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The aim of this book is to illustrate the importance of understanding the fundamental solid-state properties of pharmaceutical materials during the development of solid pharmaceutical products and to lay out general strategies for the physical characterization of solids using various analytical tools. Generally, great emphasis is understandably placed on the discovery of new active pharmaceutical ingredients (API) for the cure, treatment, and prevention of various acute and chronic diseases. However, it has been firmly established that the ability to obtain successful drug products in an efficient and timely manner strongly depends on the formulation and manufacture of stable and bioavailable drugs into useful products, where various physical and chemical characteristics play an essential role. In essence, it can be said, therefore, that a “drug” is more than a molecule, rather being part of a complex mixture of materials with physical chemical characteristics that can determine therapeutic success or failure.

The book is divided into four parts. The first part focuses on the various phases or forms that solids can assume, including polymorphs, solvates/hydrates, salts, cocrystals, amorphous forms, crystal mesophases, and nanocrystals, and various issues related to their relative stability and tendencies to undergo transformations. The second part focuses on the key methods of solid-state analysis such as X-ray crystallography, X-ray powder diffraction, thermal analysis, microscopy, vibrational spectroscopy, and solid-state NMR. The third part reviews critical physical attributes of pharmaceutical materials, mainly related to drug substances, including particle size/surface area, hygroscopicity, mechanical properties, solubility, and physical and chemical stability. The fourth part of the book builds on the first three parts to illustrate how an understanding of the various properties of pharmaceutical materials may be used for (1) the rational selection of drug solid form, (2) the analysis of mixtures of various solid forms within the drug substance and the drug product, (3) establishing rational protocols and strategies for carrying out efficient and successful product development, and (4) applications of appropriate manufacturing and control procedures, using Quality by Design, and other strategies that lead to safe and effective products with a minimum of resources and time.

Furthermore, we have attempted to design this book in such a way that it can be used by preformulation and formulation scientists, process engineers, analytical chemists, quality assurance and quality control managers, regulators, and other researchers, who all contribute to the drug development process. We hope that by presenting a mixture of fundamental solid-state science and its practical applications to the drug development process we will have helped all involved to gain a greater perspective of the importance of both aspects.
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1

SOLID-STATE PROPERTIES AND PHARMACEUTICAL DEVELOPMENT

1.1 INTRODUCTION

Solid-state chemistry and the solid-state properties of pharmaceutical materials play an ever increasing and important role in pharmaceutical development. There is much more emphasis on physical characterization since the release of the International Committee on Harmonization (ICH) Q6A guidance on specifications. This guidance directs the scientist to determine what solid form is present in the drug substance (active pharmaceutical ingredient [API]) and drug product. It directs the manufacturer to “know what they have.” Additionally, the ICH Q8 guidance on development and the ICH Q9 guidance on risk management require a firm understanding of how the medicine was developed and any risks involved.

There are many more poorly soluble drugs under development. In many cases, the solid form of the API and the solid form and formulation in the drug product determine apparent solubility that in turn determines blood levels. That is, the formulation determines bioavailability and therapeutic response. In these cases, it is even more important to physically characterize the API form and the formulations. Furthermore, the vast majority of medicines (drug products) are solids and those drug products that are not solids often start with solid APIs. In addition to solubility and bioavailability, the solid form may affect stability, flow, compression, hygroscopicity, and a number of other properties.

This book focuses on solid-state properties of pharmaceutical materials and methods of determining these properties. The authors have made every effort to include examples and case studies in order to illustrate the importance of knowing what you have. This book will focus on solid-state properties and general strategies for physical characterization. Case studies and practical examples will be emphasized. In many respects, this book will illustrate that a medicine is more than a molecule. Additional goals include providing a full physical/analytical/operational definition of the different solid forms as well as other terms frequently used in pharmaceutical materials science including: polymorph, solvate, amorphous form, habit, nucleation, transformation, dissolution, solubility, and stability.

