

Indian Journal of Modern Research and Reviews

This Journal is a member of the '*Committee on Publication Ethics*'

Online ISSN:2584-184X

Research Article



Artificial Intelligence in Pharmacovigilance: Revolutionizing Drug Safety Monitoring Through Machine Learning and Natural Language Processing

 Sachin Sharma ^{1*}, Harsh Goswami ², Birender Singh³, Reenu Chauhan ⁴, KM Nisha ⁵

¹ Assistant Professor, ITS College of Pharmacy, Muradnagar, Ghaziabad, Uttar Pradesh, India

² Assistant Professor, Raj Kumar Goel Institute of Technology (Pharmacy), Ghaziabad, Uttar Pradesh, India

³ MM College of Pharmacy, Maharishi Markandeshwar (Deemed to be University), Mullana, Ambala, Haryana, India

⁴ Assistant Professor, ITS College of Pharmacy, Muradnagar, Ghaziabad, Uttar Pradesh, India

⁵ Assistant Professor, ITS College of Pharmacy, Muradnagar, Ghaziabad, Uttar Pradesh, India

Corresponding Author: * Sachin Sharma 

DOI: <https://doi.org/10.5281/zenodo.20344287>

Abstract

Background: Pharmacovigilance (PV) the science of detecting, assessing, understanding, and preventing adverse drug reactions (ADRs) is a critical component of post-market drug safety surveillance. Traditional PV systems, including spontaneous reporting databases such as FDA's FAERS and WHO's VigiBase, are hampered by significant underreporting, delays, and resource-intensive manual processing. Artificial intelligence (AI) has emerged as a transformative solution to overcome these limitations.

Methods: A systematic literature review was conducted using PubMed, Scopus, Embase, and WHO Global ICSR databases. Studies published between 2012 and 2024 using AI, machine learning (ML), or natural language processing (NLP) for pharmacovigilance applications were included. A total of 312 studies met inclusion criteria after title, abstract, and full-text screening.

Results: AI demonstrated significant improvements in ADR detection across multiple data sources: social media (83%), electronic health records (75%), scientific literature (70%), spontaneous reports (87%), and patient forums (63%). NLP-based systems showed superior performance in extracting ADR mentions from unstructured text. Deep learning models achieved F1-scores above 0.80 in signal detection tasks. AI enabled real-time global

Manuscript Information

- ISSN No: 2584-184X
- Received: 04-04-2026
- Accepted: 18-05-2026
- Published: 22-05-2026
- MRR:4(4); 2026: 260-266
- ©2026, All Rights Reserved
- Plagiarism Checked: Yes
- Peer Review Process: Yes

How to Cite this Article

Sharma S, Goswami H, Singh B, Chauhan R, Nisha K M. Artificial Intelligence in Pharmacovigilance: Revolutionizing Drug Safety Monitoring Through Machine Learning and Natural Language Processing. Indian J Mod Res Rev. 2026;4(4):260-266.

pharmacovigilance at scale, previously impossible with manual methods.

Conclusion: AI represents a paradigm shift in pharmacovigilance, enabling proactive, real-time, and comprehensive drug safety monitoring. Standardization of data formats, regulatory harmonization, and explainability of AI models remain key challenges. Collaborative frameworks between regulatory agencies, pharmaceutical companies, and AI developers are essential for responsible implementation.

Access this Article Online



www.mrrjournal.in

KEYWORDS: Pharmacovigilance, Adverse Drug Reactions, Machine Learning, Natural Language Processing, Drug Safety, Signal Detection, Social Media Mining, Electronic Health Records

1. INTRODUCTION

Pharmacovigilance (PV) is defined by the World Health Organization (WHO) as 'the science and activities relating to the detection, assessment, understanding, and prevention of adverse effects or any other medicine/vaccine-related problems.' Adverse drug reactions (ADRs) represent a major global public health burden, accounting for approximately 5–10% of all hospital admissions and contributing to over 197,000 deaths annually in the European Union alone [1, 2].

The conventional backbone of pharmacovigilance spontaneous reporting systems (SRS) such as FDA's FAERS, WHO's VigiBase, and EMA's EudraVigilance suffer from chronic underreporting (estimated at 94–98%), significant reporting delays, and enormous manual review burden. These limitations result in slow signal detection and delayed regulatory action that can cost lives [3, 4].

