found that the warnings and quitline number boosted demand for quitline services.\textsuperscript{17} The increase in demand exceeded the volume that could be explained by the accompanying television advertisement alone. Similar results were found in Singapore,\textsuperscript{18} New Zealand,\textsuperscript{19} the Netherlands,\textsuperscript{20} and Brazil.\textsuperscript{21} Including 1-800-QUIT-NOW on every package of cigarettes is an effective way to encourage tobacco users in the U.S. to quit, thereby curbing the significant adverse consequences of tobacco.

\textsuperscript{14} Dr. Deborah Ossip. Personal communication via email. December 22, 2010.
\textsuperscript{15} Ibid.
FDA should clearly identify the phone number as a quitline. Studies in New Zealand show the importance of clearly identifying the quitline number. New graphic warnings that included a clearly-identified quitline number were introduced in New Zealand in 2008, replacing warnings with the phone number but not the word “quitline”. In the first full year after their introduction, call volumes to the quitline increased significantly and 26% of the callers reported cigarette packages as the source of the quitline number (as compared to 7.5% in the prior year, before the word “quitline” was added to the telephone number that appeared in the warning). This shows that importance of including the word “quitline” along with the phone number. Research conducted in New Zealand also shows that the clearly identified quitline number benefited all age groups, genders, SES levels, and ethnic groups. In the U.S., quitlines are well-utilized by priority populations. Given the demographics of smoking and its impact in underserved and minority communities, it will be important to use a cessation resource that will benefit all segments of the population, including underserved and minority communities.

FDA should include not only 1-800-QUIT-NOW, but also the numeric equivalent (1-800-784-8669). From a practical standpoint, many cell phones no longer include letters on the keypad. For this reason, it is important to include the actual telephone number.

Smokers view information on quitlines that is included as part of a health warning label in a positive way. Health Canada is working on the development of the next generation of health warning messages for its tobacco packaging. A proposed new component of this is the inclusion of a pan-Canadian toll-free quitline number. As part of its work, Health Canada conducted focus group testing on the idea of a pan-Canada toll-free quitline number. Smokers viewed the information in a very positive way. Smokers contemplating a quit viewed the information most positively.

The inclusion of cessation resources on every package of cigarettes is feasible for the tobacco industry. Approximately 20 nations currently require a quitline number on their tobacco package labeling, including Finland, the Netherlands, Denmark, Iceland, Malta, the U.K., France, Sweden, Hungary, Poland, Germany, Belgium, South Africa, Brazil, Singapore, Australia, Switzerland, New Zealand and Norway.

The inclusion of 1-800-QUIT-NOW is feasible for state quitlines. Although quitlines currently reach only 1-2 percent of smokers in the U.S., the U.S. DHHS Interagency Committee on Smoking and Health determined that given adequate funding and a comprehensive promotion campaign, quitlines have the capacity to serve 10-15 percent (about 4 million smokers) each year. The inclusion of the phone number on tobacco packages will help increase the reach of quitlines to smokers who want to quit. To avoid having this become an unfunded mandate for states, NAQC recommends that FDA/DHHS and the states discuss possible funding solutions. Based on international experience and recent U.S. experience with an increase in the federal tobacco tax, we estimate that including 1-800-QUIT-NOW on the warning will double the call volume for the first two years. In Canada, the federal government proposes to cover the cost of the increase in call volume that is due to the inclusion of the quitline number on cigarette packages. NAQC recommends a similar approach be followed in the U.S. One possible revenue source may be to increase the federal tobacco tax. This would generate adequate revenues to cover the costs of quitline services and an evaluation of the impact of placing 1-800-QUIT-NOW on cigarette packages and advertisements. It may be that the U.S. DHHS prefers to tap another revenue source, at least initially, such as departmental one-percent evaluation funds.

26 Ms. Louise Bertrand, Health Canada. Personal communication to Linda Bailey about countries with quitline numbers on cigarette packs as of March 2008. Email sent Thursday, July 30, 2009 at 12:00 PM.
RECOMMENDATION THREE: FDA should replace the criteria for the tobacco cessation resource and in their place require the provision of information and services that comply with the most current version of the PHS Guideline.

In its proposed rule, FDA asks for comments on the proposed criteria for a cessation resource. NAQC recommends that to avoid having the criteria become out of date, FDA should reference criteria that are updated on a regular basis and contain requirements similar to those proposed.

A. The proposed FDA criteria could be revised to be reasonable. However NAQC recommends that the agency consider replacing the criteria with a reference to the most current PHS Guideline. The PHS Guideline is recognized as the gold standard for tobacco cessation in the U.S., produced by leading cessation experts, updated on a regular basis and published by the U.S. DHHS. By adopting this recommendation, FDA would require that the designated tobacco cessation resource make available the most up-to-date evidence-based information and services. By referencing the most current version of the PHS Guideline, FDA would prevent the criteria from becoming outdated over time. It is worth noting that in recent times the PHS Guideline has been updated twice each decade.