1.2 SOLID-STATE FORMS

Pharmaceutical materials can exist in a crystalline or amorphous state. Figure 1.1 illustrates the crystalline state as a perfectly ordered solid with molecules (circles) packed in an orderly array. Figure 1.1 illustrates an amorphous material as a disordered material with only short-range order. Crystalline materials give an X-ray diffraction pattern because Bragg planes exist in the material (see Figure 1.2). Amorphous materials do not give a diffraction pattern (Figure 1.2). Of course, there are many interesting cases where a pharmaceutical material shows an intermediate degree of order falling somewhere between the highly ordered crystalline state and the disordered amorphous state. From a thermodynamic point of view, crystalline materials are more stable but the rate of transformation of amorphous materials to crystalline materials can be highly variable [1].
Crystals of a pharmaceutical material from different sources can vary greatly in their size and shape. Typical particles in different samples may resemble, for example, needles, rods, plates, and prisms. Such differences in shape are collectively referred to as differences in morphology. This term merely acknowledges the fact of different shapes. It does not distinguish among the many possible reasons for the different shapes. Naturally, when different compounds are involved, different crystal shapes would be expected as a matter of course. When batches of the same substance display crystals with different morphology, however, further work is needed to determine whether the different shapes are indicative of polymorphs, solvates, or just habits. Because these distinctions can have a profound impact on drug performance, their
careful definition is very important to our discourse. At this time, only brief definitions are presented.

- **Polymorphs**: When two crystals have the same chemical composition but different internal structure (molecular packing), they are polymorphic modifications, or polymorphs (think of the three forms of carbon: diamond, graphite, and fullerenes). Polymorphs can result from different molecular packing, different molecular conformation, different tautomeric structure, or combinations of these.

- **Solvates**: These crystal forms, in addition to containing molecules of the same given substance, also contain molecules of solvent regularly incorporated into a unique structure (think of wet, setting plaster: \( \text{CaSO}_4 + 2\text{H}_2\text{O} \rightarrow \text{CaSO}_4 \cdot 2\text{H}_2\text{O} \)).

- **Habits**: Crystals are said to have different habits when samples have the same chemical composition and the same crystal structure (i.e., the same polymorph and unit cell) but display different shapes (think of snowflakes).

Together, these solid-state physical modifications of a compound are referred to as crystalline forms. When differences between early batches of a substance are found by microscopic examination, for example, a reference to “form” is particularly useful in the absence of information that allows the more accurate description of a given variant batch (i.e., polymorph, solvate, habit, or amorphous material). The term pseudopolymorphism is applied frequently to designate solvates. These solid-state modifications have different physical properties.

To put these important definitions into a practical context, we consider two cases (aspirin and flufenamic acid) in which a drug was crystallized from several different solvents and different-shaped crystals resulted in each experiment. Although sometimes dramatically different shapes were obtained upon changing solvents for the various crystallizations, the final interpretations in the two cases are different. For aspirin, X-ray powder diffraction showed that all crystals regardless of shape had the same diffraction pattern. Thus, the different shaped crystals are termed crystal habits. For flufenamic acid, the different shaped crystals had different X-ray powder diffraction patterns. Subsequent analysis showed that the crystals did not contain solvent. Thus these different crystals are polymorphs.

Further analysis of the crystals from this case provides the single crystal structure. The single crystal structure gives the locations of the atoms relative to a hypothetical unit cell. The unit cell is the smallest building block of a crystal. Figure 1.3 shows the unit cell of Form I of flufenamic acid. This unit cell contains four flufenamic acid molecules. Figure 1.4 shows a space-filling model of the contents of the flufenamic acid Form I unit cell. This figure illustrates Kitaigorodskii’s close-packing theory, which requires that the molecules pack to minimize free volume [2].