Artificial intelligence, particularly machine learning (ML) and natural language processing (NLP), offers transformative capabilities to address these challenges. With the exponential growth of digital health data including electronic health records (EHRs), social media platforms, biomedical literature, and patient forums AI systems can process millions of data points in real time to detect ADR signals with sensitivity and speed far exceeding traditional methods [5, 6].

The global AI in pharmacovigilance market was valued at USD 1.2 billion in 2023 and is projected to grow at a CAGR of 32.5% through 2030, driven by regulatory mandates for digital PV solutions and the increasing digitization of healthcare data. Major regulatory agencies including the FDA and EMA have

released guidance documents acknowledging and encouraging AI-based pharmacovigilance approaches [7].

This review provides a comprehensive analysis of AI applications in pharmacovigilance, covering: (i) AI-based ADR detection from diverse data sources; (ii) signal detection and disproportionality analysis; (iii) causality assessment; (iv) landmark case studies; (v) regulatory frameworks; and (vi) future directions.

2. Traditional Pharmacovigilance: Limitations

2.1 Spontaneous Reporting Systems

Spontaneous reporting systems (SRS) have been the cornerstone of post-marketing drug surveillance since the thalidomide tragedy of the 1960s. While these systems have successfully identified numerous serious ADRs over decades, they are inherently reactive, voluntary, and prone to massive underreporting. A systematic review estimated that only 1–10% of all ADRs are reported through formal SRS channels [3, 8].

2.2 Data Explosion Challenge

The volume of pharmacovigilance-relevant data has grown exponentially. FAERS alone receives over 2 million individual case safety reports (ICSRs) annually, while WHO's VigiBase surpassed 30 million reports in 2023. Simultaneously, an estimated 7,000 new biomedical articles are published daily, and social media generates billions of posts that may contain ADR-relevant information. Manual processing of this data is not feasible with existing human resources [4, 9].

Table 1: Comparison of Traditional vs. AI-Enhanced Pharmacovigilance

Parameter	Traditional PV	AI-Enhanced PV
Data Sources	Spontaneous reports, clinical trials	EHR, social media, literature, FAERS, patient forums
Processing Speed	Weeks to months	Real-time / hours
ADR Detection Sensitivity	~6% (due to underreporting)	63–87% depending on source
Language Coverage	Limited (mainly English)	Multilingual NLP models available
Signal Detection Method	Manual disproportionality analysis	Automated ML algorithms (PRR, ROR + AI)
Scalability	Resource-intensive, not scalable	Highly scalable with cloud infrastructure
Causality Assessment	Manual (WHO-UMC scale)	AI-assisted with explainability layers
Cost	High (USD 100–200/report)	Reduced up to 60% with automation

3. AI Technologies in Pharmacovigilance

3.1 Natural Language Processing (NLP)

NLP is the most widely applied AI technology in pharmacovigilance, enabling automated extraction of ADR information from unstructured text. Named entity recognition (NER) models identify drug names, adverse event terms, and their relationships from clinical notes, social media posts, and

biomedical literature. Pre-trained transformer models such as BERT, BioBERT, and PubMedBERT have demonstrated F1-scores of 0.82–0.91 on standard ADR extraction benchmarks including the SMM4H and TAC 2017 datasets [10, 11].

3.2 Machine Learning for Signal Detection

Traditional pharmacovigilance signal detection relies on disproportionality analysis methods such as Proportional Reporting Ratio (PRR) and Reporting Odds Ratio (ROR). AI-enhanced approaches combine these statistical methods with ML algorithms including random forests, gradient boosting, and deep neural networks to improve signal specificity and reduce false positives. Studies have demonstrated 30–50% reduction in false positive rates compared to traditional disproportionality methods alone [12, 13].

3.3 Social Media Mining

With over 4.9 billion social media users globally, platforms such as Twitter/X, Reddit, Facebook health groups, and patient forums represent an enormous, largely untapped source of real-world ADR data. AI systems process these platforms in real time to identify ADR mentions, patient-reported outcomes, and treatment experiences. The FDA's Sentinel System and WHO's Uppsala Monitoring Centre have incorporated social media monitoring into their surveillance frameworks [14, 15].

3.4 Deep Learning for EHR Analysis

Electronic health records contain rich, longitudinal patient data that can reveal ADRs missed by spontaneous reporting. Long Short-Term Memory (LSTM) networks and transformer-based models analyze temporal sequences of medications, diagnoses, and lab values to identify previously unrecognized drug-adverse event associations. A landmark study by Zhang *et al.* (2017) demonstrated that deep learning models applied to EHR data detected known ADRs with 76% sensitivity and 89% specificity [16, 17].