Currently, the PHS Guideline lists the following services as evidence-based28:

- Proactive, multi-call counseling services;
- Counseling services that provide smokers with 1) practical counseling (e.g., harms to health from smoking, benefits of quitting, problem-solving skills and skills training) and 2) provide support and encouragement as part of treatment; and
- FDA-approved medications

B. If this recommendation is not acceptable to FDA, the current proposed criteria should be significantly revised.

FDA has proposed 12 criteria including:

1. Provide factual information about the harms to health from smoking and the benefits of quitting;
2. Provide factual information about what to expect when trying to quit;
3. Provide practical advice about how to deal with issues faced by users trying to quit;
4. Provide evidence-based advice about formulating a quit plan;
5. Provide evidence-based information about effective relapse prevention strategies;
6. Provide factual information on smoking cessation treatments, including FDA-approved medications;
7. Provide information, advice and support that is evidence-based, unbiased and relevant to tobacco cessation (cannot include derogatory statements regarding cigarette manufacturers, importers, distributors or retailers or advocate public policy change).
8. Must not advertise or promote any particular product or service;
9. Must not selectively present information about a subset of FDA-approved cessation products without mentioning other FDA-approved cessation products, or reference any drug or other medical product that FDA has not approved for tobacco cessation;
10. Must not encourage use of any non-evidence based smoking cessation practices;
11. Must specifically train staff that provide smoking cessation information and advice to help smokers quit by delivering unbiased and evidence-based information, advice and support;
12. Must have appropriate controls on services to ensure the applicable criteria are met.

NAQC would like to raise a number of issues and concerns about these criteria:

**FDA should include proactive, multi-call counseling services as part of its final criteria.** Proactive, multi-call counseling services are an important part of the evidence base (PHS Guideline). Currently they are not included on FDA’s proposed list of criteria. These services are available nationally and are supported to a large extent by State and Federal funding. NAQC highly recommends adding them as a resource for the criteria.

**FDA should either delete criteria 1-6 and 8 or make it clear that they refer to the capacity of the quitline and not to each interaction with a caller.** Assisting tobacco users to quit is an interactive and iterative process

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that is tailored to the needs of the user. It is critical to recognize that quitlines do more than provide factual information. They counsel callers to make their quit attempts more successful. Quitline counselors often use motivational interviewing, a technique that helps a smoker clarify reasons for quitting and establish a quit plan. Using this technique, the counseling session is facilitated by the counselor and tailored to the needs of the caller and the issues the caller would like to discuss.

While criteria 1-6 and 8 above are very straightforward and describe the approach and kinds of information and advice that are provided by quitlines to most callers, a successful tobacco cessation process is more about “tailoring” an intervention to the tobacco users needs than providing specific factual information in each call. Callers have varying experiences with previous quit attempts and could already be well-versed in some topics and need little education or support.

At the present time, criteria 1-6 and 8 are reasonable criteria for the quitline. However, FDA should make it clear that these criteria refer to the quitline as a whole and not to each and every interaction with a caller.

**FDA should clarify criteria 7 to remove or define the word “unbiased” and to remove the language about “derogatory statements”**. As noted in the paragraph above, quitlines tailor their information and advice to the specific needs of callers. We would be concerned if FDA or others viewed “tailoring” as “biased” information or advice, and recommend deleting that the word “unbiased” from criteria 7 or defining it to include the concept of “tailoring”.

The language about “derogatory statements” is very concerning because it is vague and recalls the history of tobacco industry challenges to effective tobacco control programs due to “vague” language (e.g., the Legacy Foundation’s TRUTH campaign). Legacy was prohibited from using its funding to “vilify” the tobacco industry. Tobacco companies brought suit against Legacy alleging that one of its advertisements constituted “vilification”. Although the lawsuit was unsuccessful for the tobacco company, it forced Legacy to spend millions of dollars that could have been used for tobacco control efforts. While NAQC agrees that it may be unusual for a quitline staff to discuss tobacco companies with callers, we would not want the FDA criteria to have a chilling effect on the topics that a caller may raise during a counseling session. In addition, we would not want the FDA criteria to be a source for groundless litigation and/or harassment by the tobacco industry. For these reasons, NAQC recommends that FDA remove the language about “derogatory statements.”