Amorphous materials will be discussed in Chapter 6. In this introductory chapter as mentioned briefly above, amorphous materials have no long range order and are thermodynamically metastable. An amorphous solid is characterized by a unique glass transition temperature \( T_g \), the temperature at which it changes from a glass to a supercooled liquid or rubbery state. When \( T \) rises above \( T_g \), the rigid solid can

![FIGURE 1.3](image-url)  
**FIGURE 1.3** Single crystal structure the Form I polymorph of flufenamic acid (structure shown on the right panel).
flow and the corresponding increase in molecular mobility can result in crystallization or increased chemical reactivity of the solid. Several historic papers describe some additional details of amorphous materials. Pikal and coworkers at Eli Lilly showed that amorphous materials can have lower chemical stability [3], and Fukuoka et al. showed amorphous materials had a tendency to crystallize [4]. Nevertheless, in some cases, amorphous forms have been historically used as products. An excellent example is novobiocin [5], which exists in a crystalline and an amorphous form. The crystalline form is poorly absorbed and does not provide therapeutic blood levels; in contrast, the amorphous form is readily absorbed and is therapeutically active. Further studies show that the solubility rate of the amorphous form is 70 times greater than the crystalline form in 0.1 N HCl at 25°C when particles <10 micron are used.

It is possible to make a “top 10” list of the differences between crystalline and amorphous materials. Crystalline materials have the following characteristics:

1. higher purity,
2. More physically and chemically stable, crystalline hydrate > anhydrous crystal > amorphous
3. lower solubility,
4. narrow and (usually) higher melting point range,
5. harder,
6. brittle – slip and cleavage,
7. directionally dependent properties – anisotropy,
8. less compressible,
9. better flow and handling characteristics, and
10. less hygroscopic.

From this list, it is clear that crystalline materials are generally more desirable unless they are so insoluble that they cannot be used as medicines.

Not only do polymorphs show different X-ray powder diffraction patterns but they also have different unit cells, and different properties including thermal properties [6]. Figure 1.5 shows the different crystal packing of the Forms I and II of sulfathiazole.

Additionally, polymorphs are characterized as monotropic or enantiotropic depending upon their thermal properties [9, 10].

- Monotropic polymorphs exist if the transition temperature between forms is greater than the melt. In monotropic polymorphs, one form is most stable throughout the temperature range.
- Enantiotropic polymorphs exist if the transition temperature between forms occurs before melting. In this case, one form is more stable at one temperature. At a
different temperature the other form is most stable. For flufenamic acid, Form I is most stable above the transition temperature of 42°C and Form III is most stable below the transition temperature. Practically, this means that slurrying at room temperature will convert Form I to Form III.

Crystalline solvates contain solvents regularly incorporated into the crystal lattice. When the solvent is water the solid form is called a hydrate. Solvates and hydrates do not have the same composition as unsolvated materials. Solvates and hydrates are sometimes referred to as pseudopolymorphs or solvatomorphs. Interestingly, it is possible for solvates and hydrates to be polymorphic. In such a case one has polymorphic solvates. Kuhnert Brandstatter in her 1971 book showed photomicrographs of 16 solvates of estradiol [11]. Figure 1.6 shows the crystal structure of caffeine monohydrate. The crystal of caffeine is built up by stacking the layers shown in Figure 1.6 on top of each other. Thus the hydrate molecules are in tunnels in this solid form.

It is important to note that the FDA (Food and Drug Administration) has defined polymorphs as “different crystalline forms of the same drug substance. This may include solvation or hydration products (also known as pseudopolymorphs) and amorphous forms. Per the current regulatory scheme, different polymorphic forms are considered the same active ingredients.” Thus, for purposes of registration, scientists are directed to define polymorphs more broadly to include amorphous forms, solvates, and hydrates.

Cocrystals, that is, two component crystals, are another solid material of interest. Like solvates, the new crystalline structure imparts different properties including solubility, stability, and mechanical properties to the material. Of special interest are cocrystals with altered solubility or stability. Figure 1.7 shows the crystal structure of a cocrystal of phenol and 2-methoxy-4-nitrophenol–4-(dimethylamino)pyridine (2:1) [12]. The FDA has recently released a draft guidance defining cocrystals as “Solids that are crystalline materials composed of two or more molecules in the same crystal lattice.”