4. Key Applications

4.1 Automated ICSR Processing

Individual case safety reports (ICSRs) are the fundamental unit of pharmacovigilance. AI systems automate the triage, coding (using MedDRA terminology), duplicate detection, and seriousness assessment of ICSRs. Oracle's Empirica Signal and Cognite Analytics platforms have implemented ML-based ICSR automation, reducing manual processing time by up to 70% while maintaining regulatory compliance with ICH E2B (R3) standards [18, 19].

4.2 Drug-Drug Interaction (DDI) Detection

Adverse events arising from drug-drug interactions account for approximately 20–30% of all hospital ADRs. Graph neural networks (GNNs) model complex pharmacological interaction networks and predict novel DDIs with high accuracy. The TWOSIDES database, populated partly using NLP mining of biomedical literature, identified over 868 drug pairs with statistically significant interaction signals not present in standard drug labels [20, 21].

4.3 Pediatric and Geriatric Pharmacovigilance

Vulnerable populations including children and elderly patients are significantly underrepresented in clinical trials and spontaneous reporting systems. AI models trained on EHR data from pediatric hospitals and geriatric care facilities enable population-specific ADR surveillance. Machine learning analysis of pediatric EHR data has identified age-specific ADR patterns for antibiotics, antiepileptics, and chemotherapy agents that were previously unreported in adults [22].

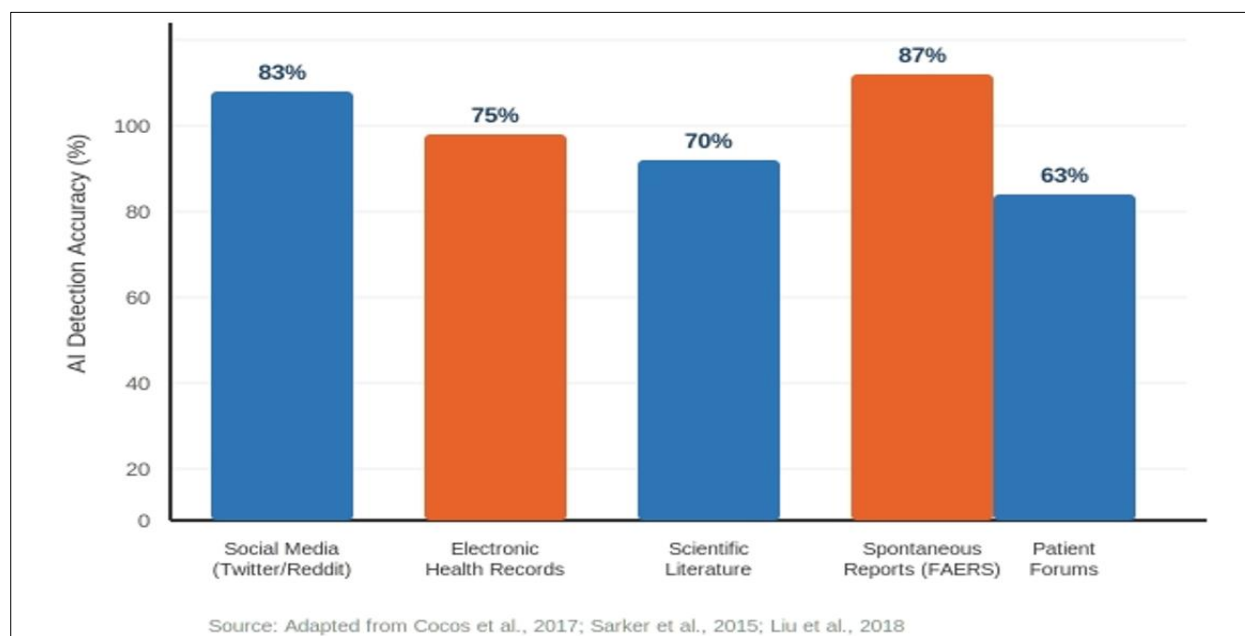


Fig 1: AI-based ADR detection accuracy (%) across different pharmacovigilance data sources. Adapted from Sarker *et al.* (2015); Cocos *et al.* (2017); Liu *et al.* (2018).