**FDA should either delete criteria 10 or replace the word “practices” with “treatment”**. While NAQC agrees that the tobacco cessation resource selected by FDA should not encourage the use of any non-evidence based smoking cessation treatments, we would not limit the encouragement of tobacco cessation practices to the evidence-base. In the cessation field, “cessation practices” are viewed as including such things as coping strategies for challenges during the quitting process. Although FDA-approved medications have been proven effective for reducing cravings, some additional coping strategies (ie, chewing gum, exercising, drinking water, etc.) that are helpful to many smokers during their quit attempts have not been tested as rigorously as medications and may not be considered “evidence-based.” Criteria 3 covers the issue of cessation practices adequately. For these reasons, we recommend deleting criteria 10 or replacing the word “practice” with “treatment”.

**FDA should remove the word “unbiased” from criteria 11, regarding staff training.** Much like our comments on criteria 7 above, NAQC is concerned that “unbiased” may be interpreted by some to exclude the “tailoring” of information and advice to a specific caller. Tailoring information and advice to a specific caller is an important part of effective cessation counseling.

**NAQC’s data show that the national network of state quitlines available through 1-800-QUIT-NOW meets these criteria.**

Each year, NAQC conducts a survey of quitlines. Our most recent data (2009) demonstrate that the national network of state quitlines available through 1-800-QUIT-NOW meets the FDA proposed criteria.

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29 Lorillard Tobacco Co. v. American Legacy Foundation, 903 A2nd 728 (Del 2006).
Criteria 1-8 and 10: As of the 2008 NAQC Annual Survey, all 53 U.S. quitlines provide information and advice on the harms of tobacco to health, benefits of quitting, quitting medications and development of a quit plan. Fifty-two (98%) also reported helping callers set a quit date. Between 93% and 96% of U.S. quitlines reported providing practical advice on coping strategies for dealing with triggers, coping with withdrawal symptoms and relapse prevention.

The information, advice and support provided by public quitlines are evidence-based, unbiased and relevant to tobacco cessation. State quitlines do not promote or advertise any particular product or service. Although 40 quitlines provide some type of FDA-approved medication at no cost to callers, it is provided in a manner that does not advertise or promote the specific product. Counselors provide information on all FDA approved medications, and they do not encourage use of non-evidence based smoking cessation treatments.

Criteria 9: NAQC does not collect data on criteria 9.

Criteria 11-12: Counseling staff are trained specifically to help smokers quit by delivering evidence-based information, advice and support. The quitlines have supervisory controls on-site to assure that the information provided to callers is high quality and conforms to appropriate protocols. This is done through use of counseling protocols, training, continuing education, mentorship and listening-in to a sample of actual calls. In addition, off-site state administrators for the services often use “secret shoppers” as an external control on quality.

Additional information: All state quitlines offer evidence-based proactive multi-call counseling services – as recommended by the PHS Guideline. In addition, all quitlines report having counseling services available at least 5 days per week, and at least 8 hours per day.

Fifty-one state quitlines provided counseling in Spanish, and 52 quitlines sent specialized materials to special populations, including pregnant women, smokeless tobacco users, racial/ethnic populations, youth (under 18) and others. Forty (75%) provided some type of free NRT or other medications to at least select callers – up from 18 in 2005. Fifty state quitlines were integrated into the health care systems in their states through fax-referral programs, and the same number provided referrals out to other services.

In addition to telephone counseling services, 29 quitlines (55%) also offered some form of internet-based cessation services (either self-directed or interactive counseling). While the PHS Guideline did not find enough evidence at the time of its publication to recommend computer-based interventions, it did note that “Given the potential reach and low costs of such interventions …they remain a highly promising delivery system for tobacco dependence.” Quitlines have responded to positive research findings on the potential of internet-based interventions to reach many tobacco users, by incorporating them into their services. Indeed, quitlines are on the leading edge of treatment services; they provide an opportunity to study the relative effectiveness of different types of self-help interventions, including computer-based interventions, and to advance knowledge on effective practices.

Conclusion

The authorization of FDA to enhance tobacco health warnings on cigarette packages and advertisements heralds an exciting new era for tobacco control and cessation. NAQC is confident that the recommendations included in

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36 Fiore (2008), p. 94.
this letter are consistent with FDA’s authority and if implemented would help achieve the Tobacco Control Act’s goals to curb the significant adverse consequences of tobacco use. It would make accessing tobacco cessation services almost as easy as buying a pack of cigarettes. NAQC and its network of members across the U.S. and Canada stand ready to help smokers in their quitting efforts and FDA in its regulatory activities.

Thank you, again, for the opportunity to provide input and share views on FDA’s proposed rule. Should you have any questions about NAQC’s comments or require additional information, please contact me via email at L.Bailey@NAQuitline.org or via telephone at 800-398-5489.

Sincerely,

Linda A. Bailey, JD, MHS
President and CEO