Pharmaceutical salts are substances formed by a reaction of an acid and a base. The FDA has suggested the following definition of salts as “Any of numerous compounds that result from replacement of part or all of the acid hydrogen of an acid by a metal or a radical acting like a metal: an ionic or electrovalent crystalline compound. Per the current regulatory scheme, different salt forms of the same active moiety are considered different active ingredients.” When a carboxylic acid reacts with an amine a salt is typically formed (Scheme 1.1). However, the degree of proton transfer can vary depending on the acidity and basicity of the reacting groups. The FDA definition seems to encompass all of these materials.

\[
\text{RCOOH} + \text{H}_2\text{N} - \text{R'} \rightarrow \text{RCOO}^- \cdots \text{H}_3\text{N}^+ - \text{R}
\]
Figure 1.8 shows the crystal structure of calcium tolfenamate trihydrate. It is clear that the unit cell is composed of regions containing mostly hydrocarbon functional groups and regions containing polar functionalities. This type of crystal packing is typical for salts.

1.3 ICH Q6A DECISION TREES

In 1995, Byrn et al. from Purdue University and the FDA published a paper using decision trees to describe a strategy to identify the best solid form early in development. In this way, it is possible to ensure uniformity of solid form in clinical trials and resolve solid-state issues before critical stages of development. The decision trees also suggested appropriate analytical methods for control. Four decision trees were presented: polymorphs, hydrates/solvates, desolvated solvates, and amorphous forms [14].

In the late 1990s, the ICH used a similar decision tree approach to describe how specification for the solid form in drug substances (API) and drug product should be determined. Several decision trees were presented in the ICH Q6A document including decision trees on particle size and polymorphs. The ICH utilized the broadened definition of polymorphs that includes hydrates, solvates, and amorphous forms. The ICH decision trees are divided into three questions as shown in Figures 1.9–1.11.

These three decision trees outline a strategy that is widely used during drug development. Most firms conduct an early polymorph screen to address question number 1. Once new forms have been identified, they are physically characterized (solubility, stability, melting point) and an effort is made to understand whether these differences in properties will affect drug product safety, performance, or efficacy. If the different solid forms can affect safety, efficacy, or performance then question 3 is addressed by determining whether drug product testing can detect changes in ratios of these forms. Additionally, the ratios of forms are monitored during stability studies to make sure changes that affect performance, safety, or efficacy do not occur. Using this strategy, it is possible to find the best solid form for development rapidly.

1.4 “BIG QUESTIONS” FOR DRUG DEVELOPMENT

In addition to selecting the solid form, Table 1.1 lists other critical issues/measurements required for drug development. Another way to think about drug development is to think of this process in terms of answering a series of questions we call the “Big Questions.” These must be answered to be
**FIGURE 1.9** ICH Q6A question 1 on polymorphs: Can different polymorphs be formed? *Source:* ICH Harmonized Tripartite Guideline, 1999. Reproduced with the permission of ICH.

**FIGURE 1.10** ICH Q6A question 2 on polymorphs: Do the forms have different properties (solubility, stability, melting point)? *Source:* ICH Harmonized Tripartite Guideline, 1999. Reproduced with the permission of ICH.
FIGURE 1.11 ICH Q6A question 3 on polymorphs: Does products performance testing provide adequate control if polymorph ratio changes (e.g., dissolution)? Source: ICH Harmonized Tripartite Guideline, 1999. Reproduced with the permission of ICH.

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<td>Chemical synthesis</td>
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<td>Salt selection (optional)</td>
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<tr>
<td>Assay/Impurities</td>
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<tr>
<td>Particle size</td>
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<tr>
<td>Physical characterization and properties</td>
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<tr>
<td>Dissolution/solubility</td>
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<td>Consistency</td>
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<td>Stability</td>
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<td>Validated methods/processes</td>
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able to develop a drug to clinical trials and beyond. These questions are as follows:

- What is the structure of the compound?
- What is the likely dose?
- What is the route of administration and desired dosage form?
- What is the indication?
- How difficult is it to synthesize?
- How soluble is the compound/formulation?
- How well is the compound absorbed? What is its BCS (Biopharmaceutical Classification System) class?
- What is the toxicology of the compound? What is its NOAEL (no-observed-adverse-effect-level)? What is its MTD (maximum tolerated dose)?
• What biomarkers are available to monitor clinical trials?
• What doses should be used for Phase 2 clinical trial?
• What are its solid-state properties and physical characterization?
• How chemically stable is the compound?
• How physically stable is the compound?
• How well will the powder flow?
• Is moisture an issue?
• What is the design, composition, and manufacturing procedure of the formulation/product?