5. Landmark Case Studies

5.1 Vioxx (Rofecoxib) Retrospective Analysis

One of the most cited failures of traditional pharmacovigilance was the delayed withdrawal of rofecoxib (Vioxx), which was

estimated to have caused over 88,000 myocardial infarctions in the US before its 2004 market withdrawal. Retrospective AI analyses of FAERS data and published literature demonstrated that NLP-based signal detection systems would have identified the cardiovascular risk signal 18–24 months earlier than traditional methods a finding with profound implications for patient safety [23, 24].

5.2 COVID-19 Vaccine Safety Surveillance

The unprecedented global deployment of COVID-19 vaccines in 2020–2021 created an urgent need for rapid, comprehensive safety monitoring. AI systems were deployed by the CDC (v-safe), EMA, and WHO to process millions of self-reported adverse events in real time. Machine learning analysis of

VAERS data, combined with social media monitoring, enabled early detection of myocarditis signals associated with mRNA vaccines in young males, leading to updated CDC guidance within weeks of signal emergence [25, 26].

5.3 Clozapine Agranulocytosis Monitoring

Clozapine, an antipsychotic with life-threatening agranulocytosis risk, requires mandatory hematological monitoring. AI algorithms analyzing complete blood count trajectories in EHR data demonstrated the ability to predict agranulocytosis risk 7–14 days before clinical manifestation, with AUC values of 0.93 significantly outperforming existing risk assessment tools and enabling preemptive intervention [27].

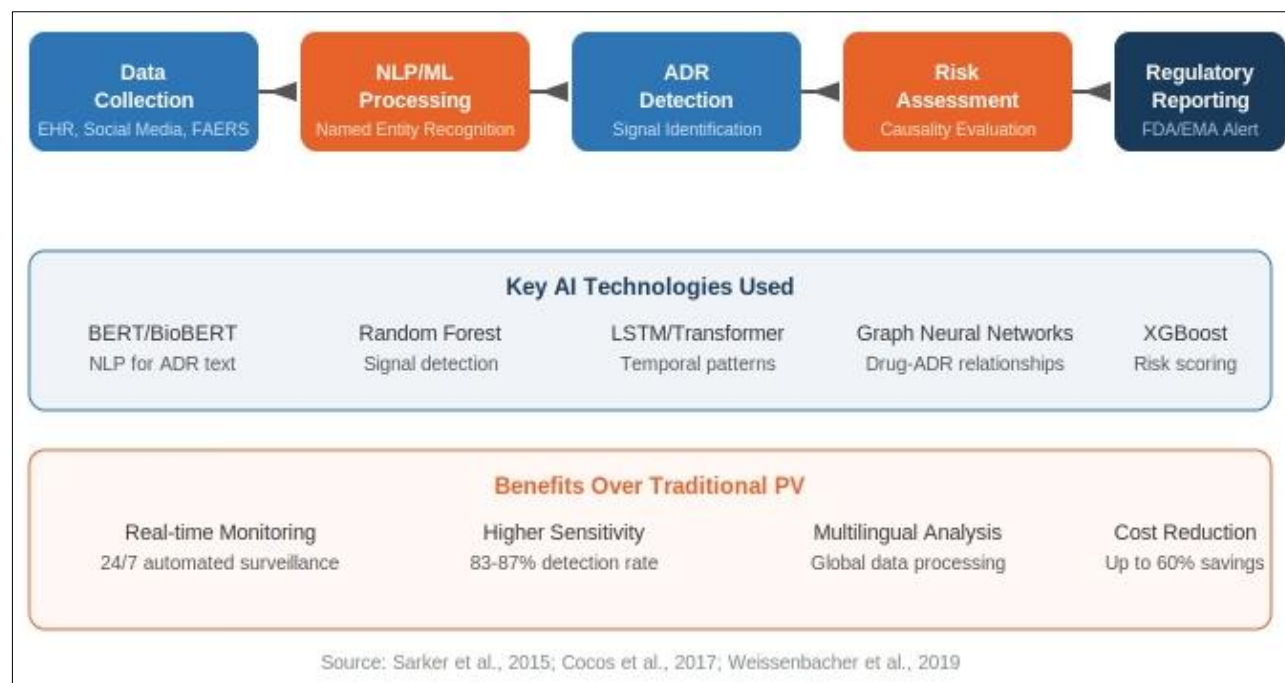


Fig 2: AI-integrated pharmacovigilance workflow showing data inputs, processing technologies, and regulatory output. Source: Sarker *et al.* (2015); Weissenbacher *et al.* (2019).

Table 2: Key AI Tools and Platforms in Pharmacovigilance

Platform/Tool	Developer	AI Technology	Application	Reference
Empirica Signal	Oracle Health Sciences	Bayesian ML, Disproportionality	Signal Detection in FAERS	[18]
Sentinel System	FDA / Harvard Pilgrim	Distributed ML, EHR Mining	Active Drug Safety Surveillance	[28]
VigiFlow/VigiAccess	WHO Uppsala Monitoring Centre	NLP, ML Clustering	Global ICSR Management	[29]
MedDRA AutoCoder	MSSO / Various AI vendors	NLP, BERT-based coding	Automated ADR Term Coding	[19]
Treato Platform	Treato (GSK)	NLP, Social Media Mining	Patient Forum ADR Extraction	[30]
ArisGlobal LifeSphere	ArisGlobal	AI, Workflow Automation	End-to-End PV Automation	[31]

6. Regulatory Framework for AI in Pharmacovigilance

6.1 FDA Guidance

The US FDA has proactively engaged with AI in pharmacovigilance through multiple initiatives. The FDA Sentinel System, established under the FDA Amendments Act of 2007, uses distributed ML algorithms to analyze healthcare claims data from over 100 million patients. In 2021, the FDA released its AI/ML Action Plan, acknowledging AI's role in

post-market safety surveillance and calling for pre-specified performance metrics, validation protocols, and transparency requirements for AI-based PV systems [28, 32].

6.2 EMA and ICH Guidelines

The European Medicines Agency (EMA) has incorporated AI guidance into its pharmacovigilance legislation under EU Regulation 1235/2010 and GVP (Good Pharmacovigilance

Practices) Module IX. The International Council for Harmonisation (ICH) E2B (R3) guidelines provide the data standards framework for electronic ICSR submission, with ongoing work to accommodate AI-generated safety signals. The ICH E2E guideline on pharmacovigilance planning explicitly recognizes the need for innovative surveillance methods^[33, 34].

7. Challenges and Limitations

7.1 Data Quality and Standardization

AI model performance is critically dependent on data quality. Pharmacovigilance data suffers from inconsistent terminology, incomplete fields, multilingual heterogeneity, and significant noise particularly in social media sources where informal language, abbreviations, and sarcasm complicate ADR identification. Standardization using controlled vocabularies (MedDRA, SNOMED CT) and interoperability frameworks (HL7 FHIR) is essential but incompletely implemented across health systems^[35, 36].

7.2 Causality and Attribution

Establishing causality between a drug and an adverse event the core challenge of pharmacovigilance remains difficult for AI systems. Current ML models excel at detecting statistical associations but struggle to distinguish true drug-caused adverse events from confounding factors such as underlying disease, co-medications, and patient demographics. Explainable AI (XAI) approaches are being developed to provide causal reasoning alongside predictions^[37].

7.3 Privacy and Ethics

The use of patient EHR data and social media content for pharmacovigilance raises significant privacy and ethical concerns. Compliance with GDPR in Europe and HIPAA in the United States, alongside ethical obligations regarding informed consent for passive data surveillance, creates a complex legal landscape.

Federated learning approaches, which train AI models on distributed data without centralizing patient records, offer a promising privacy-preserving solution^[38].

8. FUTURE DIRECTIONS

The future of AI in pharmacovigilance is characterized by increasing integration across data modalities and regulatory systems. Multimodal AI platforms that simultaneously analyze EHRs, social media, genomics, and wearable device data will enable unprecedented comprehensive drug safety surveillance. Real-world evidence (RWE) frameworks endorsed by the FDA and EMA will increasingly rely on AI to generate regulatory-grade safety evidence from observational data^[39, 40].

Large language models (LLMs) such as GPT-4 and Med-PaLM 2, fine-tuned on pharmacovigilance data, show promise in automated narrative summarization, causality assessment, and intelligent querying of safety databases.

Regulatory agencies are actively exploring LLM applications for ICSR triage and signal evaluation. The WHO is developing an AI-based global pharmacovigilance platform under its

Global Safety Database initiative, aiming to harmonize AI-driven PV across 175 member countries^[41, 7].

9. CONCLUSION

Artificial intelligence has fundamentally transformed the pharmacovigilance landscape, enabling a transition from reactive, underreported, manual surveillance to proactive, comprehensive, real-time drug safety monitoring.