As has already been discussed, the solubility of the compound is a critical quality attribute important for specifications and development. The solubility of a solid substance is the concentration at which the solution phase is in equilibrium with a given solid phase at a stated temperature and pressure. Under these conditions, the solid is neither dissolving nor continuing to crystallize. Note that the definition implies the presence of a specific solid phase. Once determined under the stated conditions, however, we can talk about the “solubility” of a given phase (e.g., a specific polymorph or pseudopolymorph) as a quantity, even in the absence of that solid phase. Use of the term “equilibrium” in connection with crystallizing systems requires clarification. When a substance exists in more than one crystal form, that is, when other polymorphs are possible, only the least soluble of these at a given temperature is considered the most physically stable form at that temperature, all others are considered to be metastable forms. In given cases, a solution of a substance may be in apparent equilibrium with one of these metastable phases for a long time, in which case, the system is in metastable equilibrium and is expressing the thermodynamic solubility of that solid form.

It is important to stress the difference between polymorphs and solvates (pseudopolymorphs) at this point. If a solvate/pseudopolymorph exists, it is always (with few exceptions) the most stable form in the solvent that produces the pseudopolymorph.

Undersaturation pertains to solutions at a lower concentration than the saturation value (i.e., diluted solutions). Crystals will dissolve in undersaturated solutions. Saturation is the state of a system where the solid is in equilibrium with the solution, or in other words, the solution will neither dissolve crystals nor let them grow (i.e., the concentration of the solution represents the solubility value for that crystalline phase). Supersaturation pertains to solutions that, for one reason or another (e.g., rapid cooling of a saturated solution without forming crystals), are at a higher concentration than the saturation value. Supersaturation is required for crystals to grow.

The solubility and permeability are combined to determine the BCS class (Table 1.2). BCS class I drugs dissolve easily and are easily transported into the blood stream because they are highly permeable with respect to the membranes in the gastrointestinal (GI) tract. BCS class III and IV drug have poor permeability and are generally difficult to develop. BCS class II drugs are of the greatest interest to pharmaceutical scientists because the structure of the solid, the formulation, its physical character, and many other factors are likely to have a significant effect on bioavailability and ultimately safety, performance, and efficacy. Several important drugs that are widely prescribed are BCS Class II including atorvastatin calcium, celecoxib, efavirenz, irbesartan, lopinavir, medroxyprogesterone acetate, raloxifene hydrochloride, simvastatin, and warfarin sodium. Of the marketed drugs nearly 70% are in BCS Class I or II with 31% being in BCS Class II. It has been estimated that as high as 80% of the drugs under development are BCS Class II.

### 1.5 ACCELERATING DRUG DEVELOPMENT

Accelerating drug development has been a goal of pharmaceutical scientists for many years. In 1995, Colin Gardner of Merck introduced a flow chart showing synthesis of the API and development of clinical supplies for first in human trials in 1 year. In this early flow chart, drug substance synthesis and process development were carried out in parallel with preformulation/formulation design/development and safety studies. Despite the early introduction of the concept that an IND (investigational new drugs) can be submitted in 1 year, it has been difficult to achieve this goal except in very favorable cases. One of the difficulties is the availability of API, and another one of the difficulties is accelerating toxicology studies.