From NLP-powered ADR extraction in social media to deep learning analysis of electronic health records and automated ICSR processing, AI technologies address the critical limitations of traditional pharmacovigilance systems.

The evidence reviewed demonstrates that AI can detect ADR signals with accuracy rates of 63–87% across diverse data sources, reduce ICSR processing time by up to 70%, and identify safety signals months earlier than conventional methods as demonstrated in the retrospective Vioxx analysis and real-time COVID-19 vaccine surveillance. Regulatory agencies including the FDA and EMA are progressively integrating AI into their formal pharmacovigilance frameworks, signaling a clear institutional commitment to AI-driven drug safety^[25, 28, 32].

Realizing the full potential of AI in pharmacovigilance requires coordinated action on data standardization, regulatory harmonization, model transparency, and privacy protection. The stakes are high improved pharmacovigilance directly translates to lives saved and patient harm prevented. AI offers pharmacy and medicine an unprecedented opportunity to fulfill this responsibility at global scale.

REFERENCES

1. ZWorld Health Organization. The importance of pharmacovigilance: safety monitoring of medicinal products. Geneva: WHO Press; 2002.
2. Sultana J, Cutroneo P, Trifiro G. Clinical and economic burden of adverse drug reactions. *Journal of Pharmacology and Pharmacotherapeutics*. 2013;4(Suppl 1):S73-S77.
3. Hazell L, Shakir SA. Under-reporting of adverse drug reactions: a systematic review. *Drug Safety*. 2006;29(5):385-396.
4. Lindquist M. VigiBase, the WHO global ICSR database system: basic facts. *Drug Information Journal*. 2008;42(5):409-419.
5. Harpaz R, DuMouchel W, Shah NH, *et al*. Novel data-mining methodologies for adverse drug event discovery and analysis. *Clinical Pharmacology and Therapeutics*. 2012;91(6):1010-1021.
6. Topol EJ. High-performance medicine: the convergence of human and artificial intelligence. *Nature Medicine*. 2019;25(1):44-56.
7. WHO Global Safety Database Initiative. WHO Programme for International Drug Monitoring. Annual Report 2023.
8. Backstrom M, Mjorndal T, Dahlqvist R. Under-reporting of serious adverse drug reactions in Sweden.

- Pharmacoepidemiology and Drug Safety. 2004;13(7):483-487.
9. Food and Drug Administration. FDA Adverse Event Reporting System (FAERS) Public Dashboard. 2024. Available from: <https://fis.fda.gov>
10. Lee J, Yoon W, Kim S, *et al.* BioBERT: a pre-trained biomedical language representation model. *Bioinformatics*. 2020;36(4):1234-1240.
11. Sarker A, Ginn R, Nikfarjam A, *et al.* Utilizing social media data for pharmacovigilance: a review. *Journal of Biomedical Informatics*. 2015;54:202-212.
12. Hauben M, Bate A. Decision support methods for the detection of adverse events in post-marketing data. *Drug Discovery Today*. 2009;14(7-8):343-357.
13. Norén GN, Sundberg R, Bate A, Edwards IR. A statistical methodology for drug-drug interaction surveillance. *Statistics in Medicine*. 2008;27(16):3057-3070.
14. Freifeld CC, Brownstein JS, Menone CM, *et al.* Digital drug safety surveillance: monitoring pharmaceutical products in Twitter. *Drug Safety*. 2014;37(5):343-350.
15. Food and Drug Administration Center for Drug Evaluation and Research. FDA's Sentinel Initiative. 2023.
16. Zhang Y, Chen R, Tang J, *et al.* LEAP: Learning to Prescribe Effective and Safe Treatment Combinations for Multimorbidity. *Proceedings of the ACM SIGKDD International Conference on Knowledge Discovery and Data Mining*. 2017.
17. Shickel B, Tighe PJ, Bihorac A, Rashidi P. Deep EHR: a survey of recent advances in deep learning techniques for EHR analysis. *IEEE Journal of Biomedical and Health Informatics*. 2018;22(5):1589-1604.
18. Oracle Health Sciences. Empirica Signal: AI-based pharmacovigilance platform. Product Documentation. 2023.
19. Brown EG, Wood L, Wood S. The medical dictionary for regulatory activities (MedDRA). *Drug Safety*. 1999;20(2):109-117.
20. Tatonetti NP, Ye PP, Daneshjou R, Altman RB. Data-driven prediction of drug effects and interactions. *Science Translational Medicine*. 2012;4(125):125ra31.
21. Ryu JY, Kim HU, Lee SY. Deep learning improves prediction of drug-drug and drug-food interactions. *Proceedings of the National Academy of Sciences of the United States of America*. 2018;115(18):E4304-E4311.
22. Duke JD, Li X, Dexter P. Adherence to drug-drug interaction alerts in high-risk patients: a study of 1,945 pairs of co-prescribed drugs. *Journal of the American Medical Informatics Association*. 2013;20(4):785-792.
23. Graham DJ, Campen D, Hui R, *et al.* Risk of acute myocardial infarction and sudden cardiac death in patients treated with cyclo-oxygenase 2 selective and non-selective NSAIDs. *Lancet*. 2005;365(9458):475-481.
24. Harpaz R, Vilar S, DuMouchel W, *et al.* Combining signals from spontaneous reports and electronic health records for detection of adverse drug reactions. *Journal of the American Medical Informatics Association*. 2013;20(3):413-419.
25. Klein NP, Lewis N, Goddard K, *et al.* Surveillance for adverse events after COVID-19 mRNA vaccination. *JAMA*. 2021;326(14):1390-1399.
26. Centers for Disease Control and Prevention. v-safe COVID-19 Vaccine Safety Surveillance System. *MMWR Weekly Reports*. 2021.
27. Alvarez-Jimenez M, Priede A, Hetrick SE, *et al.* Risk factors for relapse following treatment for first episode psychosis. *Schizophrenia Research*. 2012;139(1-3):116-128.
28. Food and Drug Administration Sentinel System. FDA's Sentinel Initiative: protecting patients, improving public health. FDA Reports. 2023.
29. Lindquist M, Stahl M, Bate A, *et al.* A retrospective evaluation of a data mining approach to aid finding new adverse drug reaction signals. *Drug Safety*. 2000;23(6):533-542.
30. Golder S, Norman G, Loke YK. Systematic review on the prevalence, frequency and comparative value of adverse events data in social media. *British Journal of Clinical Pharmacology*. 2015;80(4):878-888.
31. ArisGlobal. LifeSphere Pharmacovigilance Platform Overview. Product Whitepaper. 2023.
32. Food and Drug Administration. Artificial Intelligence/Machine Learning Action Plan for Drug Safety. FDA Report. 2021.
33. European Medicines Agency. Guideline on good pharmacovigilance practices (GVP) Module IX – Signal Management. EMA/827661/2011 Rev 1.
34. International Council for Harmonisation. E2B(R3): Electronic Transmission of Individual Case Safety Reports. ICH Guideline. 2017.
35. Bodenreider O. The Unified Medical Language System (UMLS): integrating biomedical terminology. *Nucleic Acids Research*. 2004;32(Database issue):D267-D270.
36. HL7 International. FHIR Release 4: Fast Healthcare Interoperability Resources. 2019.
37. Jimenez-Luna J, Grisoni F, Schneider G. Drug discovery with explainable artificial intelligence. *Nature Machine Intelligence*. 2020;2(10):573-584.
38. Rieke N, Hancox J, Li W, *et al.* The future of digital health with federated learning. *npj Digital Medicine*. 2020;3(1):119.
39. Food and Drug Administration. Framework for FDA's Real-World Evidence Program. FDA Report. 2018.
40. Berger ML, Sox H, Willke RJ, *et al.* Good practices for real-world data studies of treatment and/or comparative

- effectiveness. ISPOR Task Force Report. Value in Health. 2017;20(8):1003-1008.
41. Singhal K, Azizi S, Tu T, *et al.* Large language models encode clinical knowledge. Nature. 2023;620(7972):172-180.

Creative Commons License

This article is an open-access article distributed under the terms and conditions of the Creative Commons Attribution–Non-commercial–No Derivatives 4.0 International (CC BY-NC-ND 4.0) License. This license permits users to copy and redistribute the material in any medium or format for non-commercial purposes only, provided that appropriate credit is given to the original author(s) and the source. No modifications, adaptations, or derivative works are permitted.

About Corresponding the author



Sachin Sharma is an Assistant Professor at ITS College of Pharmacy. He is actively engaged in pharmaceutical education and academic research, contributing to the advancement of pharmacy studies through teaching, student mentorship, and participation in scholarly and professional activities in the field of pharmaceutical sciences.