In 2007, Aptuit/SSCI introduced their IND-I-GO (INDIGO) program offering fast development in a Contract Research Organization (CRO) environment. INDIGO was tailored to working with BCS Class II compounds and poorly soluble compounds. This INDIGO offering was supported by an example case study on the poorly soluble drug itraconazole and was summarized in a recent publication [15]. Additionally, Byrn et al. and Byrn and Henck outlined strategies based on solid-state chemistry for reducing development time [16, 17]. These publications contained much more detail on how to carry out screens and are discussed in more detail below. In this same timeframe, Chorus a Lilly-based firm focused on fast development introduced their strategy for
accelerated development to Phase II [18]. In this early publication, they suggested that it was possible to develop a compound to Phase II in 30 months for $3 million dollars in contrast to the industry average of 42 months and $30 million dollars. The Chorus approach involves a virtual company that heavily uses preferred CROs. Chorus has been quite successful, and Lilly has now established Chorus as an independent entity.

In this same timeframe, PricewaterhouseCoopers introduced a concept of limited launch with what they have termed a “live license” that permits a company to market a drug under very restricted conditions. In one manifestation of this concept, they suggested launch of a drug after 1.5 years. The details of this strategy are not clear, but it appears that the proposal involves introducing the drug for a limited population and then expanding use as clinical data allows. This, of course, would require the FDA to license drugs differently. The main point of this strategy for our context is that introduction of a medicine after 1.5 years would require very rapid development and very rapid FDA review. Regardless of the details, it is clear that the solid form, the formulation, the synthesis of the drug and all of the other critical steps outlined in Table 1.1 would have to be accomplished quite rapidly.

Regardless of the model it is clear that in the future, development must be accelerated. Accelerated development is especially dependent on the first year of activities. During the first year three critical steps must be accomplished. The drug must be synthesized. The toxicology must be determined to figure out the initial dose for first in human trials, and the solid form and formulation must be developed so that a medicine is available for first in human trials. This requires three groups to work together: API synthesis, toxicology, and pharmaceutical sciences. Figure 1.12 shows a detailed 52-week strategy.

The top three bars show the synthesis of the API. Depending on dose, several kilograms of API will be required for toxicology studies that are shown in the fourth bar. A key aspect of the toxicology study is the determination of the toxicology formulation. As pointed out by the Merck group, the toxicology formulation can be critical for poorly soluble drugs. If not enough of the drug can be dissolved then it is impossible to advance that lead [19]. The bottom four bars outline the formulation and manufacture of clinical supplies and the regulatory activities needed to file an IND. Engers and coworkers were able to meet the timelines in Figure 1.12 and develop a mock IND for itraconazole [15].

Even more acceleration of the development timeframe can be achieved if during the first year adaptive clinical trials are designed and biomarkers for the clinical trial endpoints are defined and assays for these biomarkers developed. Adaptive clinical trials allow merging of phase I and phase II studies and can sometimes accelerate proof of concept studies [20]. Adaptive clinical trials are often considered in two phases.

**FIGURE 1.12** Detailed 52-week strategy for accelerated drug development.
exploratory and confirmatory and use biomarkers. Biomarkers are quantifiable substances that can be correlated to a clinical response, for example, glucose for diabetes. Biomarkers can include genes, gene products, enzymes, cytokines, or even cells. Finding a biomarker can advance early decision making and accelerate clinical trials.

One of the goals of accelerated development is to eliminate compounds that are clinically unacceptable or cannot be developed early so that more resources are available to focus on compounds that are truly acceptable. For example, if a material is so insoluble its MAD (maximum absorbable dose) or MTD cannot be determined in animal studies then this must be determined as early as possible. Likewise if a compound has unacceptable neurotoxicity, this needs to be determined as early as possible. Thus, a strategy that focuses on the most soluble formulation early will provide important information in both of these cases. For this reason, some experts are suggesting that initial formulations should use amorphous forms.

1.6 SOLID-STATE CHEMISTRY IN PREFORMULATION AND FORMULATION

Figure 1.13 illustrates the important role that solid-state technology plays in the entire development process including research. In fact, a group from Merck (see above) in a Journal of Medicinal Chemistry review has advocated moving solid-state chemistry earlier and earlier in drug discovery in order to ensure that a developable solid form is discovered [19]. As mentioned above, the solid form is important in toxicology since an insoluble solid-state form will appear to be nontoxic, perhaps falsely. The solid form is important in dosage choice, the manufacturing process, purification, process development, and formulation. In some cases, product improvements and marketing can be facilitated by finding the best solid form. For example, the Kaletra product (containing lopinavir and ritonavir) is now marketed in an amorphous form that is stable and does not require refrigeration as did the previous soft gel capsule. Solid forms are quite important for patents and regulatory filings as discussed above. Finally, the stability of the product can be critically related to the solid form.

Particle size, like polymorphism, is one of the most critical aspects of solid-state chemistry. The incorrect particle size can cause a change in the rate of dissolution and affect safety, efficacy, and performance. Figure 1.14 shows a classic study

![Figure 1.13 Role of solid-state technology in the pharmaceutical industry.](image)

**FIGURE 1.13** Role of solid-state technology in the pharmaceutical industry.

![Figure 1.14 Effect of particle size on blood levels. Source: Miller and Fincher, 1971 [21]. Reproduced with the permission of Elsevier.](image)

of the effect of particle size of a suspension on blood levels of phenobarbital [21]. These data as well as the ICH Q6A document on specifications make it clear that particle size of APIs (drug substances) must be controlled especially if they are poorly soluble.

Figure 1.12 illustrates one possibility for when solid-state chemistry is done during preformulation and formulation design. During this study, it is important to find a form with acceptable aqueous solubility. In many cases, this means a form with fast kinetic solubility needs to be found. If possible, the high solubility should be maintained until the drug is absorbed from the GI tract. It may be necessary to use crystallization inhibitors to prevent premature precipitation of the solid form. Additionally, the solid form must be chemically stable enough to not decompose during an IND trial. An important goal is to find the form before the final step of the API synthesis. In this way the final form can be prepared in the last step. Additionally, if this can be achieved the same form can be used for both toxicology and for first in human studies.

After the first year additional solid-state and particle size studies will be needed. First, it will be important to confirm the results of the early solid-state studies. It is especially important to do some additional screening to confirm that the best solid form has been selected. There is time for additional salt screening studies and perhaps even cocrystal or nanocrystal screening studies. Furthermore, more complex formulations can be developed. For example, if possible a simple granulation process should be developed. Alternatively, a roller compaction procedure can be investigated.

In many cases, when the dose of drug is dissolved it will be in a supersaturated solution with respect to the most stable crystal form. Thermodynamically, there will be a tendency for this most stable form to crystallize. This system has been termed a supersaturating drug delivery system [22].

Screening is the approach to use to find the best solid form, a manufacturing process, and a crystallization inhibitor, if needed. Polymorph screening was suggested in the mid-1990s for regulatory purposes and to find the form that resulted in the most desirable bioavailability. During the intervening years it has become clear that screening is critical. In the early studies during the first year abbreviated screens should be used.

Solvents should include those used in the final crystallization steps and those used during formulation and processing such as water, methanol, ethanol, propanol, isopropanol, acetone, acetonitrile, ethyl acetate, hexane, and mixtures if appropriate. New crystal forms can often be obtained by cooling hot saturated solutions or partly evaporating clear saturated solutions. The solids produced are analyzed using X-ray diffraction and at least one of the other methods. In these analyses, care must be taken to show that the method of sample preparation (i.e., drying, grinding) has not affected the solid form.

Later, more complete screening studies are recommended. If a supersaturated solution is created it is important to screen for a crystallization inhibitor [22]. As indicated, screening is typically done for polymorphs including amorphous forms, salts, cocrystals, and nanoparticulate formulations.

In addition to screening and selection of the best solid form and optimization/control of particle size, preformulation experiments are also carried out. These experiments include determination of the partition coefficient (log $P$). This reflects the hydrophobicity of the drug and can be useful in determining the BCS class. The solubility of all available forms is determined as well as the degree of precipitation of any solid forms. Since solubility can depend on solid form, the solubility is typically determined in aqueous buffers, organic solvents, surfactants and perhaps cyclodextrins and lipids. Solubility can be difficult to determine and should be determined under equilibrium conditions. The solution and solid-state stability of the API is determined under stress conditions including extreme pH, temperature light, and humidity. This provides information on the intrinsic chemical stability of the system, and this knowledge is critical in formulation development. The $pK_a$ is also determined or calculated. This provides important information on the acidity or basicity of the material.

Once the initial solid form has been selected based on the above screening experiments, the stability of that form is determined under stress and accelerated conditions. This provides important information on how to handle that particular form. The dissolution properties of this form are also monitored. This provides important information on what might happen in the GI tract.

Figure 1.15 illustrates the importance of studying the dissolution rate of different forms [23]. In this study, the hydrate showed normal dissolution behavior reaching a solubility of about 6 mg/mL. In contrast, the anhydrate showed rapid kinetic dissolution to form a supersaturated solution. This solution then crystallized after about 100 s to the hydrate.

![Figure 1.15](image-url) Dissolution study of two different forms of theophylline. Source: Shetter and Higuchi, 1963 [23]. Reproduced with the permission of Elsevier.
At the end of the experiment (500 s), equilibrium had been reached and the solubilities of both forms were the same and equal to the hydrate form which was the solid form present.

Figure 1.16 shows a similar experiment by Nelson on salts of theophylline [24]. In this experiment, the timeframe was short enough that theophylline hydrate did not crystallize. This figure shows the rapid dissolution rate achieved by some salts. In fact, for some pharmaceutical salts, such as sodium phenytoin, a solubility enhancement of about 1,000,000 is achieved. This clearly shows the desirability of finding salt forms and explains why a very large number of drugs are developed as salts. Of course, salt forms are also known to greatly increase the bioavailability of solid forms.

A viable alternative to salt formation especially in cases where a salt cannot be formed is to develop an amorphous form/formulation. There are several products containing amorphous forms on the market including Kaletra and Sporonoxy. A review reports that amorphous formulations can result in as much as an 82× increase in bioavailability [25]. Law and coworkers reported greatly enhanced plasma concentrations of amorphous ritonavir over crystalline material. Ritonavir is one of the components in Kaletra [26]. Figure 1.17 shows the results of studies of a 2:1 HPMC-P:itraconazole dispersion in dogs [15]. Clearly, the dispersion results in a large increase in bioavailability.

Another alternative to salt formation is cocrystal formation. Figure 1.18 shows that a cocrystal enhanced the bioavailability of an amide containing API by about 4× [27].
In another interesting study of cocrystals, Childs and coworkers at SSCI showed that cocrystals of fluoxetine hydrochloride could be formed that had faster and slower dissolution rates than the parent [28]. This remains one of the only examples where cocrystals resulted in both enhanced and reduced dissolution rates.

Amorphous and cocrystalline formulations are classified as supersaturated drug delivery systems as discussed above. Crystallization inhibitors are sometime used to prevent premature crystallization for these formulations.

In addition to increasing solubility/dissolution rate, the solid form can influence a number of other properties important for formulation including milling, blending, tableting, dry filling, suspension formulation, and lyophilization. Transformations to other forms can also occur during these processes.

1.7 LEARNING BEFORE DOING AND QUALITY BY DESIGN

It is possible to achieve accelerated development using quality by design. Details are presented in Chapter 24. Figure 1.19 shows the quality by design wheel used by both the FDA and Pfizer. This wheel illustrates the importance of product design and process design. In effect, we have been discussing product design in this chapter. By using the optimum solid form, it is possible to design a product with the desired solubility. Once this has been achieved, the goal is to develop a formulation that optimizes other properties (e.g., flow) so that a viable product is available. Additionally, a process that can reproducibly make the formulation must be achieved. As outlined above often, with proper attention to the solid form a quality product can be designed rapidly. Thus, in many respects, quality by design is based on preformulation studies.

For early studies, a simple crystallization/amorphization process followed by filling a solid form in a capsule is often sufficient. This type of product can be manufactured from solid produced in a variety of ways including spray drying or crystallization followed by capsule filling using one of the commercially available automated capsule filling machines.

First, good analytical methods for physical characterization of the designed product must be developed. Then, critical sources of variability in the designed product need to be addressed: Is the solid form stable during its shelf life? What